Integrated Care System
Nottingham & Nottinghamshire

Nottingham City Council | Nottinghamshire County Council | NHS

# Integrated Care System Board

Meeting held in public

**Thursday 12 September 2019, 09:00 – 12:00**
**Rufford Suite, County Hall, Nottingham**

## DRAFT AGENDA

| | Time | Agenda Items | Paper | Lead | Action |
|---|---|---|---|---|---|
| 1. | 09:00 | Welcome and Introductions: | Verbal | Chair | To note |
| 2. | 09:05 | Conflicts of Interest | Verbal | Chair | To note |
| 3. | 09:10 | Minutes of 8 August 2019 ICS Board meeting and action log | Papers A1-2 | Chair | To agree |
| 4. | 09:15 | Patient Story | Paper B | Neil Marshall | To discuss |
| **Outcomes Framework, Prevention and Inequalities** | | | | | |
| 5. | 09:30 | ICS Outcomes Framework – operationalising the framework:<br>• Health and Wellbeing domain | Paper C | Tom Diamond | To agree |
| **Strategy and System Planning** | | | | | |
| 6. | 09:45 | ICS 5 Year Plan update | Paper D | Helen Pledger | To agree |
| 7. | 10:00 | Local engagement on NHS Long Term Plan - update | Paper E1-2 | Alex Ball | To discuss |
| 8. | 10:10 | People and Culture strategy – impact of initiatives | Paper F1-2 | Lyn Bacon/ Nicky Hill | To discuss |
| 9. | 10:25 | Update on System Staff Engagement and OD | Paper G | Alex Ball / Julian Eves | To discuss |
| 10. | 10:35 | Approach to analytics - update | Paper H | Tom Diamond | To discuss |
| *Short break* | | | | | |
| 11. | 10:45 | The Development of Primary Care Networks for Nottingham and Nottinghamshire | Paper I1-2 | Nicole Atkinson | To discuss |
| 12. | 11:00 | Update from ICPs:<br>• Mid – to discuss<br>• South – to note<br>• City – to note | Papers J1-3 | Richard Mitchell | To note |

| | Time | Agenda Items | Paper | Lead | Action |
|---|---|---|---|---|---|
| **Oversight of System Resources and Performance Issues (including MoU)** | | | | | |
| 13. | 11:05 | ICS Integrated Performance Report - Finance, Performance & Quality. | Paper K1-3 | Wendy Saviour / Helen Pledger | To discuss |
| 14. | 11:10 | 2019/20 Financial Sustainability – NHS System Control Total | Paper L | Helen Pledger | To discuss |
| 15. | 11:15 | Urgent and Emergency Care Deep Dive | Paper M | Amanda Sullivan | To discuss |
| 16. | 11:25 | Update on drivers of demand in urgent and emergency care in Min-Nottinghamshire | Paper N1-2 | Andy Haynes | To discuss |
| 17. | 11:35 | First draft of winter plans – Mid Nottinghamshire | Paper O To Follow | Richard Mitchell | To discuss |
| **Governance** | | | | | |
| 18. | 11:50 | Terms of reference for the Greater Nottingham Transformation Board | Paper P1-2 | Chair | To agree |
| 19. | 11:55 | Governance Matters for Approval:<br>• Dissemination of meeting papers<br>• System Architecture Group ToR<br>• Rural Network<br>• Governance review | Paper Q1-2 | Chair | To agree |
| **12:00 Close** | | | | | |

**Date of the next meeting:**
**9 October 2019, 13:30 – 16:30, Rufford Suite, County Hall**

# Integrated Care System Board

Meeting held in public

**Thursday 8 August 2019, 09:00 – 12:00**
**Rufford Suite, County Hall, Nottingham**

**Present:**

| NAME | ORGANISATION |
|---|---|
| Alex Ball | Director of Communications and Engagement, Nottinghamshire ICS |
| Andrew Haynes | Clinical Director, Nottinghamshire ICS |
| Colin Monckton | Director of Strategy and Policy, Nottingham City Council |
| David Pearson | ICS Independent Chair |
| Dean Fathers | Chair, Nottinghamshire Healthcare NHS FT |
| Deborah Jaines | Deputy Managing Director, Nottinghamshire ICS |
| Elaine Moss | Chief Nurse, Nottinghamshire CCGs and ICS |
| Eric Morton | Chair, Nottingham University Hospitals NHS Trust |
| Gavin Lunn | Clinical Lead from Mid Nottinghamshire Representing PCNs<br>Clinical Chair, Mansfield and Ashfield CCG |
| Helen Pledger | Finance Director, Nottinghamshire ICS |
| John Brewin | Chief Executive, Nottinghamshire Healthcare NHS FT |
| John MacDonald | Chair, Sherwood Forest Hospitals NHS FT |
| Jon Towler | Lay Chair, Nottinghamshire CCGs |
| Jonathan Gribbin | Consultant in Public Health, Nottinghamshire County Council |
| Lucy Dadge | Director of Commissioning, Nottinghamshire Clinical Groups |
| Richard Henderson | Chief Executive, East Midlands Ambulance Service |
| Richard Stratton | Clinical Lead from Greater Nottingham representing PCNs<br>GP, Belvoir Health Group |
| Thilan Bartholomeuz | Clinical Lead from Mid Nottinghamshire<br>Clinical Chair, Newark and Sherwood CCG |
| Tracy Taylor | Chief Executive, Nottingham University Hospitals Trust |

