NHS
Nottingham and Nottinghamshire

Integrated Care Board Meeting Agenda (Open Session)

Thursday 10 November 2022 09:00 – 12:00

Chappell Meeting Room, Arnold Civic Centre
Arnot Hill Park, Arnold, NG5 6LU

"We will enable each and every citizen to enjoy their best possible health and wellbeing."

Principles:

- We will work with, and put the needs of, our **citizens** at the heart of the ICS.
- We will be **ambitious** for the health and wellbeing of our local population.
- We will work to the principle of **system by default**, moving from operational silos to a system wide perspective.

Values:

- We will be **open** and **honest** with each other.
- We will be **respectful** in working together
- We will be **accountable**, doing what we say we will do and following through on agreed actions.

	Item	Presenter	Type	Time
Introductory items				
1.	Welcome, introductions and apologies	Kathy McLean	Verbal	09:00
2.	Confirmation of quoracy	Kathy McLean	Verbal	
3.	Declaration and management of interests	Kathy McLean	Paper	
4.	Minutes from the meeting held on: 08 September 2022	Kathy McLean	Paper	
5.	Action log and matters arising from the meeting held on: 08 September 2022	Kathy McLean	Paper	
Leadership				
6.	Chair's Report	Kathy McLean	Paper	09:05
7.	Chief Executive's Report	Amanda Sullivan	Paper	09:20
Health inequalities and outcomes				
8.	Nottingham and Nottinghamshire ICS Primary Care Strategy	Dave Briggs	Paper	09:35
9.	Strategic approach to transforming health and care for people with mental health needs	Lucy Dadge	Paper	09:55
10.	Strategic approach to transforming health and care for children and young people	Lucy Dadge	Paper	10:15
11.	ICS Health Inequalities Plan	Dave Briggs	Paper	10:35

10-minute comfort break

Assurance and system oversight

12.	Integrated Performance Report		Paper	11:05
	a) Finance	Stuart Poynor		
	b) Service Delivery	Stuart Poynor		
	c) Health Inequalities	Dave Briggs		
	d) Quality	Rosa Waddingham		
	e) Workforce	Rosa Waddingham		
13.	Committee Highlight Reports		Paper	11:25
	a) Strategic Planning and Integration	Jon Towler		
	b) Quality and People	Marios Adamou		
	c) Finance and Performance	Stephen Jackson		
	d) Audit and Risk	Caroline Maley		
14.	Board Assurance Framework	Lucy Branson	Paper	11:35

Closing items

15.	Risks identified during the course of the meeting	Kathy McLean	Verbal	11:50
16.	Questions from the public relating to items on the agenda	Kathy McLean	Verbal	
17.	Any other business	Kathy McLean	Verbal	

Confidential Motion:

The Board will resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1[2] Public Bodies [Admission to Meetings] Act 1960)

Date and time of next Board meeting held in public: 12 January 2023 at 9:00 (Arnold Civic Centre)

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	10/11/2022
Paper Title:	**Declaration and management of interests**
Paper Reference:	ICB 22 031
Report Author:	Jo Simmonds, Head of Corporate Governance
Report Sponsor:	Lucy Branson, Associate Director of Governance
Presenter:	Kathy McLean, Chair
Recommendation(s):	The Board is asked to **RECEIVE** this item.

Summary:

As custodians of tax-payers money, Integrated Care Boards (ICBs) are required to implement and demonstrate robust arrangements for the identification and management of conflicts of interest. These arrangements should support good judgement about how any interests should be approached and managed; safeguarding the organisation from any perception of inappropriateness in its decision-making and assuring the public that money is being spent free from undue influence. The ICB's arrangements for the management of conflicts of interests are set out in the organisation's Standards of Business Conduct Policy.

Details of the declared interests for members of the Board are attached at **Appendix A**. An assessment of these interests has been performed against the meeting agenda and the outcome is recorded in the section below on conflicts of interest management.

Members are also reminded of their individual responsibility to highlight any interests not already declared should a conflict (or potential conflict) become apparent in discussions during the meeting. Should any interests arise during the meeting, the ICB's agreed arrangements for managing these are provided for reference at **Appendix B**.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	It is essential that the ICB establishes effective arrangements for managing conflicts and potential conflicts of interest to ensure that they do not, and do not appear to, affect the integrity of the ICB's decision-making processes towards the achievement of the four core aims.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:

Appendix A: Extract from the ICB's Register of Declared Interests for members of the Strategic Planning and Integration Committee.

Appendix B: Managing Conflicts of Interests at Meetings.

Board Assurance Framework:
Not applicable to this report.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	No
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	No
Duties as to reducing inequalities	No
Duty to promote involvement of each patient	No
Duty as to patient choice	No
Duty to obtain appropriate advice	No
Duty to promote innovation	No
Duty in respect of research	No
Duty to promote education and training	No
Duty to promote integration	No
Duty to have regard to the wider effect of decisions	No
Duties as to climate change	No
Duties regarding public involvement and consultation	No
Public sector equalities duties	No

Report Previously Received By:
Not applicable to this report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Register of Declared Interests

• As required by section 14Z30 of the NHS Act 2006 (as amended), the ICB has made arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interests.

• This document is extracted, for the purposes of this meeting, from the ICB's full Register of Declared Interests.

• The register is reviewed in advance of the meeting to ensure the consideration of any known interests in relation to the meeting agenda. Where necessary (for example, where there is a direct financial interest), members may be fully excluded from participating in an item and this will include them not receiving the paper(s) in advance of the meeting.

• Members and attendees are reminded that they can raise an interest at the beginning of, or during discussion of, an item if they realise that they do have a (potential) interest that hasn't already been declared.

Name	Current position(s) held in the ICB	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To:	Action taken to mitigate risk
ADAMOU, Marios	Non-Executive Director	South West Yorkshire Partnership NHS Foundation Trust	Employed as a Consultant Psychiatrist	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ADAMOU, Marios	Non-Executive Director	Marios Adamou LTD - providng eductional and advisory services	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ADAMOU, Marios	Non-Executive Director	University of Huddersfield	Visiting Professor			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ADAMOU, Marios	Non-Executive Director	National Institute for Health and Care Research	Member of Health Technology Assessment Prioritisation Committee			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
BRIGGS, David	Medical Director	British Medical Associaton	Member		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Mid Nottinghamshire and Greater Nottingham Lift Co (public sector)	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Valley Road Surgery	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Nottingham Schools Trust	Chair and Trustee			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Care Workers Union	Director (not remunerated)			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Cleaners Union	Director (not remunerated)			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Nottingham Business Improvement District (BID)	Non-Executive Chair		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Nottingham High School	Governor		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Portland College	Governor		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Marketing Nottingham	Non-Executive Director		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.

Name	Current position(s) held in the ICB	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To:	Action taken to mitigate risk
JACKSON, Stephen	Non-Executive Director	Derbyshire Health United CIC	Non-Executive Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	IBC Ltd (currently inactive)	Joint Owner and Chief Executive Officer	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Ravenshead Surgery (Abbey Medical Group)	Registered patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LIM, Dr Kelvin	Primary Care Partner Member	Primary Integrated Community Services	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LIM, Dr Kelvin	Primary Care Partner Member	NEMS	Shareholder	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LIM, Dr Kelvin	Primary Care Partner Member	Church Walk Medical Services	Shareholder	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LIM, Dr Kelvin	Primary Care Partner Member	Eastwood Primary Care Centre	GP Partner	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LIM, Dr Kelvin	Primary Care Partner Member	Eastwood Primary Care Centre	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MALEY, Caroline	Non-Executive Director	Village Health Group	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	University Hospitals of Derby and Burton NHS Foundation Trust	Trust Chair	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Treetops Hospice	Spouse is a trustee of Treetops Hospice				✓	01/07/2022	30/06/2022	Interest expired - no action required. .
MCLEAN, Kathy	ICB Chair	Kathy McLean Limited - Private limited company to offer health related advice	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Barts Health NHS Trust (London)	Non-Executive Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS Employers	Chair of the national negotiation committee for Staff and Associate Specialists on behalf of NHS Employers		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Care Quality Commission (CQC)	Occasional Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Public Sector Consultancy	Senior Clinical Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS England/Improvement	Lay Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NEMS Healthcare Ltd	Spouse is shareholder				✓	01/07/2022	30/06/2022	Interest expired - no action required. .
MCLEAN, Kathy	ICB Chair	NHS Providers Board	Trustee		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
POYNOR, Stuart	Director of Finance	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable

Name	Current position(s) held in the ICB	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To:	Action taken to mitigate risk
ROBINSON, Paul	NHS Trust and NHS Foundation Trust Partner Member	Sherwood Forest Hospitals NHS Foundation Trust	Chief Executive	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
SULLIVAN, Amanda	Chief Executive	Hillview Surgery	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
TOWLER, Jon	Non-Executive Director	Sherwood Medical Practice	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
TOWLER, Jon	Non-Executive Director	Major Oak Medical Practice, Edwinstowe	Family members are registered patients				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
TOWLER, Jon	Non-Executive Director	YPO - a publicly owned central purchasing body based in Wakefield, Yorkshire. It is owned and governed by a consortium of county, metropolitan and borough councils in Yorkshire and the North West England. It provides a wide range of resources and services to schools, councils, charities, emergency services, and other public sector organisations.	Independent Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
UNDERWOOD, Catherine	Local Authority Partner Member	Nottingham City Council	Corporate Director of People	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
WADDINGHAM, Rosa	Director of Nursing	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
WILLIAMS, Melanie	Local Authority Partner Member	Nottinghamshire County Council	Corporate Director for Adult Social Care and Health	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
The following individuals will be in attendance at the meeting but are not part of the Board's membership:										
BRANSON, Lucy	Associate Director of Governance	St George's Medical Practice	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
NEWHAM, Anne-Maria	Deputy Partner Member	Nottinghamshire Healthcare NHS Foundation Trust	Interim Chief Executive Officer	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
NEWHAM, Anne-Maria	Deputy Partner Member	Nurture Care	Senior Advisor on Board		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ROYLES, Dean	Interim People and Culture SRO	KPMG	Associate	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ROYLES, Dean	Interim People and Culture SRO	Healthcare People Management Association	President		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.

Appendix B

NHS
Nottingham and Nottinghamshire

Managing Conflicts of Interest at Meetings

1. A conflict of interest is defined as a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.
2. An individual does not need to exploit their position or obtain an actual benefit, financial or otherwise, for a conflict of interest to occur. In fact, a perception of wrongdoing, impaired judgement, or undue influence can be as detrimental as any of them actually occurring. It is important to manage these perceived conflicts in order to maintain public trust.
3. Conflicts of interest include:
    - Financial interests: where an individual may get direct financial benefits from the consequences of a commissioning decision.
    - Non-financial professional interests: where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their reputation or status or promoting their professional career.
    - Non-financial personal interests: where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit.
    - Indirect interests: where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision.
    - Loyalty interests: where decision making is influenced subjectively through association with colleagues or organisations out of loyalty to the relationship they have, rather than through an objective process.

    The above categories are not exhaustive, and each situation must be considered on a case-by-case basis.
4. In advance of any formal meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals.
5. At the beginning of each formal meeting, members and others attending the meeting will be required to declare any interests that relate specifically to a

particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting.

6. The Chair of the meeting (or person presiding over the meeting) will determine how declared interests should be managed, which is likely to involve one the following actions:

    - Requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to decision-making arrangements.
    - Allowing the individual to participate in the discussion, but not the decision-making process.
    - Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to decision-making arrangements.
    - Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.

Integrated Care Board (Open Session)
Unratified minutes of the meeting held on
08/09/2022 09:30-11:50
Chappell Room, Civic Centre, Arnot Hill Park

Members present:	
Dr Kathy McLean	Chair
Professor Marios Adamou	Non-Executive Director
Lucy Dadge	Director of Integration
Dr Dave Briggs	Medical Director
Stephen Jackson	Non-Executive Director
Caroline Maley	Non-Executive Director
Stuart Poynor	Director of Finance
Paul Robinson	NHS Trust/Foundation Trust Partner Member
Amanda Sullivan	Chief Executive
Jon Towler	Non-Executive Director
Catherine Underwood	Local Authority Partner Member
Rosa Waddingham	Director of Nursing
Melanie Williams	Local Authority Partner Member
In attendance:	
Lucy Branson	Associate Director of Governance
Anne-Maria Newham	Deputy NHS Trust/Foundation Trust Partner Member
Sue Wass	Corporate Governance Officer (minutes)
Apologies:	
Dr Kelvin Lim	Primary Care Partner Member

Cumulative Record of Members' Attendance (2022/23)

Name	Possible	Actual	Name	Possible	Actual
Kathy McLean	2	2	Stuart Poynor	2	2
Marios Adamou	2	2	Paul Robinson	2	1
John Brewin	1	0	Amanda Sullivan	2	2
Dave Briggs	2	2	Jon Towler	2	2
Lucy Dadge	2	2	Catherine Underwood	2	1
Stephen Jackson	2	2	Rosa Waddingham	2	2
Kelvin Lim	2	0	Melanie Williams	2	2
Caroline Maley	2	1			

Introductory items

ICB 22 013 **Welcome, introductions and apologies**

Kathy McLean welcomed members to the meeting of the Board. A round of introductions was undertaken and apologies were noted as above.

ICB 22 014 **Confirmation of quoracy**

The meeting was confirmed as quorate.

ICB 22 015 **Declaration and management of interests**

No interests were declared in relation to any item on the agenda. The Chair reminded members of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.

ICB 22 016 **Minutes from the meeting held on: 01 July 2022**

The minutes were agreed as an accurate record of the discussions held.

ICB 22 017 **Action log and matters arising from the meeting held on: 01 July 2022**

The one action from the last meeting was confirmed as complete.

Leadership

ICB 22 018 **Chair's Report**

Kathy McLean presented the item and highlighted the following points:

a) Following the establishment of the Integrated Care Board (ICB) in July, it was important for all partners to continue to see themselves as part of the system. This enthusiasm was very much in evidence at the 'Together we are Notts' event, which brought people together from across the system including NHS, local authority, and voluntary and community organisations. This had been an opportunity to showcase expertise, experience, and efficiencies across acute, community and primary care. A further event will be planned for later in the year.

b) The inaugural meeting of the Integrated Care Partnership would be held on 16 September. The focus of the meeting would be to discuss and agree the approach to developing an Integrated Care Strategy for the system. A steering group would sit under the Partnership to drive development of the strategy, which would build

on the existing Health and Wellbeing Boards' strategies. A wider assembly of partners would also meet on 25 October to shape the Strategy's development.

c) An initial work programme for the Board had been drafted to ensure its responsibilities can be discharged effectively. As this was the first period of operation for the ICB, it would remain subject to ongoing review and change over the coming months as new ways of working evolve and embed.

The following points were made in discussion:

d) Members requested that citizen stories be incorporated into the Board's work programme.

The Board **RECEIVED** the Chair's Report.

ACTION: Lucy Branson to update the Board's work programme to include citizen stories.

ICB 22 019 Chief Executive's Report

Amanda Sullivan presented the item and highlighted the following points:

a) The system continued to operate under significant pressure, with several factors impacting on services, including a rise in Covid infections, staff absence and vacancies. A critical incident had been declared on 26 July, which required actions from all partners to be taken to ensure safe services; and it was stood down at the earliest opportunity. Learning from the incident had been incorporated into preparations for winter.

b) The autumn vaccination programme had commenced, and, as in previous roll outs, the first wave would focus on over 75s and frontline health and social care workers. Flu vaccines would also be available to everyone aged over 50. Evidence from the southern hemisphere had indicated a high prevalence of flu; and it was important that citizens were protected against both dangerous significant as winter approached. The Nottingham and Nottinghamshire Covid Vaccination Programme had won two awards at an event held by NHS Midlands on 12 July 2022.

c) The rising cost of living could also potentially have an adverse impact on health, particularly respiratory health; and in these unprecedented times partners were being brought together to

identify if any further support that could be given to prevent ill health over the winter period.

d) Over the summer period the Board's urgent decision-making powers had been used on two occasions where rapid decisions had been required. Due to exceptional circumstances, the inaugural meeting of the Board had not been quorate, and several decisions required the formal ratification of the Board; and as part of winter planning preparations, expenditure had been agreed for a system-wide Discharge to Assess model. These decisions were presented for formal ratification.

Melanie Williams joined the meeting at this point.

e) The establishment of local arrangements for engaging with citizens and communities was progressing well and positive feedback on the ICB's approach had been received from NHS England.

f) Discussion with NHS England on a Memorandum of Understanding was nearing completion and would be brought to the next meeting for information. This would set out how the ICB and NHS England would work together to address development-specific needs across the Integrated Care System (ICS).

g) The final Annual Reports and Accounts for the former NHS Bassetlaw CCG and NHS Nottingham and Nottinghamshire CCG were presented. Both organisations had achieved their statutory financial duties, received Head of Internal Audit Opinions providing significant assurance and had no significant control issues to report.

h) A Digital Charter had been signed by all system partners to aid the development and administration of collaborative digital projects.

i) Recent appointments were noted. A new Chief Executive had been announced at Nottinghamshire Healthcare NHS Foundation Trust, Ifti Majid; and Karen Tomlinson had been appointed as Chair of the East Midlands Ambulance Service NHS Trust.

j) The ICB was engaged in discussion with NHS England on how its new operating model would work in practice at the local level.

The following points were made in discussion:

k) Members discussed the possible implications and opportunities of the new operating model for NHS England. On balance, it was seen as an opportunity to reduce duplication.

l) Members discussed the prolonged pressures on health and social care staff and queried how the system could help to retain and support its workforce. It was noted that it was helpful that

colleagues had a better understanding of wider system pressures and were able to have a joined-up approach. Wellbeing support mechanisms were in place and the new people and culture function for the ICB would have a focused whole system approach to staff support, retention, skills, and career progression. It was agreed to have a more in depth focus on workforce issues at the next meeting.

m) Members queried whether any further tangible support could be provided locally to mitigate the adverse health impacts of the rising cost of living. It was noted that discussions were at an early stage and conversations at a regional level were also taking place. Further details would be brought to the next meeting.

n) Members requested that the Board be sighted on the impact of the Discharge to Assess Model, which had been approved during August. It was noted that benefits realisation had been discussed as a key point in the approval process and would be overseen by the Strategic Planning and Integration Committee on behalf of the Board.

The Board **RECEIVED** the Chief Executive's Report and **RATIFIED** the urgent decisions made during July and August 2022 using the Board's emergency powers.

ACTIONS:

- **Rosa Waddingham to bring a report on system workforce issues to the November Board meeting.**
- **Amanda Sullivan to provide an update on system actions to mitigate the humanitarian impacts of the rising cost of living to the November Board meeting.**

Health inequalities and outcomes

ICB 22 020 **Urgent and Emergency Care: Winter Planning**

Lucy Dadge presented the item and highlighted the following points:

a) The urgent care system continued to operate under intense pressure, with long delays and bottlenecks impacting acutely unwell patients. The urgent care system was both impacted by and had an impact on all health pathways. As such, a system-wide focus was required.

b) The key priority was to develop system mitigation plans for the expected rise in demand during the winter months to ensure patient safety and to minimise impact on the Elective Care Recovery Programme.

c) An Integrated Care System Surge and Escalation Plan would be operational throughout winter. Demand and capacity modelling had been undertaken. Daily oversight and Operational Pressures Escalation Levels (OPEL) reporting would be introduced, overseen by the ICS Urgent and Emergency Care Delivery Board.

d) The three areas of focus and the initiatives underpinning them were detailed: services supporting admission avoidance, maintaining acute flow, and discharge schemes.

e) A communications strategy would be rolled out to support the public to access the right care services over the winter period.

f) Although several demand and capacity scenarios had been mapped, there remained several risks to the Plan including unplanned sickness, recruitment challenges, higher than anticipated levels of Covid or/and flu infections, and the consequences of the rising cost of living on the immediate health of our population.

The following points were made in discussion:

g) Members queried whether the scenario plans indicated that the system would cope with the anticipated rise in demand. It was noted that capacity matched demand in all but the highest levels of demand and further mitigations were being put in place to bridge this gap.

h) Members queried monitoring arrangements and requested oversight of the key metrics of the plan. It was noted that the ICS Urgent and Emergency Care Delivery Board would monitor all schemes.

i) It was noted that if the impact of the cost of living on health and wellbeing made the cost of care packages unsustainable in the longer term, there was a need for the system to consider different approaches in future years.

j) Members queried the robustness of prevention plans. It was noted that the ‘Aging Well Programme’ was progressing well and a more detailed update on preventative measures was included within the Board’s work programme for January.

k) In summary, the Board expressed concern regarding the impact on health inequalities of the rising cost of living, and at this stage

Members could not be fully assured of the robustness of the winter plan. A brief update was requested at the October Board Development Session and a further update on progress was requested at the November Board meeting.

The Board **RECEIVED** the report.

ACTIONS:

- **Lucy Dadge to provide a brief progress update on winter planning at the October Board Development Session.**
- **Lucy Dadge to provide a progress update on winter planning to the November Board Meeting.**

ICB 22 021 Elective Recovery Plan

Lucy Dadge presented the item and highlighted the following points:

a) Elective waiting lists had increased because of the requirement to focus on the response to the pandemic. There was a national imperative to reduce waiting list sizes and an Elective Recovery Plan was in place to deliver national elective waiting time targets, overseen by the ICS Planned Care Board.

b) The plan aimed to make a sustainable improvement in performance for elective and cancer treatments by increasing elective capacity, ensuring early diagnosis, and providing information to support patients with shared decision-making.

c) Good progress had been made and the system had eliminated waits of 104 weeks, other than in exceptional cases, and focus was now on the elimination of 78 week waits. This was being achieved by bringing additional capacity, using the independent sector where appropriate, and mutual aid between the system's acute trusts.

d) Key to reducing the elective care backlog and earlier cancer diagnosis was an increase in diagnostic provision and work was ongoing to develop Community Diagnostic Centres to facilitate this. Workforce constraints had been the main limiting factor in current performance against diagnostic waiting times and recruitment was underway.

e) The main risk to the Elective Recovery Plan was pressure from rising demand in urgent care. The plan was to create elective care hubs to ring-fence elective care treatment. Other best practice

opportunities were also being explored by clinical and managerial leads.

The following points were made in discussion:

f) Members queried whether demand and capacity modelling, as discussed under the previous item would inform the ICB when the demand would impact on elective care capacity. It was noted that the modelling did indicate a threshold when elective care would be impacted by a surge in demand in urgent care. However, elective care capacity was likely to be maintained by Sherwood Forest and Bassetlaw hospitals, where cases were of lower complexity.

g) Members noted that the greatest risk to the delivery of both the urgent and elective care plans was the capacity of the workforce and noted the consequent impact on the social care sector if the Elective Recovery Plan did not deliver.

h) The need to maintain communication with patients on waiting lists and undertake harm reviews was discussed. It was noted that the current harm review process was being reviewed with a view to providing greater assurance.

i) The Chair noted only partial assurance could be taken at this time, pending the impact of winter pressures on the system and noted the need for system partners to be ambitious in their focus on the Elective Recovery Plan.

The Board **RECEIVED** the report.

ICB 22 022 Maternity Services Update

Rosa Waddingham presented the item and highlighted the following points:

a) The report gave an update on how the Nottingham and Nottinghamshire Local Maternity and Neonatal Services (LMNS) partnership was driving transformation plans across the system to address safety and quality concerns; and provided an update on work to address the issues specific to maternity services at Nottingham University Hospitals NHS Trust (NUH).

b) The LMNS provided system visibility and ownership of the quality and safety for local maternity services. Over the past year governance structures had been strengthened to support timely identification and escalation of safety and quality concerns,

including the monitoring of progress against all Ockenden immediate and essential actions.

c) The ICB would ensure more user voices and patient experiences are fed into all service delivery via the Maternity Voices Partnership and a Neonatal Voices Partnership would also be established.

d) NUH maternity services had been subject to enhanced surveillance since autumn 2020 in response to quality concerns. Following CQC inspections, a Maternity Improvement Plan had been put in place. Although progress had been made on the Plan, it was widely acknowledged that the pace of improvement had been slower than expected. To date 43% of the actions had been completed and 8% were now indicated as embedded. A full review of all actions was currently underway.

e) The ICB welcomed the independent review of NUH maternity services chaired by Donna Ockenden, which would give further opportunity for the families involved in maternity services at NUH to have their voices heard and provide valuable learning to support the rapid improvement in quality in these services.

The following points were made in discussion:

f) Acknowledging and applauding the progress made to date at NUH, Members nevertheless expressed concern at the slow pace of change and queried how a step change could be made to hasten progress. It was noted that progress had been hampered both by the operational imperative to respond to the pandemic and by cultural and leadership issues within the Trust. New senior leaders were now in place and had instigated strengthened governance and oversight procedures. There was optimism that the pace of change would increase, albeit there was a significant risk that the plan would not be completed by the completion date of 31 March 2023.

g) Members queried where emerging recommendations from the Ockendon review would be captured. It was noted that any new recommendations would be incorporated into the existing Maternity Improvement Plan.

h) Members queried whether there was more that the ICB and system partners could do to provide further support. It was noted that the former CCG, other local acute trusts, and system partners had been providing capacity and support for several years.

i) Members were assured that the LMNS had measures in place to monitor improvement in the overall culture within maternity services at NUH.

j) The Chair noted that only partial assurance could be obtained from the report pending the impact of the new leadership at NUH on the pace of the completion of their Maternity Improvement Plan.

The Board **RECEIVED** the report.

Assurance and system oversight

ICB 22 023 **Highlight Report from the Finance and Performance Committee**

Stephen Jackson presented the item and highlighted the following points:

a) The Committee had discussed in detail the challenging financial position of the ICB and the wider system, including the current difficult economic environment.

b) The Committee had reviewed and endorsed the opening budgets, annual financial plan and capital expenditure plan for onward submission to the Board for approval.

c) A comprehensive discussion on the purpose and format of the Integrated Performance Report had also been held.

The Board **RECEIVED** the report.

ICB 22 024 **Financial Plan, Opening Budgets and Capital Resource Use Plan**

Stuart Poynor presented the item and highlighted the following points:

a) The report presented for approval the System Capital Resource Plan 2022/23 and planned distribution of capital resources to ICS provider organisations, the ICB's 2022/23 Capital Plan, and the ICB's Opening Budgets. As noted in the previous item, these items had been reviewed in detail and endorsed by the Finance and Performance Committee at its meeting in July 2022.

b) The ICS had been working within a system-wide capital envelope since 2019/20. Currently the plan was an amalgamation of individual providers' capital plans; however, moving forward, a more mature system approach would need to be taken, which reflected a place-based focus on integrated care. This would require a broader approach to estates planning.

c) There were several risks to the delivery of the capital plan and there was a need to develop a capital prioritisation process to ensure best value from remaining capital resources.

d) Allocations for the 2022/23 Financial Plan had been provided on a system-wide basis. It was a balanced plan that required a 3.7% efficiency saving. An efficiency plan to deliver the target was still under development. National planning requirements stipulated that all plans should contain a minimum 0.5% contingency arrangement. At this stage this was not considered affordable within the Financial Plan.

e) There was considerable risk to the delivery of the plan and there was an expectation that the underlying deficit of circa £26 million should also be addressed. Mitigations were in place to address and manage known risks to the delivery of a break-even position.

The following points were made in discussion:

f) Members noted that capital plans were key to tacking health inequalities and queried whether local authorities were involved in estates planning. It was noted that all available estate within the system was visible, and the next stage would be to engage fully with the local authorities.

g) Members emphasised the need to retain an ambitious programme of transformation to ensure a long term sustainable financial position, albeit noting that headroom in the budget would be required for transformational change.

h) The need to make difficult decisions, such as the re-allocation of funds, was discussed, which members noted should be undertaken using evidence-based decision support tools.

i) Members discussed the need to ensure sufficient time and resource was dedicated to planning for the future, whilst managing current delivery, and noted the role that system data analytics played in enabling this.

j) Members queried what impact a severe winter would have on financial resources. It was noted that any reduction in elective activity would impact on the system's ability to draw down Elective Recovery Fund resource and would be a financial pressure for the ICB.

The Board:

- **APPROVED** the system capital resource plan for 2022/23 and distribution of capital resources to the ICS provider organisations.
- **APPROVED** the ICB 2022/23 Capital Plan.
- **APPROVED** the ICB 2022/23 Opening Budgets.

ICB 22 025 Integrated Performance Report

Stuart Poynor, Rosa Waddingham, Dave Briggs, and Lucy Dadge presented the item and highlighted the following points:

a) This was the first Integrated Performance Report to be presented to the Board, its intention was to present compliance towards a suite of nationally mandated and progress in areas of quality, service delivery, finance, workforce, and health inequalities.

b) Narrative exception reports were provided for areas of concern, along with the actions being taken to address the current issues, and assurance as to whether these actions would impact upon and improve the position, as summarised in the report.

c) The ICB area was currently over target for learning disability and autism inpatients. System partners were strengthening capacity to avoid inappropriate admissions. Many of the current cohort had complex needs that proved difficult to discharge into community settings.

d) Performance against the target for learning disability annual health checks was currently below trajectory as work focused on the 'hard to reach' cohort of patients requiring a health check. Actions were in place and the target was expected to be achieved.

e) Increases in in Healthcare Associated Infections (HCAI) including Covid-19 were being examined on a case-by-case basis, although it was noted this was a national trend.

f) A significant number of targets were showing an adverse position as flow through and out of hospital remained an issue, and was impacting on elective care activity, as discussed earlier in the meeting. This was also impacting on the out of area placements target, which was significantly over trajectory.

g) Diagnostic treatment targets were proving challenging to meet.

h) Community waiting lists were significantly over plan and work to review plans was being undertaken.

i) A health inequalities dashboard had been produced and would include up to date metrics in future reports. The focus of work to reduce health inequalities was split into five areas: infant mortality, severe mental illness, respiratory disease, cancer and hypertension.

j) High levels of agency staff were still being required as vacancy levels and sickness absence levels throughout the system were higher than planned.

The following points were made in discussion:

k) It was noted that the report was still work in progress and feedback was given on how beneficial members had found it in providing assurance that areas of poor performance were being identified and addressed.

l) Going forward each ICB Committee would scrutinise their respective sections of the Integrated Performance Report and would bring assurance reports to the Board.

The Board **RECEIVED** the report.

Governance and risk

ICB 22 026 **Board Assurance Framework**

Lucy Branson presented the item and highlighted the following points:

a) The Board Assurance Framework enables the Board to understand how strategic risks to the achievement of the ICB's aims are being managed.

b) The report presented 15 proposed strategic risks for review and approval as the basis for developing the full Board Assurance Framework; these had been developed via an executive-led exercise and once the risks were approved, work would be completed with executive risk owners to fully develop the Board Assurance Framework.

c) The proposed risks had been reviewed in line with NHS system partners' strategic risks, which had confirmed good alignment, while recognising the differing roles and responsibilities of the relevant organisations.

d) This is an atypical year for the ICB, and as such, the timeline for developing the Board Assurance Framework was more condensed than normal; mid-year and year-end position statements would be presented. A programme of executive-led targeted assurance reports would also be scrutinised by the Audit and Risk Committee in-year.

e) It was recognised that operational risk management arrangements would need to continue to evolve throughout the remainder of the financial year. In particular, the arrangements relating to the management of system risk.

f) It was further highlighted that a development session to examine the ICB's risk appetite was planned for later in the year.

The following points were made in discussion:

g) Members queried whether there should be any risks relating to estates. It was noted that capital allocations was included within risk nine and that the system estates strategy would most likely be part of the control or mitigation method rather than a risk in itself.

h) Members agreed that more time should be allocated to allow the Board to develop a collective understanding of the risks and associated risk appetite scores and there was agreement that the Board Assurance Framework should drive the Board's agenda.

The Board:

- **APPROVED** the ICB's strategic risks to enable the full development of the 2022/23 Board Assurance Framework.
- **NOTED** the development timeline and future monitoring and reporting arrangements for the Board Assurance Framework.

Closing items

ICB 22 027 **Questions from the public relating to items on the agenda**

No questions were raised.

ICB 22 028 **Any other business**

No other business was raised, and the meeting was closed.

Date and time of next Board meeting held in public: 10 November 2022 at 9:00 (Arnold Civic Centre)

NHS
Nottingham and Nottinghamshire

ACTION LOG for the Integrated Care Board meeting held on 08/09/2022

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
Closed	08.09.22	Chair's Report	Lucy Branson to update the Board's work programme to include citizen stories.	Lucy Branson	10.11.22	Included in the Annual Work Programme as a required element of the Service Transformation Updates. Will commence in practice from January 2023.
Open – On track	08.09.22	Chief Executive's Report	To bring a report on system workforce issues to the November Board meeting	Rosa Waddingham	08.12.22	Added to the agenda for the December Board Development Session to allow for a more thorough consideration of workforce issues.
Closed	08.09.22	Chief Executive's Report	To provide an update on system actions to mitigate the humanitarian impacts of the rising cost of living to the November Board meeting.	Amanda Sullivan	10.11.22	On this agenda at item 7.
Closed	08.09.22	Urgent and Emergency Care	To provide a brief progress update on winter planning at the October Development Session	Lucy Dadge	13.10.22	Report brought to the October Development Session
Closed	08.09.22	Urgent and Emergency Care	To provide a progress update on winter planning, including a report on preventative actions, at the November Board Meeting	Lucy Dadge	10.11.22	On this agenda at item 7.

Key:

Closed – Action completed or no longer required	Open – Off track (may not be achieved by expected date of completion)
Open – On track (to be achieved by expected date of completion)	Open – Off track (has not been achieved by expected date of completion)

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	10/11/2022
Paper Title:	**Chair's Report**
Paper Reference:	ICB 22 034
Report Author:	Dr Kathy McLean, ICB Chair
Report Sponsor:	Dr Kathy McLean, ICB Chair
Presenter:	Dr Kathy McLean, ICB Chair
Recommendation(s):	The Board is asked to: • **RECEIVE** this item for information, noting in particular the amendments to the ICB's Constitution as directed by NHS England. • **APPROVE** the amended terms of reference for the Integrated Care Partnership. • **APPROVE** the proposed change in committee oversight arrangements for research and patient and public engagement and consultation.

Summary:
This report outlines my activities and actions in my role as Chair and provides a synopsis of some of the meetings I have attended on behalf of the Nottingham and Nottinghamshire Integrated Care Board. The report also describes ongoing ICB and system governance developments.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	The work of the Chair is focussed on meeting the four core aims.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:
Appendix A: Amended ICP Terms of Reference

Board Assurance Framework:
Not applicable for this report.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes

Applicable Statutory Duties:	
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	Yes
Duty to promote innovation	Yes
Duty in respect of research	Yes
Duty to promote education and training	Yes
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	Yes
Duties as to climate change	Yes
Duties regarding public involvement and consultation	Yes
Public sector equalities duties	Yes

Report Previously Received By:
Not applicable for this report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Chair’s Report

Introduction

1. It has been over four months since we were established as an Integrated Care Board. I am positive about the progress that we have made during this time, and system partners are working well together. I feel increasingly confident about our future and the improvements in health and wellbeing we can deliver for our population. It will not always be easy, and we are certainly facing a challenging Winter period and the potential for constrained budgets going forward but the foundations are in place for our success.
2. The Board does not need me to stress how much concern there is around the rising cost of living and food, fuel and energy affordability for our citizens. This will undoubtedly result in dilemmas of eating or heating and other unwelcome trade-offs. On recent visits to Hyson Green in Nottingham, to the Bellamy Estate in Mid Nottinghamshire and to Bassetlaw, I was able to see and hear about the impact first-hand. This is a difficult context, but I am optimistic because of our partnerships that will help align our public sector approach to the rising cost of living.
3. Linked to this, whilst we know that nationally set budgets for the NHS and Local Authorities are likely to become more constrained going forward, we do still undoubtedly have considerable resources at our disposal. The provision of a free-at-the-point-of-use healthcare system is one of the strongest protections against a rising cost of living for citizens – removing at least the financial worry regarding access to healthcare is something that we should cherish. And in addition to this, we have the chance locally to steward our allocation of national funding to make the biggest impact – maximising the “NHS Pound” on local services and providers wherever possible. This is something that we should return to in the future.

Integrated Care Partnership

4. Further to my report in September, the inaugural meeting of our Integrated Care Partnership (ICP) was due to take place on 16 September. Like all public bodies, we observed the national guidance regarding mourning after the death of the monarch and therefore the meeting was postponed to 13 October.
5. At that re-arranged meeting we were able to discuss the role and responsibilities of the ICP, as described within its terms of reference, and agree the overall approach to the development of the Integrated Care Strategy, including arrangements for engaging with citizens in its development. There was overwhelming support for the proposed ambition to embed prevention,

equity and integration across our four strategic aims, and for the proposed involvement and engagement approach for developing the strategy.

6. Further meetings of the Integrated Care Partnership have been agreed for 2022/23 as follows:

   a) Friday 16 December 2022, 14:00-16:30 (The Council Chamber, County Hall, Loughborough Road, Nottingham, NG2 7QP).

   b) Friday 17 March 2023, 14:00-16:30 (The Council Chamber, County Hall, Loughborough Road, Nottingham, NG2 7QP).

   Agendas and papers will be published on the Integrated Care System's website here: Our Integrated Care Partnership - NHS Nottingham and Nottinghamshire ICS - NHS Nottingham and Nottinghamshire ICS (healthandcarenotts.co.uk).

7. The focus of the December meeting will be to approve the Integrated Care Strategy, ahead of the nationally set deadline of the end of the calendar year.

8. At the time of approving the Integrated Care Partnership's terms of reference, it was recognised that these would need further refinement following the receipt of guidance and advice, particularly in relation to decision-making arrangements as a joint committee in the context of the new legislation. This has now been received and the proposed amendments to the ICP's terms of reference are attached at Appendix A for the Board's consideration and approval. These are presented with tracked changes for ease of reference and will also be presented to the Full Council meetings of both Local Authorities for approval during October and November.

9. The full list of nominated ICP members is detailed at Appendix B for information.

ICS Partners Assembly

10. On 25 October, we held our first ICS Partners Assembly. This brought people together from across our system including NHS, local authority, voluntary, community and social enterprise organisations, citizens and patients. Joined by the two Vice Chairs of the ICP (Cllr Adele Williams, Nottingham City Health and Wellbeing Board Chair, and Cllr John Doddy, Nottinghamshire County Health and Wellbeing Board Chair), we spoke about our journey so far, the enduring challenges faced by our citizens, the urgent need to address these and the opportunities that the development of our Integrated Care Strategy will bring. There were keynote presentations from Professor Daniel King from Nottingham Trent University and Jules Sebelin from Nottingham Community and Voluntary Service, who looked at the impact of the Voluntary, Community and Social Enterprise sector, lessons learned from the pandemic and integration through the Voluntary, Community and Social Enterprise Alliance.

11. During the event we took the opportunity to reflect upon our purpose *"to enable every citizen to enjoy their best possible health and wellbeing"*, and heard from colleagues about what, as a system, we could be doing differently to deliver on this. We were also able to share the emerging content of the Integrated Care Strategy and receive detailed feedback from delegates. This feedback, as part of our overall approach to listening to our population, will hugely help as we move forward with developing and delivering the strategy. Whilst listening to the discussions, I was delighted to hear the appetite for change and desire for greater collaboration. It is clear that we have huge assets in our communities and partners that we need to fully harness as we move forward.

System partner engagement

12. We continue to engage with our partners and have held Board to Board events that have aided in aligning our organisations. We have bought together Non-Executive Directors across our system and also elected members. I plan to do the same in due course with Foundation Trust Governors.

13. I have recently spent a full day each at Nottinghamshire County Council and Nottingham City Council, really immersing myself in the world of our local authority colleagues. I was struck in particular by the connections between all Local Authority service provision and health. It is clearer to me than ever that it is not just around social care that we need to be aligned but across all public services where we can leverage the real benefits of working together to impact on the wider determinants of health – transport, housing, public open spaces, education, leisure and much more.

14. As an ICS, we have a wealth of data and insights that tell us about the health and care needs of our citizens that we need to use more. I have also spent time with primary care colleagues and met with clinical leads to discuss what evidence-based actions are in place to promote equity within our local communities.

Winter pressures

15. I am fully aware that many Board members and the teams within the ICS will be extremely busy planning and preparing for what will be a really challenging winter. I have a high level of confidence that the comprehensive plans we have in place will ensure that we will continue to deliver safe care at all times – but it will undoubtedly require strong and collaborative work across the system to get us there. The establishment of the System Control Centre will be a key part of that delivery as well as honest and direct conversations between system partners. I was pleased to chair the recent 'Winter Summit' where we agreed a number of additional actions to further bolster this winter's plan. Of course, the

real long-term approach, as will be described within our Integrated Care Strategy, is to invest more in preventative activities.

Amendments to the ICB's Constitution

16. Following the establishment of the ICBs on 1 July 2022, NHS England has made several housekeeping amendments to the ICB model constitution and has requested they be replicated in our Constitution. The amendments, which are not material, are summarised below and the Board is requested to **NOTE** the updating of the ICB's Constitution to reflect these amendments, as directed by NHS England:

Section 1.4.7 (f) – Health and Care Act reference 'section 14Z44' corrected to read 'section 14Z45'
Section 3.2.4 – Reference to the 'sections 56A to 56K of the Scottish Bankruptcy Act 1985' replaced with 'Part 13 of the Bankruptcy (Scotland) Act 2016'.
Section 3.2.7 – 'A health care professional (within the meaning of section 14N of the 2006 Act)….'. First line updated to remove reference to section 14N of the 2006 Act and capital letters for 'Health Care Professional'. Line to read as follows 'A Health and Care Professional or other professional……..'
Section 7.1.1 – Reference to 'paragraph 11(2)' amended to 'paragraph 12(2)'.
Appendix 1 – Add definition of 'Health Care Professional' to the table. Definition to be added: 'An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.'

Governance Review

17. Now that we have completed our first 100 days post-establishment, I have asked for a governance stocktake to be completed to ensure that our ICB structures are fit for purpose and arrangements are working well in practice. I aim to feedback on the outcome of this work at our next meeting.

18. Prior to this, it is proposed that oversight of research and patient and public engagement and consultation is moved from the Quality and People Committee to the Strategic Planning and Integration Committee, providing better alignment to the Committees' remits. The Board is asked to approve this change to the relevant Committee terms of reference.

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Nottingham and Nottinghamshire Integrated Care Partnership

Terms of Reference

1. Description/ status	The Nottingham and Nottinghamshire Integrated Care Partnership ("**the ICP**") is a joint committee of NHS Nottingham and Nottinghamshire Integrated Care Board**,** Nottingham City Council and Nottinghamshire County Council ("**the Statutory Organisations**"), established in accordance with Section 116ZA of the Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Care Act 2022). The ICP will act as the 'guiding mind' of the Nottingham and Nottinghamshire Integrated Care System (ICS) and is authorised to operate within these terms of reference, which set out its purpose, membership, authority and reporting arrangements. The ICP will not duplicate the work of the Nottingham City and Nottinghamshire County Health and Wellbeing Boards. ICP members will champion and act as ambassadors of effective partnership working for local population benefit.
2. Purpose	a) The primary purpose of the ICP is to produce an Integrated Care Strategy and Outcomes Framework for Nottingham and Nottinghamshire, setting out how the assessed health and social care needs identified by the Nottingham and Nottinghamshire Joint Strategic Needs Assessments (JSNAs) are to be met by the Statutory Organisations or NHS England, in line with their respective commissioning responsibilities. b) In preparing the Integrated Care Strategy, the ICP will: i) Involve Nottingham and Nottinghamshire Healthwatch and the people who live and work in Nottingham and Nottinghamshire. ii) Consider the extent to which health and social care needs could be met more effectively through arrangements for pooled budgets, joint commissioning and integrated delivery under section 75 of the NHS Act 2006 (as amended).

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	iii) Have regard to the mandate published by the Secretary of State for Health and Social Care under section 13A of the NHS Act 2006 (as amended). iv) Have regard to any further guidance issued by the Secretary of State for Health and Social Care. c) The ICP may also include within the Integrated Care Strategy its views on how arrangements for the provision of health-related services in its area could be more closely integrated with arrangements for the provision of health services and social care services in the area. d) To support the development of the Integrated Care Strategy, the ICP will engage with a wider assembly of partners, at least once a year, comprising people who rely on care and support, unpaid carers, the full range of social care and NHS providers, the voluntary and community sector, local professional committees (e.g. optical and pharmaceutical committees), the Office of the Police and Crime Commissioner, etc. e) The ICP will review the impact of the Integrated Care Strategy, focusing on improving outcomes in population health and healthcare, tackling inequalities in outcomes, experience and access, enhancing productivity and value for money and supporting broader social and economic development. f) The ICP will also receive reports on insights gained from service users and citizens. g) The ICP will consider the extent to which the Integrated Care Strategy needs to be revised on receipt of an updated JSNA.
3. Principles	The following principles will be used to guide the work of the ICP: a) Focus on improving equity of outcomes for people, including improved health and wellbeing, supporting people to live more independent lives, and reduced inequalities. b) Support the triple aim (better health and wellbeing for everyone, better care for all and efficient use of the collective resource).

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	c) Enable consistent standards and policy across the ICS (strategically sound) whilst allowing for different models of delivery in accordance with diverse populations served (locally sensitive). d) Ensure all delivery mechanisms (e.g. primary care networks, place-based partnerships and provider collaboratives at scale) are equally respected and supported, in line with the principle of subsidiarity. e) Champion co-production and inclusiveness throughout the ICS. f) Put at the forefront the experience and expertise of professional, clinical, political and community leaders, and promote strong clinical and professional system leadership. g) Create a learning system, fostering a culture of innovation, bravery, ambition and willingness to learn from mistakes. h) Optimise the role of health and care as anchor organisations within the local community. i) Utilise existing networks, groups, and governance structures, including staff forums and insights gained from place and neighbourhood engagement. j) Come together under a distributed leadership model and commit to work together equally. k) Accountable to one another and the public including through transparency and building trust.
4. Membership	The membership of the ICP will be comprised as follows: *Nottingham City Council:* a) Elected Member Representative who is the Chair of the Health and Wellbeing Board b) Corporate Director for People Services c) Director of Public Health for Nottingham d) Two further partner members nominated by Nottingham City Council ~~City Partner to be identified~~ ~~City Partner to be identified~~ *Nottinghamshire County Council:* e) Elected Member Representative who is the Chair of the Health and Wellbeing Board

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	f) Corporate Director, Adult Social Care and Health g) Director of Public Health for Nottinghamshire h) Two further partner members nominated by Nottinghamshire County Council ~~County Partner to be identified~~ ~~County Partner to be identified~~ *NHS Nottingham and Nottinghamshire Integrated Care Board:* i) Chair of the Integrated Care Board j) Chief Executive k) Director of Integration l) Medical Director m) Representative of the Nottingham and Nottinghamshire Provider Collaborative at Scale *Other:* n) Representative of Healthwatch Nottingham and Nottinghamshire o) Chair of the Nottingham and Nottinghamshire Voluntary, Community and Social Enterprise Alliance p) Representative of the Bassetlaw Place-based Partnership q) Representative of the Nottingham City Place-based Partnership r) Representative of the Mid-Nottinghamshire Place-based Partnership s) Representative of the South Nottinghamshire Place-based Partnership
5. Chair and vice-chair arrangements	The ICP will be Chaired by the Chair of NHS Nottingham and Nottinghamshire Integrated Care Board. The Chairs of the Nottingham City and Nottinghamshire County Health and Wellbeing Boards will act as joint Vice-Chairs of the ICP.
6. Substitutes	Members are permitted to nominate a suitable substitute to attend a meeting of the ICP on their behalf should they be unable to attend themselves. Members are responsible for fully briefing any nominated substitutes. Substitutes need to be confirmed in writing to the Chair of the ICP ahead of the meeting.

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7. Quorum	The quorum will be seven members, including at least one member from each of the Statutory Organisations. Nominated substitutes will count towards the quorum. Members (or nominated substitutes) will not count towards the quorum if attending remotely. If any member (or nominated substitute) of the ICP has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may only proceed on an informal basis and no decisions may be taken.
8. Decision-making arrangements	It is expected that at the ICP's meetings, decisions will be reached by consensus ~~and a vote will not be required.~~ ~~If consensus cannot be reached and if timeframes allow, then the item will be re-scheduled for discussion at the next meeting of the ICP. Otherwise, decisions will be taken by simple majority.~~ Should this not be possible, then a vote of the ICP's members will be required, the process for which will be as follows: a) All members of the ICP (or nominated substitutes) who are present at the meeting will be eligible to cast one vote each. Members attending remotely will not be eligible to vote. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote. b) A decision will be passed if more votes are cast for it than against it. c) Casting vote – If an equal number of votes are cast for and against a resolution, then the Chair of the ICP will have a casting vote. Any decisions taken will be recorded in the minutes of the meeting.
9. Conflicts of interest	A register of the declared interests of ICP members will be maintained and published. In advance of any meeting of the ICP, consideration will be given as to whether conflicts of interest are likely to arise in

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	relation to any agenda item and how they should be managed. At the beginning of each meeting of the ICP members will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the ICP will determine how any declared interests should be managed. ICP members must ensure that they comply with their organisational/ professional codes of conduct at all times.
10. Meeting arrangements	The ICP will meet at least twice per year. Extraordinary meetings may be called for a specific purpose at the discretion of the Chair in consultation with the Vice-Chairs. At least five clear working days' notice will be given when calling meetings. Remote attendance at meetings will be permitted at the discretion of the Chair. Meetings of the ICP shall be open to the public unless considering exempt information. The ICP is subject to the same requirements of openness and transparency as other meetings of the Statutory Organisations. As such, agendas and supporting papers, including ratified minutes of meetings, will be published. A protocol will be published separately for members of the public to set out arrangements for submitting questions to meetings of the ICP.
11. Secretariat	Secretariat support will be provided to the ICP by NHS Nottingham and Nottinghamshire Integrated Care Board. Agendas will be agreed by the Chair in consultation with the Vice-Chairs prior to each meeting. Any items to be placed on the agenda are to be sent to the secretary no later than ~~nine~~ ten clear ~~calendar~~ working days in advance of the meeting. Items that miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair.

Appendix A

	Agendas and supporting papers will be circulated no later than five clear working days before each meeting. Minutes will be taken at all meetings and will be ratified by agreement of the ICP at the following meeting.
12. Reporting arrangements	The ICP must: a) Publish its Integrated Care Strategy (and any revised strategies). b) Provide a copy of its Integrated Care Strategy (and any revised strategies) to the Statutory Organisations.
13. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time in order to adapt to any national guidance as and when issued. An early review of these terms of reference may be required during the ICP's first year of operation, as arrangements across the Nottingham and Nottinghamshire Integrated Care System evolve. Any proposed amendments to the terms of reference will be submitted to the Statutory Organisations for ratification.
14. Date approved	~~July~~ November 2022

Appendix B – List of nominated ICP members

Nottingham City Council nominated members	Cllr. Adele Williams	Chair of Nottingham City Health and Wellbeing Board
	Catherine Underwood	Corporate Director for People Services, Nottingham City Council
	Lucy Hubber	Director of Public Health, Nottingham City Council
	Donna Sherratt	Nottingham City Place-Based Partnership Race Health Inequalities Programme Lead
	To be confirmed	*Nottingham City Partner*
Nottinghamshire County Council nominated members	Cllr. John Doddy	Chair of Nottinghamshire Health and Wellbeing Board
	Melanie Williams	Corporate Director, Adult Social Care and Health
	Jonathan Gribbin	Director of Public Health, Nottinghamshire County Council
	Andrew Redfern	Chief Executive, Framework Housing Association
	Volt Sacco	Chief Executive, Fosse Healthcare
NHS Nottingham and Nottinghamshire ICB nominated members	Dr Kathy McLean	Chair of NHS Nottingham and Nottinghamshire ICB
	Amanda Sullivan	Chief Executive, NHS Nottingham and Nottinghamshire ICB
	Lucy Dadge	Director of Integration, NHS Nottingham and Nottinghamshire ICB
	Dr Dave Briggs	Medical Director, NHS Nottingham and Nottinghamshire ICB
	Anthony May	Chief Executive, Nottingham University Hospitals NHS Trust (Representative of the Nottingham and Nottinghamshire Provider Collaborative at Scale)
Other members	Jane Laughton	Chief Executive Officer, Healthwatch Nottingham and Nottinghamshire
	Jules Sebelin	Chair of the Nottingham and Nottinghamshire Voluntary, Community and Social Enterprise Alliance
	Victoria McGregor-Riley	Locality Director, Bassetlaw Place-based Partnership
	Dr Hugh Porter	Clinical Director, Nottingham City Place-based Partnership
	Dr Nicole Atkinson	Clinical Director, South Nottinghamshire Place-based Partnership
	To be confirmed	*Mid-Nottinghamshire Place-based Partnership representative*

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	10/11/2022
Paper Title:	**Chief Executive's Report**
Paper Reference:	ICB 22 035
Report Author:	Amanda Sullivan, Chief Executive
Report Sponsor:	Amanda Sullivan, Chief Executive
Presenter:	Amanda Sullivan, Chief Executive
Recommendation(s):	The Board is asked to: • **RECIEVE** this item for information. • **APPROVE** the signing of the Mencap pledge.

Summary:
This report provides a summary of recent local and national developments and areas of interest for Integrated Care Boards (ICBs) and the wider NHS.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	This item ensures that the Board is kept informed of organisational, system and national developments that promote achievement of the ICB's core aims.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:
Appendix A: Winter Plans Appendix B: The rising cost of living – pulling together to support local people Appendix C: Embedding Citizen Voice in Nottingham and Nottinghamshire ICS

Board Assurance Framework:
Not applicable to this report.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	Yes
Duty to promote innovation	Yes
Duty in respect of research	Yes
Duty to promote education and training	Yes

Applicable Statutory Duties:	
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	Yes
Duties as to climate change	Yes
Duties regarding public involvement and consultation	Yes
Public sector equalities duties	Yes

Report Previously Received By:
Not applicable to this report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Chief Executive's Report

System status and planning

Second critical incident declared

1. Following continued and unprecedented pressure on services, the Nottingham and Nottinghamshire healthcare system declared a second critical incident on 28 September 2022. This action was taken in order to maintain safe services for our patients and manage emergency care services. It was stood down at the earliest opportunity on 6 October 2022. This was following swift and extraordinary effort by our health and care teams.
2. Through system working there has been an easing of pressures as a result of additional actions. However, a critical incident is an indication of the pressure the system is facing, with continuing significant levels of patients with Covid-19 infections and other conditions, paired with staff sickness levels, annual leave and difficulties in discharging patients.
3. Staff at the front line remain under significant pressure in their efforts to provide safe care and patients and members of the public will continue to be asked to use services wisely to ensure those patients with the greatest need can access care and support.

Winter plans

4. Following an increase in Covid-19 infections and the possibility of high prevalence of flu, NHS England has recently issued further guidance on additional actions for systems to consider in their winter planning preparations:
    a) **New variants of Covid-19 and respiratory challenges:** Systems should actively consider establishing Acute Respiratory Infection (ARI) hubs as part of preparing for managing increased ARI in the community.
    b) **Demand and capacity:** all systems to establish 24/7 System Control Centres that will balance the risk across acute sector, community, mental health, and social care services with an aim of ensuring that clinical risk is appropriately dispersed across the whole ICS during periods of surge.
    c) **Discharge:** NHS England is working with cross-government colleagues through the National Discharge Taskforce to explore further options to reduce delays to discharge. This includes supporting the £500m fund to recruit and retain more care workers and speed up discharge.
    d) **Ambulance service performance:** all ambulance services to deploy 24/7 mental health professionals in emergency operation centres and on-scene and implement new models of improving flow out of emergency departments.

e) **Preventing avoidable admissions:** all local systems should have a community-based falls response service in place between 8am and 8pm for people who have fallen at home including care homes. Consider targeted, proactive support for people who have high probability of emergency admission, sometimes called 'high frequency users'.

f) **Workforce:** NHS England is extending their workforce support by re-launching the National NHS reserve campaign to bolster local surge capacity; launching a staff offers hub to support spread of local good practice over winter; providing a full list of recommended workforce solutions for Integrated Care Boards and providing targeted support teams to any region or system that falls into difficulty.

The full publication can be found here: https://www.england.nhs.uk/long-read/going-further-on-winter-resilience-plans/

5. In response to the NHS England ask for the development of a system control centre operating 24/7, 365 days a year from 4 December 2022, the ICB has established a working group to deliver the requirement and a Winter Director role is being established to provide oversight of the development. System control centres will deliver:

   a) Visibility of operational pressures and risks across providers and system partners.

   b) Concerted action across the ICS on key systemic and emergent issues impacting patient flow, ambulance handover delays and other performance, clinical and operational challenges.

   c) Dynamic responses to emerging challenges and mutual aid.

   d) Efficient flows of information.

6. The additional developments for falls, proactive care, care home support and respiratory hubs are also being assessed and plans established to develop the required services. All of this is being shared with partners at the Urgent and Emergency Care Board. An overview of how local organisations are working together to meet anticipated urgent and emergency care needs this winter can be found at **Appendix A**. It provides projections for healthcare demand and assimilates organisational actions to increase capacity and activity. Progress on the Plan will be reported to the Board at its next meeting in January 2022.

Autumn vaccination programme

7. To date more than 150,000 people in Nottingham and Nottinghamshire have booked appointments for a Covid-19 autumn booster vaccination. The vaccination is now being rolled out to people aged 50 and over, as well as people who are at high risk due to certain health conditions, carers, pregnant women and frontline health and care workers.

8. There are more than 50 sites in Nottingham and Nottinghamshire offering Covid boosters, these are mainly community pharmacies and GP premises; however, several larger centres and walk in centres are available.

9. The flu vaccine is also being rolled out, with eligible people able to get their flu and Covid jab at the same time in some venues. Flu vaccinations can be booked at GP practices or local pharmacies.

Collective actions that the NHS will need to take to mitigate health and humanitarian impacts of the rising cost of living

10. Further to my report in September regarding discussions on how we as system partners can further support our workforce and citizens during these unprecedented times of rising food, fuel, energy and living costs, at a recent meeting System Executives have agreed action areas across the ICS. The report can be found at **Appendix B**. The next step is to collate information regarding developing support offers and ensure that this is shared for organisations and practitioners to use for signposting and referral.

ICB updates and developments

Mencap's 'Treat Me Well' pledge

11. Following a recent broadcast of a BBC Panorama investigation 'Will the NHS care for me?', which investigated the failures of healthcare for people with a learning disability, Mencap has written to all ICB Chairs and Chief Executives to invite them to sign Mencap's 'Treat Me Well' pledge. The Board is requested to endorse the signing of the pledge to demonstrate the ICB's commitment to people with a learning disability.

12. The pledge calls for commitment from ICBs to:

    a) Nominate a system champion for learning disability and autism with responsibility across, and a sound understanding of, both health and social care.

    b) Work with primary, secondary, acute and community care and mental health providers to put reasonable adjustments in place so services are safe and accessible.

    c) Ensure that our system provides joined up and co-ordinated care for people with a learning disability with complex health and support needs.

    d) Analyse our LeDeR data and producing an action plan to reduce the number of avoidable deaths of people with a learning disability.

    e) Support the timely roll out the Oliver McGowan Mandatory Training.

    f) Build robust community support and reducing the number of people with a learning disability being detained indefinitely in mental health hospitals.

g) Work with councils and the voluntary sector to make sure there are services to reduce loneliness and boost the confidence of people with a learning disability.

h) Involve people with a learning disability and their families in meaningful engagement, co-producing services as standard.

13. The Learning Disability and Autism (LDA) partnership, which consists of both health and social care partners, has a programme of activity to improve the lives of autistic people and those with a learning disability across Nottingham and Nottinghamshire. There is a Senior Responsible Officer within the ICB, with joint chairing arrangements at Board level across health and social care. The programme has an Executive Board, an Operational Delivery Group and a number of workstreams, with a number of task and finish groups sitting underneath. The programme has a number of priorities around reducing reliance on inpatient provision by developing appropriate and effective community services; increasing the number of annual health checks undertaken for people with learning disabilities and ensuring they have a Health Action Plan in place, ensuring the learning from LeDeR reviews is translated into clear actions across the system, which is documented in an annual report; and ensuring services are making reasonable adjustments so that autistic people and those with a learning disabilities are able to access services; and improving pathways across the system.

14. Co-production is central to the LDA programme and experts by experience are engaged and involved as equal partner representatives at all levels, including the Executive Board. A workforce strategy has been developed, including a training plan and as part of this, the roll out of the Oliver McGowan training will be supported. The LDA partnership is committed to Mencap's 'Treat Me Well' pledge, which will be delivered through the workstreams and overseen by the Executive Board.

Embedding Citizen Voice in the Nottingham and Nottinghamshire Integrated Care System

15. Good progress is being made in embedding the ICB's structures and systems for working with people and communities. We are on track with the delivery of key elements including: the Citizens' Panel, the ICS Engagement Practitioners Forum, the ICB Citizen Intelligence Advisory Group (CIAG) and the Voluntary, Community and Social Enterprise (VCSE) Alliance. Further details can be found at **Appendix C**.

ICB Finalists in Innovate 2022 Awards

16. Two of our ICB projects were finalists for the category of "Excellence in Patient and Public Involvement in Transformation and Innovation" at this year's Innovate Awards:

a) Children and young people's emotional wellbeing early support transformation.

b) Establishing co-production through organisational and system cultural change.

The Innovate Awards celebrate excellence in innovation in health and care and is a collaboration between the Academic Health Science Network, which operates as the innovation arm of the NHS and the NHS Confederation, the membership body representing healthcare in the UK.

Partner Updates

Health and Wellbeing Board updates

17. The Nottinghamshire County Health and Wellbeing Board met on 12 October 2022. The meeting received a report on securing a smoke free generation for Nottinghamshire. The papers for this meeting are published on Nottinghamshire County Council's website here: https://www.nottinghamshire.gov.uk/dms/Committees/tabid/62/ctl/ViewCMIS_CommitteeDetails/mid/381/id/548/Default.aspx

18. The Nottingham City Health and Wellbeing Board met on 28 September 2022. The meeting received a report on the Pharmaceutical Needs Assessment 2022-25, the Joint Strategic Needs Assessment Annual Report, an update from the Nottingham City Place-Based Partnership and an update from the Joint Health Protection Board. The papers and minutes from the meeting are published on Nottingham City Council's website here: https://committee.nottinghamcity.gov.uk/ieListMeetings.aspx?CId=185&Year=0.

National Updates

Publication of 'Reading the Signs' Report into maternity services at East Kent Hospitals University NHS Foundation Trust

19. In February 2020 concerns were raised in Parliament regarding the quality and outcomes of maternity and neonatal care at East Kent Hospitals University NHS Foundation Trust. NHS England and NHS Improvement commissioned an independent investigation led by Dr Bill Kirkup. On 19 October 2022 the investigation report was published 'Reading the Signs'.

20. The report describes how those responsible for the provision of maternity services failed to ensure the safety of women and babies, leading to repeated suboptimal care, significant harm and poor outcomes. It describes stark findings of deep problems at every level in the Trust, from labour ward clinicians to the Board and external relationships. In particular, it highlights a failure to listen to families and a lack of compassion and kindness, impacting heavily on the experience of women and families both as part of their care and afterwards, when they sought answers to understand what had gone wrong. The report also describes grossly flawed teamworking among and between midwifery and medical staff, and an organisational response

characterised by internal and external denial with many missed opportunities to investigate and correct devastating failings.

21. In a shift from a traditional approach, the report does not seek to identify recommendations that include detailed changes of policy directed at specific areas of either practice or management. Instead it identifies four key action areas for action to tackle fundamental issues affecting maternity services.

22. In the coming weeks we will actively engage with all our partners to ensure Nottingham and Nottinghamshire digests and responds to the findings of the report. We will build this into our support and oversight arrangements already in place following the publication of Donna Ockenden report, in addition to the targeted support and oversight at Nottingham University Hospitals NHS Trust. The Local Maternity and Neonatal System (LMNS) will coordinate local activity and actions working closely with maternity providers and the Maternity Voices Partnership. A review of findings will be presented at Integrated Care Board in January 2023.

23. Reading the Signs is hard to read, and our thoughts are with the women, their babies and families who have been impacted by these events. We continue to work tirelessly to do all within our power to ensure high standards of care for all those accessing maternity services across Nottingham and Nottinghamshire. Ensuring that all women, babies and families get the safe, high-quality maternity care they deserve is our priority. We are taking this seriously and we are fully committed to make sure the locally we have real change.

NHS England Operating Framework

24. NHS England has recently published their Operating Framework. The Framework sets out how NHS England will operate within the new structures created by the 2022 Health and Care Act and describes how accountabilities and responsibilities will be allocated to improve local health and care outcomes. The Framework signals a more collaborative partnership-based way of working, with NHS England creating policy and strategy priorities, giving system leaders the autonomy to identify the best way to deliver agreed priorities in their local context. Many of the key formal powers and accountabilities of NHS England will remain broadly the same, however for ICBs and NHS provider trusts, the primary relationship will be with the NHS England regional teams; and NHS England will conduct an annual assessment of ICBs, the first of which will be completed during quarter one of 2023/24.

25. Of note for ICBs is their role to lead on the oversight of providers and work with NHS England regional teams if support is required at System Oversight Level 3. NHS England regional and national teams will continue to lead on support and intervention at System Oversight Level 4.

26. The Framework also signals the next steps in the transformation of NHS England, with the proposed merger of NHS England, Health Education England and NHS Digital on 1 April 2023, with the aim of putting workforce, data, digital and technology at the

heart of plans to transform the NHS. The full document can be found here: https://www.england.nhs.uk/wp-content/uploads/2022/10/B2068-NHS-England-Operating-Framework.pdf.

Consultation on Revised NHS Enforcement Guidance

27. As a result of the 2022 Health and Care Act, NHS England has recently launched a consultation on proposed changes to its Enforcement Guidance. The guidance sets out how NHS England intends to exercise its enforcement powers for both ICBs (including in relation to patient choice requirements) and providers, including setting out how it would use the powers to direct an ICB and the licence enforcement mechanisms that apply to foundation trusts, NHS trusts, licensed independent providers of NHS services and licensed NHS controlled providers.

28. The ICB will be responding to the consultation, the closing date of which is 9 December 2022. Further information can be found here: https://www.england.nhs.uk/long-read/nhs-enforcement-guidance-draft/.

The Care Quality Commission's (CQC) annual assessment of the state of health and social care in England

29. The CQC has recently published its annual assessment, based on its own inspection activity, information received from the public and those who deliver care. The overall assessment is that the health and care system is gridlocked and unable to operate effectively.

30. The CQC report notes that health and care staff want to provide good, safe care but are struggling to do so. This is reflected in growing public dissatisfaction with health and care services, which is mirrored in staff dissatisfaction.

31. The report recognises that solutions to the problems that affect people's care can only come from long-term planning and investment, with local areas taking a whole system view that recognises the relationship between health and social care and addresses the root causes behind the immediate and obvious problems.

32. The report calls for workforce shortages across all sectors to be addressed, with the focus being on shaping more flexible workforce models that help local systems meet the needs of all people.

33. In this year's report, the CQC also highlights its concerns about specific service areas, in particular maternity services and those that care for people with a learning disability and autistic people, areas where inspections continue to find issues with culture, leadership, and a lack of genuine engagement with people who use services.

34. The full report can be found here: https://www.cqc.org.uk/publications/major-report/state-care.

National Audit Office Report: Introduction of Integrated Care Systems

35. The National Audit Office has published a report on the introduction of ICSs. The report acknowledges the strong support for ICSs and highlights the challenges that ICS leaders face. The report conclusions are:

    a) The statutory Integrated Care Boards and Integrated Care Partnerships that form these systems are broadly welcomed by local service leaders.

    b) At present, the inherent tension between meeting national targets and addressing local needs, the challenging financial savings targets, the longstanding workforce issues and wider pressures on the system, particularly social care, mean that there is a high risk that ICSs will find it challenging to fulfil the high hopes many stakeholders have for them. To address these risks, DHSC and NHSE will as a first step need to clarify what a realistic set of medium-term objectives looks like under current circumstances, building on the work done on core NHS objectives to ensure ICSs can make progress on prevention and local priorities.

    c) NHSE and DHSC also need to tackle those pressures on ICSs that require national-level strategies and solutions, including workforce shortages, NHS financial sustainability and pressures on social care. ICSs need the time and capacity to build relationships and work together to design services that better meet local needs. If DHSC, NHSE and partners can address these challenges, then ICSs could bring real improvements in the longstanding challenge of bringing health, social care and other services together with the ultimate aim of improving the health and well-being of the populations they serve.

36. The full report can be found here: https://www.nao.org.uk/reports/introducing-integrated-care-systems-joining-up-local-services-to-improve-health-outcomes/.

APPENDIX A

Urgent and Emergency Care

System Winter Plan 2022

1. Our approach

This paper provides an overview of how local organisations are working together to meet anticipated urgent and emergency care needs this winter. It assimilates projections for healthcare demand, organisational actions to increase capacity and activity and shows the overall impact on our hospital beds. Our winter plan prepares us to respond effectively when people need to access urgent and emergency care. We are also working to increasingly prevent ill health and to anticipate care needs, shifting our focus to prevention as well as response. In future years, our plan will include more measures to prevent illness and crises happening in the first place, working alongside communities and primary care services.

Typically, pressures increase over the winter period because people are more likely to need admission to hospital or suffer winter illnesses. However, the level of pressure has been sustained and extreme in recent months, with many people working as if they were in the middle of a difficult winter for more than two years. This plan takes into account the current situation that front line teams are facing and builds in anticipated further mitigations for added service demands over the winter.

Organisations have put in place detailed plans to manage increased demand for their services and these have been brought together as a whole system plan[1]. Additionally, our system-wide Demand and Capacity Group has developed scenarios of demand for services over the winter period; founded on current activity, previous winter demand increases, influenza levels in the southern hemisphere this year and likely COVID-19 infection rates[2].

Based on our projections of what will be required, we are putting additional capacity into many of our services, including hospital and community-based beds and increased care in home settings. We are also undertaking the Autumn vaccination programme for influenza and COVID-19 to prevent as many infections as possible. We are expanding services that can safely care for people outside of hospital and we are improving our ability to discharge people from hospital in a timely manner.

[1] Mitigation impacts will continue to be iterated in the coming weeks, as organisational positions change. The assumptions include all current plan schemes, but more are likely to be quantified and added to the model.
[2] This scenario is termed a challenging winter, as it has addition COVID-19 and influenza projections, with the potential for a 'twindemic'

The ability of services to respond to demand levels is partly dependent on hospital / community bed and home support capacity. It also depends on the availability and skill levels of the workforce and operational processes within each organisation. A further factor is the ability of services to complete their care interventions and then work together so that people can move from one care setting to another as their needs change (known as flow). System flow is a key contributor to current service pressures, with delays and backlogs in accessing care at each point of care. The system winter plan combines actions in relation to each of these factors. All are inter-dependent in terms of overall impact and effectiveness of the plan. The table below shows the schemes that have been put in place or enhanced, over and above current services in 111, 999, general practice, community and mental health services, social care and hospitals[3].

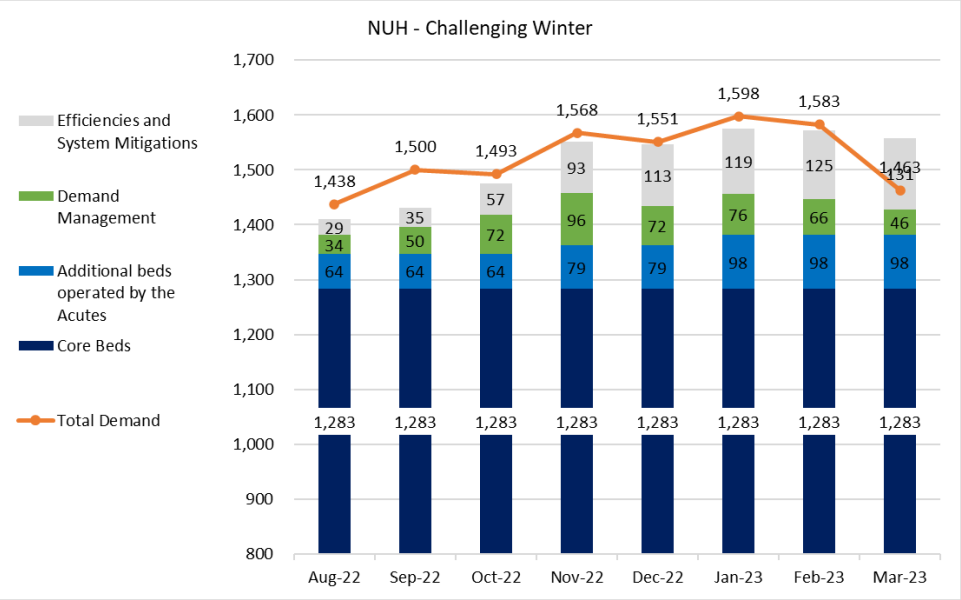
[3] Each organisation has detailed plans, with many operational actions within them.

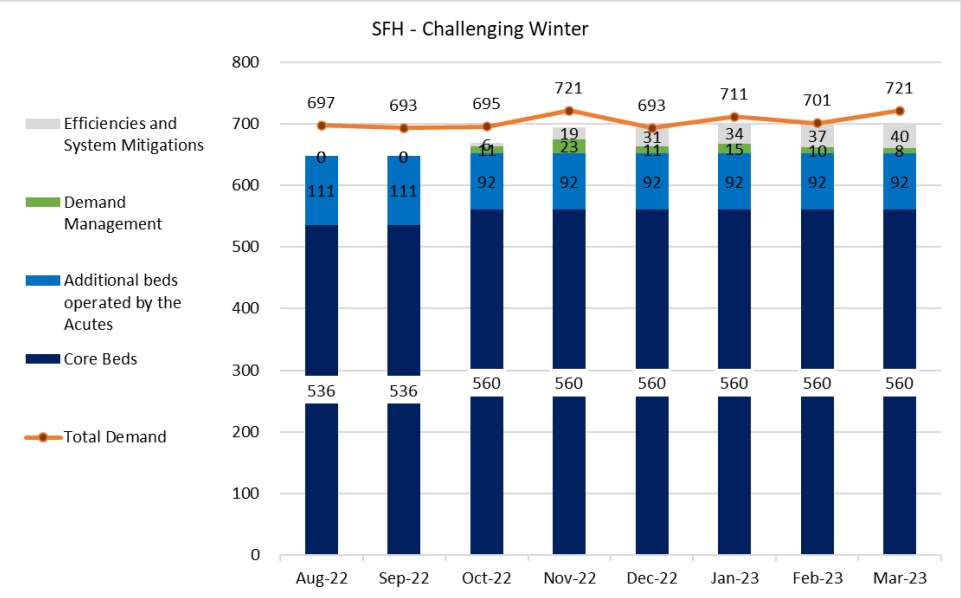
2. Our schemes

Preventing admission to hospital	In hospital assessment and treatment	Discharge from hospital and ongoing care
• Autumn COVID-19 and influenza vaccination programmes • Revised mental health crisis sanctuary model, with voluntary sector capacity to support statutory provision • Mental health expertise for 999 ambulance calls • Diversion of 111 ED dispositions through a Clinical Assessment Service and prevention of ED attendances • 111 direct bookings into primary care appointments, mental health helpline and text messaging • Alternative ambulance pathways, avoiding ED and going straight to relevant services • 2-hour urgent community response • Falls prevention, non-injury falls pathway and care homes pilots to reduce ambulance conveyances • Same day emergency care (SDEC) expansion • Hot clinics • High intensity user services and social prescribers in ED • Expansion of pulmonary rehabilitation services • Hydration in care homes	• New acute mental health inpatient unit with additional 14 beds • Opening additional acute hospital bed capacity • Rolling deep clean programme to reduce healthcare associated infections • Maintain high standards for ambulance handover times • Review of internal triggers and protocols • Reverse bed chains to improve flow from ED into the hospital • Timely clinical decision making / eliminating delays • Review of support services cover for additional capacity / weekend discharges • Staffing level reviews • Direct commissioning of additional 'step down' capacity • Ward one over processes	• Embed discharge to assess – discharge from a hospital bed with funded support and longer-term care assessments made at a more appropriate time • Development of discharge hubs to speed up discharge processes • Virtual wards with remote monitoring to reduce hospital admission / length of stay (frailty and respiratory) • Increased care home and home care capacity • 100 - day discharge challenge to improve processes across organisations • Maximise community bed utilisation and flow • Criteria led discharge • Fee uplift for homecare providers

3. Overall impact of the projected demand for hospital beds and our winter plans

Our demand and capacity hospital bed modelling shows projected demand and the system mitigations that are planned to bridge projected increases in demand and activity. The baseline assumes that delayed discharges will follow current trends, with some additional seasonal increases. The grey and green bars show the impact of confirmed winter schemes; based on activity trends, implementation phases and risk. The model also includes a risk-adjusted assessment of the impact of discharge and internal hospital schemes on length of stay. This is reviewed on a weekly basis at our system bed modelling group and will be a dynamic tool, with a report produced fortnightly for review by the Demand and Capacity Group. It will be regularly tracked against actual data points, as well as projected values as we go through the winter. Individual schemes will also be tracked in terms of their progress and impact through our ICS Urgent and Emergency Care Board.





Any shortfalls in terms of demand versus capacity would result in hospital occupancy increasing above the planned 90-92% levels within the model and / or reduced capacity to reduce elective care treatment backlogs. There was a national announcement of further winter social care funding over the summer and associated schemes are scheduled to come into effect in line with the model from the end of November, pending clarity on national funding mechanisms. Should these funding assumptions change, there could be up to a 2% increase in bed occupancy in later winter months if all other factors remain constant.

Our experience shows us that mismatches in capacity and demand can arise because of peaks in demand (such as COVID-19 waves), flow issues, process issues and workforce shortages preventing timely interventions at points of care. Frequently, a combination of these factors cause increased pressure at points of care, often manifested as overcrowding and delays in our emergency departments. For example, length of hospital stay has increased locally and nationally in recent months and this has an impact on the overall availability of hospital beds. These issues are monitored closely within organisations and across the system and relate to both patient and hospital factors. Escalation and trigger actions are under review to strengthen flow and the use of our capacity further.

4. Discharge and flow from hospital into community settings when people require ongoing support and rehabilitation

Flow through our system is a key priority, since this is a significant contributor to overcrowding in our emergency departments, ambulance delays and delays getting onto the relevant ward when admission to hospital is required. Delayed discharges

into home environments with supportive care result in people being less likely to maintain their independence in the longer-term and are a significant cause of system flow issues. Our analysis shows that a key constraint is the availability of home care and this has a knock-on impact on hospital and community service flow. This is a common problem across the country. Further detail on this aspect of the winter plan is therefore described in more detail.

We have been working together to understand what level of home care capacity is required to enable acute hospital discharges and recovery at home, enhance hospital flow and reduce risks and harm at all points of care. A discharge to assess business case has been approved, which builds a new model of care and the required capacity in pathway 1 (hospital to home with support). This increases capacity for hospital discharges from 214 per week to 302 per week by March 2023. We are now starting to see increases in activity levels as new capacity comes into effect.

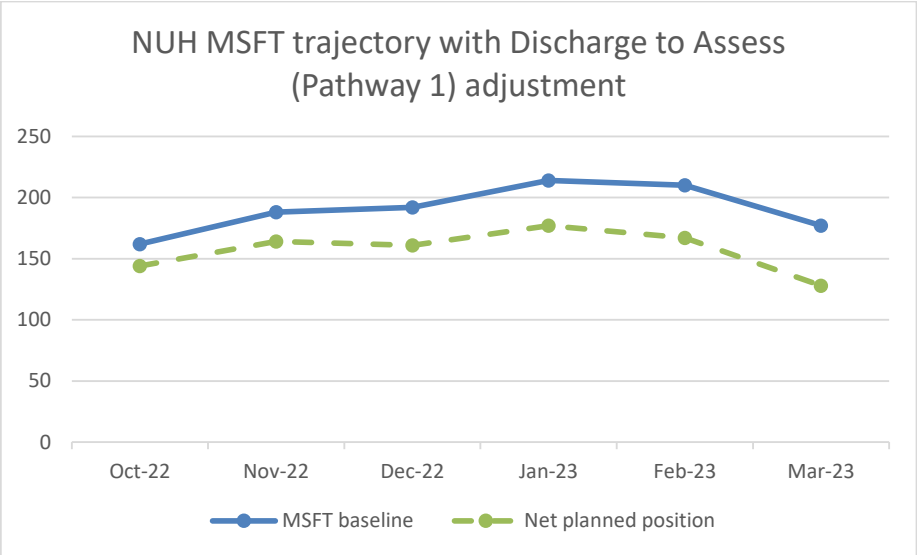
Summary	Weekly Demand being met met today (inclusive of temporary arrangements)	Demand met by proposal per week
Nottinghamshire Healthcare Trust	48	103
Nottingham City Council	21	40
Nottinghamshire County Council	81	90
CityCare	51	57
CCG / ICB	8	8
Total	209	297
Nottm County Council - EDASS	5	5
Total	214	302

Weekly Activity Trajectory Shown Per Month								
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
48	55	62	68	75	82	89	96	103
21	23	26	28	30	33	35	38	40
81	82	83	84	85	87	88	89	90
51	52	53	53	54	55	56	56	57
8	8	8	8	8	8	8	8	8
209	220	231	242	253	264	275	286	297
5	5	5	5	5	5	5	5	5
214	225	236	247	258	269	280	291	302
	11	22	33	44	55	66	77	88

The business case calculated the direct impact of increased pathway 1 capacity on delayed discharges from hospital, with increasing impact as more capacity takes effect. However, there isn't a standalone cause and effect relationship between pathway 1 capacity and reductions in delayed discharges from hospital because there are lots of different causes of delayed discharges. Capacity for home care following discharge is one key cause of delayed hospital discharges, but other internal and external factors and processes come into play and are significant. Discharges for people with ongoing care needs are in the minority in terms of overall hospital discharges, so a greater impact on overall flow will be achieved by looking at all discharge processes. We have therefore brought teams together to reduce all causes of discharge delays and have introduced hospital discharge hubs to streamline processes between different services and settings.

Taking all of this into account, our organisations have worked together to forecast the likely impact of the additional pathway 1 capacity on the levels of delayed hospital discharges (over 1 day). We will monitor this on a weekly basis and additional actions will continue to be taken to reduce delayed discharges further.

Estimated impacts for NUH are shown below. Similar calculations are also in progress for SFH.



5. Plan impact and delivery

Our plan brings together the efforts and expertise of all parts of our local NHS and care system. It includes a broad range of actions in many different care settings. There are no single solutions that will resolve the level of pressure on our urgent and emergency care services. Great care has been taken to make our assumptions as robust as possible, but they are plans rather than predictions and there are many interdependencies that could affect how the system works together over the winter. We will monitor impact and progress very regularly.

National and local evidence and metrics are emerging concerning delay-related patient harm. We have analysed the impacts of serious incidents across the system and will introduce clinical delay-related harm measures into our plan monitoring processes. We will also track impacts on staff and will continue staff wellbeing offers.

Risks to delivery of the plan include workforce availability, ongoing support needs at home (reducing outflow from the additional pathway 1 capacity into step down services), infection outbreaks requiring beds to be closed to new admissions, impacts on reducing elective care backlogs, inclement weather, industrial action and health impacts associated with the increased cost of living.

However, we can take additional steps to monitor and manage risks as they arise. We will put in place a System Control Centre to ensure a consistent and collective approach to managing system capacity, demand and clinical risk. This will work

closely with organisational operational controls to coordinate and mitigate pressures across the system. We also have defined escalation levels, with additional triggers as levels of pressure and delays increase. We have interim care home placements that we use to support flow from hospitals when people need somewhere to recuperate from the acute phase of their illness.

We have also learnt from previous critical incidents and have adapted operational processes as a result. We work closely together to understand and escalate actions when organisations experience high levels of pressure. We have daily operational calls, whereby partners can take supportive actions to pre-empt further pressure building up. Examples include ambulance diverts and staff redeployment. There is a high level of commitment to work across organisations to respond to increased winter demand and a strong spirit of collaboration.

Our plan is based on robust analysis and a comprehensive set of actions across all organisations. We will closely monitor implementation and impacts of the plan for the population that we serve, recognising that all elements are important and all have a part to play in the overall effectiveness of our plan.

Amanda Sullivan

ICB Chief Executive

Appendix B

The rising cost of living – pulling together to support local people

1. Our staff and citizens are facing an unprecedented combination of pressures that require collective action

The NHS is currently facing a combination of pressures that require a concerted and collective approach. Some are directly related to the pandemic, including treatment waiting times backlogs, a tired workforce, increased mental health presentations and long covid. Recent heatwaves have added to demand for urgent care. We are also unable to maintain adequate flow across the urgent and emergency care pathways, with bottlenecks at each care point. This creates increased ambulance response times, emergency department overcrowding, delayed discharges and longer waits to access emergency assessment and treatment.

Considerable work is underway to address elective waiting times backlogs and to plan for anticipated winter emergency demand. It is likely that there will be significant levels of respiratory infection because of flu, covid and pneumonia.

Additionally, there are factors that add another layer of complexity, unpredictability and risk to our plans and forecasts. A key constraint relates to workforce, with problems in terms of both recruitment and retention. Disruptive industrial action is also possible across a wide range of service areas.

Furthermore, there are humanitarian concerns regarding the rising cost of living and food, fuel and energy affordability for a substantial proportion of our population (dilemmas of eating or heating). This may result in short and long-term health impacts such as:

- increased respiratory infections
- excess deaths
- lower attendance for healthcare appointments if there are associated travel costs
- poorer nutrition and increased vulnerability to illnesses and disease
- poorer mental health
- reduced access to co-payment services such as prescriptions, dentists, opticians and sexual health

This paper is specifically focused on the collective actions that the NHS will need to take to mitigate health and humanitarian impacts of the rising cost of living.

2. The ICS has a role in ensuring that we improve health outcomes and that the NHS contributes to social and economic development

ICSs were developed to integrate care and to marshal our collective resources for maximum population benefit. This means that boundaries between organisations and sectors should blur in the overall interests of local citizens. We have established the core partnerships and collaboratives across our system, so we now need to identify how we work together to support people with the rising costs of living, alongside provision of NHS care and the management of service pressures. We will also work with multi-agency partners to align our public sector approach to the rising cost of living. Proposed action areas across the ICS are:

Integrated Care Board	Place Based Partnerships
• Coordinate the flu and covid vaccination programme, with a focus on increasing uptake in vulnerable groups and reducing inequalities • Maximise the use of communication channels to provide advice and information to the public, amplifying partner messages where required • Work with partners to agree approach and support mechanisms for NHS and social care staff • Provide staff support and signposting to ICB staff, working in line with the provider collaborative approaches. • Share details of different support services across communications teams and organisations • Monitor the impacts of increased costs on small contract holders, including general practice and support where appropriate. • Work with Place-Based Partnerships and Primary Care Networks to help citizens save money on the cost of medicines. This includes promoting the NHSBA low income scheme, prepayment certificates, over the counter generic brands, inexpensive self-care on minor ailments	• Work alongside community, faith and voluntary groups to identify vulnerable groups and provide support / signposting to appropriate advice • Work with local authority partners to maximise uptake of support schemes / benefits / financial advice across the area • Ensure that the partnership maximises health prevention activities, such as vaccine uptake and access to healthcare • Support access to food banks, travel schemes and heating support through partnerships with voluntary and community services, multi-disciplinary teams, falls prevention, long-term conditions and paying for medicines
Provider Collaborative	Primary Care Networks

• Develop and provide staff wellbeing interventions and support mechanisms • Maximise recruitment and retention, developing common approaches • Maximise staff vaccination • Maximise opportunities as anchor institutions to support local employment and opportunities • Making every contact count – enquiring about access to food and heating • Increase virtual follow-ups to reduce travel costs • Develop approaches to respiratory illness and admission avoidance with partners	• Ensure social prescribing and MDT working maximises support and signposting to support mechanisms • Identify and support vulnerable households, with proactive signposting and the provision of support mechanisms where available, working with the VCS, public health teams. The SAIU has identified fuel poverty areas for targeted support. The Integrated Care Board and Place-Based Partnerships will support PCNs to develop approaches where appropriate. • Ensure comprehensive access to urgent care appointments through collaborative working, reducing travel costs and linking with other support services where required

3. Organisations have worked to develop support mechanisms and services

Councils at District and Upper Tier level are developing a wide range of support mechanisms and services. NHS organisations are also taking steps to support staff and citizens. Place-Based Partnerships will have an important role in working with communities and understanding where particular vulnerabilities exist. This work will continue to develop as services and support offers evolve. Chief Officers have also agreed to work together and share information on support offers. This will be discussed on an ongoing basis at the Chief Officers' Forum.

4. Next steps

- Collate information regarding developing support offers and ensure that this is shared for organisations and practitioners to use for signposting and referral.
- Discuss and agree next steps at the ICS Executive Leadership Group and with leadership teams across organisations
- Continue to support the development of initiatives that mitigate impacts of the rising cost of living.

Amanda Sullivan, ICB Chief Executive

Appendix C

Embedding Citizen Voice in Nottingham and Nottinghamshire Integrated Care System

Citizens' Panel

In September 2022 the approach for the development of the Citizens' Panel was presented to the Engagement Practitioners Forum, Locality Directors and City Place Based Partnership Execs. Consideration has been given to the feedback shared at that time, specifically how the Citizens' Panel fits in with existing work within the Place Based Partnerships, the accessibility and detail of the information for all system partners and how the Panel will be made available to other areas of Nottinghamshire.

The Panel was launched in late September and recruitment of citizens is currently underway. The first engagement survey will be issued in November. Surveys will be issued every three months and the survey schedule will be developed in conjunction with the ICS Engagement Practitioners Forum.

A comprehensive communications plan highlighting the planned work including an activity plan, social media launch, and press release has been developed, and is being implemented in line with Panel recruitment.

Panel Member resources have also been compiled including clear guidelines on roles of all parties, information on how their data will be used, and a comprehensive welcome pack for those recruited to the Panel.

The Engagement Team continue to work closely with key stakeholders such as Nottingham CVS, Healthwatch Nottingham and Nottinghamshire, Nottingham Trent University, University of Nottingham Business School, CityCare, NUH and other Place representatives.

ICS Engagement Practitioners Forum

The first formal meeting of the Engagement Practitioners Forum took place on 14 September 2022 with over 20 engagement professionals in attendance from system and partner organisations. This meeting was chaired by Healthwatch Nottingham and Nottinghamshire.

At the meeting, colleagues were provided with information around the Integrated Care Strategy and the upcoming ICS Partners Assembly. Colleagues also heard from our Quality Team around the ICS Quality Strategy and the engagement work that will be happening across Nottingham and Nottinghamshire to inform its development.

During the meeting colleagues also shared current engagement opportunities from their organisations and how we can work in partnership to deliver priorities.

The next meeting will be held in November 2022.

The ICS Engagement Practitioners Forum will continue to provide a platform for all system partners working with people and communities to work collaboratively, share resources, knowledge and expertise and maximise existing knowledge and insights.

Citizen Intelligence Advisory Group (CIAG)
The CIAG is a group of experts in the fields of research/insight/engagement working across the system, to provide assurance and challenge that the appropriate work is being done to listen to and involve our citizens. This group will have a link to the ICP and ICB Board.

An informal introduction session took place on 21 September, with representation from the ICB, VCSE Alliance, Healthwatch Nottingham and Nottinghamshire, Nottingham Place and Mid Nottinghamshire Place. Apologies were received from Bassetlaw Place and SFHT.

The key discussion points were regarding the draft Terms of Reference and the wider system engagement structures.

The first formal meeting will take place on 1 November.

Voluntary, Community and Social Enterprise (VCSE) Alliance
The first formal meeting of the Voluntary, Community and Social Enterprise (VCSE) Alliance took place on 4 October 2022 with members from 15 different VCSE organisations in attendance.

The VCSE Alliance Terms of Reference have been agreed, and members are inviting other VCSE organisations to join the Alliance.

The Alliance members agreed that an Independent Chair should be recruited to lead the group. This approach has been endorsed by the ICB Executive team. A sub-group has been created to develop the recruitment process.

A framework for capturing VCSE Alliance intelligence and insight is under development. This will help us understand and theme the information and insight that VCSE organisations hold, what they are hearing from people and communities and what mechanisms they use. A Task and Finish Group has been established that will co-design the framework.

The next VCSE Alliance meeting will be held on 6 December 2022.

NHSE ICB Engagement Leads events

In light of the positive feedback from NHSE on our overall approach to working with people and communities, we were invited to present at the inaugural National Share and Learn session for ICB Engagement leads on 7 October 2022. At this event, we spoke about how people and communities are represented across System and Place.

On 13 October 2022 the Engagement Team attended a face-to-face conference with national ICB Engagement Leads. At the event there was an opportunity to meet and learn from other ICBs to understand how they are working and engaging with their people and communities. At the event our structures and mechanisms were discussed within round table settings along with our planned involvement activities to develop the Integrated Care Strategy.

Both events were great opportunities to showcase the work that is happening across our system.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	10/11/2022
Paper Title:	**Nottingham and Nottinghamshire ICS Primary Care Strategy**
Paper Reference:	ICB 22036
Report Author:	Dr Stephen Shortt, Clinical Lead
Report Sponsor:	Dr Dave Briggs, Medical Director
Presenter:	Dr Dave Briggs, Medical Director
Recommendation(s):	The Board is asked to **APPROVE** the ICS Primary Care Strategy.

Summary:

The Nottingham and Nottinghamshire Integrated Care System's Primary Care Strategy responds to the key priorities of patient need, workforce capacity and the need to transform primary care within the context of system working. It recognises that primary care is the linchpin of the health and social care system and is central to transforming people's health and wellbeing outcomes and experience.

The strategy needs to:

a) Establish a 5+ year strategic intent, against which every idea will be tested
b) Create the motivation for system transformation
c) Ensure a fairer distribution of resources which equitably reflects difference
d) Outline a credible plan for recruitment and retention
e) Create mechanisms to engage and work with other independent contractor professional networks

Delivery of the strategy will not be without its challenges; however, success will be achieved through shared commitment to the delivery of realistic outcomes.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	There is as well established and strong and evidence base that when performing well, primary care over time saves lives, improves health outcomes and experience of care, reduces inequalities and can also reduce costs. Moreover, continuity of personal care is strongly associated with lower mortality and a reduced need for acute hospital care and urgent care services.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:
Appendix 1 - Transformed and sustainable primary care: benefits and risks

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 2: System Resilience (for Managing Today) – Failure to work effectively across the system to ensure current levels of demand are met across primary, community and secondary care. • Risk 3: Transformation (for Making Tomorrow Better) – Failure to work effectively across the system to reform and improve services to ensure best possible health outcomes within available resources.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	Yes
Duty to promote innovation	Yes
Duty in respect of research	Yes
Duty to promote education and training	Yes
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	Yes
Duties as to climate change	No
Duties regarding public involvement and consultation	Yes
Public sector equalities duties	Yes

Report Previously Received By:
N/A

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Nottingham and Nottinghamshire ICS Primary Care Strategy

Introduction

1. Our vision for a strong and effective Integrated Care System can only be achieved with strong and effective primary care, which is the linchpin of any health and care system. The steady personal commitment in primary care over time saves lives, improves health outcomes and the experience of care, reduces inequalities and moderates costs. Day by day, year by year primary care clinicians provide care, which is first contact, continuous, comprehensive, co-ordinated, collaborative and cost effective.
2. We propose a policy focus on continuous relationship-based, tiered, and progressive care which can prevent thousands of our citizens from suffering and ultimately dying from conditions that can increasingly be predicted, prevented, and managed. This is not in competition but in sync and in partnership with specialist care.
3. Patients are changing both in the complexity of their conditions and in their expectations, and this means that if primary care is going to continue to provide its essential contribution to the health and care system, it must evolve and innovate.

Our ambition

4. The ICS Primary Care Strategy needs is compliant with the NHS Long-Term Plan and the Fuller Stocktake report, and needs to:
    a) Establish a 5+ year strategic intent, against which every idea will be tested.
    b) Create the motivation for system transformation.
    c) Ensure a fairer distribution of resources which equitably reflects difference.
    d) Outlines a credible plan for recruitment and retention.
    e) Create mechanisms to engage and work with other independent contractor professional networks.