**In Attendance:**

| | |
|---|---|
| Joanna Cooper | Assistant Director, Nottinghamshire ICS |
| Julie Repper (item 4) | Director of IMROC, Nottinghamshire Healthcare NHS FT |
| Jill Mathers (item 4) | Patient |

| | |
|---|---|
| Will Legge (item 10) | Director of Strategy and Transformation, East Midlands Ambulance Service |

**Apologies:**

| | |
|---|---|
| Amanda Sullivan | Accountable Officer, Nottinghamshire CCGs |
| Eunice Campbell-Clark | Chair, Nottingham City Health and Wellbeing Board |
| Ian Curryer | Chief Executive, Nottingham City Council |
| Melanie Brooks | Corporate Director Adult Social Care and Health, Nottinghamshire County Council |
| Richard Mitchell | Chief Executive, Sherwood Forest Hospitals NHS FT |
| Steve Vickers | Chair, Nottinghamshire County Health and Wellbeing Board |
| Tony Harper | Chair, Nottinghamshire County Council Adult Social Care and Health Committee |
| Wendy Saviour | ICS, Managing Director |

1. **Welcome and introductions**

Apologies received as noted above.

2. **Conflicts of Interest**

No conflicts of interest in relation to the items on the agenda were declared.

3. **Minutes of 12 July 2019 ICS Board meeting and action log**

The minutes of the ICS Board meeting held on 12 July 2019 were agreed as an accurate record of the meeting by those present. The action log was noted.

4. **Patient Story**

Julie Repper and Jill Mathers attended the meeting to discuss the Let's Live Well in Rushcliffe (LLWiR) project and how taking a personal centred holistic informal approach can support health and wellbeing.

Board thanked Jill and Julie for their inspirational presentation.

Board to reflect on the need for informal support structures in communities to support the health and wellbeing of citizens, sustainable sources of funding, and the language used by health and care professionals (e.g. social prescribing) and how services are promoted to communities.

RS offered to work with Jill to establish support in her local community.

## 5. ICS Workstream Review

DJ presented the circulated paper on the ICS workstream review highlighting that current workstreams do not provide a cohesive system approach and do not fully meet the requirements of the Long Term Plan.

Board discussed the paper and noted the following:

- Clarity needed on workstream governance with the work led by workstreams to be more visible to the Board.
- Endorsement of the proposed oversight structure.
- Board needs assurance that workstreams are integrated and not working in silos.
- Configuration of workstreams should be shifted from organisational / workstream to population and population groups to aid integration.
- Rationalisation of workstreams and resources supported.
- Meaning of integrating to "business as usual" need to be clarified for workstreams as accountability for different parts of the system (ICP / PCN roles) is not fully scoped and established e.g. 52ww are not a system issue, they are an organisational issue where ICS Board discussion does not add value.

Board endorsed the paper as presented. Further work to take place on workstreams to ensure that the Board receives regular updates on progress.

Board supported a governance review to bring clarity to the issues raised. Board member support needed to understand:

- Role and purpose of groups across the different levels of the system
- Strengths and weaknesses of the current configuration
- Topics which should be discussed at and owned by the ICS Board
- Membership of the groups within the ICS structure
- Consideration to an Executive Team layer within the system with NEDs and Chairs holding Executives to account for delivery.

**ACTIONS:**
**DJ** to ensure that workstream reporting to the Board is in place.
**DP** to lead the development of a governance review for the ICS.

## 6. ICS Five Year Plan update

HP presented the circulated paper to update the Board on progress with the Long Term Plan. HP highlighted that this is a complex planning round made more challenging by the operational and financial challenges facing the system. The timeframe for development of the plan is tight and guidance is continuing to emerge.

Measures are in place to manage this process and work is being led by the ICS Planning Group which is meeting on a fortnightly basis.

Workshops are taking place with representation from across all levels the system, this is a pragmatic approach recognising the timeframe and the importance that this is co-designed and owned by the system. Clinical and professional ownership is vital to the development of the plan, this will be through established ICS and ICP clinical forums. ICPs are being involved in the planning process and planning group.

Board agreed that an extraordinary meeting should be convened on 13 / 14 November to agree the final Five Year Plan submission on 15 November. Prior to this meeting, the Boards / Governing Bodies of statutory organisations will receive the plan for approval.

**ACTIONS:**
**HP / Tom Diamond** to prepare a report for the 6 November ICS Board meeting.
**JC** to arrange for an extraordinary Board meeting to be held on 13 or 14 November to agree the Long Term Plan response.
**All** organisations to confirm approval mechanisms for the Long Term Plan to ensure approval of the plan prior to 13 November.

## 7. Update from ICPs

JB presented the circulated paper from South Nottinghamshire ICP which is in the early stages of forming.