A picture of transformed and sustainable primary care in Nottingham and Nottinghamshire

5. Primary care will remain the bedrock of the health and care system, central to transforming people's health and wellbeing outcomes and experience. Key attributes of future primary care in Nottingham and Nottinghamshire will include:

a) Partnership working: practices will work with each other in an increasingly integrated and community-oriented way and also with other local health and care services.

b) Patients as partners: patients and carers are core members of the care team.

c) Strong health promotion and illness prevention: good joined up wellbeing policies and plans across sectors.

d) Excellent population and patient segmentation and stratification: tailoring equitable support to enable citizens to enjoy their best possible health and wellbeing.

e) Continuous personal, integrated health and care for our elderly, frail citizens and those with complex needs: provided seamlessly at or close to home and funded fairly.

f) Community-based mental health services: recognising the societal and personal importance of mental health, and interdependency with physical health and wellbeing.

g) Excellent evidenced-based care plans and pathways: developed by clinicians and patients, supported by improvement science.

h) Scaled primary care working: more resilient with the capacity and resources to deliver more services where this makes sense. Scaled up primary care will have access to diagnostics and treatments provided in fit for purpose facilities and supported by integrated neighbourhood teams.

i) Accountability: through the registered list and for outcomes not activity.

j) 'Hub and spoke' services: care in communities where possible but consolidated when necessary to improve outcomes and efficiency.

k) Workforce training development and motivation: delegation of skills from both the perspectives of patients and providers and achieving a positive workplace and workday experience for all.

Strategic framework for transforming primary care

6. The ICS Primary Care Strategy is built on the detailed insight obtained through co-creation and strong engagement with a broad range of existing stakeholder groups, including Primary Care Network (PCN) Clinical Directors, Place-based Partnership Leaders, Locality Directors, the Local Medical Committee, GP federations, primary care commissioners, general practice providers, patient and public representative groups and Trust Clinical Directors.

7. Three themes and ten objectives form the strategic framework for transforming primary care and identify opportunities for innovation and adaptation. The ten

objectives of the strategy are distinct but are interdependent and mutually reinforcing. The full value opportunity can only be only realised through the implementation of them all.

Theme 1: Laying the foundations to recover primary care
1. Establishing the clear culture, narrative and purpose
2. A focus on the person, patients and population; restoring the person - professional 'compact'
3. Enhancing access to primary care services
4. Improving communication, enabling information technology, sharing records and securing fit for purpose estate
Theme 2: Improving primary care quality
5. Supporting clinical transformation; the adoption of the population health management model
6. Supporting PCNs and establishing integrated care teams
7. Quality, data, and performance; research and innovation
Theme 3: Making our system sustainable
8. Workforce development and motivation; engaged and visible leadership
9. Evolving the finance and contractual model
10. Supporting provider and business model reform; green primary care

8. To achieve our ambition for high performing primary care, we will have a focus on at scale provision and integrated new models of care, delivering a person-centred approach. Key enablers include:

   a) Provider developments with particular attention to PCNs enabling service and workforce integration

   b) Local workforce priorities and actions which support development of an expanded workforce and Multi-Disciplinary Team (MDTs)

   c) Maximising and improving our estate, use of digital technology, and analysis and information to increase access for patients

9. Appendix 1 sets out the underpinning detail for each of the ten objectives within the strategy, along with the associated benefits and risks.

Delivery

10. This primary care strategy is a road map not a rule book and describes the health and care system we wish to create working with all local partners to deliver it. Implementation will require us to build transformational leadership capacity and capability, supported by building a change platform for innovation and improvement to spread progress in a more dynamic way than we have been able to do previously.

11. Implementation will be led and sustained by providers, not from a top-down managed process or hierarchical leadership model. It will require local planning and customisation.
12. Effective communications and engagement are essential to the successful delivery of the primary care plan. So far there has been a very strong appetite to move forward into implementation and delivery. A further wider and meaningful engagement with 'front line' primary care is proposed.
13. Delivery aims to overcome silo working and make connections between ICS programmes including the community, mental health and hospital transformation programmes, Place and PCNs. Delivery will be taken forward at both a local level by PCNs and Place, and as a system for sharing good practice and common solutions.
14. We propose that the governance and delivery arrangements be embedded into the ICB organisational structure, processes, and plans.
15. We propose the establishment of a Primary Care Transformation Board to provide strategic oversight and testing from across the ICS and ensure the strategy is ambitious enough to meet the needs of the people and professionals in the ICS. We will recruit both clinicians and caregivers to test rigour and practicality of the plan, and patients and public to provide insight and direction.
16. We will identify headline programme monitoring indicators e.g., patient and staff satisfaction, system impact, clinical outcomes, investment profile, change registered in the service offer.
17. Finally, we propose identifying an evaluation and learning partner e.g., a local university and establishing development opportunities to improve quality improvement capability.

Conclusion

18. The ICS Primary Care Strategy will not sit in isolation and should be considered alongside the Community Transformation Programme and PCN and Place development plans. The confluence of these plans and strategies creates a clear vision for the future role of primary care and bringing them together will form a singular delivery road map for primary care in Nottingham and Nottinghamshire.
19. The Primary Care Strategy does not begin from a standing start but builds on the significant recent and ongoing transformations in the system, including the Five Year Forward View, Additional Role Reimbursement Scheme (ARRS), Extended Access Directed Enhanced Service (DES) and a number of other innovations supported by the System Development Fund. Despite these foundations the strategy will require a significant increase in the pace and

support of transformation to our primary care sector and to expand rapidly into the pharmacy, optometry and pharmacy sectors.

20. The ICB's Strategic Planning and Integration Committee will oversight the Primary Care Transformation Board, which will further develop and ensure delivery of the Primary Care Roadmap. The Primary Care Transformation Board will promote and facilitate the collaborative design and implementation with and at Place.

21. The Strategic Planning and Integration Committee endorsed the proposed strategy at its November meeting, recognising the complex nature of this process and agreeing that accelerator sites should be sought to conduct supported rapid collaborative redesign and implementation at scale enabling essential learning to be established and shared at a system level. These 'test beds' will have the necessary support to transform access both for continuity of care but also more general access for the population they serve, working at scale and with local Place based partners. It is envisaged that an external academic partner will support with the evaluation process, this external evaluation will be essential for rapid roll out of the learning from the sites to other parts of the system.

22. In addition, to support wider primary care transformation and system integration the Strategic Planning and Integration Committee recognises the need to support primary care in the expansion of the Pro-Active Care Model. This programme focuses on members of our population with some of the most complex needs and the specific requirements for continuity of care that is needed and forms the first part of the significant changes required to deliver the ICB's Population Health Management Plan.

23. Delivery of the Primary Care Strategy will see more efficient and effective services, improved financial stewardship and excellence in outcomes, and will enhance the trust, support and confidence of our population.

Appendix 1 – Transformed and sustainable primary care: benefits and risks

Benefits

Attribute		Details	Benefits
a)	**Partnership working**	Enhance integrated working within GP federations, with PCNs, place, secondary care and wider health and care services. Build from strong existing PCN base. Facilitate PCNs to evolve into Fuller "integrated neighbourhood teams". Develop and embed best primary care medical standards that recognise the whole practice team contribution of continuity to quality of care. Strong focus on Multi-Disciplinary Team (MDT) working, information sharing and care planning. Build a culture of collaboration and co-production across organisations and sense of belonging to and accountability for the system. Embed strong primary care leadership and influence in the ICS. Build more productive, less competitive relationships.	Ongoing PCN development will enable practices to: • meet complex needs, improve access, and reduce unwarranted variation through standardised care pathways and consistent delivery through an MDT approach • Empower communities to develop asset-based interventions to improve health and wellbeing (e.g., dementia networks, social prescribing initiatives) • Develop alternative access opportunities and care pathways utilising Additional Role Reimbursement Scheme (ARRS) roles will create capacity for GPs to manage patients with complexity. Further developing a primary care model which is less dependent on GPs, sharing responsibility for patient care across lower cost professionals will increase value (as defined by quality/cost) Well recognised benefits of continuity of care including: • Increased satisfaction, both for patients and staff • Reduced costs: prescriptions, tests, Emergency Department attendance, and hospital admissions • Increased trust within the clinician - patient relationship

Attribute		Details	Benefits
			• Increased willingness to accept medical advice, including adherence to long-term preventive regimens • Improved problem recognition and quality of management Cross-organisation collaboration and relationship building will: • Facilitate development of standardised streamlined patient-centred pathways • Accelerate system development and innovation • Overcome system roadblocks
b)	**Patients as partners**	Ensure a strong patient voice, both as individuals receiving care and as stakeholders. Ensure patients and carers are core members of their care team. Shared decision making embedded as standard. *"No decision about me without me".* Co-production in design, delivery, and governance of primary care. Development and embedding of Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) to assess the quality and experience of healthcare, as reported by patients. Enhance the role of Patient Participation Groups (PPGs) within practices to ensure patients voice is heard in the way services are delivered to best meet their needs, and the needs of the local community.	Building trust between patients and primary care will: • Facilitate the restoration of the social contract • Create opportunities to agree and enact reasonable and mutual expectations • Facilitate ongoing calibration of patient experience and expectations with service delivery Evaluation of shared decision making has shown the potential to: • Improve communication and establish trust between patients and clinicians • Improve outcomes (including decreased anxiety, quicker recovery, and increased compliance with treatments) through engagement and empowerment of patients • Reduce costs as people who are fully informed about the risks and benefits of treatments tend to choose less-

Attribute		Details	Benefits
			invasive, less-costly interventions and are happier with their decisions • Reduce unwanted clinical variation and enhance allocative efficiency Use of PROMS and PREMS will enable primary care and the wider system to make informed changes to their services Enhancing the role of PPGs can: • Help clinicians to develop an equal partnership with their patients and the wider community • Help to improve services and resource utilisation by identifying changes that the practice may not have considered, which reflect what patients want and need • Nurture mutually supportive networks for patients and the practice • Play a role in encouraging healthier communities through the provision of information and support
c)	**Health promotion and illness prevention**	Ensure all members capitalise on the many opportunities in primary care to promote health and well-being, as the first point of contact for most patients. Embed as standard, a "*Making Every Contact Count*" approach.	Supporting individuals to make healthier choices will reduce the risk of developing ill health, disease, and premature death from preventable diseases caused by behavioural factors such as smoking, poor diet and excessive alcohol consumption. Adopting a person-centred approach improves patient engagement and activation.

Attribute		Details	Benefits
		Adopt a person-centred approach to empower individuals to take actions for their own health, utilising appropriate support tools. Utilise our network of social prescribing link workers to effectively signpost and our PPGs to promote healthier communities through the provision of information and support. Ensure localised tailoring and delivery of system-wide strategies including our ICS Health Inequalities Strategy. Undertake evaluation and monitoring of approaches.	Tailoring strategies and resources to take account of local priorities will potentially increase impact on populations with greatest needs. Ongoing evaluation will help to shape further interventions.
d)	**Segmentation and stratification**	Use knowledge of the health and care needs of local populations to target interventions and resources to best effect. Provide the right amount of the right care, neither too much nor too little care, rather than meeting a minimum standard for all segments. Understanding which individuals and cohorts are at greatest risk of needing certain types of care and interventions.	Providers can take responsibility and create bespoke services for populations with heightened risks as determined by analysis of local population needs. Tailoring services to local population needs can improve health outcomes and experience for both groups of patients and individuals. Ensuring resource and capacity are better distributed to where most needed will promote equity of access to and quality of care. Developing specialist expertise can ensure the optimal response to the needs and preferences of a specific population segment.

Attribute		Details	Benefits
e)	**Integrated care for frail elderly**	Coordinated responsive pathways which focus on holistic person-centred care and not just disease-specific interventions and treatments. Care will be underpinned by a strong evidence base around effective assessments and interventions for frailty. Strong focus on prevention (for example falls, UTIs) and early identification of frailty Development of registries and registry managers to identify and manage care gaps. Patients will be listened to and treated with dignity and respect. *"What matters to me"* not *"What is the matter with me".*	Evidence-based, person-centred care with a strong focus on prevention: • Enables people to live better and more independently with frailty • Supports a reduction in the number of unscheduled primary and secondary care contacts Potential costs savings can be realised through: • Reducing avoidable hospital attendances and admissions, and reducing lengths of stay • Reducing or delaying the need for home care and residential care Facilitating early medical assessment (within two hours) followed by appropriate care and treatments for unwell frail patients, is associated with lower mortality, greater independence, and reduced need for long-term care.
f)	**Enhanced mental health services**	Embed a cultural shift (as outlined in the ICS All-age integrated mental health and social care strategy), so that all staff see mental health as their business, understanding the issues people face, the support they need and the resources available to provide that support. Responsive holistic services which deliver care in an integrated way to ensure that a person's mental health, physical health and socioeconomic needs are addressed together.	A responsive holistic approach to mental health care can improve outcomes and experience, and reduce costs through: • Encouraging the prompt uptake of treatment • Promoting mental health awareness and faster diagnosis • Identifying and addressing a person's needs more quickly and accurately • Reducing a person's use of physical health services • Improving relationships within teams and services

Attribute		Details	Benefits
		Deliver parity of esteem so that mental health is placed on a par with physical health. Ensure timely access to effective crisis management both within primary care and with the wider system. Ensure comprehensive access to talking therapies through Improving Access to Psychological Therapies (IAPT) Improve mental health awareness and understanding through delivery of mental health awareness training to all health care professionals in line with our ICS aim Ensure that there is high quality, comprehensive primary care mental health support for children and adolescents, and for older people, and that there is timely and seamless access to specialist services when required.	• Empowering people to manage their condition and access appropriate support Efficiencies can be realised through: • Reducing the number of frequent attenders and repeat assessments • Decreasing the likelihood of people not attending appointments • Increasing the quality of referrals whilst reducing the demand for specialist services • Effective management of transitions between services • Supporting people to access/remain in employment, thereby increasing economic productivity Talking therapies help to improve self-management and health outcomes in people with long-term conditions, who also have with anxiety and depression. Successful therapy can help to reduce reliance on primary and emergency care. There is also strong evidence for the use of therapies to support people with medically unexplained symptoms. Timely access to primary, community and specialist services reduces the need for crisis services.
g)	**Care plans and pathways**	Pathway development and implementation will be clinically led. There will be adequate funding for both development and implementation of pathways. Pathways will be standardised and based on best available clinical evidence.	Widespread use of standardised evidence-based pathways has many benefits including: • Reducing unwanted clinical variation • Improving outcomes through clinical adherence

Attribute		Details	Benefits
		Pathways will be holistic and person-centred, and will include all stages of care including prevention, primary care, and specialist care, ensuring delivery of the right care at the right time in the right place. There will be a focus on managing transitions between different parts of the system. Pathways will be supported by patient and clinician information and education. Pathways will be digitally enabled to facilitate data sharing among providers. Pathway implementation will be supported an effective governance structure to ensure clear, pathway-wide accountability for outcomes and costs.	• Increasing system delivery efficiencies through more appropriate use of specialised services and reducing duplication and waste • Facilitating close working between primary care clinicians, specialists, and other health and care professionals Clinical involvement in pathway development builds support and buy-in from clinicians for the changes to care delivery. Evidence based clinical pathways enable systems to determine the interventions' relative importance, prioritise how resources are allocated, and identify the outcome metrics that will help ensure optimal care delivery. Patient education is important, especially for chronic disease care pathways, because it strongly influences whether patients are willing to adopt healthier behaviours, comply with treatment, and engage in other forms of self-care. An effective governance structure ensures accountability as patients are transferred between providers.
h)	**Delivering primary care at scale**	Primary care 'at scale' brings groups of general practices together to provide care, working within multidisciplinary teams to support first-contact with patients. PCNs are the key delivery vehicle for primary care 'at scale'. Accountable clinical directors from each PCN are the link between primary care and the wider system.	Delivering primary care at scale offers many benefits including increasing resilience in primary care and improving quality and clinical outcomes for patients. Improved quality and clinical outcomes can be achieved through: • Working at scale to meet agreed best practice standards for access and for continuity of care

Attribute	Details	Benefits
	Primary care ‘at scale’ should be large enough to have impact and economies of scale, but not so large to lose the personal care ethos valued by both patients and primary care clinicians. Primary care ‘at scale’ will take a proactive approach to managing population health and assessing the needs of their local population.	• Releasing resources for front-line patient care by delivering efficiencies through economies of scale • Realising opportunities to expand the range of services to patients and to easily integrate with the wider health and care system Greater resilience within primary care can be achieved through working at scale to: • Managing financial and estates pressures and enabling better use of the primary care estate. • Achieving efficiencies from shared admin/business support functions, facilitating growth in capacity and capability • Streamlining fixed cost base (e.g., workforce, estates) • Improving the ability of practices to recruit and retain staff • Planning and mobilising rapid ‘at scale’ delivery of services in times of crisis • Volume consolidation through specialist generalist role reduces specialist utilisation without a reduction in outcomes or experience Primary care ‘at scale’ supports the expectations and preferences of younger GPs, many of whom want to combine General Practice with other clinical work and prefer not to take on the administrative demands of partnership. It also offers opportunities to get involved in innovation and

Attribute		Details	Benefits
			transformation that will improve patient care in the longer term.
i)	**Accountability**	Embed a culture of accountability based on common values and motivations, as an integral part of primary care. This includes a culture of safety rather than blame. Ensure a culture of transparency and clear communication. Leaders will demonstrate honesty and integrity and the opinion of everyone will be valued. Clear channels for feedback and reporting will be developed. Develop and embed a formal code of conduct for the workforce as part of staff induction and ongoing rolling training programmes. Develop a set of standards which primary care is measured against (e.g., access, patient experience) to measure progress. Create incentives for clinicians to accept some fiscal responsibility for influenceable spend through continuous quality improvement.	A culture of accountability improves clinician-patient trust, reduces the misuse of resources, and helps organisations provide better quality care. Outcomes-based accountability to drive improvements and efficiencies. Accountable organisations can learn from mistakes and continuously improve. If primary care leaders model accountability, transparency, and ethical behaviours, they set an example for other staff and provide a strong trusted voice within the system. Staff are more likely to go above and beyond when they feel heard and empowered. A culture of accountability also provides greater professional satisfaction by improving the work environment.
j)	**Hub and spoke services**	Hub and spoke models facilitate delivery of care by the right person, in the right place, first time. Services may be: • Centrally managed and centrally delivered • Centrally managed but locally delivered	Hub and spoke services can deliver integrated services working in partnership with primary care and with the wider system. Benefits of the model include:

Attribute		Details	Benefits
		• Locally managed and locally delivered Hub and spoke models support the delivery of both primary care services and more specialist services being delivered in primary care settings.	• Provision of patient-sensitive access offers, based on needs and preferences, including face-to-face and virtual (synchronous and asynchronous) • Shared expertise, accountability and risk across providers • Quality improvements through standardisation of care and greater continuity of team-based care • Increased efficiencies through minimising duplication of services and increasing economies of scale • Increased treatment capacity • Mitigation of unwarranted use of and pressure on other services (e.g., urgent and emergency care)
k)	**Workforce plan**	The workforce plan for primary care is aligned to the wider ICS People and Culture Strategy 2019-2029 Priorities include: • Growing a sustainable workforce with the right skills, knowledge and capacity, making effective use of people's skills and experience. • Developing robust recruitment and retention plans, promoting the ICS as a vibrant and progressive place to work. • Providing training and development opportunities, ensuring people are working at the top of their	Primary care will benefit from a motivated, passionate and diverse workforce which supports service delivery and improvement. Benefits of an effective and comprehensive workforce plan which include: • Ensuring adequate capacity, flexibility, skill mix, and capability within the workforce, to support delivery of clinical excellence, aid recruitment and retention and ensure a better workday experience for all • Developing new roles and innovative ways of working

Attribute	Details	Benefits
	licence, and supporting new starters and newly qualified staff. • Providing career planning and development. • Building teams and leaders within primary care with the confidence and capability to work in partnership across the ICS. Developing general practice management capability. • Equipping the workforce with the skills to take forward digitalised care and work with new technologies and artificial intelligence • Demonstrating a commitment to strong equality, diversity and inclusion values, including opportunities for the diverse workforce to develop and to progress into senior roles. • Provision of quality health and wellbeing support for everyone. • Facilitating flexible and remote working to support work-life balance. • Ensuring the workforce feels valued and has a voice, through the development of the “immersion programme” • Reconnecting GPs with traditional values and increasing ‘caring’	• Widening participation and ensuring equity of opportunity for all, through a comprehensive equality, diversity and inclusion strategy • Providing career development opportunities including clinical leadership training and mentoring • Embedding and supporting the specialist- generalist model to support career development opportunities and aid retention

Attribute		Details	Benefits
		Develop a set of performance metrics, including retention and vacancy rates, skill mix of teams, sickness levels, reasons for leaving.	
l)	**Improving primary care infrastructure**	Investment in primary care estates will provide modern, efficient buildings, equipped with the latest technologies. Investment in digital infrastructure will facilitate the expansion of virtual consultations including online consultation tools and provide patients and professionals access to electronic health and care records. Development of digital technologies and data analytics will support development, implementation and monitoring of services. Estate transformation will consider factors including: • Inclusivity – ensuring everyone can use the building safely and with dignity, regardless of their age, gender, mobility, ethnicity, or circumstances • Flexibility – ensuring different people can use the building in different ways Planning and designing a net zero estate will be a part of estate transformation plans in line with UK commitments to being net zero by 2050.	Investments in estates has been shown to have a significant, measurable impact on the quality of care and patient experience including reducing patient harm (especially falls). Improved estates can also improve workplace experience for staff and reduce staff sickness and turnover. New and improved estates can help the move towards being net zero by 2050. Developing primary care infrastructure can facilitate the expansion of services and MDT working. It can help to reduce siloed working and can support small practices with high rents and service charges and can also mitigate against the 'last man standing' scenario in GP owned premises. It can also provide opportunities to provide joined-up out of hospital care for patients. Investment in technology will support better consultation tools and workload management systems and support the development of record sharing technologies across organisations.

Risks

Overall risks to implementation of the primary care strategy	• Enormous undertaking which will need to be implemented at pace • Insufficient transformation and implementation capacity and capability • Dependent on culture change within primary care, within our patients and public and across our ICS • Requires building of trust between primary care and patients to develop a model which is less dependent on GPs and asks patients to take more personal responsibility for their health • Serious recruitment and retention challenges within GP and nursing workforce • Current significant socioeconomic challenges which may create barriers to behaviour change • Potential for confusion about roles and responsibility between GP Federations and PCNs • Whilst prevention can be cost effective, some interventions can also increase costs

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	10/11/2022
Paper Title:	**Strategic Approach to Transforming Health and Care for People with Mental Health Needs**
Paper Reference:	ICB 22 037
Report Author:	Lucy Anderson, Head of Mental Health Commissioning, Contracting and Performance Maxine Bunn, Associate Director of Commissioning – Mental Health, Children and Community
Report Sponsor:	Lucy Dadge, Director of Integration
Presenter:	Lucy Dadge, Director of Integration
Recommendation(s):	The Board is asked to consider and **ENDORSE** the progress of the Mental Health Transformation Programmes and the system approach to co-production, strategic planning and service delivery to meet the needs of the population

Summary:

This paper provides an overview of the strategic approach to improve mental health provision across Nottingham and Nottinghamshire and reduce local health inequalities. Our local approach is well established through partnership working, and founded on the approach set out in the Nottingham and Nottinghamshire Integrated Care System (ICS) Mental Health Strategy 2019 to 2024; and in response to the NHS Mental Health Long Term Plan (LTP)

The fundamental organising principle underpinning service transformation is a single set of system priorities and outcomes for mental health improvement, which informs an integrated strategic planning approach, encompassing health, public health and social care and support dimensions. Managing interdependencies between services and effective utilisation of resources by working with Place, provider collaboratives and local communities to develop plans to address differentials in mental health outcomes in each area is critical, particularly given the impact of mental health on wider health and wellbeing outcomes.

The Covid pandemic has resulted in a demonstrable increase in demand for mental health services, across all ages. There has however also been an increase in the availability, range, expertise and integration of services and pathways and a focus on reducing waiting times, all with the objective of ensuring the right service is provided at the right time and meets the need of the patient.

The challenges for the Integrated Care Board (ICB) in managing the integrated planning and delivery of mental health services are described, as well as potential opportunities for the future, with delivery informed by the development of provider collaboratives and Place.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	All mental health transformation programmes aim to improve mental wellbeing and treatment, through increased and quicker access to services, by ensuring integrated planning and delivery. Service transformation plans are patient focused, evidence based, utilising best practice guidelines
Tackle inequalities in outcomes, experience and access	Transformation programmes have been adapted to local population health needs. There are several examples of engagement with under-represented groups to address specific local issues relating to access to services.
Enhance productivity and value for money	NHS benchmarking for mental health services has been utilised to assess spend on transformation programmes to ensure it aligns with national guidance. In addition, established working relationships between the Local Authorities and the ICB have increased opportunities for collaborative planning and securing integrated provision. In turn examples can be given of how this has made better use of limited resources and make sense to providers and service users.
Help the NHS support broader social and economic development	Investment by the ICB in mental health services has increased job opportunities in the NHS, Local Authorities and the Voluntary and Community Sector, in particular through the ongoing development of sustainable teams which address specific workforce challenges and which are designed around the needs of the population. In addition, a number of transformation programmes support people to return to work.

Appendices:

Appendix A: Mental Health Transformation Update – Strategic Planning and Integration Committee, October 2022

Appendix B: Mental Health Transformation Plan – Plan on a Page

Appendix C: Nottingham and Nottinghamshire Integrated Care System: All Age Integrated Mental Health and Social Care Strategy 2019-2024

Board Assurance Framework:

This paper provides assurance in relation to the management of the following ICB strategic risk(s):

- Risk 3: Transformation (for Making Tomorrow Better) – Effective system working may not transform (reform) and improve services to ensure best possible future health outcomes within available resources.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes

Applicable Statutory Duties:	
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	Yes
Duty to promote innovation	Yes
Duty in respect of research	Yes
Duty to promote education and training	Yes
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	Yes
Duties as to climate change	Yes
Duties regarding public involvement and consultation	Yes
Public sector equalities duties	Yes

Report Previously Received By:
N/A.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Strategic Approach to Transforming Health and Care for People with Mental Health Needs

Purpose and introduction

1. Mental health services in Nottingham and Nottinghamshire are being transformed to effectively utilise available resources to address local health inequalities and meet the holistic needs of the population through collaborative working with system partners. Set in the context of the system outcomes framework the integrated planning and delivery approach aims to improve the health and wellbeing of our population and improve the overall quality of care and life our service users and carers experience and receive. Examples highlight how joint strategic planning is increasingly the approach to deliver truly integrated services, informed, and shaped through co-production with people with lived experience.

2. The NHS Mental Health Long Term Plan (LTP), published in 2019, outlined Transformation Programmes across mental health services. The Plan sets out quality, service specific and pathway improvements, including improved access, to be delivered up to 2023/24. In order to respond to these national requirements, across Nottingham and Nottinghamshire there are seven Transformation Programmes led by multi-partner steering groups ensuring delivery of LTP objectives, together with a local focus on developments through working at Place, covering; Specialist Community Perinatal Mental Health; Children and Young People's (CYP) Mental Health; Adult Severe Mental Illnesses (SMI) Community Care; Adult Common Mental Illnesses (IAPT); Mental Health Crisis Care and Liaison; Therapeutic Acute Mental Health Inpatient Care; Suicide Reduction and Bereavement Support.

3. A progress update on each Transformation Programme was presented to Strategic Planning and Integration Committee in October 2022 and is included as Appendix A. An overview Plan on a Page is also included as Appendix B.

4. The Nottingham and Nottinghamshire ICS mental health strategy, was ratified in 2019 (Appendix C). The Strategy provides context on the Nottinghamshire population and the social factors that impact on mental health and outlines local objectives to improve mental wellbeing and reduce inequalities, which broadly align with the LTP and are incorporated into local plans, which are also informed by the ICS Health Inequalities Plan (2022) at whole system and Place level.

5. Since implementation of the LTP started (noting that the Transformation Programme runs to 2023/24) there has been an increase in the availability, range, expertise and integration of services and pathways and a focus on reducing waiting times. The key driver for transformation is ensuring the right service is provided at the right time and meets the need of the patient.

6. Nationally and locally, services have reported an increase in patient acuity following the Covid 19 pandemic, which has been evidenced by an increase in presentations to Crisis Resolution and Homes Treatment Teams and increased length of stay in inpatient wards. There was a reported increase in referrals to children and young people's mental health services. As anticipated, the pandemic has impacted on the pace of transformation. There are ongoing challenges with recruitment, however recovery plans are in place which outline system actions to ensure service transformation and performance improvements. Service delivery has also diversified due to the pandemic with an increase in digital and non-face to face appointments where clinically appropriate.

7. The ICB is allocated non-recurrent ringfenced service development funding assigned to each mental health transformation area. This investment aligns with the requirement to meet the Mental Health Investment Standard (MHIS), which in 2022/23 is £12.9m, evidencing year on year increased spend on transforming mental health services. Planning is increasingly looking at how whole system resource can be used to deliver the best possible outcomes to our diverse population.

Context for People with Mental Health Needs in Nottingham and Nottinghamshire

8. Nottingham and Nottinghamshire has a range of social factors that results in a higher incidence of mental illness:

    a) 20% of homeless people with mental health issues are not receiving any support or treatment and a high proportion will have substance misuse and addition problems.

    b) There are approximately between 33,000 to 49,000 people with long term conditions and co-existing depression.

    c) More than 500,000 people will have been exposed to at least one adverse childhood experience with 45,000 experiencing four or more.

9. Nottingham City Population Overview:

    a) The 11th most deprived district in England and the most deprived in the East Midlands region

    b) 57% of the City Neighbourhoods fall into the 20% most deprived groups nationally

    c) Approximately 34% of the population are from Black Asian and Minority Ethnic (BAME) backgrounds (higher than England average)

d) An overall employment rate (9.6 per 1,000) higher than the national rate of 3.7 and the regional average of 3.5

e) There are high rates of alcohol and drug misuse and mortality

10. Nottinghamshire Population Overview:

a) Has an older demographic than the national average and the City, with an average age of 43.8.

b) Nottinghamshire is the 9th most deprived shire county in England (out of 26). However, the Rushcliffe district is in the three percent least deprived districts in the Country. Mansfield however is in the top 20% most deprived districts in England

c) One in ten adults live with a moderate or severe disability

d) 4% of the population are from a BAME background, this is lower than the England average.

e) Unemployment rates are lower than the national averages, though Nottinghamshire residents with specialist mental health needs are 70% less likely to be in employment

Sources:Nottingham and Nottinghamshire Health Inequalities Plan (2022), Nottingham and Nottinghamshire ICS All-age integrated Mental Health and Social Care Strategy (2019-2024) and eHealthscope (2022)

The Future Vision for Mental Health Services in Nottingham and Nottinghamshire

11. Our purpose is to ensure that the incidence of presenting mental health conditions reduces in our populations, and that all of our people are supported to avoid crisis wherever possible. In addition we must continue to deliver the required improvements in treatment and care of those with diagnosed illness. Our ambition is to move towards a Place and outcomes focused approach, with collaborative planning, against which an alliance of providers will arrange services in direct response to the differential needs of their populations. All interventions will respond to our well-established population health management insights. As provider collaboratives and Places continue to mature, it is anticipated their role in the development and delivery of broader aspects of care and support to mental health provision will also develop and increase.

12. Examples of our ongoing Place-based focus to reduce health inequalities across national transformation programme areas are outlined below:

a) A Community Support Worker, based in Nottingham City to work with South Asian Communities to increase access to primary care

psychological therapies, has been expanded to include all mental health services.

b) A Community Support Worker based in Nottinghamshire to work with over 65s to increase access to primary care psychological therapies (IAPT).

c) A Community Support Worker to increase access to community perinatal services from under-represented groups.

d) Peer support workers (with lived experience) have been recruited as part of new pathways, including in the Co-existing Substance Misuse and Mental Health pathway and in the Personality Disorder Pathway. These roles offer further engagement through non-clinical, person-centred support.

e) A Peer Support and Engagement Worker has been recruited in the mental health crisis sanctuaries to increase access and gain feedback to continually improve service provision.

f) HealthWatch has been commissioned to undertake engagement to understand the experience and outcomes of people accessing mental health services and identify priorities to improve equity of access, this will be reported in quarter four 2022/23. Transition Workers are in place in the new Community Mental Health model and are co-producing the 18-25 pathway with Mental Health Two Thousand (MH:2K), a pioneering youth-led model for engaging young people in conversations about mental health in their local area.

g) New approaches are designed by engaging with people who have lived experience, ensuring local expertise is used to shape service plans. Effective and targeted communications has been a key focus in 2022/23. Engagement is currently underway to develop a single website for public and professionals to find information on mental health support services. Furthermore, a dedicated system Mental Health Communications Lead will coordinate mental health communications across the system, helping address barriers to access for population groups that can be at risk of exclusion.

h) Place Based Mental Health Partnership Groups have been established to review needs in each area and shape services. City PBP is focussing on mental health prevention and the population health management analysis undertaken in Mid Notts has identified children and young people’s mental health as priority.

i) Homelessness Mental Health Practitioners have been recruited in Nottingham City to provide assessment and support and provide the specialist mental health input in the wider Rough Sleeper Multi-Disciplinary Team in the City.

j) A targeted Suicide Prevention Pilot Project is underway to improve engagement with men at risk of suicide and/or experiencing risk factors associated with suicide into support. In addition, grants received through the first round of a small grant scheme are initially also focussing on this high-risk group.

Future opportunities and challenges for improving services for people with mental health needs

13. A single system set of priorities and outcomes provides the ongoing opportunity to improve integrated care delivery, focusing on prevention, and will inform the future system financial allocation for support to people with mental health needs. This will drive a single health and social care strategic planning approach that focusses on those actions that will have the most impact on improving health and care for patients with mental health needs and reducing unacceptable variation in outcomes across our populations. This is in development and will solidify new ways of working across the system, focusing on an approach which reduces health inequalities and delivers against the ICS outcomes framework.

14. An example of this collaborative approach is creating mental health accommodation to support system flow and system resilience. This is to ensure citizens can remain in the community with effective mental health support with accommodation available to facilitate discharge from mental health inpatient services, including locked rehabilitation. The work will inform the ICS Mental Health Accommodation Strategy.

15. Furthermore, there is a multi-agency focus across the system on suicide prevention and self-harm with recent developments including Wave 4 Suicide Prevention Plans, utilising the NHS England (NHSE) funding allocation to implement an All-Age Self Harm and Suicide Crisis Service; a Multi-agency All-Age Self-Harm Steering Group to deliver on recommendations from a review of the self-harm pathway in 2021/22. The Multi-agency Suicide Prevention Group has been shortlisted for an ‘Excellence in Partnership Working’ award as a part of Nottinghamshire County Council’s Adult Social Care and Health Celebrating Success awards, in recognition of the joint work that has been undertaken.

16. New arrangements for Improving Access to Psychological Therapies (IAPT) services are planned to be in place from April 2023. The new arrangement has enabled co-development of operational services at Place to address local population need and health inequalities.

17. There has been a continued focus on improving the estate that mental health services are delivered from, eradicating dormitory provision, and ensuring the required level of Health Based Places of Safety (Section 136 suites) are in

place. An application for capital funding has been submitted to NHSE to improve facilities and meet national requirements.

18. There is an opportunity with the delegation of specialist mental health commissioning from NHSE to align the whole pathway for patients of all ages, ensuring the right care at the right level of acuity to meet the local population needs, developed and delivered in a co-ordinated way. It will be extremely important to work collaboratively with other ICBs to maximise the outcomes for our population given the larger geography served by specialist providers.

19. Transformation of care and support for people with mental health needs in Nottingham and Nottinghamshire will continue to be delivered through a collaboration between system partners and people with lived experience. The foundations for this are in place, as evidenced by commendation of the delivery of community mental health transformation for people with Severe Mental Illness by NHSE.

APPENDIX A: Mental Health Transformation Programme

Purpose

1. The purpose of this briefing is to provide an update on the mental health transformation programme and an overview of each of the seven programme areas, highlighting progress to date and challenges and risks. It will also summarise challenges that the Integrated Care Board (ICB) is managing in commissioning and ensuring the delivery of mental health services.

Introduction

2. The NHS Mental Health Long Term Plan (LTP), published in 2019, outlined transformation programmes across mental health services. The plan, and subsequent updates, outline quality, service specific and pathway improvements to be delivered up to 2023/24. There are seven transformation programmes:

    a) Specialist Community Perinatal Mental Health

    b) Children and Young People's (CYP) Mental Health

    c) Adult Severe Mental Illnesses (SMI) Community Care

    d) Adult Common Mental Illnesses (IAPT)

    e) Mental Health Crisis Care and Liaison

    f) Therapeutic Acute Mental Health Inpatient Care

    g) Suicide Reduction and Bereavement Support

3. Each transformation area has a multi-partner steering group from across the Integrated Care System (ICS), ensuring the delivery of programme objectives and a local focus on developments. There is increased working with Place to ensure a local focus on population requirements through transformation plans. Programme deliverables are assured by NHSE, including a review of performance against key metrics, as reported in the ICB performance report (Appendix 1).

4. Nottingham and Nottinghamshire ICS developed a system wide mental health strategy, which was finalised in 2019 (Appendix 2).The Strategy outlines local objectives to improve mental wellbeing and reduce inequalities, which broadly align with the LTP and are incorporated into local plans.

5. Since implementation of the LTP started, noting that the transformation programme runs to 2023/24, there has been an increase in the availability, range and expertise of services, integration of services and pathways and a focus on reducing waiting times, all with the objective of ensuring the right service is provided at the right time and meets the need of the patient.

6. A key objective for the ICB in 2022/23 to support transformation is to progress joint commissioning for Mental Health with both Local Authorities. Collectively agreeing priorities, understanding commissioning and service delivery interdependencies and utilising resources most effectively. This work has already commenced with a Senior Mental Health Commissioning Group and supporting multi-partner commissioning group established and ongoing development of new ways of working.

7. As anticipated, COVID 19 has impacted on the pace of transformation, through recruitment delays and core service (such as inpatient ward) prioritisation. There are ongoing challenges with recruitment, however recovery plans are in place which outline system actions to ensure service transformation and performance improvements.

8. In addition to the implementation of transformation plans, this paper identifies a number of significant commissioning and service delivery challenges being managed across the system.

Funding for Mental Health Services

9. The ICB is allocated non-recurrent ringfenced service development funding for mental health which is assigned to each mental health transformation area. This investment aligns with the requirement to meet the Mental Health Investment Standard (MHIS), evidencing year on year increased spend on transforming mental health services. Investment in Mental Health transformation in 2022/23 is £12.9m. Investment for each transformation programme is provided in the update.

10. Services are commissioned from a range of organisations with a proportion of the funding allocated for secondary care services commissioned from and delivered by Nottinghamshire Healthcare NHS Foundation Trust (NHT) and where appropriate through subcontracts with the Voluntary, Community and Social Enterprise sector (VCSE) to support the delivery of integrated pathways of care.

Transformation Update

11. The national transformation plans for mental health are evidence based and comprehensive and are aligned with local plans that aim to transform care and delivery models, improve patient experience, and reduce health inequalities.

a) Specialist Community Perinatal Mental Health

12. **Objectives**: Expanding specialist community perinatal mental health teams, increasing access to evidence based psychological therapies and extending the period of care from 12-24 months.

13. **Progress Highlights**: Additional investment in 2022/23 of £1.423m. The inclusion of new and increased multi-disciplinary posts aims to address risks associated with recruitment to traditional clinical roles. This approach has delivered increased local capacity and period of care. One example of this to support shaping services to address health inequalities, is the appointment of a community engagement role to work with women from underrepresented groups who are not accessing the service.

14. **Risks to Delivery**: Access to the service is currently below standard due to low referrals numbers; a recovery plan is in place to deliver the target by March 2023.

b) Children and Young People's (CYP) Mental Health

15. **Objectives**: Expansion and transformation of specialist community services (tier two and tier three), including expansion of Mental Health Support Teams in schools; Expansion of specialist community Eating Disorder Services and implementation of Avoidant Restrictive Food Intake Disorder (AFRID) pathway; 24/7 mental health crisis provision for CYP.

16. **Progress Highlights**: Additional investment in 2022/23 of £3.745m. Mental Health Support Teams provide evidence-based interventions in or close to schools and colleges for those with mild to moderate mental health issues, providing a link to specialist NHS services. The ICS's mobilisation plan will deliver 47.8% coverage of schools against the national requirement of 35%.

17. The 24/7 CYP Crisis Response and Home Treatment Team provide intensive support for children and young people mental health experiencing crisis. The team are commissioned in partnership with NHS England via the Tier 4 CAMHS Provider Collaborative and has reported a reduction in NHSE commissioned tier four admissions.

18. The CYP Specialist Eating Disorder Service has been resourced to ensure it can meet the urgent (treatment within one week) and routine (four week) response standards. Plans are underway to agree the Avoidant Restrictive Food Intake Disorder (ARFID) model by December 2022 which will expand the scope of the local service provision. Inpatient care is commissioned by NHSE through the Provider Collaborative.

19. Local feedback and national evidence highlight the importance of transition for children and young people and transition workers have been recruited to ensure transition to adult services is effectively managed.

20. **Risks to Delivery**: The implementation of system plans has resulted in the service predicting achievement of the waiting time standards by Q3 2022/23.

c) Adult Severe Mental Illnesses (SMI) Community Care

21. **Objectives**: Transform and enhance community services with the aim of developing enhanced primary care based integrated support to help manage fluctuating needs

22. **Progress Highlights**: Additional investment in 2022/23 of £3.966m. New model commenced in Mid Notts and Bassetlaw in 21/22 and in South Notts in 22/23 currently spanning 67% of ICS area. Increase in staffing into the community model, including Mental Health Practitioner roles in Primary Care Networks (PCN), Peer Support Workers, a new joint pathway for people who access a Mental Health Service (with a substance misuse need) or a Substance Misuse Service (with a mental health need), Transition Workers and VCSE roles as well as a mental health enhancement to PCN social prescribing to increase the capacity and capability of social prescribing to support patients with common and severe mental illness. The access standards for number of adults and older adults receiving contacts in new transformed community model and Early Intervention in Psychosis and Individual Placement Support (employment support) are being achieved.

23. **Risks to Delivery**: Recruitment remains challenging and options to address this are continually reviewed; despite having a Locally Enhanced Service (LES) in place in primary care, physical health checks for people with SMI, are increasing but still below the national target, actions are currently being refreshed, with learning from the areas achieving the standard being reviewed.

d) Adult Common Mental Illnesses (IAPT)

24. **Objectives**: Expand service availability to meet the increasing national target for people entering treatment; maintain waiting times and recovery rates.

25. **Progress Highlights:** Additional investment in 2022/23 of £1.653m. Three-month rolling access performance is increasing, and the service continues to achieve the six week and 18 week waiting time standards and the recovery standard.

26. **Risks to Delivery**: The increasing access target is challenging, in terms of available workforce (national issue) however there is a recovery plan in place with mitigating actions, including recruiting trainees to increase future capacity. A review has been undertaken at Place level and to increase referrals from underrepresented groups, a community support worker has been recruited in Nottingham City to work with South Asian Communities.

e) Mental Health Crisis Care and Liaison (including ambulance response)

27. **Objectives**: Maintain 100% coverage of 24/7 Adult Crisis Resolution and Home Treatment (CRHTs); commission a range of complementary and alternative crisis services (including VCSE/Local Authority provided services); develop a model with EMAS to improve the ambulance response to mental health; maintain 24/7 mental health liaison services within acute hospitals; eliminate all out of area placements (OAPs).

28. Crisis services are a key part of system resilience. Service plans and capacity form part of system resilience plans, with a separate annual mental health winter plan submitted to NHSE.

29. **Progress Highlights**: Additional investment in 2022/23 of £1.290m. Increase in CRHT provision to cover 24/7 and core fidelity staffing; 24/7 Crisis Line established, and Crisis Sanctuaries provided by the VCSE; ongoing mobilisation of mental health professionals in the EMAS Emergency Operations Centre and mental health training to frontline crews to improve the rate of hear/see and treat during 2022/23, reduce the level of conveyance and increase referral and signposting to appropriate mental health services and pathways.

30. **Risks to Delivery**: Eliminating OAPs continues to be a challenge for the system, patient acuity and system flow being cited as the main contributing factors. System wide plans have been agreed to improve patient flow and NHT have reviewed internal reporting and escalation processes to facilitate improved flow.

f) Therapeutic Acute Mental Health Inpatient Care

31. **Objectives**: Therapeutic approach to improve outcomes and experience from inpatient care and reduce length of stay (LOS) to 32 days or fewer by 2023/24. Eliminate all inappropriate adult acute out of area placements (OAPs)

32. **Progress Highlights**: Additional investment in 2022/23 of £810k. Inpatient demand modelling review for adults and older adults has been undertaken to determine future bed requirements, actions being agreed for implementation in 2022/23; New acute mental health inpatient unit, scheduled to open in November 2022 increasing the number of local acute NHS beds by 14.

33. **Risks to delivery**: Patient acuity and delays with identifying complex packages of care are contributing to Delayed Transfers of Care (DTOC). System plans are in place to address this.

g) Suicide Reduction and Bereavement support

34. **Objectives**: Develop and implement multi-agency suicide prevention plans, to reduce suicides for people in contact with mental health services; deliver suicide bereavement support services

35. **Progress Highlights**: Additional investment in 2022/23 of £272k. Training needs analysis on suicide prevention, mental health awareness and self-harm training across the system and communities, training has been commissioned and commences in November 2022. Targeted support for at risk groups through a pilot focused on males. Implementation of the new information system to support real time surveillance has commenced and will be used through work with partners to drive further improvements to processes and data collection. Suicide Bereavement Service in place.

36. **Risks to Delivery**: The service is currently very small and will likely require further investment to offer more timely support to those at higher risk due to bereavement

Current Commissioning and Service Delivery Challenges

37. Locked rehabilitation inpatient services are for patients who are liable to be detained under the Mental Health Act 1983 or Deprivation of Liberty Safeguards. They will have not recovered adequately after an acute severe mental health episode. The ICB was unable to secure a direct award for provision within a financial envelope outside the regional provider framework procurement (in line with other systems) with NHT from September 2022. Urgent discussions are currently underway with NHT and other framework providers to secure good quality, value for money local services to meet patient needs. It is anticipated there will be a financial impact which will require a formal decision in due course.

38. A procurement is underway for IAPT services, with a new contract in place from April 2023. All necessary actions, including procuring additional capacity this year, are in place to minimise the impact to patients during the transition period. The new contract will focus on developing services at Place and working to reduce health inequalities.

39. There has been a continued focus on improving the estate that mental health services are delivered from, eradicating dormitory provision, and ensuring the required level of Health Based Places of Safety (Section 136 suites) are in place. An application for capital funding has been submitted to NHSE and further discussions are taking place in 2022/23 to improve facilities and meet national requirements.

Recommendations

40. The Committee is asked to**:**

    a) **Note** the progress that has been made across all mental health transformation programmes

    b) **Note** the risks and mitigating actions for each transformation area

    c) **Note** the current Commissioning and Service Delivery Challenges

APPENDIX B: Adult and Older Adult Mental Health – Plan on a Page 2022 /2023

Integrated Care System
Nottingham & Nottinghamshire

National Priorities

The NHS Long Term Plan (2019) set out the following key priority areas for transformation with timescales for delivery through to 2023/24:

- Specialist Community Perinatal Mental Health
- Children and Young People's (CYP) Mental Health (separate plan)
- Adult Common Mental Illnesses- Improving Access to Psychological Therapies (IAPT)
- Adult Severe Mental Illnesses (SMI) Community Care, including
  - Transforming pathways for Eating Disorders, Personality disorders and community rehabilitation
  - Individual placement and support /Employment support (IPS)
  - Physical Health Checks for Severe Mental Illness (SMI)
  - Early Intervention in Psychosis (EIP)
- Mental Health Crisis Care and Liaison
- Therapeutic Acute Mental Health Inpatient Care, in particular reducing Length of stay, improving flow and eliminating inappropriate out of area placements
- Suicide Reduction and Bereavement Support
- Mental Health of Rough Sleepers

Supported by:

- Digitally Enabled Mental Health Care
- Workforce Support

There are performance standards for each area, system action plans are in place to ensure delivery and detail any mitigating actions, if performance is not on track

Local Priorities

- **Transformation of services** to deliver the NHS Long Term Plan (we are in year 4 of a 5-year plan), with ring fenced funding to deliver priorities; working with place to develop local services, aligned to the Integrated Care Board (ICB) planning submission
- **Transformation plans** co-produced with people with lived experience. HealthWatch have been commissioned to undertake engagement to understand access, experience and outcomes of people accessing mental health and identify priorities to improve equity of access. Following this the ICS will be phasing in mental health co-production roles to undertake co-production with those with lived experience, focussing on specific pathways improvements
- **Tackle Health Inequalities** -currently testing approaches such as community engagement in IAPT to reach South Asian Communities and people over 65.
- **Improving communications** on what services are available locally and how to access them
- **Improve the Self- Harm pathway** following mapping of the local pathway in 2021/22
- **Build on system partnership working** particularly to improve system flow, address health inequalities and effectively utilise system resources
- **Ensuring evaluation** to enable service developments to be tested and scaled up quickly

Achievements

- Performance is on track for EIP, IPS, CYP Access, Dementia diagnosis, IAPT waiting times and recovery rates. Recovery Action Plans in place for all areas, monitored monthly by the ICB and at the monthly NHS England (NHSE) Mental Health Assurance Meeting
- Positive feedback from NHSE on the SMI transformation plan and progress to date, recruitment to Mental Health Practitioner roles in Primary Care Networks, working and contracting with the Voluntary Community Social Enterprise (VCSE) sector, and the newly developed coexisting substance misuse and mental health pathway
- The system has been successful in a bid to NHSE for a Project Manager to embed personalised care approaches in the annual health check for Learning Disability and SMI, to increase individualised care packages and uptake of the check.
- Implementation of new services across the crisis and urgent mental health pathway, including 24/7 Crisis Line, Crisis Sanctuaries and Day Car for Police Street Triage Model to reduce mental health inpatient admissions and attendances at the Emergency Department (ED).
- Improved partnership working across the Mental Health Transformation Programme including with Local Authorities and VCSE, increasing service capacity and expertise.
- IPS/employment support & opportunities to develop this into other mental health services following successful implementation in specialist mental health services
- Bid submitted to NHSE for Mental Health Response Vehicles to support Ambulance Response to Mental Health (outcome later in 2022/23). This will support a reduction in conveyance to ED.

Governance

- Place based Mental Health Partnership Groups
- Workstream meetings & Steering Groups
- Suicide Prevention Strategy Group
- Severe Mental Illness Transformation Programme Board
- Integrate Care System (ICS) Mental Health Crisis and Urgent Care Taskforce Group
- ICS Mental Health and Social Care Partnership Board (under review)
- Newly formed Collaborative Commissioning Senior Leadership Team of ICB, Local Authorities and Public Health

Opportunities, issues and challenges to be worked through

- Working through the Learning Lab programme for a Collaborative Mental Health Commissioning approach across the ICS. Opportunity for working together (ICB, Local Authorities and Public Health) and sharing responsibility for delivering system priorities and commissioning intentions supported by joint development of a single set of system deliverables and outcomes, shared values and objectives
- Increasing acuity being reported across mental health services, impacting on inpatient admissions and Length of Stay (LOS)
- Working with Place Based Partnerships: transformation and commissioning at place level
- Despite ring fenced investment there are workforce Challenges in Mental Health; focused on developing new and innovative solutions to enable delivery of the transformation e.g., recruit to train roles, subcontracting VCSE
- Working with Community Voluntary Sector infrastructure organisations on development of VCSE alliance and how that can support Mental Health Transformation

Guiding Principles

Guiding principles: 5 pillars from the Nottingham and Nottinghamshire Mental Health Strategy 2019-2024, which align with the Long Term Plan deliverables and inform Mental Health Transformation in Nottingham and Nottinghamshire:
Increasing support for prevention, self-care and the wider factors that affect people's health
Implementing an approach that focuses on the individual (physical and mental health)
Improving access to services
Equipping a mental health-aware workforce
Establishing a truly integrated system

Transformation Programme Infrastructure

Senior Responsible Officer (SRO): TBC
Senior Leadership Team – Maxine Bunn (ICB), Kash Ahmed (County LA), Katy Ball (City LA), Catherine Pritchard (County PH), Helen Johnstone (City PH), Lucy Anderson (ICB)
Transformation Programme Lead – Lucy Anderson (ICB)

ICB Corporate Team
(working with place and system partners)

Maxine Bunn, Lucy Anderson, Tracey Duggan, Kate Burley, Clare Fox, Alex Julian, Judith Dixon, Katie Watts, Becki Nolan
Clinical Lead: Dr James Read

APPENDIX C

The Nottingham and Nottinghamshire
Integrated Care System

Everyone's different, everyone's equal

All-age integrated mental health and social care strategy

2019-2024

Nottingham City Council

Nottinghamshire County Council

NHS

CONTENTS

OUR VISION

This vision was identified by the stakeholder and service user engagement group.

A whole system, all-age, person-centred approach, driven by access to physical and mental health and social care in the same place at the same time, with no wrong door, where prevention is at the heart of all we do.

We will reduce inequalities and narrow the gap between Serious Mental Illness (SMI) life expectancy and the rest of the population by 3 years and increase healthy life expectancy by 3 years.

"The costs of mental ill health – whether to the individual, their family or carer, the NHS or wider society – are stark. People can, and do, recover from mental ill health. The evidence is clear that improving outcomes for people with mental health problems supports them to achieve greater wellbeing, build resilience and independence and optimise life chances, as well as reducing premature mortality. But moreover, the evidence is equally clear on the potential gain for the NHS and wider public sector from intervening earlier, investing in effective, evidence-based care, and integrating the care of people's mental and physical health. Mental health should be an intrinsic element of every ICS – threaded throughout and not an afterthought."

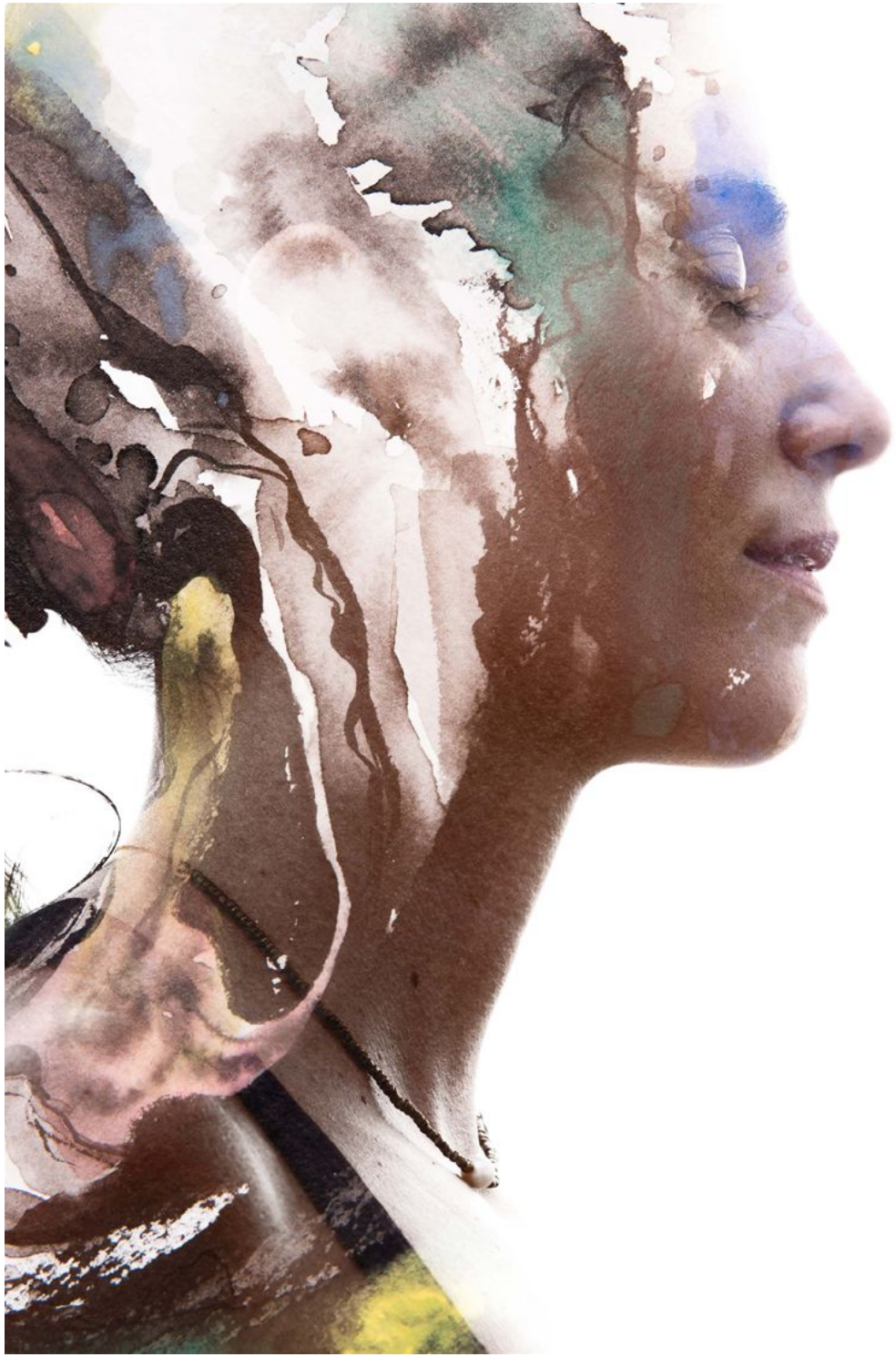
The Five Year Forward View for Mental Health, published 2016

"Mental health problems often develop early and, between the ages of 5-15, one in every nine children has a mental disorder. Half of all mental health problems are established by the age of 14, with three quarters established by 24 years of age. Prompt access to appropriate support enables children and young people experiencing difficulties to maximise their prospects for a healthy and happy life...

Over the next five years, the NHS will therefore continue to invest in expanding access to community-based mental health services to meet the needs of more children and young people. By 2023/24, at least an additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services and school or college-based Mental Health Support Teams...

Mental illness is a leading cause of disability in the UK. Stress, anxiety and depression were the leading cause of lost work days in 2017/18. The cost of poor mental health to the economy as a whole is estimated to be far in excess of what the country gives the NHS to spend on mental health. So reducing the impact of common mental illness can also increase our national income and productivity."

The NHS Long Term Plan, published 2019



Executive summary

Following widespread engagement, we are delighted to publish this integrated mental health and social care strategy, aiming to transform mental health and wellbeing in Nottingham and Nottinghamshire.

This document considers mental health across the whole age range but excludes dementia which will be the subject of a separate strategy. This strategy builds on the many positive aspects of services provided by NHS and local authority partners in our area, and the improvements already being made in support of NHS England's *Five Year Forward View for Mental Health* and latterly the *NHS Long Term Plan*.

Mental health and wellbeing is a continuum across the lifespan. Following a workshop in 2018 with all relevant stakeholders, we were given a clear steer to create an all-age strategy; this approach was supported by the Sustainability and Transformation Partnership (STP) Board (known since December 18 as the Integrated Care System (ICS) Leadership Board). An outline strategic approach was agreed by the STP Leadership Board in August 2018. Further work has been ongoing since to streamline and simplify the strategy and provide more focus on key actions required to achieve our vision.

The strategy represents our system's commitment to the re-shaping of services and other interventions so that they better respond to the mental health and care needs of the population. Our ambition was to develop a mental health strategy for Nottingham and Nottinghamshire that aligns health and social care, provides the framework for more detailed, collaborative work, and delivers in accordance with the *Forward View and Long Term Plan*. Ultimately we wish to seek a material transformation in the mental health landscape across the ICS, and importantly, a transformed experience for service users, carers and staff, with improvements in outcomes within a transformed system.

This strategy fully integrates with social care, reflecting a social model not just a medical model. It considers the crucial role of prevention, the interaction between mental and physical health needs, and the mental health impact of physical conditions. It considered a number of actions at ICS level, mindful of work already being advanced at other levels of the system.

There has been significant engagement with the public, patients, staff and partner organisations at all stages of the process. Using existing channels of engagement and special events, we have heard people's views and are acting upon them. This is in line with the common principles set out in the *Forward View*, emphasising co-production with people with lived experience of services, their families and services, working in partnership, and seeking to identify needs and intervene at the earliest opportunity. In particular, we are focused on designing and delivering person-centred care, underpinned by evidence, which supports people to lead, fuller, happier lives.

The process has involved stakeholder workshops, focus groups, a review of evidence, analysis of existing services, and a review of existing strategies in partner organisations. We have considered best practice from other areas of the country and how our emerging strategic framework fits in with the national direction of travel. From all this we have established a shared vision. Our vision is:

A whole system, all-age, person-centred approach, driven by access to physical and mental health and social care in the same place at the same time, with no wrong door, where prevention is at the heart of all we do.

We will reduce inequalities and narrow the gap between SMI life expectancy and the rest of the population by 3 years and increase healthy life expectancy by 3 years.

Within this overarching vision and strategic direction, our stakeholders have identified a set of five key strategic objectives (or 'pillars') that will frame and support our subsequent work to realise our vision. They also seek to bring together key elements in the strategies and plans of our partner organisations, and meet the challenges set out in the *Forward View* and *Long Term Plan*.

We are hugely grateful to all the individuals and teams who have contributed to the development of this strategy. We are however conscious that this is only the beginning of the work required.

If we are successful in delivering this strategy then the people in Nottingham and Nottinghamshire will be able to see the difference it makes to their mental wellbeing. During the life of this strategy we would hope to see

- 170 new patients supported in an Early Intervention in Psychosis service (EiP) each year
- 2670 more Children able to access child and adolescent mental health services (CAMHS) (based on current achievement of 20%)
- Children and young people with eating disorders, if identified as urgent, will be seen within 1 week
- 140 more women supported by perinatal services each year
- All age Rapid Response and Liaison will be available in all Emergency Departments – resourced to meet 1 hour assessment targets.
- Patients would be able to access crisis support within 4 hours every day of the week, with workforce linked to caseloads.
- 66.7% of dementia patients diagnosed – 7925 patients – will be able to access appropriate after care.
- 25% of patients requiring support will be able to access IAPT (Improved Access to Psychological Therapies) services
- 4396 of the 8887 patients identified on the Serious Mental Illness (SMI) register will receive a physical health check (based on 2018/19 figures)
- Eradicate inappropriate mental health Out of Area Placements by 20/21

Much greater engagement is now required with all our stakeholders but especially those with lived experience of using mental health services. We will ensure that services users are engaged fully in the design of services and that they have maximum choice and control in the care and support they access. As a first step, the Partnership Board will establish a service user co-design group to inform, check and challenge the ongoing work.

More detailed planning work must now be undertaken to translate our objectives into actionable improvements. We will do this through establishing a small number of delivery groups with defined responsibilities, reporting to the Partnership Board. An initial implementation plan has been developed setting out the actions needed for the groups and how these interact.

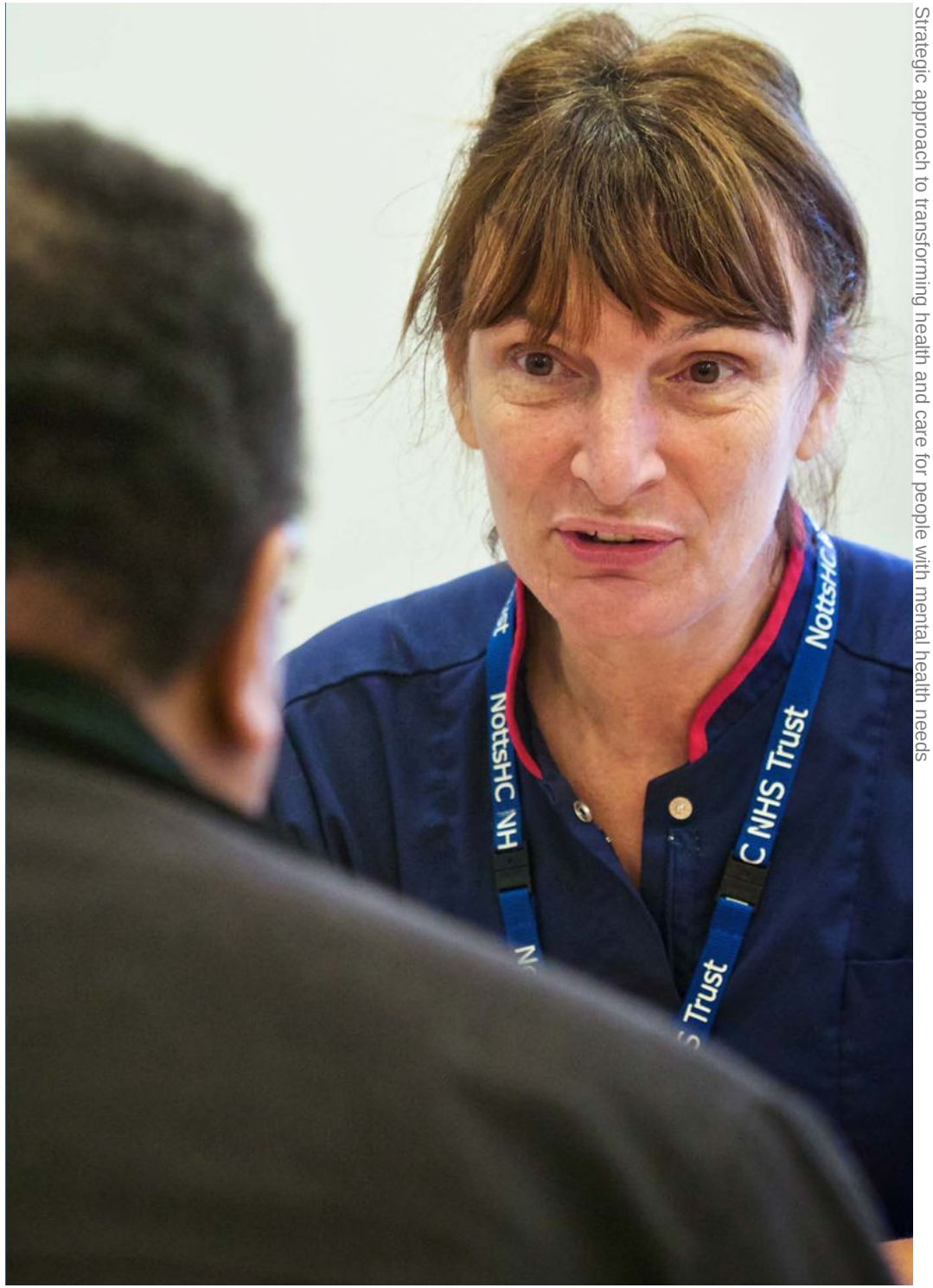
This strategy needs to be factored into all relevant aspects of other ICS work if true integration is to be enabled. This includes the parallel clinical strategy work around acute, community and primary care services. This strategy represents our system's commitment to the re-shaping of services and other interventions so that they better respond to the needs of our population. We now need to plan together how to achieve this, including where to focus our combined efforts in the short, medium and longer term. We are seeking a seamless service and a step change in people's mental health and wellbeing. Our strategy seeks to recognise that everyone is different and care and support needs to be personalised accordingly, yet everyone deserves equality (with parity of esteem in all situations and scenarios). With the foundations and strategic pillars in place, we now need to build the rest of the structure. We look forward to widening our conversations further to enable this to take place.

Julie Hankin

Julie Hankin
Medical Director, Nottinghamshire Healthcare

Amanda Sullivan

Amanda Sullivan
Clinical Commissioning Group Chief Officer



Introduction

Many ICS partners already have their own strategies and plans in relation to mental health and wellbeing. This strategy sits above these and takes them into account.

This strategy will allow partner organisations, and others involved in advancing mental health and wellbeing, to overcome barriers they have encountered to progress.

It allows everyone to take advantage of opportunities for advancing the scope or scale of work. It will allow us to take a wider population health perspective and to improve services across the area. Importantly it will provide an overall direction of travel and a framework on which to base decisions.

The Mental Health and Social Care Partnership Board determined that this strategy should be underpinned by 12 key principles:	
1	Good system leadership
2	The individual with their own lived experience of mental health will be at the heart of each and every decision that is made
3	Decisions must be locally led
4	Care must be based on the best available evidence
5	Services must be designed in partnership with people who have mental health problems and with their carers
6	Inequalities must be reduced to ensure all needs are met, across all ages
7	Care must be integrated – spanning people's physical, mental and social needs. Referral pathways should be seamless both within, and between, services (for example, between primary and secondary mental services)
8	Prevention and early intervention must be prioritised, with a core focus on services provided in community settings working with multi-disciplinary teams
9	Care must be safe, effective and personal, and delivered in the least restrictive setting
10	Mental health services are understandable and accessible to all, including groups within the population who currently find services difficult to use for cultural reasons or because they believe the service will not meet their needs
11	The priorities in NHS England's Five Year Forward View for Mental Health must be successfully implemented
12	The right data must be collected and used to drive and evaluate progress.

A stakeholder-developed strategy

The work to develop this strategy did not follow a pre-determined course. It was important that the design process involved a broad range of stakeholders with sufficient experience and understanding to identify the actions that would enable transformation of the local mental health landscape. These stakeholders included those with lived experience of mental health issues and representatives of the NHS, local authorities, and voluntary and community sector. We will seek to further extend engagement in the next phase.

The development of this strategy involved stakeholders attending a series of workshops in which the current position (need, services and strategies) were analysed; a series of emerging priorities identified and refined; and a number of key outcomes and supporting actions proposed under each strategic pillar. External inputs were provided by Mind, the West Midlands Combined Authorities Mental Health Commission and NHS England's Mental Health Team.

We are building on our initial work by forming a service user co-design group to help shape the work of the Partnership Board and are committed to using the principles of co-design, across all the strategic pillars. Stakeholders have highlighted that this needs to include definition of the parameters and expectations around service user involvement. A full report on the engagement inputs to this strategy can be found in appendices.

Organisations involved in the strategy workshops

- Base 51
- Bassetlaw CCG
- Carers Federation
- Derbyshire, Leicestershire, Nottinghamshire & Rutland Community Rehabilitation Company
- East Midlands Ambulance Service
- Framework Housing Association
- Gedling Borough Council
- Greater Nottingham CCGs
- Healthwatch Nottingham and Nottinghamshire
- Let's Live Well in Rushcliffe
- Mid Nottinghamshire CCGs
- NHS England
- Nottingham City Council
- Nottingham CityCare Partnership
- Nottingham CVS
- Nottingham University Hospitals NHS Trust
- Nottinghamshire County Council
- Nottinghamshire Healthcare NHS Foundation Trust
- Nottinghamshire Local Medical Council
- Nottinghamshire Local Pharmaceutical Committee
- Nottinghamshire Office of the Police and Crime Commissioner
- Opportunity Nottingham
- Public Health England
- Rethink Mental Illness
- Royal College of General Practitioners
- Royal Pharmaceutical Society
- Self Help UK
- Sherwood Forest Hospitals NHS Foundation Trust
- The Strategy Unit
- Together Everyone Achieves More (TEAM)
- Tuntum Housing Association
- University of Nottingham

Our population

The ICS is responsible for planning and delivering the health and care for more than one million people. This is a population that is both growing and changing over time. People are generally living longer despite an increasing number of physical and mental health conditions.

At the same time, there are some stark differences in the population across the geographical footprint – Nottingham City and Mansfield are generally younger, more ethnically diverse, experience higher levels of socio-economic deprivation but have good access to services while other areas across the county such as Rushcliffe are generally older, better educated and less deprived but may be more isolated and have poorer access to services and amenities. Nottingham also has a very high university population.

The population of Nottingham and Nottinghamshire is 1.1 million. Of that population a large percentage will look after themselves and not access mental health services, while some will be cared for by their GPs and not need a referral into secondary care. For some 12,500 people there will be a need for longer term support and care, with some 500 people a year needing inpatient care. Knowing this information about the population allows us to plan and locate services where people most need them – whether that is in their local community, at GP surgeries, in specialist clinics or in hospital. This mapping of services applies as equally to mental health as physical health.

Local mental health needs

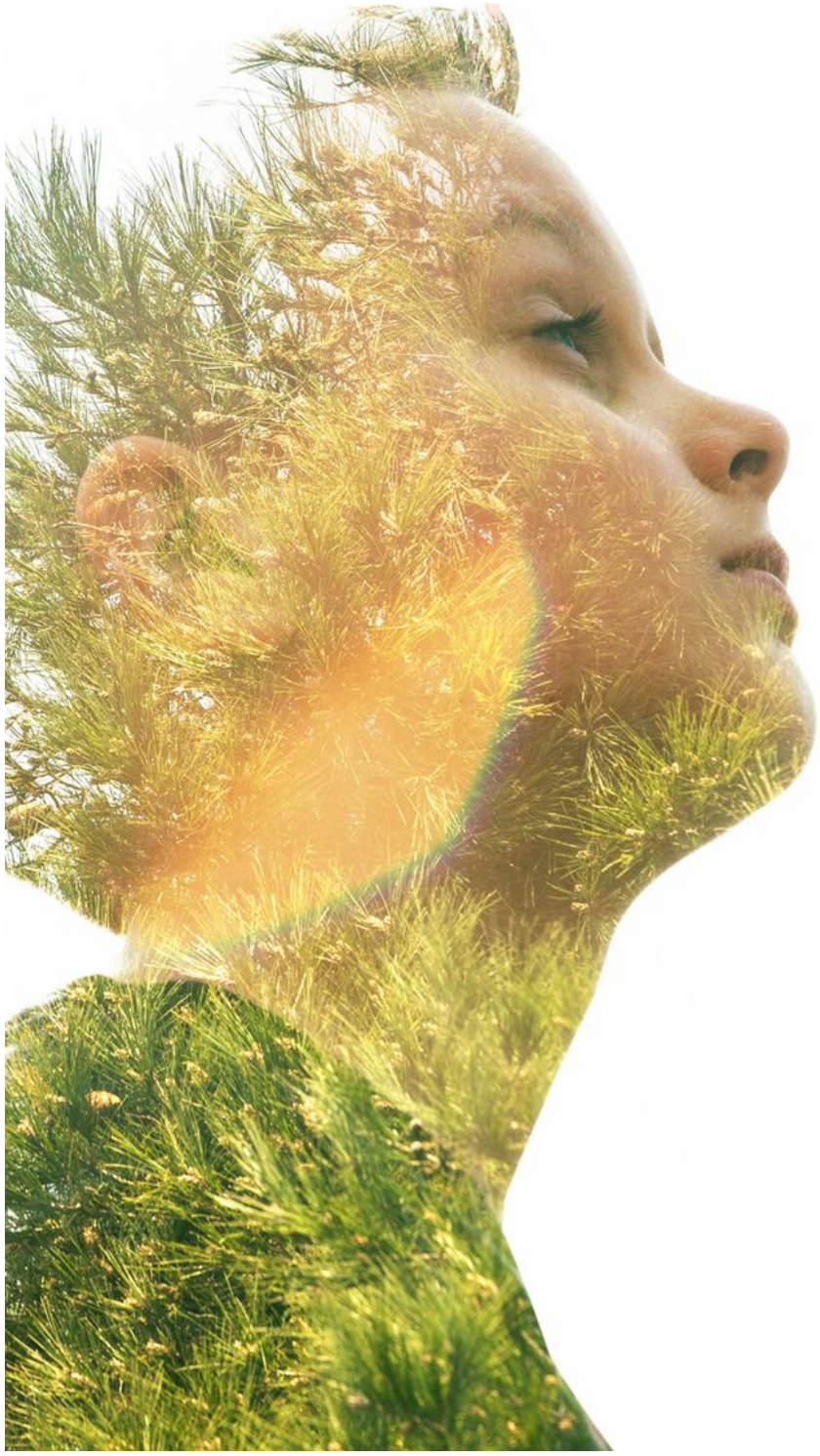
There are currently 73,000 patients on GP depression registers – an increase of 9,000 from the previous year but lower than the national prevalence.

8,600 patients are on mental health registers for schizophrenia and psychosis – an increase of 400 from previous but again, lower than national prevalence.

15,000 people are in contact with adult mental health services and 700 in contact with children and young people's services.

Each year there are around 2,000 contacts with crisis teams. Liaison services are now identifying more than 100 patients a month in A&E or inpatient wards suitable for referral to mental health services and local 'talking therapy' services are seeing around 25,000 patients, of which 50% complete a treatment course.

Life expectancy also varies across the footprint and is linked with deprivation. People living in the least deprived areas do on average live longer than those living in areas with higher deprivation. The difference between the most and least deprived areas is almost 8 years for men and 6 years for women across the ICS footprint.



What we know

Mental health service improvement is a national priority, particularly focusing on crisis care, perinatal mental health, children and young people, avoiding inappropriate out of area admissions, ending inappropriate use of police intervention, better access to psychological therapies and parity of esteem (giving equal value to mental and physical health). Building on the NHS Mandate, NHS England has published the Five Year Forward View and the NHS Long Term Plan.

The long term plan builds on the mental health five year forward view. The Plan proposes to increase the budget for mental health, in real terms, by a further £2.3 billion a year by 2023/24. Specific waiting time targets for emergency mental health services will take effect from 2020. It sets out an expansion of talking therapies, new integrated primary care and community provision, a reduction in the average inpatient length of stay to 32 days and an upgrade of the physical environment for inpatient psychiatric care.

Over the next 10 years, NHS 111 will be established as the single point of contact for those experiencing a mental health crisis. There will also be a new Mental Health Safety Improvement Programme, with a focus on suicide prevention.

The Long term Plan sets out a goal that over the coming decade 100% of children and young people who need specialist mental health care will be able to access it.

Funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending.

By 2023/24, at least an additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services and school/college-based mental health Support Teams.

Current service models will be extended to create a comprehensive offer for 0-25 year olds that reaches across mental health services for children, young people and adults.

Milestones for mental health services for adults

- New and integrated models of primary and community mental health care will give 370,000 adults and older adults with severe mental illnesses greater choice and control over their care and support them to live well in their communities by 2023/24.
- By 2023/24, NHS 111 will be the single, universal point of access for people experiencing mental health crisis. We will also increase alternative forms of provision for those in crisis, including non-medical alternatives to A&E and alternatives to inpatient admission in acute mental health pathways. Families and staff who are bereaved by suicide will also have access to post crisis support.
- By 2023/24, we will introduce mental health transport vehicles, introduce mental health nurses in ambulance control rooms and build mental health competency of ambulance staff to ensure that ambulance staff are trained and equipped to respond effectively to people experiencing a mental health crisis.

The case for change

The national picture

Mental health problems are common and **exist throughout life** affecting children, adults and older people.

Based on national estimates, more than **175,000 adults** aged over 16 and more than **5,000 children** aged 5-16 living within the ICS are experiencing mental health conditions.

Recent estimates put the full cost of mental health problems in England at **£105.2 billion,** accounting for about 13% of the total NHS spend.

Those with serious mental illness are experiencing inequality in life expectancy, dying on average **17 years** (for men) and **15 years** (for women) earlier than the general population.

In Nottinghamshire

Overall Nottinghamshire has a range of social factors that mean we are more likely to see a higher incidence of mental health illness than elsewhere:

Overall incidents of reported crime have been increasing, **27% higher than five years ago**.

20% of homeless people with mental health issues are not receiving any support or treatment. A high proportion will have substance misuse and addiction problems.

There are approximately between **33,000 to 49,000 people** with long term conditions and co-existing depression.

Across the ICS it is estimated that more than **500,000** people will have been exposed to **at least one adverse childhood experience**, with around **45,000 experiencing four or more.**

Nottinghamshire residents with specialist mental health needs are **70% less likely to be in employment**, suggesting there may be less employment support and/or opportunities.

In Nottingham

While this is significant, Nottingham has other issues that will influence mental ill health including:

High rates of **alcohol and drug misuse** and high rates of **alcohol related mortality**

High rates of people living with **multiple and complex needs** (a combination of homelessness, offending, substance misuse and mental ill health)

Higher levels of **socio-economic deprivation**

Spend per 50,000 population in 2017/18 only slightly higher than national average (0.2m) but is **£2m higher in Nottingham City CCG.**

An overall **unemployment rate (9.6 per 1,000)** higher than the national (3.7) and regional averages (3.5).

Services

Our services are not keeping pace with demand as evidenced by patterns of commissioning and service utilisation/expenditure:

Mental health service users account for **19% of all A&E attendances** and result in **26% of all unplanned admissions to hospital.**

The ICS has one of the **lowest access rates for Children and Young People's Services across the country** - 17.6% against 32% expected performance.

Contacts with Crisis Resolution and Home Treatment Team per head of population **lower than national rate.**

3x Crude rates of out-of-area placements approximately **three times higher than national average** (Nov 16-Feb18).

Challenge in sustainably **meeting the constitutional standards**.

A challenge in meeting the Health Education England workforce plan for 2021.

Mental Health First Aid training is not routinely offered to employers.

Our workforce

The latest ICS submission to Health Education England (HEE) reveals an NHS mental health workforce comprising 6,242 funded posts in 2016 - 2,588 (41%) of which were for professionally qualified clinical staff and 484 (8%) of which were vacant at the time of submission (see figure below).

Funded Posts - 2016							
	Medical	Nursing and Midwifery	Allied Health Professional and Scientific, Theraputic and Technical Staff	Total Professionally Qualified Clinical Staff	Support to Clinical Staff	Administrative and Infrastructure Staff	Total
CYP	9	74	62	145	21	37	202
Adult IAPT		4	118	122	14	14	150
Perinatal	2	18	1	21	9	4	34
Crisis - CRHTTs		53	9	62	21	8	91
Liaison MH		20	1	21	3	2	25
EIP			5	5	2	4	10
Liaison & diversion		11		11	7		17
Total T.A.s	10	179	196	386	76	69	531
Core Acute	212	660	179	1,050	1,613	541	3,204
Core Community	38	565	549	1,152	731	625	2,508
Total Core	250	1,224	728	2,202	2,344	1,166	5,711
TOTAL	**260**	**1,404**	**924**	**2,588**	**2,420**	**1,235**	**6,242**

Figure one: NHS funded mental health posts in the ICS, 2016

Meeting the HEE plan for 2021 would anticipate funded posts increasing to 6,455 (3.4% above 2016). This increase is currently projected to be achieved through a combination of:

- 1,282 locally-hired replacement non-clinical staff
- 1,076 retained clinical staff that might otherwise have left
- 556 newly qualified clinical staff from training
- 219 new clinical roles such as nurse associates, physician associates and crisis telephone triage staff.

These changes, if achieved, would more than offset the expected number of clinical and non-clinical leavers during this period (2,780 or c.45% of the current workforce).

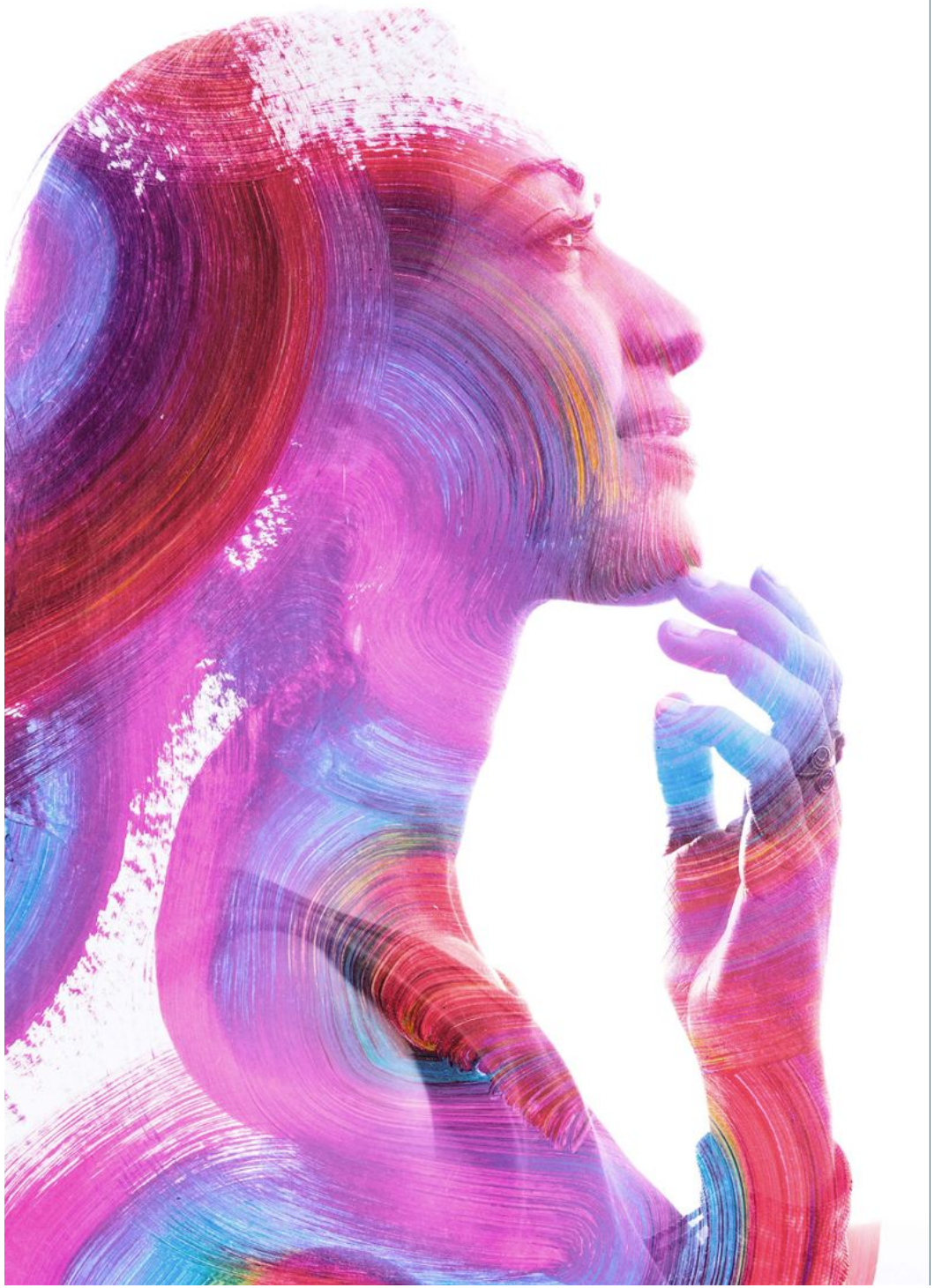
We recognise, however, that these plans will need to be revised in the light of this strategy and the implementation plans that flow from it.

Strengths and weaknesses

While the focus of this review was to identify areas where we should focus more resource, we can acknowledge our current strengths. Some of these are:

- Suicide rate reduction
- Life expectancy gap for male mental health service users (reduced by four years since 2006/07)
- The lowest mortality rates among ICS peers in the mental health cohort for circulatory disease and cancer
- The inclusion of housing and employment status in patient assessments and long-term employment of those in mental health services
- Overall patient experience of using community mental health services – contact points and communication
- Low emergency re-admission rate
- Low psychiatric intensive care unit length of stay
- Special recognition and awards for local projects including new models of care, extension of psychiatric liaison, and Fulfilling Lives funding.

Beyond these areas of strength, however, we have identified several areas of concern. Stakeholders reflected on these issues as part of the strategy development process to inform the content of the strategic pillars. As the delivery plans are developed they will need to demonstrate clear action plans against each of these emerging issues.



Our shared vision

Our vision

Based upon stakeholder engagement, our strategic vision is:

A whole system, all-age, person-centred approach, driven by access to physical and mental health and social care in the same place at the same time, with no wrong door, where prevention is at the heart of all we do.

Our aims

We will seek to:

- Reduce inequalities and narrow the gap between life expectancy for people with serious mental illness and the rest of the population by three years
- Reduce depression and anxiety prevalence
- Deliver the mental health workforce plan set out by NHS England with an additional 384 whole time equivalent posts in mental health by 2020
- Deliver mental health awareness training to all health care professionals
- Improve the patient experience of services and produce a formal mechanism for training service user evaluators
- Ensure everyone can access mental health services in the right place, at the right time
- Deliver parity of esteem – so that mental health is placed on a par with physical health
- Have one strategic commissioner and one system control total for mental health services across the ICS with an outcome-based contract
- Achieve all performance and transformation assurance standards

Our commitment

If we are successful in delivering this strategy then the people in Nottingham and Nottinghamshire will be able to see the difference it makes to their mental wellbeing. During the life of this strategy we would hope to see

- 170 new patients supported in an Early Intervention in Psychosis service (EiP) each year
- 2670 more Children able to access child and adolescent mental health services (CAMHS) (based on current achievement of 20%)
- Children and young people with eating disorders, if identified as urgent, will be seen within 1 week
- 140 more women supported by perinatal services each year
- All age Rapid Response and Liaison will be available in all Emergency Departments – resourced to meet 1 hour assessment targets.
- Patients would be able to access crisis support within 4 hours every day of the week, with workforce linked to caseloads.
- 66.7% of dementia patients diagnosed – 7925 patients – will be able to access appropriate after care.
- 25% of patients requiring support will be able to access IAPT (Improved Access to Psychological Therapies) services
- 4396 of the 8887 patients identified on the Serious Mental Illness (SMI) register will receive a physical health check (based on 2018/19 figures)
- Eradicate inappropriate mental health Out of Area Placements by 20/21

Our strategic pillars

We have identified a set of five key strategic pillars that will frame our work:

1. Increasing support for prevention, self-care and the wider factors that affect people's health
2. Implementing an approach that focuses on the individual (physical and mental health)
3. Improving access to services
4. Equipping a mental health-aware workforce
5. Establishing a truly integrated system

It is important that these pillars are not considered in isolation of each other. The following table sets out our five key pillars, highlighting the likely areas of interaction with other pillars in this strategy as well as their alignment with other areas of ICS work and with the delivery priorities of NHS England's Five Year Forward View for Mental Health.

1

Increasing support for prevention and the wider factors that affect people's health

Overview

We need to:

- Work with citizens in a personalised manner to increase awareness and understanding of mental health and wellbeing so that resilience is increased and the onset of ill health is avoided or delayed
- Work with local communities to promote and increase the local assets that can support those with mental ill health in managing and improving their conditions
- Work with wider system partners, including business and industry, to promote mental resilience and wellbeing and to address the wider determinants of mental ill health
- Meet our local stakeholders' position that we should place greater priority on children and younger people, especially those who suffer adverse childhood experience. This aligns with recent findings of the Mental Health Policy Commission which noted: *"a compelling case for investing in the positive mental health of young people in order to build a resilient generation for the future"*
- See a systemic culture change – moving to a system that takes a longer-term view and thinks about prevention rather than treatment alone
- Address transition points (for example, from child and adolescent mental health services to adult mental health) and to focus on areas that need strengthening (such as suicide prevention, social isolation, and vulnerable groups such as people leaving prison)
- Ensure that in children and young people's services, every contact with a child should discuss wellbeing
- Ensure that the prevention of mental ill health is a consideration for all age groups, not only for children and young people, so a 'life-course' approach to prevention is needed
- Provide better wraparound services in each locality to enhance self-care, independence and resilience
- Support the community and voluntary sector to further extend its impact on outcomes through initiatives such as ending social isolation
- Increase access to low level, responsive support to stop people's needs from escalating, as well as action to prevent suicide and self-harm
- Link with PHM workstream with regards to risk stratification of mental health population cohort including quantification and characterisation of cohorts
- Address the known causes of mental illness.

Wider factors that affect people's health

It is important to identify opportunities for the effective use of resources upstream to further reduce pressures on health, social care, criminal justice and other services downstream. There is a large body of evidence, for example, which highlights the link between poor quality, unaffordable or insecure housing and mental health. Similarly, alcohol issues transcend all areas of mental health: Mid Nottinghamshire is an outlier for alcohol-related harm and people fall through the gaps in the system.

While some aspects of the wider determinants of health may benefit from a whole-ICS approach, much of the infrastructure and relationships for doing this exist at other levels. Our ICPs and their constituent parts are best placed to facilitate integrated partnership working across sectors to mutual benefit. We know, for example, that those who are out of work are more at risk of experiencing adverse mental health and therefore to generate additional demand for health and other services. We also know that adverse mental health impacts the wider economy not just the individuals concerned.

Key outcomes

The outcomes we want to generate under this pillar are that:

- The overall demand for services is reduced, as a result of work on prevention, self-care and the wider determinants of health
- Mental health needs are being identified and addressed at an earlier stage, especially for children and young people
- Those accessing services report:
  - » Feeling more empowered to manage their condition and to access the right additional support when required
  - » Receiving integrated care and support across their mental and physical health needs
  - » Being able to access primary and community mental health services in a timely manner, reducing their need to rely on crisis services
  - » Experiencing a smooth and effective transition between child and adult services
- At a perinatal stage, service users will experience improved access to support and efficient pathways for referral
- More people with mental health conditions are able to access/remain in employment, improving wellbeing and increasing economic productivity.

2

Implementing an approach that focuses on the individual (physical and mental health)

Overview

We need to:

- Move towards parity of esteem and practice in relation to the physical and mental health needs of citizens. The differentiation of need into mental and physical categories is an historically established framing device but one that does not reflect underlying human reality
- Provide coherent pathways of care for people, integrating mental wellbeing, mental health and physical health. These pathways begin with supporting physical and mental health for people in the community, such as community support groups for people with diabetes, community referrals, self-care and self-management, and screening
- Ensure all primary care and community services staff are skilled and feel confident to have conversations with patients about mental and physical health
- Strengthen acute admission pathways across the secondary physical and mental health system, including reducing waiting times in Emergency Department
- Re-commission based on 'triple wins' - for the service users whose mental health and physical health needs are met together, for the services who do not waste time bouncing people around the systems, and for the commissioners in being able to utilise resources more effectively
- Understand how we can manage people's increasing physical and mental health long term conditions in terms of complexity and work with the interactions between the two rather than treating them as separate entities

Integrated place based working

The notion of 'place' has become increasingly important in health and care policy. The developing Primary Care Networks will provide:

a) An integrated multi-disciplinary team in each locality, built around primary care operating at scale, that co-ordinates the provision of holistic care. The multi-disciplinary team should consist of representation from all sectors who can contribute to effective health and social care provision for the patients.

b) The intelligence and information systems that enable teams to proactively identify and then co-ordinate the care management of specific service user cohorts. This latter is a broader approach than simple risk stratification: it includes the intelligence that informs both individual patient care and ongoing service improvement, supporting Primary Care Networks (PCNs) to become self-improving systems.

The integrated and holistic provision of anticipatory and response care should also be 'trauma-informed', adopting a locally-appropriate approach based on national and international evidence.

Key outcomes

The outcomes we want to generate under this pillar are that:

- There should be a focus on parity of esteem between physical and mental health, such that all health and care staff consider and assess mental health and wellbeing alongside physical health in all services and contacts.
- Integration should be seamless across community, primary, secondary and acute care services. This could include the co-location of a broad range of services (not just within health and social care) within locality hubs in order to provide holistic, 'one-stop shops'. The potential for whole-system, integrated crisis management responses could be explored to reduce pressure on Emergency Department

Stakeholders described a person-centred model in which:

- Health and care professionals are alert to the broad range of service user concerns and needs
- Services are flexible to meet needs, with co-produced care plans that embrace the multiple factors affecting individual health and wellbeing
- Relevant service user information can be proactively shared between services appropriately
- Additional physical health checks
- Improved access to psychological therapies.

3 Improving access to services

Overview

We need to:

- Provide the right care in the right place and ensure that service users get the support they need when they need it
- Ensure from the service user perspective that there is 'no wrong place' where they would be turned away without being helped to access the right support
- Reduce unwarranted out-of-area placements driven by capacity issues rather than clinical need (this currently affects over 30 people across the ICS)
- Focus on the urgent care system which was perceived as failing currently by stakeholders. Any proposed changes would need to consider previous business cases (for example the 'blue light' hub), the crisis concordat and social care proposals where significant work has already been undertaken
- Improve access to children and young people's services (Nottinghamshire has one of the lowest rates of access nationwide)
- Make sure that people with multiple and complex needs are able to access help from local services, particularly among vulnerable groups such as the homeless and victims of sexual violence
- Address the transition from children's to adult services, re-visiting how services are configured
- Create a system that provides integrated 24/7 access for service users, including those with multiple complex needs. No service user should fall through the gaps between services or their operating hours.
- Ensure that citizens have access to the right services when they need them – especially when approaching or enduring a crisis phase. Particular care needs to be taken to ensure that this is the case for more vulnerable citizens including those who are homeless, victims of abuse or sexual violence, at risk of suicide or self-harm, living with a dual-diagnosis, veterans, students (especially around transition issues), black or minority ethnic, refugees, or within the criminal justice system
- Provide mental health services based on a model of 'care and place', addressing the housing as well as care needs of service users, particularly during periods of transition to the community
- Ensure that person-centred care that is recovery focused should be delivered by a compassionate workforce at the first instance, wherever and whenever needed

Key outcomes

The outcomes we want to generate under this pillar are that there will be:

- Timely access to inpatient beds, reduced out-of-area placements and reduced delays in transfers of care
- Reduced use of the Mental Health Act
- Proactive, holistic care for higher-risk cohorts
- Clear pathways for care, with routes in and out of them, which may not need to go thought GP gatekeeping, but which can flex to meet individual needs
- Users involved in the design of the pathways and/or networks of care
- Care co-ordination along defined pathways, underpinned by a coherent single IT system
- Effective crisis structures in place across the system
- Improved access to services for children and young people
- Improved access to Early Intervention in Psychosis services
- Reduced inappropriate out of area placements.

4

Equipping a mental health-aware workforce

Overview

This pillar is about all staff in health and social care, not just specialist mental health staff . We believe that the proposed change in the non-specialist workforce needs to include:

- A cultural shift so that all staff see the mental health of citizens as their business – understanding the issues people face, the support they may need and the resources available to provide that support
- The protection of adequate capacity in defined roles (for example, 'front door' staff in GP surgeries, job centres, housing departments) so that staff are practically able to respond more appropriately to those with mental health issues
- The promotion of an ethos of compassion for those coping with mental ill health (including the mental health impact of physical health conditions)
- The development of core mental health competencies
- Improved resilience
- New ways of working - recruitment and retention strategy.

Key outcomes

The aim is to create a workforce that operates on a person-centred approach, keeping the citizen's holistic needs at the centre of all interactions. There is a particular need to embed this approach in services more likely to be working with vulnerable groups who are more at risk of mental health issues developing or becoming exacerbated. This includes the unemployed, the homeless, victims of crime (especially sexual violence), those within the criminal justice system and children and young people.

The outcomes we wish to generate under this pillar are that:

- Those accessing public and voluntary sector services report that:
  - » their mental health needs were appropriately considered
  - » they were treated with compassion
- Staff report feeling more comfortable and better equipped to respond appropriately to citizens with mental health issues
- The development or exacerbation of mental health conditions is prevented
- Specialist mental health staff report receiving more appropriate referrals
- Users of mental health services report:
  - » experiencing reduced stigma in accessing other public/voluntary services
  - » being actively signposted to other appropriate sources of support
  - » being helped to access specialist help in a timelier manner.
- Working with families and carers to understand their role and how best to support them.

5

Establishing a truly integrated system

Overview

We need to:

- Create an integrated system that supports the more effective delivery of mental health and wellbeing across the ICS – this would see a move towards one ICS/ICS integrated commissioning function
- Over-ride condition-specific services and standardise specifications across the ICS – as people are currently reporting that they are being passed from service to service
- Design and deliver a system that brings together the work of individual organisations such that the overall impact is greater than the sum of its parts
- Improve our strategic commissioning and funding so that we obtain the maximum benefits in terms of cost effectiveness and clinical impact
- Make better use of the voluntary and community sector as full partners – gaining a better understanding of what resources are available
- Make care more integrated – involving multi-disciplinary team meetings and using population health management

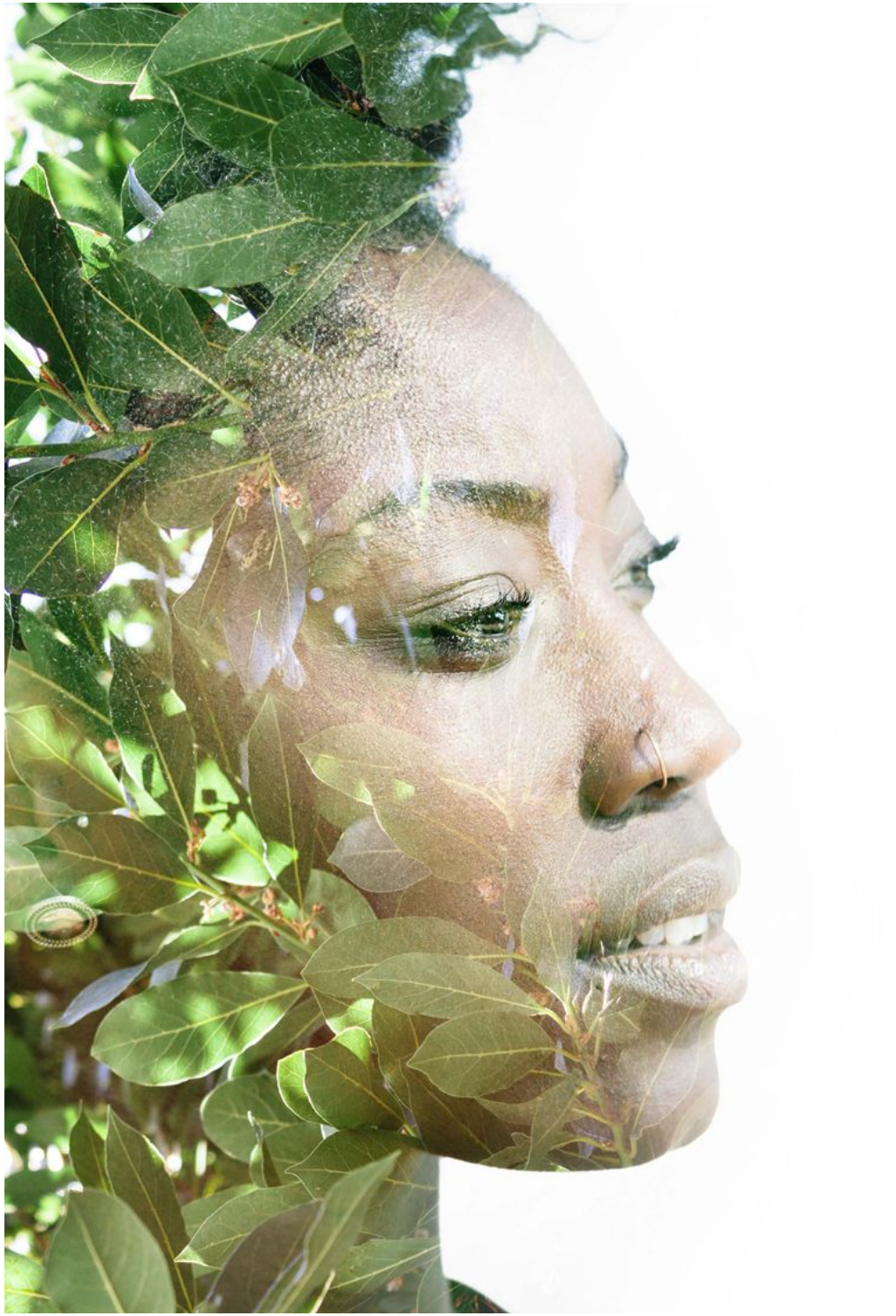
Workforce

- In order to create a sustainable workforce for the future, there needs to be a focus on training and development to address shortages in skills and to explore the potential for new roles, focusing on the competencies required rather than solely on established disciplines and professional groups
- Workforce skills need to be mapped with gaps identified, leading to training and knowledge sharing
- Clear career pathways need to be developed, and staff should be supported with their progress
- There should be recognition and acknowledgement of key achievements, successes and progress made by staff and their patients
- A plan needs to be put in place to effectively utilise the additional capacity resource for primary care highlighted in NHS England's *GP Forward View*
- These initial mapping exercises should inform and support the development of a ICS workforce organisational development strategy, working with the wider ICS Workforce workstream
- Alternative workforce solutions need to be considered that move beyond traditional roles, such as peer support workers or non-social worker approved medical practitioners

Key outcomes

The outcomes we want to generate under this pillar are that:

- Those accessing the services in the system report that:
  - » They understand the system, they know who is responsible for their care, and it is easy to navigate
  - » They are experiencing improvements from the care they receive in terms of outcomes and clinical effectiveness
  - » They feel that services are flexible in meeting their needs, rather than having to access multiple different services
  - » They have a positive experience of using the services in the system
- There is increasingly joint and integrated commissioning against a shared set of outcomes metrics
- Health outcomes are improved within the available resource levels
- Appropriate service-user information is accessible to providers across the system, enabling the most appropriate, holistic response in line with agreed plans (including in crisis)
- The system is financially stable and mental health funding targets are met or exceeded
- Contractual arrangement and financial mechanisms are in place that enable the right care to be provided at the right time without service users being passed between services
- There is a comprehensive service offer which is fit for purpose
- There is clear governance and decision-making at neighbourhood, place and system level, and clarity about the services to be delivered at each level
- There is a proactive, universal service offer for low-level mental health conditions
- The increased integration of the voluntary and community sector in service provision increases the impact of the sector on service user outcomes and provides a source of innovation for the wider system
- A mental health workforce plan is in place that is providing the workforce currently required and building the roles required in the future.



Immediate next steps

1. Increasing support for prevention, self-care and the wider factors that affect people's health

- Link with PHM workstream with regards to risk stratification of mental health population cohort including quantification and characterisation of cohorts
- Map staff training offer and uptake - prioritise and provide training
- Link with prevention, person and community-centred workstream to implement social prescribing (picking up debt, loneliness and low level anxiety/ depression), personal health budgets to be introduced for people with a personality disorder, expand shared decision making, alcohol prevention and making every contact count.
- Liaise with Suicide Prevention Partnership to identify priority areas for support, working towards a 10% reduction in suicide by 2020/21
- Each CCG should ensure increased access to NICE concordant community-based specialist perinatal mental health services (in secondary care settings) for at least 4.5% of their population birth rate, equating to an additional 20,000 women nationally
- Link with homelessness group to develop and implement action plan for homeless citizens
- Expand programme of individual placement support into Mid Nottinghamshire
- Begin to scope work being undertaken across county and city for adverse childhood experiences.

2. Implementing an approach that focuses on the individual (physical and mental health)

- Identify services in place to deliver annual physical health checks and follow up care for people living with serious mental illness
- Link with primary care workstream in the development of place-based multi-disciplinary teams, sharing responsibility for monitoring and managing the physical health of people with serious mental illness between primary and specialist mental health services
- Undertake actions identified in IAPT access recovery plans to achieve current IAPT standard. Action plan required for delivery of IAPT long term conditions and IAPT 22% access rates by end 2019/20.
- Target cognitive behavioural treatments and social interventions for those at risk due to their long term physical condition
- Link with primary care workstream in the development of integrated mental health support with primary care and chronic disease management programmes
- Scope appropriate pathways for patients with co-existing mental health and substance misuse issues
- Scope feasibility of expanding current Time to Change activity into county.

3. Improving access to services

- Implement crisis/liaison and out-of-area placements/urgent care action plan
- Complete review and reconfiguration of current Crisis and Home Treatment Teams and mobilise new care model to ensure services meet the minimum functions
- Spread coverage of liaison mental health teams through sustained commissioning of core 24 teams by 2020/21. Progress plans for acute hospitals to have mental health liaison services that can meet the specific needs of people of all ages, including children and young people and older adults by 2020/21
- Work to ensure crisis teams meet core fidelity standards by 2020/21
- Develop new care model for local mental health teams and local multi-agency urgent response
- Implement improvement plan for the Nottinghamshire Crisis House
- Implement findings of the liaison psychiatry service models, ensuring continued core 24 compliance
- Children and young people (CYP) – undertake actions articulated in CYP recovery plan. Develop actions to support the 2019/20 requirement of increasing access to 34% of estimated 2004 CYP prevalence

- CCGs should ensure there is a crisis response 24/7 which combine crisis, liaison and intensive community support functions, meeting needs of under 18-year-olds
- CYP - Deliver against regional implementation plans to ensure that by 2020/21, inpatient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements, within a context of 150-180 additional beds by 2020/21
- CCGs to ensure the 2018/19 commitment for NICE concordance for early intervention in psychosis from the implementation plan is met; deliver against the further ambition for 50% of services to be graded level three by end 2019/20.

4. Equipping a mental health-aware workforce

- Each CCG should work closely with their NHS and non-NHS provider partners and arm's-length bodies locally to deliver against workforce plans, including expansion and enabling of training and retention schemes. Workforce requirements should form part of finance and mental health investment plan discussions to ensure alignment with CCG financial submissions
- Continue work to deliver expansion in the capacity and capability of the CYP workforce, building towards 1,700 new staff and 3,400 existing staff trained to deliver evidence-based interventions by 2020/21.

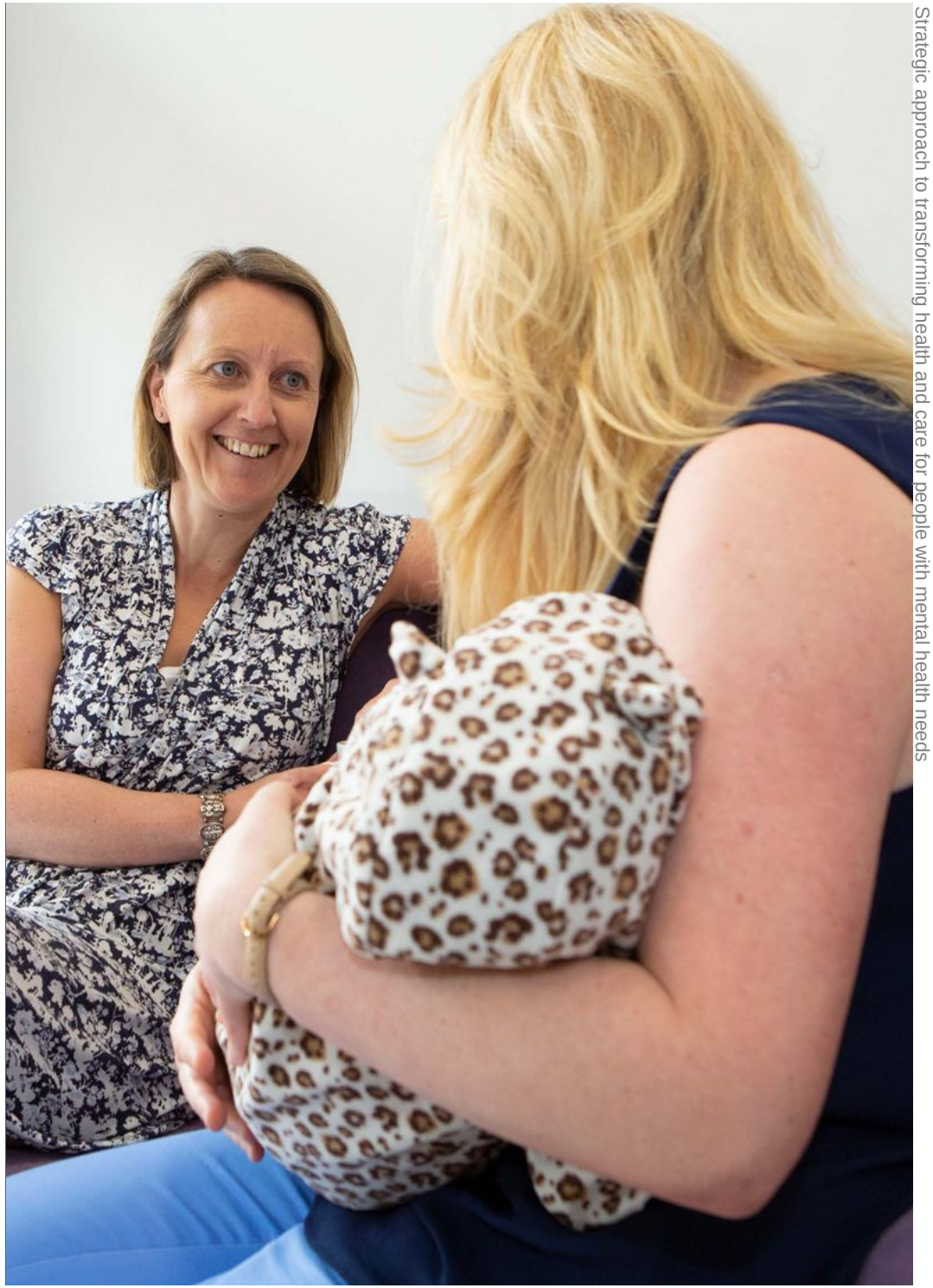
5. Establishing a truly integrated system

- CCGs to create a single commissioning function, ensuring that people's needs are met no matter where they come into contact with services
- Align local authority strategic commissioning resource
- Develop outcomes framework
- All CCGs to meet the Mental Health Investment Standard (MHIS). Full information is in section 3.6 of the NHS Operational Planning and Contracting Guidance 2019/20
- Commissioners to develop a comprehensive picture of current activity and spend on mental health cohort
- Single patient record and integrated systems.

Governance, Communications and Engagement

This strategy represents a major step forward in collaborating to transform the mental health landscape in Nottinghamshire and meet demand. Five strategic pillars have been identified to achieve our vision for mental health and wellbeing. We can take some short term action now to obtain immediate gains:

- The ICS Leadership Board has recognised this is a vital piece of work and have already committed key resources in terms of joint senior responsible officer (SRO) leadership and a programme director to drive forward this work
- Identifying director level SROs for the delivery of each strategic pillar
- We will work with those involved in this strategy to communicate and engage with them on implementation.



Conclusion

The ICS needs to enable meaningful, multi-level involvement throughout the workplans that will be developed for each strategic pillar.

Third sector, voluntary sector and citizen engagement is a core principle of the ICS and this strategy, as well as a key component of services at all levels. Citizens (including experts by experience) will be involved in co-design, co-production and in evaluation activities, as well as recruitment and governance, from the outset, underpinned by clear governance structures.

We need to ensure that involvement and engagement includes people from Black and Minority Ethnic (BAME) communities, carers, students, ex-military personnel and the homeless – especially people who are vulnerable individuals who are not well served by the current delivery of services. in second tier mental health services and tend to bypass primary services.

Work on the foundations must begin with a plan for engagement and involvement. This plan, to be developed under the Integrated Mental Health and Social Care Board, will cover a clear set of short, medium and long term aims, as well as the purpose of the collaborative partnership with citizens and clarity on differing roles within this partnership. Governance processes and terms of reference and accountability will also be covered in this plan, as will guidance on cultivating personal development benefits for citizens involved in engagement. A charter or code of conduct may be developed to help with oversight of engagement activities.

An initial workshop will be held to introduce the principle and plan for citizen engagement. This workshop should be attended by key stakeholders from services who will be co-ordinating citizen engagement and citizens who may be interested in being involved. This workshop should pave the way for subsequent service-specific engagement work, dictated by a tailored engagement plan for each service. It is acknowledged that there is already much expertise in this area locally, including the work of the Practice Development Unit - a partnership between Opportunity Nottingham and Nottingham CVS. More specifically, the Mental Health Partnership Board will recruit service users into a standing co-design group that will be able to check and challenge the Board's ongoing work, including the implementation of this strategy.

Choice and control in accessing support

We are concerned that our work in this area should not be confined simply to engaging citizens in the shape and content of strategies and plans, as important as this is. Citizens will also be enabled and empowered to exercise the maximum appropriate choice and control in the support they access, including how, when and where they do so.

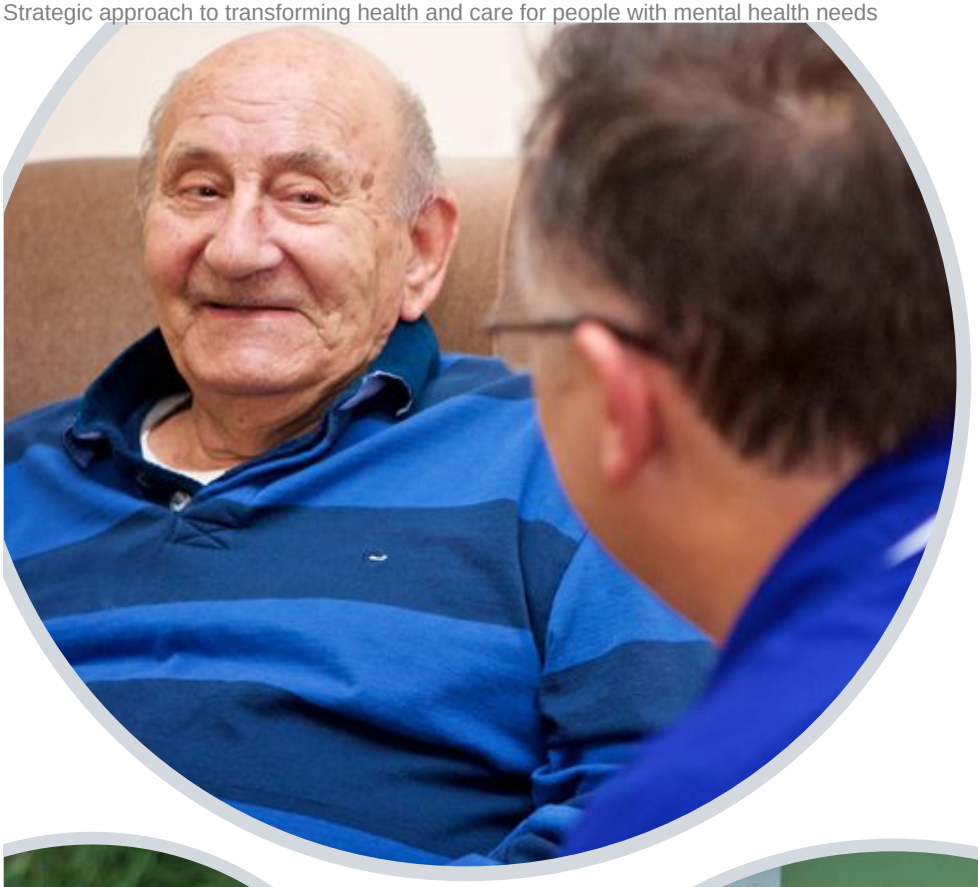
All service users will have a care plan (including advance crisis planning) that is co-produced and will be accessible to all relevant parties, including service users, carers, families and key staff. Care plans will be based on a holistic approach to health and care, including both clinical and other approaches to care and support. The plans we develop will also be able to take advantage of the opportunities provided by technology and digital health solutions to increase the ways in which people will be able to access support.

Choice should be incorporated into service delivery and service user care plans. Citizens will be empowered to make choices and decisions regarding their own health and wellbeing and these choices and decisions will be informed and considered. More detailed planning under each strategic pillar will also consider the potential to facilitate direct access to defined services so that our system can become more person-centred and less service-centred.

In the life of this strategy we hope to achieve our vision of:

A whole system, all-age, person-centred approach, driven by access to physical and mental health and social care in the same place at the same time, with no wrong door, where prevention is at the heart of all we do.

We will reduce inequalities and narrow the gap between SMI life expectancy and the rest of the population by 3 years and increase healthy life expectancy by 3 years.



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Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	10/11/2022
Paper Title:	**Strategic Approach to Transforming Health and Care for Children and Young People**
Paper Reference:	ICB 22 038
Report Author:	Maxine Bunn, Associate Director of Commissioning – Mental Health, Children and Community Karon Foulkes, Head of Maternity and Children's Commissioning and Transformation
Report Sponsor:	Lucy Dadge, Director of Integration and Catherine Underwood, Corporate Director for People Services
Presenter:	Lucy Dadge, Director of Integration
Recommendation(s):	The Board is asked to **ENDORSE** the progress of the Children and Young People's Transformation Programmes and the system approach to co-production, strategic planning and service delivery to meet the needs of the population

Summary:

Children and Young People (CYP) are 25% of the Integrated Care System (ICS) population and 100% of our future. Conscious investment in evidence-based services now will accelerate prevention of health and care needs in the future.

This paper outlines the collaborative approach of the ICS in the context of CYP's health needs in terms of demographics and health inequalities with particular attention to the impact of COVID-19. The nationally determined elements of service transformation for young people shows progress in mental health outcomes, and more recently physical health improvements.

There is a strong track record of joint strategic planning between Local Authorities, Public Health, and the Integrated Care Board (ICB); informed by co-production with children, young people and their carers which ensure delivery of the right care in the right place at the right time, addressing the holistic needs of children and young people. Challenges and opportunities for the system include the need to invest in reducing childhood obesity now, transition, thinking differently about our workforce and the opportunities the devolvement of specialised commissioning will afford.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	The focus of the collaborative way of working across the system seeks to improve outcomes through focusing on evidence-based practice, including the voice of CYP in what matters to them and improved pathways from prevention to specialist intervention. There is evidence that investing in improving the

	health and wellbeing of all children will impact on improvement in outcomes of the population now and in the future.
Tackle inequalities in outcomes, experience and access	Each area of change can demonstrate an understanding of the inequalities affecting the health and wellbeing of children. Specific measures to address these inequalities have included seeking to understand from those who are most vulnerable in communities and who may not have a voice. One way has been through citizen research by young people as to what matters to them to encourage access and improve experience.
Enhance productivity and value for money	Established working relationships between the Local Authorities and the ICB have increased opportunities for collaborative planning and securing integrated provision. In turn examples can be given of how this has made better use of limited resources and make sense to providers and families.
Help the NHS support broader social and economic development	Working as a system to improve the health and wellbeing of children supports their ability to access learning, reduces their reliance on services in the future and supports them moving onto employment.

Appendices:
Appendix A: Children and Young People plan on a page **Appendix B**: Pathways to inequalities in child health **Appendix C**: Nottingham City Child and Maternal Health Data **Appendix D**: Nottinghamshire Child and Maternal Health Data **Appendix E**: Commissioning responsibilities for child and young person health services

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 3: Transformation (for Making Tomorrow Better) – Effective system working may not transform (reform) and improve services to ensure best possible future health outcomes within available resources.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	Yes
Duty to promote innovation	Yes
Duty in respect of research	Yes

Applicable Statutory Duties:	
Duty to promote education and training	Yes
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	Yes
Duties as to climate change	Yes
Duties regarding public involvement and consultation	Yes
Public sector equalities duties	Yes

Report Previously Received By:
This report has been produced for this ICB Board

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Strategic Approach to Transforming Health and Care for Children and Young People

Purpose and Ambition

1. System partners are working together to strategically plan and integrate services to improve the overall health and wellbeing of children and young people (CYP) in Nottingham and Nottinghamshire. A plan on a page is in Appendix A.
2. Fundamentally, the ICS has an ambition to reframe prevention as a continuum of approaches. All forms of investment in children and young people's education, health and families have an element of prevention that yield high returns later in life. Direct investments in low-income children's health and education generate the highest pay-off, through increased earnings and lower demand on public services. This potential does not decline as children get older.
3. Our shared vision is shaped by the ICS outcomes framework with the aim of ensuring all children and young people to have the best start in life with the support and healthcare needed to enable them to be safe from harm and enjoy healthy lifestyles, do well in learning and have skills for life. Our approach to realising this vision will focus on planning and delivering care which meets the holistic needs of young people. This will be through closing the gap in health and wellbeing outcomes for all children and young people no matter where they are born, live or go to school and providing equitable access to the right care at the right time in the right place.

Context for Children and Young People in Nottingham and Nottinghamshire

4. The age range for accessing children's services is from birth up to 19 years, or potentially up to 21 for those who have left local authority care; or 25 for those with special educational need or disability. This is around 25% of the ICS population.
5. Although Nottinghamshire has a deprivation level comparable with England, variability means that communities within the county have the highest and lowest levels of deprivation in England. Nottingham is ranked as the 11th most deprived district in England. In 2020/21 this equated to 36,864 children under 16 years living in relative low-income families in the ICS. Appendices B and C summarise key health and outcome data for City and County.
6. Low income can lead to persistent disruptions to child development, particularly brain architecture, stress responses, and metabolic balance over the life course, affecting the risk of many adult chronic diseases. In addition, poverty affects family functioning, and can lead to worse nutrition, a less stimulating

learning environment. Furthermore, low-income families are more likely to live in polluted neighbourhoods. Those factors which can drive inequalities in child health are summarised in Appendix D

7. Challenges for the health and wellbeing of children reflect those of adults in terms of COVID-19 but have a different impact. For example, in elective surgery the waits may be similar but the impact of a 104 week wait for a child who is 104 weeks old now, in terms of their physical and neurological development can have lifelong consequences.

8. Health inequalities have been exacerbated by COVID-19 in relation to early childhood development outcomes through limited access to health, socialisation and good quality early years settings. Children born in lockdown are presenting in early years settings with limited speech and language as well as developmentally immature behaviour.

9. Data over the past two years shows one in six young people aged 6-19 years now has a probable mental health disorder. The number who are obese or severely obese has significantly increased so four in ten children are now overweight or obese at age 11 years. Locally 4% in the County and 7.1% in the City are *severely* obese at age 11. There is an over-representation of Black African and Bangladeshi ethnic groups in Nottingham City compared to the national prevalence of obesity in children. There is increasing concern about disparity in levels of vaccinations and immunisations in some communities.

10. Birth rates for City and County are similar to the regional average although the teenage birth rate in the City is 3.3% higher than the England average. Children with teenage parents are more likely to have higher mortality rates, lower educational achievement, and socio- emotional problems.

11. Improved technology and advances in care at birth and in childhood have increased the numbers of children who are living into adulthood with complex health needs, reliance on technology for communication and daily care, and those requiring palliative services.

12. In Nottinghamshire, 4% of the population is black, Asian and minority ethnic (BAME), whereas in Nottingham City 35% are BAME. Research also shows that people with BAME heritage have poorer health outcomes which can relate to diagnosis. In Nottingham City for example there is a statistically significant difference in white groups of CYP being recorded as having asthma compared to all other ethnic groups, in contrast to the national trend.

Working differently to improve services for Children and Young People

13. Accountabilities for arranging for children's health and care services are complex and interrelated across Local Authorities including Public Health and the ICB. They are summarised in Appendix E. Our ICS integrated planning and

delivery approach focusses on system partners working together with children, young people and families.

14. The ICS already has a number of established approaches to working together differently. The ambition is to move towards a Place and outcomes focused approach, with collaborative planning against which an alliance of providers will arrange services. As provider collaboratives and Places continue to advance and mature, it is anticipated their role in the development and delivery of broader aspects of care and support to children and young people will also develop and increase.

15. The 2021 review of the arrangements for planning and securing children's services and support strengthened the strategic working relationship with the City Council, County Council and the ICB. Best Start for children 0-5 years has been agreed as a collective priority focus for 2022/23.

16. The benefits of this strengthened approach to planning are evident; for example, through provision of integrated early intervention and specialist speech and language service in the County, jointly funded, with a single contract between the ICB and provider, resulting in a single access route and more flexible workforce. In addition, a joint approach between the City Council and the ICB has created a single residential unit for short breaks for children with highly complex health needs and for those who are medically fit for discharge from hospital so they can leave the hospital earlier.

17. Inspection and peer reviews in 2022 of each Local Authority (LA), recognised effective partnerships across the ICS in delivering joined up care for those with Special Educational Need or Disability (SEND). Recently a single Health Assurance Group has been tasked to coordinate the health response to both accountability boards.

Transformation Programmes for Children and Young People

18. The NHS Long Term Plan (LTP), 2019, sets out a vision for the future of the NHS and new action in relation to CYP aged 0-25. It includes a commitment to expand mental health services including increasing access to evidence-based treatment, crisis support and for those with eating disorders. Latest data over the past two years shows one in six CYP aged 6-19 years has a probable mental health disorder. This is reflected locally through increased referrals for self-harm, CAMHS (Child and Adolescent Mental Health Services) and school health services.

19. Locally there has been an increase in the availability, range and expertise of services, integration of services and pathways and a focus on reducing waiting times for CYP with mental health needs. Key collective developments include implementation of the very successful 0-25 Emotional Wellbeing Early Support Service and continued roll-out of Mental Health in Schools Teams for those with mild to moderate mental health issues.

20. In 2021 NHS England launched a Transformation Programme of physical health for CYP. There are six physical health transformation programmes: asthma, obesity, emergency admissions, epilepsy, diabetes and infant mortality to be developed by 2024. The programmes for emergency admissions and reducing infant mortality are yet to commence.

21. Non recurrent test and learn funding has supported work with Nottingham University Hospitals (NUH) as a regional hub for CYP with Complications due to Excess Weight (CEW) and for transition work in relation to young people with diabetes moving to adult services at Sherwood Forest Hospital (SFH). A pilot has also recently commenced for integrating the ICS approach to provide the best health and social care for children and young people who are in care and have complex behavioural and mental health needs.

22. Around one in 11 children has asthma. That is three in every classroom. The national Children and Young People's Transformation Programme has released a bundle of care to be implemented locally by 2024. In the ICS, there is an established clinically led Asthma Partnership Group which has used population health management (PHM) data to determine priorities. Training for professionals both specialist and non-health has commenced to include inhaler technique. Use of Personalised Asthma Action Plans (PAAP) by all PCN areas is inconsistent and targeted work will be undertaken. Work has begun on greener asthma care, with Rushcliffe PCN leading local pilots**.** A deeper dive into understanding the inequalities of diagnosis of asthma in the City is underway.

23. There is a gap in service provision for services for children who are severely obese or who are obese but have other complex needs. Work is ongoing in co-designing a new service for this cohort with system partners, CYP and their carers, starting with a small pilot utilising personalised care project funds to take a whole family approach. This will commence in December 2022, with priority given to increasing equity of access to more vulnerable families.

Co-production with Children and Young People to Improve Outcomes

24. Co-production with CYP and their carers is embedded in the ICS through development of pathways, regular membership or representation at steering groups and consultation. In mental health, young people have been trained as citizen researchers to give voice to the more vulnerable. Peer mentoring schemes are being piloted in schools to deliver mental health support. NUH Youth Forum is working with the ICB and CEW clinic to co-design a course for CYP who are discharged from CEW to support transition to community services.

25. The new NottAlone website for CYP with mental health needs was the culmination of collaborative work and coproduction with children, young people and system partners. The award-winning website is funded by both Local

Authorities and the ICB in recognition of the necessity to have a single source of information. Plans are underway to expand the website to adults over the coming year**.**

26. Use of Patient Knows Best (PKB) as a digital platform to promote self-management, tailored resources and means of communication between the child/young person and clinician has been successfully trialled in SFH with epilepsy. CYP are working with PKB development leads to improve PKB further, particularly for asthma or weight management needs.

Future Opportunities and Challenges in the delivery of services for Children and Young People

27. Children and young people transitioning to adult services with long term conditions such as mental health, require palliative care, diabetes and asthma are more likely to have poor outcomes. Progress has been made through transition workers in provider services to ensure transition to adult services is effectively managed and planned to reduce avoidable and unplanned hospital admissions. Co-production with children and young people with mental health concerns is underway to develop the transition pathways and review 18-25 years models of care. There is an opportunity for the Integrated Care Strategy to adopt this as a medium-term preventative strategy that can have measurable results.

28. Provider collaboratives at service pathway level give us an opportunity to improve productivity and manage the pressure on the workforce. For example, reducing reliance on highly specialist community paediatrics or Allied Health Professionals by taking an integrated approach to assessing and meeting the needs for those who may have Autism or ASD or through new models of providing continuing care for children.

29. There is an opportunity, through delegation of specialised commissioning from NHS England, for the ICB to strengthen approaches for specialist physical health conditions and Tier 4 CAMHS for forensic, Learning Disability and Autistic Spectrum. Our ICS is already a model of excellence in the region for working at system level to improve outcomes for CYP in diabetes, palliative care and CAMHS so could enhance local services and lead best practice for others.

30. Gaps have been identified in provision for CYP who are overweight, obese, and severely obese. To ensure we can support an increase in life expectancy, reduce future illness and disease prevalence and support our population living healthy lives, we need to prioritise significant investment for CYP if the ICS is to limit the longer-term health, wellbeing and economic consequences for our population.

Appendix A: Children and Young People – Plan on a Page

2022 /2023 Children are 25% of our population and 100% of our future

Integrated Care System
Nottingham & Nottinghamshire

Physical Health

National Priorities

- NHS Long Term Plan: national transformation programme priorities around obesity, asthma, epilepsy, diabetes, infant mortality, Urgent Care/ED
- National pilots around integrated care for children with complex care and health needs
- National pilot around severe obesity (CEW clinic pilot at NUH)
- National pilot on transitions for diabetes care (SFH and Newark Hospitals)

Local Priorities

ICS Clinical and Community Services Strategy:

- Healthy start in life: school readiness, vaccination rates, obesity (gap at tier 3 weight management services) and addressing inequalities
- Out of hospital services for CYP: urgent care, children with complex health needs, palliative, and end of life care
- Transitions
- Continuing Care model transformation
- Children in care- review of health provision

Mental Health

National Priorities

- NHS Long Term Plan: increasing access, eating disorder access standards, early intervention into psychosis NICE guidance and timeliness, 0-25 models of care, 24/7 crisis and intensive support, mental health support teams in schools, national 4-week waiting time pilot.
- Independent Review of Children's Social Care: ensuring we meet needs of local population and achieve statutory timeframes.
- Learning Disability and Autism: ensuring better preventative support earlier, keyworker pilot, Autism in Schools pilot, autism diagnosis and support
- SEND Green Paper-health role

Local Priorities

- Transitions
- SEND Health Assurance Group
- Development and delivery of SEND joint commissioning strategy
- Review of CYP mental health pathways
- Joint commissioning of Targeted CAMHS service in Nottingham City
- Joint commissioning of Short Breaks in Nottingham City
- Joint planning of specialist children's residential provision for those with complex care and mental health needs

Emerging Areas

- Development of ICS all-age joint commissioning framework – Better Start theme agreed for learning lab
- Children in crisis and inappropriate settings
- Rapid increase in obesity rates
- Increase in CYP with type 1 diabetes since COVID in young children
- Children who are Long Term Ventilated with complex needs becoming adults
- Challenges in Community Paediatrics
- Sleep offer and escalating melatonin prescription costs
- Maternity and neonates
- Tier 4 CAMHS provider collaborative and interface with local area
- More aligned working between health and care in CAMHS
- Integration of physical and mental health
- Elective waiting times for CYP post Covid

Immediate Challenges

- CYP Governance within the ICS to be developed to agree system priorities and drive change.
- Assessing the impact of Covid-19 on CYP and families: do we understand the effect that has been had and how is this informing our short, medium and long-term system response across education, health, and care?

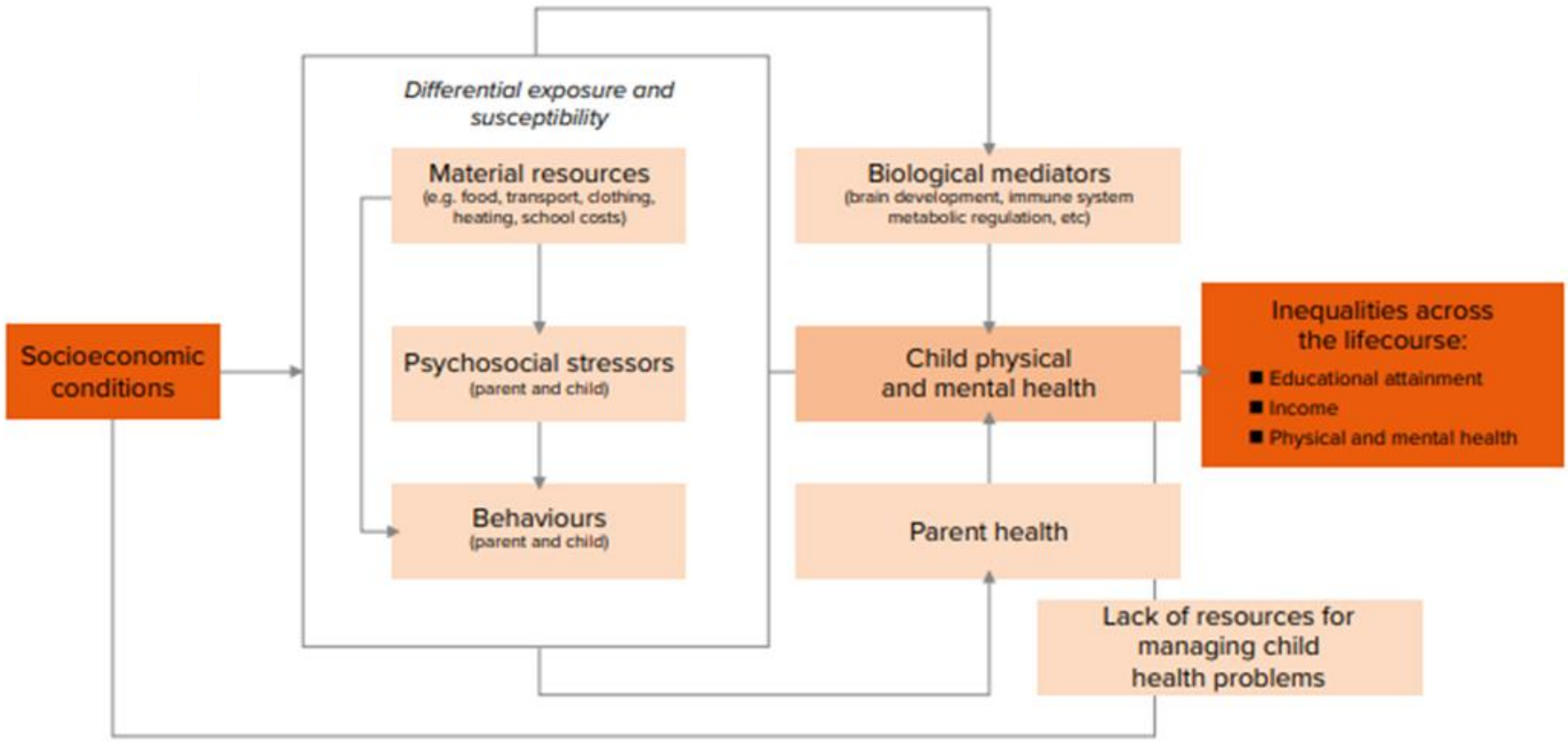
Opportunities, issues and challenges to be worked through

- Emerging ICS architecture: do all partners know of changes and implications?
- Role of Place Based Partnerships: is transformation and commissioning possible at place level?
- Do we have a collective understanding of education, health and care needs/inequalities for CYP across Nottingham and Nottinghamshire, at system and place level and how does this inform our collective priorities?
- UNICEF Child Friendly initiative for Nottingham City: how can the tools and mechanisms benefit the whole ICS?
- Workforce:
  - Stocktake of current CYP workforce and future workforce projections
  - Visibility of CYP workforce in ICS People and Culture arrangements
  - Long-term CYP workforce strategy
- Role of the ICB Exec Lead with responsibility for CYP- opportunities for raising profile of CYP amongst competing adult priorities

CYP Leadership

SRO and Exec Lead: Lucy Dadge
Children's Commissioning and Transformation Programme Director: Karon Foulkes
Clinical Lead: Dr Jen Moss Langfield
Programme Managers: Katharine Browne and Helen Lappin

Appendix B: Factors that drive inequalities in child health Source:Child-of-the-North-Report-FINAL-1.pdf (thenhsa.co.uk)



Appendix C: Nottingham City Child and Maternal Health

Data Source: Child and Maternal Health - Data - OHID (phe.org.uk)

Indicator	Period	Nottingham			England			
		Recent Trend	Count	Value	Value	Worst/ Lowest	Range	Best/ Highest
Infant mortality rate	2018 - 20	–	68	6.1	3.9	6.8		
Child mortality rate (1-17 years)	2018 - 20	–	34	17.3	10.3	17.7		1
Population vaccination coverage - MMR for one dose (2 years old) <90% 90% to 95% ≥95%	2020/21	→	3,398	87.3%	90.3%	70.7%		97.9%
Population vaccination coverage - Dtap / IPV / Hib (2 years old) <90% 90% to 95% ≥95%	2020/21	↓	3,608	92.7%	93.8%	77.8%		99.2%
Children in care immunisations	2021	→	454	94.0%	86.0%	22.0%		100%
School readiness: percentage of children achieving a good level of development at the end of Reception	2018/19	↑	2,502	66.9%	71.8%	63.1%		
Average Attainment 8 score	2020/21	–	147,754	46.1	50.9	42.9		
Average Attainment 8 score of children in care	2020	–	930	17.9	21.4	10.6		
16-17 year olds not in education, employment or training (NEET) or whose activity is not known	2020	→	420	6.3%	5.5%	13.8%		4%
First time entrants to the youth justice system	2021	↓	130	446.9	146.9	446.9		56.3
Children in absolute low income families (under 16s)	2020/21	↓	11,708	18.7%	15.1%	39.2%		5.2%
Children in relative low income families (under 16s)	2020/21	↓	15,694	25.1%	18.5%	42.4%		2%
Homelessness - households with dependent children owed a duty under the Homelessness Reduction Act	2020/21	–	841	24.0	11.6	32.2		3.6
Children in care	2021	→	685	99	67	210		24
Children killed and seriously injured (KSI) on England's roads	2018 - 20	–	26	13.9	15.9	55.0		2.6
Low birth weight of term babies	2020	→	120	3.8%	2.9%	4.9%		
Reception: Prevalence of obesity (including severe obesity)	2019/20	→	-	12.2%	9.9%	14.6%		
Year 6: Prevalence of obesity (including severe obesity)	2019/20	→	-	26.0%	21.0%	30.1%		
Percentage of 5 year olds with experience of visually obvious dental decay	2018/19	–	-	35.8%	23.4%	50.9%		
Hospital admissions for dental caries (0-5 years)	2018/19 - 20/21	–	10	13.7	220.8	7.5		
Under 18s conception rate / 1,000	2020	→	-	19.3	13.0	30.4		7
Teenage mothers	2020/21	–	25	0.8%	0.6%	1.8%		0%
Admission episodes for alcohol-specific conditions - Under 18s	2018/19 - 20/21	–	45	21.7	29.3	83.8		7.7
Hospital admissions due to substance misuse (15-24 years)	2018/19 - 20/21	–	135	57.6	81.2	229.4		16.9
Smoking status at time of delivery	2020/21	↓	-	13.9%	9.6%	21.4%		
Baby's first feed breastmilk	2018/19	–	2,185	58.7%	67.4%	43.6%		
Breastfeeding prevalence at 6-8 weeks after birth - current method	2020/21	–	-	50.9%	47.6%*	-		*Insufficient number of values for a spine cha*
A&E attendances (0-4 years)	2019/20	–	15,055	740.4	659.8	1,700.5		2
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2020/21	–	255	43.2	75.7	144.0		
Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	2020/21	–	645	82.1	112.4	264.7		45.8
Hospital admissions for asthma (under 19 years)	2020/21	–	45	60.6	74.2	290.2		22.5
Hospital admissions for mental health conditions (<18 yrs)	2020/21	–	40	57.7	87.5	263.5		21.0
Hospital admissions as a result of self-harm (10-24 years)	2020/21	–	335	309.4	421.9	1,173.7		112.4

Appendix D: Nottinghamshire Child and Maternal Health

Data Source: Child and Maternal Health - Data - OHID (phe.org.uk)

Better 95% Similar Worse 95% Not applicable Quintiles: Best Worst Not applicable

Recent trends: – Could not be calculated → No significant change ↑ Increasing & getting worse ↑ Increasing & getting better ↓ Decreasing & getting worse ↓ Decreasing & getting better ↑ Increasing ↓ Decreasing

Benchmark Value: Worst/Lowest | 25th Percentile | 75th Percentile | Best/Highest

Indicator	Period	Notts			England			
		Recent Trend	Count	Value	Value	Worst/ Lowest	Range	Best/ Highest
Infant mortality rate	2018 - 20	–	101	4.3	3.9	6.8		
Child mortality rate (1-17 years)	2018 - 20	–	45	9.6	10.3	17.7		1
Population vaccination coverage - MMR for one dose (2 years old) <90% 90% to 95% ≥95%	2020/21	→	7,474	92.9%	90.3%	70.7%		97.9%
Population vaccination coverage - Dtap / IPV / Hib (2 years old) <90% 90% to 95% ≥95%	2020/21	↓	7,686	95.5%	93.8%	77.8%		99.2%
Children in care immunisations	2021	→	650	99.0%	86.0%	22.0%		100%
School readiness: percentage of children achieving a good level of development at the end of Reception	2018/19	↑	6,585	70.5%	71.8%	63.1%		
Average Attainment 8 score	2020/21	–	421,309	51.4	50.9	42.9		
Average Attainment 8 score of children in care	2020	–	1,676	20.9	21.4	10.6		
16-17 year olds not in education, employment or training (NEET) or whose activity is not known	2020	↑	2,320	13.8%	5.5%	13.8%		4%
First time entrants to the youth justice system	2021	↓	94	124.5	146.9	446.9		56.3
Children in absolute low income families (under 16s)	2020/21	↓	15,894	10.5%	15.1%	39.2%		5.2%
Children in relative low income families (under 16s)	2020/21	↓	21,170	14.0%	18.5%	42.4%		2%
Homelessness - households with dependent children owed a duty under the Homelessness Reduction Act	2020/21	–	493	6.1	11.6	32.2		3.6
Children in care	2021	↑	996	59	67	210		24
Children killed and seriously injured (KSI) on England's roads	2018 - 20	–	61	13.5	15.9	55.0		2.6
Low birth weight of term babies	2020	→	150	2.2%	2.9%	4.9%		
Reception: Prevalence of obesity (including severe obesity)	2019/20	→	-	9.0%*	9.9%	14.6%		
Year 6: Prevalence of obesity (including severe obesity)	2019/20	↑	-	19.2%	21.0%	30.1%		
Percentage of 5 year olds with experience of visually obvious dental decay	2018/19	–	-	19.9%	23.4%	50.9%		7%
Hospital admissions for dental caries (0-5 years)	2018/19 - 20/21	–	175	108.9	220.8	7.5		
Under 18s conception rate / 1,000	2020	↓	-	13.0	13.0	30.4		7
Teenage mothers	2020/21	–	55	0.8%	0.6%	1.8%		0%
Admission episodes for alcohol-specific conditions - Under 18s	2018/19 - 20/21	–	130	25.9	29.3	83.8		7.7
Hospital admissions due to substance misuse (15-24 years)	2018/19 - 20/21	–	215	83.9	81.2	229.4		16.9
Smoking status at time of delivery	2020/21	→	-	13.8%	9.6%	21.4%		
Baby's first feed breastmilk	2018/19	–	4,585	62.9%	67.4%	43.6%		
Breastfeeding prevalence at 6-8 weeks after birth - current method	2020/21	–	-	43.7%	47.6%*	-		Insufficient number of values for a spine cha
A&E attendances (0-4 years)	2019/20	–	24,100	545.6	659.8	1,700.5		2
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2020/21	–	860	60.6	75.7	144.0		
Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	2020/21	–	1,035	121.2	112.4	264.7		45.8
Hospital admissions for asthma (under 19 years)	2020/21	–	75	42.4	74.2	290.2		22.5
Hospital admissions for mental health conditions (<18 yrs)	2020/21	–	140	83.1	87.5	263.5		21.0
Hospital admissions as a result of self-harm (10-24 years)	2020/21	–	595	459.7	421.9	1,173.7		112.4

Appendix E: Commissioning responsibilities for child and young person health services

Key LA Public Health commissioning responsibilities for CYP
Healthy child programme for 0-19 years including school-age children
Contraception (over and above what GP's provide), testing and treatment of sexually transmitted infections, sexual health advice, prevention and promotion
Mental health promotion, mental health illness prevention and suicide prevention
Local programmes to address physical inactivity and promote physical activity
Local programmes to prevent and address obesity, including national child measurement programme and targeted weight management services
Drug misuse services, prevention and treatment
Local smoking related activity, including stop smoking services and prevention activity
Locally led initiatives on nutrition
Population level interventions to reduce and prevent birth defects (with PHE)
Dental - oral health promotion

Key ICB commissioning responsibilities for CYP
Children's community paediatric services including Child in Care health assessments, child protection medicals, Designated Doctor
Maternity services (and routine new-born services)
Child and adolescent mental health services including eating disorders, those in care and youth justice , school teams, early intervention in psychosis, suicide prevention
Perinatal mental health services
Community health services, including children in youth justice and care, paediatric nursing and all paediatric therapy services continence, wheelchair services and home oxygen services
Elective hospital care
Urgent and emergency care, including A&E and ambulance services (for anyone present in their geographic area), OOH primary medical services except where retained by practices
Services for those with learning difficulties, Autism or ADHD
NHS continuing healthcare
End of life and palliative care services for respite care and support in the community
Long term conditions including asthma, those who are severely obese, epilepsy and type 1 diabetes. Commissioning may straddle Acute, Primary and Community services

Key NHSE commissioning responsibilities: Public Health
Child Health Information Services
National Immunisation programmes
National Screening programmes such as New-born Blood Spot
Public Health services for CYP in prison or places of detention
Sexual Assault referral services

Key NHSE commissioning responsibilities: healthcare
Primary medical services commissioned under GP contract, out of hours where retained by practices
Pharmaceutical services provided by community pharmacy services, dispensing doctors and appliance contractors
NHS sight tests and optical vouchers
Dental services
All health services for children, young people and adults in prisons and other custodial settings (adult prisons, young offender institutions, juvenile prisons, secure Childrens homes, secure training centres, immigration removal centres, policy custody suites)
Health services for families of members in the armed forces (where they are registered with the Defence Medical Services) (Primary care for members of the armed forces will be commissioned by the MoD)
Specialised and highly specialised services

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	10/11/2022
Paper Title:	**ICS Health Inequalities Plan**
Paper Reference:	ICB 22 039
Report Author:	Hazel Buchanan, Associate Director of Health Inequalities and Strategic Clinical Programmes
Report Sponsor:	Dr Dave Briggs, Medical Director
Presenter:	Dr Dave Briggs, Medical Director
Recommendation (s):	The Board is asked to **APPROVE** the ICS Health Inequalities Plan

Summary:

The Integrated Care System (ICS) approved the ICS Health Inequalities Strategy in October 2020, which included the five NHS priorities in addressing health inequalities. Since that time, the joint Health and Wellbeing Strategies have been refreshed and the three strategies therefore underpin the ICS Health Inequalities plan.

In addition, the NHS Core20+5 framework has been introduced and the ICS has adopted Equity as a core principle. The ICS Health Inequalities plan therefore focuses on delivery within this context and how, with Place being central the system in Nottingham and Nottinghamshire, can ensure they not only improve access to, and quality of, healthcare, but also contribute to reducing the impact of wider determinants.

The plan has been developed with sign off provided through the ICS Health Inequalities and Prevention Oversight Group which includes membership from the Directors of Public Health, Health and Wellbeing Board Chairs, Place Based Partnership representatives, PCN representatives, provider Health Inequality Leads, Core20+5 Ambassadors and ICB leads including finance and the System Analytics and Intelligence Unit. The Plan was presented to the Strategic Prioritisation and Investment Committee on 3 November, which recommends the Plan for approval.

The existing ICS Health Inequalities Strategy will be incorporated into the new ICS Strategy. As such, the ICS Health Inequalities Plan will underpin delivery of the new strategy. The ICS Health Inequalities Plan will also be submitted to NHS England following approval from the ICB.

Appendices:

Appendix A: ICS Health Inequalities Plan

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	Plan outlines delivery to the ICS Health Inequalities Strategy and the Joint Health and Wellbeing Strategies. It details how Equity as a core principle will be applied along with the Core20+5 framework.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Board Assurance Framework:

This paper provides assurance in relation to the management of the following ICB strategic risk(s):

- Risk 1: Health Inequalities and Outcomes – Failure to adequately address health inequalities and improve health outcomes for the population of Nottingham and Nottinghamshire.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	No
Duty to promote innovation	Yes
Duty in respect of research	Yes
Duty to promote education and training	No
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	Yes
Duties as to climate change	Yes
Duties regarding public involvement and consultation	Yes
Public sector equalities duties	Yes

Report Previously Received By:

ICS Health Inequalities and Prevention Oversight Group – Fully supported with next steps being to define ambitions and articulating expected impact and outcomes.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

ICS Health Inequalities Plan

Introduction

1. ICSs have four key aims listed below, and the Nottingham and Nottinghamshire Health Inequalities plan sets out our approach and commitment to tackling inequalities in outcomes, experience and access whilst also ensuring a foundation and robustness to delivering across the other aims.
2. ICS Key Aims
    a) Improving outcomes in population health and health care
    b) Tackling inequalities in outcomes, experience and access
    c) Enhancing productivity and value for money
    d) Helping the NHS to support broader social and economic development
3. Furthermore, the plan supports the achievement of the Nottingham and Nottinghamshire ICS shared purpose of Every Citizen Enjoying Their Best Possible Health and Wellbeing. The purpose recognises the need to improve outcomes in the context of stark differences across our communities with people dying earlier and living with ill health longer than they should. As a result, in order to achieve the greatest impact, the ICS Partnership adopted Equity as a core principle and the ICS Health Inequalities Plan describes how this principle will be applied along with the Core20+5 approach.
4. The ICS Health Inequalities Plan is underpinned by the Joint Health and Wellbeing Strategies and engagement on these, recognising the central role of place and neighbourhood along with the wider response from across the system, that builds a multi-agency approach responding to national policy, organisational responsibility and working with our communities.

Purpose and approach

5. The ICS has a stated aim to improve the health and wellbeing of the population of Nottingham and Nottinghamshire. It is clear from data on health of our population that there are significant differences (inequalities) in outcomes. These inequalities can be connected to things you are born with, things that happen in your life, such as the food you eat or how much you exercise. However, the largest contributions to outcomes are from ‘wider determinants’, which include things like household income, housing, education and work.
6. The ICS health inequalities plan focuses on how the health and care services in Nottingham and Nottinghamshire can make sure they not only improve access to and quality of healthcare but also contribute to reducing the impact of wider determinants.

7. A “one size fits all” approach to health and social care services has led to groups being under-represented in our services or not receiving the right help they need at the right time, leading to worsening health outcomes. Therefore, Equity has been identified adopted as a core principle and an approach that recognises that we need to use our resources in different ways to help include those who may experience barriers to accessing services and worst outcomes.

8. If we want to change life expectancy and healthy life expectancy, we need to understand why what affects people’s health and what might make it difficult for some people to lead healthier lives and then do more or differently for some people to give them the same chances (see Figure 1).

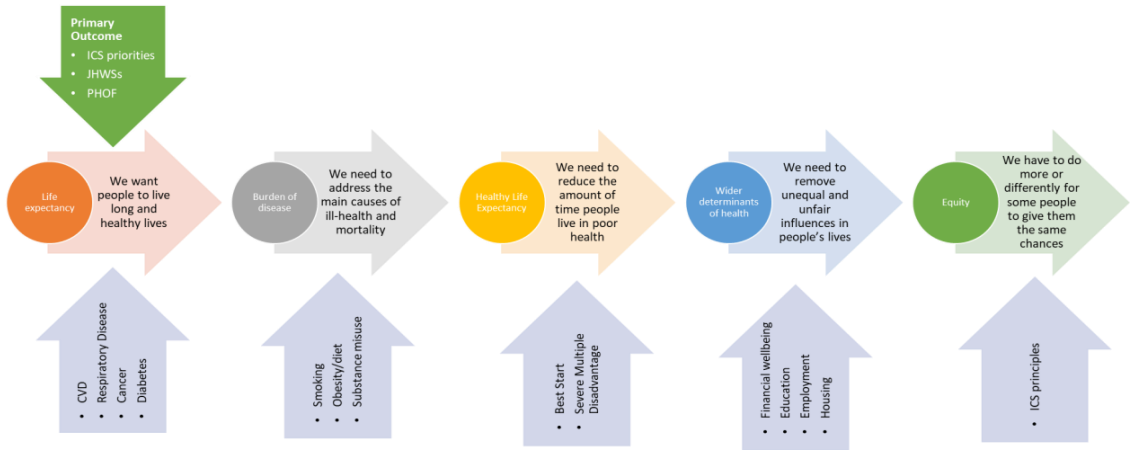


Figure 1

9. The plan includes delivery to the Core20+5 approach which is a national framework to impact on health inequalities as outlined in Figure 2. Furthermore, the plan outlines a provider framework that incorporates equity and the Core20+5 approach.

Figure 2

Place-based Partnership and system plans

10. Place and neighbourhood are central and it is through understanding our population and the barriers and enablers to health that we can impact on both met and unmet need. Therefore, how we function as a system and continually enhance on the enablers and tools outlined in the plan will be fundamental to our success in impacting on the health of our local communities and the sustainability of our health and care system.

11. The plan provides detail on actions being taken across Place Based Partnerships and PCNs and their link to the Joint Health and Wellbeing Strategies. It highlights the level of opportunity and the opportunities in co-creating and working with local communities.

12. Detail is provided in relation to action being taken to deliver the ICS Health Inequalities Strategy including the NHS priority actions of restoring NHS services inclusively, mitigating against digital exclusion, ensuring datasets are complete and timely, accelerating preventative programmes and strengthening leadership and accountability. Alongside these actions, the ICS is progressing with integrated working and increasing accessibility to smoking cessation services, weight management support and alcohol harm reduction. Plans are also progressing in relation to managing environmental sustainability and supporting the local economy with a focus on employment.

13. The final section of the plan includes the enablers that underpin how we will progress the responsibilities as an ICS. Enablers include data, profiling, modelling and evaluation including Population Health Management, connected communities and personalisation, leadership, training and research.

Conclusion

14. The ICS Health Inequalities Plan is a comprehensive document outlining both the commitment and approach as well actions across system, place and neighbourhood. The plan forms part of a wider response from across the system, that builds a multi-agency approach responding to national policy, organisational responsibility and working with our communities. The ICS Health Inequalities Plan will inform delivery of the new ICS Strategy.

Integrated Care System
Nottingham & Nottinghamshire

Nottingham and Nottinghamshire Integrated Care System Health Inequalities Plan

Introduction

Integrated Care System
Nottingham & Nottinghamshire

Integrated care systems (ICSs) are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas. ICSs have four key aims listed below, and the Nottingham and Nottinghamshire Health Inequalities plan sets out our approach and commitment to tackling inequalities in outcomes, experience and access whilst also ensuring a foundation and robustness to delivering across the other aims.

ICS Key Aims

- improving outcomes in population health and health care
- tackling inequalities in outcomes, experience and access
- enhancing productivity and value for money
- helping the NHS to support broader social and economic development.

Furthermore, the plan supports the achievement of the Nottingham and Nottinghamshire ICS shared purpose of **Every Citizen Enjoying Their Best Possible Health and Wellbeing**. The purpose recognises the need to improve outcomes in the context of stark differences across our communities with people dying earlier and living with ill health longer than they should. As a result, in order to achieve the greatest impact, the ICS Partnership adopted **Equity as a core principle** and the ICS Health Inequalities Plan describes how this principle will be applied along with the Core20+5 approach.

The ICS Health Inequalities Plan is underpinned by the Joint Health and Wellbeing Strategies and will form part of a wider response from across the system, that builds a multi-agency approach responding to national policy, organisational responsibility and working with our communities. Place and Neighbourhood are central and it is through understanding our population and the barriers and enablers to health that we can impact on both met and unmet need. Therefore, how we function as a system and continually enhance on the enablers and tools outlined in the plan will be fundamental to our success in impacting on the health of our local communities and the sustainability of our health and care system.

Summary of the Plan

Integrated Care System
Nottingham & Nottinghamshire

In communities across Nottingham and Nottinghamshire people are dying earlier and living with ill health longer than they should. There are stark differences across Nottingham and Nottinghamshire between the most and least deprived. This creates a difference in the outcomes for the population, with those in the least deprived areas often having some of the worst outcomes.

In order to tackle health inequalities in Nottingham and Nottinghamshire we need to work together as an integrated care system to embed equity as a core principle in our approach to planning and managing services.

Place based approaches are central in understanding and enabling our local populations, capturing local knowledge and ensuring services work for local people.

We need to embed a continuous cycle of understanding our populations, the drivers of inequality and the barriers which prevent them accessing care based on need.

We need to integrate across partners as the health and care system, using local and national strategies to help tackle health inequalities and how best to target our local populations.

We need to embed equity as a principle across the system and ensure the services we provide consider the populations they serve.

We need to use place-based approaches, population health management, utilise enablers and establish the need/supply/demand of services as well as identifying unmet need.

To mobilise all partners around our communities recognising the opportunity to have an established and sustainable equitable health and care system which is reducing health inequalities in our population and improving outcomes for those in the most deprived areas.

Summary of the Plan

Integrated Care System
Nottingham & Nottinghamshire

Approach

1. Equity as a Core Principle

- Identifying need and unmet need and how impacted differently across communities by barriers to access and in experience
- Changing the dynamic between need, demand, supply including focus on unmet need
- Focus on preventative measures
- Implementing building blocks in how services are delivered and resources allocated i.e. shared decision making through to differential funding and distribution of services, along with a focus on wider determinants
- Applying tools as an ICS including strength of place and enabling and engaging with communities, data integrity and analysis, financial resources, integration and partnerships

2. Core 20+5

- Place and 20% most deprived recognising that this includes 57% of Nottingham City and pockets in Nottinghamshire.
- Inclusion health groups are identified through priorities of PBPs and include, but not limited to severe multiple disadvantage, different ethnic groups, carers.
- ICS programme on smoking cessation impacting across the five clinical areas
- Actions across the five clinical areas including a focus on 20%+

Strategies

1. ICS Health Inequalities

Based on place based approaches to health inequalities including a varying emphasis on civic, community and service based interventions.

Strategy Includes three areas of focus impacting on short, medium, long term:

- NHS Five Priority Actions – restoring services, digitally enabled care, accelerate preventative programmes, datasets, leadership and accountability
- Lifestyle Factors – smoking, alcohol weight mgmt
- Living and Working Conditions – economy and environment

2. Joint Health and Wellbeing Strategies

Nottingham City priorities include Severe Multiple Disadvantage; Smoking and Tobacco Control; Health Eating &Physical Activity

Nottinghamshire County priorities include Best Start; Mental Health; Healthy Weight; Tobacco Control; Air Quality; Alcohol; Homelessness; Food Insecurity; Domestic Abuse

Place Based Partnership Plans

Each Place Based Partnership has identified plans at place and neighbourhood level that apply the ICS approach and delivery to the strategies. Plans focused on differing needs across neighbourhood and place including but not limited to:

- Community development
- Health and wellbeing coaches
- Social prescribing
- Long Term Condition case finding, prevention and management reaching out to and engaging with local communities
- Childhood Immunisations
- Improving uptake for imms and vaccs
- Improving access for those with a Learning Disability
- Supporting carers
- Mental illness with a focus on those with a severe mental illness
- Lifestyle management programmes targeted at specific communities
- Redefining pathways for homeless and severe multiple disadvantaged

ICB and Provider Plans

Targeted action across the five clinical areas in the Core20+5 including maternity, SMI, respiratory, cancer, CVD
Focus on inequities in waiting lists and restoring NHS services inclusively
Ensure datasets are complete and timely including work to improve ethnicity data capture
Preventative programmes including a focus on diabetes plus smoking, alcohol, weight management
Children and young people transformation programme
Anchor institution, environment and employment

Enablers

Data, profiling, modelling and evaluation including PHM
Connected Communities and Personalisation
Partnership & Leadership including Training
Research

Glossary

Integrated Care System
Nottingham & Nottinghamshire

Health Inequalities - Health inequalities are avoidable, unfair and systematic differences in health between different groups of people (Kings Fund, Aug 21). These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing (UK Government, 2021).

Health Disparity/health inequity - Used in the context of a specific type of inequality that denotes an unjust difference to health. Health disparities/health inequities are individual/population/group differences reflecting an unfair distribution of health risks and resources i.e. differences in access, experience and/or outcomes.

Health Equity (Equity) - Health equity is achieved when everyone can attain their full potential for health and well-being (WHO).

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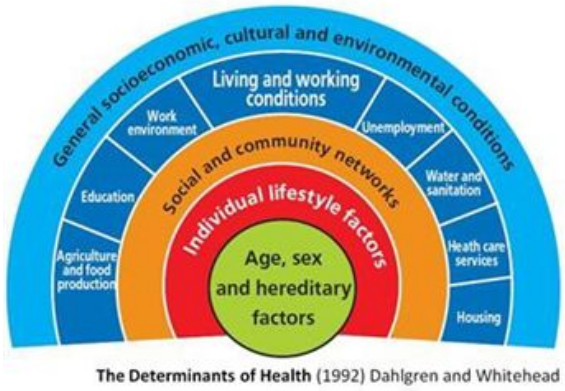
Integrated Care System
Nottingham & Nottinghamshire

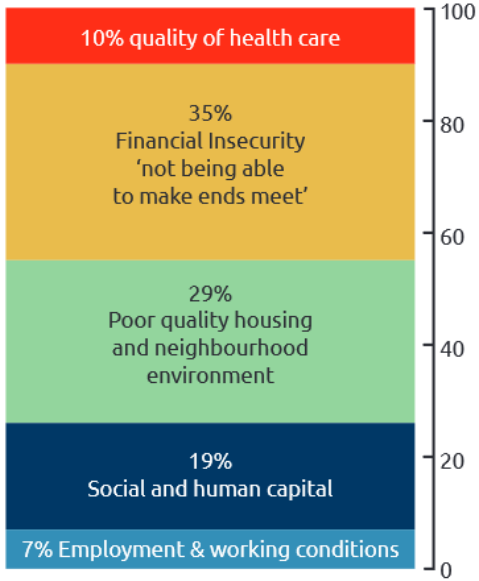
Purpose of the ICS Health Inequalities Plan

Integrated Care System
Nottingham & Nottinghamshire

- The ICS has a stated aim to improve the health and wellbeing of the population of Nottingham and Nottinghamshire.
- It is clear from data on health of our population that there are significant differences (inequalities) in outcomes.
- These inequalities can be connected to things you are born with, things that happen in your life, such as the food you eat or how much you exercise. However, the largest contributions to outcomes are from 'wider determinants', which include things like household income, housing, education and work.
- This plan will focus on how the health and care services in Nottingham and Nottinghamshire can make sure they not only improve access to and quality of healthcare but also contribute to reducing the impact of wider determinants.



The Determinants of Health (1992) Dahlgren and Whitehead

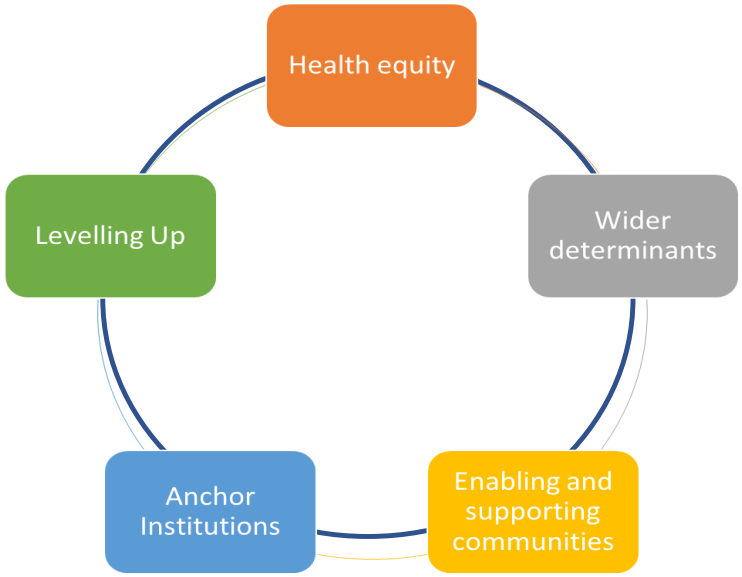


From health-inequalities.eu

How does this plan fit with system work on health inequalities?

Integrated Care System
Nottingham & Nottinghamshire

- It is the responsibility of the wider system to address the challenges of health inequalities.
- The ICS Health Inequalities Plan will focus on the role of health and care services in addressing inequalities and wider determinants of health.
- It will form part of a wider response from across the system, that builds a multi-agency approach responding to national policy, organisational responsibility and working with our communities.
- The ICS Plan will consider both direct areas of responsibility for action and identify areas for shared working.



Integrated Care System
Nottingham & Nottinghamshire

A. Key Strategies

Working and Aligning as a System

Integrated Care System
Nottingham & Nottinghamshire

Since writing the ICS Health Inequalities strategy, the context and partnerships have developed further, as we move closer to the legislative status of becoming an ICS. With the impact of COVID, working effectively as a partnership is even more vital to address health inequalities, recognising what can be achieved through healthcare along with the role of the ICS in relation to wider determinants. The role of the ICS in relation to wider determinants will be directly informed by the Joint Health and Wellbeing Strategies supported by a place based approach to health inequalities.

The figure below provides an overview of the ICS partners. Leadership and partnership with a clear focus on health inequalities will be instrumental in order to have an impact and to mobilise resources around population need. This is supported by Place being at the centre as outlined in the PHE/UK Health Security Agency Population Intervention Triangle.

<table>
<tr><td colspan="8">Our family portrait - Nottingham and Nottinghamshire Integrated Care System (ICS)</td></tr>
<tr><td>Nottingham City PBP 396,000 population</td><td colspan="2">South Nottinghamshire PBP 378,000 population</td><td colspan="2">Mid Nottinghamshire PBP 334,000 population</td><td colspan="3">Bassetlaw PBP 118,000 population</td></tr>
<tr><td>8 PCNs</td><td colspan="2">6 PCNs</td><td colspan="2">6 PCNs</td><td colspan="3">3 PCNs</td></tr>
<tr><td colspan="8">NHS Nottingham and Nottinghamshire Integrated Care Board (ICB)</td></tr>
<tr><td colspan="4">Nottingham University Hospitals NHS Trust</td><td colspan="2">Sherwood Forest NHS Foundation Trust</td><td colspan="2">Doncaster and Bassetlaw NHS Foundation Trust</td></tr>
<tr><td colspan="8">Nottinghamshire Healthcare NHS Foundation Trust (mental health)</td></tr>
<tr><td>Nottingham CityCare Partnership (community provider)</td><td colspan="7">Nottinghamshire Healthcare NHS Foundation Trust (community provider)</td></tr>
<tr><td colspan="8">East Midlands Ambulance NHS Trust</td></tr>
<tr><td rowspan="2">Nottingham City Council (Unitary)</td><td colspan="7">Nottinghamshire County Council</td></tr>
<tr><td>Broxtowe Borough Council</td><td>Gedling Borough Council</td><td>Rushcliffe Borough Council</td><td>Ashfield District Council</td><td>Mansfield District Council</td><td>Newark & Sherwood District Council</td><td>Bassetlaw District Council</td></tr>
<tr><td>Voluntary and community sector input</td><td colspan="2">Voluntary and community sector input</td><td colspan="2">Voluntary and community sector input</td><td colspan="3">Voluntary and community sector input</td></tr>
</table>

Health and Wellbeing Strategies + Place

In order to have due regard and to ensure the right focus on health inequalities, the ICS Plan is informed by and integrates with the Nottingham City and Nottinghamshire County Health and Wellbeing Strategies and the ICS health inequalities strategy. The priorities of the Health and Wellbeing Strategies provide the priorities for the ICS in order to impact on health inequalities and it's how these can be delivered through healthcare along with opportunities at a community and wider place level.

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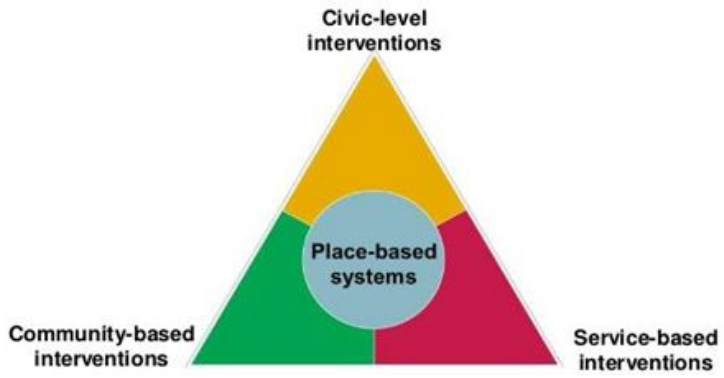
The ICS Health Inequalities Plan is informed by and integrates with the two health and wellbeing strategies. Each of the Local Authorities have defined principles and priorities that will drive forward what is happening at a place level and inform the priorities for the ICS.

As well as delivery to the strategies, it is through the place based and neighbourhood structures that there is the intelligence and relationships with local communities to inform change. This includes a level of understanding to support a preventative approach that can be targeted by being culturally and environmentally relevant.

It will therefore be important that the enablers for the Health Inequalities Plan are also underpinned by due regard to the Health and Wellbeing Strategies.



Within the ICS structure the key strength is in relation to Place Based Partnerships and PCNs and the opportunity these provide to work with and in our local communities and to impact on wider determinants. The relationships they hold and the focus driven through the Health and Wellbeing Boards and the Joint Health and Wellbeing Strategies will provide a solid operating model for addressing health inequalities, working alongside Local Authorities and Public Health.

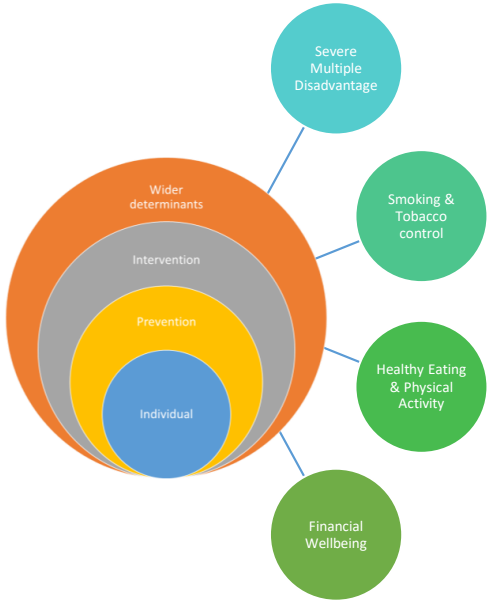
Health and Wellbeing Strategy Priorities

Integrated Care System
Nottingham & Nottinghamshire

The Health and Wellbeing Strategy priorities will inform the opportunity as an ICS to impact on health inequalities. In particular, if the ICS is going to impact on health inequalities for the Core20+, then this has to be done by supporting the priorities as outlined in the Health and Wellbeing Strategies

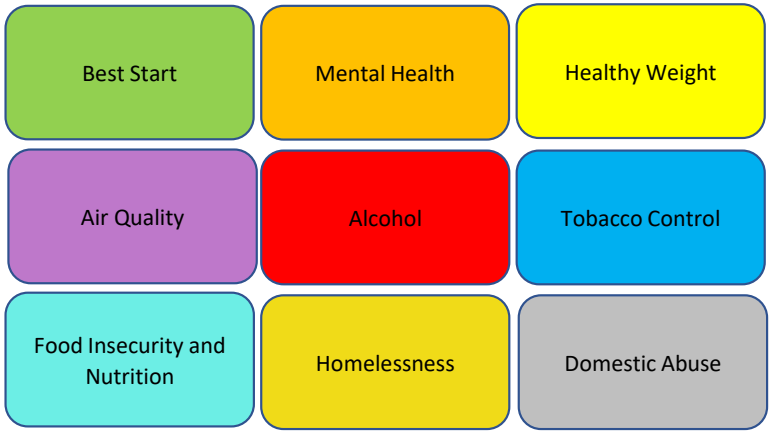
Nottingham City

Nottingham City has purposely focused on a small number of priorities that are focused on delivering outcomes which can have the biggest impact on the mental and physical health and wellbeing for city residents. The priorities are ones that will require collaborative efforts from a wide range of partners and stakeholders through a renewed focus.



Nottinghamshire

Nottinghamshire County priorities also recognise the importance of partnership working and are related to four ambitions including to give every child the best chance of maximising their potential, creating health y and sustainable places, ensuring all can access the right level of support to improve their health and to keep communities safe and healthy.



ICS Health Inequalities Strategy

The ICS Health Inequalities Strategy 2020-2024 mobilised partners and provided a shared commitment and vision for addressing health inequalities. Since writing the strategy both Councils have agreed new Joint Health and Wellbeing Strategies which therefore directly inform the ICS health inequalities plan, along with the Core20+5 and the ICS health inequalities strategy.

Integrated Care System
Nottingham & Nottinghamshire

At the time of writing in 2020, the strategy recognised the impact of COVID-19 (direct and indirect), and it reflected the ICS Clinical and Community Services Strategy and the ICS Five Year Strategic Plan (including the Joint Health and Wellbeing Strategies). The ICS Health Inequality strategy includes areas for action impacting on health inequalities across the short, medium and long term.

18 months on, the ICS Health Inequalities plan is an opportunity to outline progress against priorities and to highlight the opportunities in relation to the newly forming ICS structures and the strength of partners and partnerships across Nottingham and Nottinghamshire. Also, a key dimension is that the plan is directly informed by the two newly developed Joint Health and Wellbeing Strategies and aims to recognise the contribution that can be made through health alongside the necessity to impact on the wider determinants.

ICS Health Inequalities Strategy – Areas for Action

Short Term

Health and Care Services

1. Protect most vulnerable from COVID
2. Restore health and care services inclusively
3. Digitally enabled care
4. Accelerate preventative programmes
5. Particularly support those who suffer mental ill health

Medium Term

Lifestyle Factors

1. Alcohol
2. Smoking
3. Diet and physical activity
4. Children and young people

Long Term

Living and Working Conditions

1. Environment
2. Economy/employment
3. Housing
4. Education

The CORE20 Plus 5 and ICS Strategies & Plans

Integrated Care System
Nottingham & Nottinghamshire

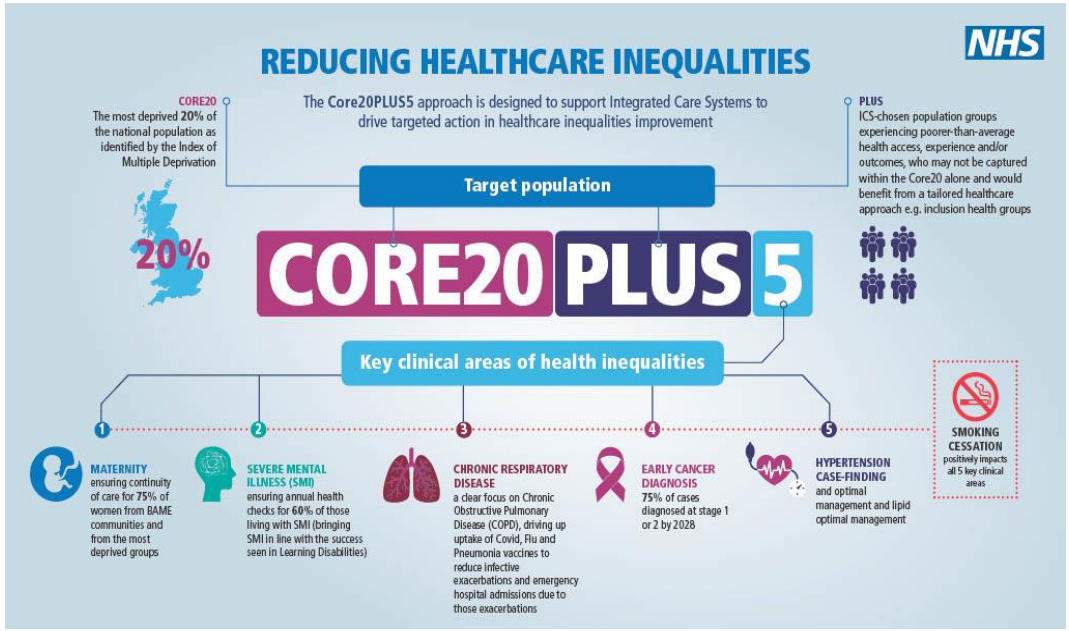


Figure 6 - Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

More detail on the Core20Plus5 can be viewed in section C.

Figure 7 illustrates the combination of plans, along with the Core20+5 approach, that as a collective will aim to impact on health inequalities informed by the health inequality strategy and Joint health and wellbeing strategies.

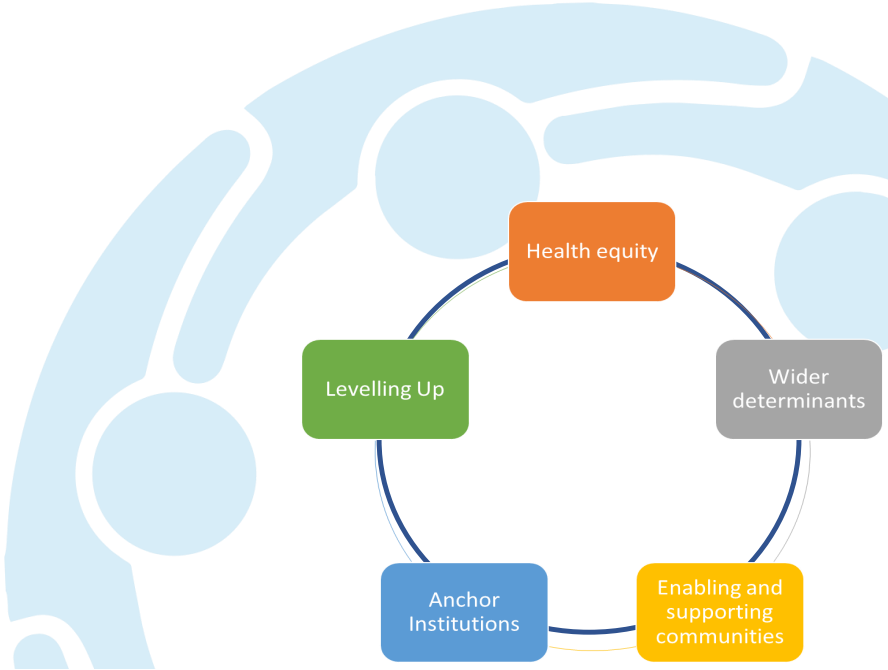
Therefore, the ICS health inequalities plan is written with the communities at the centre with a line through from PCNs and PBPs to the ICS.

Integrated Care System
Nottingham & Nottinghamshire

B. ICS Approach

The ICS approach to health inequalities is underpinned by Equity as a Core Principle. The following section outlines what this means and how this sits alongside the Core20+5 approach.

For Health, Equity as a Core Principle will be supported by the NHS Core20+5 approach. These elements combined will drive forward change.



Equity as a Core Principle of the ICS Health Inequalities Plan

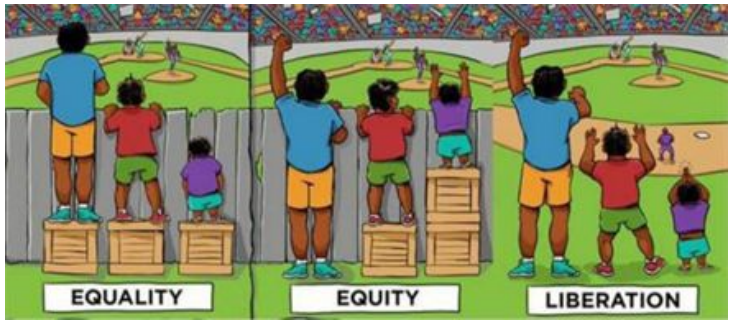
Integrated Care System
Nottingham & Nottinghamshire

We know that health inequalities exist in our system and across the country which are unfair and avoidable.

Health and health equity are determined by the conditions in which people are born, grow, live, work, play and age, as well as biological determinants. Structural determinants (political, legal, and economic) with social norms and institutional processes shape the distribution of power and resources determined by the conditions in which people are born, grow, live, work, play and age.

A “one size fits all” approach to health and social care services has led to groups being under-represented in our services or not receiving the right help they need at the right time, leading to worsening health outcomes.

In order to tackle this we need to systematically identify and eliminate inequities resulting from differences in health and in overall living conditions. Once these inequities are identified, we can establish what each of our communities need and target our resources differently and more effectively to reach different groups of people, helping to reduce barriers to access and encouraging positive outcomes.



Story Based Strategy

Why Equity?

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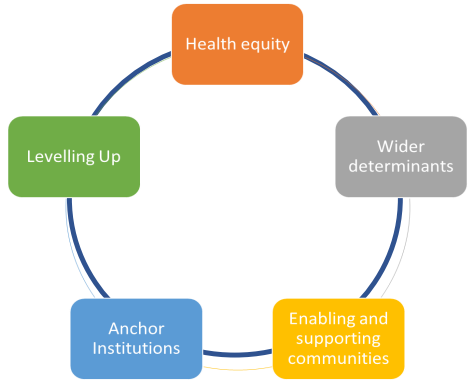
Nottingham & Nottinghamshire

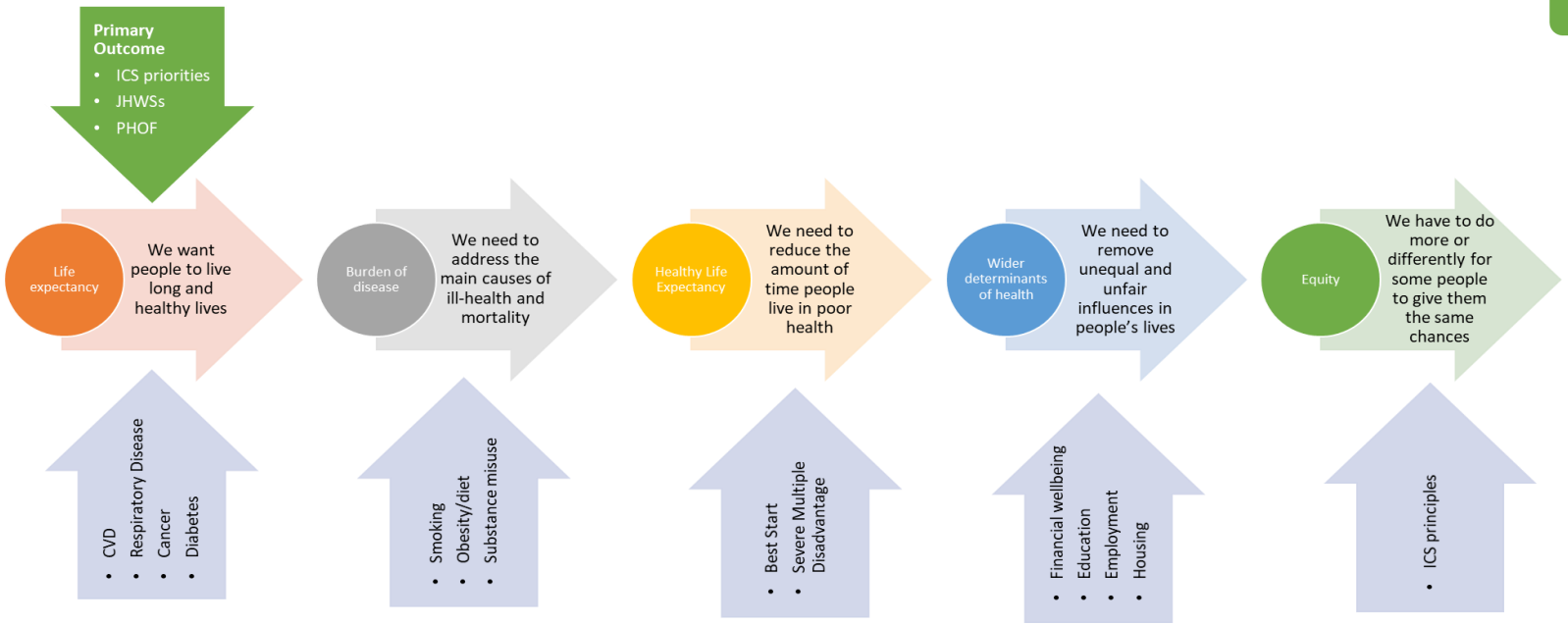
Equity has been adopted as the core principle in impacting on health inequalities . This provides an approach that recognises that a “one size fits all” method for services can exclude certain groups of people. Equity recognises that we need to use our resources in different ways to help include those who may experience barriers to accessing services.

Equality is about sameness, equity is about fairness. This means that sometimes, to give people equal health outcomes, we have to do something more or different for some people, to make it fair.

If we want to change life expectancy, we need to understand why what affects people’s health and what might make it difficult for some people to lead healthier lives.

Health and care services need to use this information to think differently about how they inform people about their health, provide services and link in with other partners to tackle the wider determinants of health.





Equity and breaking down barriers and enablers in the current system

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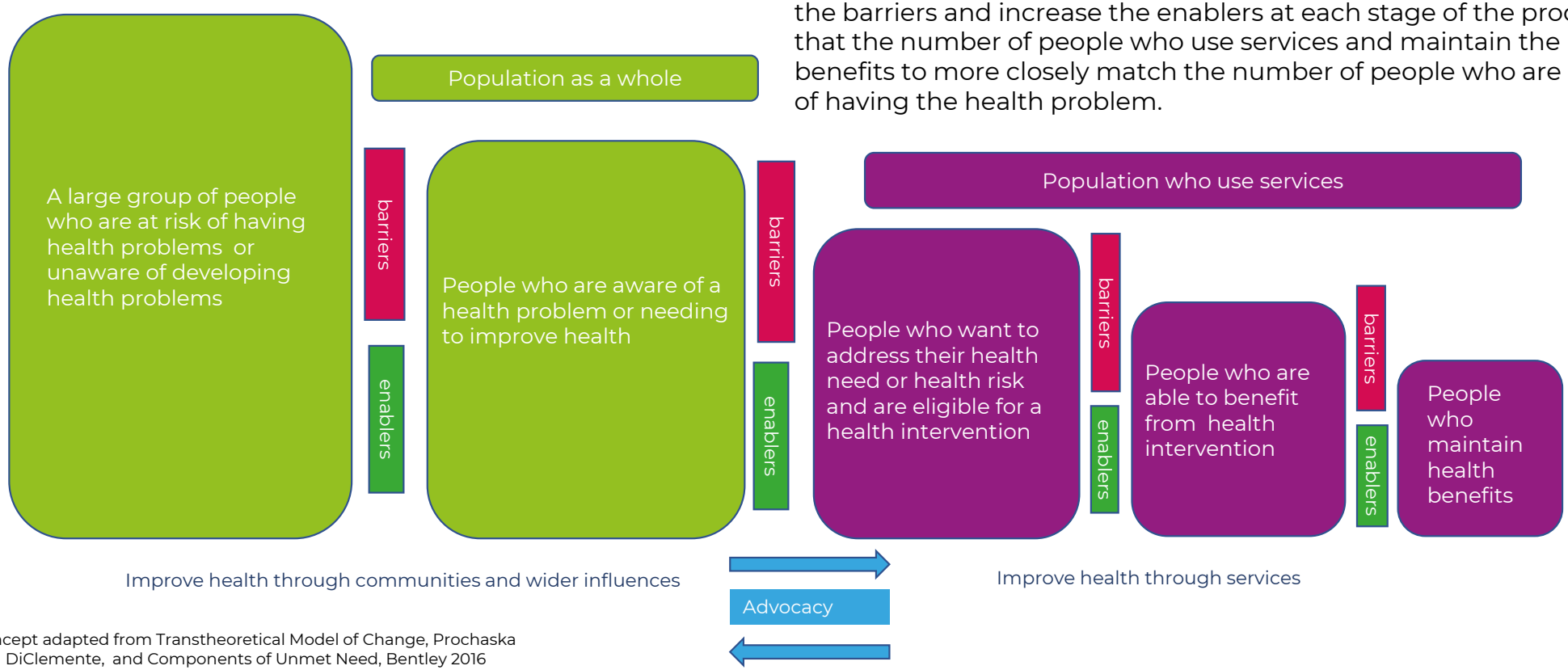
The current health and care system relies on patients knowing the signs of ill health, knowing who to contact and coming forward to present to health professionals. Patients will experience both barriers to this as well as things which will enable this. These barriers and enablers change through the progression of the diagram and leads to a smaller percentage of people maintaining the health benefits of treatment.

In an ideal system, due to preventative measures, less people would be at risk of health problems. We would also be able to break down the barriers and increase the enablers at each stage of the process so that the number of people who use services and maintain the health benefits to more closely match the number of people who are at risk of having the health problem.



Concept adapted from Transtheoretical Model of Change, Prochaska and DiClemente, and Components of Unmet Need, Bentley 2016

Inequalities and Barriers in the Health and Care System

Integrated Care System
Nottingham & Nottinghamshire

How Inequity is Reflected in the Wider Health and Care System

- Higher levels of DNA and cancellations in services
- Multi-morbidities, more complex patients
- Worst health outcomes
- Overuse of medications i.e. opioids
- Increasing levels of basic care to allow people to remain independent (increased demand)
- Unable to complete or continue with treatment
- Increase risk of premature death
- Increased attendances at ED
- Presenting at a later stage of disease progression so higher acuity
- Higher number of urgent vs elective admissions
- Longer waiting times
- Receiving different treatments at different stages
- Higher disease prevalence in specific population cohorts

How Barriers Translate into Health Inequalities within local communities

- Unable to make or afford healthier food options
- Unable to take time off work or change shift pattern for appointments
- Unhealthy coping mechanisms may be used to relieve stress; alcohol, substances, smoking, unhealthy foods.
- Living in a state of worry can lead to chronic stress, anxiety and depression, which can lead to more barriers.
- Inability to afford prescriptions
- Inability to afford transport to appointments
- Poor housing conditions such as cold, damp homes can exacerbate existing conditions, especially respiratory conditions.
- Higher priority is given to other life issues other than health

How are Barriers Experienced by Local Communities

- Challenges in communicating needs, being heard or understanding advice
- Limited transport options
- Worries over money, lifestyle, family, housing and other insecurities
- Unsure how to access and navigate the complex health and care system
- Insecure or irregular work
- Poor mental health can affect decision making, lifestyle and ability to engage with services
- Services that are not flexible to meet individual needs
- Physical disabilities can make access to services difficult, experiences of accessing serviced may also be worse
- Lack of trust and confidence in the healthcare system

Applying equity in understanding how people access health care services in our system

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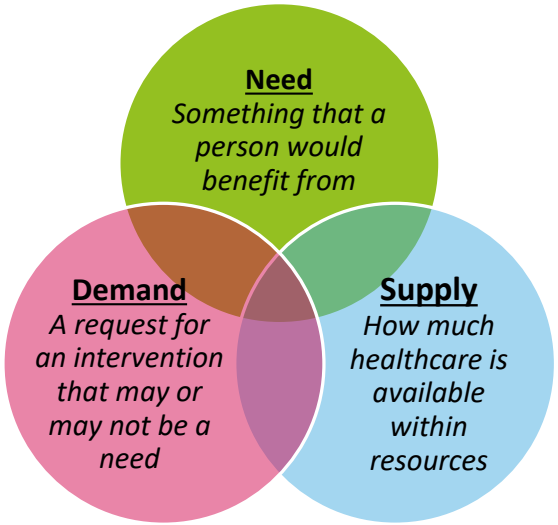
Nottingham & Nottinghamshire

Through understanding our population and the barriers and enablers we can impact on both met and unmet need, in turn improving outcomes and helping to manage demand relevant to supply. Generally, the NHS relies on people 'demanding' health services. This might be making a routine dental check-up, or seeing your GP when you have symptoms or going to the Emergency Department after an accident.