Circulated papers from Mid Nottinghamshire and City ICPs noted.

Greater Nottingham Transformation Board role and Terms of Reference to be finalised and agreed.

**ACTIONS:**
**AS** to lead development of Greater Nottingham Transformation Board role and Terms of Reference

## 8. Update on information exchange with EMAHSN

AH has met with AHSN and discussed at the Clinical Reference Group on 25 July. Innovation Exchange to be coordinated for the system. AH to bring an update to the Board at a future meeting.

**ACTIONS:**
**AH** to update the Board on progress with the AHSN Innovation Exchange.

## 9. Nottinghamshire ICS MOU with NHSE/I

DJ presented the circulated paper outlining the requirements of the ICS MOU and the July Maturity Matrix assessment.

Board noted the final contents of the MOU and agreed to ensure that organisational Boards were aligned to its contents. Organisations to provide a brief statement of intent in response to this request. Annex to be amended with simple form of words to be signed up to.

TB highlighted that the cancer target timescales are incorrect. The correct timescales for this change is April 2020.

JM asked that it be clarified which priorities are the responsibility of the ICS Board and which are the responsibility of organisations.

**ACTIONS:**
**Organisation Leads and ICP Leads** to confirm that their organisation / ICP endorses the ICS MOU and confirm how they will contribute to the delivery of priorities.
**WS** to raise the cancer target timescales in the ICS MOU with colleagues in NHSE/I.
**JC** to amend the report to organisational Boards to clarify the requirements from organisations.

## 10. EMAS Current Position and Future Plans

RH and Will Legge presented the circulated paper providing an overview of the future clinical operating model and the opportunities that this brings for PCN, ICP and ICS development.

Board noted and congratulated RH and the rest of the team at EMAS on their recent 'Good' rating from CQC which included an 'Outstanding' rating for Caring.

Board noted the following points:

- That the model needs to be costed for the implications to be fully understood. It was felt there could be a risk in the model that the approach to Category Two calls could increase the risk of pressure on resources.
- AH encouraged EMAS to be radical as Trusts are seeing increasing numbers of people being conveyed and no treatment needed.
- Further consideration should be given to rotational posts
- Previous learning shows that implementation at PCN level is not sustainable and that ICPs is the preferred option.
- Connections between the development of the model and the Long Term Plan response are needed.

ICPs, Clinical Leads and Commissioners to work together to develop a business case for Nottinghamshire to test this new model. RH to provide a report on progress to the Board at a future meeting.

**ACTIONS:**
**RH** to ensure that ICPs, Clinical Leads and Commissioners to work together to develop a business case for Nottinghamshire to test a new model for EMAS. RH to provide a report on progress to the Board at a future meeting.

## 11. ICS Integrated Performance Report - Finance, Performance & Quality.

HP presented the July 2019 Integrated Performance Report for information. Issues and emerging risks are detailed in the report:

- Urgent Care System delivery
- Cancer Services Delivery
- Financial Sustainability
- Mental Health OAPs

Report also contains response to the request for the system to revisit capital plans.

CCGs have all received a rating of good for the 2018/19 annual assessment, which is an improved position for Mid Nottinghamshire CCGs.

HP highlighted that the first System Review Meeting is taking place on 16 August. Organisational Performance Review Meetings have been stood down as part of this. Joint assurance meetings with NHSI/E are being established and have commenced with financial assurance meetings for Mid Nottinghamshire and Greater Nottingham.

EM queried the absence of data from the City Council. HP advised that this is due to a timing issue and the finance teams are currently working together to address this.

Board agreed that benchmarking should be included in the performance report, and that the governance review should consider requirements in the MOU and reporting formats used in other ICSs.

**ACTIONS:**
**HP** to liaise with Sarah Bray to ensure that future performance reports include benchmarking data for key metrics.

## 12. Flexible Transformation Fund Plans

HP presented the circulated paper on Flexible Transformation Fund Plans following the discussion at the 22 July meeting.

JT queried the Clinical Services Strategy request for funding in 19/20 and 20/21. HP confirmed that the funding relates to 19/20 only and therefore the decision was for 19/20 at this stage. Future transformation funding has now been incorporated in to the 5 year planning process and the request for 20/21 would be considered as part of that process.

Board approved the system wide proposals for Flexible Transformation Funding.

### 13. Revised ICS Board Assurance Framework and Risk Register

EIM presented the circulated paper on the Board Assurance Framework and risk register. Following discussion of earlier items, EIM proposed that the Board Assurance Framework be considered as part of the proposed governance review.

Board agreed the proposed categories in the Board Assurance Framework and that the risks identified in the report are not impacted by discussions today. EIM highlighted that there are high scoring risks which have not been considered at this meeting, which will need to form part of the governance review.

RS highlighted the potential duplication with CCG risk registers and JT asked for the CCG and ICS risk registered to be compared and consolidated as appropriate.

Work underway to develop risk registers for workforce and health inequalities.

**ACTIONS:**
**EIM** to develop the Board Assurance Framework in line with the discussion at the Board.

### 14. Governance Matters for Approval:

DP presented the circulated paper outlining three issues for approval:

- Approach to Conflicts of Interest
- Finance Group TOR
- Membership

Board approved the approach to Conflicts of Interest and the Terms of Reference for the Finance Group.

EM highlighted the importance of the governance review in determining this longer term and that representation for workforce may be better suited to an executive level group.

Board did not agree recommendation 3 to amend the membership of the ICS Board to include the 'system SRO for Workforce'. Board did agree that membership should include CityCare Chief Officer as a significant provider within the system.

**ACTIONS:**
**DP** to secure membership of CityCare for the ICS Board.

## 15. Any other business

None

**Time and place of next meeting:**
**12 September 2019**
**9am – 12pm**
**Rufford Suite, County Hall**

Integrated Care System
Nottingham & Nottinghamshire

Nottingham City Council | Nottinghamshire County Council | NHS

## ICS Board Action Log (September 2019)

**Item 3. Enc. A2**

| ID | Action | Action owner | Date Added | Deadline | Action update |
|---|---|---|---|---|---|
| B195 | To raise the cancer target timescales in the ICS MOU with colleagues in NHSE/I | Wendy Saviour | 8 August 2019 | 16 August 2019 | ICS MOU discussed at the System Review Meeting on 16 August. A revised MOU is being agreed with NHSE/I. |
| B175 | To identify necessary leads from the respective Local Authorities to support health and social care integration for End of Life care | Jonathan Gribbin/Colin Monckton | 12 July 2019 | 31 August 2019 | Representatives for Nottinghamshire County Council identified to support this work. |
| B176 | Re: ICS Outcomes Framework, TD to discuss the proposed workforce metrics with workforce leads. | Tom Diamond | 12 July 2019 | 31 August 2019 | There are ongoing conversations with the ICS People and Culture workstream leads on the proposed workforce metrics. In the last two weeks through the Long Term Plan (LTP) process, a set of LTP 'headline' metrics have been reduced that all systems are expected to deliver against, there are several that relate to workforce. The ICS Outcomes Framework and Performance Report is to be reviewed against these headline metric to ensure alignment. This will include making sure the workforce metrics used by the system align to national expectations and are measurable. |
| B174 | To ensure that EMAS progress actions to embed an automated solution to accessing end of life care plans and the roll out of the ReSPECT Tool. | Richard Henderson | 12 July 2019 | 30 September 2019 | |

| ID | Action | Action owner | Date Added | Deadline | Action update |
|---|---|---|---|---|---|
| B178 | To lead on the development of a clear mandate from the Board on the analytical work to draw upon the progress already made, to determine whether external facilitation from a partner ICS/STP was needed, and ensure that individuals of appropriate seniority are involved from each partner organisation. | Andy Haynes | 12 July 2019 | 30 September 2019 | |
| B180 | To lead a piece of work with all system partners to:<br>1. ascertain the impact of actions in place to improve cancer performance and identify further actions to improve and maintain 62 day performance in year.<br>2. model activity and actions over 5 years as cancer is a key part of the Five Year Plan. | Richard Mitchell | 12 July 2019 | 30 September 2019 | |
| B187 | To ensure that workstream reporting to the Board is in place. | Deborah Jaines | 8 August 2019 | 30 September 2019 | Review of the Board workplan shows majority of current workstreams have report to the ICS Board during 2019. Actions underway to confirm forward work plan. |
| B191 | All organisations to confirm approval mechanisms for the Long Term Plan to ensure approval of the plan prior to 13 November | All | 8 August 2019 | 30 September 2019 | Organisations to confirm their approval mechanisms by 30 September |
| B194 | To confirm that their organisation / ICP endorses the ICS MOU and confirm how they will contribute to the delivery of priorities | Organisation Leads and ICP Leads | 8 August 2019 | 30 September 2019 | Organisations and ICP Boards to confirm to the ICS Board that they will contribute to the delivery of the ICS MOU in 2019/20 through submitting a brief statement of commitment. |

| ID | Action | Action owner | Date Added | Deadline | Action update |
|---|---|---|---|---|---|
| | | | | | |
| B189 | To prepare a report on Five Year Plan for the 6 November ICS Board meeting. | Helen Pledger/Tom Diamond | 8 August 2019 | 6 November 2019 | |
| B179 | AS to lead conversations on the alignment of resources during Autumn reporting back to the October ICS Board for a wider discussion | Amanda Sullivan | 12 July 2019 | 9 October 2019 | |
| B193 | To update the Board on progress with the AHSN Innovation Exchange | Andy Haynes | 8 August 2019 | 31 October 2019 | |
| B198 | To liaise with Sarah Bray to ensure that future performance reports include benchmarking data for key metrics | Helen Pledger | 8 August 2019 | 31 October 2019 | |
| B199 | To develop the Board Assurance Framework in line with the discussion at the Board | Elaine Moss | 8 August 2019 | 31 October 2019 | |
| B200 | To secure membership of CityCare for the ICS Board | David Pearson | 8 August 2019 | 31 October 2019 | |
| B197 | To ensure that ICPs, Clinical Leads and Commissioners work together to develop a business case for Nottinghamshire to test a new model for EMAS. RH to provide a report on progress to the Board at a future meeting | Richard Henderson | 8 August 2019 | 31 December 2019 | |

| ID | Action | Action owner | Date Added | Deadline | Action update |
|---|---|---|---|---|---|
| B188 | To lead the development of a governance review for the ICS. | David Pearson | 8 August 2019 | 31 December 2019 | Work underway to define the scope of a governance review. ICS Board members to shape scope via correspondence. Proposal for consideration by Board to be shared by end of September, completion anticipated to be end of December 2019. |