We know that some people who really need healthcare don't come forward. There are lots of reasons for this but this unmet need can mean worse health outcomes for some individuals and communities.



We know that getting treated earlier can make a big difference in things like cancer and heart disease. It is also true that making small changes, such as a healthier diet or stopping smoking can make a huge difference. This means that prevention and earlier intervention is really important.

To reduce unmet need, we need to improve awareness, access, availability and acceptability of services. These all require us to understand our population and the barriers, as well as making structural changes to address the wider determinants.

Building Blocks to Health Equity

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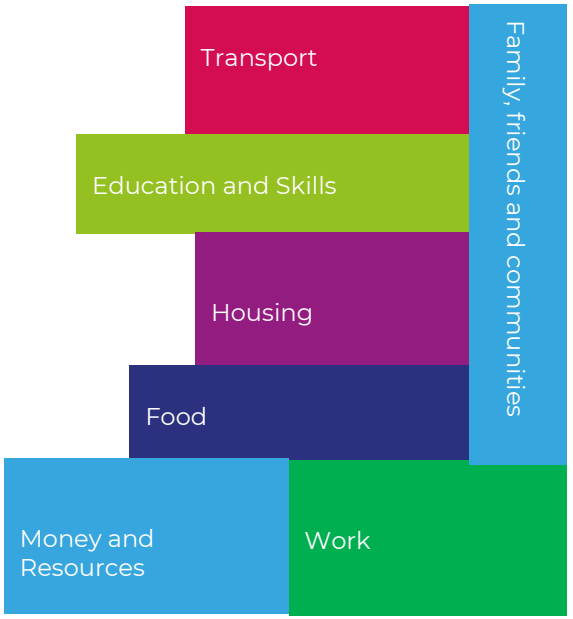
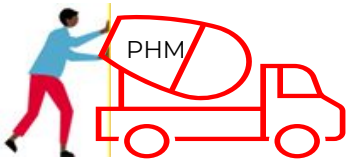
In understanding how inequities present themselves and the barriers experienced by patients and citizens, it is easy to see that in order to make a difference a range of building blocks are required that together will have an impact. These sit alongside and are influenced by the wider determinants, the blocks that build a health society and how these are constructed differs across our different communities. How the building blocks are constructed depends on the gaps in our communities and scale and type of disparities being experienced.

Health and Care Services

Place, Neighbourhood & Anchor Institutions





Population health management approaches, understanding our local population, is “cement” holding the building blocks together. We need to understand the needs of the population and how we can address this at every aspect of the approach.

Key Tools help build an equitable health and care system

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We have discussed the building blocks of health equity and PHM approaches as the cement. However there are also tools we can use which will help to enable us to build a more equitable healthcare system.

1. Local Insight, Engagement & Place

Knowing, engaging, enabling our local communities

Structure around Place & Neighbourhood

2. Data Quality and Analysis

Using population health management approaches

What are the disparities, inequities and how can we impact

Consistency in defining and measuring outcomes

3. Finance

Targeted use of resources

Allocations and investment

4. Partnership Working and Integration

Wider Determinants

Local Authorities and wider partners including voluntary sector

Core20+5

Alongside equity, the ICS has adopted Core20+5 as an approach. More detail is included in subsequent sections and detail below confirms the approach.

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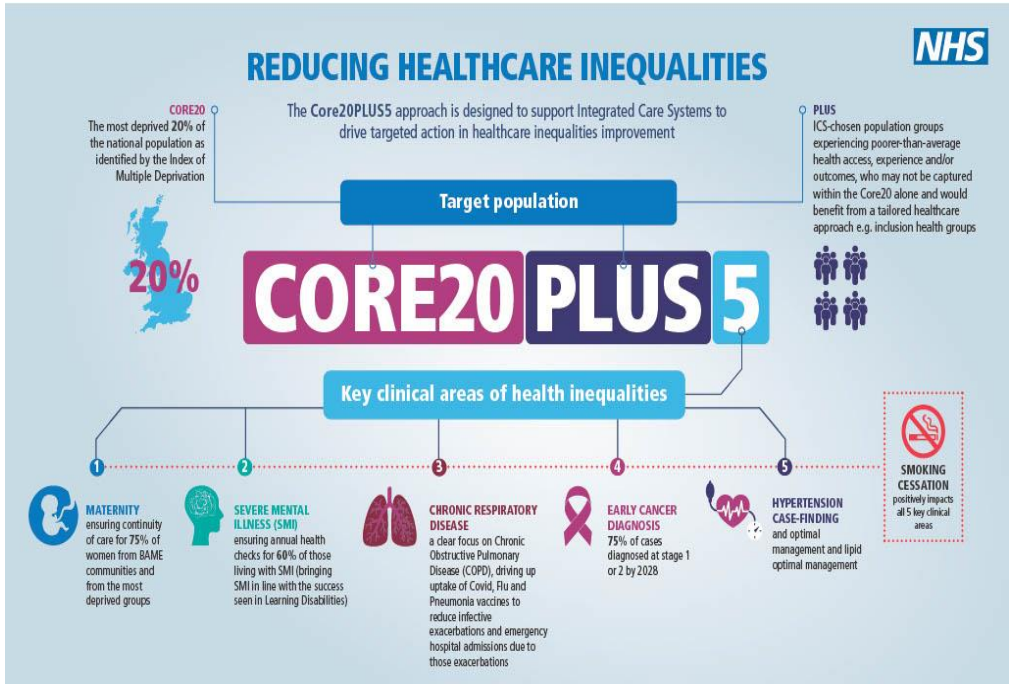

Core 20 – all analysis identifies the relevance and impact in relation to the 20% most deprived. As outlined in the population profile, this indicates a highly concentrated approach in Nottingham City with specific pockets across the county.
Plus – are inclusion health groups. These are identified through Place Based Partnership Plans, and linked to Health and Wellbeing Strategies. A system wide view may be taken for specific inclusion health groups but the approach will be relevant to local needs and Place.
Five – The ICS Health Inequalities Strategy has prioritised smoking and includes a partnership approach across the ICS and with Local Authorities. Priorities, including with a focus on the core20+ have been identified for each of the five clinical areas as outlined in subsequent sections of the plan.

ICS Leadership Commitments

In adopting equity as a core principle, the ICS Partnership Board also agreed leadership commitments. Leadership commitments support all partners within the ICS to apply equity as a core principle and to highlight how a consistent approach will be taken across the system.

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The starting point is always understanding and describing the local population and inequalities in our communities

- Using data and lived experience to create an intelligence-led approach to understanding inequalities
- Describing and understanding our populations for what they are as the starting point – geography, protected characteristics, inclusion health, socio-economic factors
- Connected communities and co-production

Taking an intelligence led approach and targeting solutions and resources based on evidence

- Using population health tools to design and deliver services based on different needs
- Building intelligence into service/programme planning and delivery – implementing intelligence systems that surface the 'gaps'
- Opportunities and constraints in equitable distributions of services
- Taking an approach that embraces opportunities and constraints in differential investment and differential access
- Being transparent will be central in relation to the management of and shifts in resources

Enabling our communities and recognising the role the ICS in addressing wider determinants

- Engendering a key focus and commitment to enabling and supporting our local communities
- Integrating addressing wider determinants into our service/programme planning and delivery
- Using our role as anchor institutions to impact on local communities, informed by the Local Authorities
- Alignment with the Health And Wellbeing Strategies and delivery of priorities through Place

Delivering accessible, quality healthcare services

- Informed changes in relation to addressing disparities across access, experience and outcomes and providing equity
- What should we expect and what is happening
- Ensure a strong core service to support all communities whilst recognising the differences and strengths
- Building and maintaining trust and connected communities through place and neighbourhoods is central

Changing the conversation

- In Boards, meetings, teams and with patients – focusing on building trust and breaking down barriers
- Recognising and valuing the characteristics of local communities across Nottingham & Nottinghamshire
- Jointly planning and commissioning services based on population need
- Providing a mandate to be responsible collectively
- Taking a learning approach – approaching as a journey where failure is a valuable experience for learning

Provider framework

The provider framework pulls the different elements together to identify where providers can have the biggest impact in relation to health inequalities that is aligned with the system approach and supports the Core20+5.

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A. Core 20 plus 5

- Identify what existing performance / routine data needs a 'CORE 20' analysis
- Plus – support for place based initiatives and targeted action in relation to the inclusion health groups. Recognising and working with place on different needs of plus groups
- The '5' – through a greater awareness of the five clinical areas, delivering care and treatment plans that align through neighbourhood, place, system, organisation

B. Measure equity in patient

- Access – analysing and taking action in relation to inequities in access
- Experience – capturing patient level data in relation to experience. Identifying performance data that aligns with experience
- Outcomes – acting on inequalities in outcomes

C. Address health inequalities where they can be influenced including a targeted approach. Opportunities include but are not limited to:

- Peri-operative care
- Prevention (smoking, alcohol, weight)
- Digital inclusion
- Staff health

D. Planned care

- Recovery patterns by deprivation and ethnicity
- Strategic approach based on inequities and targeted action across the pathway

E. LTP 'must-do's

- specific commissioned activity

In Summary

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Nottingham & Nottinghamshire

In order to reduce health inequalities across Nottingham and Nottinghamshire and improve outcomes for the most in need, we must build an Equitable Health and Care System.

To build and equitable health system we need to:

Set the foundations: Through strong partnership working; utilising the Joint Health and Wellbeing strategies and understand our local population, their needs, the barriers they face and the drivers of inequality.

Understand the building blocks: The factors which affect people using the health and care system and how inequalities present themselves. We need to look at this from a system wide perspective, combining the issues to create solutions which can be tackled by all partners.

"Cement" the building blocks together: using PHM approaches to understand the population health needs and how these differ between areas and conditions and what the inequalities are.

Use "tools" effectively: Use resources available to us across the ICS, such as data, finance and other partners to help target specific population groups and know what is available to tackle the inequalities

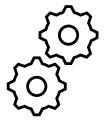
To maintain an equitable health and care system and make a difference to the lives of those in our ICS, we need:

Leadership commitments from across the ICS

To work in place-based-partnerships to help combat health inequalities specific to our local areas.

Increase and maintain staffing capacity and ensure staffing is representative of the population we serve.

To follow national workstreams such as the Core20Plus5



To utilise our enablers to help projects run smoothly

To monitor the need/supply/demand of services across the ICS, to ensure resources are being targeted effectively and in the right way.

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Nottingham & Nottinghamshire

C. Nottingham and Nottinghamshire Population Profile

- Population Profile
- Drivers of Inequality
- Core20+5

ICS Population Profile Overview

Nottingham and Nottinghamshire has many diverse communities, and the health inequalities plan aims to recognise the characteristics and strengths of the local communities along with understanding the disparities and systematic differences in health, mortality and quality of life.

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Nottingham & Nottinghamshire

There are 4 geographical locations which make up Nottingham and Nottinghamshire ICS; Nottingham City, South Nottinghamshire, Mid-Nottinghamshire and Bassetlaw, with a total population of 1,170,475 (mid-year 2020).

Each district has a different population profile where inequalities vary, however the starkest difference is the gap between life expectancy and healthy life expectancy in the most and least deprived areas of the ICS. Nottingham City has some of the lowest life expectancy ages in England.

- Those in the least advantaged areas spend an additional 14 years living in ill-health, compared to those living in most advantaged areas. Life Expectancy is 8.4 years lower for men and 8.6 years lower for women in the most deprived areas of Nottingham and 7.5 years in Nottinghamshire.
- Infant mortality is also an indicator of the general health of an entire population and reflects the social, economic and environmental conditions in which children live, including their health care. Nottingham is among the ten worst areas in England for child poverty and child mortality rate. Alongside this, most indicators for infancy and early years in Nottingham are worst that the values for England and Nottinghamshire Count. This demonstrates some of the challenges in the City compared to the rest of the ICS.

Life Expectancy across the ICS

Females

81 in Nottingham City compared to the England average of 83.1.

83 in Nottinghamshire County.

Healthy life expectancy is 55.6 in the City (2nd lowest in England) and 61.6 in the County.

Males

76.6 in Nottingham City, compared to the England average of 79.4.

80 in Nottinghamshire County.

Healthy life expectancy in Nottingham City is 56.4 (3rd lowest in England) and 63.4 in Nottinghamshire County.

Deprivation across the ICS

The Index of Multiple Deprivation (IMD) is the official measure of deprivation in England. The IMD combines 7 domains of deprivation to give an overall deprivation score. The scores are compared across 32,844 Lower Super Output Areas (LSOA) in England. Scores are given on a scale of 1 – 10, with 1 being the most deprived and 10 the least.

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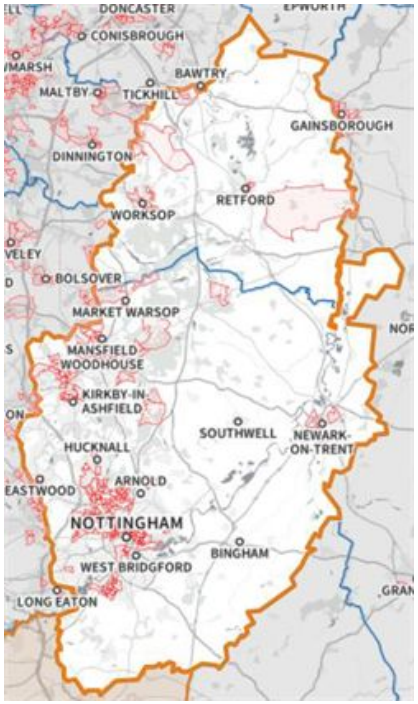
Nottingham & Nottinghamshire

20% Most Deprived Areas



Areas outlined in red are in the 20% most deprived nationally. The majority are concentrated in the City, followed by Mid-Notts, however every district has pockets of deprivation.

The Index of Multiple Deprivation (IMD) is the official measure of deprivation in England. The IMD combines 7 domains of deprivation to give an overall deprivation score. The scores are compared across 32,844 Lower Super Output Areas (LSOA) in England. Scores are given on a scale of 1 – 10, with 1 being the most deprived and 10 the least.

The 7 domains used to measure deprivation are listed below.

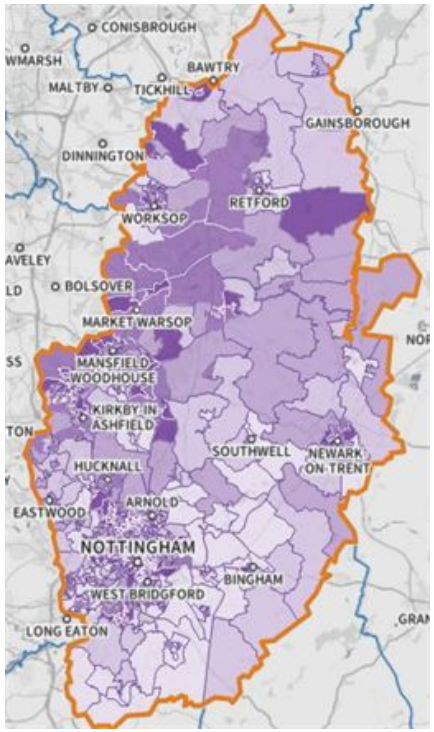
- Income
- Health
- Employment
- Education
- Crime
- Barriers to Housing and services
- Living environment

Deprivation scores are linked to health and wellbeing outcomes. Those living in the most deprived areas are more likely to have a lower life expectancy, have higher mortality rates from diseases and have poorer health outcomes in general. There are also higher rates of lifestyle factors which link to adverse health outcomes such as smoking and obesity. Deprivation scores allow the ICS to see which areas may require more support and resources to improve the population outcomes, which forms part of an equity approach.

Within Nottingham 56 of the 182 LSOAs fall amongst the 10% most deprived in the country. 104 fall in the 20% most deprived, which is an increase from the 2015 indices. Therefore 57% of Nottingham falls within the 20% most deprived.

In Nottinghamshire there are 31 LSOAs in the 10% most deprived concentrated in the districts of Ashfield, Mansfield, Bassetlaw and Newark and Sherwood. There are 79 LSOAs in the 20% most deprived.

Index of Multiple Deprivation (IMD)



The higher the deprivation, the deeper the purple.

Health Literacy Across the ICS

Health Literacy is a person's ability to understand and use information to make decisions about their health. Those with low health literacy may struggle to read and understand health related information and therefore may not know how to take action or access appropriate services. Health literacy is more likely to affect those from disadvantaged socioeconomic groups and migrant populations and those from BAME backgrounds.

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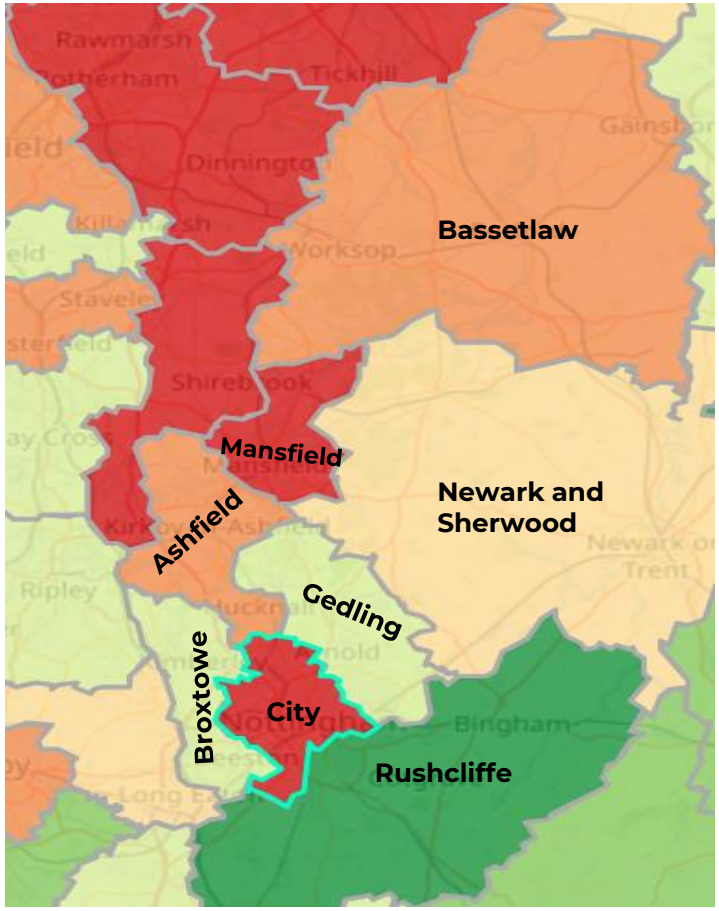
Nottingham & Nottinghamshire



The map on the left shows the levels of health literacy across the ICS. The red areas reflect the lowest levels of health literacy. Lower levels of health literacy corelate with higher levels of deprivation:

- In Nottingham, 53.5% of the population are below the threshold for health literacy. In Mansfield this is 48.81%.
- The most affected areas are Nottingham City and Mansfield, followed by Bassetlaw and Ashfield.

HEALTH LITERACY - Home (geodata.uk)

Impact on patients with low health literacy:

- May not be able to make informed choices about their care.
- May struggle to access the right services at the right time, resulting in more A&E attendances and longer inpatient stays.
- Medication instructions may be harder to understand and so may be mis-taken
- It may be harder to self manage conditions
- Patients with low health literacy are more likely to have depression and have higher mortality.
- Patients with low health literacy are more likely to have lifestyle factors which negatively impact health

The Ethnicity Profile of the ICS Population:

Integrated Care System
Nottingham & Nottinghamshire

The ethnicity of the population is a key factor to consider when planning services and tackling health inequalities. Different ethnicities may be more at risk of developing certain health conditions and may face different challenges and experiences when accessing health and social care services. Through the Place Based Partnerships there is an in depth knowledge of the strengths within these and an understanding of how best to focus resources and support, with more information provided in the PBP section of the plan. The ICS holds an overall view of the population recognising the different needs across population characteristics as determinants of health.

Ethnicity	% of the ICS Population	Key Notes
White/White British	85%	Mortality from Cancer, dementia and Alzheimer's is higher in white groups.
Asian/British South Asian	3.6%	Those of South Asian heritage are more likely to develop high blood pressure, cardiovascular disease and diabetes.
Asian/British Chinese	0.8%	Chinese people have a relatively low uptake of health and social care services across the UK.
Black British/African/Caribbean/ Other	2.5%	Women from black backgrounds are 4x more likely to die in childbirth than white women. Rates hypertension and diabetes are also higher in black people and mortality rate from strokes and are more likely to have strokes at a younger age. The risk of developing certain cancers (e.g. prostate) can also be higher. Adult and Childhood obesity rates tend to be higher in black ethnicities.
Mixed/Multiple Ethnic Groups (Asian/Black/British/Other)	2.8%	Those with a mixed ethnicity may still carry the risk factors in developing conditions from their heritage groups. Those from mixed groups have the lowest life expectancy than other ethnicities in the UK. Smoking rates in mixed groups also tends to be higher.
White Gypsy or Irish Traveller	0.1%	Newark and Sherwood as a higher traveller population than the rest of the county with around 400 pitches in the district alone. The number of pitches across the ICS is set to increase by 193. Travellers are a marginalised group with some of the worst health outcomes, life expectancy 10-15 years lower than the rest of the population. Mental health problems and risk of suicide is higher in this population. Housing, education, working conditions and poverty are also pressures for this population.
Other	4.6%	This other group may represent people from a variety of lesser known ethnicities who may find it harder to be catered for if they are not represented in the system. As an ICS we must ensure inclusion in our pathways to support people from all backgrounds.

Ethnicity proportion can also vary between age groups and should be considered when planning services targeted at certain age groups..

As a whole BAME populations have poorer access and health outcomes overall than the white population although there are some differences between each different group.

It should also be noted that ethnicity alone doesn't capture the full picture of the ICS profile and languages spoken should also be considered. There is a high Eastern European population across the ICS with Polish one of the most common languages spoken. Those who's first language is not English can struggle to access and navigate the system. Although translation services are available, It can still be difficult for them communicate their needs to professionals.

Ethnicity by Place:

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Nottingham & Nottinghamshire

The ethnicity profile varies significantly between each place based in the ICS. Understanding the ethnicity profile of each area will help us to understand the needs of each area and how we need to be mindful of this when planning services. It is also important for the system workforce to be representative of the population we serve.

Ethnicity	% of the ICS Population	% of City Population	% of South Notts Population	% of Mid-Notts Population	% of Bassetlaw Population
White/White British	85%	65.4%	90%	94.5%	94.5%
Asian/British South Asian	3.6%	9.1%	2.5%	0.6%	0.7%
Asian/British Chinese	0.8%	2%	0.6%	0.6%	0.2%
Black British/African/Caribbean/ Other	2.5%	7.3%	0.96%	0.5%	0.5%
Mixed/Multiple Ethnic Groups (Asian/Black/British/Other)	2.8%	6.63%	1.91%	1%	0.88%
White Gypsy or Irish Traveller	0.1%	0.1%	0.06%	0.1%	0.1%
Other	4.6%	9.55%	3.89%	3.23%	3.2%

Population Profiles – Nottingham City

Integrated Care System
Nottingham & Nottinghamshire

Nottingham and Nottinghamshire varies significantly between each place. The prevalence of health conditions, health outcomes and inequalities vary from district to district.

Nottingham City Population Overview

- An urban, densely populated area
- The 11th most deprived district in England and the most deprived in the East Midlands Region.
- 57% of the City neighbourhoods fall into the 20% most deprived groups nationally
- Approx. 34% of the population are from BAME backgrounds (Higher than England average). Asian/Asian British is the
- A younger population demographic, 30% aged 18-30.
- A more transient population
- More than 1 in 4 Children live in low income families
- GCSE Attainment and people in employment are both lower than the England averages

Mortality Outcomes in Relation to the England Average

Indicator	Comparison to the Eng. Average
Life expectancy at birth	Worse for both males & females
Under 75 mortality rate from all causes	Worse
Mortality rate from cardiovascular diseases	Worse
Mortality rate from cancer	Worse
Suicide Rate	Similar

Child Health in Relation to the England Average

Indicator	Comparison to the Eng. Average
Teenage conception rate	Worse
Smoking status during pregnancy	Worse
Infant mortality rate	Worse
Breast feeding initiation	Worse
Y6 Obesity prevalence	Worse

Lifestyle factors:

Approx. 64% of the adult population is classified as overweight or obese.

Smoking rates are worse than the England averages and below current reduction targets. Smoking remains the leading risk factor for ill health and death in the City.

Hospital admissions for alcohol related conditions are also worse than the England average.

What are the health inequalities in the City population?

Integrated Care System
Nottingham & Nottinghamshire

High levels of deprivation are associated with poorer health outcomes and lower life expectancy.

Lower GCSE attainment can affect employment prospects in later life which can affect income. Income , employment and education are 3 factors which are used to measure deprivation. Lower income households may live in lower quality housing which can affect physical and mental health. Income can also affect ability to travel to health appointments. Working conditions can also affect ability to access services and appointments due to shift patterns or losing pay to take time off , this has higher impact on lower income households. Lower income households may also have limited access to technology, data and phone credit which would allow them to access digital services.

Nottingham and Nottinghamshire has the lowest rates in the East Midlands region for baby's first feed being breastmilk. Breastfeeding can help reduce baby hospital admissions and illnesses as well as helping to prevent against illnesses in later life for mothers and babies.

People from BAME backgrounds are more likely to experience poorer health outcomes and poorer experiences of using health services.

Although the population demographic is younger, in the city there are still high rates of people living with ill health or disability.

The leading causes of ill health and death in the City are linked to lifestyle factors such as smoking and obesity.

Smoking during pregnancy is more likely to lead to lower birth weight babies and still birth. Lower birth weight can affect babies development and be a risk factor for infant mortality and poorer health in later life.

Children living in lower income households are more likely to:
- Have poorer education attainment
- Develop chronic health conditions
- Have poor nutrition
- Experience mental health issues
- Have poorer cognitive development

Population Profiles – Nottinghamshire County

Integrated Care System
Nottingham & Nottinghamshire

Nottinghamshire is made up of 7 districts. Overall, the statistics in the county show better outcomes for the population than those in the City, however there are wide variations between the North and South of the County were the health status and life expectancy differ significantly.

Nottinghamshire Population Overview

- There are more rural areas across Nottinghamshire
- Has an older demographic than the national average and the City, the average age is 43.8.
- Nottinghamshire is the 9th most deprived shire county in England (out of 26). However, the Rushcliffe district is in the 3% least deprived districts in the Country. Mansfield however is in the top 20% most deprived districts in England.
- 1 in 10 adults live with a moderate or severe disability
- 4% of the population are from a BAME background, this is lower than the England average.
- Unemployment rates are lower than the national averages

Mortality Outcomes in Relation to the England Average

Indicator	Comparison to the Eng. Average						
	Rushcliffe	Broxtowe	Gedling	Mansfield	Ashfield	Bassetlaw	Newark & Sherwood
Life expectancy at birth	Better for both males & females	Better for both males & females	Better for both males & females	Worse for both males and females	Worse for both males and females	Males: Similar Females: Worse	Similar for both males and females
Under 75 mortality rate from all causes	Better	Similar	Similar	Worse	Worse	Worse	Better
Mortality rate from cardiovascular diseases	Better	Similar	Better	Similar	Worse	Similar	Better
Mortality rate from cancer	Better	Similar	Similar	Worse	Worse	Similar	Similar
Suicide Rate	Similar	Similar	Better	Better	Similar	Worse	Similar

Child Health in Relation to the England Average

Indicator	Comparison to the Eng. Average						
	Rushcliffe	Broxtowe	Gedling	Mansfield	Ashfield	Bassetlaw	Newark & Sherwood
Teenage conception rate	Better	Similar	Similar	Worse	Similar	Similar	Similar
Smoking status during pregnancy	Worse	Worse	Worse	Worse	Worse	Worse	Worse
Infant mortality rate	Similar	Similar	Similar	Similar	Similar	Similar	Similar
Breast feeding initiation	Better	Better	N/A	Worse	Worse	Worse	Worse
Y6 Obesity prevalence	Better	Better	Similar	Similar	Similar	Worse	Similar

What are the health inequalities in the County population?

Integrated Care System
Nottingham & Nottinghamshire

Inequalities in the Mid and the North of the County

Deprivation is higher. Life expectancy is lower and people also live in poorer health for longer here.

Poorer access to public transport especially in more rural areas. This can affect access to services.

There are higher levels of unemployment and lower qualifications, which can affect a persons life trajectory, living conditions, housing and overall health and wellbeing.

Levels of self-reported poor/very poor health and limiting long-term illness were highest here.

Rates of teenage pregnancy is higher. Babies born to teenage mothers are more likely to live in lower income families. be at risk of poorer lifestyle factors and be low birth weight.

People are more likely to have lifestyle factors which negatively impact on their health e.g. smoking, obesity, alcohol misuse

A higher proportion of Gypsy, Roma and Traveller populations live here. These are a marginalised group who often have poorer health outcomes.

Inequalities in the South of the County (excluding City)

Higher concentration of people from BAME backgrounds, mainly Asian and Mixed Ethnic backgrounds.

A higher proportion of people are non-UK born resident live here than the rest of the county. This can impact access to services, knowing how to navigate the health and social care system and getting the right support at the right time.

Although South Notts is less deprived than Bassetlaw and Mid-Notts, there are still some areas in the 20% most deprived such as Eastwood in Broxtowe and Arnold in Gedling

Inequalities facing the whole County

Aging population. Means more people living alone, more carers and more people likely to be living with disability.

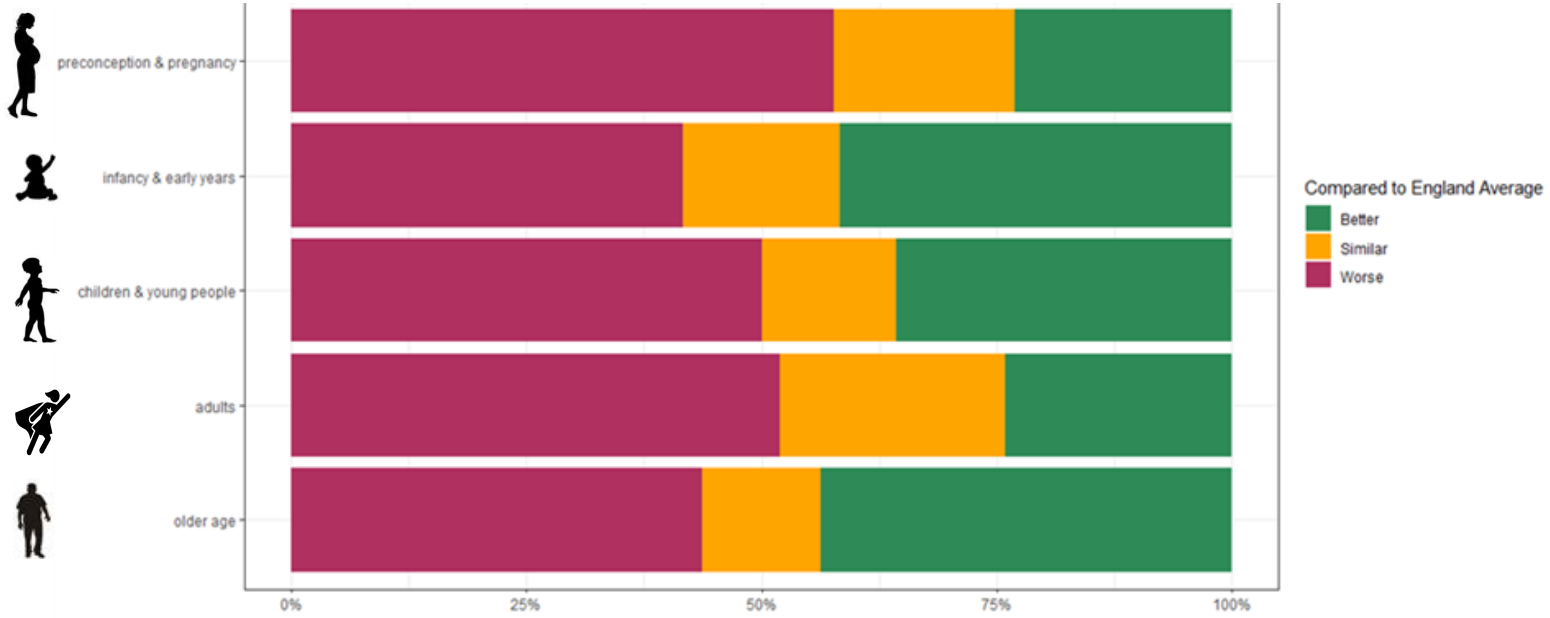
There are high disability rates in Nottinghamshire, although levels are associated with higher deprivation. Disabilities can affect a persons quality of life and available opportunities.

Smoking rates in pregnancy are higher than the England Average across the county. Smoking in pregnancy is linked to higher infant mortality, babies development in the womb and low birth weight.

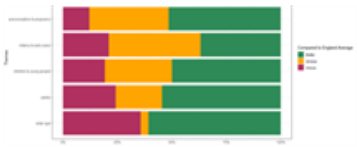
How inequalities across the ICS affect the life course of the population

Integrated Care System
Nottingham & Nottinghamshire

It's important that an understanding of health inequalities reflects the full life course. Too often we focus on adults without understanding the impact and relevance of the early years. Growing up in poverty can have a negative impact on a child's health and wellbeing as well as adversely impacting their health and quality of life in adulthood. The higher the proportion of red reflects worst population health.

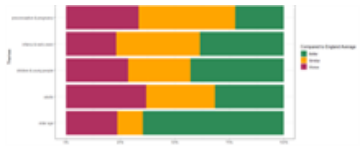


Leicester, Leics & Rutland



Lincolnshire

Derbyshire



A recent report from NHS Midlands public health team and UKSA presented composite indicators to characterise health and healthcare use at each stage of the lifecourse, based on the priorities in the NHS Long Term Plan. This includes characteristics of the population which drive the need for healthcare, factors which are a product of differences in access to healthcare and factors which are amenable to healthcare.

The chart to the right shows that about half of all indicators used at each stage of the life course for Nottingham and Nottinghamshire are worse than the England average. There is also a stark difference with neighbouring ICSs in the Midlands.

Drivers of inequality across infants

Infant mortality is an indicator of the general health of an entire population. It reflects the social, economic and environmental conditions in which children (and others in society) live, including their health care.

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Infant mortality is an indicator of the general health of an entire population. It reflects the social, economic and environmental conditions in which children (and others in society) live, including their health care. Nottingham City has infant mortality rates higher the England averages, reflecting the higher needs in the City.

The first 1001 days from conception to age two are extremely important for setting the foundations for lifelong health and wellbeing. This is a period of rapid development both physically and cognitively.
Evidence shows that healthy development in the early years is supported by a stable environment and nurturing relationships with parents or caregivers.

Investment in the first 1,001 days can prevent problems developing later in life, such as mental health disorders, youth violence, substance misuse, obesity and poor educational attainment.

Factors which can support a more positive first 1001 days of life such as healthy birth weight and breastfeeding initiation are lower in more deprived areas.

Regular and prolonged levels of stress can impact on pregnancy and impact the interactions between parents and the baby which can affect development.
Those living in poverty are more likely to have higher stress levels which can adversely impact on these outcomes, creating inequalities throughout life.

Indicator	Nottingham	Nottinghamshire
Infant mortality (2018-2020)		
Low birth weight of term babies (2020)		
Hospital admissions for dental caries 0-5 (2020)	6th worst in the region (out of 9)	2nd worst in region (out of 9)
A&E Attendances aged under 5 (2017-2020)		
Emergency admissions for injuries in under 5 years old (2015-2020)		
MMR for one dose (2yrs old %) 2019/20		

Drivers of inequality across children and young people

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Having the best start in life isn't just limited to the first 1001 days, health in later childhood and teenage years can also affect health in later life. The experiences we have early in our lives and particularly in our early childhoods have a huge impact on how we grow and develop, our physical and mental health, and our thoughts, feelings and behaviours

Children living in more deprived areas are more likely to experience poorer outcomes by the time they start school than those in less deprived areas. Most indicators for childhood and adolescence in Nottingham are worse than the values for England and Nottinghamshire County, reflecting the poorer socio-economic status of the City compared to the rest of the ICS.

Growing up in poverty can have a negative affect on children's health and well-being as well as adversely impacting their health and life in adulthood. Nottingham is among the ten worst areas in England for child poverty with around a third of children and young people in Nottingham are living in workless households

Adverse childhood experiences (ACE) can increase the risk of physical and mental health conditions in later life; 1 in 3 diagnosed mental health conditions in adulthood directly relate to ACEs. The longer an individual experiences or has more exposure to these experiences, the bigger the impact this will have on development.

Across England the incidences of childhood obesity and severe obesity is increasing. The prevalence in Nottingham and the more deprived areas of Nottinghamshire are significantly worse than the England averages. Obese children are more likely to become obese adults which significantly increases the risk of long-term conditions and reduced life expectancy.
There is a correlation between deprivation and severe obesity but in the City there is also a significantly higher ratio of severe obesity for those from Mixed, Black and Asian ethnicity compared to the national ethnicity ratio. There is also a significant growing gap in rates of severe obesity for boys compared to girls.

School readiness is an important marker on the life course trajectory. School readiness can be considered as a social determinant of health in that better development at this early age improves a child's ability to make the most of his or her learning opportunities, achieving higher grades and better employment prospects. This creates a cycle for those who grow up experiencing poverty being able to improve their outcomes in later life.

Indicator	Nottingham	Nottinghamshire
Children in absolute low income families (under 16) 2020/21		
Child mortality rate (1-17yrs)		
School readiness: % of children receiving a good grade at end of reception		
Hospital admissions for Mental Health conditions under 18s (19/20)		
Y6 Obesity prevalence		
Children in care		
Smoking prevalence at age 15 – Current smokers (2014/15)		
Admission episodes for alcohol specific conditions under 18		

Leading risk factors for ill health

The Global Burden of disease shows us that the leading risk factors for ill health in Nottingham and Nottinghamshire are smoking, high BMI and harmful alcohol use. These are all modifiable factors, are socioeconomically patterned and contribute significantly to widening health inequalities.
If we can reduce smoking and obesity rates across the ICS, it would have a positive impact on the health of the population.

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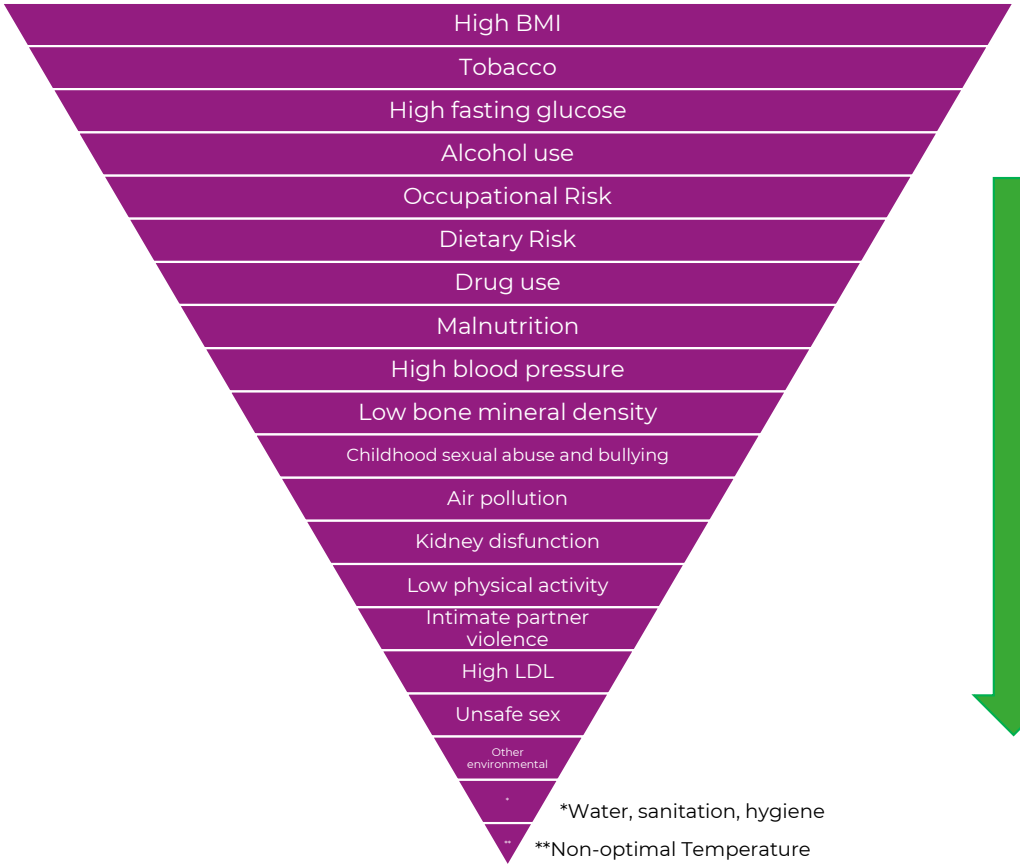
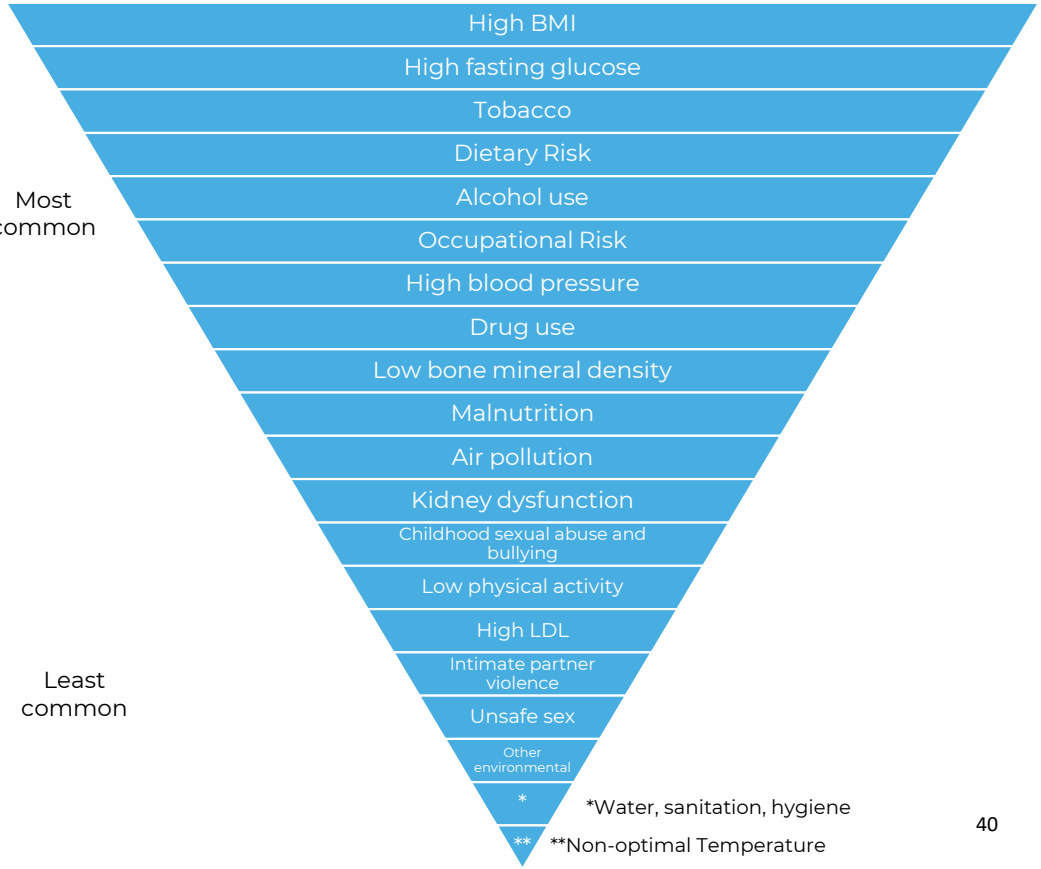
Nottingham City



Most common

Least common

Nottinghamshire



Drivers of inequality in life expectancy across the ICS

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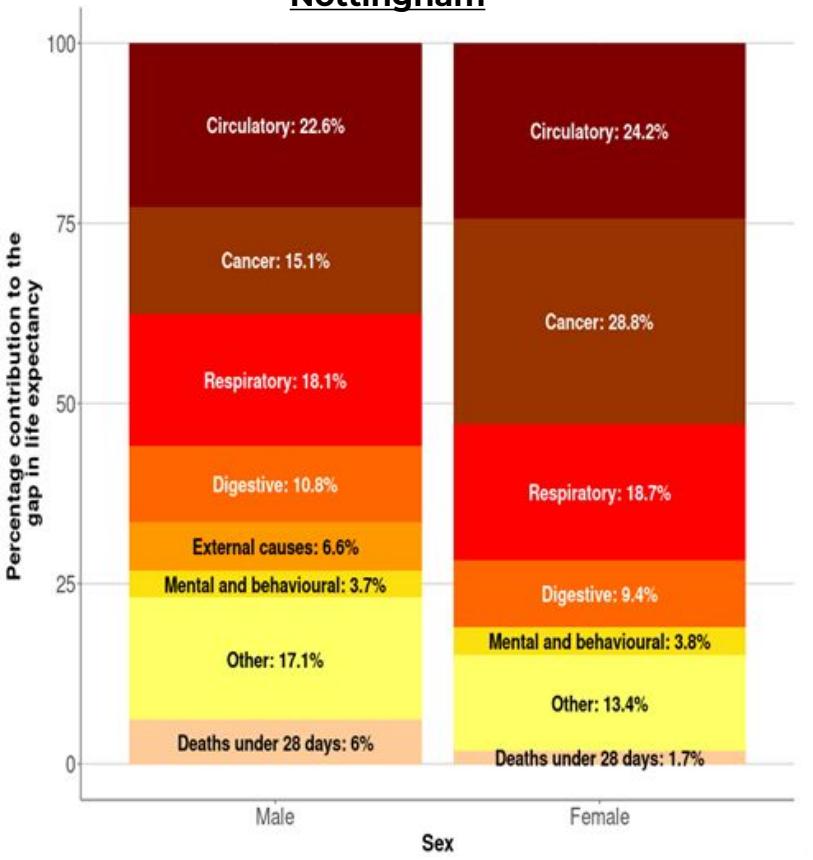
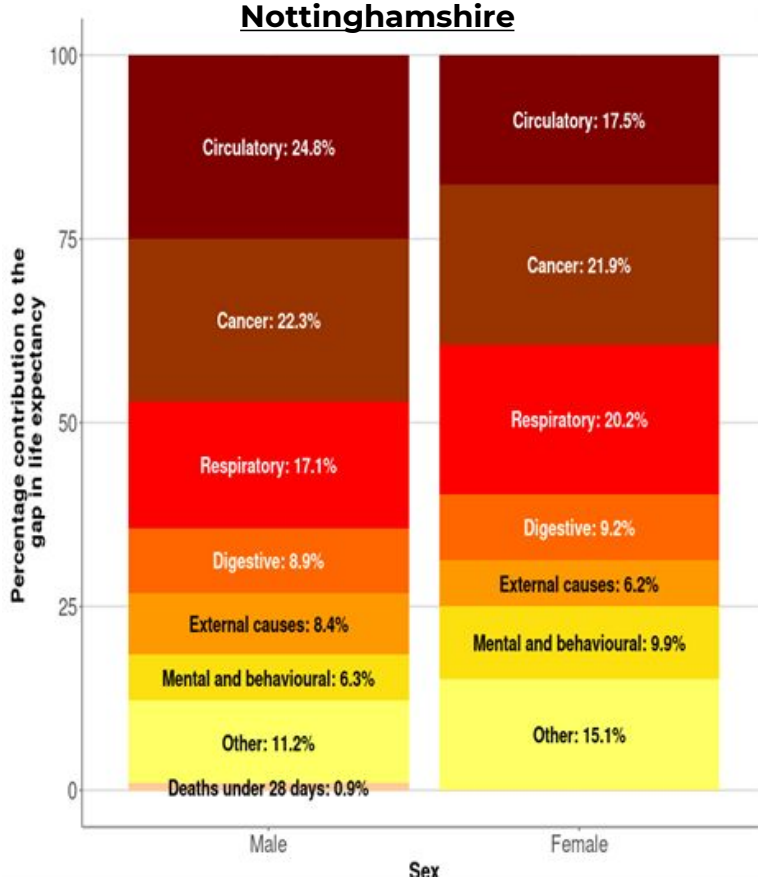
The charts below give an indication of the drivers of inequality in life expectancy and the differences across males and females (PHE segment tool). The % indicates the level of contribution to the gap in life expectancy between the least and most deprived emphasising the importance of focusing on cancer, diabetes, CVD and respiratory programmes in relation to prevention (primary and secondary) and treatment, through a targeted approach. There are similar themes in the drivers across England.

Nottingham



Nottinghamshire



The CORE20 Plus 5

Nationally, there are conditions which are driving health inequalities. Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

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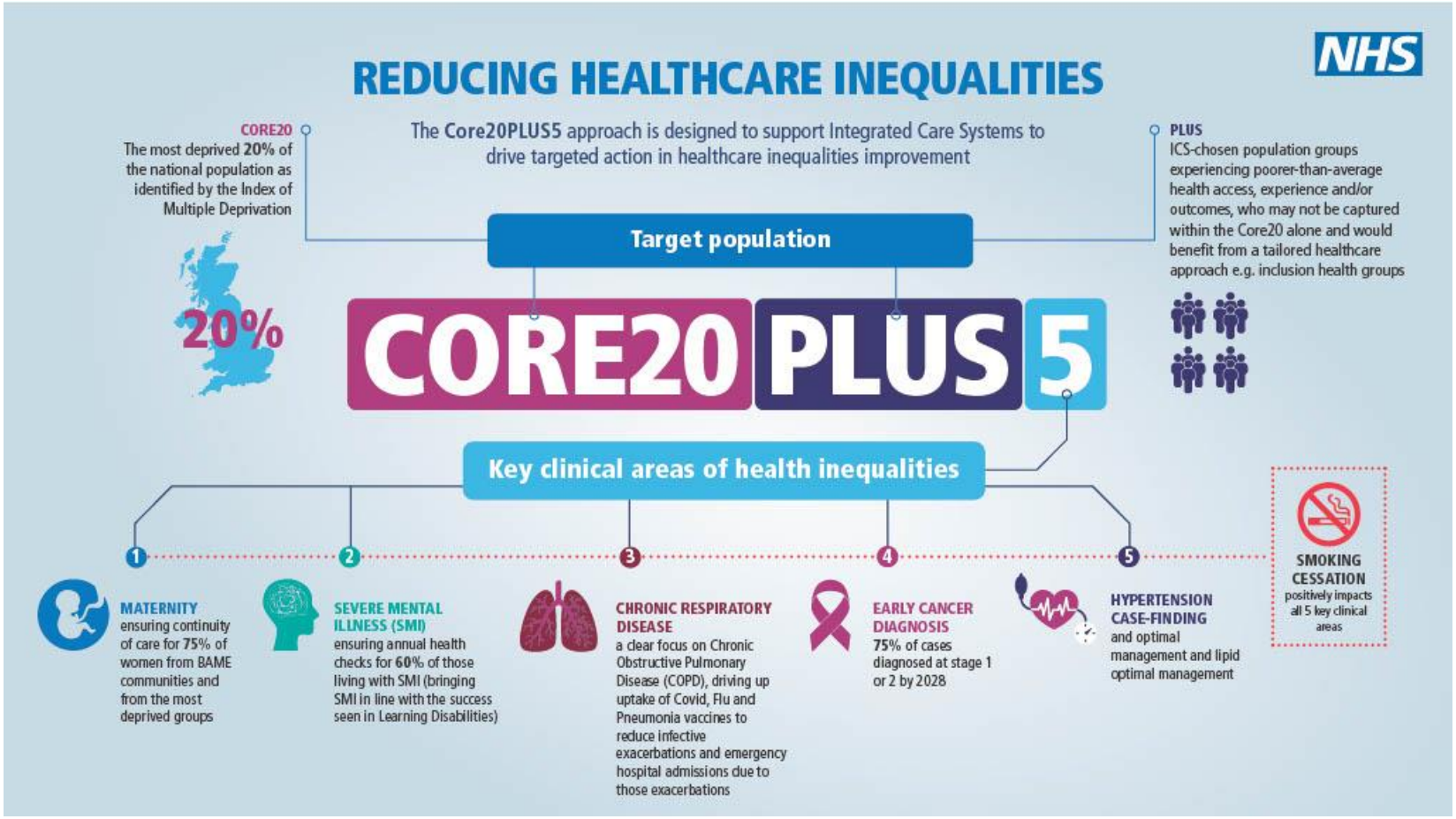

The Plus 5 – ICS current position

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ICS Smoking Rates: City: 13.4% (2020) County: 11.4% (2020)

	Maternity Ensuring continuity of carer for 75% of women from BAME communities and the most deprived groups	Severe Mental Illness (SMI) Ensuring annual health checks for 60% of those living with SMI	Respiratory A clear focus on COPD driving uptake of flu, COVID and pneumonia vaccs	Cancer 75% of cases diagnosed at stage 1 or 2 by 2028	Hypertension Case finding and optimal management and optimal lipid management
Key Stats	• Maternal mortality is more than 4x higher in black women, 2x higher for mixed ethnicity women and 2x as high for Asian women. Stillbirths and infant mortality are highest amongst Pakistani and Black ethnicities. NUH has a high percentage of BAME mothers. • A higher proportion than the national average of mothers are from the most deprived areas • 15.6% mother present as smokers at time of booking across the ICS, 12.8% self report as smokers at time of delivery - worse than the England average across every district in the ICS.	• People with a SMI on avg have 15 to 20 years shorter life expectancy • Premature mortality in adults with SMI is much higher in Nottingham than the England Average. • Smoking prevalence is 24.5% in Nottingham and 20.7% in Notts. • The ICS is targeted to undertake 6,237 SMI health checks for 2022/23. 12 month performance currently sits at 41% of this target. Although performance has increased since 2021/22, it has plateaued in Q1 2022/23, this is now similar to the regional average but slightly below national average.	• 2% of the total ICS population have a diagnosis of COPD. The highest rates are in Bassetlaw and Mid-Notts . • Nottingham City has the lowest prevalence of COPD but has higher COPD emergency hospital admissions than the rest of the ICS and is higher than the regional and national averages. • Uptake of the flu and covid vaccines is lower in the most deprived areas but also amongst BAME communities, regardless of deprivation quintile. • 33% of COPD patients across the ICS are smokers, 41% of COPD patients in Nottingham City are smokers.	• 20/21 saw an improvement with approx 30% of cancers diagnosed at an early stage. • In Nottinghamshire as whole, under 75s mortality rate from cancer is similar to the England average, however in Mansfield and Ashfield it is significantly worse. • Under 75 mortality rates from cancer in Nottingham City is also significantly worse than the England average and the worst in the East Midlands Region.	• Approximately 14.4% of the N&N population have a hypertension diagnosis. • 64.2% of expected cases have been diagnosed. Target is 80% by 2029. • 71.5% of hypertension cases are treated optimally. Target is 80% by 2029. • Hypertension is more prevalent in areas of higher deprivation in the ICS. Those from Black backgrounds are twice as likely to be diagnosed with hypertension than those from White backgrounds.

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D. How place based partnerships and PCNs plan to tackle health inequalities

Nottingham City Place Based Partnership

The Nottingham City Place-Based Partnership (PBP) is made up of a range of different partners who can influence the health and wellbeing of people within the city.
This includes social care, urgent and emergency care, mental health, voluntary services, primary and community care. The partners have worked together to identify a programme of priorities to improve the health and wellbeing outcome of the citizens of Nottingham.

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Nottingham City Place Based Partners

Nottingham City General Practice Alliance

NHS Nottingham and Nottinghamshire Integrated Care Board

Nottingham City Council

8 Primary Care Networks (PCNs):
GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices.

Nottingham City Homes

CityCare Building Healthier Communities

Nottingham Community and Voluntary Service

Framework For your future

NHS Nottingham University Hospitals NHS Trust

NHS Nottinghamshire Healthcare NHS Foundation Trust

healthwatch Nottingham

Nottingham City Place Based Partnership Priorities

The Nottingham City Integrated Care Partnership (place-based partnership) shares the same geography as Nottingham City Council and the Health and Wellbeing Board for Nottingham City. The Joint Health and Wellbeing Strategy 2022-2025 was published in Spring 2022 and it was agreed the place-based partnership have responsibility for the oversight in the delivery of the strategy.

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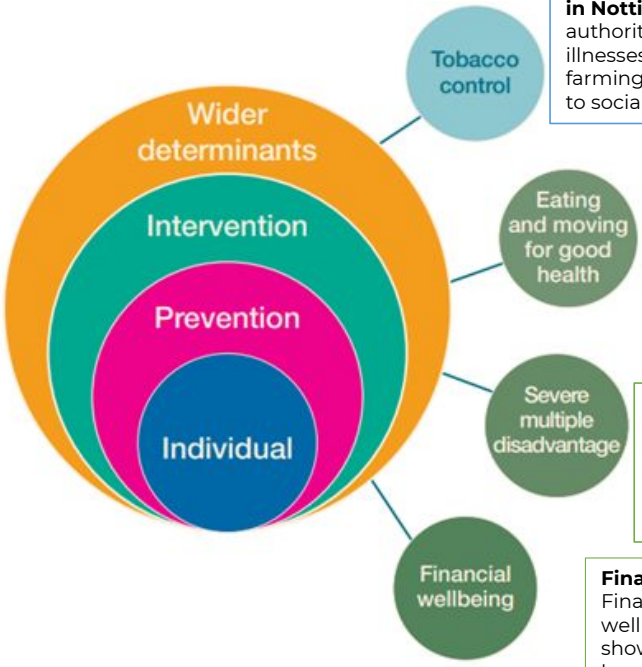
Joint Health and Wellbeing Strategy for Nottingham (2022-2025) Overview

The overarching ambition of this Strategy is to increase both the life expectancy and healthy life expectancy of Nottingham's residents, as well as reducing the inequality gap for these outcomes. The health and wellbeing strategy will focus on four areas:



Smoking and Tobacco Control
Smoking is the single largest cause of preventable death and disease in Nottingham. It is one of the largest drivers of health inequality. **1 in 5 adults in Nottingham are current smokers** – this is significantly higher than the England average and is the 4th highest smoking prevalence of all local authority areas in England. Tobacco imposes an economic burden on society. As well as the direct medical costs of treating tobacco-induced illnesses there are other indirect costs including loss of productivity, fire damage and environmental harm from cigarette litter and destructive farming practices. Each year it is estimated that smoking costs Nottingham about £137M; this includes £12M in healthcare costs; and £6.82M in costs to social care.

Eating and Moving for Good Health
Nottingham has high rates of people who are overweight or obese across its child and adult population. The latest data tells us that **1 in 4 (25.2%) of Reception children are overweight or obese and this increases to 2 in 4 (40.8%) of children by the time they are in Year 6.** Nottingham's rates are increasing at a faster pace than the national average and the gap to elsewhere is widening. Everyone experiences multiple barriers and challenges to eating and moving for good health. These factors are complex and broad and can be outside the control of individual choices: for example: how easy it is to walk or cycle in the community; if we live surrounded by fast food shops; the skills we acquire as we grow up and affordability of healthy food, activities and equipment needed to be active. Therefore this is not just about individuals but involves looking at the facilitators and barriers that can only be solved by involving communities and making changes to the local system or built environment.

Severe Multiple Disadvantage (SMD)
People who experience (SMD) are categorised as experiencing 3 of 5 sources of disadvantage; homelessness, mental ill-health, substance misuse, offending or domestic abuse. **Nottingham has the 8th highest prevalence of SMD in England**, approximately 50% are whom are female. People experiencing SMD can feel services are difficult to access and that their care and support can feel fragmented or stigmatising. People experiencing SMD can sometimes be frequent users of emergency services, but their outcomes are still poorer than the general population.

Financial Wellbeing
Financial wellbeing means being able to meet current needs comfortably and being able to maintain this in the future. A lack of financial wellbeing contributes to stress and poor mental wellbeing, and has a negative influence on our health behaviours and choices. National data shows us that there is a strong correlation between household income and healthy life expectancy. Areas with higher average household income have higher average healthy life and areas with lower average household income have lower average healthy life expectancy. **Nearly 17,000 children in Nottingham live in low income families – that is more than 1 in 4 children (27.2%).**

Nottingham City Place Based Partnership Priorities

In addition to the programmes that will be delivered though the Joint Health and Wellbeing Strategy, the place-based partnership will continue to have a focus on partnership programmes of work that add value to the work on individual partners.

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Additional Place Identified Inclusion Health Groups

Those with Mental Health Conditions

Good mental health and well-being is fundamental, it drives everything we do, how we think, how we behave and more importantly how we feel and act. As a diverse population we are all susceptible to mental health problems, however the risk of experiencing mental ill-health is not equally distributed across the population, it is often those who are living in deprived communities who are at highest risk of experiencing difficulties with their mental health. Since the COVID-19 pandemic and the associated measures that have been introduced (i.e. lockdown, social distancing), the longer-term socioeconomic impacts have increased, impacting on the inequalities that contribute towards the increased prevalence and unequal distribution of mental ill-health across the population.

Inequalities experienced in black, Asian and minority ethnic communities

People from Black, Asian and minority ethnic (BAME) communities generally experience poorer health than the overall population and that significant health inequalities exist between different population groups. People from black, Asian and minority ethnic communities are twice as likely to be living in poverty. There is clear evidence that people from BAME communities are at higher risk of dying from COVID-19 than the rest of the population though that risk may not be the same for all ethnic groups.

Care Leavers

Care Leavers, sometimes referred to as care experienced young people, often experience higher levels of health inequality, are more likely to experience challenges with their mental and physical health and are over represented in the criminal justice system when compared to the wider population. Children in care have poorer outcomes than the general child population across a variety of indicators primarily because of the impact of their early life experience prior to entering care, indicators include educational attainment, school attendance, school exclusion, offending behaviour, emotional and mental health, teenage pregnancy and substance misuse.

Working with communities

Working with communities forms a key part of place based partnerships and tackling health inequalities. The Place Based Partnership has brought together key partners to develop a coordinated response to reducing specific inequalities, to help engage with communities and remove barriers to accessing services. This has been especially important so far in increasing COVID vaccine uptake in the City and engaging with BAME communities.

Nottingham City Place Based Partnership & PCN Initiatives

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Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Dementia (PCN Health Inequalities DES) Admiral Nurse 8.7.2	Carers (Children, Adults) who are caring for loved ones with Dementia	• Providing support by way of clinics, telephone, counselling or face to face consultation • Asset mapping, creating links engaging with other organisations such as working age dementia service, dementia support groups, carers hub, links to translators, locate free course help reduce inequalities • Education, sharing information around risk factors and risk reduction • Improving ways to identify and support carers	• Improvement in the quality of life and mental health outcomes for both carers and their loved ones with Dementia • Educate carers around the disease, informed decision making, preventing a crisis • Reduction in GP appointments and A&E attendances • Hospital admissions avoidance	City South Clifton and Meadows BACHS Bulwell & Top Valley	✓	✓	
Annual Dementia Reviews (PCN HI DES) 8.7.3 (d)	Carers (Children, Adults) who are caring for loved ones with Dementia	• Opportunistic enquiries re informal carers, annual dementia reviews, documenting in patients records and the carers record, directing to carers hub. Signposting on practice websites	• Key part of a person with dementia's health and wellbeing. • Opportunity to discussing planning ahead and support for carers. Getting right care at the right time	City South	✓	✓	
Diabetes and Pre-Diabetes (PHM Improvement Project)	Patients at risk of pre-diabetes and Type 2 diabetes with an emphasis on BAME community	• Engage with patients who do not currently access services • As an outlier improve offering of patient education and opportunity to upskill staffing – increasing knowledge • Improve the general lack of awareness and symptoms for BAME population	• Reduction in the risk of pre-diabetes to improve quality of life outcomes and the debilitating impact and risk factors associated • Prevent heart disease, stroke and kidney failure making healthy changes • Reduce the burden on the NHS	City South BACHS	✓	✓	
Community Days of Action (PCN Health Inequalities DES) 8.7.2 (b)	All	• Engaging with local assets to deliver pop up stalls for the public to provide information available in their local area • Digital NHS App support • Providing information in different languages	• Increase awareness of local services to promote and self manage, behaviour change to make the right choices	City South Clifton and Meadows BACHS Bulwell & Top Valley Radford & Mary Potter Bestwood & Sherwood City East	✓	✓	

Nottingham City Place Based Partnership & PCN Initiatives

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Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Recording ethnicity of all patients registered within the PCN (PCN Health Inequalities DES) 8.7.1 (c)	Ethnicity of the registered population	• All practices continue to record the ethnicity of all new registrations – achieved 90+% to date	• Routine monitoring of access, use of services, and key processes and outcomes of care by race and ethnicity is essential to ensuring compliance	City South BACHS Bulwell & Top Valley	✓	✓	✓
Increase awareness of PCN services and improving staff occupational health (PCN Mid-Career Fellow) (PCN Health Inequalities DES) 8.7.1 (c)	Patients with health conditions and Staff welfare	• Ensure local assets are up to date (identify any gaps), accessible and that patients are aware of local services • Engage with stakeholders to formulate a regular internal and external Newsletter • Mid-Career Fellow sets out a plan for occupational health	• Improvement in quality of life for patients increasing knowledge local services and assets • Improve staff morale and look forward to a sustainable future	City South	✓	✓	
Cardiovascular Disease (Mid-Career Fellow) PCN HI DES & PCN Improvement Project	Socioeconomically deprived patients at risk of COPD, Cancer and other related Long Term Conditions	• Involving and engaging stakeholders and partners to plan a campaign aimed at smoking cessation to improve the cardiovascular health and quality of life	• Reduction in smoking rates. improve cardiovascular disease risks and affects associated with a long term condition	Clifton and Meadows	✓	✓	✓
Cancer & Breast Screening (PCN Health Inequalities DES) Mid-Career Fellow PHM	All	• Role is part funded by Macmillan and PCN6 & 8. Self-Help UK are the lead employer • Cancer care co-Ordinator undertaking holistic reviews (beyond cancer model) of patients recently diagnosed with cancer • Contacting directly non participants in cancer screening programmes • Identifying issues causing non attendance • Connecting with partners to address reasons for non-attendance e.g. linking in with community leaders, considering promotion	• Focused on improving cancer screening uptake and increasing cancer review numbers in PCN • Increase in early detection rates and making a difference to the quality of life outcomes for patients • To improve access and reduce health inequalities	Clifton and Meadows	✓	✓	✓
LD Screening (PCN Health Inequalities DES) Mid-Career Fellow PHM	Patients with Learning Disabilities	• Ensure LD register is up to date by sending pre-screening list to GP practices so that eligible patients with LD can be identified in advance and sent easy-read information • Ensure appropriate coding in the notes of screening events	• Patients with LD experience poorer health outcomes. Improved screening may help identify unrecognised health needs and avoidable health inequalities • Form a strategy for improving access to screening services	Clifton and Meadows	✓	✓	

Nottingham City Place Based Partnership & PCN Initiatives

Integrated Care System
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Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Social Prescriber Link Worker	Forging links with local population, Ethnic Groups and solutions encountered by language barriers	• Engaging with local assets, linking in with tertiary voluntary sector organisations • Increasing links with population by way of a Newsletter • Initiating local regular venues for holding group activity • Apply for funding to help implement an allotment to grow produce that can be consumed by the community • Support by way of cooking hints and tips groups	• Improvement in quality of life for patients increasing knowledge local services and assets • Improving physical activity and education around the importance of diet and wellbeing	Clifton and Meadows BACHS	✓	✓	
Lung Cancer hotline (PCN Health Inequalities DES) (PHM Improvement Project)	Socioeconomically deprived patients at risk of lung cancer PCN has the highest rate of 2ww lung referrals in the City	• Letters and text messages sent out to patients if they have any of the NICE NG12 red flag symptoms for lung cancer • Symptoms assessed and high risk individuals invited to attend for a chest CT	Rapid access to diagnosis leads to decreased mortality Reduce the burden on the NHS	BACHS	✓	✓	✓
Pulmonary Rehab (PCN Health Inequalities DES) (PHM Improvement Project)	Socioeconomically deprived patients	• Collaborative partnership with City Care Integrated respiratory service • Targeted education through the teams with colleagues in practices. • Review patients who did not take up the offer of pulmonary rehab • Work with the Social Prescribing team	Improvement in quality of life, dyspnea, and functional capacity independent of baseline disease burden	BACHS	✓	✓	✓
Obesity and Cardiovascular (PCN Health Inequalities DES) (PHM Improvement Project) (Mid-Career Fellow)	Socioeconomically deprived patients with health conditions such as diabetes and cardiovascular disease	• Asset mapping • Engagement with partners, community, practices, Health and Well Being coaches and providers of weight management services • Descriptive study and case studies looking at the perceptions of obesity • Design an intervention and pathway which will include the Health and Well Being Coaches	Reduction in the risk of diabetes and cardiovascular disease	BACHS	✓	✓	

Nottingham City Place Based Partnership & PCN Initiatives

Integrated Care System
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Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Identify and include all patients with a learning disability on the LD register and to deliver an annual LD health check and health action plan (PCN Health Inequalities DES)	Patients with Learning Disability Patients with Learning Disability from BAME communities	• Identifying and including all patients who are aged over 14 with a Learning Disability on the LD register • Supporting atleast 75% of those patients to get an annual LD health check and health plan • Signposting patients and their families to any support required from health services or social care • Offering support to further appointments if required • Using an interpreter if required	Promoting health and wellbeing Early diagnosis leads to decreased mortality Support with long term conditions, if they are diagnosed	BACHS	✓	✓	
Childhood Immunisations (PCN Acceleration Programme) (PHM Improvement Project)	Unvaccinated pre-school children from young, disadvantaged, deprived families Low income and immigrant families	• Targeted approach/programme of work including a draft proposal/model • Engagement with partners, community and schools • SSBC Family mentor approach	Reduction in infant mortality	Bulwell & Top Valley Radford and Mary Potter	✓	✓	
Healthy Lifestyle (PCN Acceleration Programme) (PHM Improvement Project)	Socioeconomically deprived patients with health conditions such as diabetes and cardiovascular disease	• Asset mapping • Engagement with partners, community and schools • Understand from experience and models of delivery • Design an intervention and pathway which will include the Health and Wellbeing Coaches	Reduction in the risk of diabetes and cardiovascular disease	Bulwell & Top Valley Radford and Mary Potter	✓	✓	
Mental Health (PCN Acceleration Programme) (PHM Improvement Programme) (Mid-Career Fellow)	Low income, high long-term unemployment, disadvantaged patients	• Address and improve the mental health and wellbeing of citizens • Improve access to relevant teams and services • Engagement with partners, community and schools • Support and mentor the new Mental Health Practitioner • Upskill all the staff in mental health education	Improvement in mental health and wellbeing	Bulwell & Top Valley	✓	✓	
Identify and include all patients with a learning disability on the LD register and to deliver an annual LD health check and health action plan (PCN Health Inequalities DES)	Patients with Learning Disability Patients with Learning Disability from BAME communities	• Identifying and including all patients who are aged over 14 with a Learning Disability on the LD register • Supporting at least 75% of those patients to get an annual LD health check and health plan • Signposting patients and their families to any support required from health services or social care • Offering support to further appointments if required • Using an interpreter if required	Promoting health and wellbeing Early diagnosis leads to decreased mortality Support with long term conditions, if they are diagnosed	Bulwell & Top Valley	✓	✓	

Nottingham City Place Based Partnership & PCN Initiatives

Integrated Care System
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Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Identify and include all patients with a learning disability on the LD register and to deliver an annual LD health check and health action plan (PCN Health Inequalities DES)	Patients with Learning Disability Patients with Learning Disability from BAME communities	• Identifying and including all patients who are aged over 14 with a Learning Disability on the LD register • Supporting at least 75% of those patients to get an annual LD health check and health plan • Signposting patients and their families to any support required from health services or social care • Offering support to further appointments if required • Using an interpreter if required	Promoting health and wellbeing Early diagnosis leads to decreased mortality Support with long term conditions, if they are diagnosed	Bulwell & Top Valley	✓	✓	
Engagement with schools (PCN Health Inequalities DES)	Children and young people Young, disadvantaged, deprived families Low income and immigrant families	• Poster competition with the theme 'looking after your body' • Clinicians having conversations with children and their parents, carers and families about how they can look after their health, including healthy eating, exercise, being active and not smoking; along with information about careers in the healthcare sector; and to share information with them on coping with anxiety, immunisations etc • Social Prescribing Link Workers and Health and Wellbeing Coach engaging with schools and community • School representation at BTV Health Forum and Childhood Immunisations working group	Improvement in physical and mental health and wellbeing	Bulwell & Top Valley	✓	✓	
COVID vaccine uptake in marginalised populations (Vaccine programme)	Muslim families Non English speaking families Black African, Caribbean and British families	• Provision of dedicated clinics at a range of appropriate religious/cultural community settings - mosques, churches • Patient engagement for vaccine sanctuaries • Provision of interpretation and translation in patient engagement - dedicated phone contact • Development of resources in appropriate languages and formats • Dedicated GP time for Q&A for COVID vaccine hesitant patients	Increased uptake of COVID vaccine	Radford and Mary Potter	✓	✓	✓

Nottingham City Place Based Partnership & PCN Initiatives

Integrated Care System
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Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Green Social Prescribing (PHM Improvement Programme)	Marginalised patients	• Promoting exercise and nature based activities including Community Walking Group, Community Garden Project, Community chair based exercise and social wellbeing groups. • Appropriate referrals and engagement with the social prescribing team looking at the potential difficulties with smoking patients whilst being supported by the stub it programme. • Encouragement, support and guidance to patients who are reluctant to attend social activities from the social prescribing team to ensure that all patients are able to access local community services.	Promoting a healthy life style and wellbeing. Reducing loneliness, improving mental health and reducing obesity	Radford and Mary Potter City East	✓	✓	
Increasing access to PC services (PCN Improvement Project)	Promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death	• Implementing a GP+ spoke model in the PCN to enable patients to receive access to services that are currently unavailable	• Enabling patients to received the right care, from the right professional including access from and to other PC and GP services such as urgent care	City South	✓	✓	
Childhood Immunisations (PHM Improvement Project) (Mid Career Fellow project)	Adult patients in the Obese and Morbidly Obese BMI categories Paediatric patients in the Obese and Overweight BMI categories	• Aiming to improve engagement with preventative services for this cohort • Targeted approach/programme of work alongside partners in community health local authority, commercial and third sector partners • Clinical data analysis • Engagement programme with community and schools	• Improved understanding of ethnicity and disability data for this cohort • Dedicated clinics and messaging for adult and paediatric cohorts • Improved in uptake of preventative services from this cohort • Increased proportion of patients with recent weight recording • Increased referral rates to prescribed weight loss programmes	Bestwood and Sherwood City East	✓	✓	
Social Prescribing (PHM Improvement Programme)	Marginalised patients experiencing social and mental health issues	• Promoting exercise and nature based activities including Community Walking Group, Community Garden Project, Community chair based exercise and social wellbeing groups. • Promoting preventative health service engagement within this cohort • Encouragement, support and guidance to patients who are reluctant to attend social activities from the social prescribing team to ensure that all patients are able to access local community services.	• Promoting improved self management of health conditions • Reducing isolation and improving mental health	Bestwood and Sherwood	✓	✓	

Nottingham City Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Review SMI register and review data to deliver physical health checks (PCN Health Inequalities DES)	Patients with a SMI, high intensity users with poorly controlled chronic disease	• Appointed Health Improvement Worker, Mental Health Practitioner and Health & Wellbeing coaches • Practices took part in a review of SMI register to identify individuals for a health check • HIW working with practices to achieve at least 60% • Supporting those with mental health problems beyond the expertise of Primary Care	Avoid reaching the accepted thresholds for secondary care input Improving poorly controlled chronic disease, recurrent but ineffective presentations to practices and OOH services including ED	BACHS Bulwell & Top Valley Radford and Mary Potter Bestwood and Sherwood	✓	✓	✓
SSBC Non-English Speaking Families (PCN Acceleration Programme) (PHM Improvement Project)	Non – English speaking young Families with language barriers	• Engagement via survey with non-English speaking parents with young families within Nottingham City East to better understand the barriers in accessing health care including immunisations and nursery places. • Sisters of Noor (local organisation) were awarded £12k lottery funded contract to perform survey's with 100 local families - 25 each speaking Urdu, Arabic, Tigrinya, Czech. • Multi agency steering group - plans for Coproduction and involvement of the community and coproduction in future projects	• The results of this project will be used to inform improvements to the clinical delivery offer to meet the individual needs of children 0-5, which aim to improve health outcomes for these children. • Improve knowledge of parents around the services they can access including nursery places	City East	✓	✓	
On boarding Videos (PHM Improvement Programme)	Local population – Including BAME – non English speaking asylum seekers/ refugees	• Project entails educating patients by creating video based information in their own languages • working closely with refugee forum to establish how patients can effectively access primary care. Information will be personalised to NCE population to support those patients who don't speak English and are new to the UK.	• To increase understanding of the role of Primary Care and how to access services. • To improve health outcomes • Enabling patients to receive the right care, from the right professional including access from and to other PC and GP services and reduce inappropriate use of primary care and A&E.	City East	✓	✓	

Nottingham City Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Community Fibroscan Pilot (PHM Improvement Programme)	Targeting patients at high risk of fatty liver and Cirrhosis. Obesity, those at risk of pre-diabetes and Type 2 diabetes and people with high alcohol consumption	• Liver Fibro scans to check at risk patients for fatty livers • To offer lifestyle advice and connections to weight and alcohol management services	• To improve health outcomes by promoting healthy life style and wellbeing • Reduction in the risk of long term conditions • To improve quality of life outcomes and the debilitating impact and risk factors associated	City East	✓	✓	
Cancer & Breast Screening (PCN Health Inequalities DES) PHM	Reviewing screening rates for all patient group and carrying out Cancer Reviews	• Role is part funded by Macmillan and PCN 6 & 8, Self Help UK are the lead employer • Cancer care co-ordinator undertaking holistic reviews (beyond cancer model) of patients recently diagnosed with cancer • Contacting directly non participants in cancer screening programmes • Identifying issues causing non attendance • Connecting with partners to address reasons for non- attendance e.g. linking in with community leaders, considering promotional events etc.	• Focused on improving cancer screening uptake and increasing cancer review numbers in PCN. • Increase in early detection rates and making a difference to the quality of life outcomes for patients. • to improve access and reduce health inequalities.	City East	✓	✓	✓
Safeguarding Care Coordinators (PCN Health Inequalities)	Targeting children and adults with safeguarding risks	• Employment of two care coordinators to improve the processes within GP practices in order to identify and manage the risks of those who are at risk of abuse • To improve liaison and communication with other agencies involved in the care of this cohort	• To reduce risk of abuse in vulnerable cohorts • To improve health and wellbeing • To improve liaison with services	City East	✓	✓	
Local Church Pilot (Mental Health)	Those experiencing bereavement and loss	• Trained church of England clergy and church lay workers providing sessions for people experiencing loss and bereavement with the main therapy being supported listening	• Improve mental health and prevention of deterioration	City East	✓	✓	

Nottingham City Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Student Carer Identification & Support (PCN DES HI Project)	Students with caring responsibilities for family and/or friends in Nottingham or their home city	• Health promotion to identify and offer support to the carers population within the student body • Identify new carers champion across both GP surgeries • Engagement with university partners and services	• Identification of carers • Provision of support for carers • Signposting to appropriate resources or services • Improvement in mental health and wellbeing • Raise awareness with the wider team of the specific challenges carers face and support that is available • Improvement in data collection • Aim is to improve physical health in this cohort	Unity	✓	✓	
Personality Disorder Physical Health PHM Project (ESDS)	Patients with mental health problems often suffer with worse physical health than the wider population. Patients with personality disorders are often hard to engage. GP resource and targets are not often directed at this cohort of patients.	• Aim to improve the data collection of BP, BMI, Smoking status and alcohol intake in this cohort. • Offer brief interventions where appropriate • Offer of support from SPLW and health and wellbeing coach.	• Improvement in data collection • Aim is to improve physical health in this cohort	Unity	✓	✓	

Nottinghamshire Priorities

Integrated Care System
Nottingham & Nottinghamshire

Nottinghamshire has 3 place-based partnerships; South Nottinghamshire, Mid Nottinghamshire and Bassetlaw who are working to deliver the priorities in the Nottinghamshire Joint Health and Wellbeing Strategy.

Joint Health and Wellbeing Strategy for Nottinghamshire (2022-2026) Overview

The overall aim of the strategy is to work together to enable everyone in Nottinghamshire to live healthier and happier lives, to prosper in their communities and remain independent in later life. There are 4 ambitions outlined in the strategy which present a range of opportunities, these ambitions have been broken down into 9 areas of focus, chosen due to the big impact they have on health and wellbeing.
The ambitions and focus area are shown below:

1. Give every child the best chance of maximising their potential:
We will work together for every child in Nottinghamshire to have the best possible start in life, because we know that a good start shapes lifelong health, wellbeing and prosperity

2. Create healthy and sustainable places:
Everyone will grow, live, work and age in places that promote good health, tackle the causes of health inequalities and address the climate crisis.

3. Everyone can access the right support to improve their health:
Health, care and community services will work together to strengthen their focus on promoting good health and wellbeing and preventing illness, by building on people's strengths.

4. Keep our communities safe and healthy:
We will support people who are marginalised in our communities to ensure they are safe from harm and their needs are met. Services will support people to build on their strengths to live the lives they want

Best Start	Mental Health	Healthy Weight
Air Quality	Alcohol	Tobacco Control
Food Insecurity and Nutrition	Homelessness	Domestic Abuse

South Nottinghamshire Place Based Partnership

South Nottinghamshire PBP are working together to join up health and social care services across Broxtowe, Gedling, Rushcliffe and Hucknall (Ashfield). Their aim is to support people to live healthier lives and get the care and treatment they need, in the right place, at the right time.