ENC. B1

| | |
|---|---|
| **Meeting:** | ICS Board |
| **Report Title:** | Single MSK Model - Patient Story |
| **Date of meeting:** | 12 September 2019 |
| **Agenda Item Number:** | 4 |
| **Work-stream SRO:** | |
| **Report Author:** | Steven Smith – Head of Planned Care, Greater Nottingham CCGs |
| **Attachments/Appendices:** | Appendix 1 – Single MSK Model Diagram |

**Report Summary:**

**Scope and background of single MSK Model**

- It was proposed that there should be a single MSK model across the ICS to deliver integration across pathways/specialties leading to improved clinical outcomes, improved patient experience, and reduced duplication. It is anticipated that this would reduce clinical variation and ultimately reduce the overall spend on MSK related specialties.
- Within scope of the single MSK model are the following six specialties:

| | | | | | |
|---|---|---|---|---|---|
| Elective orthopaedics | Pain management | Spinal surgery | Rheumatology | Sports and exercise medicine | Podiatry (surgical/ MSK) |

- The single MSK model covers a standardised approach to MSK in Primary Care, community MSK services and the onward referrals made into secondary care.

**Action:**

☒ To receive
☐ To approve the recommendations

**Recommendations:**

**Key implications considered in the report:**

| | | |
|---|---|---|
| Financial | ☐ | |
| Value for Money | ☐ | |
| Risk | ☐ | |
| Legal | ☐ | |
| Workforce | ☐ | |
| Citizen engagement | ☐ | |
| Clinical engagement | ☐ | |
| Equality impact assessment | ☐ | |

**Engagement to date:**

| Board | Partnership Forum | Finance Directors Group | Planning Group | Workstream Network |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |
| Performance Oversight Group | Clinical Reference Group | Mid Nottingham-shire ICP | Nottingham City ICP | South Nottingham-shire ICP |
| ☐ | ☐ | ☐ | ☐ | ☐ |

| **Contribution to delivering the ICS high level ambitions of:** | |
|---|---|
| Health and Wellbeing | ☐ |
| Care and Quality | ☐ |
| Finance and Efficiency | ☐ |
| Culture | ☐ |

**Is the paper confidential?**

☐ Yes
☐ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

# SINGLE MSK MODEL - PATIENT STORY

## 12 SEPTEMBER 2019

## Development of single MSK model

1. The model was developed with clinical leads for MSK (Dr Hugh Porter and Dr James Hopkinson). The model takes into consideration:

   - The clinical benefits delivered by integrating associated specialties into a single model.
   - Learning from the delivery of MSK services across the ICS
   - Integration with other Greater Nottingham initiatives and strategies – e.g. F12, Health Improvement in the Surgical Pathway, Referral Support Service – which support the delivery of consistent, evidence based care.
   - Implementation of the key interventions identified within the NHS England document - *Transforming musculoskeletal and orthopaedic elective care services.*
   - Patient engagement

2. The model has been agreed by:

   - Greater Nottingham Clinical Commissioning Executive – August 2018
   - Mid Nottinghamshire Clinical Cabinet – September 2018
   - Nottinghamshire Clinical Reference Group – October 2018

3. The model is shown in the appendix below.

## Patient engagement

4. An engagement plan was agreed with the Communications and Engagement team to gain feedback on the model that has been developed, and also to gain feedback on existing MSK services.
5. Actions included completion of an EQIA, reviewing existing feedback and completion of a patient survey.
6. The patient survey was distributed through Greater Nottingham CCGs networks and links with patients and members of the public. The survey ran from 22nd October – 18th November 2018. There were 207 responses. Key themes were:

| Summary of responses – MSK Patient Survey (207 responses) | |
|---|---|
| **Positive** | **Negative** |
| **Current provision:** | • 18% of people were not happy with how long it was taken to be seen. |

| | |
|---|---|
| • 88% of respondents would recommend the service/s to others.<br>• 89% of respondents felt like they were directed to the correct service, first time.<br><br>**Future model:**<br>• 91% would access self-care information around MSK problems if it was available<br>- 57% felt that support with lifestyle changes were/would be the most valuable.<br>• 87% would be happy to see a physiotherapist rather than a GP for MSK related issues.<br>• 90% felt the new service model would reduce time and duplication.<br>• 93% felt that the new service model would reduce the 'post code lottery' across Greater Nottingham. | • Within the additional comments, there were multiple responses around:<br>- The 2 session cap on community physiotherapy that exists within Rushcliffe CCG (n=3).<br>- The time taken to access treatment, either through referral processes or administrative processes within the community<br>- More could be done to make the MSK services easily accessible for patients, for example self-referral (n=10). |