Integrated Care System
Nottingham & Nottinghamshire

South Nottinghamshire Place Based Partners

Nottinghamshire County Council

Broxtowe Borough Council

Gedling Borough Council

Rushcliffe Borough Council

Ashfield District Council

NHS Nottingham and Nottinghamshire Integrated Care Board

Rushcliffe Community & Voluntary Service

pics Primary Integrated Community Services Ltd

Partners Health Stronger Together

Newark & Sherwood CVS

active notts

NHS Nottingham University Hospitals NHS Trust

NHS Nottinghamshire Healthcare NHS Foundation Trust

healthwatch Nottingham

6 Primary Care Networks (PCNs):
GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices.

South Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Chilwell/Beeston, Stapleford and Kimberley Insights	Residents of Chilwell, Beeston, Stapleford and Kimberley	• Working with stakeholders and residents to gain a real understanding of their lives, enabling a co-produced and collaborative approach to reducing physical inactivity and improving health. Understanding the link between mental health and physical activity for individuals in Broxtowe	• Improving health outcomes for the residents of Broxtowe	N/A - Broxtowe Borough Council	✓	✓	
Hypertension Case Finding	Patients aged 18+ who are not diagnosed with hypertension but who have had a BP reading of >140/90 recorded in their medical records in the last 2 years.	• Identify any groups who are overrepresented in the number of citizens currently living with undiagnosed hypertension and look to engage community partnerships to understand the needs of this population and how we can reduce this inequality relating to hypertension • . Exploring community partnership opportunities to provide access and support for healthier lifestyle choices to reduce long term conditions and early fatality. • Through cross organisational working with GP Clinical Leads, Community Pharmacies, Broxtowe Borough Council, Liberty Leisure, Partners Health, religious and charitable organisations, and Nottingham CCG to identify appropriate patient cohorts and hear from them how they would most like to access blood pressure monitoring and care pathways. • Recruit a 'Cardiology' team, who will be prescriber-led to work closely with community pharmacies to support appropriate members of our community to navigate and access BP monitoring, subsequent follow up and treatment. As well as improving access to wider lifestyle advice and support to reduce health inequalities and improve health outcomes in line with CORE20PLUS5 priorities.	• Reduction in strokes and myocardial infarctions through improved detection and management of undiagnosed hypertension, • Reducing obesity and improving smoking cessation outcomes by appropriate referral to targeted services as identified through the hypertension case finding work.	Nottingham West Rushcliffe	✓	✓	✓

South Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Durban House Community Hub: developing a health and wellbeing centre of excellence Eastwood	Low level mental health	• Provide a multi-functional central space for local service users and services to come together • Within Broxtowe we have seen how an inclusive centre of health and wellbeing support can work positively through the model of the Middle Street Resource Centre in Beeston. • Durban House will provide formal and informal support networks, co-located with commissioned healthcare services and spaces available for CVS groups to congregate for activities. • There will be a café which provides both a safe space for centre users as well as supported employment opportunities for the citizens of Eastwood, including those whose life circumstances may make employment difficult to access through more traditional routes.	• Improved provision of employment, training and development opportunities for citizens of Eastwood. • Improved access to preventative services • Improved access to non-medical health and wellbeing support services • Improved local support networks for local citizens	Nottingham West	✓	✓	✓
Utilising the PCN digital inclusion officer(s), we will develop and implement a digital inclusion strategy to support those digitally excluded across Nottingham West PCN..	Those that are digitally excluded. The Ukrainian community residing or moving to Nottingham.	• Support those who are currently digitally excluded to access primary care services. We have begun making relationships with organisations locally who support Ukrainian nationals with a view to us being ready to focus this work, should it become necessary, to support those fleeing civil war in the Ukraine in line with domains 1 and 5 of the PHM ESDS Action plan 22/23. • Help to navigate access to; Register with a GP, Repeat prescriptions. Care for long term conditions, Health Checks, Women and Children health needs, Mental health support • Aim to engage the whole of the PCN to support those seeking refuge in our neighbourhoods to not only access health care systems but also wider societal networks to give these families the best start to their resettlement within Notts West PCN. We will plan other similar interventions should we identify any other predictors of unequal access to health care as we progress this current work plan.	Supporting those digitally excluded within Nottingham West PCN to access primary care services to maintain their wellness / ongoing medical needs without the need to access secondary care services. Improved experience of resettlement and community integration for Ukrainian national looking to resettle within Nottinghamshire.	Nottingham West Rushcliffe	✓	✓	

South Notts Place Based Partnership & PCN Initiatives

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Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Increasing the uptake of cervical screening amongst the South Asian community in Broxtowe.	South Asian female community.	• Identified that this cohort have a low uptake for their cervical screening. • Completed some community engagement and using this feedback have begun to create an information video with key leaders / people within this community speaking on the importance of taking up the offer of cervical screening (and other intimate health examinations). • We plan to edit this with Punjab subtitles and then circulate via WhatsApp - a platform that the community told us is widely used to communicate due to the voice message functionality etc.	• Improved access to preventative screening services • Improved access to, and experience of, women's health services	Nottingham West	✓	✓	✓
"Working it Out" in conjunction with Liberty Leisure and Broxtowe Women's Project.	Women experiencing domestic abuse.	• A partnership with Liberty Leisure and Broxtowe women's project has seen the creation of the their "Working it Out" project to help reduce social isolation and promote wellbeing for women experiencing domestic abuse. • Funding has been secured to facilitate some safe space events coaching and to run activities aimed at getting this group of women more active and build friendships. • Virtual classes have been set up to allow participants to test a number of different types of exercises and once they evaluate these options we plan to run some targeted exercise classes of their choice, again in a managed 'safe space'. • Fund 30 free gym passes through this project and plan to move these members onto the exercise referral scheme once this ends to encourage lifelong health and wellbeing.	• Improved social connection and social confidence amongst this cohort • Improved access to health and wellbeing services • Improved ability in managing health and wellbeing	Nottingham West	✓	✓	

South Notts Place Based Partnership & PCN Initiatives

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Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Increasing the uptake of cervical screening amongst the South Asian community in Broxtowe.	South Asian female community.	• Identified that this cohort have a low uptake for their cervical screening. • Completed some community engagement and using this feedback have begun to create an information video with key leaders / people within this community speaking on the importance of taking up the offer of cervical screening (and other intimate health examinations). • We plan to edit this with Punjab subtitles and then circulate via WhatsApp - a platform that the community told us is widely used to communicate due to the voice message functionality etc.	• Improved access to preventative screening services • Improved access to, and experience of, women's health services	Nottingham West	✓	✓	✓
"Working it Out" in conjunction with Liberty Leisure and Broxtowe Women's Project.	Women experiencing domestic abuse.	• A partnership with Liberty Leisure and Broxtowe women's project has seen the creation of the their "Working it Out" project to help reduce social isolation and promote wellbeing for women experiencing domestic abuse. • Funding has been secured to facilitate some safe space events coaching and to run activities aimed at getting this group of women more active and build friendships. • Virtual classes have been set up to allow participants to test a number of different types of exercises and once they evaluate these options we plan to run some targeted exercise classes of their choice, again in a managed 'safe space'. • Fund 30 free gym passes through this project and plan to move these members onto the exercise referral scheme once this ends to encourage lifelong health and wellbeing.	• Improved social connection and social confidence amongst this cohort • Improved access to health and wellbeing services • Improved ability in managing health and wellbeing	Nottingham West	✓	✓	

South Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Keyworth Insight	Residents of Keyworth	• Identify barriers to physical activity, mapping community assets and increasing/improving the opportunities for young people to be physical active in Keyworth, an area with some of the highest health inequalities in the borough, working with local community groups, schools and organisations.	• Improve health and wellbeing outcomes for the residents of Keyworth	N/A – Rushcliffe Borough Council	✓	✓	
Rushcliffe Community Cohesion Network	All Rushcliffe residents	• A forum to ensure voices from all sectors of Rushcliffe's communities are represented, to influence the work of the council to ensure policies and strategies engage everyone.	• Ensure community voices are heard in council planning activities, allowing barriers to be reduced based on feedback	N/A – Rushcliffe Borough Council	✓	✓	
Reach Rushcliffe	Those living in areas of deprivation and vulnerable cohorts at risk of loneliness	• A fund to support local initiatives that aim to tackle loneliness and social isolation in the borough, aiming to identify and support areas of deprivation and vulnerable cohorts of the population	• Reduce adverse affects of loneliness and isolation • Prevent worsening mental health	N/A – Rushcliffe Borough Council	✓	✓	
Reduce potential ED attends by providing guidance, information and support to those seeking asylum and who may use urgent and emergency services as first line for primary care needs.	Those seeking asylum and refugees	Through cross organisational working with Rushcliffe Borough Council, GP Clinical Lead, Partners Health, Nottingham CCG, and Connected Notts will implement a digital platform which both identifies patient cohorts and supports them to navigate and access wider health, social care and voluntary services to reduce health inequalities, improve access at the right time and place and improve health outcomes. This will work along side care co-ordination which already established in Rushcliffe is likely to need further capacity. Develop and implement a digital inclusion strategy for asylum seekers, to access healthcare, right time, right place, promoting health prevention and selfcare through greater knowledge and inclusion	• Increase ability to selfcare through improved lifestyle choices, to prevent new onset and/or deterioration of long-term conditions; adding quality to life years with digital inclusion as a starting platform	Rushcliffe PCN	✓	✓	
Carlton Insight	All Carlton Residents	Community representatives come together with professionals to assess data, develop local coproduced health solutions and address gaps in provision.	• Improve health and wellbeing outcomes for the residents of Carton	N/A Gedling Borough Council	✓	✓	

South Notts Place Based Partnership & PCN Initiatives

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Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Hucknall (Broomhill & Butler's Hill)		ADC are committed to prioritising resources and focus on areas of greatest need for health improvement. Work in Hucknall will remain a priority area. Key priority areas identified are: - Disabled people, including those with a LTC - Adults experiencing multiple disadvantage - Low income families, including children and young people within them - Residents significantly impacted by Covid 19 pandemic	• Improve the health and wellbeing of the residents of Broomhill and Butlers Hill, especially those who are most deprived.	N/A – Ashfield District Council	✓	✓	✓
Health promotion Working in collaboration with Borough Councils and partners to help increase awareness to those living in the most deprived areas of the PCN to increase access to preventative services. An additional focus on pre-diabetic patients.	Those living in Arnold and Calverton and Hucknall	• Promote preventative services via link worker and Base 51 and practice staff. • Increase awareness of diabetes via social media platforms, Gedling BC contacts/newsletter • Increase awareness of preventative services via Envisage screens, mobile phone messaging, conversations with patients • Increase referrals to link workers and Base 51 to enable signposting to preventative services • Invite pre-diabetic patients in for screening • Working closely with SIM health workers to screen patients for diabetes • To work with a digital inclusion officer to support health promotion in all age groups.	• Increased number of additional patients screened for diabetes through the NHS Health Check and opportunistically; • Increased number of referrals of those identified with pre-diabetes; Increased number completing a preventative programme for weight management. • CPCS to increase access to patients and promote good health management and BP measurement and support appropriately with conditions that do not require a GP appointment • Extended Hours continue to be on offer for patients to access to help manage their health care needs and requirements • Patient experience to continue to be monitored via comments on social media platforms, NHS Choices and Friends and Family surveys • Review data to understand outcomes and how the intervention impacts	Arnold and Calverton Byron	✓	✓	✓

South Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Hucknall Cavell Centre	All registered patients of Byron PCN GP practices, with a focus on Diabetes, Cardiology, Respiratory, Alcohol and Drug misuse, and Elderly Care/Frailty	Cavell Centres will offer a range of joined-up health and social care services closer to home for the patient. The Centres form part of a national estates programme and are designed around a core primary care offering, but also promote the co-location of community services, outpatients, diagnostics and other NHS health services in addition to third sector and Local Authority services (e.g. social care and housing support); helping to support the wider determinants of health. Occupation of the Centres will be informed by Primary Care Networks (PCNs) and local system priorities based on population health data and demographics.	• Access to both medical and non-medical health and wellbeing services closer to home • Improved patient experience • Emphasis on preventative care will result in a reduction of long term, chronic illnesses • Emphasis on service integration will result in better holistic care and improved patient outcomes	Byron	✓	✓	✓
Cancer Screening for patients with Learning Disabilities	LD patients within Arrow Health PCN.	The PCN have in place a GP Fellow who will be working with the 6 PCN practices to identify necessary cancer screening interventions for LD Patients i.e. cervical and breast cancer.	• Putting interventions in place and assessing its effectiveness. • Detection of cancer at earlier stages in patients with LD	Arrow Health	✓	✓	✓
Advice on Prescription	Patients presenting to primary care due to social welfare issues, such as debt, housing and benefit issues,	There is a direct link to the health and wellbeing of people and their access to money and resources. There is also evidence that people experiencing social welfare issues, such as debt, housing and benefit issues, present more frequently to primary care services and that primary care clinicians are spending increasing amounts of time discussing such non-clinical issues with their patients. Advice on Prescription is a service in which people can be supported to address difficulties with their financial situation is through specialist advice. Clear findings of Advice of Prescriptions services is that is very different to broader social prescribing services, and they meet patient's needs in different ways. Advice on Prescription supports clients with their advice needs, and is seen as a 'problem-solver', which can then mean that they are better able to engage with social prescribing services, and gain more from these services.	• Improving the health, wellbeing and resilience of the population • Reducing deprivation • Promoting the resilience of general practice by reducing workload that is linked to debt and benefits	Synergy Health, Arrow Health, Bryon, Arnold & Calverton, Nottingham West	✓	✓	

South Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Reduction of the Heart Failure backlog	Patients with a diagnosis of heart failure awaiting cardiac rehabilitation.	A heart failure transformation group has been established to address inequalities that exist for current heart failure patients in the South locality. The aim is to pilot a cardio-pulmonary rehabilitation service over a 4-month period to address a current backlog of heart failure patients. These patients will be reviewed by a clinical team to ensure care and medication plans are in place and robust, to manage their current presentation to avoid attendance and/or admission to hospital. A multi-disciplinary approach will be taken through a range of health care professionals including a clinical pharmacist, physiotherapist, heart failure nurse and Community Pharmacy PCN leads. This will include an education programme for patients with a diagnosis of heart failure or COPD or both.	• Quicker access to cardio-pulmonary rehabilitation services • Better self management of condition • Better ability to identify exacerbations early to prevent significant deterioration and admission to secondary care • Improved physical ability and quality of life for patients	Synergy Health, Arrow Health, Bryon, Arnold & Calverton	✓	✓	
Recruitment of Digital and Social Inclusion Co-ordinator	Older people, people in lower income groups, those with disabilities, people with fewer educational qualifications.	Through digital inclusion we plan to support those within our PCN who are currently digitally excluded to access primary care services.	• Supporting those digitally excluded within the PCNs to access primary care services to maintain their wellness / ongoing medical needs without the need to access secondary care services.	Synergy Health, Arrow Health, Bryon, Arnold & Calverton	✓	✓	

Mid-Nottinghamshire Place Based Partnership

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

Integrated Care System
Nottingham & Nottinghamshire

Mid-Nottinghamshire Place Based Partners

Nottinghamshire County Council

Ashfield District Council

Mansfield District Council

Newark & Sherwood District Council

NHS Nottingham and Nottinghamshire Integrated Care Board

NHS East Midlands Ambulance Service NHS Trust

Ashfield Voluntary Action

Newark & Sherwood CVS

Mansfield Community & Voluntary Service

pics Primary Integrated Community Services Ltd

healthwatch Nottingham

NHS Nottingham University Hospitals NHS Trust

NHS Sherwood Forest Hospitals NHS Foundation Trust

NHS Nottinghamshire Healthcare NHS Foundation Trust

6 Primary Care Networks (PCNs):
GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices.

Mid-Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Bellamy Road Estate, Mansfield	Residents of Bellamy Road Estate	To gather general practice intelligence and to develop a whole-system approach to support these priority areas to look at opportunities to do things differently led by the needs of the community. • A whole-system approach will be developed to support these priority areas to look at opportunities to do things differently led by the needs of the community. • Positive outcomes are already being achieved through the work being undertaken by the community officer working on the estate, collaborating with a local college has seen a horticulture course, first aid and food hygiene course being undertaken on the estate and attended by a number of residents.	Improving access to healthcare for health and inequalities and meeting the needs of the local population.	N/A – PBP Partners	✓		
Coxmoor Estate, Kirkby in Ashfield	Residents of Coxmoor Estate	To gather general practice intelligence and to develop a whole-system approach to support these priority areas to look at opportunities to do things differently led by the needs of the community. • A whole system approach will be developed to support these priority areas to look at opportunities to do things differently led by the needs of the community. • Talks with services already on the estate are ongoing and the option of using a local church to hold events and a drop-in session going forward are happening, also they are currently looking for community resource gaps within the community, they have also done a drop in at Ashfield Health Village for Men and LGBTQ community.	Improving access to healthcare for health and inequalities and meeting the needs of the local population.	N/A – PBP Partners	✓		
Vaccination Health Inequalities	Targeted work on particular communities and cohorts with low uptake	Targeted work on particular communities and cohorts with low uptake • To promote and encourage vaccination for areas and cohorts of low uptake (race and ethnicity, inequalities by geography and deprivation, age, clinically extremely vulnerable, maternity, LD & autism, homeless refugees, asylum seekers, dementia, SMI and vaccine hesitancy) • Data is utilised to agree immediate priority areas of focus and cohorts. • The vaccination vans offer a door-to-door vaccination service and pop-up clinics in communities. Vaccination sanctuaries are also being held to address any vaccine hesitancy or concerns. • Health and Wellbeing hubs are also being based in key locations engage and support local communities and provide advice to help people keep themselves protected against Covid-19 and improve their health and wellbeing.	Reduced inequality in vaccine uptake rates leading to reduced inequalities in outcomes	N/A – PBP Partners	✓	✓	✓

Mid-Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Health and wellbeing pop up clinics	Health promotion activity and interventions	· Health and wellbeing pop ups organised (one in each district and according to geographical area). · Pop ups include covid testing, handing out lateral flow tests, GP registration and care navigation. · CVS deliver leaflets to promote, advertise via social media and provide care navigation for patients (directing patients into the correct services including extended hours).	Making health care more accessible	N/A – PBP Partners		✓	✓
Opt Out Smoking Cessation Referrals - Primary Care	Patients who smoke who live in socio economic decline 1 (10% most deprived)	· If the patient doesn't opt out within 14 days, they are referred to the smoking cessation service. · Patients will then be contacted by Your Health Your Way, Nottinghamshire's integrated wellbeing service, and offered enrolment onto a smoking cessation programme. · As of July 2022, 3 practices in Ashfield have participated. In total there were 643 patients who did not opt out of the text message and were therefore referred to Your Health Your Way. This project is now being rolled out across all practices in Mid Notts	Decrease in the number of smokers.	All		✓	✓
Opt Out Smoking Cessation Referrals - Secondary Care	Smokers who are on the elective waiting list for surgery.	• All patients that are on the waiting list for elective surgery are matched with an active smoking status in GPRCC. An opt out text message is then sent to all smokers. If the patient does not opt out within 14 days, they are referred to Your Health Your Way.	To decrease the number of smokers and improve surgical outcomes.	N/A – PBP Partners		✓	✓
DWP Access to Work Project – Ashfield South PCN	To try and support patients on long term sick to get back into work	• Access to work can offer discretionary grant-based awards to pay for work related support to try and get people who are on long term sick back into work. This includes mental health support, specialist equipment, travel, support workers etc. • Patients are identified using a SystmOne report and contacted by a SPLW to discuss a referral. • 50% of patients contacted in Ashfield agreed to a referral to the Access to Work scheme. This is now being expanded across Mid Notts.	Providing services to patients out of work due to ill health.	N/A – PBP Partners			✓
GP Registration (Mansfield)	To encourage people who aren't registered with a GP practice to register and provide support doing this	• GP registration is a joint project with Mansfield PCNs and Mansfield CVS. GP registration sessions are being held in Mansfield assisting people with completing the necessary forms for registering with a GP practice. • Priority areas of focus are homeless and non-English speaking residents – however all cohorts are being targeted. • CVS Health and Wellbeing pop ups include GP Registration. • Comms have been sent to all GP practices ensuring practices all have the correct information on their websites regarding GP registration (patients do not need ID or proof of address to register).	Ensuring people at risk of health and inequalities have access to healthcare.	N/A – PBP Partners	✓		✓
Financial Incentives for Pregnant Women who smoke	To encourage pregnant women to stop smoking	• Young pregnant women in the lowest socioeconomic decile are most likely to be smokers at delivery. Financial incentives have shown to be effective in pregnant smokers. • Sherwood Forest Hospitals are offering financial incentives for pregnant women to stop smoking. Patients who join the financial incentive scheme can get up to £400. • The financial incentive scheme is now in month 5 (as of July22) – SFH are collecting milestones and outcomes for each participant for evaluation.	Decrease in the number of pregnant smokers.	N/A – PBP Partners		✓	✓

Mid-Notts Place Based Partnership & PCN Initiatives

Integrated Care System
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Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Fuel Poverty	Patient who are at the highest risk of cold related harm to be referred to the Healthy Housing Service.	• Patients living in fuel poverty who are at risk of cold-related harm and hospital admissions are identified using e-Healthscope. • Patients are then contacted and offered a referral to the Healthy Housing Service who can offer free or subsidised home heating upgrades such as insulation and fuel vouchers and a range of other interventions. • This has been piloted in Rosewood PCN. 31 referrals have been made into the healthy housing service. This is now being expanded to Ashfield North and Sherwood PCN.	To prevent hospital admissions due to cold related harm and to improve health through living conditions.	Rosewood Ashfield North Sherwood		✓	
Virtual Wards	Supporting early discharge	• Supporting early discharge from hospital using pulse oximeters and digital remote monitoring.	Reducing length of stay	N/A – PBP Partners		✓	
Asthma Biological Therapy	To improve access to severe asthma biologics	• Patients with severe asthma to be identified using e-Healthscope and referred via email for Asthma Biological Therapy. • A virtual MDT will then be held by the respiratory consultant at SFH to discuss whether the patients are eligible. • Eligible patients will then be given monoclonal antibodies by subcutaneous injection every 2-8 weeks. • The purpose of the injections is to reduce the need for systemic corticosteroids in order to spare patients from their long-term side effects.	To help improve asthma and decrease the risk of long term side effects from corticosteroids	Piloted at Abbey Medical Centre – to rolled out across Mid-Notts		✓	
Diabetes Case Finding (Sherwood PCN)	To invite patients at high risk of type 2 diabetes for a HBA1C.	• The aim of the project is for early diagnosis of Diabetes. • Patients at risk of type 2 diabetes are identified using E-Healthscope. These patients are then invited for a HBA1C blood test. There is a payment associated for referrals into the National Diabetes Prevention Programme. Newly diagnosed patients may be suitable for the NHS Low Calorie Diet Programme.	To prevent CVD	Piloted at Abbey Medical Centre – to rolled out across Mid-Notts	✓	✓	
Hypertension Case Finding (PCN DES)	To identify patients with a last high blood pressure reading without diagnosis of hypertension.	• Patients living in socio economic decile 2 (20% most deprived) with a last high blood pressure reading without diagnosis of hypertension are identified using e-Healthscope. Patients are contacted by the Health and Wellbeing Coach and advised to record a home blood pressure diary for 5-7 days. • If the average reading is raised - GP review for further management.	Case finding patients to prevent CVD.	N/A – PBP Partners	✓		✓
NHS Low Calorie Diet	Obese type 2 diabetic patients are identified for the programme.	• Patients to be identified using e-Healthscope. • This is a 12-week meal replacement drink programme that encourages rapid weight loss. • Over half achieve remission of Diabetes • Clinician needed to refer because medications are stopped when meal replacement starts.	Improve the management of diabetes	N/A – PBP Partners		✓	

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Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Pulmonary Rehab Case Finding	Patients with COPD to be referred for pulmonary rehab.	· Patients with COPD who haven't had pulmonary rehab in the last 24 months are identified on e-Healthscope and contacted by the care navigator to discuss a referral.	To help improve COPD rates and outcomes	N/A – PBP Partners		✓	
National Population Health Management Programme – PLACE Workstream PCN Coaching Sessions	To develop a scalable plan to restore services inclusively and address inequalities by linking elective data with person level population health analysis	The Population Health Management Development Programme's Place Workstream has commenced. At the 3rd Action Learning Set it was agreed that the focus cohort for the rest of the programme would be Younger People with Mental Health Conditions and planning interventions and assessing impact on the system as a result. Due to the time commitments for the PCN workstream it was agreed to incorporate the PCN workstream into the PLACE wokstream. The GP Coaching sessions provided by Optum have been used to help PCNs design a proactive intervention. Ashfield North are case finding patients aged 20-39 who are obese and have asthma. Patients with mental health problems are excluded. Identified patients are signposted into existing community assets and services.	Meeting the future needs of local populations and reducing future risks to ill-health, utilisation and financial risk Changes to care delivery to address unwarranted variation in health outcomes.	N/A – PBP Partners		✓	
Dementia - Recruitment of Admiral Nurses. (PCN DES)	Target carers (Children, Adults) who are caring for loved ones with Dementia	· Providing support by way of clinics, telephone, counselling or face to face consultation · Asset mapping, creating links engaging with other organisations such as working age dementia service, dementia support groups, carers hub, links to translators, locate free course help reduce inequalities · Education, sharing information around risk factors and risk reduction · Improving ways to identify and support carers	Improvement in the quality of life and mental health outcomes for both carers and their loved ones with Dementia Educate carers around the disease, informed decision making, preventing a crisis	N/A – PBP Partners	✓	✓	
Social Prescribing Link Workers and Health and Wellbeing Coaches	To help reduce health inequalities by supporting people with complex issues affecting their wellbeing	·Engaging with local assets, linking in with tertiary voluntary sector organisations · Initiating local regular venues for holding group activity	· Improving quality of life for patients · Increasing knowledge of local services and assets · Improving physical activity and education around the importance of diet and wellbeing	N/A – PBP Partners		✓	✓
Social Prescribing in ED	Engagement with patients that are by-passing Primary Care by choosing to have their primary care needs met in an urgent care setting.	By collaboratively working with secondary care colleagues, social prescribing support will be provided to patients arriving at ED with complex socio-economic issues rather than requiring medical intervention. Patients will be advised on how to correctly access services, provided with support to register at a GP practice of their choice and will receive holistic care tailored to their needs through onward referrals to established services within their community. Education will also be provided to staff in ED on services that are available that will help reduce inappropriate attendances at A&E.	To create a health prevention and promotion environment in ED that takes a behavioral/lifestyle approach rather than the current medical approach.	N/A – PBP Partners	✓	✓	✓

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Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Strength Based Approaches	All	Managing resources and work with partners across the department and the wider system effective, efficient and consistent in supporting good outcomes for people.	Support people to enjoy meaningful lives where they can make positive contributions to their families, networks and communities. Support people to live as independently as possible Enabling them to be in control of their lives and support and having a better quality of life	N/A – PBP Partners	✓	✓	
Community Urgent Response and Rehab Team (CURRT) via Call for Care	Patients at risk of hospital admission	The CURRT Team provide care navigation, urgent response and short-term intensive rehabilitation to support timely discharge from hospital and prevent unnecessary hospital admission. Providing additional project management capacity to support the integration of the delivery of the Strength-Based approach innovation site programme funded by Nottinghamshire County Council to include the Living Well Social care teams, health, relevant PCN ARRS roles and community and voluntary sector within the innovation sites. Urgent Response – Following a referral from health and social care professionals the team will provide a face-to-face assessment to prevent hospital admission within 2 hours. Also, initiation of most appropriate community service and signposting to other health and social care providers. Hospital at home – Diagnosis, treatment and review of medically unwell patients who do not require acute medical intervention and are stable to be cared for at home. Supporting timely discharge for continued medical monitoring and /or intensive rehabilitation at home.	Reduction in emergency admissions and ED attendances. Increased access to alternative services. Reduce avoidable hospital admissions	N/A – PBP Partners	✓	✓	
GP Prescription Scheme	Patients with a new diagnosis of depression or anxiety	Membership to try and help improve their mental health. Also signposting into IAPT. Patients with diabetes or obesity are offered a gym membership. Patients are identified using e-healthscope. Also, in the process of creating a pop up in SystmOne. Patients to then be contacted and offered a referral onto the GP exercise referral scheme.	To improve mental health To encourage weight loss in obesity and patients with diabetes	N/A – PBP Partners	✓	✓	
Reducing alcohol consumption	Patients with harmful drinking	Patients who are drinking harmfully are identified using e-healthscope. Patients are then contacted by a social prescribing link worker to discuss a referral to Change Grow Live, Nottinghamshire's drug and alcohol support.	Reducing alcohol consumption	N/A – PBP Partners	✓	✓	
Smoking Cessation	Smokers	Comms campaign to encourage smokers to use e-cigarettes instead of smoking. E-Cigarettes have been found to be a lot less harmful than smoking.	To decrease the number of smokers.	N/A – PBP Partners	✓	✓	✓

Mid-Notts Place Based Partnership & PCN Initiatives

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Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	CS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Exploration of the care pathways for children and young adults with mental health or behavioural symptoms around the health, education and social care services.	Children ages 5-16 with mental health or behavioural symptoms.	• Consult stakeholders in the pathways of care from wellness to illness affecting children and young people (such as schools, healthy families team members, child and adolescent mental health services, educational psychology, community sector leaders and organisations). • listen to their experiences and reflect on how to do things differently in the future. • Increase awareness of health services amongst children and young people (through greater engagement with schools, local media and consultation with third sector organisations who have close links with young people).	To remove barriers to healthcare	Ashfield North		✓	
Patients with mild to moderate COPD	Patients with Chronic Obstructive pulmonary disease	• To invite patients within the PCN with mild to moderate COPD for an appointment. The aim is to educate patients about their condition, advise on self-management and when to seek help. • To also design a workshop based on group sessions to encourage and offer advice on exercises, health living, educate to increase Covid / Flu / Pneumonia vaccination, to reduce infection exacerbation and prevent emergency admissions. • To work with the smoking cessation project to encourage COPD patients to stop smoking .	To educate patients with mild to moderate COPD on self-management and lifestyle advice to reduce emergency admissions.	Ashfield South		✓	✓
Physical health checks for patients with SMI	Patients with SMI	To provide a PCN clinic to complete physical health checks for patients with SMI with help from the health improvement worker.	To improve physical health in patients with SMI	Ashfield South		✓	✓
Increase the uptake of annual health checks for learning disability patients	Patients with LD	A LD Practitioner has been employed by the PCN to focus on pts on the LD register, who have not had a completed annual health check. The focus is for increasing uptake on patients that have not engaged with the practice and appointments can be offered in their own homes or day centres etc.	To improve the care for learning disability patients	Mansfield North and Rosewood PCNs		✓	
Identify, support and increase uptake of health checks for patients with severe mental illness.	Patients with Severe Mental Illness	To employ an SMD Care CoOrdinator, SMD Social Prescriber, Mental Health OTs, Mental Health Nurse and Health & Wellbeing Coach to support patients experiencing Severe Mental Illness. The team are to support patients to explore opportunities available to them to improve their mental wellbeing, look at the lifestyle and offer support for areas which could be/are contributing to the level of the SMI as well as offering support with 1-2-1 Mental Health and Health & Wellbeing sessions	To improve physical health in patients with severe mental illness	Rosewood		✓	✓
Improve understanding of barriers to accessing healthcare in the most deprived Type II Diabetic population in Sherwood PCN.	Patients with type II diabetes who live in socio economic decile 1	• Conduct in-depth interviews with the ten most deprived Type II Diabetic patients from each practice population to discuss their management, self-management and any barriers they experience to care. This may involve onward referral/signposting to appropriate services, support groups, PCN Social Prescribing Link Workers and/or Health & Wellbeing Coach. • To feed back findings to PCN practices and local services to highlight any changes needed to design services around our most deprived population. This may include group consultations to encourage the development of support from within communities themselves.	Long term improved outcomes for patients with type II diabetes.	Sherwood	✓	✓	✓
Improve lifestyle factors for patients at CVD and Stroke Risk	Patients at risk of CVD and stroke	To look at potentially treatable lifestyle factors for CVD and stroke prevention such as untreated hypertension, atrial fibrillation, diabetes and lifestyle factors such as obesity, smoking and alcohol excess. To implement targeted support and interventions for these cohort of patients including patients who don't present to primary care by collaborating with local partners for health promotion in the community.	To decrease the risk of CVD and Stroke through improving patients lifestyles.	Newark		✓	✓

Bassetlaw Place Based Partnership

Bassetlaw Place Partners have collaboratively developed 6 place priority areas and a range of initiatives to support achieving key local ambitions
Bassetlaw Place has a focus on marginalised communities due to rurality, deprivation and ethnicity, with minority ethnic group including individuals from Eastern European communities.
21% of the Bassetlaw population live within an area of high deprivation

Integrated Care System
Nottingham & Nottinghamshire

Bassetlaw Place Based Partners

Nottinghamshire County Council

NHS
Nottingham and Nottinghamshire
Integrated Care Board

3 Primary Care Networks (PCNs):
GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices.

Bassetlaw DISTRICT COUNCIL
North Nottinghamshire

healthwatch

BCVS
Bassetlaw Community and Voluntary Service

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

NHS
Nottinghamshire Healthcare
NHS Foundation Trust

Bassetlaw Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Recreational green spaces	All Bassetlaw population	Publication of Bassetlaw Local Plan: Planning and Open Spaces Chapter.	Increased access. Increasing ill health prevention. Improved outcomes experiences	N/A – PBP Partners	✓	✓	
Green social prescribing initiatives	All Bassetlaw population	VCSE initiatives focused on green and blue social prescribing across Place, promoting healthier lifestyles and reduced air pollution	Increased access. Increasing ill health prevention. Improved outcomes experiences	N/A – PBP Partners		✓	
Respiratory care	Those with respiratory conditions	Respiratory care pathway review as part of virtual ward development leading to Reduction in emergency admissions related to respiratory (adults and children) (Baseline 19/20)	Increased access. Increasing ill health prevention. Improved outcomes experiences.	N/A – PBP Partners		✓	✓
Financial sustainability	Those at risk of financial insecurity	Financial sustainability for Place and system to deliver local initiatives that reduce HI and improve outcomes.	Access, experiences and outcomes	N/A – PBP Partners		✓	
Bassetlaw Emergency Village	Those at risk of hospital admissions	Meeting same day/urgent care needs and developing pathways of care across high volume patient flows into ED. Increasing monthly average of patients presenting at ED streamed into alternative pathways of care including self care.	Increased access. Increasing ill health prevention. Improved outcomes experiences	N/A – PBP Partners	✓	✓	
Increased crisis Support	Those with a mental health crisis	Increase in crisis support for people with SMI e.g. crisis sanctuaries, safe spaces, crisis helpline, 24/7 CRT	Increased access . Increasing ill health prevention. Improved outcomes experiences.	N/A – PBP Partners	✓	✓	
2hr Urgent Community Response Service	Those at risk of hospital admissions	Supporting admission avoidance, patients are supported to remain safely at home with appropriate services in place Reduced non-elective activity – ED attendances and non-elective admissions· Reduce ambulance dispatches and conveyances to ED Community.	Increased access . Increasing ill health prevention. Improved outcomes experiences.	N/A – PBP Partners	✓	✓	
Reducing Childhood Obesity	Children classified as overweight/obese	Childhood obesity/family weight management. Programmes with partners including a focus on most deprived areas	Reduction in childhood obesity, improve health outcomes for CYP.	N/A – PBP Partners	✓	✓	✓
Improving access to mental health and wellbeing initiatives	CYP in most deprived areas with	Community mental health and wellbeing services for children and young people including a focus on most deprived areas: PCN based CYP Social Prescribing Link workers School based MHST VCSE delivered mental health provision LGBT+ support Kooth on line mental heath support	Increased access. Improved outcomes. Increasing ill health prevention. Improved experiences.	N/A – PBP Partners	✓	✓	✓
Evergreen COVID and Flu vaccination campaign	Under 25s	PCN COVID and Flu vaccination clinics- community based vaccinations utilising health bus for eligible CYP <25 years including a focus on most deprived areas.	Improved experiences. Improved access to services. Improved outcomes. Increasing ill health prevention.	N/A – PBP Partners	✓	✓	✓

Bassetlaw Place Based Partnership & PCN Initiatives

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Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Improving Early Starts initiatives	Pregnant smokers	Improved Maternity care services working in parentship with DBTH. COVID and flu vaccination programmes to increase uptake in pregnant women Smoking in pregnancy support	Improved experiences. Improved access to services. Improved outcomes. Increasing ill health prevention.	N/A – PBP Partners	✓	✓	✓
Harworth and Bircotes Youth Hub	CYP	Multi service Youth Hub for young people, promoting earlier access to appropriate services.	Improved experiences. Improved access to services. Improved outcomes. Increasing ill health prevention.	N/A – PBP Partners		✓	
Increasing volunteering initiatives and opportunities	CYP	VCSE led- Point of View Volunteering Project, increasing access to volunteering initiatives for younger people	Improved experiences. Improved access to services. Improved outcomes. Increasing ill health prevention.	N/A – PBP Partners		✓	
Severe Mental Illness (SMI) initiatives	People with SMI	Individual Placement Support (IPS) Employment support service, increasing number of people on SMI register supported into employment Health checks for people with SMI and LD	Increased access. Increasing ill health prevention. Reducing HI. Improved outcomes experiences	N/A – PBP Partners	✓	✓	✓
Mental health and wellbeing initiatives	Adults with mental health issues	Increase in provision of mental health services and roles for adults: Admiral Nurses and Mental Health Practitioner roles in PCN's IAPT Services Bereavement support services Street Watch Programmes VCSE mental health services and projects Peer support workers Community based Health & Wellbeing Coaches Working Win employment support services Implementation of Comms initiatives to support public awareness of local mental health services	Increased access to services Improved mental health and wellbeing outcomes. Increasing ill health prevention. Improved experiences.	N/A – PBP Partners	✓	✓	
Suicide Prevention Alliance and Initiatives	Those affected by suicide	Development of Suicide Prevention Alliance, local pledges and initiatives reducing reported rates of self-harm and suicide Men's suicide prevention support groups Survives of Bereavement from suicide support groups Street Watch Programmes Suicide prevention initiatives via the Small grants schemes	Increased access. Improved mental health and wellbeing outcomes. Increasing ill health prevention. Improved experiences.	N/A – PBP Partners	✓	✓	
Early cancer diagnosis focused task and fish groups and initiatives		Increase cancer cases diagnosed at Stage 1 or 2 as a result of local initiatives: Implementation of Targeted Lung Health Checks -50yrs+ ex-smoker/occupation. Implementation of 'C the Signs' initiative across all GP practices Increased cancer Screening programmes Cancer Alliance Behavioural Science nudge techniques implementation across all GP practices Comms and public engagement cancer awareness campaigns supported by all partners PCN Cancer Champions	Increased community engagement. Increased access to services. Improved outcomes. Increasing ill health prevention. Improved experiences.	N/A – PBP Partners	✓	✓	✓

Bassetlaw Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Smoking Cessation initiatives	Smokers	Quit Programmes reducing health inequalities and premature mortality related to smoking. Pharmacy sign up local e-voucher NRT scheme	Increased access to services. Improved outcomes. Increasing ill health prevention. Improved experiences.	N/A – PBP Partners	✓	✓	✓
Bassetlaw Food Insecurities Network	Those living in more deprived area	Development of food hubs with a focus on deprived areas. Slow cooker meal preparation courses delivered within the community. Community eating events.	Increased access. Improved health and wellbeing outcomes. Increasing ill health prevention. Improved experiences	N/A – PBP Partners		✓	
Increasing access to community prevention initiatives	Overweight adults	Adult weight management, Physical Activity, Alcohol reduction. Homeless Health Team-Out of Hospital support	Increased access. Improved health and wellbeing outcomes. Increasing ill health prevention. Improved experiences	N/A – PBP Partners	✓	✓	
Evergreen COVID and Flu vaccination campaign	All	PCN COVID and Flu vaccination clinics- community based vaccinations utilising health bus	Increased access. Improved health and wellbeing outcomes. Increasing ill health prevention. Improved experiences	N/A – PBP Partners	✓	✓	✓
Health Improvement Team (HIT) focused on increasing access to care	Those living in more deprived area	Bassetlaw Health Improvement Team (HIT) focusing an annual physical health checks and follow up care for patients in deprived areas	Increased access. Improved health and wellbeing outcomes. Increasing ill health prevention. Improved experiences	N/A – PBP Partners	✓	✓	✓
Marginalised Communities initiatives	Marginalised communities	Increase community engagement and prevention initiatives. Improving equity of access for more marginalised communities due to rurality, deprivation or ethnicity (i.e. Bassetlaw's Eastern European communities). Focusing on addressing equity of access and outcomes for 20% most deprived communities, (IMD1 & 2 cohorts) fully aligned with both Core20Plus5 expectations and Bassetlaw District Councils Thriving Neighbourhoods Strategy 2021-2025.	Increased access. Improved health and wellbeing outcomes. Increasing ill health prevention. Improved experiences	N/A – PBP Partners	✓	✓	✓
Community engagement and participation initiatives	LGBT+ Communities	Increased engagement and focus on reducing health inequalities across LGBT+ communities, improving mental and physical health outcomes	Increased access. Improved health and wellbeing outcomes. Increasing ill health prevention. Improved experiences	N/A – PBP Partners	✓	✓	
Increased public engagement and Health Promotion initiatives	All	Mobile Health bus utilization for health promotion/advice. Communication and public awareness plans. Community events, increasing citizen engagement and awareness of health promotion and local services. Promoting earlier access to appropriate services.	Increased access. Improved health and wellbeing outcomes. Increasing ill health prevention. Improved experiences	N/A – PBP Partners	✓		

Bassetlaw Place Based Partnership & PCN Initiatives

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Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Increasing inclusiveness & independence initiatives	Those at risk of digital exclusion	Digital confidence and competence initiatives, increasing digital confidence and competence and reducing HI Roving exercise support for rural communities and older people	Increased access to services Increased ill health prevention. Improved outcomes and experiences	N/A – PBP Partners	✓	✓	✓
Increased all age frailty support	Those at risk of frailty	Virtual Wards- Frailty and Respiratory focusing on patients deemed to be frail and those unable to access services	Increased access to services Increased ill health prevention. Improved outcomes and experiences	N/A – PBP Partners		✓	
Reducing social isolation and loneliness initiatives	All	Social prescribing roles. VCSE delivered community programmes. Community transport schemes	Increased access to services Increased ill health prevention. Improved outcomes and experiences	N/A – PBP Partners	✓	✓	
End of Life and Palliative Care	Those at end of life	Integrated pathway development	Increased access to services Increased ill health prevention. Improved outcomes and experiences	N/A – PBP Partners	✓	✓	✓

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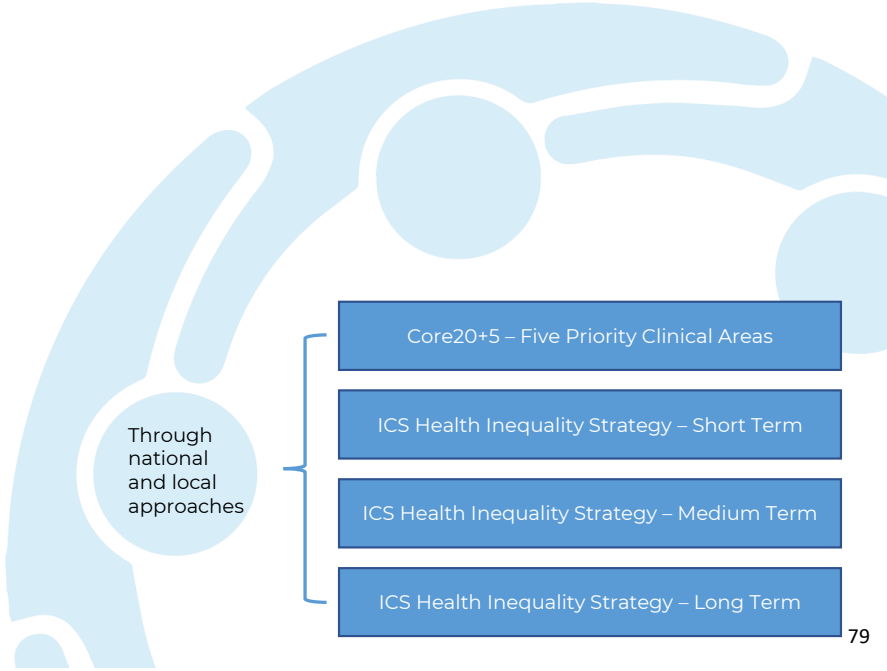
E. System Implementation Plans

Includes system level initiatives, complimenting and building on targeted actions taking place through from PCNs and Place Based Partnerships.



The Plus 5 – The ICS Plan

Integrated Care System
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Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience/Outcomes
Maternity Continuity of Carer (COC)	Ensuring continuity of carer for 75% of women from BAME communities and from the most deprived groups	✓	✓	• Achieving full implementation of COC continues to remain a considerable risk. It is anticipated that the LMNS will not achieve the national target for CoC due to current staffing challenges, and are likely to be at least a year behind target achievement. • An equity analysis for the system has been completed which will inform our planning of how to tailor COC to those most in need. • Priorities for implementation for COC being redefined. • A new digital maternity information system will be implemented which will support the opportunity to understand maternity care across different population cohorts • NUH have received external funding from Small Steps Big Changes to recruit and train a new Maternity Support Workforce.	Experience and Outcomes
SMI Health Checks	Ensuring annual health checks for 60% of those with SMI (regional average is currently at 28.3% and national average at 30%)	✓		The ICS are working to the LTP Ambitions Toolkit. In 21/22 this equates to 4,881 patients having an annual healthcheck. The system is at approx. 38% which is above the national averages . Health Improvement Workers (HIW) have had a significant impact on uptake. • Monthly monitoring of practice and PCN level data, identifying areas requiring additional focussed support. Performance dashboards are reviewed at GP and PBP level. • Continued engagement with the regional PH SMI clinical network meetings, sharing learning and implementing best practice. • The PHSMI Local Enhanced Service (LES) started this year with 98% of practices signed up to the incentive scheme to deliver the 5 additional supporting indicators as part of the physical health checks. • Performance against the PHSMI LES is monitored monthly, enabling the system to respond in a timely manner and flex support accordingly. This data is shared with the PH SMI Steering Group to agree prioritisation of outreach support from the Health Improvement Workers (HIWs) to primary care. Communications to practices continue to promote the undertaking of physical health checks. • HIW posts continue to support the uptake of physical health checks for patients accessing secondary care mental health services.	Access, Experience and Outcomes

The Plus 5 – The ICS Plan

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience /Outcomes
Chronic Respiratory Disease	A clear focus on COPD, driving up uptake of COVID, Flu and Pneumonia vaccines	✓	✓	• Lung Health Check Units are in areas where there is higher prevalence of respiratory disease. This is being used as an opportunity to find those who are undiagnosed with chronic respiratory conditions. • COVID and flu vaccination programmes are targeting those who are clinically vulnerable. Strategy being developed for 22/23 that will align the approach and combine efforts across flu, pneumonia and COVID vaccines • Weekly reporting is utilised to monitor and target uptake	Access, Outcomes
Early Cancer Diagnosis	75% of cases diagnosed at stage 1 or 2 by 2028 N&N have seen an increase in 20/21 resulting in approx. 30% of cancers diagnosed at an early stage.	✓ ✓ ✓ ✓ ✓	✓ ✓ ✓	**Targeted Lung Health Check:** Will help to diagnose cancer earlier. Implemented in Mansfield and Ashfield where have higher risk. Initial CT Scans – 1729. 3 Month follow ups – 187. Cancers diagnosed – 13 (20 patients still on an active diagnostic pathway). 7 early stage, 6 late stage. 13% of scans identified incidental findings requiring either secondary care or primary care actions. Nottingham City Project to start in 22/23. **Rapid Diagnostic Concept/Centres** (RDC): Over £1m funding received to streamline cancer diagnostic pathways. Implementing one stop diagnostic shops, holistic assessment of symptoms, coordinating diagnostic tests, single point of contact for patients. Excellent progress being made with several pathways to go live in Q4. **Galleri blood test pilot:** national study to evaluate role of a cancer blood test to diagnose 50 types of cancer before symptoms are apparent to patients. Underway in Mansfield with all 2000 appointments booked. Will also be implemented in Nottingham City. **Lung cancer hotline:** pilot in Nottingham City with opportunity to roll out wider if successful. Patients will be invited to contact the hotline if experiencing any listed symptoms of lung cancer. Callers will be triaged and have urgent chest CT booked if appropriate. The pathway will therefore bypass GP visit, 2WW referral and chest x-ray. **Community diagnostic hubs:** will be important enablers for all the projects above. ICS received indicative capital funding envelope of £24m over 3 years. Awaiting confirmation of revenue allocation. • Work with Cancer Alliances to develop and implement a plan to - make progress against the ambition in the NHS Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas where rates of early diagnosis are lower. • Timely presentation and effective primary care pathways - working with PCNs to support implementation of cancer early diagnosis as set out in the Network Contract Directed Enhanced Service (DES)	Access/Outcomes Access/Experience/ Outcomes

The Plus 5 – The ICS Plan

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience/Outcomes
Hypertension Case Finding	To allow for interventions to optimise blood pressure and minimise the risk of M.I. and stroke	x		• Hypertension Task & Finish Group set up March 2022 to support implementation and progression of hypertension case finding model as well as ongoing management and optimisation of patients. • Pilot PCNs to be identified using Core20PLUS5 principles to implement model from May 2022. Initially one PCN from each Place Based Partnership (PBP). • Model will build on BP@Home project utilising BP monitors supplied as part of the project. • Community Pharmacy to be key component of the model linking with the Hypertension Case Finding Service. • Work taking place with Connected Notts to provide support to patients via NHS App/PKB with personalised care and support plans – June 2022 • Exploring the use of PCN additional roles to support the case finding in primary care. • Proactive Care Framework for Hypertension to be used to support primary care with the management and optimisation of identified patients, working alongside the case finding model.	

ICS Health Inequality Strategy – Short Term

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience/Outcomes	1	2	3
Restoring NHS Services Inclusively	Waiting List Analysis Long Term Condition Mgmt Mental Health	✓		Waiting list data health inequalities • Quarterly system wide roundtable established to review waiting list data and take forward type and format of analysis • Deep dive analysis carried out in relation to deprivation and ethnicity from referral through to discharge across the urology and cardiology pathways – to be further developed and utilised to inform decision making • Waiting list data being utilised for waiting well services and piloting Link Worker support in this context – wider programme to be developed • Peri-op diabetes pilot implemented and to be evaluated in 22/23 Long Term Condition Management • Specific analysis undertaken has included the impact of COVID on CVD, respiratory and diabetes non-elective admissions – being utilised to inform targeted efforts • Will be analysing missing cancer patients by location and deprivation in order to target efforts A&E • A&E attendances and "health seeking behaviours" analysis being utilised to inform Mental Health • LD/SMI healthchecks • Targeted work being carried out in relation to lower access to IAPT for Asian and South Asian population	Access/Experience/Outcomes	✓		
		✓						
		✓						

ICS Health Inequality Strategy – Short Term

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience/ Outcomes	1	2	3
Ensure Datasets are Complete and Timely	ICS approach to data integrity through the SAIU	✓	✓	Additional information is included in the enablers section. All organisations across the ICS have processes in place to improve the completion rate and accuracy of capturing ethnicity in their patient records – focus will continue during 22/23 ICS will be using local technology that will allow systems to communicate with each other in order to safely share ethnicity information. This will allow individual organisations to use this shared access to improve completion rates and processes can be put in place to improve accuracy if there are any conflicting records. Local databases of GP records have been used to identify Primary Care Networks with a high proportion of 'Not Stated' or 'Unknown' ethnicity codes (ranges from 3%-18%). Practices within these PCNs have been targeted for a pilot programme using direct messaging to patients with 'Not Stated' or 'Unknown' ethnicity code, patients are asked to complete a short survey to update their ethnicity. Project in place to substitute ethnicity codes from secondary care settings where they are available but missing from the primary care record. The governance structures of the ICS includes a Strategic Analytical Unit with representation from analysts across all partners. The SAIU is supported by an operational group and strategic oversight board. The ICS also has a Data and Information Board with a focus on data sharing and data integrity.	Access/Experience/Outcomes	✓	✓	✓
Accelerate Preventative Programmes **(see medium term for alcohol, smoking, obesity)**	Vaccination Uptake (including COVID, flu and pneumonia)	✓	✓	**Vaccination uptake:** Since first going live with the vaccination programme, the ICS has had a strategy and operational focus on increasing uptake for those groups most at risk. The initiatives to target specific areas has developed throughout the programme, recognising the complexity and need for locally designed interventions, which have been supported by robust reporting and the SHAPE tool. A COVID and vaccine inequality report is updated weekly and this is used to target activities. Comprehensive weekly reporting is also produced for uptake of the flu vaccine with teams and PBPs working with practices to target specific populations. Targeting local communities has been effectively implemented through partnership working with the CVS, community champions and local authorities. Plans are currently being produced for the ongoing management of a COVID vaccination programme that includes learnings from actions being taken and the success of these in targeting populations.	Access, Outcomes	✓	✓	✓

ICS Health Inequality Strategy – Short Term

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience/ Outcomes	1	2	3
Accelerate Preventative Programmes **(see medium term for alcohol, smoking, obesity)**	Diabetes (see also transformation programme for children)			Extensive PHM review has been refreshed which will support the implementation of impactful interventions and targeted actions taking into consideration the impact of COVID on the local population. Continuing with transformation programme including pre-op case management for high risk individuals, specifically with a focus to impact on inequities in access and outcomes. Low Calorie Diet – targeted approach to promoting and take up in order to reach the communities most in need. Structured Education – Returning to face to face sessions. Actively promoting structured education. Plans to provide Diabetes UK Type 2 Packs through community pharmacies which supports structured education. NDPP - Targeted campaign to increase uptake of NDPP in cohorts and areas where this is lowest including additional communications and promotional efforts in relation to self-referrals, progress work of local educators that speak multiple languages, attending community events, provider is continuing to recruit patient locality champions (includes 20% most deprived and inclusion health groups). Care Processes & Treatment Targets - LES for diabetes management that supports an improvement in the care processes and treatment targets, including in areas of highest risk.	Access, Experience, Outcomes	✓	✓	✓

ICS Health Inequality Strategy – Short Term

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience/ Outcomes	1	2	3
Accelerate Preventative Programmes **(see medium term for alcohol, smoking, obesity)**	Diabetes (see also transformation programme for children)	✓	✓	Children Transformation programme to address : CYP with type 1 diabetes from ethnic minority backgrounds are more likely to have higher than average HbA1c levels. CYP from the most deprived areas are most likely to have higher HbA1c levels. Those living in the most deprived areas were founds to have a higher risk of retinopathy and albuminuria, and were found to require more psychological support There is evidence showing a lower use of insulin pumps in ethnic minority groups. There is a gap in the percentage of CYP from the most deprived areas and least deprived areas using insulin pumps. This gap is widening. Addressing this inequality is important because technology, such as insulin pumps and glucose monitors, can help people regulate and monitor their diabetes, reducing the risk of hypoglycaemic events, DKA and other long term complications.	Access, Experience, Outcomes	✓	✓	✓
Accelerate Preventative Programmes **(see medium term for alcohol, smoking, obesity)**	Respiratory	✓	✓	Targeted work is being undertaken in relation to disparities in non-elective admissions Assistive technology projects inclusive of digital inequalities approaches Programme progressing to support an increase in the uptake of and completion of pulmonary rehab Severe asthma reviews and asthma biologics. Children Transformation Programme to develop plans to address asthma outcomes which are worst for CYP in more deprived areas and significantly higher rates in minority ethnic groups.	Access, Outcomes	✓	✓	✓
	CVD			Hypertension case finding is part of the ICS CVD priorities and includes working with PBPs to identify "teachable" moments with a holistic approach that is relevant to communities of highest risk. As in the Core20+ approach the PBPs have identified inclusion health groups where consideration of protocols is being undertaken. In relation to CVD management the ICS are progressing with a risk stratified approach to managing the backlog of people with hypertension Working with AHSN and medicines management team to undertake AF screening and review, approach to opportunistic atrial fibrillation screening being reviewed Targeting Blood Pressure at Home through practices in more deprived areas plus consideration of how Social Prescribers can support self-management plans.	Access, Outcomes			

ICS Health Inequality Strategy – Short Term

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience/ Outcomes	1	2	3
Smoking Cessation	Tobacco control strategy, Long-term plan commitments	✓	✓	**NHS Staff** – piloting a system wide NHS staff smoking cessation service. Implement programme through smoking cessation app. Part of pilot is to evaluate whether app increases or hinders access (will be informed by digital inclusion work) Programme supported by a robust comms and engagement strategy Long Term Plan Priorities	Access/Experience/Outcomes	✓	✓	✓
		✓	✓	**Maternity** – In house (SFH and NUH) smoking cessation services for pregnant mothers. Early implementer service for maternity commenced in SFHT in December 2021. Smoking cessation incentive scheme is being piloted in SFH, targeted at young pregnant ladies and partners. Through NUH targeted smoking cessation services for pregnant ladies in two of the most deprived areas is in place and plans are being developed for implementation of the NHS maternity model.				
		✓	✓	**In-patient** - Plans to expand on existing inpatient services in NUH and SFH are being developed ready for roll out during 22/23.				
		✓	✓	**Mental Health** - NHT have been accepted as an early implementer for the inpatient/outpatient mental health model. This will complement the existing smoking cessation programme and in-patient services are offered through the Trusts with the opportunity to expand on these. See also PBP plans. ICS to work with and take direction from Public Health in relation to the Tobacco Control Strategies plus the CLEAR approach. This will allow for a wider consideration to the Long Term Plan commitments.				

ICS Health Inequality Strategy – Medium Term

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience/ Outcomes	1	2	3
Obesity	Provision of weight management services and progressing strategy that recognises the complexity of obesity (obesogenic environment)	✓	✓	Implementation of Low Calorie Diet programme – will target areas of highest need Implementing a fixed term tier 3 service for adults that addresses current gaps and increases capacity in order to respond to the impact of COVID (increased waiting lists, changes to referral criteria) Tier 3 weight management service for children being implemented that includes a whole family approach Promoting Digital Weight Management Service Working with Public Health to review weight management services as an overall programme across the system including addressing gaps for tier 3 and the more severe obese Along with HWS plans to work at PBP, with Public Health to identify system wide actions that fall outside of weight management services	Access/Experience/ Outcomes	✓	✓	✓
Alcohol	Long Term Plan commitments in relation to ACTs and local priorities	✓	✓	Alcohol Care Team operational in NUH. Working with NUH to evaluate and understand how best to integrate services to meet the needs based on population cohorts accessing, recognising that COVID has changed the demographics for high risk drinkers. In order to understand and match services to population need (recognising the Core20+ approach), a mapping exercise is being carried out of existing services which will inform the type and level of service required across Nottingham and Nottinghamshire. Progressing with plans to target high risk communities with local fibroscanning.	Access/Experience/ Outcomes	✓	✓	✓
Children and Young People	Children's Transformation Plan and a focus across mental and physical health. To progress with a plan that supports HWS Best Start in Life programmes across City and County. To ensure that all workstreams consider the lifecourse.	✓ ✓ ✓	✓ ✓ ✓	Children's Transformation Plan including: Asthma, Diabetes, Infant mortality, obesity, Epilepsy, hospital/ED admissions Mental Health – Advancing mental health inequality framework for under 18s. Being driven by JSNA Actions LD/Autism – Progressing three year road map for children and adults with learning disabilities and autism which includes 10 activities to improve physical health, community provision, partnership working and active learning and development. Physical – In addition to the transformation plan is the tier 3 weight management services outlined in Obesity. The CYP Planning submission template was informed by Nottinghamshire's JSNA for mental health for CYP aged 0-25, the local transformation plan refresh and engagement with young people.	Access/Experience/ Outcomes	✓	✓	✓

ICS Health Inequality Strategy – Medium Term

Integrated Care System
Nottingham & Nottinghamshire

Children and Young People Transformation Priorities

Obesity

Nationally
9.9% children 4-5 years were obese.
1 in 5 children 10-11 years were obese
Nottingham City
12 % children 4-5 years were obese
1 in 4 children 10-11 years were obese
Nottinghamshire County
9 % children 4-5 years were obese
1 in 5 children 10-11 years were obese

Asthma

Nationally
158.3 emergency admissions for asthma per 100000 children aged 0-19

Nottingham and Nottinghamshire
better than 99.8% of other areas in England with a rate of 96 emergency admissions for asthma per 100000 children 0-19 (number =85)

Hospital / ED admissions

Nationally
655 ED attendances per 100000 children under 4 years
Nottingham City
717 ED attendances per 100000 children under 4 years (number =14900)
Nottinghamshire County
553.2 ED attendances per 100000 children under 4 years (number =24830)

Epilepsy

Nationally
77.2 emergency admissions for epilepsy per 100000 children aged 0-19

Nottingham and Nottinghamshire
better than 95% of other areas in England with a rate of 55.5 emergency admissions for epilepsy per 100000 children 0-19 (number =130)

Diabetes

Nationally
51.1 admissions for diabetes per 100000 children aged 0-19

Nottingham and Nottinghamshire
better than 95% of other areas in England with a rate of 38.4 admissions for diabetes per 100000 children 0-19 (number =90)

Infant mortality

Nationally
3.9 deaths per 1000 live births for babies under 1 year
Nottingham City
5.6 deaths per 1000 live births for babies under 1 year (number =22)
Nottinghamshire County
3.8 deaths per 1000 live births for babies under 1 year (number = 31)

ICS Health Inequality Strategy – Long Term

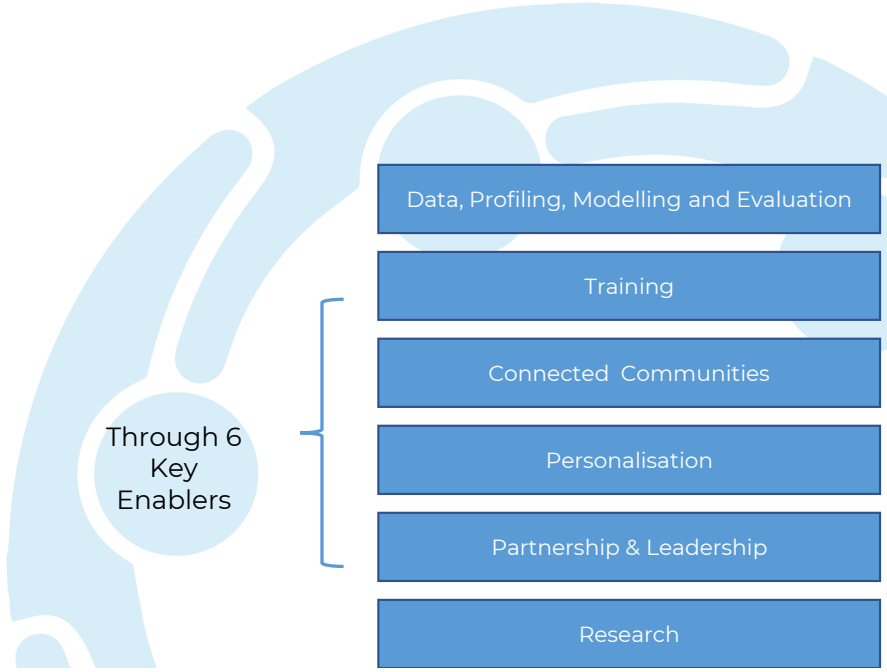
Integrated Care System
Nottingham & Nottinghamshire

Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience/ Outcomes	1	2	3
Environment	Green Plan	✓	✓	The ICS Green Plan will sit alongside the environmental plans of the Local Authority and is informed by partner organisations plans. As part of the ICS Green Plan it highlights that the NHS will work to reduce its own contribution to air pollution and work with partners on actions to improve air quality and improve local environments, thereby supporting the development of local economies in geographical areas of deprivation. Air pollution disproportionately affects people in these areas, many of whom are already at risk of poorer health outcomes. Examples of the links between climate change, sustainable development and health inequalities are seen across the country	Outcomes	✓	✓	✓
Employment	Nottingham & Nottinghamshire Universities Alliance	✓	✓	Participation in the Universities for Nottingham programme by the ICS and individual health and care partners is one of the ways that the ICS is working with other local partners to support local recovery from the pandemic and leverage the wider public sector efforts to improve our local area. Signatories of the UfN agreement have agreed that, "We are bound by a shared mission to improve levels of prosperity, opportunity, sustainability, health and wellbeing for local citizens, families and communities".	Outcomes	✓	✓	✓

Integrated Care System
Nottingham & Nottinghamshire

F. Enablers

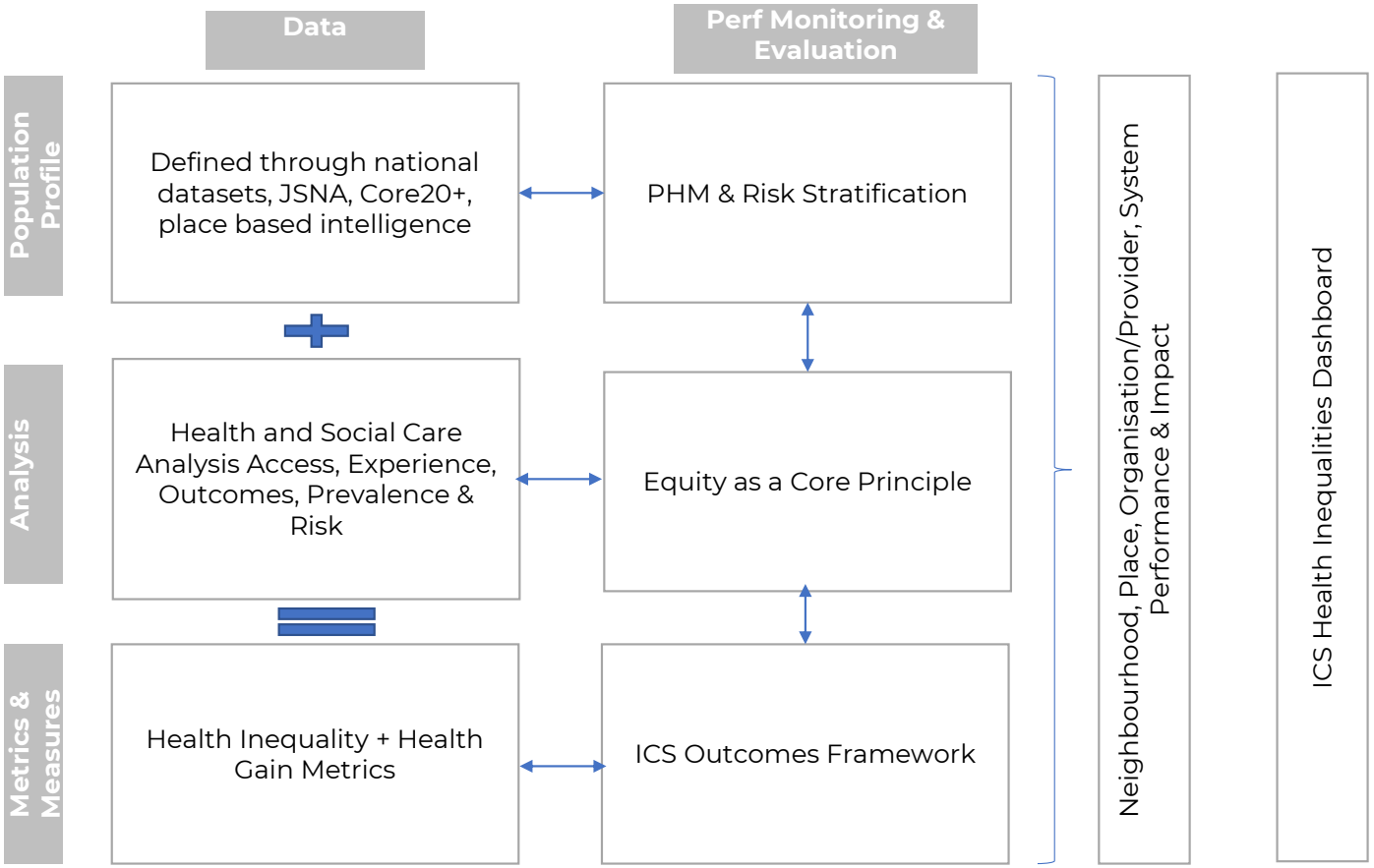
Providing a robust infrastructure to support focus, traction, impact across the ICS. These are resources we can use to help further create an equitable health system and are fundamental in making changes to the wider system



1. Data, Profiling, Monitoring & Evaluation

Integrated Care System
Nottingham & Nottinghamshire

Through the structures and partnership working the ICS has the foundations for data driven improvement. The diagram illustrates how the different elements of data and monitoring and evaluation interact. The ICS has progressed with embedding a structure for effective monitoring, analysis and evaluation for health inequalities and this is supported by the implementation of the Systems Analytics Intelligence Unit (SAIU)



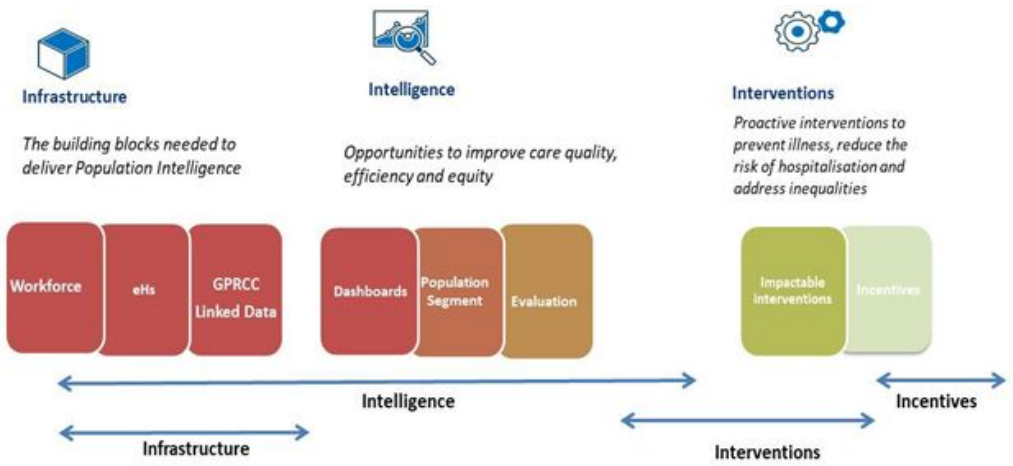
1. Data, Profiling, Monitoring & Evaluation

Integrated Care System
Nottingham & Nottinghamshire

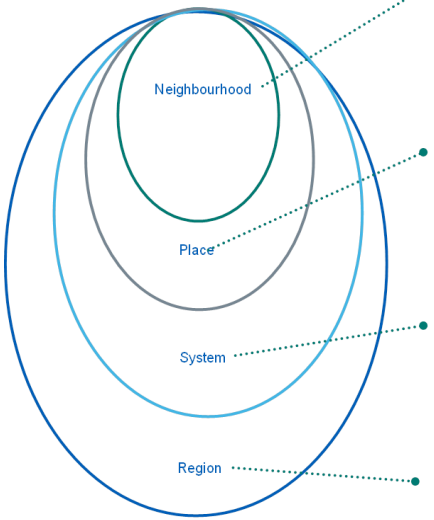
The core deliverables of the SAIU includes the PHM elements of infrastructure, intelligence and interventions which together contribute to actionable insight across the ICS . The SAIU operates as a central unit working across all partners and with all sources of data, embedding health inequalities principles as part of the analytical approach. The SAIU has a structured approach with a focus from a neighbourhood through to a regional understanding.

The SIAU is the ICS System Analytics & Intelligence Unit which is helping us move from a traditionally "data heavy" system, to an "intelligence rich" system. The SAIU is supporting us to collect meaningful data and analysis which can support population intelligence and support decision making. This data will actively help us identify inequalities and gaps in the system which we can then act upon.

Core Deliverables of the SAIU



Functions of the SAIU



Population profiles and implementing individual care packages for patients based on recommended interventions and targeting.

Describing the needs of different groups. Pathway modelling and implementation supporting transformation with PBPs, along with consideration of wider determinants.

Whole population segmentation and forecasting change. Supporting strategic overview of performance, peer review of unwarranted variation and productivity opportunities. Transformation between partners.

Clinical service planning across multiple systems. Specialised commissioning decisions driven by integration with other data systems.

1. Data, Profiling, Monitoring & Evaluation

Integrated Care System
Nottingham & Nottinghamshire

The SAIU provides the platform to have a system wide approach to data integrity, analysis and interpretation of data in relation to health inequalities. Taking a system wide approach not only means that we have the right focus on population characteristics and access, experience and outcomes in relation to service but also, incorporating the wider determinants. The ICS has an established PHM approach that supports the work on health inequalities. PHM is being used by the system and local teams to understand and look for the best solutions to people's needs – not just medically but also socially – including the wider determinants of people's health.

Initiative	Development focus	22/23	23/24
Health Inequalities & Population Health Management Approach	Using local data intelligence enables strategic commissioners to procure integrated care for the citizens of Nottingham/Nottinghamshire, improve outcomes, reduce duplication and use our resources more effectively bringing equity for all.		
	• Production and development of a population/health inequalities profile, using wider determinant data in conjunction with the PHM deep dives, support and embed the development of the Health Inequality framework system wide.	✓	
	• Production of health needs Profiles in line with JSNA and HWBB (working with PH colleagues)	✓	
	• Production and maintenance of inequalities system intelligence dashboard – (SID) and System Intelligence Reports (SIR's)	✓ ✓	
	• Developing a Health Inequality Framework; including reporting methods to support inclusion across all analytical teams dashboards and functions	✓	
	• Aligning annual plan, population demographics and high level model to strategically agreed outcomes.	✓	
	• Presenting how inequalities are likely to shape provision and highlight/mitigate risk between provider organisations	✓ ✓	
	• Working with primary care/digital colleagues to improve – defining segments, coding (ethnicity), outcomes etc	✓	
	• Supporting further HI analytical development of training with partnership organisations		
	• Development of an overarching evaluation framework; how to evaluate positive outcomes, meet the local and national outcomes framework and strategic priorities of the system.	✓	
	• Monitors and evaluates performance against a consistent set of quality measures for health and care services	✓ ✓	
	• Evaluate performance on population segment basis	✓	
	• Service pathway metrics benchmarked against comparable/local organisations and national averages		
	• Embed adoption of evaluation and service improvement initiatives system wide.		

1. Data, Profiling, Monitoring & Evaluation

There will be an ICS approach in order that across the system there is a shared understanding of Nottingham and Nottinghamshire health inequalities across prevalence, risk factors, access, experience and outcomes.

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Development focus	22/23	23/24
Improving ethnicity coding	• Work is underway to improve ethnicity coding in Primary Care – using direct text messaging to patients. This work is targeted in areas that have a high percentage of patients with "Unknown" or "Not stated" ethnicity codes. • Data mapping exercises are being carried out to use secondary care data to fill in the gaps in primary care data for population health management and health inequalities analysis.	✓	
Developing a local Health Inequalities Dashboard	• A Health Inequalities dashboard is being developed to explore health inequalities across domains of Access, Experience and Outcomes. • The dashboard will pull together datasets from primary, secondary, community, mental health as well as external data from PHE fingertips and other sources. • Metrics relating to CORE20PLUS5 deprivation and areas of clinical focus will also be presented at system, ICP and PCN levels. • This dashboard will allow exploration of inequalities across the system, to develop a shared understanding of what inequality and deprivation mean, what inequalities exist within our system and where. Which can feed into the population health management approach for system transformation. • The Health Inequalities dashboard will be supported by 10 other dashboards exploring Place, Demand and Capacity, Quality and Patient Experience, Maternity, Care Homes, Urgent Care and Planned Care. Where possible these dashboards will incorporate metrics broken down by IMD, ethnicity, sex and age.	✓	
Developing Health Inequalities System Information Reports	• Once complete the Health Inequalities Dashboard will be used to produce 'System Information Reports' focused on exploring the health inequalities visible in the dashboard in more detail. • These reports will provide deep dive analysis into an area of health inequality and can be used at place level to identify areas for transformation. • Reports will align with Population Health Management work programme and system priorities.	✓	✓
Developing a local framework for monitoring and evaluation	• A local framework for monitoring and evaluation is being developed to evidence impact of transformation programs on ICS outcomes. • The framework will encourage a process of understanding population health, using research and evidence to inform change, aligning change initiatives to system outcomes framework and ensuring a robust monitoring and evaluation process.	✓	✓

1. Data, Profiling, Monitoring & Evaluation

The ICS has an established outcomes framework and in 2022/23 this will be supported by five year ambitions for health inequalities. Work is also progressing on a value framework and recognising health gain metrics as being central to prioritisation.

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Development focus	22/23	23/24
Outcomes Framework	• The ICS has developed an Outcomes Framework which covers three domains – Improving the health and wellbeing of tour population, Improving the overall quality of care and life our service users and carers ae able o have and receive and improving the effective utilisation of resources. The metrics across all three of these aims relate to an understanding of the impact on health inequalities in relation to access, experience and outcomes as well as recognising the value of health gain alongside financial value. (see appendix 1)		
	• Actions to be carried out to further reflect the impact on health inequalities through the outcomes framework includes:	✓	
	• Agreeing ambitions with the ICS Partnership Board	✓	
	• Identifying proxy measures which includes assigning initiatives from the health inequalities plan to the outcomes	✓	
	• Ensuring that we reflect the impact of inequities through access and experience		
	• Validating that it effectively represents outcomes for the Core20+		
	• Idenfitying opportunity and expected impact		✓
	• Illustrating line through from neighbourhood initiatives to system		
Value Framework	• Representing the value of the contribution of health alongside factors and initiatives taken elsewhere		✓
	• Monitoring and re-evaluating impact and measures		
	The ICS is developing a value framework which recognises health gain.		
	• Health gain metrics that can be utilised to support prioritisation to be identified	✓	
	• Aligning the value framework alongside the finance framework	✓	

2. Training and Education

Upskilling and increasing an awareness of how to understand health inequalities, interpret the value of impacting on disparities and addressing inequities in relation to health and care services and the wider determinants is central to delivering the cultural change required.

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Development focus	22/23	23/24
Health Economics, PHM & Health Inequalities for the ICS and partners.	A series of six interactive workshops to be held with service change, finance and analytical colleagues on health economics, including understanding the three types of value – personal, technical and population (allocative efficiency) and including practical sessions using prepared data and the Social Technical Allocation of Resources (STAR) tool. Action learning sets for analysts will focus on segmentation, risk stratification, impactability, machine learning and quasi-experimental design to support PHM.	✓	
ICS Workshops – Understanding the analysis	Following a successful workshops in 20/21 on elective recovery waiting lists, inequalities in access to secondary care, ED and health seeking behaviour the ICS is planning on holding workshops ongoing to support learnings across the system. A schedule of workshops to be produced for 22/23.	✓	✓
Health Equity Assessment Tool (HEAT) Training Sessions	HEAT training has been promoted in 21/22 and following colleagues attending the Train the Mentor course, a programme of mentoring will be progressed across the ICS. The ICS will develop an internal programme that combines effectively using and understanding HEAT, EQIAs, effective service change and the outcomes framework.	✓	✓
PCN Health Inequality Forums	Bi-monthly workshops have been established with PCNs as an open forum for discussion and collaboration on health inequalities. The sessions will alternate between delivery of plans and an education session which will include external speakers as well as internal experts.	✓	✓
NHS Confed Health Inequalities Leadership Framework	The NHS Confederation has developed a programme of health inequalities improvement seminars for Chairs and Non-Executives on provider boards within Integrated Care Systems, to provide a legacy for the future as well as tools for immediate application.	✓	

3. Connected Communities

Integrated Care System
Nottingham & Nottinghamshire

Connected Communities is about working with, alongside and in our local communities ensuring that we are inclusive and representative of the Core20+. The COVID vaccination programme has provided considerable opportunity to understand how we can more effectively reach out to our local communities and has informed our approach as an ICS. The following tables outline the ICS approach which sits alongside the PBPs, with plans to progress from 22/23. The strength of connected communities is in our Place Based Partnerships and the relationships they hold with the voluntary sector, community groups and citizens. The overall aim and approach is to ensure that as an ICS all elements actively listen to the communities and local population.

Initiative	In place	Development focus	22/23	23/24
ICS Citizens Intelligence and Engagement Strategy		The Citizens Intelligence approach dovetails with co-production and the community connectors and champions in PBPs. Citizens Intelligence is described as a process of actively listening to citizens to understand their experiences of health and care services to enable a focus on areas that need improvement or changes. An on-going cycle of activities that generate genuine citizen insights to guide the work of transformation and commissioning		
Citizens' Panel		Our **Citizens' Panel** will provide a consultative body of 1000+ residents who are representative of the population of Nottingham and Nottinghamshire. Panel members will be part of an on-going engagement process whereby members opt-in and agree to engage on a regular basis. Our Citizens Panel will provide; • A broad, representative and balanced input from our citizens to inform strategy and planning at system level • Analyse insight via geographies to support place-based partnerships and primary care networks • Engage on areas/services of interest to support planning, commissioning and service provision • Allow engagement to be conducted at relatively short notice • Deliver potentially higher survey responses than one-off surveys • Allow for the tracking of local views and sentiment over time Training - we will develop a training package for individuals working with people and communities to ensure the necessarily skills, confidence and tools they need to generate and utilise high quality citizen intelligence and insight.	✓ ✓	✓

3. Connected Communities

In order to assimilate, disseminate and use the intelligence gained through co-production and engagement the ICS are establishing an engagement practitioners forum and community insights hub. The community insights hub will be a repository of information on our local communities and will help to inform programmes on community needs and characteristics.

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Development focus	22/23	23/24
ICS Engagement Practitioners Forum	To provide a platform for all system partners working with people and communities to work collaboratively, share resources, knowledge and expertise and maximise existing knowledge and insights. Membership will be inclusive of NHS, local government (District, Borough, City and County Councils), Healthwatch, VCSE sector and colleagues leading on patient experience and co-production. To be established during the first quarter of 22/23	✓	
Community Insights Hub	Our **Community Insights Hub** will be a key resource for capturing and reporting community intelligence that includes findings drawn from all system partners including statutory sector, VCSE, Healthwatch, citizens' panel and networks at place and neighbourhood level. It will also draw in data and insights created and published from outside our system, e.g., census data, ONS reports and wider public sector focussed reports and research. All of this will be captured and recorded in a database (to be developed over time) enabling a systematic record of what we know about certain communities or geographies. The Hub will be a key way that the primacy of Place will be delivered but that a system-wide view of our available insights would also be able to be produced.	✓	✓
PCN Toolkit	PCN Toolkit - Primary Care Network (PCN) Engagement toolkit was coproduced with our Patient and Public Engagement Committee and VCSE sector colleagues. This is being revisited and refined to reflect the changes in the system and will be disseminated to support the generation of community intelligence at neighbourhood and place.	✓	

3. Connected Communities

Nottingham and Nottinghamshire ICS are 1 of 10 sites to develop and embed coproduction (peer support and funding) via NHS England and NHS Improvement Experience of Care Team programme. The project benefits from access to peer networks, learning from other sites and national best practice, as well as £20,000 funding to support development of the strategy and involvement in national evaluation work. Co-production is part of the wider engagement strategy that has evolved and strengthened over the past two years of Nottingham and Nottinghamshire working as an ICS.

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Development focus	22/23	23/24
Co-production	To embed a system wide approach to co-production by building on existing initiatives and that is aligned with Core20+ and initiatives in PBPs. The PBPs are developing and supporting community-based roles that empower and provide a voice to link with decision makers and highlight the barriers across not only health services but also prevention. Through their programmes of work the PBPs are also defining processes for lived experience involvement and it's through them that the ICS will have robust links with communities and community leaders.		
	The aspiration is for genuine coproduction to be embedded within all elements of system design and delivery, including transformational activity, commissioning activity, service/system redesign and quality improvement.	✓	
	A system wide coproduction strategy and practical coproduction toolkit will be developed (for staff and people with lived experience) with expertise and learning from all elements of the system, including experts by experience. This will set out the coproduction principles and expectations for the system, with partner strategies on coproduction aligning to the system-wide strategy.	✓	
	A training package for both staff and people with lived experience to ensure that people have the skills, confidence and tools they need to work together in partnership and coproduce effectively. For staff this will mean ensuring they are confident at coproducing with people with lived experience, moving to a facilitator role rather than someone that knows all the answers. For people with lived experience this will mean ensuring that they are activated and confident in sharing the views of people with lived experience effectively and consistently in different meeting settings or in key communications. The toolkit will be accessible for staff, people with lived experience and the public.	✓	
	Establishment of a strategic coproduction group to ensure that strategic decisions and planning around the future of the ICS includes people with lived experience as an equal partner. Our intention is to establish a group of people with lived experience to advise on system design, delivery and commissioning. This group will be a core group that will be involved in key priority work across the system and will also report into and represent the group at ICS Board.	✓	
	Culture change across the system to support the coproduction approach This will form the basis of system wide culture change, supported by shared system commitment and ownership, along with key coproduction champions in key areas/organisations of the system.		

4. Proactive care, self-management and personalisation

Integrated Care System
Nottingham & Nottinghamshire

A key enabler to progress the ICS health inequalities strategy and through 21/22 there has been an increased awareness of the importance in relation to addressing inequities in health across access, experience and outcomes. The programme is reviewed through a Personalisation Board.

Initiative	Development focus	22/23	23/24
Increasing Primary Care roles Expand social prescribing, Health and wellbeing coaches and Care Co-ordinators roles in Primary Care Networks	• Support the recruitment of DES funded social prescribing link workers in PCNs across the ICS. • Increase the CCG funded number of social prescribers to support the increasing numbers of referrals for people with mental health issues. • The increase in social prescribers also targets groups of people who need support, using our Population health management data • Restoring and increasing access to primary care services by working with Primary Care Networks (PCN) to actively recruit, retain, support and develop social prescribers/link workers, health and wellbeing coaches and care coordinators. • Each ICP in collaboration with commissioners, LAs and VCSE organisations, will develop a local plan using Population health management data, PCN Maturity Matrix, this will help form a system wide social prescribing strategy • Each Place based partnership to develop a strategic plan and maturity framework o Leadership, strategy and governance o Planning and commissioning o Workforce development o Digital and technology o Evidence and impact • Work with all system partners in the ICS to build community assets	✓	✓
Green Space	Green Space is a nationally funded, 2 year test & learn project working to build a network of trusted groups and organisations to embed green social prescribing throughout Nottingham City and Nottinghamshire. The aim of the project is to test how to embed green social prescribing into communities in order to: o Improve mental health outcomes o Reduce health inequalities o Reduce demand on the health and social care system o Develop best practice in making green social activities more resilient and accessible.	✓	✓
Increase the number of personalised care and support plans (PCSPs) for identified cohorts in line with the standard replicable PCSP model.	Continue to increase the numbers of services having personalised conversations with people and completing a care and support plan, that can be shared with health and social care. Work with the NHS app and Patient Knows Best to increase the digital use of peoples care and support plan, and a one page profile – All about me - so it can be shared and used as a starting point to understand what matters to people, and what they want to achieve in relation to their health and wellbeing and how they can achieve it. Areas of development are End of life, Mental health and Elective care	✓	✓
ICS Integrated personalised commissioning signature scheme	To work with our system partners, to join up care and support around the person, to joint commission where it makes sense, and focus on shared market development. To share good practice and the impact through an 'Our stories' booklet, which we aim to develop into pages that are the go to place for personalised care, on the ICS website.	✓	✓
Workforce development	Deliver on the NHSE workforce Memorandum of Understanding to train 1231 staff in personalised care approaches.	✓	✓

4. Proactive care, self-management and personalisation

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Development focus	22/23	23/24
Proactive Care at home Restoring and increasing access to primary care services by developing and implementing a Proactive Care @home pathway	• Introduce the proactive Care @home pathway for patients with hypertension. • Focussing initially on hypertension by increasing access to and uptake of BP@Home. • Prioritise those populations with increased health inequalities identified through population health management. Each PBP to manage distribution of the BP monitors via their PCNs. • Provide BP monitors to patients who are at highest risk in the most deprived areas, each monitor can be reissued if a patient has finished with it during the time of the project • Identify behavioural risk factors for individuals with CVD (linking directly to their condition) and embed personalised care components within the pathway to promote supported self-management	✓	
Elective Care Maximise elective activity, taking full advantage of the opportunities to transform the delivery of service including embedding personalised care into elective recovery programmes	The overall goals are: • To embed shared decision making conversations in the MSK pathway for over 65s • That over 65s with MSK conditions are empowered and prepared to have a shared decision making conversation with clinicians • That people who are over 65 on the MSK pathway are supported to wait well – My planned care and prepare for surgery, thereby maximising surgery and minimising the days in hospital to recover post-surgery. • To use population management health data to target additional support to people with wider determinants of health and address health inequalities • 3 x social prescriber providers appointed to deliver this approach to support people waiting for elective care operations on the MSK pathway and the Pre-rehab Cancer pathway. The support will be focussed to people with health inequalities and wider determinants of health.	✓	
Local Maternity and Neo-natal services Deliver improvements in maternity care, including responding to the recommendations of the Ockendon review	• 700 maternity staff trained in personalised care and support planning and Shared decision making • Personalised care and support plans and their use will be coproduced with women, and will be reviewed o 3 coproduction workshops with women to review quality and use of PCSP o Monthly strategic coproduction meetings to review progress and use o All 6345 PCSP for 21/22 are coproduced with women	✓	
Personal health budgets Promote and offer personal health budgets for people with a legal right to have a personal health budget and in priority local cohorts (as identified in the STP/ICS LTP local implementation plan).	Everyone with a right to have will have a personal health budget, providing choice and control over how they manage and organise their health and care needs: People eligible for Continuing Healthcare; Continuing Healthcare FastTrack; Continuing Care; S117 aftercare; wheelchair budgets. They are also provided to adults with joint health and social care funding; NHS carers breaks – to give carers a break from their caring role to manage their own health and wellbeing, You Know Your Mind, for children and young people who are under Local Authority care, to support them to manage their health and wellbeing. Since December 2021, personal health budgets have been provided to support peoples discharge from hospital. Areas of further development of personal health budgets are in End of life care; Learning disability and Autism and Mental health services. Opportunities being explored for link workers to provide personal health budgets.	✓	✓

5. Leadership & Partnership

Through the Health and Wellbeing Boards and the Joint Health and Wellbeing Strategies there is the understanding of the priorities to impact on health inequalities. Through the PCBs and PCNs is the integration with local communities that informs the themes and inclusion health groups for the system to drive forward change in relation to disparities and inequities. Therefore, the PBP governance structures include relevant groups and committees that will link into and inform the ICS Health Inequalities Group and through this, wider partners.

Integrated Care System
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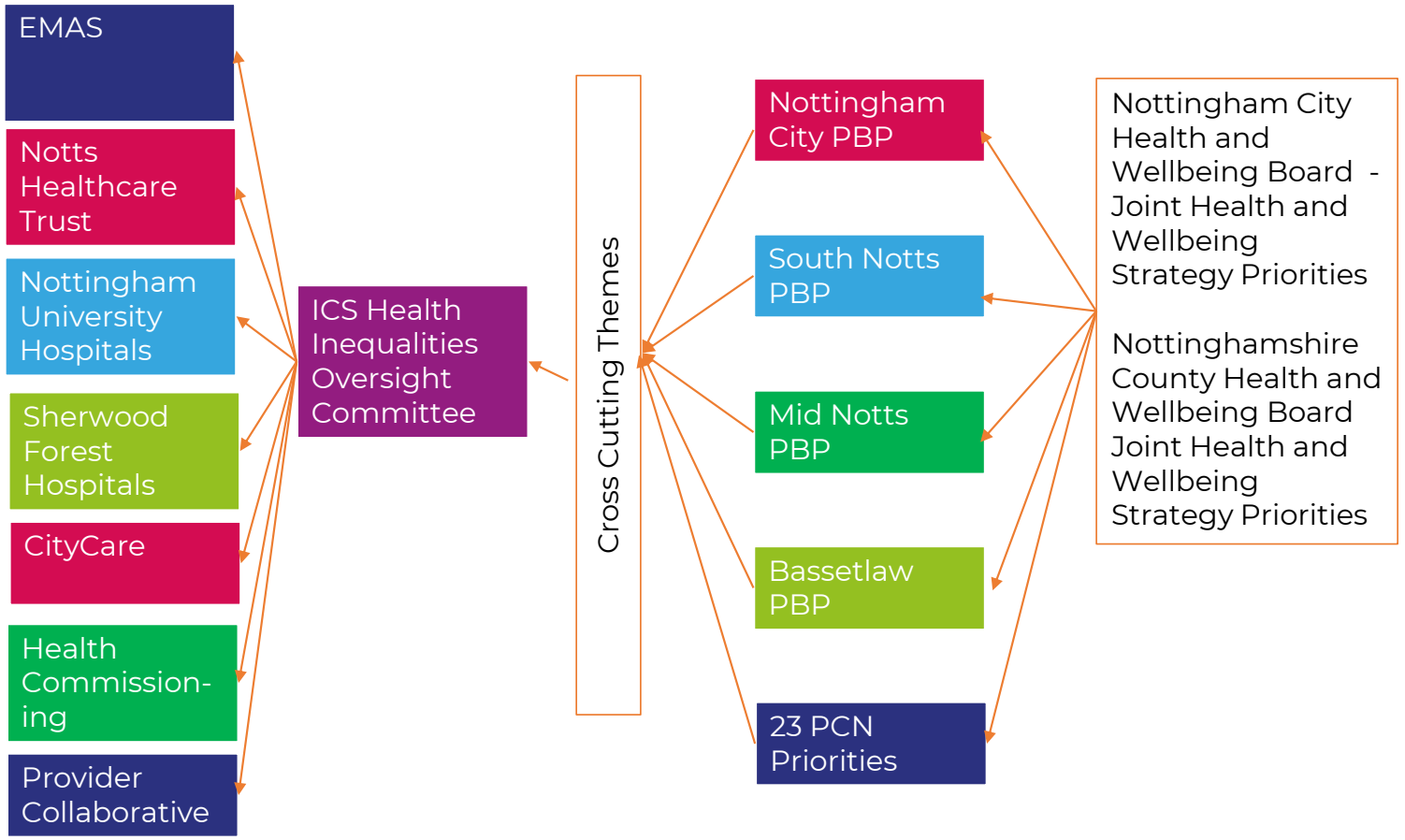


5. Leadership & Partnership

The ICS Health Inequalities Group reports into the ICS Strategic Oversight Group. The Strategic Oversight Group membership includes partner Chief Execs who sit on the ICS Board.

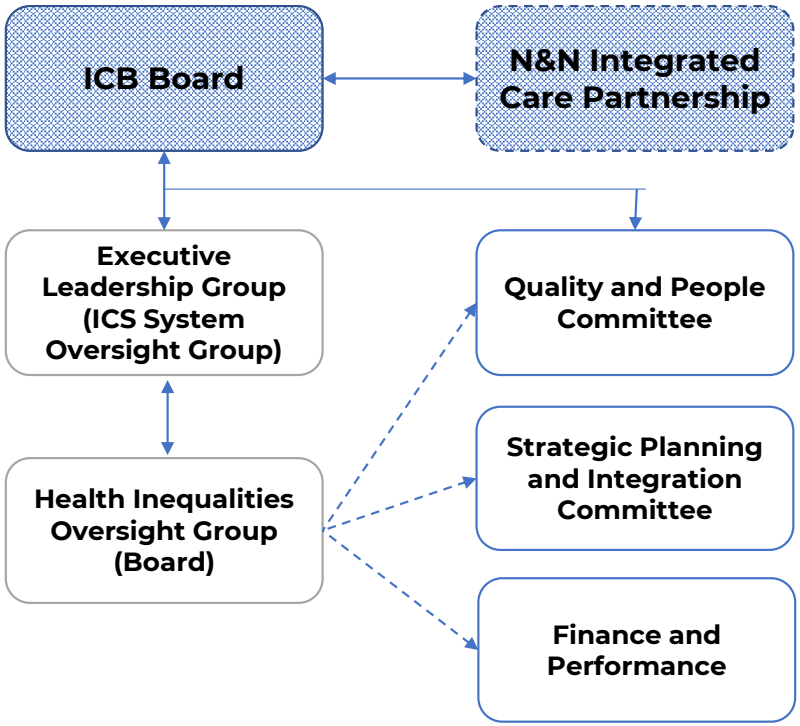
Integrated Care System
Nottingham & Nottinghamshire

Initiative	In place	Structure
ICS Health Inequalities, Prevention and Wider Determinants Oversight Group	x	• Membership includes • ICS Health Inequality Lead • ICS Workstream SRO(s) • Provider Health Inequality Exec Leads • ICS Chief Nurse • Directors of Public Health • PBP and PCN Representatives - Clinical and Managerial • Health and Wellbeing Board Chairs • ICS Health Inequality Champion/Expert • Population Health Management and SAIU Director Objectives of the Group include: Embedding health equity as a strategic priority within organisational, place and neighbourhood partnership strategies and plans – developing a strategic approach that is defined on population need from neighbourhood through to place and ICS Clear and consistent approach in relation to population need, to addressing health inequalities across the system on a short, medium and long term basis. To include 1) short term evidence based actions in health 2) in-service monitoring and impact in relation to access, experience, outcomes 3) longer term health promotion as a system Co-production with Health and Wellbeing Boards in order to provide a balanced focus on the elements of the Population Intervention Triangle (civic level interventions, service-based interventions, community centred interventions). Establishing ICS strategic and shared ambitions that are reflected throughout and are supported by programmes at a system, organisational (including commissioner and providers), place and neighbourhood basis By working effectively with and at ICP/Place level, generating an ICS commitment across all partners based on agreed Nottingham and Nottinghamshire population profiles and priorities Influencing financial planning and budget allocation System wide focus across all age groups and the life course Embed a population health management approach that delivers to the JSNAs and is underpinned by community engagement and robust networks through place/PBPs To create the conditions for frontline staff working in the ICS/across the system to better work together to understand and impact on health inequalities Developing and monitoring against a framework for health inequalities that allows

5. Leadership & Partnership

Integrated Care System
Nottingham & Nottinghamshire

The following diagram outlines the ICB governance structure, specific to health inequalities. ICPs are expected to provide opportunity to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for local populations. ICPs will facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development. What is not reflected in this diagram are the individual groups which each of the PBPs have as they are part of their wider governance structures with place being central to the Health Inequalities Oversight Group.



6. Research

The ICS are encouraging research in relation to health inequalities that will both educate and inform action across the ICS.

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Initiative	In place	Development focus and actions	22/23	23/24
A research study is being commissioned to develop understanding of the experience of Severe Multiple Disadvantage (SMD) for people from ethnically diverse communities in Nottingham	Approach and funding agreed	• Reducing health inequalities in Nottingham's ethnically diverse population is a key priority for Nottingham City Place Based Partnership (PBP) however there is a gap in evidence relating to inequalities in outcome and access to services for people from ethnic minority groups who experience SMD. • The research findings will influence the Changing Futures Programme in Nottingham and future commissioning approaches in relation to SMD. • The research proposal has been developed by the Nottingham City PBP SMD workstream. • The research will be commissioned and managed by Nottinghamshire Healthcare NHS Foundation Trust. The research is being jointly funded by the Trust, Nottingham City Council and Nottingham and Nottinghamshire CCG. • A procurement exercise for the research study is in preparation as at February 2022. The aim is for the research to be completed and have reported during Quarter 3 2023/24. • A research steering is being set up chaired by the lead for the Nottingham PBP SMD workstream and will include people with lived experience and representatives from local organisations and services. The steering group will report to the Nottingham SMD Partnership.	✓	✓ ✓
Taking forward the recommendations from the 'Improving the mental health outcomes of Nottingham's LGBT+ populations' research study.	Final Research Report	• A research study was commissioned by one of the predecessor CCGs because evidence shows mental health inequalities are experienced by LGBT+ people who are at higher risk of poor mental health, self-harm and suicide and report lower well-being compared to the wider population. This is due to a range of issues experienced including discrimination, harassment, bullying, rejection and social isolation. For some people other factors such as age, religion or ethnicity can exacerbate mental health needs. • The research recommendations relate to: training and cultural competence; systematic recording of patient/service user sexual orientation and (where appropriate) gender identity; the specific needs of LGBT+ people being reflected in the commissioning and delivery of services; visibly inclusive LGBT+ services; improved access to mental healthcare; and developed and/or strengthened relationships between services. • The CCG is coordinating a system-wide action plan with partners to implement the recommendations. This work will be transferred to the ICB at the time of its establishment.		

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G. Appendices

Appendix 1: ICS Outcomes Framework

The ICS System Level Outcomes Framework was agreed by the ICS Board in April 2019 following extensive stakeholder and public engagement and is based on the triple aim (improved health and wellbeing, transformed quality of care, and sustainable finances) and the priorities within the Health and Wellbeing Board Strategies. The Health and Wellbeing Board strategies are informed by the need of our population and have undergone consultation and engagement with local health and social care stakeholders and the public.

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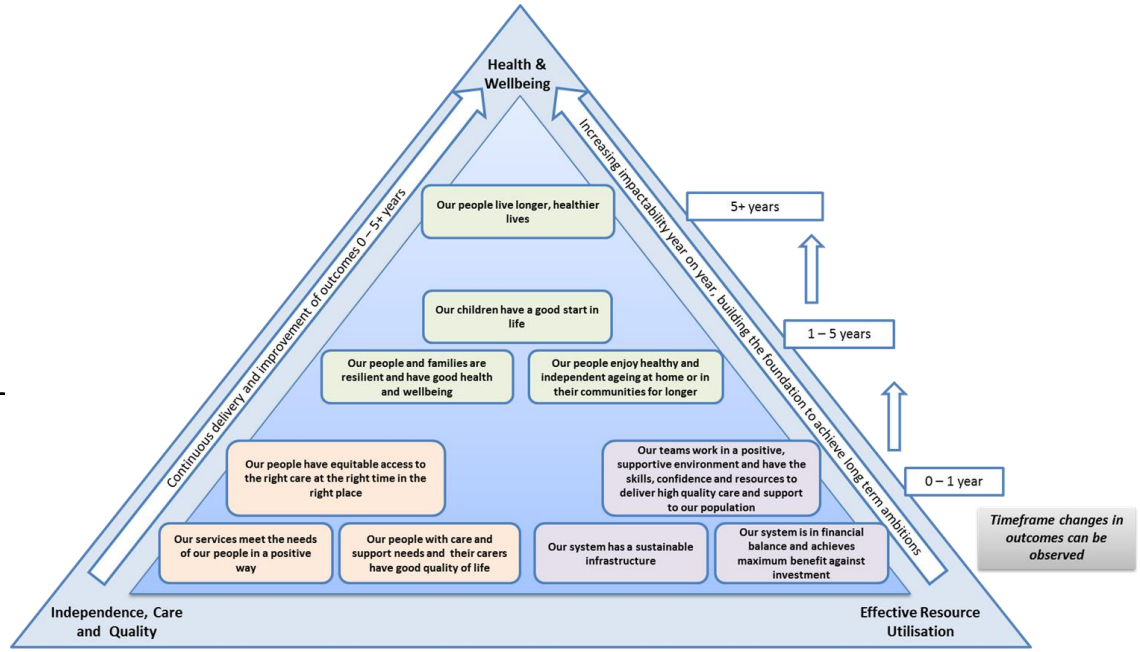
The ICS System Level Outcomes Framework does not replace, but instead sits alongside, existing frameworks and indicator sets that will still need to be monitored and delivered e.g. the ICS System Integrated Performance Report, the NHS System Oversight Framework, Quality Outcomes Framework, Adult Social Care Outcomes Framework, NHS Outcomes Framework and Public Health Outcomes Framework. However, it is recognised that the ICS System Level Outcomes Framework development cannot be in isolation from these and the relationships and any interdependencies need to be explicit. Longer term the aim is to reduce the number of outcome frameworks used within the system, where possible, to increase focus and streamline monitoring and reporting.

The intention is that all action and activity within the system, including service transformation, service change and greater integration, will all strive to deliver improvements across the 10 Ambitions, and will be able to identify which Outcomes will be impacted by the change and articulate targeted improvements to be achieved through actions identified.

Domain	3 domains High level grouping or classification based on the triple aim: **Health and Wellbeing** — The impact of health and care services on the health of our population **Independence, care, quality** — The overall quality of care and life our service users are able to have and their experiences of our health and care services **Effective resource utilisation** — The state of our health and care infrastructure and its ability to deliver quality care and improve health and wellbeing long term
Ambition	10 ambitions High level aspiring ambitions for our Nottingham and Nottinghamshire population mapped against the 3 domains
Outcome	28 outcomes System level outcomes and results our health and care system will aim to achieve to deliver our ambitions

Indicators — Indicators to demonstrate progress towards or achievement (or not) of our outcomes

Measures — Measures that align to the indicators and drive action and change at organisation, PCN and ICP level



Appendix 2: Our big system outcome ambitions

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Appendix 3: Our Strategic Aims

There are many plans and strategies across the system, however they have not all been developed with clear alignment to the System Outcomes Framework – clarity regarding how the plans / strategies are contributing towards the improved outcomes aims and ambitions. The system needs to undertake a full review of all Strategies & Plans to ensure clear alignment and identification to System Outcomes
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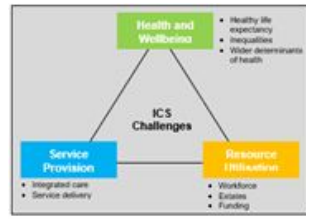

Aim 1 – Health & Wellbeing
Aim to improve the health and wellbeing of our population

Ambitions:
AMB-01 Our people to live longer, healthier lives
AMB-02 Our Children have a good start in life
AMB-03 Our people and families are resilient and have good health and wellbeing
AMB-04 Our people will enjoy healthy and independent ageing at home or in their communities for longer

Aim 2 – Independence, Care, Quality
Aim to improve the overall quality of care and life our service users and carers are able to have and receive

Ambitions:
AMB-05 Our people will have equitable access to the right care at the right time in the right place
AMB-06 Our services meet the needs of our people in a positive way
AMB-07 Our people with care and support needs and their carers have a good quality of life

Aim 3 – Resource Utilisation
Aim to improve the effective utilisation of our resources

Ambitions:
AMB-08 Our system is in financial balance and achieves maximum benefit against investment
AMB-09 Our system has a sustainable infrastructure
AMB-10 Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population

Supporting System Strategies

H&W Strategy
NHS 5 Year Plan
Anchor Institution Plans
ICS Health Inequalities Strategy
Tobacco Control Strategy
Maternity Strategy
Obesity Strategy
EOL Strategy

NHS Operational Plan
NHS Elective Recovery Plan
Urgent Care Plan
Mental Health Strategy
Cancer Strategy
Personalisation Strategy
Primary Care Strategy
Signature Schemes – Integrated Community Commissioning
Quality Strategy
LD&A Plan

NHS Financial & Workforce Operational Plans
ICS Financial Framework
NHS Greener Plan – local plan
NHS People Plan – local plan
ICS Estates Strategy
ICS DAIT Strategy

Appendix 4: System Structure Arrangements - Alignment to and Contribution to System Outcomes

Integrated Care System
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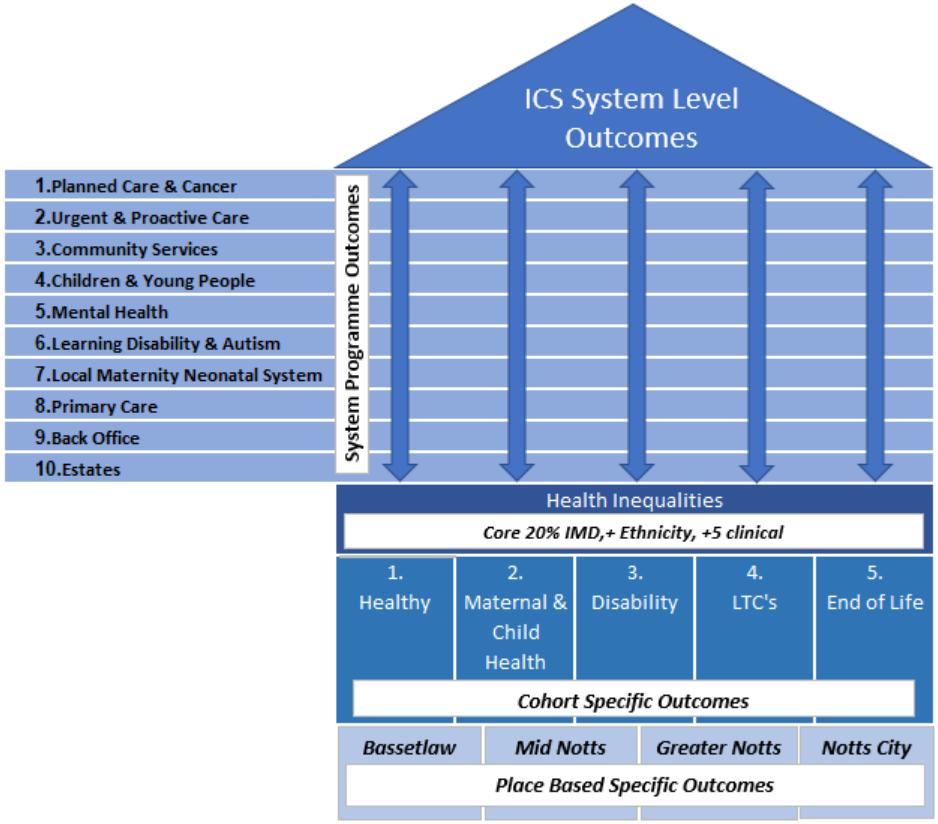
Clarity is needed as to how the different parts of the system contribute as a whole to the overall improvement of the System Outcomes

What does success look like for each part of the system?