## Service developments required in Greater Nottingham

7. Following a review of the existing community MSK services within Greater Nottingham and taken into consideration the engagement responses, the service developments identified to deliver improvements and alignment are:

| Review and alignment of administrative processes | Alignment of the service offer across Greater Nottingham | Service developments required across Greater Nottingham |
|---|---|---|
| 1. Improve primary care adherence to MSK Pathways<br>2. Standardised Referral Forms<br>3. Movement to GP direct referrals into MSK services (avoiding referral support service). | 1. Introduction of conservative management of spines in Rushcliffe CCG<br>2. Access to diagnostics for City CCG MOSIAC service | 1. Introduction of a single MSK triage hub<br>2. Development of Rheumatology triage and treatment within community services<br>3. Implementation of shared decision making within |

| | | |
|---|---|---|
| 4. Implementation of Blueteq within MSK pathway<br>5. Ensure inclusion of Referral Support Service for onward referrals to secondary care only.<br>6. Dashboard to monitor adherence to pathways (primary care), performance of community MSK providers, and secondary care activity. | 3. Formalised integration between community MSK and community pain services in county CCGs.<br>4. Removal of 2 session cap in Rushcliffe CCG | community MSK services<br>4. Review of First Contact Practitioners vs self-referral model<br>5. Review of conservative management offer across Greater Nottingham. |

8. The single MSK model has been agreed across Nottinghamshire, therefore it is expected that the Mid-Nottinghamshire team are also reviewing the current service provision against the agreed model, and developing an action plan to ensure roll-out.

## Progress to date

9. Within Greater Nottingham, the above has been formalised into an action plan to begin delivering the service developments. Achievements to date include:

- Implementation of standardised referrals form
- Greater Nottingham MSK Dashboard to monitor, inform and improve performance
- Removal of 2 session cap on physiotherapy in Rushcliffe CCG.
- Introduction of a monthly Greater Nottingham MSK group meeting (commenced in May 2019).
- Implementation of shared decision making within community MSK services
- Review of conservative management offer across Greater Nottingham

## Patient Story

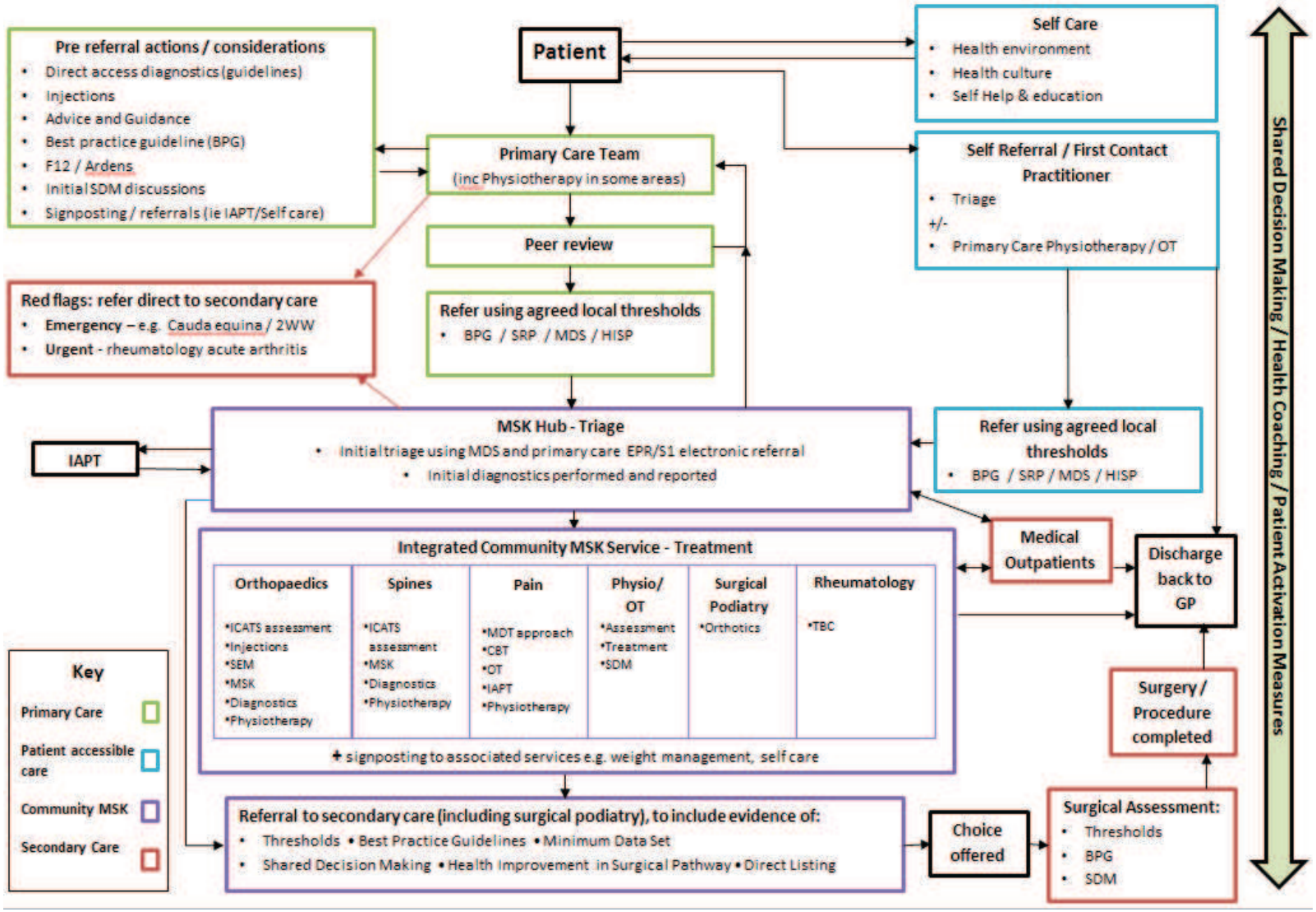
10. Connect Health are the Community MSK provider in Nottingham North East CCG and Nottingham West CCG and have been the provider of this service since April 2016. Connect Health are continually improving their service offer for the benefit of patients and the local healthcare system. Their innovative approach has helped inform the single MSK model.

11. The patient story aims to capture the excellent service that Connect health deliver to patients locally, but also shows how the service developments above have been implemented to improve patient care.

12. Whilst the main intention is to demonstrate the positive patient experiences, the aim is to also highlight the proactive approach to service improvement across a broad specialty, and how commissioners and providers are working collaboratively to deliver this vision.

**Steven Smith**
**Head of Planned Care, Greater Nottingham CCGs**
steven.smith6@nhs.net

## Appendix 1 – Single MSK Model



ENC. C

| | |
|---|---|
| **Meeting:** | ICS Board |
| **Report Title:** | The Nottingham and Nottinghamshire ICS System Level Outcomes Framework – Developing the 'Golden Thread' |
| **Date of meeting:** | Thursday 12 September 2019 |
| **Agenda Item Number:** | 5 |
| **Work-stream SRO:** | Wendy Saviour |
| **Report Author:** | Tom Diamond |
| **Attachments/Appendices:** | Annex A – Alcohol related admissions indicators and measures<br>Annex B – Smoking prevalence indicators and measures |

**Report Summary:**

**Background**

At the July ICS Board a first version of the ICS System Outcomes Framework reporting prototype was presented and reviewed. This prompted a discussion on how agreed system level outcomes drive action, particularly those that could have a considerable lag before any change in the associated indicator is seen. This concluded in agreement that by aligning key process and output measures at PCN and ICP levels with system indicators a 'golden thread' could be established through PCNs > ICPs > ICS to deliver the system level outcomes.

To take this work forward the ICS Board suggested two or three system outcome indicators should be selected and the key process and output measures that aligned to them defined, together with an assessment of how they are currently being used, if it all, across the system to drive action.

**System Outcome Indicators: Alcohol and Smoking**

The System Outcomes Task and Finish Group chose two system level indicators to focus this work on; Alcohol Related Admissions and Smoking Prevalence. The work in each of these areas to define the key process and outcome measures that align to the relevant system indicators has been led by Consultants in Public Health, drawing on best practice where possible.

For the system level indicators relating to Alcohol and Smoking an initial set of process and output measures has been defined at ICP and PCN level that could provide a focus for quality improvement activities, be aligned to and included in service and provider contracts and give confidence to improvement in the system level outcomes indicators.

Identifying an initial set of process and output measures that align to the system level indicators for Alcohol and Smoking and could drive action is a positive first step however the work has not progressed as far as anticipated in the following areas:

- Establishing/quantifying a baseline for the identified process and output measures and quantifying potential targets.
- Engaging with ICPs and PCNs on the indicators and measures and agreeing how this approach can be embedding and operationalised.
- Assessing to what extent the measures are included in current service and provider specifications and contracts (or reported elsewhere) and options for how this could be strengthened.

**Challenges faced**

Several challenges have been faced in completing this work, some of which have resolved and some of which have not:

- Short term: A change in Programme Lead combined with the summer holiday period has impacted on the pace of progress. These have now resolved.
- Medium term: The requirements on systems in relation to the Long Term Plan (LTP) and submission/publication of local plans towards the end of November is ever growing and consuming a significant amount of capacity. These demands will not change over the next three months and the LTP area of work will need to remain a priority.
- Long term: Analytical capacity continues to be an ongoing challenge to support this work (and other key areas of work). There is no plan currently in place to address this.