- **All System Programmes** need to be able to articulate how their programme will contribute towards the achievement of the System Outcomes, and how as programme they will monitor improvements against programme outcomes identified
- **Population Health Cohorts** – assessment and identification of need to inform the activities to be undertaken across programmes and place, e.g. Diabetes PHM review, CYP PHM Review – Need to determine how the system ensures that these assessments are being taken forward through programme or place activities
- **Place** – identify targeted population cohorts and areas of need specific to their place, and be able to demonstrate their alignment to the overall system outcome improvements required. Articulation of what improvements they are planning on for their targeted population and how this will be monitored



5 Clinical HI Areas:

- Maternity - Continuity of Carer
- SMI(Severe Mental Illness) - Healthchecks
- Chronic Respiratory Disease /Vaccines & COPD
- Early Cancer Diagnosis
- Hypertension Case Finding

Appendix 5: Our system outcomes and how they inter-relate to programme, service and patient outcomes

Integrated Care System
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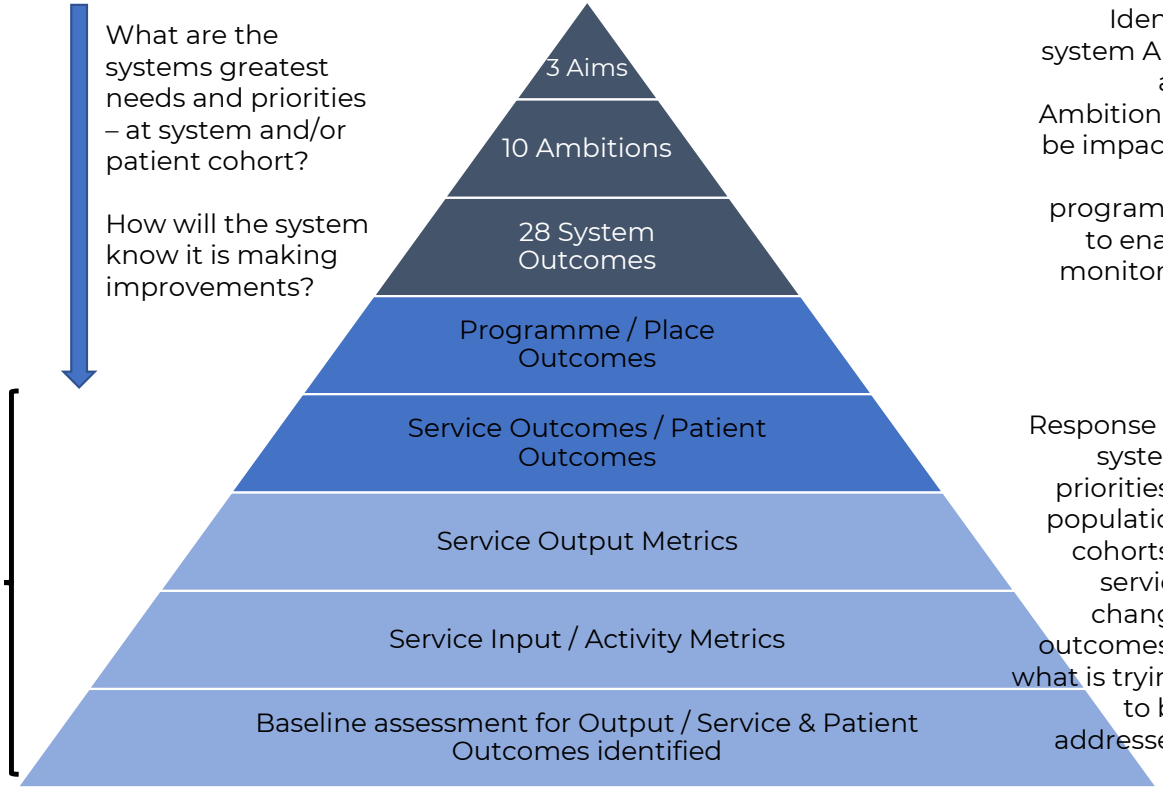
How has the need for service change been identified – what problem is trying to be solved, what is trying to be improved?

System Outcome Monitoring

Service Evaluation & Contracting

What are the systems greatest needs and priorities – at system and/or patient cohort?

How will the system know it is making improvements?



Identify system Aims and Ambitions to be impacted by programme to enable monitoring

ICS System Outcome Framework – identify areas most impacted by the service change being proposed – what will improve as a result of the investment / service

What does success look like for the programme, how does it contribute to improving system outcomes

Response to system priorities – population cohorts – service change outcomes – what is trying to be addressed

What do patients want to improve as a result of service change, what does the service want to improve for patients / staff wellbeing & engagement

Usual measures identified when undertaking service change and service spec – is the service operating as expected, how will you know? Ensure you know the baseline before service change commences

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Nottingham and Nottinghamshire Integrated Care System Health Inequalities Plan

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	10/11/2022
Paper Title:	**Integrated Performance Report**
Paper Reference:	ICB 22 040
Report Author:	Sarah Bray, Associate Director of Performance and Assurance
Report Sponsor:	Stuart Poynor, Director of Finance
Presenter:	Stuart Poynor, Director of Finance
Recommendation(s):	The Board is asked to **RECEIVE** the Integrated Performance Report.

Summary:

The purpose of this report is to present progress against compliance and commitment targets as required for 2022/23. The report includes progress against quality, service delivery, finance, workforce and health inequalities, and provides exception reports for areas of concern. Areas of particular concern identified as low assurance and high risk for delivery include:

Finance:

- Year to date performance is off plan at month six (page 38)
- Financial risks have been identified and are being actively managed (page 41)

Service Delivery:

- Urgent care – Length of stay over 21 days, ambulance conveyances and hospital handover delays over 60 minutes (pages 21-23)
- Elective care – Rising waiting lists and 52 week waits (page 25)
- Cancer – Cancer 62-day performance and 62-day backlogs (page 28)
- Mental health – Children and young people eating disorders (page 34)
- Community – High levels of community waiting lists (page 36)

Health Inequalities:

- The IPR includes a focus on smoking relevant to the Core20+5 (page 58).

Quality:

- Maternity (page 15)
- Learning disability and autism, inpatient and health checks (page 13)
- Infection prevention and control (page 16)

Workforce:

- Agency – High levels of agency are still being required across the system (page 48)
- Vacancies – The system is holding higher levels of vacancies than planned (page 45)
- Sickness absence – The system has higher levels of staff absence than planned (page 45)

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	Provides an overview of current performance in relation to quality and urgent care recovery across the ICB.

How does this paper support the ICB's core aims to:	
Tackle inequalities in outcomes, experience and access	Provides an overview of current performance in relation to elective, mental health, primary care and community care recovery, as well as an outline of current health inequalities across the ICB.
Enhance productivity and value for money	Provides an overview of current performance in relation to finance across the ICB.
Help the NHS support broader social and economic development	Provides an overview of current performance in relation to workforce across the ICB.

Appendices:
Appendix 1 – Integrated Performance Report November 2022

Board Assurance Framework:

This paper provides assurance in relation to the management of the following ICB strategic risk(s):

- Risk 1: Health Inequalities and Outcomes – Failure to adequately address health inequalities and improve health outcomes for the population of Nottingham and Nottinghamshire.
- Risk 2: System Resilience (for Managing Today) – Working effectively across the system may fail to address the current levels of demand across primary, community and secondary care.
- Risk 6: Quality Improvement – Failure to maintain and improve the quality of services.
- Risk 7: People and Culture – Failure to ensure sufficient capacity and capability within the local workforce.
- Risk 10: Financial Sustainability – Establishing a shared culture of financial stewardship may not ensure financial sustainability across the system.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	No
Duty to promote innovation	No
Duty in respect of research	No
Duty to promote education and training	No
Duty to promote integration	No
Duty to have regard to the wider effect of decisions	Yes
Duties as to climate change	No
Duties regarding public involvement and consultation	No
Public sector equalities duties	Yes

Report Previously Received By:
Sections of the IPR are reviewed by the relevant committees of the Board.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Integrated Performance Report

Executive Summary

1. An ICB Scorecard has been provided on page 4 of Appendix 1, which provides a summary of current delivery of the ICB against the various key system requirements aligned to the ICS four core aims. This highlights that the system is experiencing pressures to delivery across all areas of the ICS aims. Patients are experiencing extended waits across urgent care and elective pathways; the financial position is in a deficit position against plan at month six and there are challenges in recruitment in line with substantive staffing plans. There are also high vacancy and sickness absence levels which are leading to greater agency usage than planned.

Finance (Stuart Poynor)

2. **Year to date** – at the end of month six, the NHS System reported a £36.3 million deficit position, which is £12.9 million adverse to plan. The ICB position reported a breakeven position, acute provider position reported £12.3 million adverse variance and the mental health/community trust a £0.6 million adverse to plan. The main drivers of the deficit related to Covid costs, efficiency shortfalls, Community Diagnostics Centres (CDC) funding gap, pay award shortfall and urgent care capacity above planned levels.
3. **Forecast** – the forecast position remains breakeven against the £17 million deficit plan; however there are significant risks to delivery, particularly high risks relating to Covid, efficiency and CDC income.
4. **Financial risks** – the system has undertaken a full review of risks with potential impact upon the system financial position in year. These are detailed in the main report on page 41.
5. **Capital** – The system capital envelope is underspent by £3.2 million to the end of month six and forecasting to spend the full £89.6 million by the end of the financial year.
6. **Agency** – NHS England has introduced an agency cap of £54.6 million for NHS Nottingham and Nottinghamshire ICS, current forecast is that the ICS will exceed the agency cap by £16.7 million.

Service Delivery (Stuart Poynor)

7. The system is failing to meet the majority of the operational planning targets for 2022/23 across service performance (see Appendix 1, pages 6-9). The SPC charts indicate that whilst there are some areas of improvement, the position is not likely to return to within the set control levels within the year across many of

the areas (see Appendix 1, Page 19). The system is taking specific actions against each area to target further improvements during the year as outlined below.

8. **Urgent care demand and pressures** continue to be high across the system. Difficulties with the ability to flow patients through the acute system is contributing to patients waiting longer on ambulances or in the Emergency Department. Harm reviews are undertaken across this cohort of patients, which is overseen through the System Quality Group.

9. **System flow** is a key driver in the deteriorating performance of electives and cancer as well as the urgent care position outlined above. This is due to difficulties in discharging patients from the acute episode of care into an alternative setting, such as community, social or home care. This leads to patients remaining in acute beds longer than is necessary, which prevents other patients from accessing the hospital. Medically Safe for Transfer (MSFT) and Length of Stay (LOS) (see Appendix 1, page 22) remain the most pressured areas of concern to release bed capacity into the acute sector. The Discharge to Assess business case has been approved, which is designed to improve the discharge process and reduce reliance on interim capacity. The 100 Day Discharge Challenge continues to be progressed by the system, which aims to deliver against 10 best practice initiatives that make a significant difference in facilitating discharge and improving care for patients. It should improve the current position around discharge ahead of entering the winter period. The national 100-day challenge may lead to recommendations for the ongoing improvement, support and monitoring that the system may need around discharge going forwards.

10. **Elective Care:** Urgent care demand, flow and staffing challenges have limited the volume of elective activity that providers have been able to undertake. Providers have focused on delivery of cancer treatment and high priority waiting list activity. However, this has had a significant impact on low clinical priority cases and specialties and has led to rising waiting lists and 52-week waiters.

11. The ICB is robustly managing the patients potentially waiting 104 weeks; at the end of August 2022 there were 81 patients against a plan of nine. This will continue to be a focus area as the system moves to reduce the number of patients waiting over 78 weeks. Mutual aid across the acute system and independent sector providers continues, based on equity of waits. Any cancelled operations are being clinically reviewed daily. To increase elective capacity, building works on modular wards and theatres at City Hospital are progressing. The newly built wards are due to open in January 2023, which is later than the original plan of Autumn 2022.

12. **Cancer:** Demand for cancer services has been around 20% higher than pre-COVID levels since January 2021. Whilst it is a positive position for patients, in that missing cancer referrals during Covid appear to have come forward, the

high level of demand is causing pressure in some services. Issues relating to capacity, such as for radiology, are leading to patients being seen beyond the day 14 target across breast and urology. However, additional clinics and increased levels of diagnostic activity are being undertaken which means that some patients, whilst unfortunately waiting longer than 14 days for their initial consultation, are receiving a timely diagnosis within 28 days. Note that across all tumour sites, performance for the system against the Faster Diagnosis Standard was 77.5% in August against the 75% national standard.

The increased levels of demand are also impacting upon the volumes waiting on the cancer pathway, as can be seen with the increased volumes of patients waiting over 62 days. The latest published position for the 62-day cancer backlog relates to August 2022, which highlights that there were 487 patients against a plan of 349 patients waiting beyond 62 days. The position is also tracked weekly using provisional data, which shows that at week ending 16 October, the system backlog was 503 patients. A trajectory has been developed and submitted to NHS England, which provides a weekly forecast of the volume of patients that are expected to be waiting 62 days or more between November 2022 and the end of March 2023. The trajectory was submitted on 28th October and will be included within the November report to the ICB Finance and Performance Committee.

13. **Diagnostics:** Across all modalities there is an increasing waiting list for the system. The two modalities with most significant backlogs are MRI and Echocardiography. Significant improvements are being made across MRI at Nottingham University Hospitals NHS Trust (NUH), seeing a waiting list reduction of 1,300 patients since January 2022. Echocardiography remains an area of significant concern at Sherwood Forest Hospitals NHS Foundation Trust (SFH). SFH are working to utilise locum and insourcing providers to provide additional capacity, as well as offering weekend working to existing staff to increase capacity levels further. A diagnostic recovery trajectory has been developed by the system, which details the diagnostic waiting list volume and backlog by modality between October and March 2023. This trajectory has been submitted to NHS England, with feedback yet to be provided. Routine performance reporting to the ICB Diagnostics Board has been revised to track progress towards the end of year ambition at modality level.

14. **Mental Health:** Staffing levels remain an issue due to staff absences, and the reintroduction of infection, prevention and control measures, however new bank arrangements are being progressed ahead of winter. There are concerns relating to overspends on capital works at Sherwood Oaks due to increased inflationary costs during completion of key works which are being discussed with NHS England. The facility is to become operational in the new year to support Out of Area Placements and the eradication of dormitory accommodation. Out of area placements increased rapidly in quarter one;

however, crisis and continuity of care principles have led to reductions in August. There is a potential risk to Increasing Access to Psychological Therapies (IAPT) delivery as the system enters re-procurement processes for April 2023 which may cause uncertainty for staff, which will be actively managed.

15. **Primary Care:** The number of GP appointments was below plan in August 2022. However, the volume of appointments in September has returned to expected levels and is less than 1% below the planned number. This is a strong position considering the additional bank holiday that took place in month due to the state funeral of Queen Elizabeth II. The majority of patients are being seen the same and next day. The system continues to offer a blended model, with 67% of appointments being delivered face to face, and home visits continue to increase. Capacity and demand pressures remain high within primary care.

16. **Community Care:** Waiting lists – Work is underway to review the baseline data that was used to develop the plan and ensure that it included the correct range of services that were defined within the technical planning guidance. This work will be completed during November and an update will be included in the next Integrated Performance Report.

Health Inequalities (Dave Briggs)

17. Health Inequalities Dashboards have been provided on pages 55-56 of Appendix 1. These have been established by the National Commissioning Data Repository (NCDR) and provide an overview of metrics for ethnicity and deprivation and how the indicators vary for the different patient cohorts relative to the population mean, for the Nottingham and Nottinghamshire population. These reports will be extended further across other indicators for mortality and morbidity as they provide a clear indication of how we are performing and where the risks are in relation to health inequalities and the ICS aims and ambitions (currently aim 1 of the outcomes framework). Included in the report is also an overview of the current status in relation to smoking and the CORE20+5. Ongoing, the IPR will provide a focus on a different CORE20+5 clinical area in order to provide board level oversight.

Quality (Rosa Waddingham)

18. Appendix 1 (pages 12-17) provides detail in relation to delivery against quality plan requirements and trajectories across learning disabilities and autism, personalisation, co-production, maternity, infection prevention and control and vaccinations.

19. Under the revised National Quality Board guidance, one NHS provider is subject to intensive surveillance: Nottingham University Hospitals NHS Trust

(NUH). A system-wide Improvement Oversight and Assurance Group is in place, which includes oversight of partnership support and mutual aid arrangements.

20. One NHS provider is subject to enhanced surveillance: Nottinghamshire Healthcare NHS Foundation Trust. The Trust has a system-wide quality assurance group and partnership support in place. The final planned CQC inspection (at Rampton Hospital) concluded on 23 September 2022. Concerns were raised in relation to safer staffing and outcomes for patients. The Trust has responded to the initial feedback and concerns raised. The final report is not yet published. Joint ICB/Trust oversight of sub-contracted mental health beds at the two Priory Group hospital settings continues.

21. Flu and Covid vaccination programmes have commenced and uptake across the system is positive. There has been a focus on ensuring that the most vulnerable are protected, with an early focus on care home residents and housebound patients being vaccinated by the end of October. There has also been a clear system-wide offer for health and care staff to ensure maximum resilience of our workforce over the winter. Plans to develop a whole system immunisation and vaccination model are underway and the programme is now also looking to deliver other vaccines building on the success (especially in relation to managing inequalities) of the Covid vaccination programme.

22. Care home and home care sector governance is being refined and refreshed in light of the newly formed ICB. Terms of Reference are being updated and ratified. The highest risk is the capacity in the home care market, due to a national workforce shortage. The ICB has presented its commissioning plans for home care at the Strategic Priority and Investment Committee. Further work will be led by the Market Management Group; this group was set up by the Care Homes and Home Care 0perational Group, reporting into the Care Homes and Home Care Strategic Group. The Social Care Nursing Task and Finish Group is undertaking a review of available training and preceptorship for nurses in social care with the aim of developing a programme to support nurses to improve recruitment and retention.

23. System partners continue to work closely with NUH and regulators in relation to Maternity Services, in order to oversee and support improvements. A comprehensive partnership plan to reduce the serious incident backlog is in place, supported by NHS England and Lincolnshire Local Maternity and Neonatal System, with honorary contracts pending and panel dates booked between September and November. The Independent Review led by Donna Ockenden commenced on 1 September; the ICB continue to provide all information requested by Donna Ockenden’s team and remain available to feed in other relevant information and data as required.

24. The Local Maternity and Neonatal System programme remains under enhanced surveillance due to capacity concerns to transform services in line

with requirements given operational pressure and demands. The focus remains on implementing Ockenden recommendations, developing our Maternity Voices Partnership and Neonatal Voices, and implementing Equity Strategy Plans (see Appendix 1, page 15).

25. The Learning Disability and Autism Partnership Programme remains under enhanced surveillance due to adult inpatient numbers, rapid response to the Five Eyes recommendations, and increased host commissioner responsibilities (ensuring quality and safety of the increasing numbers of non-Nottinghamshire inpatients placed in Nottinghamshire settings). There is continued focus on adult inpatient admissions and discharges, as the target set by NHS England is forecast not to be met. Needs assessment and market development work is being strengthened and annual health checks are progressing well (see Appendix 1, page 13).

26. Infection prevention and control and hospital acquired infections remain an area of focus, due to breaches against plan positions across a range of the new reduction targets; however, this is an issue replicated in many areas and the system is not an outlier (see Appendix 1, page 16).

Workforce (Rosa Waddingham)

27. The workforce report predominantly focuses on the three acute, community and mental health trusts within the system, reporting on the September 2022 position against the Operational Plan for 2022-23. The collective position shows the Trusts are almost on plan (-50.6 WTE) with the substantive WTE yet seeing a continued use of Bank and Agency at 26% (392.8 WTE) and 30% (241.6 WTE) above plan respectively. (see Appendix 1, page 44).

28. Sickness absence in the acute, community and mental health trusts saw increases in the daily position over September to 7.2% all sickness and 1.8% Covid related sickness. The 12-month rolling average position for each Trust has fallen to a position of 5.5% sickness, which is higher than the pre-Covid levels needed to be achieved of 4.7%. Wellbeing plans remain in place in all organisations with the Staff Support Hub engaging with all partners on increasing the awareness of, and access to, the services available.

29. Substantive vacancies reported in September for the acute, community and mental health trusts remains at the same level as last month which is at 12.8%, 4.1% above target position within the Operational Plan. Vacancies are seen across all professional groups with the most significant being seen across registered nursing and Health Care Support Worker (HCSW) posts. There will have been changes to organisation establishments that, given the methodology used to determine vacancy levels, will have affected this position therefore presenting a false indicator for the number of actual vacancies. Trusts are progressing the related recruitment plans to these changes in establishment.

There are collaborative recruitment working groups in place for HCSW, midwifery and registered nurses that look at both international and domestic recruitment. Retention of our existing workforce is a key focus with Nursing and midwifery retention plans developed in each Trust and additional capacity of a system retention lead recruitment in progress.

30. Joint work with finance continues in the Agency High Impact Action Group analysing agency usage, aligned to an analysis developed on understanding the substantive workforce and its deployment in delivery of the Operational Plan 2022/23 plan. Additional capacity has been brought in to support this work from Arden & GEM Commissioning Support Unit with NHS England regional service improvement team establishing an Agency Review Group. Provider Chief People Officers/ Directors of Human Resources are informing the action plan and aligning to provider collaborative workstreams in place (HCSW recruitment, joint recruitment strategy, resourcing staff solutions and medical staffing groups).

31. Primary Care General Practice data, which includes the additional roles position, a national priority for growing our general practice workforce, is presented at a high level, showing indicative workforce numbers against the 2022/23 Operational Plan for August 2022. The general practice workforce position is collected from practices through a National Workforce Reporting Service (NWRS) support. The data collected is limited with variations in submissions linked to unclear definitions. The system is working with the national development team in NWRS to improve standardisation through clear definitions of data capture alongside consideration of local agreements to increase the utilisation of NWRS functionality.

32. Development work is in progress to agree relevant data collection on the current adult social care and care home workforce positions. The State of Adult Social Care Sector and Workforce 2022 report, published by Skills4Care (October 2022) presents the latest data on workforce characteristics, issues, and trends. A presentation from Skills4Care on the Nottinghamshire position is scheduled for consideration by the ICS People and Culture Group in October. The workforce characteristics, issues, and trends reported are included in the Appendix 2. The most notable change is the net reduction in workforce despite increased recruitment, suggesting higher numbers of leavers added to the continual churn of turnover within the sector.

NHS
Nottingham and Nottinghamshire

Nottingham & Nottinghamshire Integrated Care Board

Integrated Performance Report

Reporting Month: August 2022

Board Month: November 2022

Integrated Performance Report 2022/23 – Report Contents

NHS Nottingham and Nottinghamshire

NHS
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Introduction

This report presents progress against the key performance targets, across quality, service delivery, finance and workforce, and to note key developments and actions being taken to address performance issues. Where appropriate, information is provided for total Nottingham and Nottinghamshire population, and total provider responsibilities for those providers geographically located within Nottinghamshire, Sherwood Forest Hospitals (acute), Nottingham University Hospitals (acute) and Nottinghamshire Healthcare NHS Trust (mental health). The indicators included in the Board IPR are reviewed annually and are based on the system operational plan for 2022/23, compliance and commitment targets, and any additional key local and national measures.

The intention is that each ICS Oversight Group, which is led by an ICB Executive Lead, will propose a level of assurance following the discussion of the reported metrics based upon the ICS Assurance Escalation Framework (page 60) which will support the escalation of issues to the ICB Board. This will develop and embed as an approach over the next few months.

Service Delivery and workforce areas have adopted a new reporting approach using Statistical Process Control (SPC) charts, further detail relating to SPC is included on page 61 of the report for reference to aid the review of the performance report tables included in the report. The aim of the SPC charts is to provide richer information relating to whether a service is improving or deteriorating based on trend (variation icons) and the likelihood of the system plan or target being met (assurance icons).

An ICB Scorecard has been provided on page 4 which provides a summary of the current delivery of the ICB against the various key system requirements aligned to the ICS Four Key Aims. This highlights that the system is experiencing pressures to delivery across all areas of the ICS Aims, with patients experiencing longer waits than acceptable across urgent care and elective pathways, the financial position in a deficit position against plan at month 6 and difficulties in recruitment in line with substantive staffing plans, high vacancy and sickness absence are leading to higher levels of agency usage than planned.

The full detail of the performance measures which the ICB is required to deliver, are provided across a series of functional score cards on pages 5 –11. These provide an overview of the areas which are and are not delivering as planned. The SPC icons provide an indication of the improvement or deterioration in the position as well as an indication of whether the current process or performance levels will achieve the required level in future.

Exception reports by functional area, detailing the areas of concern, actions being taken to address the current issues, and assurance as to whether these actions will impact upon and improve the position, are provided on pages 12 – 58.

NHS Nottingham and Nottinghamshire

1. ICB Scorecard by ICS 4 Aims – Reporting @ August 2022/23

AIM-01 Improve Outcomes in Population Health and Healthcare

ID	Key Performance Indicators	Date	Plan	Actual	In Month	Variation	Assurance
	Quality						
	LD&A Annual Health Checks	22-23 Q2	29%	27%	✗	-	-
	Total LD&A Inpatients	Sep-22	51	50	✓	-	-
	No. Personal Health Budgets	21-22 Q4	5800	5271	✗	-	-
	MRSA	Aug-22	0	2	✗	-	-
	CDI	Aug-22	38	49	✗	-	-
	Ecoli BSI	Aug-22	108	116	✗	-	-
	Klebseilla BSI	Aug-22	34	55	✗	-	-
	Pseudomonas BSI	Aug-22	14	20	✗	-	-
	Flu Vaccinations	tbd	-	-		-	-
	No. stillbirths per 1000 total births	Aug-22	2.5	1.7	✓	-	-
	No. neonatal deaths per 1000 live	Aug-22	1.5	0	✓	-	-
	Urgent Care						
	12 hour breaches	Sep-22	0	685	✗	H	?
	Handover delays > 60 minutes	Sep-22	0	333	✗	H	F
	Length of Stay > 21 days	Sep-22	231	482	✗	H	F

AIM-03 Improving the Effective Utilisation of Our Resources

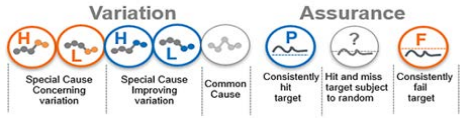
ID	Key Performance Indicators	Date	Plan £m	Actual £m		Variance £m	FOT £m
	Delivery against system plan	Sep-22	-23.5	-36.3		✗ 12.8	✓ 0.0
	Efficiency Target	Sep-22	38.0	37.0		✗ -1.0	✓ 0.0
	ESRF Income	Sep-22	23.2	23.2		✓ 0.0	✓ 0.0
	Agency Spend	Sep-22	28.9	41.5		✗ 12.6	✗ -16.7
	MHIS	Sep-22	94.1	101.5		✓ 7.4	✓ 2.4
	Capital Spend	Sep-22	31.0	27.8		✗ -3.2	✓ 0.0

AIM-04 Support Broader Social and Economic Development

ID	Key Performance Indicators	Date	Plan	Actual	In Month	Variation	Assurance
	Provider Substantive Staffing	Sep-22	29,064	29,013	✗	H	F
	Provider Bank Staff	Sep-22	1,502	1,894	✓	H	?
	Provider Agency Staff	Sep-22	805	1,046	✓	H	?
	Provider Staff Vacancy Rate	Sep-22	8.7%	12.8%	✗	H	?
	Provider Staff Absence Rate	Sep-22	4.6%	5.5%	✗	H	F
	Primary Care Workforce	Aug-22	-	2980		H	-

AIM-02 Tackle Inequalities in Outcomes, Experience and Access

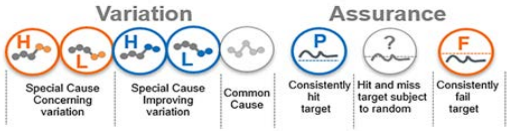
ID	Key Performance Indicators	Population Date	Population Plan	Population Actual	In Month	Variation	Assurance	Provider View Plan	Provider View Actual	In Month	Variation	Assurance
	Planned Care											
	Total Waiting lists	Aug-22	-	107507	-	H	-	101733	117417	✗	H	F
	Patients Waiting >104 weeks	Aug-22	-	64	-	-	-	9	81	✗	L	F
	Cancer 62 Day Backlog	Aug-22	-	-	-	-	-	349	487	✗	-	F
	Cancer Faster Diagnosis	Aug-22	75.0%	77.5%	✓	H	?	75.0%	77.5%	✓	H	?
	OP Remote Delivery	Aug-22	25.0%	20.3%	✗	-	?	25.0%	20.6%	✗	-	?
	Childrens Wheelchair Provision	Q1 2022/23	91.6%	68.9%	✗	-	F	-	-		-	-
	Community											
	Community Waits - Adult	Jun-22	3754	9141	✗	H	F	-	-		-	-
	Virtual Wards	From Nov 2022						-	-		-	-
	Primary Care											
	GP Appointments	Aug-22	599,832	550,013	✗	H	?	-	-		-	-
	NHS App	Oct-22	60%	51%	✗	H	F	-	-		-	-
	Mental Health											
	IAPT Access	Jun-22	8984	8110	✗	H	F	-	-		-	-
	CYP Access	Jun-22	13300	17880	✓	H	P	-	-		-	-
	Out of Area Placements	Jul-22	0	260	✗	-	F	-	-		-	-
	SMI Physical Health Checks	Jul-22	3750	3424	✗	H	?	-	-		-	-
	Health Inequalities - Prevention											
	NHS Digital WM Referrals	Jun-22	627	208	✗	-	-	-	-	-	-	-
	Offered Tobacco Treatment	Jun-22	1111	1051	✗	-	-	-	-	-	-	-



NHS Nottingham and Nottinghamshire

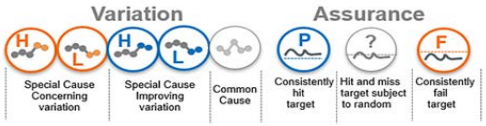
2. Quality Scorecard

Quality Scorecard	Latest Period	Population			Variation	Assurance	Exception Report
		Plan	Actual	Variance			
Learning Disability & Autism							
LD&A Inpatients Rate Adults - ICB	Sep-22	14	17	✗ 3	-	-	Page 13
LD&A Inpatients Rate Adults - NHSE	Sep-22	34	32	✓ -2	-	-	
LD&A Inpatients Rate CYP - NHSE	Sep-22	3	1	✓ -2	-	-	
LD&A Annual Health Checks	22-23 Q2	29%	27%	✗ -2.0%	-	-	
Personalisation							
No. of Personal Health Budgets	21-22 Q4	5800	5271	✗ -529	-	-	Page 14
No. PCN funded social prescribing link workers	21-22 Q4	54	68	✓ 14	-	-	
No. Social prescribing referrals into link workers	21-22 Q4	8377	8988	✓ 611	-	-	
No. active PCSPs in place	21-22 Q4	24000	40207	✓ 16207	-	-	
Personalised Care Institute Training	May-22	596	210	✗ -386	-	-	
Maternity							
No. stillbirths per 1000 total births	Aug-22	2.5	1.7	✓ -0.8	-	-	Page 15
No. neonatal deaths per 1000 live births	Aug-22	1.5	0.0	✓ -1.5	-	-	
Hospital Acquired Infections							
MRSA	Aug-22	0	2	✗ 2.0	-	-	Page 16
CDI	Aug-22	38	49	✗ 11.0	-	-	
Ecoli BSI	Aug-22	108	116	✗ 8.0	-	-	
Klebseilla BSI	Aug-22	34	55	✗ 21.0	-	-	
Pseudomonas BSI	Aug-22	14	20	✗ 6.0	-	-	



3a. Service Delivery Scorecard - Streamline Urgent Care and Flow

Urgent Care Scorecard	Latest Period	Population			Variation	Assurance	Latest Period	Provider			Variation	Assurance	Exception Report
		Plan	Actual	Variance				Plan	Actual	Variance			
Urgent Care Access													
Extended Access Primary Care Appointments Booked	Jun-22	9717	7363	✖ -2354				-	-	-	-	-	Page 20
SDEC Admissions							Aug-22	-	3846				
Ambulance Conveyances (%)	Sep-22	55.2%	55.6%	✖ 0.4%				-	-	-	-	-	
Ambulance Conveyances (Vol.)	Sep-22	7916	7932	✖ 16				-	-	-	-	-	
A&E Attendances v 19/20 (%)	Aug-22	100%	98.1%	✔ -1.9%			Sep-22	100%	104.7%	✖ 4.7%			
% Unheralded Patients attending A&E		-	-	-	-	-	Aug-22	-	69.8%	-		-	
NEL Admissions v 19/20 (%)	Aug-22	100%	93.4%	✔ -6.6%			Aug-22	100%	96.1%	✔ -3.9%			
Urgent Care - Acute Discharges and Out of Hospital													
% patients medically safe to transfer from acute setting		-	-	-	-	-	Sep-22	73	223	✖ 150			Page 21
Length of Stay > 21 days		-	-	-	-	-	Sep-22	231	482	✖ 251			
No. Patients utilising Virtual Ward		-	-	tbc	-	-		-	-	-	-	-	
2 Hour Urgent Care Response Contacts	Aug-22	395	539	✔ 144				-	-	-	-	-	
2 Hour Urgent Care Response %	Aug-22	-	90.67%	-		-							
Pathway 1 - Discharge home with health and/or social care							Aug-22	1270	747				
Urgent Care - Compliance													
Ambulance (mean) Response Times Cat 1 (Notts Only)	Sep-22	0:07:00	00:08:00	✖ 00:01:00				-	-	-	-	-	Page 22
Ambulance (mean) Response Times Cat 2 (Notts Only)	Sep-22	0:18:00	00:41:32	✖ 00:23:32				-	-	-	-	-	
Hospital Handover Delays > 60 Minutes		-	-	-	-	-	Sep-22	0	333	✖ 333			
12 Hour Breaches ED		-	-	-	-	-	Sep-22	0	685	✖ 685			
12 Hour Breaches as % NEL		-	-	-	-	-	Sep-22	2%	5.2%	✖ 3.2%			

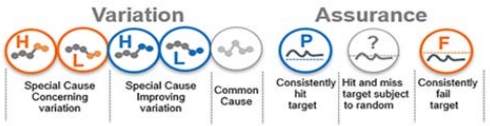


'tbc' - A number of metrics require additional data flows directly from the trusts, these are being arranged to enable monitoring of the planning metrics from next month.

NHS Nottingham and Nottinghamshire

3b. Service Delivery Scorecard - Planned Care Recovery

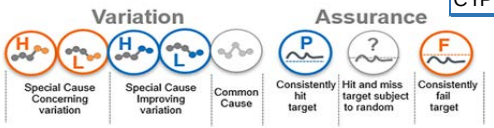
Elective Scorecard	Latest Period	Population			Variation	Assurance	Latest Period	Provider			Variation	Assurance	POG Exception Report
		Plan	Actual	Variance				Plan	Actual	Variance			
Elective Recovery - Total Waiting List & Long Waits													
Total Waiting List Size	Aug-22	-	107507	-	H	-	Aug-22	101733	117417	✖ 15684	H	F	Page 15
Incomplete RTT pathways >52 weeks	Aug-22	-	4821	-	H	-	Aug-22	3793	4945	✖ 1152	H	F	
Incomplete RTT pathways >78 weeks	Aug-22	-	796	-		-	Aug-22	802	862	✖ 60		?	
Incomplete RTT pathways >104 weeks	Aug-22	-	64	-		-	Aug-22	9	81	✖ 72	L	F	
Elective Recovery - Activity													
Total Referrals	Aug-22	26600	24626	✖ -1974	H	?	Aug-22	25394	22851	✖ -2543	H	?	Page 16
Total Ordinary Electives	Aug-22	1993	1820	✖ -173		?	Aug-22	2291	1831	✖ -460		?	
Total Daycases	Aug-22	12327	12858	✔ 531	H	?	Aug-22	13595	12294	✖ -1301	H	?	
Total Outpatients - First Appointments	Aug-22	35549	24625	✖ -10924	H	F	Aug-22	27462	22282	✖ -5180		F	
Total Outpatients - Follow Ups	Aug-22	71215	60579	✖ -10636	H	F	Aug-22	62950	58515	✖ -4435	H	?	
Total Diagnostic Activity	Aug-22	38057	35162	✖ -2895	H	F	Aug-22	33154	31298	✖ -1856	H	?	
Elective Recovery - Productivity & Transformation													
Total Outpatients - Total Virtual (%) 25%	Aug-22	25%	20%	✖ -5%		?	Aug-22	25%	21%	✖ -4%		?	Page 17
Patient Initiated Follow ups - %	-	-	-	-	-	-	Sep-22	5.0%	4.6%	✖ -0.4%	H	F	
Advice & Guidance - % of 1st OP	Aug-22	16	32	✔ 16	H	P	-	-	-	-	-	-	
Total Outpatient F/Up v 2019/20 Activity (%) 25% Reduction	Aug-22	75.0%	108.5%	✖ 33.5%	H	?	Aug-22	75.0%	109.8%	✖ 34.8%	H	?	
Completed admitted RTT pathways	Aug-22	5211	4082	✖ -1129		?	Aug-22	4850	4087	✖ -763		?	
Completed non-admitted RTT pathways	Aug-22	21422	19222	✖ -2200	H	?	Aug-22	19844	20210	✔ 366	H	?	
Diagnostic Recovery													
Diagnostic Activity	Aug-22	38057	35162	✖ -2895	H	F	Aug-22	33154	31298	✖ -1856	H	?	Page 19
Diagnostic Waiting List	Aug-22	-	28522	-		-	Aug-22	-	25680	-		-	
Diagnostic Backlog	Aug-22	-	10995	-		-	Aug-22	-	10195	-		-	
Diagnostics + 6 Weeks	Aug-22	25%	38.5%	✖ 13.5%		F	Aug-22	25%	39.7%	✖ 14.7%		F	
Cancer Recovery													
Cancer Referrals	Aug-22	-	4311	-	H		Aug-22	-	4800	-	H	-	Page 18
Cancer - Faster Diagnosis Standard 28 days	Aug-22	75.0%	77.5%	✔ 2.5%	H	?	Aug-22	75.0%	77.5%	✔ 2.5%	H	?	
Cancer - No. 1st Definitive Treatments	Aug-22	587	486	✖ -101	H	?	Aug-22	704	599	✖ -105	H	?	
Cancer - No. patients receiving 1st treatment < 31 days (%)	Aug-22	96%	89%	✖ -6.7%	H	?	Aug-22	96%	89%	✖ -6.7%	H	F	
Cancer - No. patients waiting < 62 days (%)	-	-	-	-	-	-	Aug-22	85%	60%	✖ -25.2%	H	F	
Cancer - 62 day backlog	-	-	-	-	-	-	Aug-22	349	487	✖ 138		F	



NHS Nottingham and Nottinghamshire

3c. Service Delivery - Mental Health Scorecard

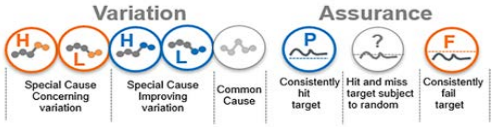
Mental Health Scorecard	Latest Period	Population			Variation	Assurance	Exception Report
		Plan	Actual	Variance			
Mental Health - Improving Access to Psychological Therapies							
IAPT - Referrals	Jun-22	-	3155	-		-	Page 30
IAPT - 1st Treatment <6 Weeks	Jun-22	75%	77.0% ✔	2.0%		P	
IAPT - 1st Treatment <18 Weeks	Jun-22	95%	100% ✔	5.0%	H	P	
IAPT - Entering Treatment 3 Months	Jun-22	8984	8110 ✖	-874	H	F	
IAPT - >90 Days between 1st and 2nd Treatment	Jun-22	10%	13.6% ✖	3.6%	H	?	
IAPT - Recovery Rate (3 months rolling)	Jun-22	50%	51.7% ✔	1.7%		P	
Mental Health - Adult Mental Health							
Adult MH Inpatient Discharges - % F Up 72 hours	Jun-22	80%	85% ✔	5.0%	H	?	Page 31
Inappropriate OAP Bed days	Jul-22	0	260 ✖	260		F	
Rate per 100,000 Older Adult MH LOS > 90 Days	Jun-22	11	18 ✖	7.25	H	?	
SMI Health Checks	Jul-22	3750	3424 ✖	-326	H	?	
Access SMI +2 Contacts Community MH Services	Jun-22	11854	12200 ✔	346		P	
Dementia Diagnosis	Aug-22	67%	68.8% ✔	2.1%		P	
Mental Health - Access							
Perinatal Access % (12 month rolling)	Jun-22	9.3%	7.1% ✖	-2.2%		F	Page 32
Perinatal Access - Volume	Jun-22	828	925 ✔	97		P	
Individual Placement Support	Jun-22	225	360 ✔	135	H	?	
Early Intervention in Psychosis (EIP)	Jun-22	60%	70% ✔	10.0%		P	
Mental Health - Children & Young People							
CYP - New Referrals	Mar-22	-	2190	-	H	-	Page 33
CYP Eating Disorders - Routine Referral Performance (Qtr)	Jun-22	95%	71% ✖	-23.9%	L	F	
CYP Eating Disorders - Urgent Referral Performance (Qtr)	Jun-22	95%	91% ✖	-3.7%	H	F	
CYP Access (1+ Contact)	Jun-22	13300	17880 ✔	4580	H	P	



3d. Service Delivery – Primary & Community Scorecard

NHS Nottingham and Nottinghamshire

Primary Care and Community Scorecard	Latest Period	Population			Variation	Assurance	Exception Report
		Plan	Actual	Variance			
Primary Care and Community Recovery							
Total Appointments	Aug-22	599,832	550,013	-49,819			Page 35
Percentage of Face to Face Appointments	Aug-22	-	67%	-			
Percentage of Same Day Appointments	Aug-22	-	43%	-			
Number of NHS App Registrations	Oct-22	60%	51%	-9%			
Community Waiting List (Patients aged 0-17 Years)	Jun-22	576	1785	1209			
Community Waiting List (Patients aged 18+ Years)	Jun-22	3754	9141	5387			



4. Finance - Scorecard

		YTD Variance £m's			FOT Variance £m's			RAG	
Financial Duties	Measure	Plan	Acts	Variance	Plan	FOT	Variance	YTD	FOT
NHS System (Breakeven)	(Deficit)/Surplus	-23.5	-36.3	-12.9	-16.9	-16.9	0.0		
Capital (within Envelope)	Spend against plan	31.0	27.8	3.2	89.6	89.6	0.0		
MHIS (meeting target)	Spend against plan	94.1	101.5	7.4	188.1	190.6	2.4		
Agency (spend within Cap)	Spend against plan	28.9	41.5	-12.6	54.6	71.4	-16.7		

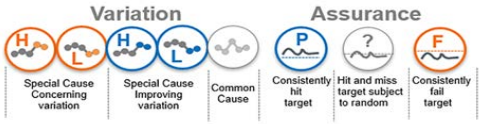
		YTD Variance £m's			FOT Variance £m's			RAG	
Drivers of the (Deficit)/Surplus	Measure	Plan	Acts	Variance	Plan	FOT	Variance	YTD	FOT
COVID Spend	Delivery against plan	14.0	19.6	-5.6	17.8	28.0	-10.2		
NHS Efficiencies	Delivery against plan	38.0	37.0	-1.0	102.7	102.7	0.0		
ERF Income	Delivery against plan	23.2	23.2	0.0	53.7	53.4	-0.3		

- **£36.3m** deficit experienced to end of month 6, which is **£12.9m** adverse to plan.
- The adverse variance is mainly experienced in the 2 acute trusts (NUH & SFH) representing **£12.3m** of the year to date deficit.
- Key drivers of the adverse variance are covid (**£5.6m**), continuing care spend **(£4.9m**) and efficiency shortfall (**£1m**). Offsetting favourable variances include clinical supplies (£5.5m) due to elective surgery performing below planned levels and delegated primary care (£3.8m).
- Agency spend remains over plan and above the agency cap, with an adverse YTD variance of **(£12.6m**).
- The forecast remains break-even but there are significant risks to delivery, particularly relating to covid, efficiency, continuing care and urgent care capacity over winter.

NHS
Nottingham and Nottinghamshire

5. Workforce - Scorecard

Workforce Scorecard	Latest Period	Total Provider			Variation	Assurance	Exception Report
		Plan	Actual	Variance			
Total Provider Workforce							
Total Provider Workforce	Aug-22	31,453	31,061	-392			Page 44
Total Provider Substantive	Sep-22	29,064	29,013	-51			
Total Provider Bank	Sep-22	1,502	1,894	393			
Total Provider Agency	Sep-22	805	1,046	241			
Total Primary Care Workforce	Aug-22	-	2,980	-			Page 46
Key Workforce Performance							
Total Provider Turnover Rate % (12 month rolling)	Sep-22	11.0%	13.7%	2.7%			Page 45
Total Provider Sickness Absence Rate %	Sep-22	4.6%	5.5%	0.9%			
Total Provider In-Month Vacancy Rate %	Sep-22	8.7%	12.8%	4.1%			



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Nottingham and Nottinghamshire

6: Quality

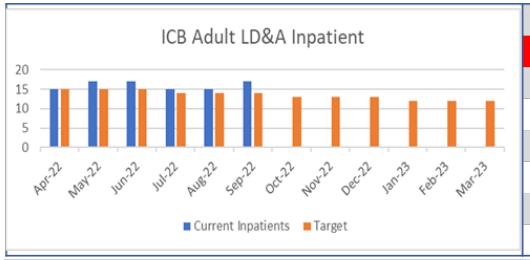
ICS Aim 1: To improve outcomes in population health and healthcare

- 6.1 - Exception Report Learning Disability & Autism
- 6.2 - Exception Report Personalisation & Co-Production
- 6.3 - Exception Report Maternity
- 6.4 - Exception Report Infection Prevention & Control
- 6.5 - Exception Report Vaccinations

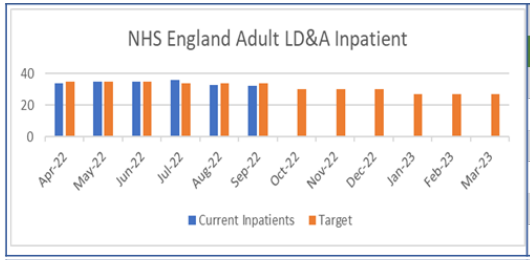
6.1 - Improving Quality of Services – Exception Report Learning Disability & Autism

NHS Nottingham and Nottinghamshire

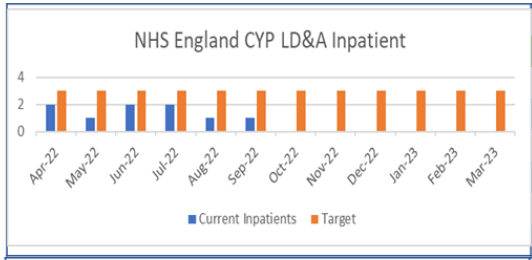
Learning Disability and Autism (LD&A)



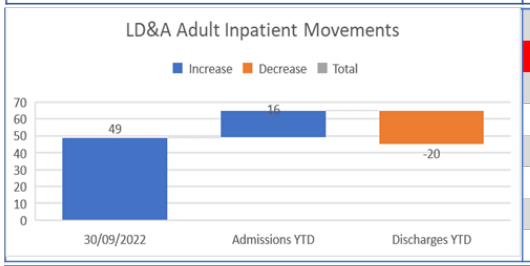
Sep-22
17
2022/23 Plan
14
Assurance
-
SPC Variation
-



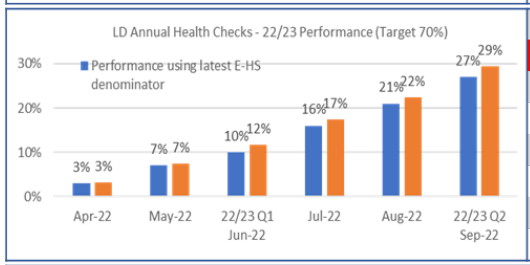
Sep-22
32
Target
34
Assurance
-
SPC Variation
-



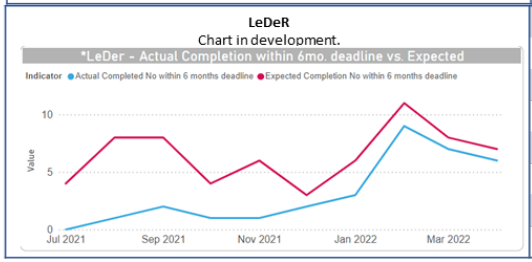
Sep-22
1
Target
3
Assurance
-
SPC Variation
-



Sep-22
0
2022/23 Plan
Assurance
-
SPC Variation
-



22-23 Q2
27%
Target
29%
Assurance
-
SPC Variation
-



Target
Assurance
-
SPC Variation
-

Current Position

LD&A Inpatients ICB: The current adult inpatient number stands at 49, which is 1 above target for the month of September (target is 48). The total number of discharges this year is 17. The total number of admissions stands at 16. Our forecasting of numbers at the beginning of the year has been accurate overall, though we now predict our inpatient number to end on 45 instead of our forecast of 44, due to the unusual number of admissions that have taken place this month (4).

LD&A Inpatients Children & Young People (CYP) (NHS England): We are currently over achieving against the target, with 1 in the system (2 under target).

Learning Disabilities Mortality Review (LeDeR): A new LeDeR Local Area Contact (LAC) started in post in August 2022 and will be pivotal in leading the programme workstream and ensuring that learning actions from reviews are embedded into the LD/A transformation plan. Key learning from reviews to date has resulted in funding being secured for an expansion to the acute liaison team and agreement with NHT for a new speech and language therapist (SALT) post to be advertised to focus on SFH. The LeDeR annual review report has been drafted and is currently going through the sign-off process, with publication expected to be in November.

Annual Health Checks (AHC): Using the latest GP register figures from E-Healthscope as the denominator (14 years and over), this puts our percentage uptake at 27%, an increase of 6% from the previous month. Of those health checks completed, 6% are recorded as not having a Health Action Plan (HAP), with the largest gap in Mid-Notts and Nottingham City (8%), closely followed by South Notts (7%). Ensuring all health checks have a HAP in place is a NHSE priority for 22/23 and GP practices are incentivised this year to improve this via the Investment and Impact Fund (IIF). As of 30 September 22, 653 health checks (30%) have been completed for the priority cohort (those who did not have a AHC last year) across the ICS (target set by NSE/I is 70%).

Actions

LDA&A Inpatients: The system has invested in strengthening the case management approach by recruiting to temporary specialist posts across the ICS, to ensure a robust oversight of admission and inpatient activity. Focused work on long term sustainability will be developed as future funding confirmation is received from NHSE. The admission avoidance workstream and children & young people (CYP) workstream have commenced work to further develop the CYP Dynamic Support register and panel process, and utilise key learning to implement an adult DSR register and panel process. This will ensure robust oversight of children and young people who are at risk of requiring continued support through to adulthood, and will better inform future market development and commissioning based on need. The adult DSR panel will commence in November.

Quality Improvement: Joint working is taking place across quality and LD/A transformation teams to ensure that quality oversight is in place regarding mental health and LD/A inpatient providers that are within our area, irrespective of the commissioning and contractual arrangements. Work is underway with City and County local authorities to develop a new Quality Management role that will support the embedding of learning from safe and well reviews and case management actions. A review of placements has been undertaken with region, with all inpatients confirmed as being in the right setting. It is expected that this role will commence in April 2023 due to delays with the recruitment process at the County Council. Region requested that the ICB share the Out of Area placement approach with the national team as an area of best practice, due to majority of inpatients being placed in ICB or regional footprint.

Workforce Development: the ICS has been successful in securing five new Advanced Clinical Practitioner (ACP) posts across Nottinghamshire Healthcare NHS Trust and Nottingham University Hospitals Trust via an expression of interest process for Health Education England (HEE). These roles are out to advert.

Annual Health Checks: Communications to Primary Care continue to highlight the importance of completing the HAP as part of the health check and encouraging the prioritisation of health checks this year for those without a check in the last 12 months or longer, with targeted conversations taking place. A prompt and link to complete the HAP has now been included on the new version of the local AHC template in F12, as a reminder for clinicians when recording the health check. The new F12 AHC template also includes a Reasonable Adjustments flag and text box to record individual adjustments the patient requires. This flag and information is linked to the Summary Care Record, therefore can be seen (and updated if required) across the health system.

Dashboard development: Initial conversations have been undertaken with the SAIU to develop an LDA dashboard that will contain key LDA performance reporting. This will include key KPI's and outcome measures to demonstrate impact. Work is underway to explore automation of the current inpatient reporting, which is currently undertaken manually.

System Quality Group Assurance – Limited Assurance

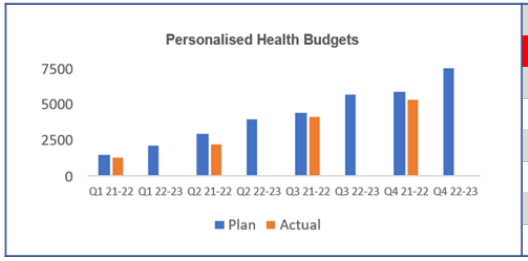
Enhanced Surveillance: Due to Adult Inpatient numbers, rapid response to the Five Eyes recommendations, and increased Host Commissioner responsibilities.

Content Author: Natasha Wrzesinski **Exec Lead: Rosa Waddingham** **System Oversight: System Quality Group** **ICB Committee: Quality & People Committee**

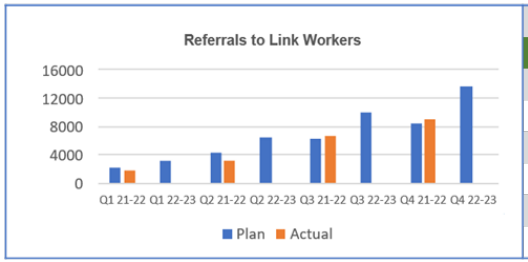
6.2- Improving Quality of Services – Exception Report Personalisation & Co-Production

NHS Nottingham and Nottinghamshire

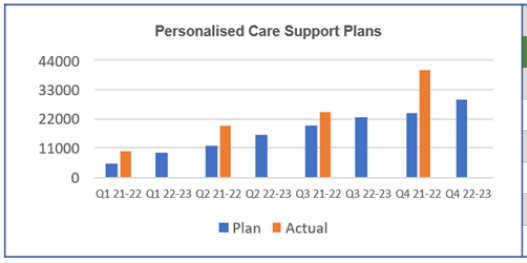
Personalisation



21-22 Q4
5271
2021-22 Plan
5800
Assurance
SPC Variation



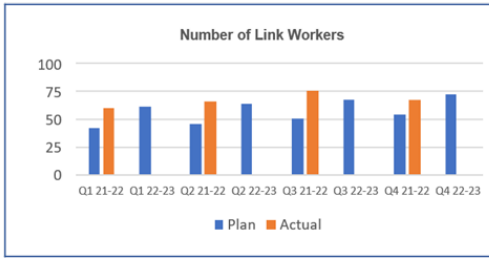
21-22
8988
2021-22 Plan
8377
Assurance
SPC Variation



21-22 Q4
40207
2021-22 Plan
24000
Assurance
SPC Variation

System Quality Group Assurance – Partial Assurance

- The Integrated Care Board Personalised Care clinical lead post has been recruited to - Dr Rebecca Barker, Consultant Anaesthetist at Sherwood Forest Hospital, has been recruited
- We have co-produced and published the Personalised Care web pages with our personalised care My Life Choices group, to inform the public - read the pages here Personalised Care - NHS Nottingham and Nottinghamshire ICB. The next step is developing a comms plan to get key messages out to the public
- We are in the process of creating three films on Personalised Care; two are people's stories of having a Personal Health Budget and employing Personal Assistants, while one is about My Life Choices co-production group
- The regional data pack shows the system as being down on Personal Health Budget (PHB) metrics; however, it is based on the regional approach to the trajectory. The target for the year is 7,250 with a Q1 achievement of 2,477
- Universal Personalised Care expansion plans have been agreed by our regional NHS team and work has started on the health inequalities & obesity project and annual health checks project
- The system has exceeded its target of 596 people completing Personalised Care Institute training, with 932 people trained
- Funding has been approved to reintroduce discharge PHB's from November 2022 (winter mitigation plan as a one-off payment of up to £400). A leaflet and a poster has been developed to share information with the public. Communications are being sent to the workforce to promote and share information on the offer to support people to be discharged from hospital.
- Permanent funding has been approved (by NHT) to appoint a Personalised Care Coordinator by Nottinghamshire Healthcare Trust and offer Personal Health Budgets to people with a Personality Disorder
- We are reviewing the hourly rates for personal assistants to aid recruitment and retention, taking a system approach with our Local Authority partners
- The Personalised Care Team are working with Digital Notts to have the CHC care and support plan on Patient Knows Best – the patient facing digital app
- The ICS Medical Director, Dave Briggs, endorsed and is driving Personalised Care to be embedded in all transformation programmes
- We are making strong links with Ageing Well, who we are working with to consider how we measure the impact as a system – we are working with the SAIU, but using the funding of an external organisation to do this work, as we need quantitative and qualitative data
- The system was successful as a site for the Active Travel bid. This work is joining up with Green Social Prescribing



21-22 Q4
68
2021-22 Plan
54
Assurance
SPC Variation

Co-Production

System Quality Group Assurance – Full Assurance

Development of the coproduction approach continues for the Integrated Care Strategy and ICS Assembly in partnership with key stakeholders, to ensure that people with lived experience get the opportunity to develop and work on ICS priorities.

The draft ICB Coproduction Strategy and policy were endorsed by the ICB Quality and People Committee in September 2022. The Coproduction Strategy will underpin the approach to all future activity. Discussions are taking place about the Coproduction Policy with the Governance Team, to ensure that the policy document is in alignment with the overall ICB governance approach; this will be adapted and amended as required before it is taken to the next stage of the governance process.

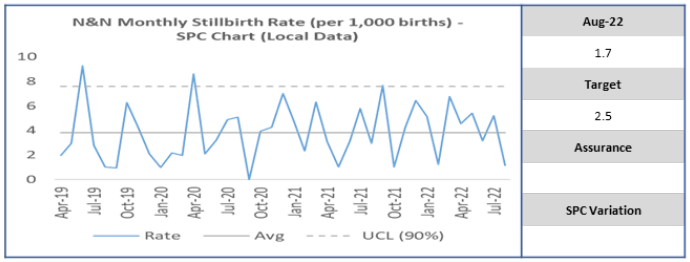
The Terms of Reference for the new Strategic Coproduction Group is currently being coproduced with the ICS Coproduction Steering group, which includes members with lived experience and system partners. The first meeting of the new Strategic Coproduction Group will be in January 2023.

Focus continues on the recruitment to the newly formed Coproduction Team; the roles are at difference stages of recruitment, with the aim that the new team is in place by January 2023.

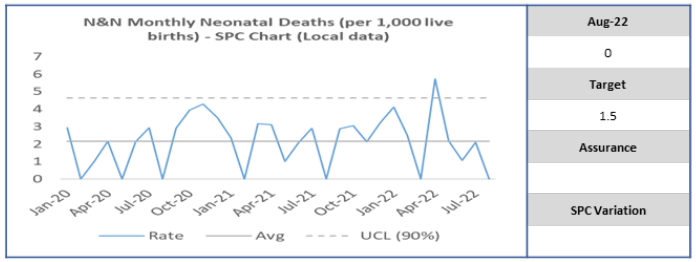
6.3 - Improving Quality of Services – Exception Report Maternity

NHS Nottingham and Nottinghamshire

Local Maternity & Neonatal System (LMNS)



Aug-22
1.7
Target
2.5
Assurance
SPC Variation



Aug-22
0
Target
1.5
Assurance
SPC Variation

Continuity of Carer

To note – the LMNS CoC Plan confirms that Nottingham and Nottinghamshire will pause CoC until safe staffing levels are in place

Current Position and Summary of Activity

Nottingham University Hospitals (NUH) maternity: The ICB continue to work closely with NUH, Care Quality Commission (CQC), and NHS England and NHS Improvement (NHSEI) to oversee improvements in maternity services. The Independent Review led by Donna Ockenden commenced on 1st September.

Ockenden Oversight: Following the Quarterly Ockenden Assurance Panel, held on 21st September 21st, NUH have been declared 100% compliant on IEA2 'Listening to Women & Families' and IEA 4 'Managing Complex Pregnancy', as well as showing significant progress in all remaining IEAs. A regionally-led Ockenden Insight Visit took place at Sherwood Forest Hospital on the 4th October.

Coproduction: The Maternity Voices Partnership (MVP) is now hosted by the ICB Coproduction Team, with close working links to the LMNS PMO team. The MVP Chair continues to take new volunteers through induction. Comparison models for MVP structures are being developed, to present to an MVP Development Coproduction working group.

Perinatal Quality Surveillance: Focus remains on CNST compliance, as progress continues at both Trusts in relation to **Saving Babies Lives Care Bundle** (SBLCBv2). A joint piece of work between NHSEI Specialised Commissioning, EMNODN and the ICB, examining Neonatal Mortality at NUH, has reached its conclusion. No immediate concerns were raised, but actions developed to ensure a system response to LMNS dashboard alerts continues to be swift and proportionate. Close working continues with Trusts, including Corporate Governance teams, to set appropriate timelines and quality expectations regarding the timeliness of **Serious Incident** reporting and the completion of investigations. A very positive **Neonatal Peer Review Visit** at SFH, led by the Neonatal ODN, took place in September in partnership with LMNS representatives.

Digital: The delivery across both maternity provider trusts of the new Maternity Information System (Badgernet) is on track. A staged roll out is being planned to commence from mid-November to allow effective training, whilst minimising any disruption to service. Engagement work with Nottingham City & County health visiting services has taken place, to ensure that the system and process change is appropriately tested and that the safeguarding information provided digitally is robust.

Equity Strategy: The Equity Strategy was approved at the Executive Partnership Board on 20th September. The Strategy was published on the ICB website and submitted to region ahead of the 30th September deadline.

Development of a coproduced LMNS website to communicate with women and families effectively (LMNS): through joint work with the ICB Engagement team, over 40 cultural, religious and support groups across the ICB footprint have been contacted to listen to their information requirements and priorities for the website, expressed in their language and words. This will develop into the identification of key information priorities, a developed coproduction work plan and the broadening of tailored information. Work with the MVP seeks to strengthen the engagement and confidence between the communities and our MVP to broaden the diversity of representation. This includes the development of virtual engagement sessions (including identifying opportunities to provide this with language translation and BSL) to offer alternate ways of listening to our communities – learning from these sessions will inform future listening/engagement and coproduction work.

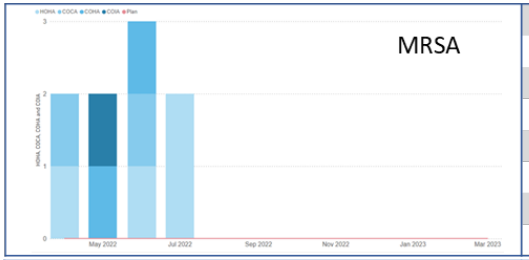
System Quality Group Assurance – Limited Assurance

Enhanced Surveillance due to capacity concerns to transform services in line with requirements, given operational pressures and workforce challenges. The focus remains on implementing Ockenden recommendations, developing our Maternity Voices Partnership (MVP) & Neonatal Voices, and implementing Equity Strategy plans.

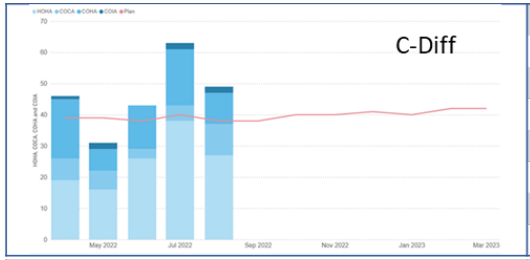
6.4 - Improving Quality of Services – Exception Report Infection Prevention & Control

NHS Nottingham and Nottinghamshire

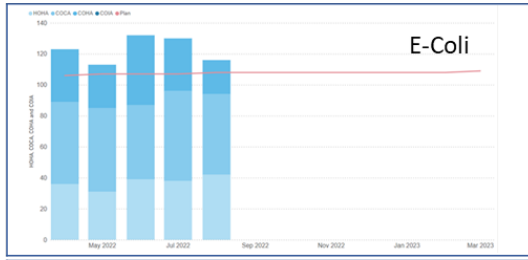
Infection Prevention and Control



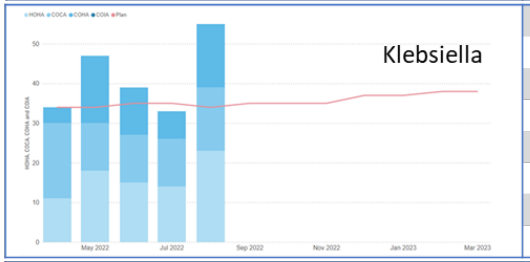
Aug-22
2
Plan
0
Assurance
Variation



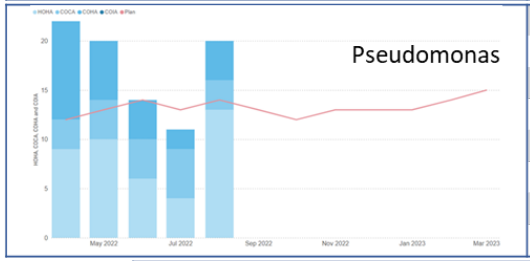
Aug-22
49
Plan
38
Assurance
Variation



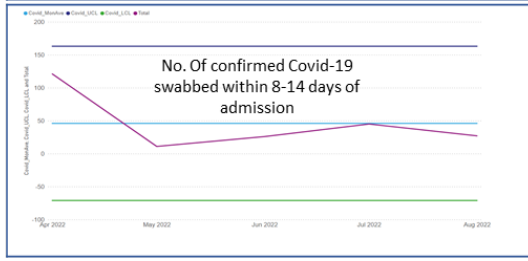
Aug-22
116
Plan
108
Assurance
Variation



Aug-22
55
Plan
34
Assurance
Variation



Aug-22
20
Plan
14
Assurance
Variation



Aug-22
27
Mean
46
Assurance
Variation

Current Position

August 22 Healthcare Associated Infections (HCAI) data

- **MRSA BSI:** No month cases to report
- **CDI:** ICB breached month plan 28/21, NUHT breached month plan 13/9, Bassetlaw breached month plan 2/1. Individual case reviews are in place to identify lapses in care. A system-wide and regional NHSEI group supports with reduction actions needed. Nationally and regionally cases are increasing. Increased bed occupancy and reduced deep cleaning programmes are considered to be contributory factors in the increase in hospital onset cases.
- **E.coli BSI:** ICB breached month plan 73/70, NUHT breached month plan 28/23, Bassetlaw breached month plan 9/7. System and regional NHSEI meetings are in place to support with HCAI prevention actions.
- **Klebsiella BSI:** ICB breached month plan 29/21, NUHT breached month plan 20/11, Bassetlaw breached month plan 4/1. System and regional meetings are in place to review and plan actions needed to reduce HCAI gram negative BSI with urinary source. The Hydration project in care homes launches in October.
- **Pseudomonas BSI:** ICB breached month plan 10/7, NUHT breached month plan 8/5. System and regional meetings are in place to review and plan actions needed to reduce HCAI gram negative BSI with urinary source.

COVID-19

- COVID-19 cases are increasing at a national, regional and local level - BA.5 remains the dominant strain. COVID-19 symptomatic testing is showing increased COVID-19 related admissions, but this is not impacting on ITU. COVID-19 outbreaks are starting to increase across services.
- COVID-19 Outbreaks/SI: themes & learning are shared across the system - no new themes to report.
- Universal mask wearing was re-introduced in July 2022; this is considered a contributory factor in reducing transmission.
- Asymptomatic testing was paused from 31st August 2022.
- There are cases of Flu A are being reported locally

Actions

Healthcare System Infection Prevention and Control Assurance Group (HSIPCAG):

Actions:

- IPC teams continue to update BAF/plans in line with new IPC guidance and the NHSE/I principles.
- Testing plans support elective care and the IPC derogation process is in place to support discharge and flow.
- Work to progress system workforce planning is in place and progressing slowly; IPC recruitment remains challenging across the system. A NHSEI project funding application was successful for system IPC development posts - details are awaited
- HCAI reduction meetings are in place (CDI, urinary source gram negative BSI) along with planned regional NHSEI meetings.

Concerns:

- Regarding winter pressures with the increase in COVID-19 cases (the next wave is predicted in November) and the start of reported Flu A locally
- Regarding IPC resilience, recruitment and retention of staff
- Regarding constant high bed occupancy and the impact on general and 'deep' cleaning at both NUHT/SFHT.
- The lack of 'deep' cleaning and inability to use a decant facility are considered to be contributory factors in the rise in trust acquired HCAI.
- There appears to be an increase in admission of complex patients and associated risk factors.

System Quality Group Assurance – Partial Assurance

Further information required: due to breaches against plan positions across a range of the new reduction targets, further information has been requested which will be reviewed at the system meetings that have been established

Content Author: Natasha Wrzesinski **Exec Lead: Rosa Waddingham** **System Oversight: System Quality Group** **ICB Committee: Quality & People Committee**

6.5 - Improving Quality of Services – Exception Report Vaccinations

NHS Nottingham and Nottinghamshire

Vaccinations

System Quality Group Assurance – Partial Assurance

Overview: Programme delivery of Covid vaccine & flu oversight - as at 21/10/2022:

COVID

Autumn Plan (Phase 5) began 05.09.22:
Autumn eligible population (c600,000 citizens) national planning for 75% of eligible population uptake

- >180,000 autumn boosters (32.9%). Lower than planned but comparable / slightly higher than national uptake
- Care home delivery on plan
- Citizens at home (housebound) delivery to plan

Delivery Model:

- 2 Vaccination Centres delivering vaccinations and supporting the Roving Team to deliver to Care Homes, "At Home" citizens
- Five Place Based community Satellite clinics operating
- Rapid response Pop up clinics being offered for hard to reach communities
- Medivan offer outreaching into homeless and asylum/ refugee sites & shelters
- Close working with Public Health to address inequalities and maximise equity in vaccine offer
- Programme outreach team delivering vaccination service to NHFT forensic and mental health in patient population
- Hospital Hub at Kings Mill Hospital offering vaccinations to staff, other health and social care workers and the general population
- Hospital Hub at NUH offering vaccinations to their own staff, paediatric completion of primary course and allergy clinics
- 38 Community Pharmacies offering to the general population
- 14 PCNs delivering vaccinations to care homes, "at home" citizens, immunosuppressed and their PCN population.
- Programme planning community outreach Monkeypox offer in partnership with sexual health services at SFHT and NUH

Risks:

- There is a reduction in financial risk as the H2 programme costs are no longer a risk to H3 period, this is now covered by national
- There continues to be low uptake of autumn boosters, being mitigated by agile workforce model to reduce financial risk

FLU

- 24% of the eligible population have had a flu vaccination
- PCN uptake ranges from 30% to 12%
- Some PCNs are able to do more coadministration that other and hence have higher uptake of flu

Over 65 years old
Eligible population 235,322
Seasonal Flu 128,549
Percentage uptake 55%

- 56% (last week 42%) of citizens over the age of 80 have received their seasonal flu vaccination
- 57% (last week 43%) of citizens aged between 70 and 79 have received their seasonal flu vaccination

Patient Safety

ICS Patient Safety Network: A paper was presented at the System Quality Group, for consideration of system support for the necessary focus and resource to respond to the PSIRF guidance. Several national and regional meetings and resources have been shared to support ICB PSIRF planning and implementation. The first ICB PSIRF implementation group will meet on the 20th October. The Patient Safety Network meetings will also continue to support system awareness and learning.

NHS
Nottingham and Nottinghamshire

7: Service Delivery Performance

ICS Aim 1: To improve outcomes in population health and healthcare

ICS Aim 2: To tackle inequalities in outcomes, experience and access

- 7.1 – Service Delivery SPC Matrix
- 7.2 - Urgent Care Pathways
- 7.3 – Elective Care Recovery
- 7.4 – Mental Health Recovery
- 7.5 – Primary and Community Care Recovery

NHS Nottingham and Nottinghamshire

7.1 - ICB Service Delivery Metrics Insights – Reporting Period October 2022/23

October 2022		Assurance: Pass	Assurance: Hit & Miss	Assurance: Falling Below
Variation	Special Cause - Improvement	Advice & Guidance (Pop) IAPT < 18 weeks CYP Access (1+ Contact)	Total Referrals (Pop & Prov) Daycases (Pop & Prov) Outpatient Fups (Prov) Total Diagnostic Activity (Prov) RTT Non-Admitted (Pop & Prov) Op Plan Diagnostic Activity (Prov) Cancer FDS (Pop & Prov) Cancer 1st Treatments (Pop & Prov) Cancer 1st <31 days % (Pop) 2 Hour Urgent Care Response Adult MH - 72 Hour Follow Ups SMI Physical Health Checks Individual Placement Support Primary Care Appointments	104 Week Waits (Prov) Outpatient 1st (Pop) Outpatient Fups (Pop) Total Diagnostic Activity (Pop) PIFU (Prov) Op Plan Diagnostic Activity (Pop) Cancer 1st <31 days % (Prov) Cancer 62 Day % (Prov) IAPT Treatments (Access) CYP Eating Disorders - Urgent NHS App Registrations
	Common Cause - Random	Primary Care Extended Access A&E Attendances vs 19/20 (Pop) IAPT <6 weeks IAPT Recovery Adult SMI +2 Contacts Community Dementia Diagnosis Perinatal Access Volume Early Intervention Psychosis	78 Week Waits (Prov) Ordinary Electives (Pop & Prov) OP Virtual (Pop & Prov) RTT Admitted (Pop & Prov) Ambulance Conveyances Volumes A&E Attendances vs 19/20 (Prov) NEL Admissions vs 19/20 (Pop)	Outpatient 1st (Prov) Cancer 62 Backlog (Prov) Diagnostic 6 Weeks % (Pop & Prov) MSFT Inappropriate OAP Bed Days Perinatal Access %
	Special Cause - Concern	-	OP Fup 25% Reduction (Pop & Prov) NEL Admissions vs 19/20 (Pop) Ambulance Response Cat 1 Ambulance Response Cat 2 IAPT <90 days 1st to 2nd Older Adult MH >90 day LOS 12 hour Breaches ED 12 Hour Breaches % NEL	Total Waiting List (Prov) 52 Week Waits (Prov) Length of Stay >21 days CYP Eating Disorders - Routine Community Waiting Lists Aged 0-17 Community Waiting Lists Aged 18+ Ambulance Conveyances % Hospital Handover Delays > 60 minutes

Items for escalation based on the indicators Falling short of the target and showing Special Cause for concern are as follows:

Electives:
- Patient Waiting List & Long Waits (Provider) - Page 25

Mental Health:
- CYP Eating Disorders - Page 34

Community:
- Community Waiting Lists - Page 36

Urgent Care:
- Length of Stay > 21 days - Page 22
- Ambulance Conveyances % - Page 21
- Hospital Handover Delays > 60 minutes - Page 23

The Matrix supports the Board to identify areas of risk and concern, as well as areas of improvement, across the range of service delivery requirements. For example, the orange bottom right box consolidates all of the areas which have deteriorating performance levels and are unlikely to achieve the required positions based on current performance levels. These, and other areas of deterioration, or areas expected to falling below requirements have been included as exception reports.

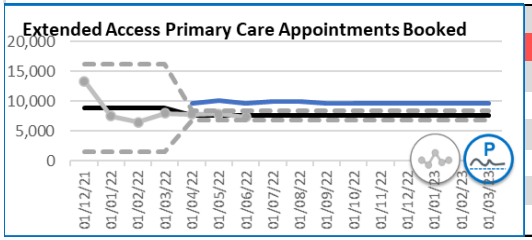
7.2 Service Delivery
Urgent Care Performance

7.2a – Urgent Care Access Exception Report
7.2b – Discharges and Out of Hospital Exception Report
7.2c – Urgent Care Compliance Exception Report

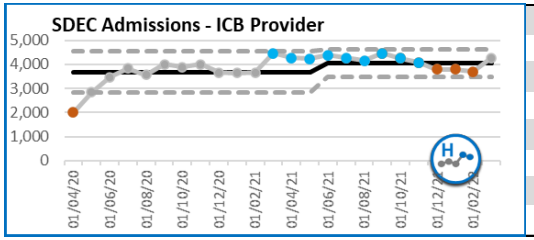
7.2a- Streamline Urgent Care – Exception Report : Access

NHS Nottingham and Nottinghamshire

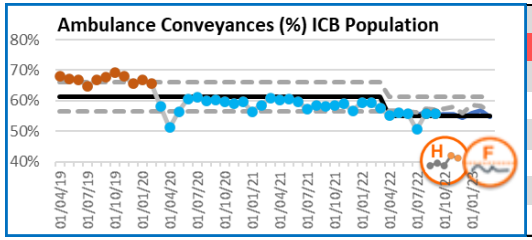
Urgent Care - Access



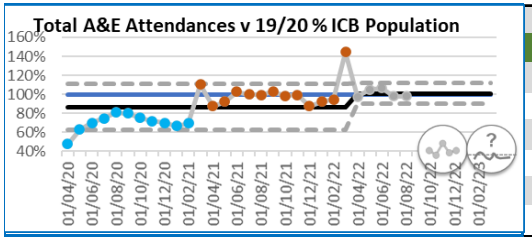
Jun-22
7363
2022-23 Plan
9717
Assurance
Pass
SPC Variation
Common Cause



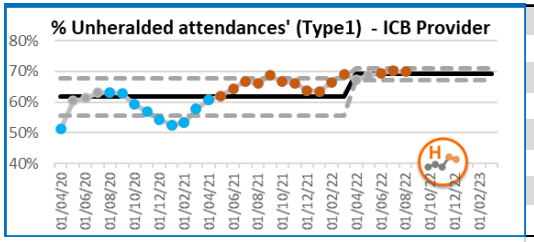
Aug-22
3846
2022-23 Plan
-
Assurance
-
SPC Variation
Improving - High



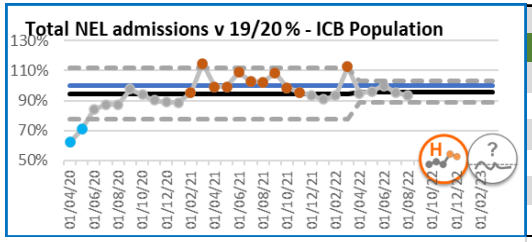
Sep-22
55.6%
2022-23 Plan
55.2%
Assurance
Fail
SPC Variation
Concerning - High



Aug-22
98.1%
2022-23 Plan
100%
Assurance
Flip
SPC Variation
Common Cause



Aug-22
69.85%
Target
-
Assurance
-
SPC Variation
Concerning - High



Aug-22
93.4%
2022-23 Plan
100%
Assurance
Flip
SPC Variation
Concerning - High

Summary

GP Extended Access - is below the planned levels and remaining along a flat trajectory - therefore common cause variation. Significant increases are needed to deliver to the planned levels.

Ambulance Conveyences continue to reduce as % and now below planned levels, following sustained improvements since pre-covid levels.

A&E and NEL activity plans were required to be set at 100% of pre-covid levels, with no growth included. The system is operating at increased levels to these planning assumptions, which is continuing to cause additional pressure on the acute urgent care system.

Unheralded Attendances continue to increase triggering a special cause-high alert.

Actions

A&E - High Intensity Service User posts have been recruited to, to work with specific patients to identify suitable alternative health and care settings and support if appropriate, which will impact upon **unheralded attendances**.

The System **Reducing Conveyance** lead role has been extended until March 2023, which will progress delivery of the logic model and plans on a page actions.

A&E Flow - SDEC Services - A review of streaming within the ED has been completed by ECIST, with recommendations having been agreed.

The national ambition is to increase the proportion of Same Day Emergency Care (SDEC) from a fifth of acute admissions to a third as defined within the long term plan. This is tracked closely within the Right Place First Time Board.

Wound care follow up pathway pilot has been agreed with community providers and GP practice nurse leads. An Acute Respiratory Care Unit proposal at NUH sites is progressing through the system.

POG Assurance - Limited Assurance

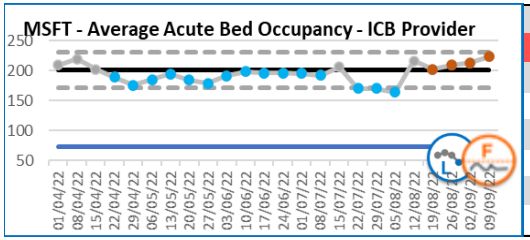
Activity levels continue to be above planned levels into the front door of urgent care.

Additional clarity is needed in relation to the Extended Access Primary Care Booked appointments, as to additional actions being taken to improve the position to planned levels.

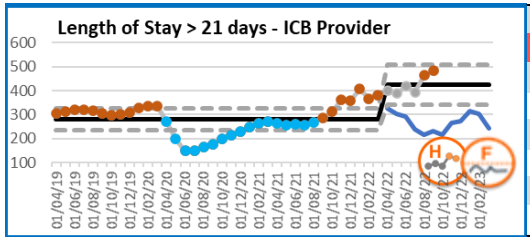
7.2b - Streamline Urgent Care – Exception Report: Discharges and Out of Hospital Provision

NHS Nottingham and

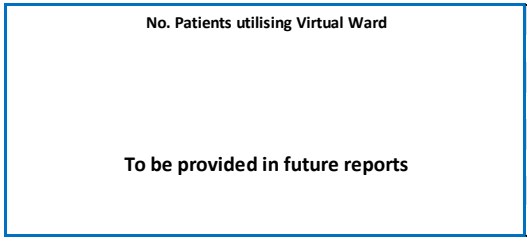
Urgent Care - Acute Discharges & out of hospital provision



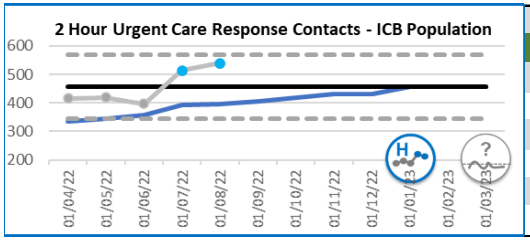
Sep-22
223
2022-23 Plan
73
Assurance
Fail
SPC Variation
Improving - Low



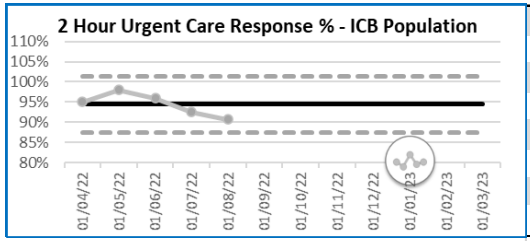
Sep-22
482
2022-23 Plan
231
Assurance
Fail
SPC Variation
Concerning - High



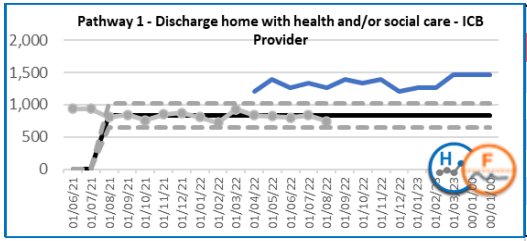
Date
2022-23 Plan
Assurance
SPC Variation



Aug-22
539
2022-23 Plan
395
Assurance
Flip
SPC Variation
Improving - High



Aug-22
91%
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause



Aug-22
747
2022-23 Plan
1270
Assurance
Fail
SPC Variation
Improving - High

Summary

Patients Medically Safe to transfer from acute episode of care are significantly higher than the acute baselines, and also significantly higher than included as modelling assumptions within the operational plans for 2022/23.

LOS >21 days - Special Cause High Alert as there are significantly more patients in acute hospitals with lengths of stay of over 21 days than planned levels and also pre-covid. 19% of all available acute beds are currently occupied by +21 day patients as at 17th October 2022. As well as the impact from the issues of flow out of the hospitals, patients are entering the system with increased acuity for emergency presentation and deconditioned presentations for elective care which lengthens recovery time and therefore period to discharge.

The systems ability to provide sufficient homecare packages and care home placements to meet current demand, continues to be the main reason for patients experiencing long delays and remaining in hospital past their determined safe transfer decision.

Actions

MSFT Actions - Daily system partner calls continue to be held to maximise use of all available capacity and determine additional actions which are able to be undertaken. An additional 160 P1 interim beds have been opened, however these obviously require actively monitoring and sourcing of packages of care, so does impact on health and social care capacity. Sciensus are providing additional P1 capacity in the city, averaging 80 home visits per day. System partners are working to identify additional interim capacity from Q3 onwards, as the Discharge to Assess business case is being finalised later than planned

LOS - a system led review of current long waits is to be undertaken as soon as capacity allows to provide further clarity as to the specific drivers for these waits, and indentify high impact actions to reduce these long lengths of stay in future months.

Virtual Wards - are being expanded to provide new pathways for frailty, respiratory and IVs. Data flows are being introduced to enable monitoring against the system plans submitted.

Urgent Community Response - continues to build additional capacity. Data flows are being introduced to enable monitoring against the system plans submitted.

POG Assurance - Low Assurance

The additional capacity being planned for within the Discharge to Assess business case will be implemented later than planned due to delays in finalising the business case.

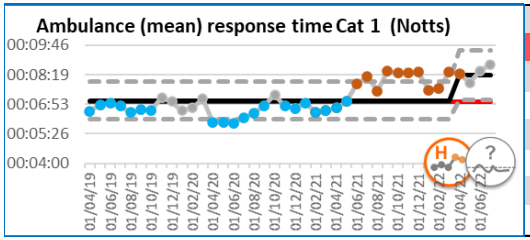
NHS England has launched a **"Discharge 100 day challenge**" requiring systems to deliver against 10 initiatives, in the first 100 days of the ICB. Focused senior leadership is required, and there should be consistent and appropriate oversight of discharge performance from trust boards and the ICB. The aim is for the position to have improved ahead of the winter period. NHS England will undertake a launch meeting with each system to determine the appropriate level of tiered support required to successfully implement the initiatives.

The recently established Ageing Well Board will be responsible for D2A, UCR and falls, and will take a lead in the production and progress of the Discharge 100 day challenge.

7.2c - Streamline Urgent Care – Exception Report : Compliance

NHS Nottingham and Nottinghamshire

Urgent Care - Performance Compliance



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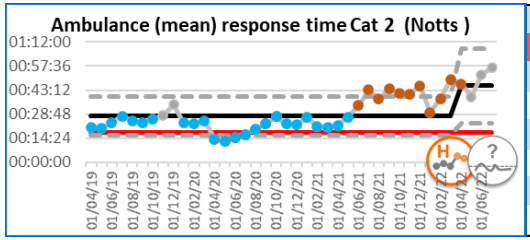
Target
0:07:00
Assurance
Flip
SPC Variation
Concerning - High



Sep-22
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Target
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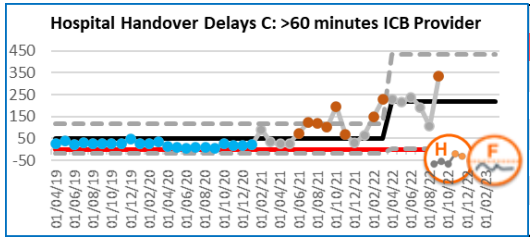
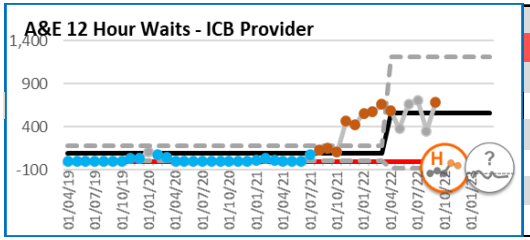
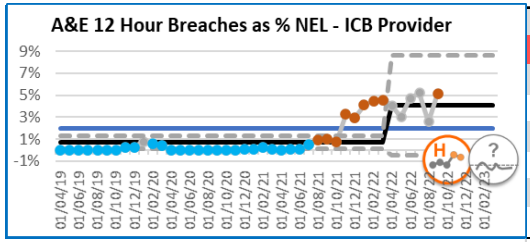
Assurance
Flip
SPC Variation
Concerning - High



Sep-22
333
Target
0
Assurance
Fail
SPC Variation
Concerning - High



Sep-22
685
Target
0
Assurance
Flip
SPC Variation
Concerning - High



Sep-22
5.2%
Target
2%
Assurance
Flip
SPC Variation
Concerning - High

Date
2022-23 Plan
Assurance
SPC Variation

Summary

Ambulance Handover Delays >60 minutes: Special cause cause alert as volumes have increased for September 2022.

Ambulance Response Times: Cat 1 and Cat 2 response times have remained at high levels since June 2021 and has continued to increase in the past 2 months, with special cause concerning variation. Flip assurance indicates that the service is not expected to achieve targets set in future months.

12-Hour Breaches: Special cause alerts as volumes of patients waiting more than 12 hours from a clinical decision to admit have increased in month above the mean.

Actions

Ambulance Delays - the system advocates a total system partner response to delays with ambulances and aims to release ambulances at the earliest opportunity. Despite the current failure to achieve handover targets, the data for August indicated that Nottingham and Nottinghamshire ICB perfoms better than its neighbouring systems, with NUH having fewer delays than peer tertiary hospitals and SFHT the fewest in the region. Actions being taken include EMAS recruiting mental health nurses to be based in ambulance call centres, additional training to navigate patients to alternative appropriate services, increased early system awareness of pressures within the ambulance service and making progress with the ICS Ambulance Improvement Plan.

12 Hour Breaches - actions include targeted work through admission avoidance initiatives to reduce footfall into ED, maximising discharge profils for simple and supported discharges to improve hospital flow, with a focus on pre-noon discharges, thematic review of long waits to identify specific high impact actions.

POG Assurance - Low Assurance

12 Hour waits - Harm reviews are being undertaken and thematic reviews being addressed through the System Quality Group.

ED Quality Metrics – an NUH quality group has been established to implement a set of quality metrics for use in ED for long waiting patients. These metrics will be regularly reviewed going forward and will be discussed through the A&E Board.

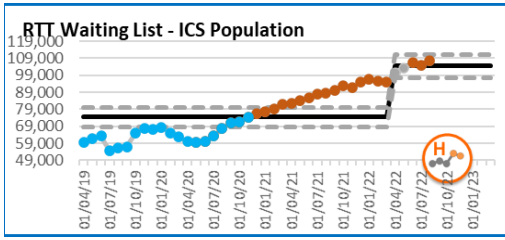
7.3 Service Delivery Elective Care Performance

7.3a – Elective Waits Exception Report
7.3b – Elective Activity Exception Report
7.3c – Productivity and Transformation Exception Report
7.3d – Cancer Exception Report
7.3e – Diagnostics Exception Report

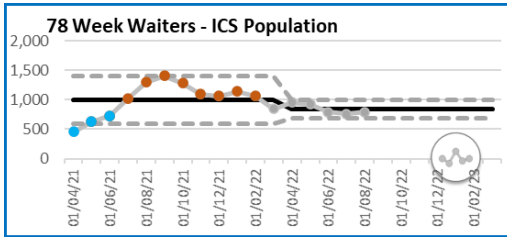
7.3a - Recover Services and Address Backlogs – Exception Report : Elective Waits

NHS Nottingham and Nottinghamshire

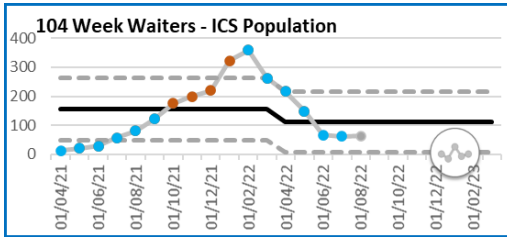
Elective Waits - Total Waiting List and Long Waits



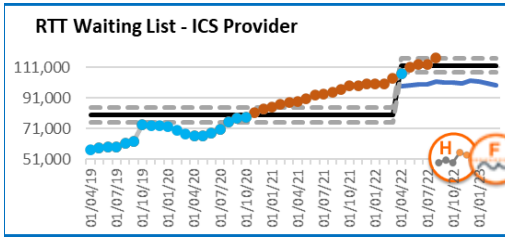
Aug-22
107507
2022-23 Plan
-
Assurance
-
SPC Variation
Concerning - High



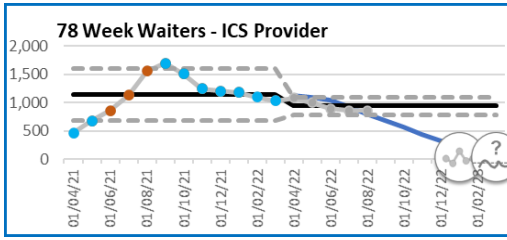
Aug-22
796
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause



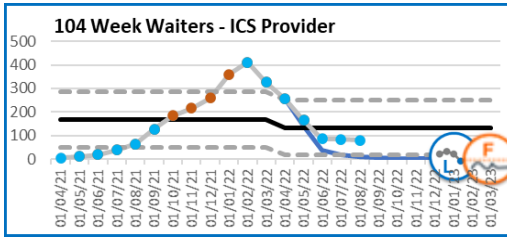
Aug-22
64
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause



Aug-22
117417
2022-23 Plan
101733
Assurance
Fail
SPC Variation
Concerning - High



Aug-22
862
2022-23 Plan
802
Assurance
Flip
SPC Variation
Common Cause



Aug-22
81
2022-23 Plan
9
Assurance
Fail
SPC Variation
Improving - Low

Summary

Waiting List - ***showing concerning-high variation due to continual deterioration of the position and failure to deliver against the plan***. A reduction of 15,684 patients is needed to return to plan.

78 Week Waits - ***showing common cause variation as the position is moving around the mean***. 78ww are not acheiving the planned level of reduction at August 2022. There are 60 more patients than planned are waiting over 78 weeks for NUH and SFH combined. Note that the plan is to eliminate waits of 78 weeks or more by March 2023.

104 Week Waits - **showing special *cause low variation as the position remains below the mean***. The national target was zero 104 week waits by the end of June 2022 except where patients choose to wait. At the end of August, there were 81 patients waiting 104 weeks or more at NUH and SFH. Whilst improvements are being made, the rate of progress currently means that the system is not delivering the level of reductions required. Of the 81 patients at the end of August, 51 were due to complexity, 0 were due to capacity, and 32 to patient choice.

Actions

Elective Capacity levels during August and September were impacted by seasonallly high levels of urgent care demand as well as a high proportion of staff absences. The staff absences were due to sickness (including COVID), vacancies and annual leave which in particular impacted upon theatre capacity - further information is included in the Activity section of this report.

Elective Hub - the system operates a system wide elective hub which reviews the current waits of patients across the local NHS trusts as well as commissioned Independent Sector providers. The aim being to ensure equity of waits across the system and that the various providers review patients on assessment of clinical need and prioritisation, and align capacity resource through mutual aid as required. Specialty reviews are also undertaken to provide organisational support where specific issues have arisen. This has been successful with over 700 patients moving between providers since summer 2021.

104 week waits - all patients at risk of breaching 104 week waits are individually contacted by the relevant provider, offered dates for the future and are actively supported while waiting. All actions possible are being taken by the system to ensure patients are treated. Interim guidance around the management of patients on the waiting list choosing to decline offered treatment dates was released this week by NHSE. This provides clear guidance on the management of choice for the longest waiting patients.

POG Assurance - Limited Assurance

Internal Oversight of the **104 position** continues to take place on a daily basis by providers. Weekly meetings with NHSE/I continue to take place to enable a granular discussion to take place around specialty level risks and mitigations. This also includes a review of the 78 week position.

The volume of 104ww has reduced substantially over recent weeks. The latest forecast for the system at the end of October is that 19 patients will be waiting 104 weeks or more for treatment. 14 of the long waiters are forecast to be due to patient choice and 5 are due to complexity. There are no breaches due to capacity.

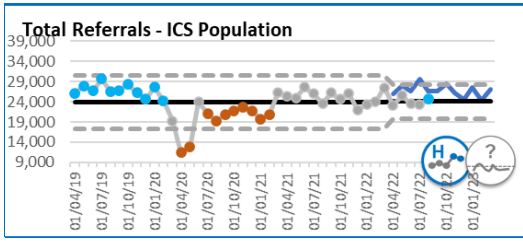
78 Weeks forecasts for the end of March 2023 have been developed by providers. The forecast for NUH is that there will be 801 patients waiting 78 weeks or more by the end of March 2023. This trajectory has been developed by individual specialties and assumes that the run rate will continue at the current level. It also accounts for seasonal risk and COVID continuing to be a constraint as well as a cohort of patients choosing to delay treatment. The equivalent forecast for SFH is 0 patients waiting over 78 weeks by the end of March 2023.

Total waiting list increase is a cause for concern, however recent months have slowed the pace of increase. The system needs to undertake a review to fully determine the forecast waiting list position and potential forecast ranges for the 'peak' position and timeframe.

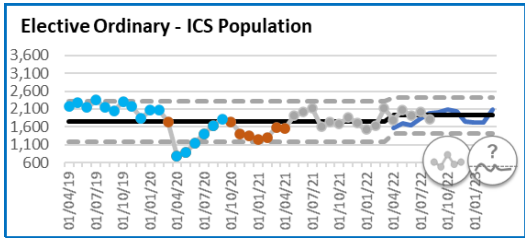
7.3b - Recover Services and Address Backlogs – Exception Report Elective Activity

NHS Nottingham and Nottinghamshire

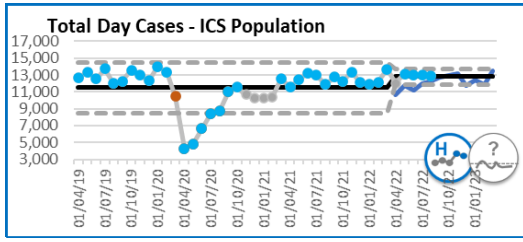
Elective Recovery - Activity



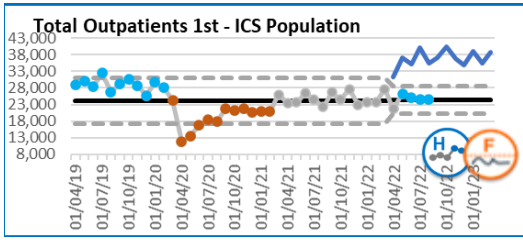
Aug-22
24626
2022/23 Plan
26600
Assurance
Flip
Variation
Improving - High



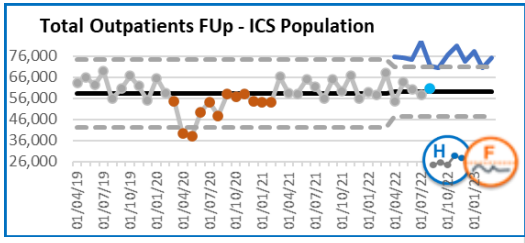
Aug-22
1820
2022/23 Plan
1993
Assurance
Flip
Variation
Common Cause



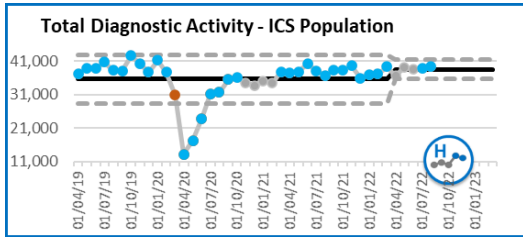
Aug-22
12858
2022/23 Plan
12327
Assurance
Flip
Variation
Improving - High



Aug-22
24625
2022/23 Plan
35549
Assurance
Fail
Variation
Improving - High



Aug-22
60579
2022/23 Plan
71215
Assurance
Fail
Variation
Improving - High



Aug-22
39562
2022/23 Plan
-
Assurance
-
Variation
Improving - High

Summary

These charts compare the August activity level to the operational plan. The charts include activity for the whole ICB population and at all providers (NHS and IS).

Five of the charts (Total Referrals, Total Day Cases, Outpatient First, Outpatient Follow Up and Total Diagnostic Activity) show Improving - High variation, which indicates a period of sustained activity above the mean. Elective Ordinary shows common cause variation as the activity is varying around the mean (black line). This demonstrates that a period of high activity has not able to be sustained due to challenging system conditions, which indicates that it is unlikely that the plan will be delivered.

However, Consistently fail alerts are shown for outpatients which illustrates that the current run rate of activity varies significantly from the planned level and that future failure of the plan is likely unless there is material increase.
Referrals (Routine, Urgent and 2ww) have increased significantly since April 2020.

Outpatients - population plan is overstated on Ophthalmology.

Actions

Reinstate Elective Capacity - In the first quarter there were a number of significant factors that impacted the volume of elective surgery including staff vacancies, staff absence due to sickness, increased demand for emergency admissions and subsequent bed pressures. As the overall number and acuity of COVID patients reduced mid way through the first quarter, this allowed the return of elective wards which were allocated to non-elective patients during extreme system pressures. During the second quarter staffing absences have been a key constraint impacting the volume of elective activity that providers have been able to deliver, especially with regard to theatre capacity at NUH.

Sourcing Additional Capacity -Fully utilising Independent Sector capacity and identifying mutual aid potential across NHS Providers where clinically appropriate. Around 700 patients have already transfered between NUH and SFHT to support treatment.
Staffing Capacity: Absences - the system continues to have high levels of staff absence with levels between 7% to 8% of the acute provider workforce.
Infection Prevention and Control (IPC) restrictions have been eased in line with national guidance, which will support more productive and flexible use of capacity.

POG Assurance - Limited Assurance

Day Case activity has delivered above plan in August. Referrals and outpatients remain below planned levels August.
OP 1st Plan at NUH is overstated on Ophthalmology, which is due to activity remaining within the NUH plan that should be allocated to an independent provider of ophthalmology services (CHEC), which impacts the plan by up to an estimated 334 appointments per month.

The pressures for hospital bed capacity are not fully resolved with delayed discharges remaining high, while this is the case there continues to be risk to delivery of the elective activity.

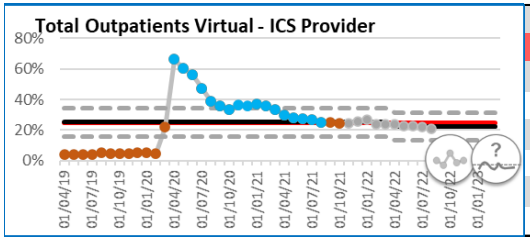
System needs to determine the most appropriate way to protect elective activity wherever possible.

The system needs to remain focused on transformation areas such as A&G, PIFU and virtual outpatients to support patients on the waiting list. (see Productivity & Transformation section of the report).

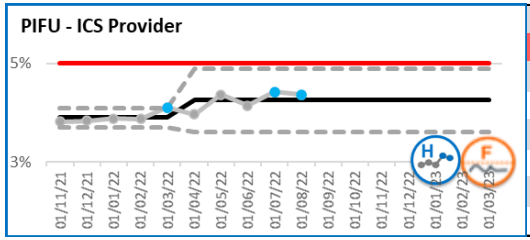
7.3c - Recover Services and Address Backlogs – Productivity & Transformation

NHS Nottingham and Nottinghamshire

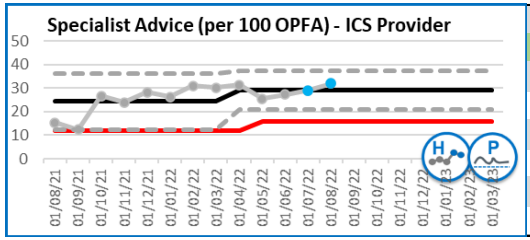
Elective Recovery - Productivity & Transformation



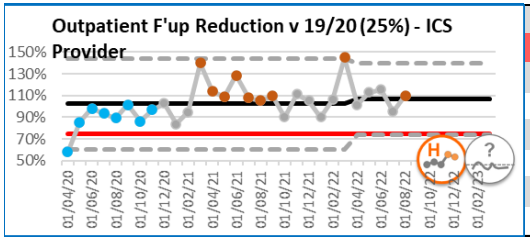
Aug-22
20.6%
Target
25.0%
Assurance
Flip
Variation
Common Cause



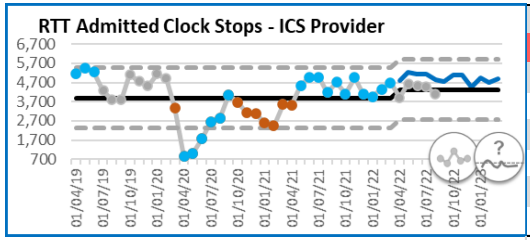
Aug-22
4.4%
March 2023 Target
5.0%
Assurance
Fail
Variation
Improving - High



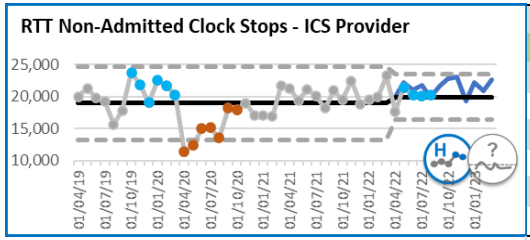
Aug-22
32
March 2023 Target
16
Assurance
Pass
Variation
Improving - High



Aug-22
110%
Target
75%
Assurance
Flip
Variation
Concerning - High



Aug-22
4087
2022-23 Plan
4850
Assurance
Flip
Variation
Common Cause



Aug-22
20210
2022-23 Plan
19844
Assurance
Flip
Variation
Improving - High

Summary

Outpatient Virtual: Common cause variation, 'flip' target delivery as the target is near the mean. The latest position for the system is 21%, which is below the national standard of 25%. Since April 2022, the position for the system has reduced from 24% to the 21% reported in July.

Outpatient Follow-up 25% Reduction: The ICS plan did not deliver the 25% reduction due to c32,000 patients at SFH and NUH who have an overdue follow up review. Reducing follow up appointments by 25% would result in patients waiting longer putting them at increased clinical risk and potentially increasing backlogs.

Advice & Guidance Target: minimum of 12 A&G requests delivered per 100 first outpatient attendance, rising to 16 by March 2023. The ICS plan exceeds this standard throughout 22/23. The utilisation rate in July 2022 was 32. The stepped increase in October 2021 related to definitional changes from NHSEI, which enabled a larger volume of activity to be captured within the target.

Patient Initiated Follow Up (PIFU): **Improving-High variation** position towards, but not as yet delivering, the year end target of 5% with current performance of 4.4%.

Admitted and Non-Admitted Clock Stops: These charts show high-improving variation, with activity being delivered above the mean. However for the system to be successful in tackling waiting lists, the activity levels need to shift above the planned levels.

Actions

Outpatient Virtual: NUH and SFH submitted trajectories which show delivery of the 25% national standard by March 2023. Monitoring is in place to track delivery against the agreed plan.SFH have set up a virtual core project team to define the barriers to utilisation and determine the range of actions to improve uptake within the trust. There is also a specialty level review to increase use. Patient facing comms has been included on the trust website describing how to access remote appointments and what to expect.

Advice & Guidance: It is the intention to measure variation at PCN level in utilisation of Advice & Guidance, however this functionality is not yet available within the national dashboard, it is under development and this work will commence when an updated dashboard is published.

Patient Initiated Follow Up (PIFU): Providers are expanding the uptake of PIFU to all major outpatient specialties, with the ambition of moving or discharging 5% of outpatient attendances to PIFU pathways by March 2023. As part of the 'Super September' initiative, SFH are engaging with paediatrics and geriatrics to explore the possibility of introducing PIFU.

Admitted and Non-Admitted Clock Stops: Over the past few months, there have been a number of inter-related factors which have limited the volume of elective activity and therefore clock stops - See activity section for further detail on actions.

POG Assurance - Limited Assurance

Outpatient Virtual attendance volumes at SFH remain significantly lower than the national standard. The position for NUH in August remained below the national standard, which is the second month in succession that that the performance level has been below the national standard since at least April 2021.

Outpatient Follow-up 25% Reduction: the national 25% reduction will not be delivered as the providers concentrate on treating patients on their current lists. Future service change plans will focus on safely progressing the reductions required.

Utilisation of **Advice and Guidance** remains high and the system continues to consistently achieve the national standard. There is confidence that this performance level will continue during the financial year.

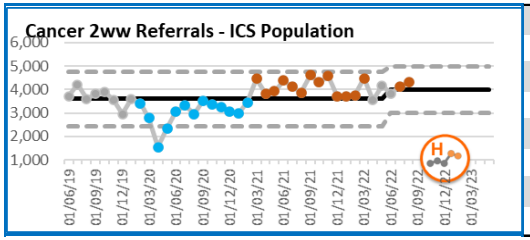
PIFU - The current performance level in August 2022 is 4.4%, which exceeds the locally set plan and is on track to exceed the March national standard.

Admitted and Non-Admitted Clock Stops. There continues to be challenges around the level of staff sickness, which will impact the volume of activity that can be delivered.

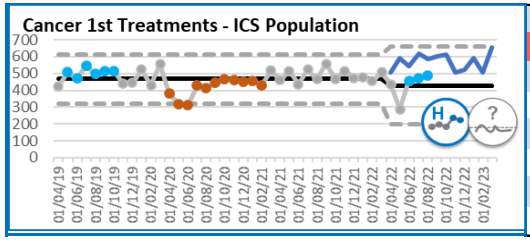
7.3d - Recover Services and Address Backlogs – Exception Report : Cancer

NHS Nottingham and Nottinghamshire

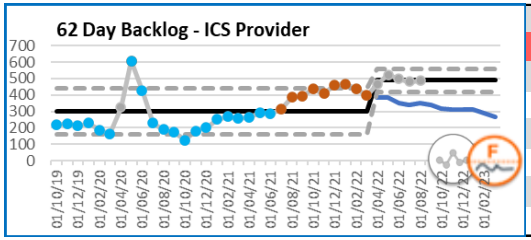
Cancer Recovery - Total Provider View



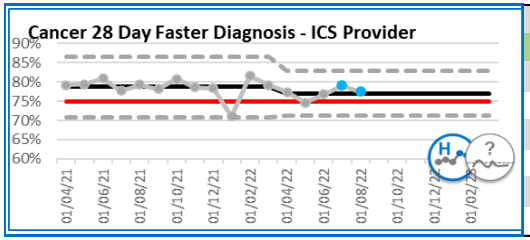
Aug-22
4800
2022/23 Plan
-
Assurance
-
Variation
Concerning - High



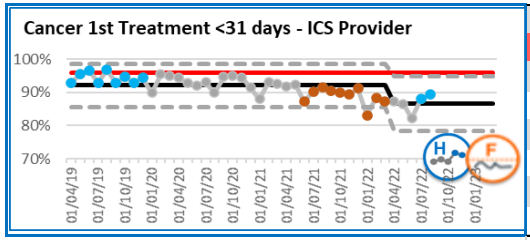
Aug-22
599
2022/23 Plan
704
Assurance
Flip
Variation
Improving - High



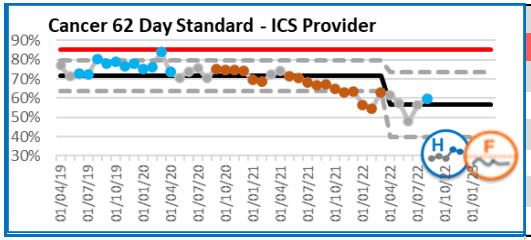
Aug-22
487
2022/23 Plan
349
Assurance
Fail
Variation
Common Cause



Aug-22
77.5%
Target
75.0%
Assurance
Flip
Variation
Improving - High



Aug-22
89%
Target
96%
Assurance
Fail
Variation
Improving - High



Aug-22
60%
Target
85%
Assurance
Fail
Variation
Improving - High

Summary

2ww Referrals: ***Concerning-High variation as the referrals are above the mean,*** with growth in demand being at c120% of pre-pandemic levels since March 2021. This is acros all tumour sites and continues to lead to pressures on services, and impacts all other measures.

28 Day Faster Diagnosis: ***common cause and 'flip' assurance indicate activity remains around the mean and will therefore hit or miss the target***. Despite increased demand the 28 day FDS continues to be achieved. The latest benchmarking data relates to August and shows that the N&N system is one of only three systems within the region that achieved the 28 day FDS standard in that month.

31 Day & 62 Day Performance: ***Special cause alert due to high values, which demonstrates an improving position.*** The continued high level of two-week wait referrals has placed pressure on outpatient capacity in some areas, especially Gynae, Urology and LGI, impacting on the 62-day pathway. At NUH, access to surgery and HDU Capacity has also affected 62 day performance.

62 Day Backlog: ***Concerning high alert as, although having reduced in August, volumes are still above the mean.*** The majority of patients waiting +62-days are in Lower GI, Urology, Gynae, Lung, Upper GI and Skin.

Actions

NUH hold the majority of the cancer backlogs for the system, due to the scale and specialist services it provides.

During the development of the operational plans, NUH specialties each developed plans that would support acheivement of the ***organisational level plan, which is a backlog of 198 patients by March 2023. The equivalent plan for SFH is to acheive a backlog of 67 patients.***

To address the 62 day backlog, NUH have held Internal meetings with all tumour site leads and clinical leads which have enabled discussion around reviewing approaches to follow ups. Joint discussions are also held across NUH and SFHT to progress mutual aid wherever possible.The 62 day backlog for NUH and SFH is discussed at tumour site level on a weekly basis. This includes the volume of patients removed from the list as well as potential and confirmed additions.

Workforce issues are a key factor impacting the capacity of histology and radiology as well as the oncology appointment capacity. 2ww outpatient first appointment capacity is a concern at NUH, in particular for the skin tumour site due to the continued high volume of referrals. This is not impacting on the 28 day FDS performance or patient outcomes. Extra sessions are being put in place to meet the demand.

POG Assurance - Limited Assurance

Following development of the NUH specialty level plans, the underlying assumptions which were linked to system level conditions fundamentally changed. As an example, the impact of COVID was more material than planned, the sickness levels of staff were greater than forecast and the impact of non-elective pressures were more servere than expected. Therefore, the backlog increased materially during April and May 2022, with reductions seen in June and July. ***The latest weekly data for week ending 09/10/22 is 499 patients against a plan of 319 patients. NUH have 392 patients against a plan of 244 and SFH have 107 patients against a plan of 75.*** NUH and SFH benchmark well nationally for the proportion of the waiting list that are waiting 62 days or more (12.1% and 6.9% respectively).

The 104 week waiter meetings that take place with NHSE have been expanded to cover cancer performance on a fortnightly basis. This enables a granular discussion to take place around plans to reduce the 62 day cancer backlog.

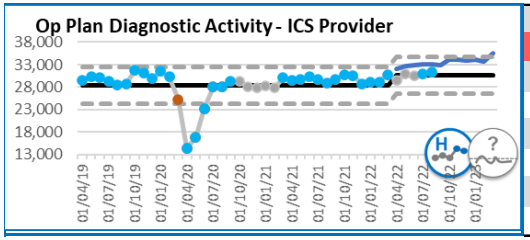
62 day standard performance is expected to remain at lower levels during the time period that longer waiting patients are progressed through to treatment. The target is a measure of the point at which treatments are undertaken.

A trajectory demonstrating recovery to the planned levels of the 62 day cancer backlog has been requested by NHSE/I. A summary including the risks to delivery will be included within next months report.

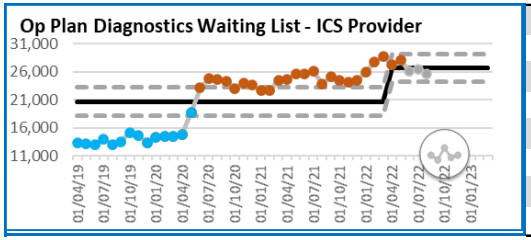
7.3e - Recover Services and Address Backlogs – Exception Report: Diagnostics

NHS Nottingham and Nottinghamshire

Diagnostics Recovery - Total Provider View



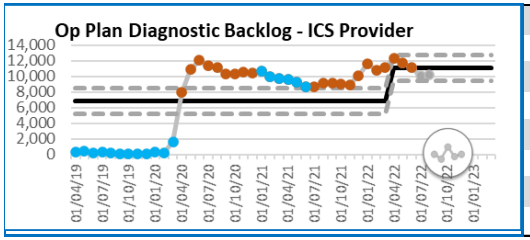
Aug-22
31298
2022-23 Plan
33154
Assurance
Flip
Variation
Improving - High



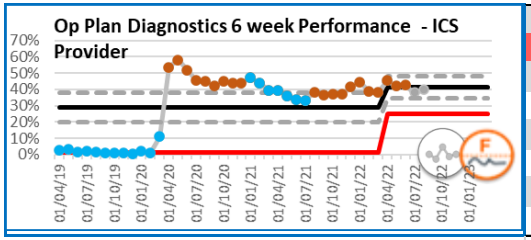
Aug-22
25680
2022-23 Plan
-
Assurance
-
Variation
Common Cause

Diagnostic Modality - Highlighted Modalities are included in the OP Plan

ICS Provider	Waiting List	Backlog	%
MRI	6,871	3,471	50.5%
Computed Tomography	2,924	541	18.5%
Non-obstetric ultrasound	7,060	1,316	18.6%
Barium Enema	0	0	
DEXA Scan	1,939	515	26.6%
Audiology	904	513	56.7%
Echocardiography	5,970	3,400	57.0%
Cardiology - Electrophysiology	0	0	
Neurophysiology	208	11	5.3%
Sleep studies	1,312	726	55.3%
Urodynamics	132	37	28.0%
Colonoscopy	1,213	612	50.5%
Flexi sigmoidoscopy	492	303	61.6%
Cystoscopy	292	58	19.9%
Gastroscopy	1,150	552	48.0%
Total - All Modalities	**30,467**	**12,055**	**39.6%**
Total - Plan Modalities	**25,680**	**10,195**	**39.7%**



Aug-22
10195
2022-23 Plan
-
Assurance
-
Variation
Common Cause



Aug-22
39.7%
2022-23 Plan
25.0%
Assurance
Fail
Variation
Common Cause

Summary

These charts display the latest position for MRI, CT, NOUS, Colonoscopy, Flexi-Sigmoidoscopy, Gastroscopy and Echocardiography, which were included in the Operational Plan (OP plan) for 2022/23. **Diagnostic activity: is showing an improving position** with activity levels above the mean, but the positon does vary by modality and provider. However, activity remains below the planned level.

Diagnostics backlog & waiting list: ***showing common cause variation*** due to values moving below the mean between June and August.

Diagnostic 6 week performance for plan modalities: September at 39.7% with the 6 week backlog increasing to 10,195 patients.

MRI: challenging at NUH, however the position has improved substantially since January 2022. The MRI waiting list and backlog have decreased by around 1000 patients. Mutual aid has been provided by SFHT during this time.

Echocardiology: The data for August shows that Echocardiography is performing at 56.9% for SFH and NUH. After a period of rapid increase, the backlog and waiting list are now showing early signs of reduction. However, pressures remain at SFH.

Actions

Echocardiology - NUH have secured locum staff and are working weekends to meet demand, these efforts have supported the backlog to stabilise and reduce the backlog level.

Mutual Support - is in place with NUH supporting SFHT with ultrasound.

The business case was submitted in draft earlier this month. Some positive initial feedback has been received with further feedback from regional finance and estates colleagues expected shortly. The final submission will be made at the end of October to the national team of NHSE/I. The business case will support the development of a single CDC within the Mid Nottinghamshire area that will align to the minimum specification national specification. This will provide additional CT, MRI, Non-Obstetric Ultrasound and X-Ray capacity. It will also provide endoscopy, physiological measurements for respiratory and cardiolgy as well as additional pathology capacity.

Providers routinely monitor the current position against modality level recovery trajectories. Copies of the trajectories have been received from service leads at the local providers and are monitored through the Diagnostics Board.

POG Assurance - Limited Assurance

The total waiting list and backlog is showing early signs of stabilisation across the key 15 modalities, however it is yet to trigger an SPC alert.

The system has submitted a Diagnostic Improvement Plan for Diagnostic Performance to NHSE, to improve current performance from 40% failing to be seen within 6 weeks, to 25% (ie to move from 60% being seen within the 6 weeks requirement to 75% by the end of March 2023, then 85% by March 2024 and 95% by March 2025).

The system was required to submit recovery trajectories to NHSE/I on the 20th October for CT, MRI, NOUS, Echocardiography and Endoscopy. All the trajectories showed improving positions, however Echocardiography and MRI are forecast to be below the 75% ambition by the end of March 2023 (52.9% and 58.1% respectively).

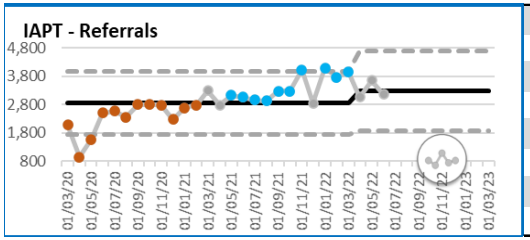
7.4 Service Delivery Mental Health Performance

7.4a – Exception Reports Mental Health IAPT
7.4b – Exception Reports Mental Health Adult Services
7.4c – Exception Reports Mental Health Access
7.4d – Exception Reports Mental Health CYP

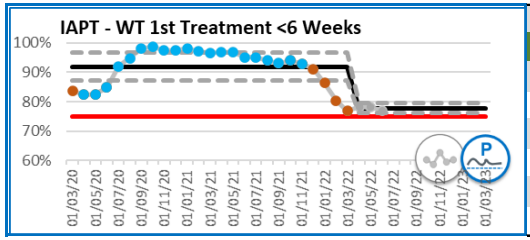
7.4a - Recover Services and Address Backlogs – Exception Report : Mental Health - IAPT

NHS Nottingham and Nottinghamshire

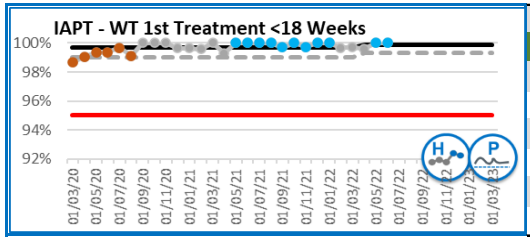
Mental Health - Improving Access to Psychological Therapies



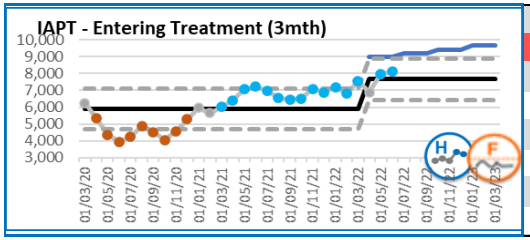
Jun-22
3155
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause



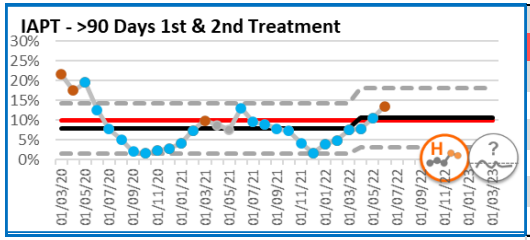
Jun-22
77%
Target
75%
Assurance
Pass
SPC Variation
Common Cause



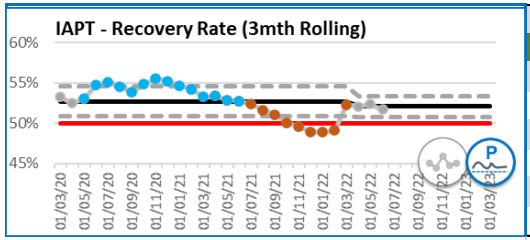
Jun-22
100%
Target
95%
Assurance
Pass
SPC Variation
Improving - High



Jun-22
8110
2022-23 Plan
8984
Assurance
Fail
SPC Variation
Improving - High



Jun-22
14%
Target
10%
Assurance
Flip
SPC Variation
Concerning - High



Jun-22
52%
Target
50%
Assurance
Pass
SPC Variation
Common Cause

Summary

- IAPT referrals are around the mean therefore common-cause.
-Treatment numbers (3-month) rolling average are at the mean, which is below planned levels, 8110 against 8984 plan, however is a the ICB highest recorded.

The service continues to achieve and exceed **waiting time standards. T**here had been a sustained reduction in treatments within 6 weeks, followed by performance around the mean, changing to common cause variation. This is largely due to a 16% increase in referrals between Q3 and Q4, as well as high levels of covid staff absence (18% at one provider), which resulted in reduced appointments available, and doubled appointment cancellations across that provider.

Patients **waiting over 90 days** between 1st and 2nd treatments have also risen over the past 4 months, causing a special cause alert in month, due to the issues described above.

There has been a sustained improvement in the **recovery standard**, with achievement since March 2022. The downward trend had reflected a reported increase in complexity of presentations, however in March 2022, 70% of patients showed reliable improvement upon completing treatment.

Actions

Key actions to increase performance over the next quarter include:
Access - Focus on service promotion, community advertising and engagement and strengthening links with localities and PCNs. This includes continuing with service promotion and awareness raising through social media animations, videos and blogs, monthly newsletters, community advertising and attendance at community events.
Waiting Times - A continued focus on staff wellbeing, supervision and caseload management including training and drop-in support sessions. Ongoing recruitment to increase capacity, including 14 trainees commenced April, agency and affiliates.
- The wider roll out of NHS Limbic will improve online access, support appropriate signposting ensuring that clinical capacity is used most appropriately and additional support to patients while they are waiting to reduce drop-out rates, and thus supporting the access and recovery standards.
Recovery - targeted support for staff with lower recovery rates including refresher training, review of case suitability and data quality and processes.
Inequalities - A continued focus on inequalities to include the roll out of online offers in different languages and the commencement of community engagement workers, with a primary focus on BAME communities and older adults.

POG Assurance - Partial Assurance

An established monthly steering group with IAPT providers is in place, with focussed monitoring of targeted actions to assess impact of improvement actions and delivery of spending review investments.

The revised trajctory for IAPT Access - Entering Treatment is for the system to achieve by the end of March 2023.

Local data is utilised to identify and address performance issues with providers and agree actions to improve capacity and service delivery, including workforce issues.

Improvement on the 6 week waiting time standard is expected by September 2022.

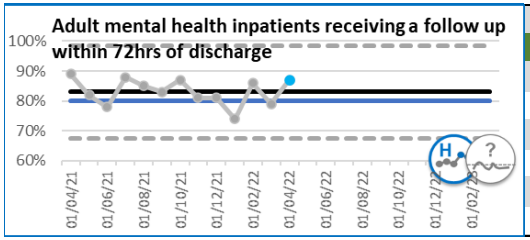
Staff sickness rates had seen some improvement during June 2022, however these are starting to rise again with the rising cases of covid in the community.

A procurement is underway for IAPT services across the ICB, a new contract will be in place from 1 April 2023. A transition plan is in place to ensure the impact on service users is minimal, the plan is reviewed on a weekly basis.

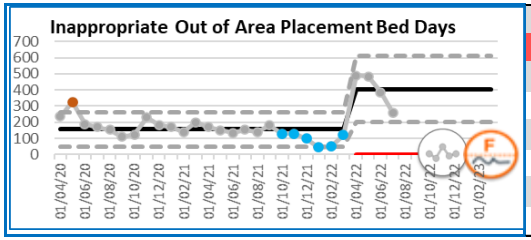
7.4b - Recover Services and Address Backlogs – Exception Report: Mental Health - Adult Services

NHS Nottingham and Nottinghamshire

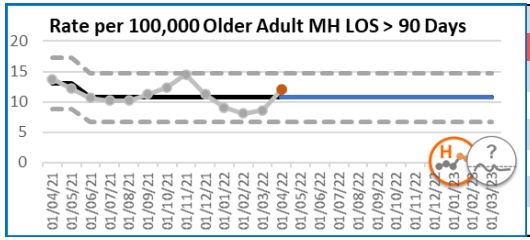
Mental Health - Adult Mental Health



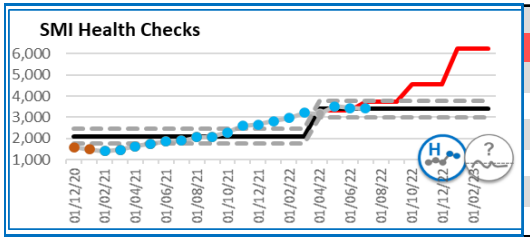
Jun-22
85%
Target
80%
Assurance
Flip
SPC Variation
Improving - High



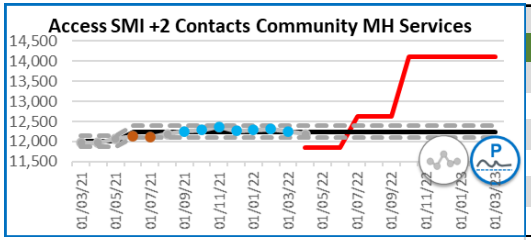
Jul-22
260
2022-23 Plan
0
Assurance
Fail
SPC Variation
Common Cause



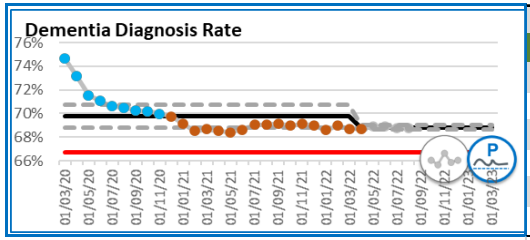
Jun-22
18
Target
11
Assurance
Flip
SPC Variation
Concerning - High



Jul-22
3424
2022-23 Plan
3750
Assurance
Flip
SPC Variation
Improving - High



Jun-22
12200
2022-23 Plan
11854
Assurance
Pass
SPC Variation
Common Cause



Aug-22
68.8%
Target
66.7%
Assurance
Pass
SPC Variation
Common Cause

Summary

72 Hour Follow Ups - this target is near the mean therefore is likely to hit and miss the target.
OAPs - Placements out of area have significantly decreased from April 2022, local data reports 260 as at July 2022. This has been driven by increased demand for inpatient admissions, acuity and complex patient delays in discharge from the acute setting.
Older Adult +90 days - the performance is near the mean therefore is likely to hit and miss the target. The recent increases have triggered a concerning-high alert.
SMI Physical Health Checks - There had been continued improvement in 2021/22 however this has plateaued since April, 41.3% (3424 checks). The target for 2022/23 increases to 5,592 (6237 including Bassetlaw).
Dementia - continues to deliver to standard. Memory Assessment Services increased capacity and has significantly reduced waiting times following additional investment.

Please be aware that due to an issue with an ONS source file that NHSD use in their processing they have been as yet unable to publish ICB level data for July. This impacts the following areas which remain the same as last month - IAPT, Perinatal Access, CYP Access, EIP

Actions

OAPS - Crisis/ Community Support - Crisis Resolution Home Treatment Teams delivering Intensive Home Support and in-reach to wards, however recruitment to some posts remains a challenge. A pilot of daytime Crisis Home provision is being undertaken from Q1 to support admission avoidance and supported discharge from inpatient wards. Inpatients Long Stay reviews have been undertaken, routine reporting established from NHT, MH MADE events held and additional beds to be opened Q3 in the new inpatient unity to support discharge and local capacity.
SMI Health Checks - Recovery Plan actions include: Monitoring against PHSMI LES (live since 1 May 2021) and practice/PCN data to target Health Improvement Workers across primary care, improvements in communication approach of HIW across primary care, scoping on role of VCSE. Nottingham City East PCN focused support to scope and address disparity in access to a health check. A pilot has commenced Q1 2022/23 testing several digital kits to enable point of care testing, funded by NHSE.
Dementia - MAS teams flex staffing and delivery methods including remote consultations, to meet variation in demand across locality to ensure equitable waits across the system. From April 2022 the Integrated Demential Wellbeing Service has enhanced the post diagnostic offer to those diagnosed and their carers, which is a key component of the MSNAP accreditation.

POG Assurance - Partial Assurance

OAPS - Mental Health Crisis and Urgent Care Steering Group meets monthly to review progress against actions. Partnership meetings are also in place to identify any actions that can be taken to alleviate system pressures. **Ambition is to have reduced to zero during Quarter 2, with early indications that this is progressing well, with initial data for August indicating c80 bed days.**

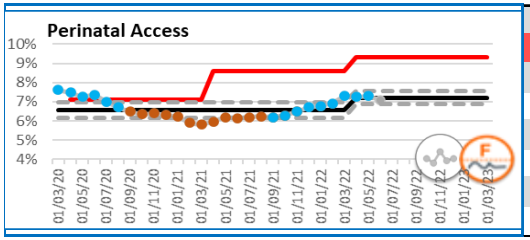
SMI Health Checks - monitoring by practice is undertaken through PHSMI Steering Group, 100% take up of PHSMI LES in 2022/23. Delivery of the standard is integrated into the Community Mental Health Transformation Programme to ensure co-ordination with all service developments, including LMHT and MH Practitioners in PCNs.

Dementia - reconfiguring data systems to accurately record referral to diagnosis. The ICB is took part in an NHS England led Dementia Diagnostic Rate deep dive in Q1 2022/23 to support full understanding of variation. Following this the ICB is working with MAS and data teams to establish a measure of equity in the DDR to be included within reporting from Q2.

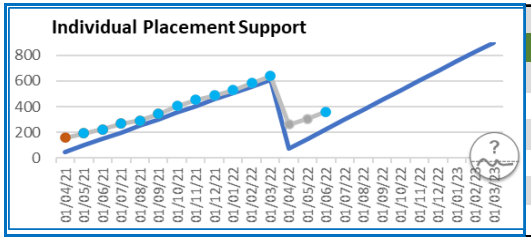
7.4c - Recover Services and Address Backlogs – Exception Report : Mental Health – Access

NHS Nottingham and Nottinghamshire

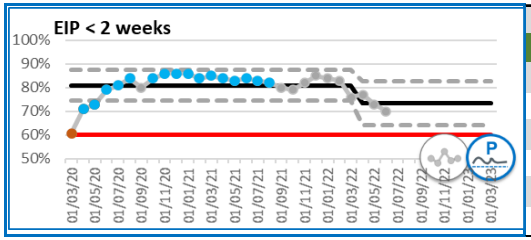
Mental Health - Access



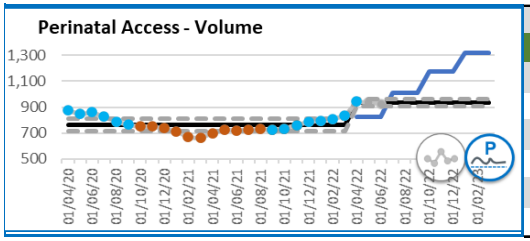
Jun-22
7.1%
Target
9.3%
Assurance
Fail
SPC Variation
Improving - High



Jun-22
360
Plan
225
Assurance
Flip
SPC Variation
Common Cause



Jun-22
70%
Target
60%
Assurance
Pass
SPC Variation
Common Cause



Jun-22
925
2022-23 Plan
828
Assurance
Pass
SPC Variation
Improving - High

Early Intervention Psychosis (EIP) Compliance Levels

NICE standard	Current performance	Rating
Access	Level 4	Top Performer
CBTp	Level 3	Performing Well
Family Interventions	Level 2	Needs Improvement
Supported employment and education	Level 4	Top Performer
Physical Health Checks	Level 4	Top Performer
Carer Focussed education	Level 4	Top Performer
Outcome measures	Level 2	Needs Improvement

Summary

Perinatal - Performance in June 2022 has decreased to 7.1%, and remains below the standard of 9.3%. National reporting guidance specifies that only face-to-face and video conferencing contacts contribute to access performance. This resulted in a decline in reportable performance from July 2020 as Covid led to virtual service delivery. Performance has stabilised and shows signs of continual improvement and analysis of local data, including telephone support, demonstrates that more women are accessing support than is reportable nationally.

IPS - The ICS meet and exceeded the 2021/22 IPS access standard. Month 3 is ahead of trajectory and track to achieve the 2022-23 year-end target of 899.

EIP - Access standard consistently exceeding target at ICS Level. Level 3 Overall compliance achieved in September 2021. Performance has been declining since January, the lower control limit is nearing the target level indicating that the process is likely to miss the target in the coming months. This has been due to workload pressures and staffing.

Please be aware that due to an issue with an ONS source file that NHSD use in their processing they have been as yet unable to publish ICB level data for July. This impacts the following areas which remain the same as last month - IAPT, Perinatal Access, CYP Access, EIP

Actions

Perinatal

- Regular and continuous promotional activity to increase the number of referrals to the service via a number of online methods.
- Dedicated admin time to follow up women who have not opted in to attend an appointment and to follow up those who have missed appointments to understand the reasons why. Analysis of this data will be reported monthly, and actions identified will inform the recovery action plan.
- Scoping the implementation self-referral and of a yes/no text response function to enable service users to share whether they can attend their appointments will be completed by end of September 2022.
- Developing data recording processes to ensure the demographic being referred is representative of the local population. This includes analysing links between deprivation and access and identifying how this can be improved. This will be completed by the end of September 2022.
- A dedicated community engagement role has been appointed to and will work with women from underrepresented groups who are not accessing the service. They will begin targeted work by October 2022.

EIP - staffing levels are expected to improve and a new process for daily reviews of incomplete pathways has been implemented.

POG Assurance - Partial Assurance

Perinatal - An ICS Perinatal Recovery Action Plan has been developed, including an improvement trajectory outlining when the service is expected to achieve the access target. Due to the metric being based on 12-month rolling position, the trajectory will represent a slow but continual improvement. This is monitored through the Perinatal Mental Health Steering Group. ***The access target increases in 2022/23 from 8.6% to 10%, the ICS aim is to achieve the revised target by Q4.***

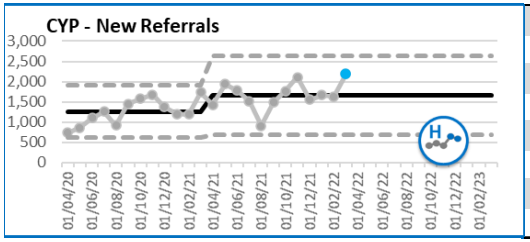
EIP Transformation meetings are in place to review progress against agreed actions, variations across teams and progression through compliance levels.

IPS - Additional investment has been agreed for 2022/23 to enable sufficient capacity to deliver the increased target, with 5 roles currently out to advert. This will ensure equity of offer across the ICS. A fidelity review of the Mid-Notts element of the service has been undertaken by IPS Grow, with the sevice assessed as a ***Centre of Excellence.*** The year end target of 899 is expected to be achieved.

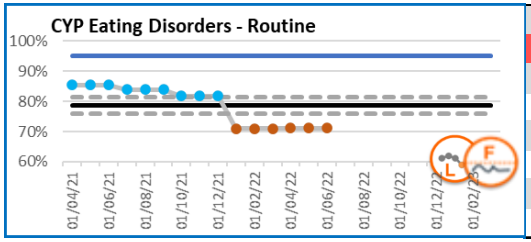
7.4d - Recover Services and Address Backlogs – Exception Report : Mental Health – Children & Young People

NHS Nottingham and Nottinghamshire

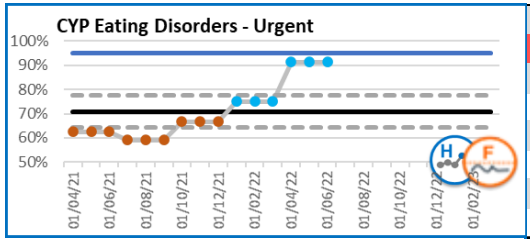
Mental Health - Children & Young People (CYP)



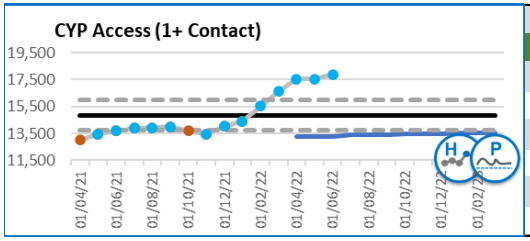
Mar-22
2190
2022-23 Plan
-
Assurance
-
SPC Variation
Improving - High



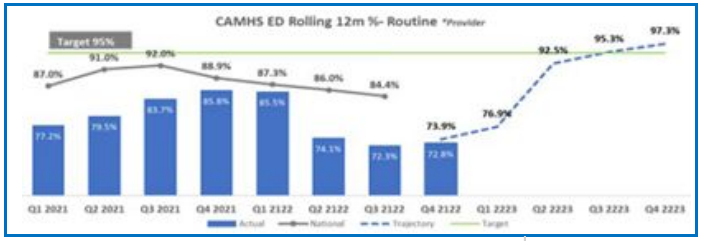
Jun-22
71%
Target
95%
Assurance
Fail
SPC Variation
Concerning - Low



Jun-22
91%
Target
95%
Assurance
Fail
SPC Variation
Improving - High



Jun-22
17880
2022-23 Plan
13300
Assurance
Pass
SPC Variation
Improving - High



Summary

CYP Referrals - have been increasing and have triggered a special cause -High alert.

CYP Access (1+ Contact) - The ICS is exceeding the new access target of number of children and young people (CYP) receiving support (1-contact); 17880 CYP were recorded as having at least 1 contact in the rolling 12 months ending June 2022, exceeding the annual plan of 13,300 this financial year. This is reporting a SPC Assurance 'Pass' as the mean is above the plan providing confidence in the delivery of the plan.

CYP ED Routine (< 4 weeks) - Special Cause Low variation due to the deterioration of performance. It is not expected that the service will meet the required standard.

CYP ED Urgent (<2 weeks) - Special Cause High variation due to the improvement in performance over the past 2 quarters. However the service remains below the requried standard and is unlikely to consistently meet the required standard.

Please be aware that due to an issue with an ONS source file that NHSD use in their processing they have been as yet unable to publish ICB level data for July. This impacts the following areas which remain the same as last month - IAPT, Perinatal Access, CYP Access, EIP

Actions

CYP Access - Due to increased demand investment has been agreed to deliver the Long Term Plan objectives for 2022/23 which enable service expansion and transformation across a range of services; schemes are being implemented throughout the current financial year and next. Regular multi-agency transformation meetings are scheduled which support the areas of transformation and ensure partnership working.

CYP Eating Disorder Service - 2022/23 investment plans have been agreed to further increase capacity in line with these increased referrals levels. Most posts have been recruited to, however there have been some issues with recruitment to the psychology post which is reflective of a national workforce issue. NHT are re-advertising and reviewing psychology resource across the the CAMHS service to ensure it is being use effectively.

POG Assurance - Partial Assurance

It not expected that referral levels will plateau. Referral trends have continued largely above the mean and the national team at NHS England advise areas to plan for a sustained response to the current level of referrals.

Investment was agreed for 2022/23 which will enable service expansion and transformation across a range of services.

The ICS remains a high performer for CYP Access.

CYP Eating Disorder - a recovery trajectory has been established based on 200 referrals per annum. It is expected that 'routines' will achieve target in Q3 and 'urgents' will achieve target in Q2. Recovery trajectories provided above.

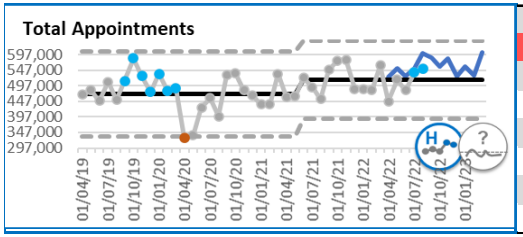
7.5 Service Delivery Primary & Community Performance

7.5a – Exception Reports Primary & Community

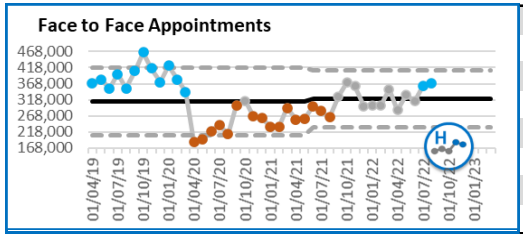
7.5a - Recover Services and Address Backlogs – Exception Report: Primary and Community Recovery

NHS Nottingham and Nottinghamshire

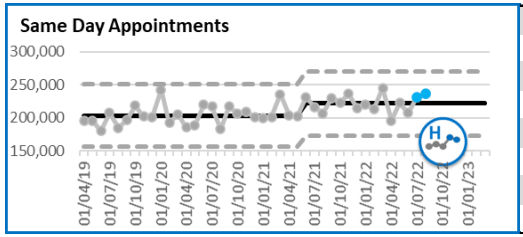
Primary Care and Community Recovery



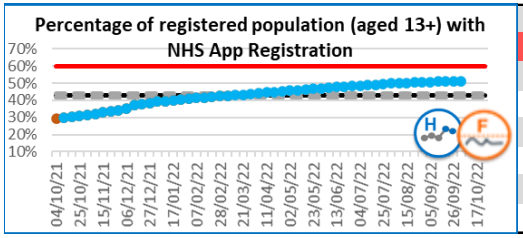
Aug-22
550013
Max Lmit / Target
599832
Assurance
Flip
SPC Variation
Improving - High



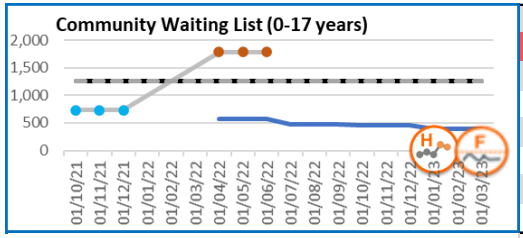
Aug-22
67%
Max Lmit / Target
-
Assurance
-
SPC Variation
Improving - High



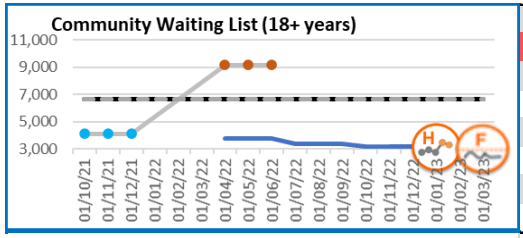
Aug-22
43%
Max Lmit / Target
-
Assurance
-
SPC Variation
Improving - High



Oct-22
51%
Max Lmit / Target
60%
Assurance
Fail
60% by March 2023
Improving - High



Jun-22
1785
Max Lmit / Target
576
Assurance
Fail
SPC Variation
Concerning - High



Jun-22
9141
Max Lmit / Target
3754
Assurance
Fail
SPC Variation
Concerning - High

Summary

Total GP Appointments, are below plan however are above prior year levels by 21%.

The percentage of appointments held face to face continues to increase at 67%, and on the same day continues to deliver around the mean at 43%. There has been a stepped increase in home visits since March 2022 as the average number per month is 2767 in 2022/23 compared to an average of 2033 per month in 2021/22.

NHS App - registrations onto the NHS App have continued to increase over the past few years. The end of March 2023 target is to achieve 60% registration.

Community Waiting Lists are significantly over the plan submitted to NHS England. This was a new measure for 2022/23 planning. It is understood that the plans may have excluded certain groups of activity, this is being reviewed with NHT and Citycare, and will be reported on in future reports.

Actions

GPs continue to respond to increasing demand, as well as the impact of the recent wave of covid. In addition they are moving to address the hidden waits of Long Term Condition reviews.

NHS App - Ensuring consistent promotion of the NHS App is being picked up via the redmoor review and part of the excellence in PCIT programme; this is also a direct target for us as part of our PFDS programme as the strategic direction is NHS App as the single front door. Within the DDAT team we have been supporting GP practices to promote the NHS App via specific target comms activities such as social media, radio ads and bus and tram advertisement.

POG Assurance - Limited Assurance

Further discussions are required with NHT and Citycare to understand the waiting list position for community services. This will be reported at future meetings.

NHS
Nottingham and Nottinghamshire

8.0 Finance

ICS Aim 3: Enhance productivity and VFM

- 8.1 – Month 6 2022/23 Financial Position – Key Metrics
- 8.2 – System Financial Performance – Key Messages
- 8.3 – Organisational Analysis
- 8.4 – Detailed Risks and Mitigations
- 8.5 – System Response – Recovery Plan

8.1 - Finance Position Month 6 2022/23 – Key Metrics

Month 6 Key Metrics

		YTD Variance £m's			FOT Variance £m's			RAG	
Financial Duties	Measure	Plan	Acts	Variance	Plan	FOT	Variance	YTD	FOT
NHS System (Breakeven)	(Deficit)/Surplus	-23.5	-36.3	-12.9	-16.9	-16.9	0.0		
Capital (within Envelope)	Spend against plan	31.0	27.8	3.2	89.6	89.6	0.0		
MHIS (meeting target)	Spend against plan	94.1	101.5	7.4	188.1	190.6	2.4		
Agency (spend within Cap)	Spend against plan	28.9	41.5	-12.6	54.6	71.4	-16.7		

		YTD Variance £m's			FOT Variance £m's			RAG	
Drivers of the (Deficit)/Surplus	Measure	Plan	Acts	Variance	Plan	FOT	Variance	YTD	FOT
COVID Spend	Delivery against plan	14.0	19.6	-5.6	17.8	28.0	-10.2		
NHS Efficiencies	Delivery against plan	38.0	37.0	-1.0	102.7	102.7	0.0		
ERF Income	Delivery against plan	23.2	23.2	0.0	53.7	53.4	-0.3		

£36.3m deficit experienced to end of month 6, which is **£12.9m** adverse to plan.

- The adverse variance is mainly experienced in the 2 acute trusts (NUH & SFH) representing **£12.3m** of the year to date deficit.
- Key drivers of the adverse variance are covid (**£5.6m**), continuing care spend **(£4.9m**) and efficiency shortfall (**£1m**). Offsetting favourable variances include clinical supplies (£5.5m) due to elective surgery performing below planned levels and delegated primary care (£3.8m).
- Agency spend remains over plan and above the agency cap, with an adverse YTD variance of **(£12.6m**).
- The forecast remains break-even but there are significant risks to delivery, particularly relating to covid, efficiency, continuing care and urgent care capacity over winter.

System Financial Performance – Key Messages

The Nottingham & Nottinghamshire ICS has a £36.3m deficit at month 6, which is £12.9m adverse to plan. This is a worsening in position of £7.6m from month 5.

Much of the in-month worsening position relates to changes in funding assumptions:

- Community Diagnostic Centres (CDC) income no longer accrued following discussions with the national team (£3.6m).
- Shortfall on 2022/23 pay award (£1.3m)
- Remaining in-month variance relates to covid (£1.2m), urgent care capacity (£0.7m), backfill for the additional bank holiday (£0.4m) and non-pay costs (£0.5m)

The £12.9m year to date adverse variance can be analysed as follows:

- Covid spend above planned levels - £5.6m
- CDC funding gap - £3.6m
- Pay award shortfall - £1.3m
- Urgent care capacity requirements - £1.0m
- Efficiency shortfall - £1.0m
- Other smaller pressures £0.4m

Reported forecast remains in line with the submitted plan of £17.0m deficit.

There are a number of risks to delivery of the plan. Highest areas of risk are:

- Covid – the 2022/23 plan was based on a low covid environment from Q2. This is not being experienced and continuing levels of covid related workforce absence is leading to high levels of overspend.
- Efficiency - £102.7m efficiency programme in place (2.9%). Plans in place to deliver with full commitment of FDs. However, delivery will include non-recurrent items, which will increase the recurrent efficiency ask in 2023/24.
- Community Diagnostic Centres - £8.5m income assumed for CDC. Available national funding has been diverted to support the 2022/23 pay award leaving this at risk. Dialogue with the national team continuing.

Organisational Analysis

NUH

- Year to date position of £24.9m deficit, £7.5m adverse to plan is driven by covid expenditure £4.8m above plan and efficiencies £0.5m adverse to plan.
- ESRF income is now assumed to be on plan following NHSE advice. Clinical supplies costs are £5.6m favourable to plan due to lower than planned elective activity levels.

SFH

- The YTD position is driven by efficiency shortfall of £0.8m, covid spend above planned levels of £0.9m and Adverse variance to plan on CDC income of £2.2m.
- Urgent care costs remain above plan but have been mitigated through the use of NHSE urgent care funding.

NHT

- Currently £0.6m adverse variance to £1.9m year to date deficit plan.
- Agency and out of area bed spend are both adverse to plan offset by a small over-recovery of efficiencies.

Month 6 Financial Position						
Organisation £'m	**YTD Plan**	**YTD Actuals**	**Variance**	**Annual Plan**	**FOT**	**Variance**
NUH	-17.5	-24.9	-7.5	-12.3	-12.3	0.0
SFH	-4.7	-9.5	-4.8	-4.7	-4.7	0.0
NHT	-1.3	-1.9	-0.6	0.0	0.0	0.0
N&N ICB	0.0	0.0	0.0	0.0	0.0	0.0
Total System	**-23.5**	**-36.3**	**-12.9**	**-17.0**	**-17.0**	**0.0**

ICB

- Breakeven position including the impact of CCG spend (N&N and Bassetlaw) to month 3.
- Adverse variances seen in continuing healthcare (£4.9m), and hospital discharge costs (interim beds supporting urgent care).
- Offset by primary care costs below planned levels and non-recurrent benefits.
- The ICB also holds a system risk of £6.3m. £0.6m of this has been covered within the year to date position.

Detailed Risks and Mitigations

Key risks

- Covid – Current risk adjusted assessment **£17m** above planned levels. To achieve this, there needs to be a £0.9m per month reduction in existing run rate.
- CDC revenue funding - **£8.5m** planning assumption. Latest correspondence is that this has been used to fund the pay award.
- Pay Award - **£3.1m** assessed cost above funding. Further assessment alongside National Insurance exercise.
- Winter and urgent care costs - **£6.8m** risk above capacity funding relating to interim beds and acute staffing currently being absorbed in the ICB's position.
- Continuing Care – Assessed at **£3.4m** above planned levels
- Elective Recovery Fund – Current assumption is that this will remain as a block into the second half of the year.
- Efficiencies – Although there is risk to the initial plan mitigations are in place to deliver in full. Main risk is within the recurrent plan with current assessment that delivery will include **£11.9m** increase in non-recurrent items over plan.

Key Mitigations

- Agency – Actions in place to reduce off framework and price cap breaches. Monthly run rate currently £2m in excess of agency cap. System trajectory would improve run rate by **£9m** in H2.
- System Transformation – Large programme of work being re-energised (see later slides). Potential for circ. **£4m** opportunity in final months of the year
- Recruitment/Investments - £14m run rate change built into existing forecast. Potential slippage due to recruitment may provide some benefit. Current assessment **£5m**. However potential impact on agency use.
- Covid – although covid remains a significant risk, assessment of covid spend and controls is underway, with a view of mitigating against future increases.
- Balance Sheet - Review of balance sheet treatment has led to approx. **£4m** of opportunity. Potentially further annual leave accrual adjustment required.

System Response – Recovery Plan

- To address the current deficit, monthly expenditure trajectories and risks within the forecast system partners have agreed to implement a system-wide recovery approach.
- Covid spend, efficiency delivery, elective recovery income (ESRF) & spend and urgent care capacity requirements are the largest drivers of current and forecast variance within the financial plan.
- These areas, alongside other areas highlighted by region for significant scrutiny, form the basis of the system-wide recovery plan. This is formed of 7 high impact areas:
  - Reductions in covid expenditure
  - Reduce acute urgent care capacity requirements to within planned levels –
  - Productivity actions to increase ESRF within existing resources
  - Delivery of 22/23 cash-releasing efficiency programmes
  - Actions to reduce agency expenditure
  - Investment review principles and processes
  - System wide transformation programme development
- Each high impact area has a system Finance Director Senior Responsible Officer (SRO). The SRO is working across the system with existing groups to oversee further development of plans, implement actions, monitor performance and unblock barriers to delivery.
- Plans have been developed for each area. SROs have now been asked to develop tangible and quantified plans that will deliver agreed trajectories to meet the current forecast.
- Governance and accountability is through the FD Group and CEO Group with fortnightly progress reports and escalations.

NHS
Nottingham and Nottinghamshire

9.0 System Workforce

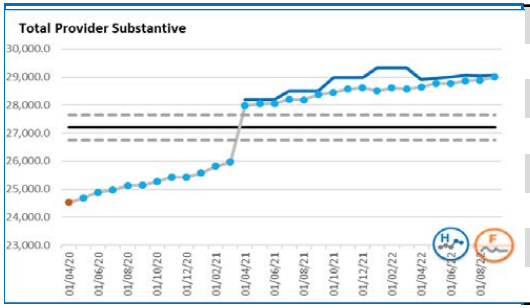
ICS Aims: All 4 (Outcomes, inequalities, productivity and social and economic development)

- 9.1 – Exception Report Provider Workforce
- 9.2– Exception Report Provider Vacancies, Turnover & Sickness
- 9.3 – Exception Report Primary Care Workforce
- 9.4 – Exception Report Agency Cost
- 9.5 – Exception Report Agency Usage
- 9.6 – Social Care Workforce
- 9.7 – Employment Overview
- 9.8 – Projections
- 9.9 – Care Homes Workforce

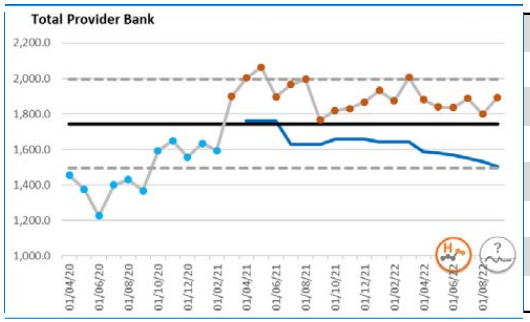
9.1 - Workforce – Exception Report Provider Workforce

NHS Nottingham and Nottinghamshire

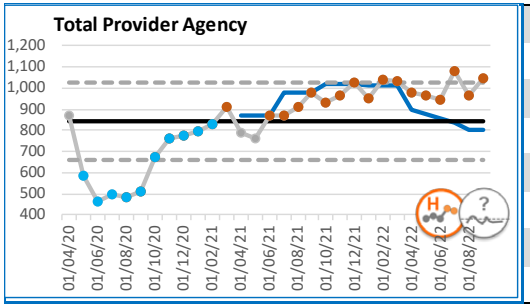
Total ICB Provider Workforce - Operational Plan v Actual 2022/23



Sep-22
29013
2022-23 Plan
29064
Assurance
Fail
SPC Variation
Improving - High

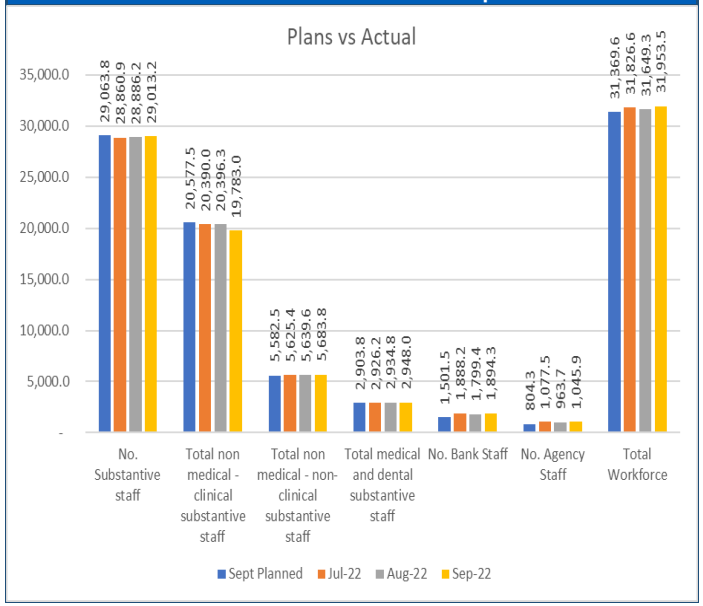


Sep-22
1894
Target
1502
Assurance
Flip
SPC Variation
Concerning - High



Sep-22
1046
2022-23 Plan
805
Assurance
Flip
SPC Variation
Concerning - High

Total Provider Workforce - Jul - Sep 2022/23



Actions

The HIA working group on Temporary staffing continues to meet monthly with Trusts leading on actions within their own organisations:
SFH - have seen reductions in breaches and off-framework usage. AHPs remain issue esp. radiographers – keen to look at options to address including collaboratively, noting CDCs likely to increase demand for staff as well. Re-setting governance arrangements through divisional meetings including focus on long standing locums
NUH – Overall spend increased in M6, Natalie spoke to report, lots of actions underway to address governance, working with NHSP, and meetings with THornbury scheduled
NHC – M6 worsened, acuity key driver, changing governance and targeting support to MH Division

Forecast for future months being looked at particularly given the recent clinical incident and ensuring HR and Finance leads are aligned on s expectations to infomr futher actions.

Trusts are implementing the 5 HIA nurding & midwifery retention:
1. Completion of the Self-Assessment tool
2. Implement Precetptorship Framework
3. Legacy Mentor Scheme to continue (Nottingham innovation now regional model)
4. Staff attendance at Pension Seminars
5. Menopause Policy & guidance implemented

Total Provider Current position:

Growth in substantive workforce seen on track with plan.
Vacancy levels are high due to changed establishments with recruitement , although on plan, not keeping at pace with the number of leavers/increased absence rates
Therefore agency and Bank staff utilisation continues above plan
Agency usage has continued above plan, with an increase in month across 2 of 3 providers. SFH has reduced to be within plan this month.

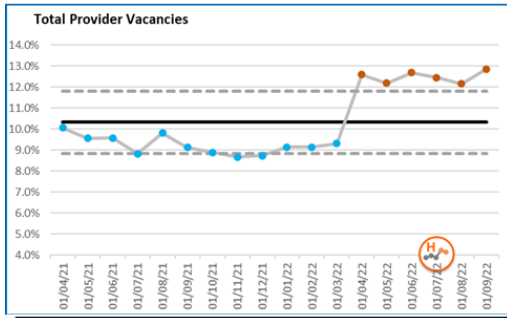
P&C Group Assurance -Enhanced Assurance Level

Total Providers:
Plans are in place but needs improved monitoring to evidence impact of each intervention and whether additional interventions are needed

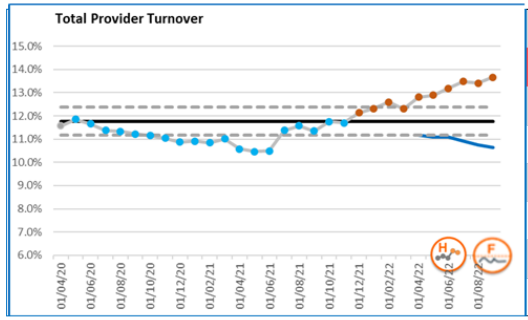
9.2 - Workforce – Exception Report Provider Vacancies, Turnover & Sickness

NHS Nottingham and Nottinghamshire

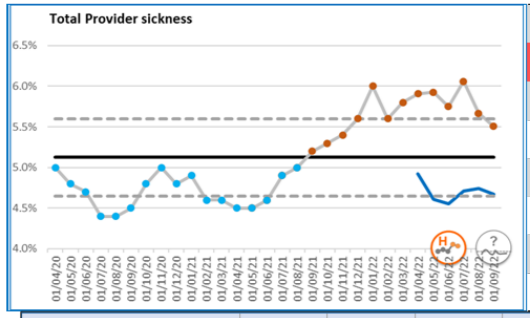
Workforce - Vacancies, Turnover & Sickness Absence



Sep-22
12.8%
Target
8.7%
Assurance
Flip
SPC Variation
Concerning - High



Sep-22
13.7%
Target
11.0%
Assurance
Fail
SPC Variation
Concerning - High



Sep-22
5.5%
Target
4.6%
Assurance
Fail
SPC Variation
Concerning - High

KPI	Latest Period	Target	Actual	Variance	Variation	Assurance
ICS Vacancies	Sep-22	8.7%	12.8%	4.1%	H	F
NHC Vacancies	Sep-22	8.7%	13.5%	4.8%	H	?
NUH Vacancies	Sep-22	8.7%	14.8%	6.1%	H	F
SFH Vacancies	Sep-22	8.7%	5.2%	-3.5%	~	P

KPI	Latest Period	Target	Actual	Variance	Variation	Assurance
ICS Turnover (12 mth)	Sep-22	11.0%	13.7%	2.7%	H	F
NHC Turnover (12 mth)	Sep-22	11.0%	18.1%	7.1%	H	F
NUH Turnover (12 mth)	Sep-22	11.0%	12.7%	1.7%	H	?
SFH Turnover (12 mth)	Sep-22	11.0%	9.5%	-1.5%	H	P

KPI	Latest Period	Target	Actual	Variance	Variation	Assurance
ICS Sickness Absence	Sep-22	4.6%	5.5%	0.9%	H	F
NHC Sickness Absence	Sep-22	4.6%	6.1%	1.5%	~	F
NUH Sickness Absence	Sep-22	4.6%	5.4%	0.8%	H	?
SFH Sickness Absence	Sep-22	4.6%	5.0%	0.4%	H	?

Summary

Vacancies have increased in Total Providers since April 22 following changes to establishments . There is a wide variation in perfomance across providers: 5.2%-14.8%

Turnover - continues to see an increase across all providers but SFH. This is in line with national trends.

Sickness levels have been higher than pre covid levels across the Total Providers with a downturn seen in this quarter in each Trust, but not to the planned levels which did allow for seasonal variation given trend seen in previous year.

Actions

Retention strategies are in place and being implemented in all three Trusts. A focus on the recruitment process through the collaborative resourcing group is looking at targeted staff groups, particularly HCSW, nursing and midwifery.

Total providers are enhancing their existing Wellbeing Plans and specifically around Financial wellbeing given teh Cost of Living challenges. Targeted support from the Staff Mental Health & Wellbeing Hub remains in Maternity and ED at NUH.

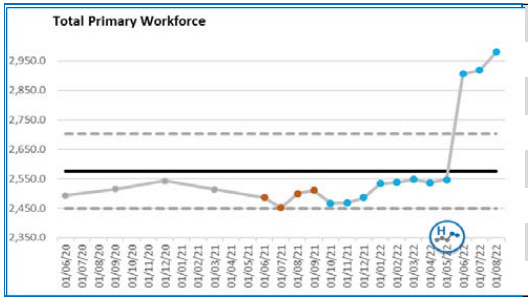
The Staff Mental Health & Wellbeing Hub has increased its accessiblity and offers, as staff sickness is increasingly attributed to stress and anxiety

People & Culture Group Assurance - Further Information Required

Plans are in place but more detail is needed to determine if targeted interventions are required.

9.3 - Workforce – Exception Report Primary Care Workforce

NHS Nottingham and Nottinghamshire



Aug-22
2980
Target
Assurance
SPC Variation

Total ICB Primary Care Workforce - Operational Plan v Actual 2022/23

Primary Care	Baseline Staff in post outturn	Plan Q1	Actual	Plan Q2	Plan Q3	Plan Q4
Nottingham And Nottinghamshire Health And Care STP	Year End (31-Mar-22)	As at the end of Jun-22	As at the end of Aug-22	As at the end of Sep-22	As at the end of Dec-22	As at the end of Mar-23
Workforce (WTE)	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE
Total Workforce	3034	3133	2980	3168	3194	3228
GPs excluding registrars	581	584	576	584	583	578
Nurses	323	362	352	372	378	383
Direct Patient Care roles (ARRS funded)	333	384	368*	406	424	434
Direct Patient Care roles (not ARRS funded)	260	265	266	267	269	284
Other – admin and non-clinical	1537	1538	1530	1539	1540	1549

Total Primary Care Current position:

Data collection at practice level shows variation due to unclear definitions on the workforce detail to be recorded. Members of the primary care team are working with the national development team to determine standardisation through clear definitions. The workforce data is therefore indicative data.

Actions

The overall workforce position is being maintained with an established retention/workforce development programme in place for General Practitioners and Practice nurses.

Recruitment continues in to the additional roles but not to the full potential of funding allocations. Training Hub support is being provided to establish and embed roles into PCNs.

Primary Care Workforce Group stocktake on the programme delivery and looking to support resilience over the winter months, ensuring wellbeing offers are clearly promoted and access intosystem resource made clear.

P&C Group Assurance -Enhanced Assurance Level

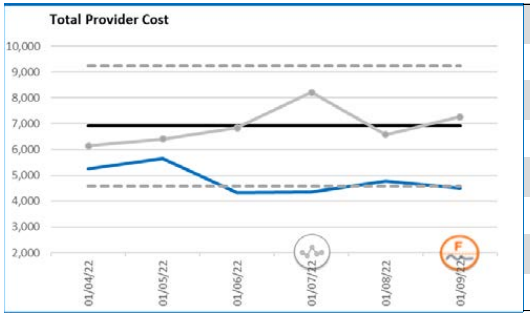
Primary Care - General Practice:

Plans are in place and are effective but more needs to be done to make general practice an attractive offer supporting staff, offering flexibility in working and cultural shift to integrated working.

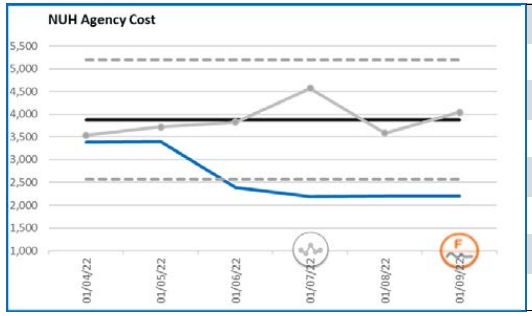
9.4 – Workforce – Exception Report Agency Cost

NHS Nottingham and Nottinghamshire

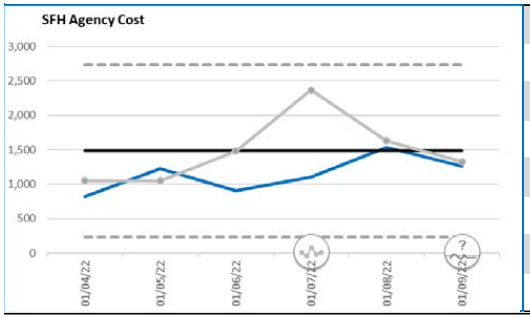
Total Provider Agency Cost



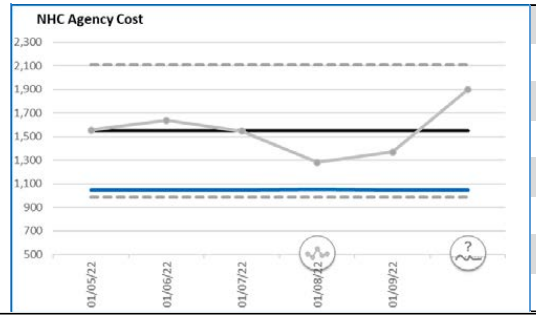
Sep-22
£7,268
2022-23 Plan
£4,508
Assurance
Flip
SPC Variation
Common Cause



Sep-22
£4,043
2022-23 Plan
£2,197
Assurance
Fail
SPC Variation
Common Cause



Sep-22
£1,326
2022-23 Plan
£1,263
Assurance
Flip
SPC Variation
Common Cause



Sep-22
£1,899
2022-23 Plan
£1,048
Assurance
Fail
SPC Variation
Common Cause

Summary

Agency usage has continued above plan, with an increase in month across 2 of 3 providers. SFH has reduced to be within plan this month
The breakdown on usage was not available fromall trusts to include inthis version of the report so the agency usage slide reflects the August posiition

Actions

SFH - have seen reductions in breaches and off-framework usage. AHPs remain issue esp. radiographers – keen to look at options to address including collaboratively, noting CDCs likely to increase demand for staff as well. Re-setting governance arrangements through divisional meetings including focus on long standing locums
NUH – Overall spend increased in M6, Natalie spoke to report, lots of actions underway to address governance, working with NHSP, and meetings with THornbury scheduled
NHC – M6 worsened, acuity key driver, changing governance and targeting support to MH Division

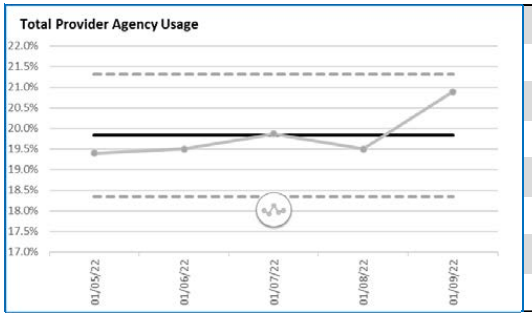
People & Culture Group Assurance - Further Information Required

Plans are in place but more detail is needed to determine if further targeted interventions are required.

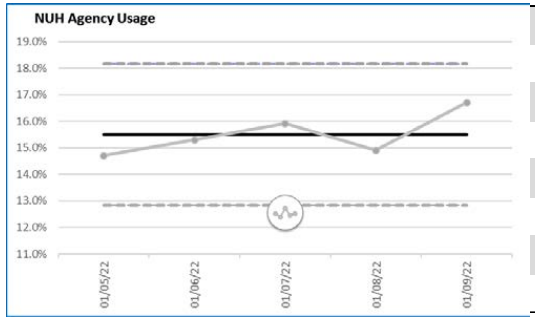
9.5 – Workforce – Exception Report Agency Usage

NHS Nottingham and Nottinghamshire

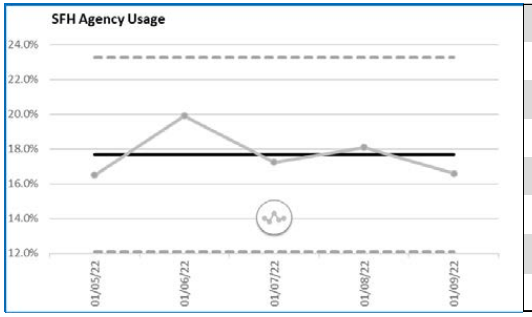
Total Provider Agency Usage



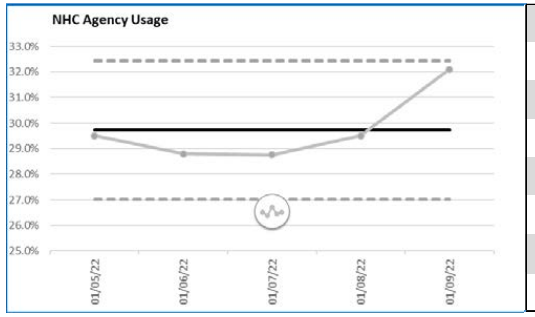
Sep-22
20.89%
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause



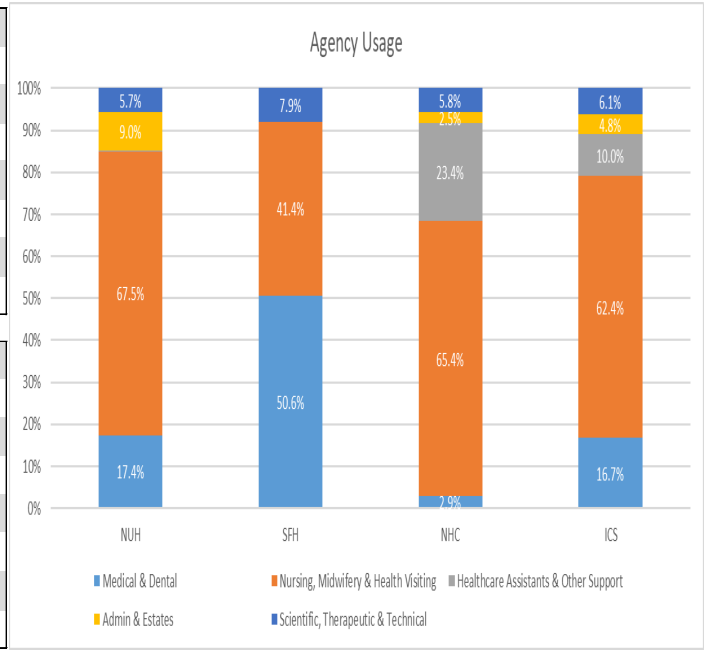
Sep-22
16.70%
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause



Sep-22
16.60%
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause



Sep-22
32.10%
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause



9.9 – Workforce – Care Homes Workforce

August workforce absence is 4.2% over all staff groups. The average absence from Jan 2021-Jun 2022 is 5.8%.

Agency staff levels have continued to rise since Feb 2021 and have been above the 3.8% average for the latest 10 months. Nursing staff averages have stayed level at an average 9.1%. Increases in agency staff during August is seen in all staff groups.

Monthly staff trend: All staff

Aligned PBP	Employed	Absence	%	Agency	%
Bassetlaw	1,528	44	2.9%	50	3.2%
Mid Notts	4,123	175	4.2%	263	6.0%
Nottm City	2,561	122	4.8%	147	5.4%
South Notts	4,361	187	4.3%	201	4.4%
Total	**12,573**	**528**	**4.2%**	**661**	**5.0%**

During August 2022 care homes are reporting overall 4.2% absence across all staff groups. For nursing staff, the absence is 3.6%, non-care workers 3.4%, the highest levels of absence is seen in Care workers at 4.5%. Nottingham City have the highest levels of absence during August 4.8%. This is mainly seen in the Nottingham City care workers group with 95 staff (4.9%) absent.

Mid Notts continues to have the highest levels of agency staff employed 6% of their total workforce. This increases to 14.4%, for nurses in Mid Notts which is 4.3% higher than the PBP average.

Data, visuals and comments taken from the Care Home & Home Care SIRs Aug 2022 on the SAIU Portal

NHS
Nottingham and Nottinghamshire

10.0 Health Inequalities

ICS Aim 2: Tackle inequalities in outcomes, experience and access

- 10.1 – Embed PHM approach
- 10.2a – Health inequalities dashboard – Metrics by Ethnicity
- 10.2b – Health inequalities dashboard – Metrics by Deprivation
- 10.3 – The 5 in the 'Core20plus5'
- 10.4 – Impact on the CORE20Plus5: Smoking

10.1 - Embed PHM Approach and Reduce Health Inequalities

NHS Nottingham and Nottinghamshire

10.1.1 The ICS Health Inequalities Group signed off the Health Inequalities Plan which will now go through the governance routes of the ICB. The Plan is under pinned by the Joint Health and Wellbeing Strategies and outlines the ICS approach of equity as a core principle and Core20+5. The Plan emphasises the central role of Place and Neighbourhood.

10.1.2 The SAIU has released the deep dive into Fuel Poverty. The deep dive identified 13,565 over-65 high risk and 4,795 very high risk (COPD/heart failure) individuals living in the 20% of LSOAs with the highest levels of fuel poverty. 80% of the high risk and very high risk patients are in 10 PCN/Neighbourhoods, mainly in Nottingham City and Mid Notts. The deep dive is being used across PBPs to align with the work of the Local Authorities and voluntary sector in supporting communities most in need.

10.1.3 The ICB has been successful in a bid for funding for the national Innovation for Healthcare Inequalities programme (InHIP). As part of the programme, the ICB will be working directly with the East Midlands Academic Health Science Network (EMAHSN) on a proposal in relation to Asthma. Respiratory disease is one of the biggest contributors for males and females in relation to the gap in life expectancy. The proposal is focused on resource to support the uptake of Asthma Biologics which includes a dedicated nursed to work within specific communities at higher risk. Initially there will be focus on PCNs/practices in areas such as Mansfield and Ashfield which is one the areas in the ICS with the highest levels of deprivation, with a larger proportion of the population falling into 20% most deprived in the country. Patients living in this area have higher incidence of poorly controlled asthma and those in Mansfield and Ashfield have particularly low uptake of Asthma Biologics when compared to other areas of the ICS.

10.1.4 There are clear links between tobacco use and inequality and therefore with health inequalities and smoking is a leading cause in preventable ill health, premature death and disability. For these reasons, the Core20+5 includes smoking as a priority across clinical areas and it is a priority in the ICS Health Inequalities Plan. Within our ICS smoking prevalence differs significantly across our communities with Rushcliffe having a rate of 5.3% and Mansfield being the highest 21.4%, and rates are also high in certain population cohorts and therefore, a targeted approach is required. The IPR provides an overview on smoking and actions being taken across the ICS and integrates with the Local Authority and Public Health programmes.

The ICS has an exciting opportunity to support our staff and therefore local communities, through a pilot of an NHS staff smoking cessation programme. The programme goes live in our Trusts in November with plans to then extend more widely.

10.2a - Health Inequalities Dashboard – Nottingham and Nottinghamshire Health Inequalities Metrics by Ethnicity

NHS Nottingham and Nottinghamshire

		Ethnicity		
Topic	Metric	Relative Difference in Mean	Trend (2017 - 2021)	Description
Cancer	Cancer morbidity in adults (percent)	0.84	Narrowing	Cancer morbidity in adults is lower in the Black and Asian population compared to the White population. The differences between populations are narrowing overtime.
	Cancer mortality age <75 (per 100,000 pop')	0.72	Steady	Cancer mortality under 75 is lower in the Black and Asian population compared to the White population.
Elderly persons	A&E Attendances age 75+ (per 100,000 pop')	0.91	Widening	A&E attendances over 75 are similar between ethnicity groups.
	Hip fracture NE Admissions age 75+ (per 100,000 pop')	0.51	Narrowing	Hip fracture NE admissions are half as frequent in the Black and Asian population as the White population. The difference between populations is narrowing over time.
H&J Spec Com	Renal morbidity in adults (percent)	1.39	Steady	Renal morbidity in adults is higher in the Black and Asian population compared to the White population,
Healthy people	A&E Attendances in adults (per 100,000 pop')	1.03	Steady	A&E attendances in adults is similar between ethnicity groups.
	All-cause mortality age <75 (per 100,000 pop')	1.10	Narrowing	All cause mortality under 75 is similar between ethnicity groups, differences between groups has narrowed overtime.
	CVD morbidity in adults (percent)	1.11	Steady	CVD morbidity in adults is similar between ethnicity groups.
	Diabetes morbidity in adults (percent)	2.39	Steady	Diabetes morbidity is 2.39 times higher in the Black and Asian population compared to the White population.
	Mortality within 60 days of a stroke (per 100,000 pop')	1.31	Widening	Mortality within 60 days of a stroke is 1.31 times higher in the Black and Asian population compared to the White population. The difference between groups is widening over time.
	Respiratory morbidity in adults (percent)	0.91	Steady	Respiratory morbidity in adults is similar between ethnicity groups.
	T&O Outpatient App. in adults (per 100,000 pop')	0.86	Steady	T&O outpatient appointments in adults are lower in the Black and Asian population compared to the White population.
Maternity & Child	Maternal C-section (per 100,000 pop')	1.65	Widening	Maternal C-section is 1.65 times higher in the Black and Asian population compared to the White population. This difference is widening overtime.
	Maternal post-partum haemorrhage (per 100,000 pop')	1.31	Steady	Maternal post-partum haemorrhage is 1.31 times higher in Black and Asian population compared to the White population.
	Mortality rate for infants aged 0-4 (per 100,000 pop')	9.73	Widening	Mortality rate for infants aged 0-4 is 9.73 times higher in the Black and Asian population compared to the White population. The difference between groups is widening over time.
Mental health	Alcohol related Admissions in adults (per 100,000 pop')	0.31	Widening	Alcohol related admissions are higher in the White population compared to the Black and Asian population. The difference between groups is widening over time.
	IAPT referrals in adults (per 100,000 pop')	0.91	Narrowing	IAPT referrals in adults are similar between ethnicity groups.
	NE Admissions for self-harm age 12+ (per 100,000 pop')	0.43	Widening	Non-elective admissions for self harm aged 12+ are higher in the White population compared to the Black and Asian population. The difference between ethnicity groups is widening over time.
Primary Care	Number of GPs in registered practice (per 1,000 pop')	0.95	Steady	Number of GPs in registered practice are similar between ethnicity groups.
	Number of nurses in registered practice (per 1,000 pop')	0.85	Widening	Number of nurses in registered practice is higher in the White population compared to the Black and Asian population. The difference between groups is widening over time.
	Received first dose of Covid-19 vaccine by 18/07/21 (%)	0.82	N/A	Covid vaccination rates are lower in the Black and Asian population compared to the White population.

The indicators here have been established by the National Commissioning Data Repository (NCDR) which utilises a number of different data sources from across the Healthcare system.

Alongside this data, the ICS local health inequalities dashboard was launched in July 2022. This dashboard presents key metrics aligned to the CORE20Plus5 as well as providing an inequality profile for each area of the ICS.
This information sits alongside the JSNA and other regional and national dashboards. Sub-groups have been established as part of the transformation programme to look at health gain value alongside financial value.

List of ICB Ambitions can be found on the next slide

	Higher Health Inequality in White population
	Higher Health Inequality in Black and Asian population

Data source: *calculations and metrics are from the 'Midlands Health Inequalities Dashboard' available in the 'National Commissioning Data Repository (NCDR)' developed by Arden and Gem. Data sets are obtained from SUS, IAPT, General Practice Workforce and Maternity Services Data Set.*

10.2b - Health Inequalities Dashboard – Nottingham and Nottinghamshire Health Inequalities Metrics by Deprivation

NHS Nottingham and Nottinghamshire

Health Inequalities Metrics				
		Deprivation		
Topic	Metric	RII	Trend (2017 - 2021)	Description
Cancer	Cancer morbidity in adults (percent)	0.97	Steady	Cancer morbidity in adults is similar between most and least deprived populations.
	Cancer mortality age <75 (per 100,000 pop')	2.53	Widening	Cancer mortality under 75 is 2.5 times higher in the most deprived population, and the inequality between groups has been widening over time.
Elderly persons	A&E Attendances age 75+ (per 100,000 pop')	1.86	Steady	A&E attendances over 75 are 1.86 times higher in the most deprived population.
	Hip fracture NE Admissions age 75+ (per 100,000 pop')	1.78	Widening	Hip fracture NE admissions are 1.78 times higher in the most deprived population. The difference between groups has been widening over time.
H&J Spec Com	Renal morbidity in adults (percent)	1.53	Steady	Renal morbidity in adults is higher in the most deprived areas.
Healthy people	A&E Attendances in adults (per 100,000 pop')	1.97	Widening	A&E attendances in adults is higher in more deprived areas and the inequality by deprivation has been widening over time.
	All-cause mortality age <75 (per 100,000 pop')	3.59	Widening	All-case mortality under 75 is 3.59 times greater in more deprived areas, and this inequality is widening over time.
	CVD morbidity in adults (percent)	1.64	Steady	CVD morbidity is 1.64 times greater in more higher areas.
	Diabetes morbidity in adults (percent)	2.37	Steady	Diabetes morbidity is 2.37 times higher in more deprived areas.
	Mortality within 60 days of a stroke (per 100,000 pop')	1.31	Narrowing	Mortality within 60 days of a stroke is 1.31 times higher in the most deprived areas, but the difference between areas has been narrowing over time.
	Respiratory morbidity in adults (percent)	1.76	Steady	Respiratory morbidity in adults is 1.76 times higher in the most deprived areas.
	T&O Outpatient App. in adults (per 100,000 pop')	1.04	Steady	T&O outpatient appointments are similar by deprivations
Maternity & Child	Maternal C-section (per 100,000 pop')	0.97	Steady	Maternal C-section rates are similar by deprivation.
	Maternal post-partum haemorrhage (per 100,000 pop')	0.80	Steady	Maternal post-partum haemorrhage is lower in more deprived population.
Mental health	Alcohol related Admissions in adults (per 100,000 pop')	6.26	Narrowing	Alcohol related admissions are 6.26 times higher in the most deprived populations, but this difference is narrowing over time.
	IAPT referrals in adults (per 100,000 pop')	0.88	Steady	IAPT referrals in adults are lower in more deprived areas.
	NE Admissions for self-harm age 12+ (per 100,000 pop')	3.15	Narrowing	Non-elective admissions for self harm aged 12+ are 3.15 times higher in more deprived areas. The difference between areas is narrowing over time.
Primary Care	Number of GPs in registered practice (per 1,000 pop')	0.86	Steady	Number of GPs in registered practices are higher in less deprived areas.
	Number of nurses in registered practice (per 1,000 pop')	0.94	Steady	Number of nurses in registered practice is similar by deprivation
	Received first dose of Covid-19 vaccine by 18/07/21 (%)	0.78	N/A	Covid vaccination rates are lower in more deprived areas.

Higher Health Inequality in Least Deprived population

Higher Health Inequality in Most Deprived Population

Calculations and metrics are from the 'Midlands Health Inequalities Dashboard' available in the 'National Commissioning Data Repository (NCDR)' developed by Arden and Gem. Data sets are obtained from SUS, IAPT, General Practice Workforce and Maternity Services Data Set.

10.3 Tackling Health Inequalities – The 5 in the 'Core20Plus5'

NHS Nottingham and Nottinghamshire

ICS Smoking Rates: City: 20.6% (2018) County: 14.4% (2019)

	Maternity Ensuring continuity of carer for 75% of women from BAME communities and the most deprived groups		Severe Mental Illness (SMI) Ensuring annual health checks for 60% of those living with SMI		Respiratory A clear focus on COPD driving uptake of flu, COVID and pneumonia vaccs		Cancer 75% of cases diagnosed at stage 1 or 2 by 2028		Hypertension To allow for interventions to optimise BP and minimise the risk of M.I. and stroke	
Key Stats	• Maternal mortality is more than 4x higher in black women, 2x higher for mixed ethnicity women and 2x as high for Asian women. Stillbirths and infant mortality are highest amongst Pakistani and Black ethnicities. NUH has a high percentage of BAME mothers. • A higher proportion than the national average of mothers are from the most deprived areas • 15.6% mother present as smokers at time of booking across the ICS, 12.8% self report as smokers at time of delivery - worse than the England average across every district in the ICS.		• People with a SMI on avg have 15 to 20 years shorter life expectancy • Premature mortality in adults with SMI is much higher in Nottingham than the England Average. • Smoking prevalence is 24.5% in Nottingham and 20.7% in Notts. • The ICS is targeted to undertake 6,237 SMI health checks for 2022/23. 12 month performance currently sits at 41% of this target. Although performance has increased since 2021/22, it has plateaued in Q1 2022/23, this is now similar to the regional average but slightly below national average.		• 2% of the total ICS population have a diagnosis of COPD. The highest rates are in Bassetlaw and Mid-Notts. • Nottingham City has the lowest prevalence of COPD but has higher COPD emergency hospital admissions than the rest of the ICS and is higher than the regional and national averages. • Uptake of the flu and covid vaccines is lower in the most deprived areas but also amongst BAME communities, regardless of deprivation quintile. • 33% of COPD patients across the ICS are smokers, 41% of COPD patients in Nottingham City are smokers.		• 20/21 saw an improvement with approx 30% of cancers diagnosed at an early stage. • In Nottinghamshire as whole, under 75s mortality rate from cancer is similar to the England average, however in Mansfield and Ashfield it is significantly worse. • Under 75 mortality rates from cancer in Nottingham City is also significantly worse than the England average and the worst in the East Midlands Region.		• Approximately 14.4% of the N&N population have a hypertension diagnosis. • 64.2% of expected cases have been diagnosed. Target is 80% by 2029. • 71.5% of hypertension cases are treated optimally. Target is 80% by 2029. • Hypertension is more prevalent in areas of higher deprivation in the ICS. Those from Black backgrounds are twice as likely to be diagnosed with hypertension than those from White backgrounds.	
Metrics	1. Continuity of carer for BAME communities. Target 75% by 2022/23 2. Smoking status at time of delivery. Target 6%, England average 9%. 3. Pre-term births. Target 6% by 2025.	**System Level Outcomes** SLO-16 SLO-14 SLO-04 SLO-06 SLO-07 SLO-03	1. Number of Physical health checks completed for people with SMI. Target 6,237 checks for 2022/23. 2. Covid vaccinations given to people with SMI 3. % of patients admitted to hospital under mental health offered tobacco treatment	**System Level Outcomes** SLO-01 SLO-02 SLO-10 SLO-07 SLO-12 SLO-14 SLO-19	1. Number of self management plans in place for COPD Patients 2. Number of referrals to Pulmonary Rehab & number of programmes completed 3. Covid vaccine uptake, Flu Vaccine uptake, Pneumonia vaccine uptake	**System Level Outcomes** SLO-01 SLO-02 SLO-18 SLO-10 SLO-09 SLO-11 SLO-13 SLO-07	1. Lung Health Checks	**System Level Outcomes** SLO-01 SLO-11 SLO-12	1. Expected no. of people to be diagnosed with hypertension. Target 80% by 2029 2. Patients with hypertension optimally treated. Target 80% by 2029 3. Stroke admissions	**System Level Outcomes** SLO-01 SLO-02 SLO-09 SLO-12 SLO-14
Current Attainment	1. 14.4% (3months end of Aug. 21 - Discontinued) 2. 12.8% (May 21 –May 22) 3. 7.6% (March 21 – March 22)		1. 3,435 completed June 21 – June 22 2. 1st Dose: 80.47%, 2nd Dose: 77.42%, Booster: 62.53% 3. N/A – not yet available		1. 73% Self management plans. 66% received annual review 2. 51.2% offered PR. Completion rates in City: 65% County: 65% 3. C: 71.2% (BAME communities low), F: 57.9%, Pn: City: 70.3% / County: 74.2%		1. N/A – Data not yet available		1. 64.2% 2. 71.5% 3. N/A – Data not yet available	

Impact on the CORE20Plus5: Smoking

England Average Smoking Rates 12.1%, Nottinghamshire: 11.4%, Nottingham City 13.4%

Smoking is the leading risk factor for ill health in Nottingham City and the second in Nottinghamshire County.
Annually smoking causes approx. 11,492 hospital admissions and 4,540 premature deaths across the ICS.
The cost of smoking to the NHS and social care each year is millions locally and £2.4b nationally.

Area	Smoking Status (2020)
Mansfield	21.40%
Gedling	14.20%
City	13.40%
Broxtowe	12.60%
Newark & Sherwood	10%
Ashfield	9%
Bassetlaw	8.30%
Rushcliffe	5.30%

What the ICS is doing:

LTP Projects for opt out smoking cessation in in-patient, maternity and mental health pathways in Trusts are being implemented across the ICS.

Mid-Notts PBP have also trialled inpatient smoking cessation services in line with the LTP, offering financial incentives for pregnant smokers.

NHS Staff Smoking Cessation pilot is underway.

10 PCN projects make reference to reducing smoking rates, improving cessation uptake and impacting smoking related illnesses and affected population groups.

Bassetlaw PBP are working in partnership with the QUIT programme which aims to offer stop smoking support to everyone seeking treatment at 8 trusts across South Yorkshire & Bassetlaw.
Exploration of Advanced Community Pharmacy Schemes is underway, linking to maternity pathways, mental health pathways and in patients (as per the LTP).

The Core20: Higher smoking rates in the most drives inequality in life expectancy and increases NHS Pressures.

Mansfield has the 4th Highest smoking rates in the country (21.4%) and is within the 20% most deprived districts nationally.

Around 23% of people in manual and routine occupation smoke across the ICS. Smoking rates are also higher in those who are unemployed or have lower educational attainment.

Across England those in the 20% most deprived have higher hospital admissions and higher mortality than the least deprived areas.

Plus Populations: The most deprived groups have the highest smoking rates

Nationally:
Homeless populations smoking rates are around 77%.
80% of people entering prison are smokers.
22% of 11-16 yr olds with a mental illness are smokers.
26% of those in social housing smoke
Those from LGBT+ groups have higher smoking rates
Across the ICS:
75% of those entering treatment for opioid addiction and 51% of those entering alcohol addiction smoke.
Mixed and White ethnicities have higher smoking rates.

Maternity	Severe Mental Illness	Respiratory	Early Cancer Diagnosis	Hypertension
Smoking status at time of delivery is similar across the whole ICS with an average rate of 13.7%. Rates are worse than the England average across every district in the ICS. Smoking during pregnancy can increase risk of poor birth outcomes and infant mortality.	Smoking prevalence in people with SMI is 24.5% in Nottingham and 20.7% in Nottinghamshire. Smoking is one of the leading causes of the 10-15 year life expectancy gap in people with SMI.	Current smokers are 15x more likely to be diagnosed with COPD. 33% of people with COPD are smokers, the highest rates are in the most deprived areas. Smoking has a negative impact on the management of respiratory conditions.	Smoking is linked to cause of at least 15 types of cancer. Smoking causes more than 7 in 10 lung cancer cases. Lung cancer is the most common cause of cancer death in the UK and is a cancer frequently diagnosed at a later stage. Around 669 people a year in the ICS die of cancer caused by smoking	Smoking can negatively impact on people with high blood pressure, increasing the risk of heart and lung problems. Around 11% of people with hypertension in the ICS are current smokers. 221 people a year die of CVD caused by smoking.

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Appendices

i – ICS Assurance Escalation Framework

ii - Key to Variation and Assurance Icons (SPC)

iii - Glossary of Terms

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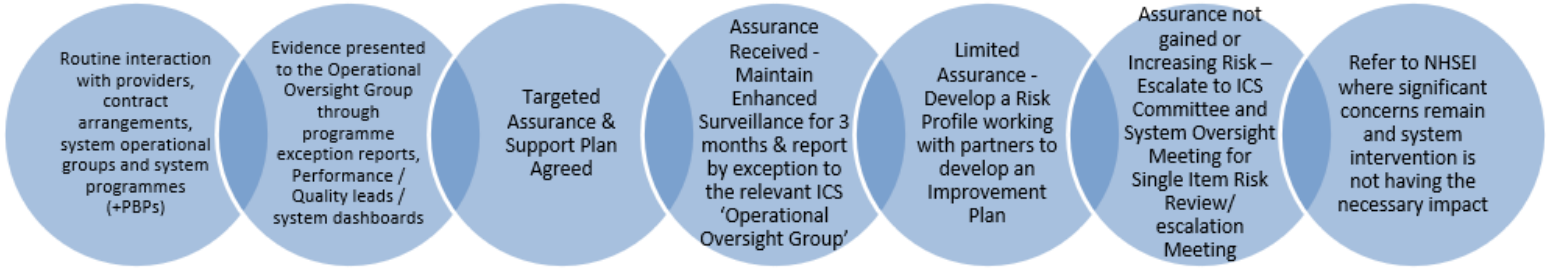
i – ICS Assurance Escalation Framework

Each key deliverable programme or oversight group will propose a level of assurance, aligned to **the assurance escalation framework**, following discussion of reported metrics and key milestones at each group. This approach is still being developed and rolled out across the ICB. The 4 levels are as follows:

Significant Assurance	Partial Assurance	Limited Assurance	No Assurance
1. Routine	2. Further Information Required	3. Enhanced	4. Escalated Risk
What does this mean? What is the assessment of risks to delivery / quality			
No Specific areas of concern identified	Potential for concern. Key milestones not achieved. More information required to determine level of risk	Delivery or quality concerns identified	Serious, specific risk to delivery or quality identified, including where there is a need to act rapidly to protect patients or staff
What actions may be taken by the relevant 'Operational Oversight Group' in response to this assessment			
Actions to be taken by Relevant Operational Oversight Group	Agree route to follow up to gain necessary information to assess risk and agree who will lead	Agree actions, and schedule for discussion at each 'Operational Oversight Group' until concerns are resolved	Trigger Escalation Review/ Deep Dive / Risk Summit

Evidence Based Assurance Process



ii – Key to Variation & Assurance Icons (SPC) and Assurance Escalation Framework

NHS Nottingham and Nottinghamshire

This performance report incorporates Statistical Process Control (SPC) charts, which plot data over time around a centre line (the average). They help us to understand variation which guides us to make appropriate decisions.
The Upper Control Limit (UCL) and Lower Control Limit (LCL) are derived by the variability of the data. It is expected that 99% of data points will fall within the process limits (probability) and SPC are therefore useful to identify / consider how likely it is that the target will be achieved.

The **Variation Icons** are derived from the movement of the actuals, either as an indication of run rate over 6 data points, or against the mean (higher or lower than the mean), showing whether the process is improving, deteriorating or having no significant change.

The **Assurance Icons** are derived from the position of the Lower Control Limit against the plan or standard – and the confidence level that provides as to whether the target or plan is expected to be achieved in the future. If the plan or target is higher than the lower control limit this will indicate 'inconsistent' passing or falling short. If plan or target is lower than the lower control limit this indicates that the target is being consistently passed. If the plan is higher than the higher control limit, this will indicate consistent falling short.

Essentially, the assurance icon is all about the future not the past. We don't need SPC to tell us whether we've hit our target in the past, we know if we have or not and we can report on that as is customary. However that approach doesn't give much assurance about what happens in future. Even if we've consistently missed our target for the past 10 months, what's the likelihood that we will do so again next month? Traditional reporting does not have an answer for that but SPC does. SPC charts allow us to see how the process we are monitoring is behaving. We can therefore use the mean and limits to 'predict' future performance which is what the assurance icon does.

Variation			**Assurance** (capability of meeting target)		
					
Common Cause - no significant change Up/Down arrow no special cause	**Special Cause** of *concerning* nature or *higher pressure* due to (H)igher or (L)ower values	**Special Cause** of *improving* nature or lower *pressure* due to (H)igher or (L)ower values	Variation indicates ***inconsistent*** passing or falling short of target - random	Variation indicates ***consistently (P)assing*** the target	Variation indicates ***consistently (F)alling short*** of the target

Blue lines on the charts represent the operational plan for 2022/23
Red Lines on the charts represent a required target position

Exception Reporting Rules

'Exception Reports' will be triggered if:

- An 'Orange' Variation icon or a 'Falling' short Assurance icon
- A Special Cause Variation (positive or negative)
- An area of escalation proposed via a sub-committee
- An area of escalation highlighted through the Executive Director from ICS Oversight Groups
- An area of escalation relating to sub-organisational level concerns

Further Reading / other resources
The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://improvement.nhs.uk/resources/making-data-count

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iii – Glossary of Terms

Acronym	Meaning	Acronym	Meaning	Acronym	Meaning	Acronym	Meaning
A&E	Accident & Emergency	FD	Finance Director	NHSE	NHS England	SLA	Service Level Agreement
A&E	Accident & Emergency Delivery Board	FOT	Forecast Out-Turn	NHT / NHC	Nottinghamshire Healthcare NHS Trust	SMI	Severe Mental Illness
AMH	Anit-Mullerian Hormone	G&A	General & Acute	NICE	National Institute for Health & Care Excellence	SOF	System Oversight Framework
BAU	Business as Usual	GI	Gastro-intestinal (referred to as Upper GI or Lower GI)	NNICB	Nottingham & Nottinghamshire ICB	SOP	Standard Operating Procedure
Blaw	Bassetlaw	HEE	Health Education England	NRC	National Rehabilitation Centre	SPC	Statistical Process Control
BLM	Back-log Maintenance	HFID	Hospital First Integrated Discharge	NUH	Nottingham University Hospitals	SRO	Senior Responsible Officer
CAMHS	Child & Adolescent Mental Health Services	HLE	Healthy Life Expectancy	OAPs	Out of Area Placements	TIF	Targeted Investment Fund
CCG	Clinical Commissioning Group	IAPT	Improving Access to Psychological Therapies	OBD	Occupied Bed Days	UEC	Urgent & Emergency Care
CDC	Community Diagnostic Centre	IBN	Information Breach Notice	OOA	Out of Area	UTC	Urgent Treatment Centre
CDEL	Capital Departmental Expenditure Limits	ICATT	Intensive Community Assessment & Treatment Teams	OP	Out Patients	WTE	Whole Time Equivalents
CDU	Clinical Decision Making Unit	ICB	Integrated Care Board	PBP	Place Based Partnerships	YOC	Year of Care
CHC	Continuing Health Care	ICP	Integrated Care Partnership	PCIT	Primary Care Information Technology	YTD	Year to Date
CoP	Court of Protection	ICS	Integrated Care System	PCN	Primary Care Networks		
CT	Computed Tomography	IPC	Infection prevention control	PFDS	Public Facing Digital Services		
CV	Contract Variation	IR	Identification Rules	PFI	Private Finance Initiative		
CYP	Children & Younger People	IS	Independent Sector	PHM	Population Health Management		
D2A	Discharge to Assess	JSNA	Joint Strategic Needs Assessment	PHSMI	Physical Health check for Severe Mental Ill patients		
DC	Day Case	KMH	Kings Mill Hospital	PICU	Psychiatric Intensive Care Unit		
DDAT	Digital, Data, Analytics and Technology	LD	Learning Disabilities	PID	Project Initiation Document		
DHSC	Department of Health and Social Care	LD&A	Learning Disabilities & Autism	PIFU	Patient Initiated Follow Ups		
DST	Decision Support Tool	LINAC	Linear Accelerator	POD	Prescription Ordering Direct		
DTT	Diagnosis to Treatment Time	LoS	Length of Stay	PoD	Point of Delivery		
EBUS	Endobronchial Ultrasound	MHIS	Mental Health Investment Standard	PTL	Patient Targeted List		
ED	Emergency Department	MHST	Mental Health Support Team	QDCU	Queens Day Case Unit		
EIP	Early Intervention Psychosis	MNR	Maternity & Neonatal Redesign	QMC	Queens Medical Centre		
EL	Electives	MOU	Memorandum of Understanding	R&D	Research & Development		
EMAS	East Midlands Ambulance Service NHS Trust	MRI	Magnetic Resonance Imaging	R&I	Research & Innovation		
EMCA	East Midlands Cancer Alliance	MSFT	Medically Safe for Transfer	RAG	Red, Amber & Green		
EMNNODN	East Midlands Neonatal Operational Delivery Network	N&N	Nottingham & Nottinghamshire	RTT	Referral to Treatment Times		
EOL	End of Life	NEL	Non-Electives	SDMF	Strategic Decision Making Framework		
ERF	Elective Recovery Funding	NEMS	Nottinghamshire Emergency Medical Services	SEG	System Executive Group		
ESRF	Elective Services Recovery Funding	NHP	New Hospitals Programme	SFH	Sherwood Forest Hospitals Foundation Trust		

APPENDIX 2 9.6 – Workforce – Social Care Workforce

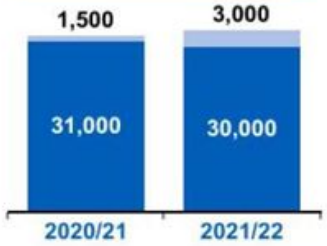
Nottingham and Nottinghamshire Social Care

33,000 total posts

30,000 filled posts

in the **local authority and independent sector.**

Change in **filled posts** and **vacancies**



There was a change of

-1,000 filled posts (-3%)

since 2020/21 in **local authority and independent sectors.**

Average hourly pay for care workers

Local authority

£10.60

Independent sector

£9.57

Recruitment and retention

Vacancy rates

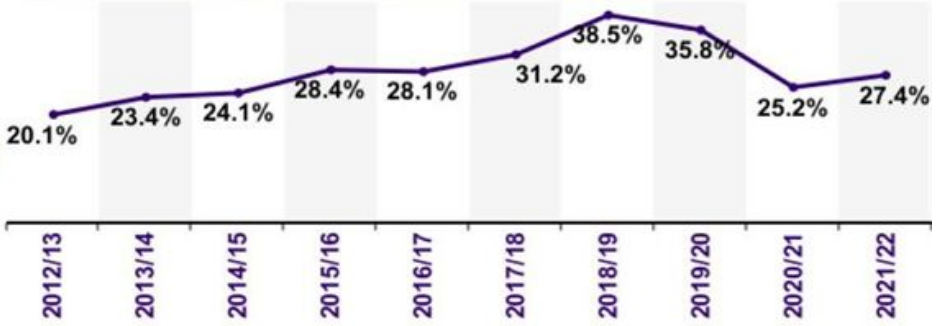
27.4%

turnover rate (or 7,700 leavers) in 2021/22

8.6

average **sickness days** taken in 2021/22

Turnover rates



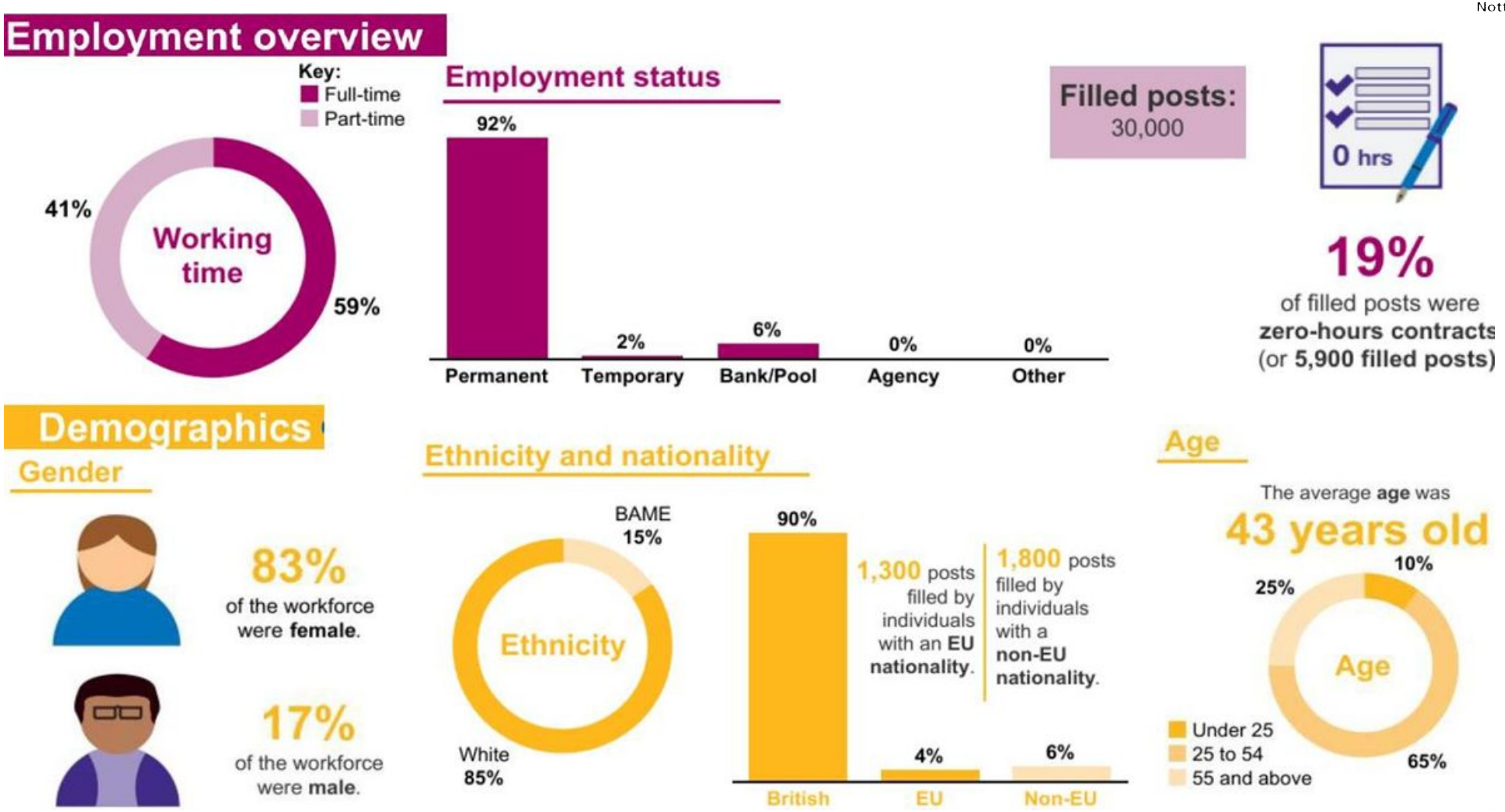
9.8%

vacancy rate (or 3,000 vacancies) in 2021/22

58%

of **recruitment** is from **within adult social care**

9.7 – Workforce – Employment Overview



9.8 – Workforce – Projections

Workforce projections

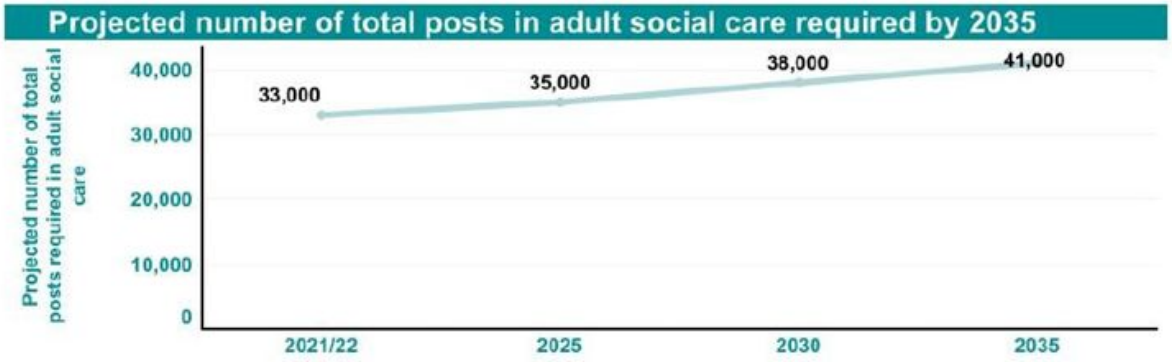
This model projects the size of the workforce if it grows proportionally to the number of people aged 65 and over in the population. This workforce includes adult social care total posts employed by local authorities and the independent sector only. Posts employed by direct payment recipients and those in the NHS are not included.
Please note that demand due to replacing leavers will be in addition to the figures shown below.

If the adult social care workforce grows proportionally to the projected number of people aged **65 and over** in the population then the number of adult social care filled posts will...

increase by 22% (7,300 total posts)

...to around 41,000 total posts by 2035

...equal to around 600 extra total posts per year up to 2035



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Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	10/11/2022
Paper Title:	**Committee Highlight Reports**
Paper Reference:	ICB 22 041
Report Author:	Committee Secretariat
Report Sponsor:	Chairs of the ICB's Committees
Presenter:	Chairs of the ICB's Committees
Recommendation(s):	The Board is asked to **NOTE** the report.

Summary:

This report presents an overview of the work of the Board's committees since its last meeting in September 2022. The report aims to provide assurance that the committees are effectively discharging their delegated duties and to highlight key messages for the Board's attention. This includes the committees' assessments of the levels of assurance they have gained from the items received and the actions instigated to address any areas where low levels of assurance have been provided.

Also included is a summary of the high-level operational risks currently being oversighted by the Committees. All ICB Committees have a responsibility to oversee risks relating to their remit, ensuring that their discussions are reflective of the risks identified and that robust management actions are being taken in response. As such, all committee meetings have risk as a standing agenda item.

The minutes of Committee meetings will be published on the ICB's website once ratified.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	The Board's committee structure has been designed to provide assurance to the Board that statutory duties and responsibilities inline with the core aims are being effectively discharged.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:

A: Highlight Report from the Strategic Planning and Integration Committee
B: Highlight Report from the Quality and People Committee
C: Highlight Report from the Finance and Performance Committee
D: Highlight Report from the Audit and Risk Committee
E: Current high-level operational risks being oversighted by the Board's committees

Board Assurance Framework:
The Board's committees scrutinise assurances in relation to the strategic risks for which they are the 'lead' committee and escalate levels of assurance to the Board via this consolidated highlight report.

Levels of assurance:	
Substantial Assurance	Reports received by the committees highlighted robust controls, designed to address the relevant risks with controls being consistently applied. Highly unlikely to impair the achievement of strategic objectives and system priorities. No remedial action required.
Reasonable Assurance	Reports received by the committees did not highlight any material weaknesses in control and risks identified can be managed effectively. Unlikely to impair the achievement of strategic objectives and system priorities. Minor remedial action is required.
Partial Assurance	Reports received by the committees highlighted some material weaknesses in control that could present material risks to the achievement of system objectives and system priorities. Some moderate remedial action is required.
Limited Assurance	Reports received by the committees highlighted significant material weaknesses in control and/or material risks to the achievement of strategic objectives and system priorities. Immediate and fundamental remedial action is required.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	Yes
Duty to promote innovation	Yes
Duty in respect of research	Yes
Duty to promote education and training	Yes
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	Yes
Duties as to climate change	Yes
Duties regarding public involvement and consultation	Yes
Public sector equalities duties	Yes

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Appendix A: Strategic Planning and Integration Committee Highlight Report

Meeting Dates:	**6 September, 6 October and 3 November 2022**
Committee Chair:	**Jon Towler, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance
1. System Development Updates a) Thriving Places and Provider Collaborations b) Primary Care Networks	An update was provided on progress with system development relating to Place Based Partnerships, PCNs and provider collaboration. Discussion was held on ensuring the system provides the right level of support to primary care recognising its critical role in delivering population health improvements. The system is demonstrating new ways of working with communities and providers at a neighbourhood level. A roadmap is being developed to ensure there is continued focus on delivery with learning from early successes used to fast track improvements across the whole population. Further quarterly updates on progress in this area will be received by the Committee.	**Reasonable**
2. Population Health Management	A report on the approach to Population Health Management (PHM) was presented, with the aim of providing assurance to the Committee as to how this is being integrated into system working. Members supported the approach being taken but noted that more work was needed to ensure embedment across the ICS. It was agreed that further updates would be scheduled for the Committee, in particular, to better understand the impact of PHM on health outcomes and inequalities and also the mechanisms for identifying planned areas for deep dives.	**Reasonable**
3. Mental Health Transformation Programme	At the October meeting, members were presented with a comprehensive report covering the seven mental health transformation programmes: • Specialist Community Perinatal Mental Health • Children and Young People's (CYP) Mental Health • Adult Common Mental Illnesses (IAPT)	**Reasonable**

Item	Summary	Level of assurance
	• Adult Severe Mental Illnesses (SMI) Community Care • Mental Health Crisis Care and Liaison • Therapeutic Acute Mental Health Inpatient Care • Suicide Reduction and Bereavement Support Members noted that progress had been made across all of the programmes, with each transformation area supported by a steering group comprised of partners across the Nottingham and Nottinghamshire ICS and mitigating actions assigned to identified risks.	
4. Pre-delegation Assessment Frameworks (PDAFs) for Pharmacy, Optometry and Dental (POD) Services and Specialised Services	At both the September and October meetings, the Committee received updates regarding requirements to demonstrate the ICB's ability to assume commissioning responsibility for POD Services from 1 April 2023. On receipt of assurance that the ICB was working with NHS England (NHSE) colleagues in preparation for April and following discussion on the risks and benefits the delegation may bring, members endorsed both the approach being taken with regard to submitting the PDAF proforma in mid-September and the proposed ICB arrangements for ensuring ongoing oversight of progress against the PDAF requirements. At the November meeting, members were advised that the PDAF had been signed off at both regional and national level. Members also reviewed the ICB's completed PDAF proforma for assuming delegated responsibility for commissioning Specialised Acute Services from 1 April 2024. The proposed delivery oversight arrangements ahead of this date were supported and it was noted that joint working arrangements with NHSE would commence on 1 April 2023.	**Reasonable**
5. Commissioning Policies	Members were updated on the progress made with regard to aligning the commissioning policies of the former CCGs. The Committee was supportive of the approach being taken, which includes splitting the work needed into two phases to ensure securement of the required clinical input and to avoid work being undertaken during the pre-election period.	**Reasonable**

Other considerations:

Decisions made:
The Committee approved a number of proposed business cases, in line with its financial limits and delegated responsibilities. These included agreement of: • Investment and associated contract awards to ensure sufficient interim community bed capacity and homecare capacity from 1 October 2022 to 31 March 2023. • A variation to the Nottingham Emergency Medical Services (NEMS) contract for additional recurrent investment across the five service areas provided. • A direct contract award to Derbyshire Health United from 1 October 2022 to 31 March 2024 for the provision of the NHS 111 service to allow sufficient time for a review of current services to be completed and a regional procurement process to be undertaken. • The continuation of the current funding allocation for unpaid carer support services to support a new service model. Funding will continue to be allocated as part of the Nottingham City and Nottinghamshire County Better Care Fund section 75 pooled funds.
Matters of interest:
The Committee also: • Endorsed a decision-making framework for the ICB which would provide the basis for decisions on all proposed service changes and Terms of Reference for a service change review group, to support the Committee's decision-making arrangements through the robust peer review and quality assurance of service change proposals. • Received an overview of the development of both Elective Hubs and Community Diagnostic Centres (CDC). • Reviewed the developing Primary Care Strategy, endorsing the progress made to date. This will come back to future meetings once a delivery plan with clear milestones is developed. • Discussed the anticipated NHS Provider Selection Regime and the impact this may have on the ICB's decision-making arrangements. Further updates will be received once the timeline for introduction of the new arrangements is known to ensure that appropriate systems and processes are established for the ICB. • Reviewed and endorsed the ICB's Health Inequalities Plan prior to submission to the Board for approval.

Appendix B: Quality and People Committee Highlight Report

Meeting Dates:	**21 September and 19 October 2022**
Committee Chair:	**Marios Adamou, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance
1. System Quality Report and Nursing and Quality Statutory Duties Report	At its inaugural meeting in September, members received the System Quality Report which reported the continuation of enhanced surveillance within the system for Nottingham University Hospitals NHS Trust (NUH), Nottinghamshire Healthcare NHS Foundation Trust (NHT), the Local Maternity and Neonatal System (LMNS) and the Learning Disability/Autism (LDA) Partnership Programme. Four exception reports were provided as part of the report, detailing the current position and progress of actions in relation to: • Maternity services across the LMNS; • LDA; • Healthcare Acquired Infections; and • Personalisation and Co-production. System wide workforce issues were highlighted as a particular risk, specifically, the ability to recruit and retain staff in the care sector. Members discussed the impact this is having on flow through the acute settings and the management of winter pressures. The Nursing and Quality Statutory Duties Report provided assurance in relation to the ICB's statutory duties in relation to quality. The report format is under development and future meetings will receive more information pertaining to key issues, challenges, and improvements across the system whilst also articulating risks to delivery. Members noted the evolving nature of the report and requested further information specifically in relation to ambulance category two responses, the backlog of serious incident	Partial

Item	Summary	Level of assurance
	investigations, the lung health project, tracking of LMNS activity and metrics associated with the care sector	
2. System Quality Improvement Report	Members were informed that system quality oversight arrangements in place in the Nottingham and Nottinghamshire ICS had been refreshed to align with the new National Quality Board (NQB) guidance and priorities. The report presented provided an update on system quality improvement programmes in place to provide, assurance, improvement, and transformation. In particular, members were encouraged to learn of the enthusiasm between partners in terms of transformation and innovation. However, members commented on the volume of information provided, expressing concern about the risk of this masking key issues and risks. It was agreed that further work was needed to develop the report for the Committee's purposes.	**Partial**
3. System Quality Dashboard	Members received a presentation of the System Intelligence Portal to demonstrate the System Quality Dashboard at its September meeting. A dashboard report was presented in October, which recognised that the dashboard is still in its infancy and more data/intelligence will be presented in future iterations of the Committee's report, including primary care, health inequalities and care sector data. Whilst members commended the report, the absence of inequalities data in relation to the Committee's remit was noted and work will be undertaken to remedy this.	**Partial**
4. People and Culture Report	The Committee received reports on people and culture at both of its meetings; the first report reflected the newness of the ICB's responsibilities in this area and provided an update on work being undertaken to fully establish the function for both the ICB and across the wider system. Members recognised the scale of the challenge and that candid discussions on the situation would be necessary to address this. The report in October focussed on the actions being taken as a result of the diagnostic exercise undertaken and the position as at month five. Progression was being made in establishing the function and reporting mechanisms were developing to include more system data. A number of key issues relating to staff turnover, sickness absence and	**Limited**

Item	Summary	Level of assurance
	recruitment remained under review, and a working group has been established to address agency usage at Trust organisations. Members agreed that the report needed further development and more measurable data before it could be considered an assurance report. That said, it was received as a helpful starting position providing the baseline data. The report included a People and Culture 'Stocktake' which had been undertaken to ensure the ICB had identified clear deliverables for 2022/23.	

Other considerations:

Decisions made:
The Committee approved the ICB's Co-production Strategy and Policy, developed to set out the ICB's approach to meeting the national guidance on working with people and communities.
Matters of interest:
The Committee received an update on the System Harm work and the actions underway to promote safety and improve patient flow. Current mapping work will capture how the system currently responds to harm and will eventually feed into the system's quality oversight arrangements. The priority is to move to a system approach, working collectively with partners to address risk and harm. Members were encouraged by the update, agreeing it as a big step forward and supporting the engagement with partners to date. It was recognised that all partners had a role in ensuring this worked and that more sophisticated conversations may be needed to fully understand the levels of risk.

Appendix C: Finance and Performance Committee Highlight Report

Meeting Dates:	**28 September and 31 October 2022**
Committee Chair:	**Stephen Jackson, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance
1. Service Delivery Performance Report	Members welcomed a refreshed format of the report, which focuses on service delivery performance across the ICB at 'total population' and 'total provider' levels, along with exception reports for areas of concern. However, whilst the new format was acknowledged as excellent from a technical perspective, it was still felt that it provided an overwhelming amount of information which was difficult to interrogate effectively. Other points discussed included the descriptions of some of the actions being taken appearing passive and the inclusion of system oversight arrangements as assurances, when members were not familiar with the role and remit of these groups. The Committee agreed it needed to further develop its approach to ensure it can fully discharge its duties regarding performance management and provide onward assurance to the Board. The approach needs to encompass the role of the ICB in overseeing performance and delivery against national standards, with the ability to examine areas of concern in more detail. Actions agreed included: • A mapping exercise on the system infrastructure for performance management to complement members' understanding and assurance of system oversight arrangements; • Establishing 'deep dive' reporting on poorly performing areas to enable a specific focus on particular issues at each meeting; and	**Limited**

Item	Summary	Level of assurance
	• Considering areas where the Committee could add value in this area, such as looking at the longer-term trajectories where it is known that performance is not going to be achieved by year-end.	
2. System Finance Report	The reports included detailed analysis of the financial performance for the system for months five and six. It was noted that the ICS would need to deliver a surplus position for each month of the remainder of the financial year to meet the 2022-23 financial plan. Key drivers of the position were urgent care capacity and subsequent costs over and above those defined in the plan, Covid-19 costs, Community Diagnostic Hub funding shortfall, Continuing Healthcare (CHC) spend and efficiency shortfalls. Funding had been received to offset an element of the urgent care costs, reducing the risk to the overall position. In September, members noted that the report described an over-established whole time equivalent staffing position within the ICS, which is not consistent with the message that the ICS has a high number of vacancies. Further work was requested to look at this and members were advised at the October meeting that a deep dive is being completed to better understand the discrepancy.	**Partial**
3. ICB Finance Report	The ICB financial position for months two and three of its operation were presented. The ICB is working towards a breakeven plan for the full financial year which combines the position of the former Clinical Commissioning Groups (CCGs) and the ICB. The key areas of pressure are CHC and Hospital Discharge Programme costs. Offsetting these overspending areas is an underspend in Primary Care, as well as a surplus in reserves which represents an over delivery of efficiency targets mainly relating to slippage on spend. The month six report described a slippage in delivery of the capital plan and work was underway to identify other capital expenditure programmes across the system to utilise the funds.	**Partial**
4. ICS Green Plan	An update on progress of the ICS's Green Plan was presented, describing some of the work being undertaken locally to help deliver the national targets. Members welcomed the collaborative approach being taken to address this important agenda, noting in	**Reasonable**

Item	Summary	Level of assurance
	particular that this was a true system approach as the local authorities had opted to mirror the approach of the NHS. The inability to quantify actual benefits due to the absence of a national mechanism for measuring reductions in carbon emissions was noted as a particular risk, along with the impact of the cost of living crisis on some of the recommendations (eg. changing energy sources). However, members were satisfied that these were recognised risks and that actions were underway to mitigate them as far as possible.	

Other considerations:

Decisions made:
The Committee approved the ICS Digital Maternity Strategy, subject to confirmation that approval had also been given by the relevant system partners. It was noted that the Strategy is an evolving piece of work, and an action was agreed to seek independent assurance on the contents as part of its ongoing development.
Matters of interest:
At the September meeting, the Committee endorsed financial planning guiding principles for use in developing the ICB's Joint Forward Plan and 2023-25 Operational Plan. In October, members received a further update on the actions being taken by the ICB in preparation of the anticipated Operational Planning Guidance. The latest informal intelligence is that national NHS Priorities and Operational Planning Requirements guidance, including financial allocations, will be published in December 2022 requiring submission of interim operational plans in February 2023 and final operational plans in April 2023

Appendix D: Audit and Risk Committee Highlight Report

Meeting Dates:	**15 September 2022**
Committee Chair:	**Caroline Maley, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance
1. Risk Management Arrangements	The Committee received an update on the work being undertaken to establish and embed strategic and operational risk management arrangements for the ICB and also discussed the development of system risk management arrangements. Assurance was taken that robust processes were in place for the capture and management of risks and welcomed developing system risk management arrangements.	**Reasonable**
2. Due Diligence	An update was given on due diligence actions that were ongoing at the time of the CCGs' close down and ICB establishment, noting that any ongoing actions or residual issues had been handed over to the appropriate committee within the ICB to oversee. The Committee agreed to receive further updates until all of the actions had been confirmed as completed.	**Substantial**
3. Standards of Business Conduct	The Committee was advised of the arrangements across the ICB to ensure the management of conflicts of interest. Members were assured that robust processes aligned to the national guidance had been implemented and that validation work had been undertaken on the ICB's Register of Interests as part of the CCGs' handover and due diligence process.	**Substantial**
4. Use of Emergency Powers	The Committee reviewed the urgent decisions that had been undertaken by the ICB to date under emergency powers, as set out in the ICB's Standing Orders or committee terms of reference and considered all decisions to have been appropriate.	**Substantial**

Item	Summary	Level of assurance
5. Temporary Worker Arrangements	Members were assured of the continuing focus to ensure the number of temporary workers was kept at an acceptable level.	**Substantial**
6. Counter Fraud Report	Members noted a positive result from a pro-active exercise to provide assurance regarding processes in place for Personal Health Budgets (PHB) within the CCGs. PHB fraud was a significant risk, which had been flagged at the national level. Although no specific instances of fraud were found, the team was able to make several recommendations to improve the control environment and mitigate the risk of fraud. Subsequently, several concerns regarding potential fraud had been flagged by the PHB Team.	**Reasonable**

Other considerations:

Decisions made:
The Committee approved: • The Terms of Reference for an internal audit review of the ICB's self-assessment on financial sustainability. As the self-assessment is a mandated requirement for ICBs and trusts, this would also feed into a wider piece of work to consider best practice and learning across system partners. • The ICB's Policy Management Framework – revised dates for ICB policies were approved following formal adoption of all policies by the Board at its inaugural meeting on 1 July 2022. • The Internal Audit and Counter Fraud Plans for 2022-23.
Matters of interest:
• Members received an update on progress of the Internal Audit Plan 2022-23, which included the completion of the draft Head of Internal Audit Opinions for the former CCGs for the period April to June 2022. For both CCGs an indicative opinion of Significant Assurance had been given. • Members were advised of the proposed process for completing the annual report and accounts for both former CCGs for the period 1 April to 30 June 2022.

Appendix E: Current high-level operational risks being oversighted by the Board's committees

Risk Ref.	Risk Description	Current Score	Responsible Committee
ORR 42	Insufficient capacity (hospital beds) may present a number of risks across urgent and emergency care, including overcrowding within Accident and Emergency Departments and increasing Ambulance handover delays.	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee
ORR 43	Lack of capacity across care homes and home care provision may adversely impact system partners' ability to promptly discharge patients from Acute and Community settings.	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee
ORR 49	Lack of available workforce may significantly impact the extent to which theatres are utilised effectively across the system. This, in turn, may present a risk to the delivery of planned care activity.	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee
ORR 02	Increasing levels of demand on healthcare services, combined with capacity constraints across providers, may widen health inequalities across the population of Nottingham and Nottinghamshire. This risk relates to both elective and non-elective care.	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee / Quality and People Committee
ORR 23	If the ICB is not robustly assured regarding the systematic improvements required in the quality of maternity services provided by Nottingham University Hospitals NHS Trust (NUH), there is a significant risk of poor clinical outcomes and/or patient safety issues for the population of Nottingham and Nottinghamshire.	**Extreme** 25 (I5 x L5)	Quality and People Committee
ORR 06	There is a significant risk to patient harm due to the current levels of demand, and capacity constraints, for non-elective (urgent and emergency care) activity. The likelihood of risk to patient harm will increase with any worsening ambulance response times/handover delays and extended waits within the Emergency Department (front door) and delays to discharge (back door).	**High** 20 (I4 x L5)	Quality and People Committee

Risk Ref.	Risk Description	Current Score	Responsible Committee
ORR 24	A number of potential, and actual, complex and significant quality and cultural issues have been identified at Nottingham University Hospitals NHS Trust (NUH). If the ICB is not robust assured regarding systematic improvements required by the Trust, there is a risk of poor clinical outcomes and/or patient safety issues for members of the ICB's population.	**High** 20 (I4 x L5)	Quality and People Committee
ORR 41	Workforce capacity issues across the Nottingham and Nottinghamshire system health and care partners may present a significant risk to the delivery of urgent and emergency care to the population of Nottingham and Nottinghamshire. This includes, but is not limited to, workforce shortages in relation to medical and nursing staff (acute and community); social care staff (adult and children's); and the home care workforce.	**High** 20 (I5 x L4)	Quality and People Committee
ORR 03	Sustained levels of significant pressure on primary care workforce, due to vaccination (and wider immunisation) programmes, increasing levels of demand, management of long-term conditions and the impact of deferrals/delays in secondary care activity, present a potential risk in relation to primary care staff resilience, exhaustion and 'burn out'.	**High** 16 (I4 x L4)	Quality and People Committee
ORR 04	There is a potential risk of poor patient outcomes and/or experiences as a result of increasing planned care waiting times; this includes, cancer treatment, diagnostics and key specialties waiting for elective care. The likelihood of this risk may continue to increase if elective recovery plans and associated planned assumptions are not met. This risk may also be further exacerbated by poor, or delayed, communication with the public/patients in relation to their position on waiting lists.	**High** 16 (I4 x L4)	Quality and People Committee
ORR 05	There is a potential risk of poor patient outcomes and/or experience as a result of increasing mental health waiting lists. This risk may be exacerbated by rising levels of demand on mental health services, with particular risk in relation to children and young people.	**High** 16 (I4 x L4)	Quality and People Committee

Risk Ref.	Risk Description	Current Score	Responsible Committee
ORR 22	If the ICB is not robustly assured regarding systematic improvements in the quality of mental health and community services provided by Nottinghamshire Healthcare NHS Foundation Trust (NHCT), there may be a significant risk of poor patient experience, adverse clinical outcomes and/or patient safety issues for the population of Nottingham and Nottinghamshire.	**High** 16 (I4 x L4)	Quality and People Committee
ORR 26	There is a potential risk of loss of public confidence in local primary and secondary care health services, as a result of national and local media/reports, known quality issues, as well as growing public concerns regarding increasing waiting list times and access to General Practice. Lack of confidence may impact the extent to which citizens interface with healthcare services. This, in turn, presents a risk of increased pressure on urgent and emergency care services as services will not be accessed until a point of crisis.	**High** 16 (I4 x L4)	Quality and People Committee
ORR 44	Sustained levels of significant pressure on health and social care workforce presents a significant risk of moral injury, staff sickness, exhaustion and 'burn out'. This, in turn, may adversely impact workforce retention.	**High** 16 (I4 x L4)	Quality and People Committee
ORR 15	Over-reliance on non-recurrent (one-off) funds / mitigations by the ICB to temporarily offset recurring (year on year) pressures may result in continued deterioration in the ICB's recurrent underlying financial position for 2022/23.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR 16	If Nottingham and Nottinghamshire Integrated Care System (ICS) do not, as a collective, meet the year-end position outlined with the 2022/23 financial plan, there is risk that the system will come under further regulation by NHS England. As well as potential reputational risks for the ICS, this may significantly impact the extent to which the system is able to create financial 'headroom' to focus on the transformation of services.	**High** 16 (I4 x L4)	Finance and Performance Committee

Risk Ref.	Risk Description	Current Score	Responsible Committee
ORR 45	Non-delivery of the financial efficiency programme presents a significant risk to the delivery of the 2022/23 system financial position.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR 47	Increasing levels of COVID may present a risk to the delivery of the 2022/23 system financial plan.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR 58	Over-reliance on non-recurrent mitigations to manage the system's 2022/23 financial position may result in continued deterioration in the system's underlying financial position (UDL).	**High** 16 (I4 x L4)	Finance and Performance Committee

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	10/11/2022
Paper Title:	**2022/23 Board Assurance Framework**
Paper Reference:	ICB 22 42
Report Author:	Siân Gascoigne, Head of Corporate Assurance
Report Sponsor:	Rosa Waddingham, Director of Nursing
Presenter:	Lucy Branson, Associate Director of Governance
Recommendation(s):	The ICB Board is asked to **REVIEW** the current position of NHS Nottingham and Nottinghamshire ICB's Board Assurance Framework.

Summary:
The purpose of the paper is to present the current position of NHS Nottingham and Nottinghamshire ICB's 2022/23 Board Assurance Framework for scrutiny and comment. This builds upon the opening position, presented in September 2022, which confirmed the strategic objectives and strategic risks for the organisation following its establishment in July 2022. The paper highlights a number of key messages for the Board from reference to the Assurance Framework in terms of controls, assurances and identified gaps. It also sets out a number of actions to move the risks towards their target scores by March 2024.

Appendices:
Appendix A: Board Assurance Framework roles and responsibilities and annual reporting cycle Appendix B: 2022/23 Board Assurance Framework

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	The Board Assurance Framework is a structured way of identifying and mapping the main sources of assurance in support of the achievement of the ICB's four aims.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Board Assurance Framework:
This paper presents the fully populated 2022/23 Board Assurance Framework, which outlines the controls and assurances across all the ICB's strategic risks.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes

Applicable Statutory Duties:	
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	Yes
Duty to promote innovation	Yes
Duty in respect of research	Yes
Duty to promote education and training	Yes
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	Yes
Duties as to climate change	Yes
Duties regarding public involvement and consultation	Yes
Public sector equalities duties	Yes

Report Previously Received By:
The opening position of the Board Assurance Framework was presented to the September 2022 meeting of the ICB Board.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

2022/23 Board Assurance Framework

Introduction

1. The ICB's strategic risk management processes are centred on the Board Assurance Framework, which is a structured way of identifying and mapping the main sources of assurance in support of the achievement of the ICB's core aims/objectives. The Assurance Framework provides the Board with confidence that what needs to be happening is happening in practice. More specifically it enables the Board to:

    a) Gain a clear and complete understanding of the control environments that have been established to manage its strategic risks.

    b) Consider the types of assurance currently obtained and whether they are effective and efficient.

    c) Identify areas where assurance activities are not present or are insufficient (i.e. assurance gaps), or where assurances may be duplicated or disproportionate.

    d) Identify areas where existing controls are failing (i.e. control gaps), and consequently, the risks that are more likely to occur.

2. The Board Assurance Framework also plays an important role in informing the production of the annual Governance Statement and is the main tool that the Board should use in discharging its overall responsibility for ensuring that an effective system of internal control is in place.

3. The purpose of this paper is to present the current position of NHS Nottingham and Nottinghamshire ICB's 2022/23 Board Assurance Framework for scrutiny and comment. It builds upon the paper presented in September 2022, which outlined the four core aims (objectives) and 15 strategic risks for the ICB.

4. Roles and responsibilities and the complete cycle of monitoring and reporting arrangements in relation to the Board Assurance Framework is set out for information at Appendix A.

Developing the Board Assurance Framework

5. Since the last report was presented to the Board, meetings have been held with the Chief Executive, Executive Directors and senior responsible officers within the ICB to identify the controls and assurances in place for their respective strategic risks, as well as to talk through any 'gaps' and actions required. As a result of these discussions, the previously defined strategic risk relating to system development has been removed, as the development of place-based partnerships and provider collaboratives is felt to be part of the system's evolving control environment, rather than a strategic risk.

6. The fully populated Board Assurance Framework is provided at Appendix B. This is introduced by an explanation of how to navigate the document and includes a summary of how each risk aligns to the ICB's four core aims (at Annex 1).

7. The Board Assurance Framework has been developed on the basis that it remains in place until March 2024. This is in recognition of 2022/23 being an atypical year, with the ICB only being established on 1 July 2022, and its core aims and strategic risks being unlikely to change over the 21-month period to March 2024. This longer time-period will enable a more realistic movement in risks scores towards identified target scores.

8. As a reminder, the unitary Boards of each statutory NHS partner organisation within the ICS will continue to maintain their own individual Board Assurance Frameworks. However, work has been undertaken to ensure there is some alignment of key strategic risks across partners, as appropriate to system priorities. The ICB's Board Assurance Framework captures 'system focused' strategic risks, in reflection of its statutory duties regarding collective system accountability.

Summary of key messages

9. The following diagram presents a summary 'heat map' of the Board Assurance Framework as at November 2022.

Note: Black dots represent the current scores for each risk and white dots indicate where scores have changed since last reported in September (only relevant to risk 10). The squares indicate the target scores for each risk; two risks (risks 9 and 14) have met their target scores. The arrows show the distance from 'current risk score' to 'target risk scores'.

10. It is important to remember that the ICB's strategic risk profile is expected to be high due to the nature of the risks contained within the Board Assurance Framework (i.e. if their impact rating isn't high or very high, then it is questionable whether they should be classified as strategic risks to the organisation).

11. The following key points are highlighted for the Board's attention:

    a) Most risks remain some way from their target risk scores; however, a good level of control has been clearly identified across all 14 strategic risks. Whilst it is recognised that some controls will evolve over time, in particular those established as part of system governance arrangements, this is reflective of the ICB being a new statutory organisation and new working arrangements being established. It is anticipated that the ICB's control environment will strengthen and embed over the remainder of 2022/23. This can be demonstrated by the timeframes associated with addressing the identified 'gaps' in control.

    b) A good level of planned assurances has been identified across each of the strategic risk areas. Assurances are scheduled to be routinely received by both ICB and system governance forums; many of which have already commenced. It is recognised that the robustness of assurances needs to be a key area of development to ensure they provide the substantial level of assurance required. Many 'positive' assurances have been received to date; however, it is also important to recognise that significant areas of challenge are also being reported, which can be demonstrated by the number of 'live' operational risks within the ICB's Operational Risk Register. Strategic risk 6 (*Quality Improvement*) and risk 10 (*Financial Sustainability*) are good examples of this.

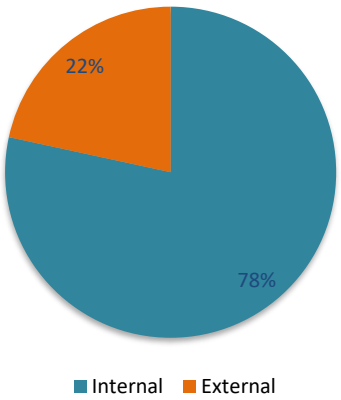
    c) Populating strategic risk 2 (system resilience) and risk 3 (transformation) highlighted the importance of ensuring that there is an appropriate balance between managing today and making tomorrow better. Many of the controls and assurances referenced across these two risks are the same; therefore, it is important to ensure both aspects are being addressed within the ICB's committees and system forums such as the Urgent and Emergency Care Board and Planned Care Board to ensure these two risks are being equally managed.

    d) The majority of the 'gaps' identified relate to known areas where work is already underway. For example, the need to finalise the Integrated Care Strategy and develop the Joint Forward Plan, along with refreshing associated enabling strategies. Similarly, 'gaps' have also been identified in relation to ongoing system development; in particular, the need to establish a System Control Centre and continue to develop primary care networks, place-based partnerships and the provider

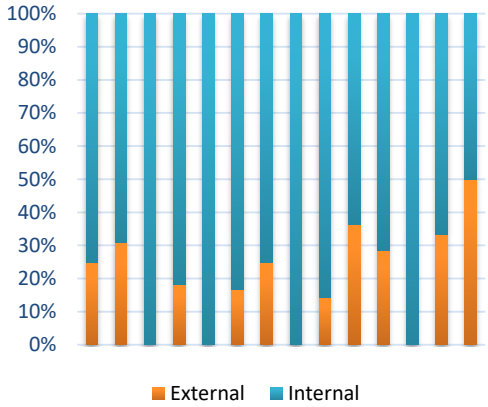
collaborative. Planned assurances in these areas have been built into the annual work programmes for the Board and its committees.

e) A review of the internal and external assurances set out within the Assurance Framework has been completed, as illustrated below. As a reminder, internal assurances are classed as any which are produced by the ICB, or system partners, and external assurances relate to parties that are independent to the ICB and its partners (e.g. regulators, internal and external audit providers).

Analysis of internal and external assurances (total)



Analysis of internal and external assurances (by risk)



Analysis found that strategic risk 3 (*Transformation*), risk 5 (*Research and Evidence*), risk 8 (*Equality, Diversity and Inclusion*) and risk 12 (*Digital Transformation*) do not currently have any external assurances listed. While this is not necessarily a cause for concern, it is proposed that an assessment of these strategic risks be undertaken by the Audit and Risk Committee when determining the content of the ICB's 2023/24 Internal Audit Plan.

Next steps

12. Actions have been identified in relation to all identified 'gaps' with named responsible officers and clear implementation timelines. As outlined in Appendix A, the 'targeted' Board Assurance Framework reports (scheduled for the January and March 2023 meetings of the Audit and Risk Committee) will provide an update on progress against all identified actions. These reports will also enable the Audit and Risk Committee to review the design and operation of the Board Assurance Framework to ensure it is 'fit for purpose' for the ICB.

Appendix A: Board Assurance Framework (BAF) roles and responsibilities and reporting cycle

BAF Roles and Responsibilities

Board	Has ultimate responsibility for risk management and as such, needs to utilise the Board Assurance Framework to be satisfied that internal control systems are functioning effectively.
Audit and Risk Committee	Has delegated responsibility for risk management and receives assurance that the ICB has robust operational and strategic risk management arrangements. The Committee specifically comments on the fitness for purpose of the Board Assurance Framework and has a role in securing independent assurances.
Board Committees	Scrutinise assurances in relation to the strategic risks for which they are the 'lead' committee and escalate levels of assurance to the Board (via routine highlight reports).
Executive Directors	Ensure a robust control framework is in place to mitigate their respective strategic risks within the BAF to drive delivery of the ICB's core aims and objectives.
Governance Team	Develop annual work programmes (which outline planned assurances in line with Board and committee duties) and co-ordinate the population of the ICB's BAF, in conjunction with the Executive Team. The Team also provides risk management expertise to establish and support the ICB's strategic risk management arrangements.

BAF Reporting Cycle

	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	March 2023	April 2023	May 2023
Board: BAF Bi-annual Reviews	✓[1]		✓						✓
Audit and Risk Committee: Targeted Assurance Reports[2]					✓		✓		
Board Committees: Receipt of assurances	✓	✓	✓	✓	✓	✓	✓	✓	✓
Executive Management Team: BAF Bi-annual Reviews (prior to Board)		✓						✓	

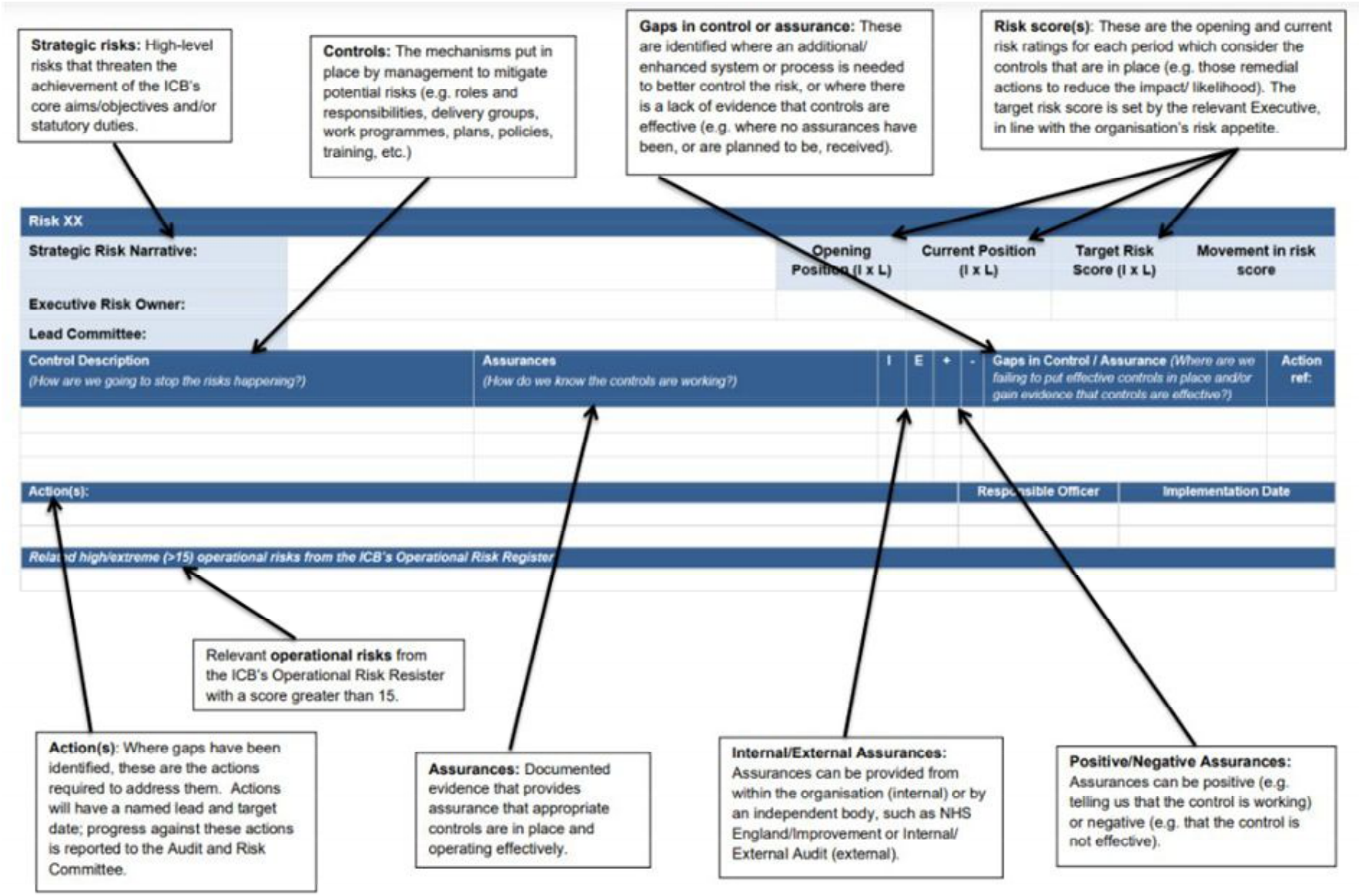
[1] Strategic risks
[2] It is recognised that these are being presented slightly later than in a typical year, given the national deferral of ICB establishment until 1 July 2022.

NHS
Nottingham and Nottinghamshire
Integrated Care Board

Board Assurance Framework

November 2022

How to navigate the Board Assurance Framework



Risk 1 - Health Inequalities and Outcomes				
Strategic Risk Narrative:	Failure to adequately address health inequalities and improve health outcomes for the population of Nottingham and Nottinghamshire.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Medical Director	High (5 x 3)	High (5 x 3)	Medium (4 x 2)	⟺
Lead Committee:	Strategic Planning and Integration Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Integrated Care Strategy, which will set out the strategic direction for health and care services across Nottingham and Nottinghamshire. Equity of delivery will be a core principle to the Strategy.	Integrated Care Strategy update to the ICB Board (scheduled January 2023).	✓				To finalise and publish the Integrated Care Strategy.	1.1
Joint Forward Plan, which will set out the plan to deliver the requirements of the Integrated Care Strategy.	Oversight of Joint Forward Plan by SPI Committee (updates scheduled November 2022 to March 2023); Joint Forward Plan presented to the ICB Board for approval (scheduled March 2023).	✓ ✓				To develop and publish the Joint Forward Plan.	1.2
Joint Local Health and Wellbeing Strategies (City and County), which will focus on what can be delivered at 'place' and in communities.	Local Joint Health and Wellbeing Strategies update to the ICB Board (scheduled May 2023)		✓			None identified.	
Development of thriving 'Places' across Nottingham and Nottinghamshire.	Place (including PCNs): System Development Update to the SPI Committee (scheduled November 2022).	✓				To establish the System Development Unit and supporting infrastructure.	1.3
Role and remit of the **ICS Health Inequalities (HI) Oversight Group.**	HI and Prevention Group assurance reporting to the System Executive Group (SEG); 2022/23 Internal Audit Review – Health Inequalities (scheduled Q3).	✓	 ✓			To establish systematic assurance reporting from the ICS HI Oversight Group.	1.4
Delivery of the **2022/23 Operational Plan**, alongside the development of 2023/25 Operational Planning.	Routine Operational Planning updates to the Finance and Performance Committee (scheduled from October 2022 onwards); Assurance reporting to NHS England.	✓	 ✓	 ✓		None identified.	
ICS Health Inequalities (HI) Plan.	HI Plan presented to the SPI Committee for review and approval (scheduled November 2022).	✓				None identified.	
Role of the **System Analytics and Intelligence Unit (SAIU)** in relation to the population health management (PHM) programme and individual 'outputs'.	PHM Approach: System Development Update to the SPI Committee (scheduled October 2022); IPR presented in full to the Board (bi-monthly) and relevant 'chapters' to each Committee (monthly).	✓ ✓	 	 ✓		To further develop the ICB's IPR to incorporate HI metrics.	1.5

Action(s):	**Responsible Officer**	**Implementation Date**
Action 1.1 To finalise and publish the Integrated Care Strategy.	Director of Integration	January 2022
Action 1.2 To develop and publish the Joint Forward Plan.	Director of Integration	April 2023
Action 1.3 To establish the System Development Unit and supporting infrastructure.	Director of Integration	March 2023
Action 1.4 To establish systematic assurance reporting from the ICS HI Oversight Group.	Medical Director	April 2023
Action 1.5 To further develop the ICB's IPR to incorporate HI metrics.	Director of Finance	April 2023

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR 02 Increasing levels of demand on healthcare services, combined with capacity constraints across providers, may widen health inequalities across the population of Nottingham and Nottinghamshire.

Risk 2 - System Resilience (for Managing Today)					
Strategic Risk Narrative:	Working effectively across the system may fail to address the current levels of demand across primary, community and secondary care.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Director of Integration	High (5 x 4)	High (5 x 4)	Medium (4 x 2)	⟺
Lead Committee:	Strategic Planning and Integration Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Role and remit of the **ICS System Oversight Meeting**, which has collective accountability for the performance of the ICS.	Integrated Performance Report (IPR) presented to ICB Board and relevant 'chapters' to ICB Committees (monthly) Assurance reporting to NHS England.	✓	✓	✓		None identified.	
Role and remit of the **Urgent and Emergency Care (UEC) Board**, and its supporting programme boards: – Ageing Well Programme Board; and – Urgent Care Right Place First Time (UCRPFT) Board.	Chief Executive's Reports to the open and confidential sessions of the ICB Board (bi-monthly) UEC Update to the ICB Board (September 2022)	✓ ✓		✓ ✓		None identified.	
Establishment of a **System Control Centre (SCC)**; the purpose of which is to ensure the safest and highest quality of care possible for the entire population across every area by balancing the clinical risk within and across all health and care settings.	SCC Update to the UEC Board (November 2022) Assurance reporting to NHS England.	✓	✓	✓ ✓		To establish and strengthen the System Control Centre (SCC) collaboratively with system partners.	2.1
Establishment of external System Development Support for Resetting UEC, Demand, Capacity and Flow	Assurance reporting to NHS England.		✓			To procure external capacity, diagnostics and implementation support for the System.	2.2
Role and remit of the **Planned Care Board**, which exists to oversee delivery of the system's elective recovery plans.	Planned Care Update to the ICB Board (September 2022).	✓		✓		None identified.	
Role and remit of the **Demand and Capacity Group,** supported by the Bed Modelling 'Task and Finish' Group.	Demand and Capacity Modelling reported to the UEC Board (September 2022).	✓		✓		None identified.	
Operational Pressures Escalation Level (OPEL) Framework across both primary and secondary care providers.	OPEL escalation reporting to the System Executive Group. OPEL review reported to the UEC Board (Nov 2022)	✓ ✓		✓ ✓		None identified.	
Delivery of the **2022/23 Operational Plan**, alongside the development of 2023/25 Operational Planning	Routine Operational Planning updates to the Finance and Performance Committee (scheduled from Nov 2022 onwards); Assurance reporting to NHS England.	✓	✓	✓		None identified.	

Action(s):	**Responsible Officer**	**Implementation Date**
Action 2.1 To establish and strengthen the System Control Centre (SCC) collaboratively with system partners.	Director of Integration	January 2023
Action 2.2 To procure external capacity, diagnostics and implementation support for the System.	Director of Integration	March 2023

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:

ORR 05 There is a potential risk of poor patient outcomes and/or experience as a result of increasing mental health waiting lists. This risk may be exacerbated by rising levels of demand on mental health services, with particular risk in relation to children and young people.

ORR 06 There is a significant risk to patient safety, outcomes and experience due to the current levels of demand, and capacity constraints, for non-elective (urgent and emergency care) activity. The likelihood of risk to patient harm will increase with any worsening ambulance response times/handover delays (front door) and delays to discharge (back door).
ORR 42 Insufficient capacity (hospital beds) may present a number of risks across urgent and emergency care, including overcrowding within Accident and Emergency Departments and increasing Ambulance handover delays.
ORR 43 Lack of capacity across care homes and home care provision may adversely impact system partners' ability to promptly discharge patients from Acute and Community settings.

Risk 3 - Transformation (for Making Tomorrow Better)				
Strategic Risk Narrative:	Effective system working may not transform (reform) and improve services to ensure best possible future health outcomes within available resources	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Director of Integration / Medical Director	High (5 x 3)	High (5 x 3)	Medium (4 x 2)	⟺
Lead Committee:	Strategic Planning and Integration Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Role and remit of the **Urgent and Emergency Care (UEC) Board**, and its supporting programme boards: – Ageing Well Programme Board; and – Urgent Care Right Place First Time (UCRPFT) Board.	Chief Executive's Reports to the open and confidential sessions of the ICB Board (bi-monthly) UEC Update to the ICB Board (September 2022)	✓ ✓		✓ ✓		None identified.	
Role and remit of the **Planned Care Board**, which exists to oversee transformational changes in the provision of planned care, cancer and diagnostic services across the ICS.	Planned Care Update to the ICB Board (September 2022).	✓		✓		None identified.	
Development of the **Primary Care Strategy.**	Primary Care Transformation Update to the ICB Board (scheduled November 2022).	✓				To finalise and publish the ICS Primary Care Strategy.	3.1
Ageing Well Programme Board, which oversees delivery of the Community Services Transformation Programme.	Community Services Transformation Update to the ICB Board (scheduled January 2023).	✓				None identified.	
System Mental Health Transformation Board, which exists to oversee delivery of mental health transformation across the ICS.	Mental Health Services Transformation Update to the SPI Committee (October 2022) Mental Health Services Transformation Update to the ICB Board (scheduled November 2022)	✓ ✓		✓		To embed the enhanced system-led Mental Health Transformation Board.	3.2
Role and remit of the **Clinical and Professional Leadership Group (CPLG)**	Primary Care Transformation Update to the ICB Board (scheduled November 2022).	✓				To revise and reinstate the Clinical and Professional Leadership Group (CPLG).	3.3
Clinical Design Authority's (CDA) role to provide clinical leadership in relation to service transformation.	Primary Care Transformation Update to the ICB Board (scheduled November 2022)	✓				To develop and expand membership of the CDA.	3.4
Development of thriving 'Places' across Nottingham and Nottinghamshire.	Place (including PCNs): System Development Update to the SPI Committee (scheduled Nov 2022)	✓				See 1.3	

Action(s):	**Responsible Officer**	**Implementation Date**
Action 3.1 To finalise and publish the ICS Primary Care Strategy.	Medical Director	March 2023
Action 3.2 To embed the enhanced system-led Mental Health Transformation Board.	Director of Integration	March 2023
Action 3.3 To revise and reinstate the Clinical and Professional Leadership Group (CPLG).	Medical Director	January 2023
Action 3.4 To develop and expand membership of the CDA.	Medical Director	March 2023

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:

ORR 4 There is a potential risk of poor patient outcomes and/or experiences as a result of increasing planned care waiting times; this includes, cancer treatment, diagnostics and key specialties waiting for elective care. The likelihood of this risk may continue to increase if elective recovery plans and associated planned assumptions are not met.

Risk 4 - Citizen Voice				
Strategic Risk Narrative:	Failure to effectively work in partnership with citizens and communities.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Chief Executive	Medium (4 x 3)	Medium (4 x 3)	Medium (4 x 2)	⟺
Lead Committee:	Strategic Planning and Integration Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Integrated Care Strategy, which will set out the strategic direction for health and care services across Nottingham and Nottinghamshire and include specific reference to engagement with citizens.	Integrated Care Strategy and ICS Outcomes Framework update to the ICB Board (scheduled January 2023) Regular 'Citizen Insight' updates to the ICP (scheduled for each meeting)	✓ ✓				See 1.1 To establish 'Citizen Insight' updates as a standing item on the ICP's agenda.	4.1
ICB Joint Forward Plan, which will set out the plan to deliver the requirements of the Integrated Care Strategy. *There is a requirement in the Health and Care Act 2022 to consult on the Forward Plan. Detailed guidance is awaited.*	Oversight of Joint Forward Plan and consultation plan by SPI Committee (updates scheduled November 2022 to March 2023) Joint Forward Plan presented to the ICB Board for approval (scheduled March 2023)	✓ ✓				See 1.2. To consult on the Joint Forward Plan in line with legislative requirements.	4.2
ICS Working with people and communities: Citizen Intelligence Strategy 2022-2025, which outlines the vision and principles to ensure that citizens are at the heart of the ICS, as well as the role of the **Citizen Intelligence Advisory Group.**	Working with People and Communities Updates to the SPI Committee (scheduled October, November 2022 and February 2023) 2022/23 Internal Audit Review – Citizen involvement and co-production (scheduled Q3)	✓	 ✓			To develop and publish the Overall Strategy for Working with People and Communities (which pulls together the Citizen Intelligence Strategy and the Co-production Strategy).	4.3
ICB Public Involvement and Engagement Policy, which sets out mechanisms to undertake meaningful involvement and engagement in the development, implementation and review of health and care policies and services across Nottingham and Nottinghamshire.	Annual Engagement Report (PENDING) 2021/22 Internal Audit Review – Compliance with *ICS implementing guidance on working with people and communities* guidance (No Opinion)	✓	 ✓	 ✓		None identified.	
ICB's Equality, Diversity and Inclusion (EDI) Policy, which outlines the requirement to meaningfully engage with people from all protected characteristic and disadvantaged groups.	Ad-hoc business cases reported via SPI Committee	✓		✓		None identified.	
The **ICB's Ethical Decision-Making Framework** outlines four key ethical principles that form the basis of decisions making (Principle1: Rationale must consider views of key stakeholders).	Ad-hoc business cases reported via SPI Committee	✓		✓		None identified.	
Equality and Quality Impact Assessment (EQIA) processes, outlined within the ICB's Strategic Decision-Making Framework.	Ad-hoc business cases reported via SPI Committee	✓		✓		None identified.	

Action(s):	**Responsible Officer**	**Implementation Date**
Action 4.1 To establish 'Citizen Insight' updates as a standing item on the ICP's agenda.	Chief Executive	March 2023
Action 4.2 To consult on the Joint Forward Plan in line with legislative requirements.	Chief Executive	April 2023
Action 4.3 To develop the Overall Strategy for Working with People and Communities (which combines the Citizen Intelligence Strategy and the Co-production Strategy).	Chief Executive	March 2023

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:

ORR 26 There is a potential risk of loss of public confidence in local primary and secondary care health services, as a result of national and local media/reports, known quality issues, as well as growing public concerns regarding increasing waiting list times and access to General Practice. Lack of confidence may impact the extent to which citizens interface with healthcare services.

Risk 5 - Research and Evidence					
Strategic Risk Narrative:	Failure to effectively facilitate and promote research and utilise evidence to inform decision-making.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Medical Director	Medium (4 x 3)	Medium (4 x 3)	Medium (4 x 2)	⟺
Lead Committee:	Strategic Planning and Integration Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Integrated Care Strategy, which will set out the strategic direction for health and care services across Nottingham and Nottinghamshire. Research will be an enabler to the Strategy.	Integrated Care Strategy and ICS Outcomes Framework update to the ICB Board (scheduled January 2023).	✓				See 1.1	
ICS Research Strategy (in development), to support delivery of the Integrated Care Strategy and Joint Forward Plan.	Annual Assurance Report: Promotion of Research and Use of Research Evidence to the ICB Board (scheduled November 2022 to March 2023); Promotion of Research updates to the SPI Committee (scheduled February 2023).	✓				To develop the ICS Research Strategy.	5.1
ICS Research Partners Group, which promotes a collaborative approach to health and care research across the system.		✓				None identified.	
Role and remit of the **ICB's Research Strategy Group**; a GP-led forum which oversees arrangements to promote, develop and increase research activity and research capacity and culture building within the ICB, Primary Care Networks and GP practices.						None identified.	
ICB commissioned **Knowledge and Library Service** (from Sherwood Forest Hospitals NHS Foundation Trust),	Annual Assurance Report: Promotion of Research and Use of Research Evidence to the ICB Board (scheduled November 2022 to March 2023); Ad-hoc business cases reported via SPI Committee.	✓		✓		To develop processes to ensure that knowledge and evidence from research systematically influences business cases.	5.2

Action(s):	**Responsible Officer**	**Implementation Date**
Action 5.1 To develop the ICS Research Strategy.	Medical Director	April 2023
Action 5.2 To develop processes to ensure that knowledge and evidence from research systematically influences business cases.	Medical Director	April 2023
Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:		
None.		

Risk 6 - Quality Improvement				
Strategic Risk Narrative:	Failure to maintain and improve the quality of services. *For 2022/23, this specifically includes the need to improve the quality of maternity services across the system.*	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Director of Nursing	High (5 x 3)	High (5 x 3)	Medium (4 x 2)	⟺
Lead Committee:	Quality and People Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
System Quality Strategy 2022/23, supported by the Delivery Plan.	Quality Strategy and Delivery Plan updates to the Quality and People Committee (scheduled Nov 2022 and March 2023).	✓				To develop the ICS Five-year Quality Strategy.	6.1
Role and remit of the **ICS System Oversight Meeting**, which has collective accountability for the performance of the ICS.	Integrated Performance Report (IPR) presented to ICB Board and relevant 'chapters' to ICB Committees (monthly); Assurance reporting to NHS England.	✓	 ✓	✓ ✓		None identified.	
Role and remit of the **System Quality Group**, which exists to drive quality improvement collaboratively and proactively.	Escalation reporting to Regional Quality Boards.		✓	✓		None identified.	
Establishment of the **System Quality Dashboard.**	System Quality Improvement Reports to the Quality and People Committee (monthly); System Quality Assurance Reports to the Quality and People Committee (monthly).	✓ ✓		✓ ✓		To embed quality across all system programmes/boards (i.e. Planned Care Board, UEC Board, etc.)	6.2
Role and remit of the **Nottingham and Nottinghamshire Local Maternity and Neonatal System (LMNS),** which is overseen by the System Quality Group and supported by: • **LMNS Perinatal Surveillance Quality Group (PSQG);** • **LMNS Quality Outcomes Dashboard Sub-group (DSG)** Role and remit of **Maternity Voices Partnership (MVP)**	Maternity Services Update to the ICB Board (September 2022)	✓		✓		None identified.	
The ICB's quality framework processes, which include a range of 'early warning' triggers and escalations. These include: • Risk-based quality insight visits across primary, community and secondary care; • Monitoring of provider compliance with key quality indicators; and • Arrangements for sharing good practice and lessons learnt (including incident management, complaints investigations, etc.).	Nursing and Quality Statutory Duties Report to the Quality and People Committee (monthly).	✓		✓		None identified.	
Primary Care Support and Assurance Groups (per 'Place' footprint), which have responsibility for delivery and improvement of quality services within primary care.	Primary Care Support and Assurance Reports to the Primary Care Sub-Committee (quarterly).	✓		✓		None identified.	

Equality and Quality Impact Assessment (EQIA) processes, outlined within the ICB's Strategic Decision-Making Framework.	Ad-hoc business cases reported via SPI Committee.	✓		✓		None identified.	
Co-production Strategy, which outlines system's approach to engaging with citizens in the development and improvement of services.	Co-Production updates to the Quality and People Committee (Sept 2022 and Feb 2023).	✓		✓		To finalise and publish the ICS Co-production Strategy.	6.3
ICB Complaint's Policy, which sets out the organisation's approach to handling complaints and concerns about commissioned services.	Nursing and Quality Statutory Duties Report to the Quality and People Committee (monthly).	✓		✓		None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 6.1 To develop the ICS Five-year Quality Strategy.	Director of Nursing	April 2023
Action 6.2 To embed quality across all system programmes/boards (i.e. Planned Care Board, UEC Board, etc.).	Director of Nursing	April 2023
Action 6.3 To finalise and publish the ICS Co-production Strategy.	Director of Nursing	January 2023

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR 22 If the ICB is not robustly assured regarding systematic improvements in the quality of mental health and community services provided by Nottinghamshire Healthcare NHS Foundation Trust (NHCT), there may be a significant risk of poor patient experience, adverse clinical outcomes and/or patient safety issues for the population of Nottingham and Nottinghamshire.
ORR 23 If the ICB is not robustly assured regarding the systematic improvements required in the quality of maternity services provided by Nottingham University Hospitals NHS Trust (NUH), there is a significant risk of poor clinical outcomes and/or patient safety issues for the population of Nottingham and Nottinghamshire.
ORR 24 A number of potential, and actual, complex and significant quality and cultural issues have been identified at Nottingham University Hospitals NHS Trust (NUH). If the ICB is not robust assured regarding systematic improvements required by the Trust, there is a risk of poor clinical outcomes and/or patient safety issues for members of the ICB's population.

Risk 7 - People and Culture				
Strategic Risk Narrative:	Failure to ensure sufficient capacity and capability within the local workforce.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Director of Nursing	High (5 x 4)	High (5 x 4)	Medium (4 x 2)	⟺
Lead Committee:	Quality and People Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
ICS People and Culture Strategy (2019 to 2029), which outlines five strategic priorities.	People and Culture strategic update to the ICB Board (scheduled January 2023). 2022/23 Internal Audit Review – NHS People Plan/Workforce plans (scheduled Q4).	✓	✓			To appoint to the ICS Chief People Officer post. To revise the ICS People and Culture Strategy in line with the ICS Integrated Care Strategy, and associated delivery and action plans.	7.1 7.2
Primary Care Workforce Strategy; supported by the Nottinghamshire Alliance Training Hub and General Practice Nurse Strategy.	People and Culture strategic update to the ICB Board (scheduled January 2023).	✓				None identified.	
System People and Culture Group, supported by the: • **People, Culture and Inclusion Collaborative**; and • **People Planning and Transformation Group.**	People and Culture Diagnostic Update to the Quality and People Committee (scheduled Nov 2022); People and Culture Assurance Reports to the Quality and People Committee (monthly).	✓ ✓				To establish the People Planning and Transformation Group.	7.3
Workforce Intelligence Group (WIG), supported by the System Analytics Intelligence Unit (SAIU).	People and Culture Dashboard to the Quality and People Committee (monthly).	✓				None identified.	
Delivery of the **2022/23 Operational Plan**, alongside the development of 2023/25 Operational Planning.	Routine Operational Planning updates to the Finance and Performance Committee (scheduled from October 2022 onwards). Assurance reporting to NHS England.	✓	✓			None identified.	

Action(s):	**Responsible Officer**	**Implementation Date**
Action 7.1 To appoint to the ICS Chief People Officer post.	Director of Nursing	December 2022
Action 7.2 To revise the ICS People and Culture Strategy in line with the ICS Integrated Care Strategy, and associated delivery and action plans.	Director of Nursing	April 2023
Action 7.3 To establish the People Planning and Transformation Group.	Director of Nursing	March 2023

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR 03: Sustained levels of significant pressure on primary care workforce, due to vaccination (and wider immunisation) programmes, increasing levels of demand, management of long-term conditions and the impact of deferrals/delays in secondary care activity, present a potential risk in relation to primary care staff resilience, exhaustion and 'burn out'.
ORR 41 Workforce capacity issues across the Nottingham and Nottinghamshire system health and care partners may present a significant risk to the delivery of urgent and emergency care to the population of Nottingham and Nottinghamshire.
ORR 44 Sustained levels of significant pressure on health and social care workforce presents a significant risk of moral injury, staff sickness, exhaustion and 'burn out'. This, in turn, may adversely impact workforce retention.
ORR 49 Lack of available workforce may significantly impact the extent to which theatres are utilised effectively across the system. This, in turn, may present a risk to the delivery of planned care activity.

Risk 8 - Equality, Diversity and Inclusion					
Strategic Risk Narrative:	Failure to comply with the general and specific Public Sector Equality Duties.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Director of Nursing	Medium (4 x 3)	Medium (4 x 3)	Medium (4 x 2)	⇔
Lead Committee:	Quality and People Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
ICB's Equality, Diversity and Inclusion (EDI) Policy which sets out how the organisation meets its statutory responsibility to comply with the Public Sector Equality Duty of the Equality Act 2010 (and associated Regulations) and how the ICB will work to achieve good equality performance outcomes.	Reports on compliance with the requirements set out in the Equality Act 2010 (and associated Regulations) to the Remuneration Committee (PENDING); ICB Workforce reporting to the Human Resources Executive Group (quarterly).	✓ ✓		 ✓		To revisit and re-establish the ICB EDI Steering Group.	8.1
Key ICB business activities where due regard to the general public sector equality duty is required include: • Assessing the health needs of our population; • Public engagement and communications; • Procurement and contract management; • Recruitment and selection; and • Cultural competence.	Public Sector Equality Duty Annual Assurance Report to the ICB Board (scheduled Nov 2022 to March 2023).	✓				None identified.	
The ICB's compliance with (or working toward the principles of) the: • NHS Accessible Information Standard; • NHS Workforce Race Equality Standard (WRES); • The NHS Workforce Disability Equality Standard (DES).	Reports on compliance with the requirements set out in the Equality Act 2010 (and associated Regulations) to the Remuneration Committee (PENDING).	✓				None identified.	
Equality Improvement Plan.	Equality Improvement Plans and Objectives reporting to the Quality and People Committee (scheduled Oct 2022 and Jan 2023).	✓				None identified.	
Equality and Quality Impact Assessment (EQIA) processes which monitor the effectiveness of arrangements in place for the completion of equality impact assessments when planning, changing or removing a service, policy or function.	Ad-hoc business cases reported via SPI Committee.	✓		✓		None identified.	
Mandated Equality and Diversity training (three-yearly).	Mandatory Training Compliance Reports to the Audit and Risk Committee (bi-annually).	✓		✓		None identified.	

Action(s):	**Responsible Officer**	**Implementation Date**
Action 8.1 To revisit and re-establish the ICB EDI Steering Group.	Director of Nursing	April 2023

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
None.

Risk 9- Safeguarding					
Strategic Risk Narrative:	Failure to safeguard children and vulnerable adults in accordance with legislative and statutory frameworks and guidance	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Director of Nursing	Medium (5 x 2)	Medium (5 x 2)	Medium (5 x 2)	⟺
Lead Committee:	Quality and People Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
ICB's Safeguarding Policy (incorporating PREVENT and Safeguarding Training and Supervision) describes how the ICB discharges its safeguarding responsibilities for commissioning health services. **ICB's Policy for Managing Allegations and Concerns** that an employee or those who act in the capacity of employees may pose a risk to a child, young person or an adult in need of safeguarding. **ICB's Mental Capacity Act (MCA) 2005 Policy** which outlines the duties placed on health and social care staff and how various processes within the MCA should be followed.	Adults and Childrens Safeguarding Arrangements Annual Assurance Report to the ICB Board (scheduled Q4 2022/23); Learning from Lives and Deaths: People with a Learning Disability and Autistic People (LeDeR) Annual Assurance Report to the ICB Board scheduled Q4 2022/23).	✓ ✓				None identified.	
Role and remit of the **Safeguarding Assurance Group (SAG)**, which has operational responsibilities for ensuring delivery of the ICB's statutory safeguarding duties. Routine safeguarding assurance processes, such as the completion of Section 11 Audits, Serious Case Reviews, Domestic Homicide Reviews and Multi Agency Audits.	Nursing and Quality Statutory Duties Report, which includes a dedicated safeguarding update (children, vulnerable adults, SEND and LAC) to the Quality and People Committee (bi-monthly); NHS England Safeguarding Commissioning Assurance Tool submissions (PENDING).	✓	✓			None identified.	
ICB partner of the **Local Safeguarding Adults Boards** and **Multi Agency Public Protection (MAPPA) Strategic Management Board** (City and County). ICB's statutory membership on the **Children's Partnership Boards** (City and County).	Adults and Childrens Safeguarding Arrangements Annual Assurance Report to the ICB Board (scheduled Q4 2022/23).	✓				None identified.	
Designated and Named Professionals in line with the Royal College of Nursing (RCN) Intercollegiate guidance.	Adults and Childrens Safeguarding Arrangements Annual Assurance Report to the ICB Board (scheduled Q4 2022/23).	✓				None identified.	
Mandated safeguarding training (three-yearly).	Mandatory Training Compliance Reports to the Audit and Risk Committee (bi-annually).	✓		✓		None identified.	

Action(s):	**Responsible Officer**	**Implementation Date**
None.		
Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:		
None.		

Risk 10 - Financial Sustainability					
Strategic Risk Narrative:	Establishing a shared culture of financial stewardship may not ensure financial sustainability across the system.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Director of Finance	High (4 x 5)	High (4 x 4)	Medium (4 x 2)	⇩
Lead Committee:	Finance and Performance Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
ICS Directors of Finance Group, which is supported by the **Operational (Deputy) Finance Directors Group**.	Reporting to System Executive Group (weekly); Assurance reporting to NHS England.	✓	 ✓	✓ ✓		None identified.	
ICS Finance Strategy, which will support delivery of the overall Integrated Care Strategy.	System finance plans and ICB budgets presented to the ICB Board for approval (September 2022 and March 2023).	✓		✓		To develop the ICS Finance Strategy.	10.1
ICS Finance Framework, which sets out the rules which govern the way finances are managed within the ICS (as identified as best practice by the HfMA).	2022/23 Internal Audit Review - HfMA Financial Sustainability (scheduled Q3); System Finance Report to the Finance and Performance Committee (monthly).	 ✓	✓	 ✓		None identified.	
Joint Long-term Financial Plan, to support delivery of the five-year Joint Forward Plan.	Reporting of the Joint Long-term Financial Plan to the Finance and Performance Committee (scheduled October 2022 and February 2023).	✓				To develop the Joint Long-term Financial Plan.	10.2
ICS Financial Planning Principles, which have been agreed by System Partners and will be adhered to when developing operational and financial plans.	Reporting of the ICS Financial Planning Principles to the Finance and Performance Committee (September 2022).	✓		✓		None identified.	
Role and remit of the **ICS System Oversight Meeting**, which has collective accountability for the performance of the ICS.	Assurance reporting to NHS England. IPR presented in full to the Board (bi-monthly) and relevant 'chapters' to each Committee (monthly).	 ✓	✓	✓ ✓		None identified.	
Delivery of the **2022/23 Operational Plan**, alongside the development of 2023/25 Operational Plans.	Routine Operational Planning updates to the Finance and Performance Committee (scheduled from October 2022 onwards); Assurance reporting to NHS England.	✓	 ✓	✓ ✓		None identified.	

Action(s):	**Responsible Officer**	**Implementation Date**
Action 10.1 To develop the ICS Finance Strategy.	Director of Finance	March 2023
Action 10.2 To develop the Joint Long-term Financial Plan.	Director of Finance	April 2023

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR 16 If Nottingham and Nottinghamshire Integrated Care System (ICS) do not, as a collective, meet the year-end position outlined with the 2022/23 financial plan, there is risk that the system will come under further regulation by NHSE. As well as potential reputational risks for the ICS, this may significantly impact the extent to which the system is able to create financial 'headroom' to focus on the transformation of services.
ORR 45 Non-delivery of the financial efficiency programme presents a significant risk to the delivery of the 2022/23 system financial position.
ORR 47 Increasing levels of COVID may present a risk to the delivery of the 2022/23 system financial plan.
ORR 58 Over-reliance on non-recurrent mitigations to manage the system's 2022/23 financial position may result in continued deterioration in the system's underlying financial position (UDL).

Risk 11 - Allocation of Resources					
Strategic Risk Narrative:	Failure to establish robust resource allocation arrangements across the system (revenue and capital).	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Director of Finance	**High (5 x 3)**	**High (5 x 3)**	Medium (4 x 2)	⟺
Lead Committee:	Finance and Performance Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
ICS Directors of Finance Group, which is supported by the **Operational (Deputy) Finance Directors Group**.	Reporting to System Executive Group (weekly); Assurance reporting to NHS England.	✓	✓	✓ ✓		None identified.	
Joint Capital Resource Use Plan, which is prepared with partner NHS trusts and NHS foundation trusts.	Joint Capital Resource Use Plan presented to the ICB Board (scheduled Nov 2022 and Feb 2023).	✓				To develop the Joint Capital Resource Use Plan.	11.1
ICS Estates Strategy, which will support delivery of the overall Integrated Care Strategy.	System-wide Estates Strategy presented to the ICB board for approval (scheduled March 2023).	✓				To develop the ICS Estates Strategy.	11.2
ICS Finance Framework, which sets out the rules which govern the way finances are managed within the ICS (as identified as best practice by the HfMA).	2022/23 Internal Audit Review - HfMA Financial Sustainability (scheduled Q3); System Finance Report to the Finance and Performance Committee (monthly).	 ✓	✓	 ✓		None identified.	
ICS Financial Planning Principles, which have been agreed by System Partners and will be adhered to when developing operational and financial plans.	Reporting of the ICS Financial Planning Principles to the Finance and Performance Committee (September 2022).	✓		✓		None identified.	

Action(s):	**Responsible Officer**	**Implementation Date**
Action 11.1 To develop the Joint Capital Resource Use Plan.	Director of Finance	December 2023
Action 11.2 To develop the ICS Estates Strategy.	Director of Finance	March 2023

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
None.

Risk 12 - Digital Transformation					
Strategic Risk Narrative:	Failure to deliver digital transformation and establish effective system intelligence solutions.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Medical Director	High (4 x 4)	High (4 x 4)	Medium (4 x 2)	⟺
Lead Committee:	Finance and Performance Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Data, Analytics, Information and Technology (DAIT) Strategy (2020 to 2024), which outlines five strategic initiatives: • Develop our Public Facing Digital Services; • Develop our Population Health Management capability; • Complete the digitisation of providers by 2024; • Develop a single summary health and care record; • Improve the digital literacy of the workforce and the capability and capacity of our digital and informatics specialists.	Digital and Data strategic update to the ICB Board (scheduled November 2022); ICS Data and Digital Transformation Plan Updates to the Finance and Performance Committee (scheduled Jan and May 2023).	✓ ✓				To revisit the DAIT Strategy in light of the new Integrated Care Strategy. To secure the required external funding to support delivery to DAIT Strategy.	12.1 12.2
ICS Data, Analytics, Information and Technology (DAIT) Strategy Group and supporting delivery group structure, which includes the **ICS Digital Executive Group**.	Digital and Data strategic update to the ICB Board (scheduled November 2022); ICS Data and Digital Transformation Plan Updates to the Finance and Performance Committee (scheduled Jan and May 2023).	✓ ✓				None identified.	
GP Information Technology (IT) Steering Group which exists to develop, support and implement the necessary IT infrastructure within primary care.	ICS Data and Digital Transformation Plan Updates to the Finance and Performance Committee (scheduled Jan and May 2023).	✓				To revisit the role and remit of the GP IT Steering Group.	12.3
Primary Care Information Technology Strategy (2021-2026) which sets out the strategy for IT services and functionality for primary care.	ICS Data and Digital Transformation Plan Updates to the Finance and Performance Committee (scheduled Jan and May 2023).	✓				To revisit the Primary Care IT Strategy in light of the new overarching ICS Primary Care Strategy.	12.4
Role of the **System Analytics and Intelligence Unit (SAIU)** in relation to the population health management (PHM) programme and individual 'outputs'; which is supported by the **SAIU Operating Group**.	PHM Approach: System Development Update to the SPI Committee (October 2022).	✓		✓		None identified.	

Action(s):	**Responsible Officer**	**Implementation Date**
Action 12.1 To revisit the DAIT Strategy in light of the new Integrated Care Strategy.	Medical Director	March 2023
Action 12.2 To secure the required external funding to support delivery to DAIT Strategy.	Medical Director	March 2023
Action 12.3 To revisit the role and remit of the GP IT Steering Group.	Medical Director	March 2023
Action 12.4 To revisit the Primary Care IT Strategy in light of the new overarching ICS Primary Care Strategy.	Medical Director	March 2023

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
None.

Risk 13 - Environment Sustainability					
Strategic Risk Narrative:	Failure to effectively deliver on the green plan.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Director of Finance	Medium (4 x 3)	Medium (4 x 3)	Medium (4 x 2)	⟺
Lead Committee:	Finance and Performance Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Nottingham and Nottinghamshire ICS Green Plan (2022 to 2025), which outlines the specific actions and priority interventions for achieving carbon net zero to lay the foundation to deliver carbon emission reductions through the delivery of sustainable health and care services.	Environmental Sustainability strategic update to the ICB Board (scheduled November 2022); ICS Green Plan updates to the Finance and Performance Committee (scheduled October 2022, February and June 2023);	✓ ✓				To establish and ICS Green Plan delivery function to monitor, manage and reduce carbon usage across the ICS.	13.1
ICS Net Zero Group.	2022/23 Internal Audit Review – Environmental sustainability governance (scheduled Q4).		✓			To revisit and revise the role and remit of the ICS Net Zero Group.	13.2

Action(s):	**Responsible Officer**	**Implementation Date**
Action 14.1 To establish and ICS Green Plan delivery function to monitor, manage and reduce carbon usage across the ICS.	Director of Finance	March 2023
Action 14.2 To revisit and revise the role and remit of the ICS Net Zero Group.	Director of Finance	March 2023

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
None.

Risk 14 - Emergency Preparedness, Resilience and Response				
Strategic Risk Narrative:	Failure to be adequately prepared to respond to major and/or business continuity incidents.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Director of Integration	Medium (5 x 2)	Medium (5 x 2)	Medium (5 x 2)	⟺
Lead Committee:	Audit and Risk Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
ICB's Emergency Preparedness, Resilience and Response (EPRR) Policy, which outlines how the ICB complies with its statutory responsibilities and EPRR obligations, planning and responding to a major incident and or a business continuity incident.	EPRR Incident Response Plan updates to the ICB Board (July 2022 and Jan 2023); EPRR and business continuity updates to the Audit and Risk Committee (scheduled Nov 2022 and April 2023); 2022/23 Internal Audit Review – EPRR and Business Continuity Planning (scheduled Q4); 2021/22 EPRR Core-Standards statement of assurance submission to NHSE/I (PENDING).	✓ ✓	 ✓ ✓			None identified.	
ICB's Incident Response Plan and Business Continuity Plan which describe the systems and processes that will be followed when responding to major incidents, significant disruptions and emergencies in line with the Civil Contingencies Act.	2022/23 Internal Audit Review – EPRR and Business Continuity Planning (scheduled Q4); EPRR and business continuity updates to the Audit and Risk Committee (scheduled Nov 2022 and April 2023).	 ✓	✓			None identified.	
ICB's On-Call Handbook / Action Cards (and rota) which ensure a robust and consistent approach to the implementation of on-call arrangements.	2022/23 Internal Audit Review – EPRR and Business Continuity Planning (scheduled Q4); EPRR and business continuity updates to the Audit and Risk Committee (scheduled Nov 2022 and April 2023).	 ✓	✓			None identified.	
ICB representative on the Local Health Resilience Partnership (LHRP) and **Local Resilience Forum (LRF).**	2021/22 EPRR Core-Standards statement of assurance submission to NHSE/I (PENDING).		✓			None identified.	
NHIS Cyber Security Strategy which outlines compliance with the 10 Steps to Cyber Security and NHIS ISO 27001 accreditation.	Reporting into the ICB's Information Governance Steering Group (PENDING).	✓				None identified.	
NHIS Cyber Assurance Programme Board and **Cyber Assurance Delivery Group,** attended by ICB representatives.	Reporting into the ICB's Information Governance Steering Group (PENDING).	✓				None identified.	
ICB Information Security Policy, which defines security measures applied through technology and encompasses the expected behaviour of those who manage information within the organisation.	2022/23 Internal Audit Review – Data Security and Protection Toolkit (scheduled Q4).		✓			None identified.	

Action(s):	**Responsible Officer**	**Implementation Date**
None.		

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
None.

Annex 1: Alignment of BAF Strategic Risks to ICB Aims and Objectives

Strategic Risks *(What could prevent us from achieving our strategic aims/objectives and statutory duties?)*	**ICB Aims and Objectives**			
	To improve outcome in population health and healthcare.	To tackle inequalities in outcomes, experience and access.	To enhance productivity and value for money.	To help the NHS support broader social and economic development.
Risk 1: Health Inequalities and Outcomes – Failure to adequately address health inequalities and improve health outcomes for the population of Nottingham and Nottinghamshire.	✓	✓		✓
Risk 2: System Resilience (for Managing Today) – Working effectively across the system may fail to address the current levels of demand across primary, community and secondary care.	✓	✓	✓	
Risk 3: Transformation (for Making Tomorrow Better) – Effective system working may not transform (reform) and improve services to ensure best possible future health outcomes within available resources.	✓	✓	✓	✓
Risk 4: Citizen Voice – Failure to effectively work in partnership with citizens and communities.	✓	✓		✓
Risk 5: Research and Evidence – Failure to effectively facilitate and promote research and utilise evidence to inform decision-making.	✓	✓		✓
Risk 6: Quality Improvement – Failure to maintain and improve the quality of services.	✓	✓		
Risk 7: People and Culture – Failure to ensure sufficient capacity and capability within the local workforce.	✓	✓	✓	
Risk 8: Equality, Diversity and Inclusion – Failure to comply with the general and specific Public Sector Equality Duties.		✓		
Risk 9: Safeguarding – Failure to safeguard children and vulnerable adults in accordance with legislative and statutory frameworks and guidance.	✓			
Risk 10: Financial Sustainability – Establishing a shared culture of financial stewardship may not ensure financial sustainability across the system.			✓	✓
Risk 11: Allocation of Resources – Failure to establish robust resource allocation arrangements across the system (revenue and capital).	✓	✓	✓	✓
Risk 12: Digital Transformation – Failure to deliver digital transformation and establish effective system intelligence solutions.	✓	✓	✓	
Risk 13: Environment Sustainability – Failure to effectively deliver on the green plan.				✓
Risk 14: Emergency Preparedness, Resilience and Response – Failure to be adequately prepared to respond to major and/or business continuity incidents.	✓			