| **Action:** | |
|---|---|
| ☒ To receive<br>☒ To approve the recommendations | |
| **Recommendations:** | |
| 1. | The ICS Board is asked to NOTE the progress to date to further refine and develop the System Level Outcomes Framework and establish a 'golden thread' through the system. |
| 2. | The ICS Board is asked to NOTE the proposed next steps to further develop and embed the System Level Outcomes Framework at ICS, ICP and PCN level. |
| 3. | The ICS Board is asked to NOTE the challenges faced in progressing this work over the coming months, in particular the draw on capacity of the Long Term Plan requirements and available analytical capacity to support. |

| **Key implications considered in the report:** | | |
|---|---|---|
| Financial | ☐ | *The system outcomes framework will reflect all of these areas* |
| Value for Money | ☐ | |
| Risk | ☐ | |
| Legal | ☐ | |
| Workforce | ☐ | |
| Citizen engagement | ☐ | |
| Clinical engagement | ☐ | |
| Equality impact assessment | ☐ | |

| Engagement to date: | | | | |
|---|---|---|---|---|
| Board | Partnership Forum | Finance Directors Group | Planning Group | Workstream Network |
| ☒ | ☒ | ☒ | ☒ | ☒ |
| Performance Oversight Group | Clinical Reference Group | Mid Nottingham-shire ICP | Nottingham City ICP | South Nottingham-shire ICP |
| ☐ | ☐ | ☒ | ☐ | ☐ |

| Contribution to delivering the ICS high level ambitions of: | |
|---|---|
| Health and Wellbeing | ☒ |
| Care and Quality | ☒ |
| Finance and Efficiency | ☒ |
| Culture | ☒ |

**Is the paper confidential?**

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

Integrated Care System
Nottingham & Nottinghamshire

Nottingham City Council | Nottinghamshire County Council | NHS

# THE NOTTINGHAM AND NOTTINGHAMSHIRE SYSTEM LEVEL OUTCOMES FRAMEWORK

**12 SEPTEMBER 2019**

## Background

1. In April 2019 the ICS Board agreed updated ambitions and outcomes proposed for the ICS System Level Outcomes Framework and agreed to receive a prototype for reporting delivery against the outcomes in the Framework.

1. In July 2019 the ICS Board received a prototype for reporting delivery against the ICS System Level Outcomes Framework. Its development continued to be in accordance with the agreed principles and Board agreement to 'learn by doing'.

2. The best available information, resource and analytical capacity was drawn upon from health and care teams to establish the prototype for reporting delivery of the outcomes, operating within the agreed governance structure.

3. In the paper received by the Board in July several key considerations were posed to the Board following development of the reporting prototype:
   a. How much time should the Board dedicate to the Outcomes Framework when each domain reports monthly?
   b. Does the reporting prototype give sufficient information to inform discussions at the Board, track progress and drive actions?
   c. How do Board members want to engage with understanding the methodology used to develop the draft system aspirations for all measures at years 1, 3 and 5 and set the level of aspiration across the system?

4. The paper also set out the following next steps for further develop the prototype:
   a. Agree the analytical capacity and approach to move from a prototype to a routine Outcomes Framework report
   b. Report the Health and Wellbeing domain of the Outcomes Framework to September ICS Board
   c. Establish governance mechanisms to determine the level of aspiration and subsequent pace at which it can be realistically achieved
   d. Further refine the measures following their initial assessment to enable reporting on all measures – acknowledging that some measures will need to develop over time as current data availability may be limited or unavailable
   e. In the longer term, ensure ability for different system and organizational levels to interpret variations in outcomes locally.

5. The review of the System Level Outcomes Framework reporting prototype by the Board prompted a discussion on how the agreed system level outcomes drive action, particularly for those that could have a considerable lag time before any change in the relevant indicator is seen.

6. The ICS Board discussed the difference between indicators and measures, describing the former as operating on a whole system level and the latter as process and output measures operating on an ICP and PCN basis. Concluding that by linking measures with indicators a 'golden thread' could be established through the system: PCNs > ICPs > ICS.

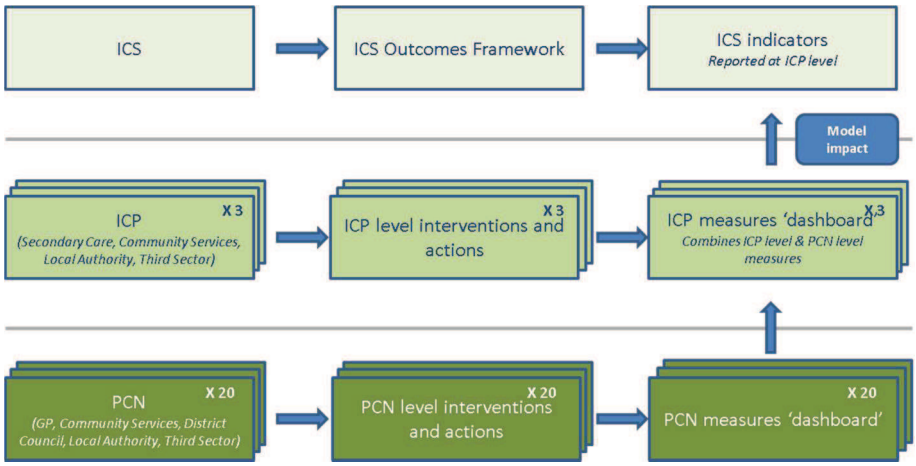
7. At the July ICS Board meeting it was agreed to continue to progress the development and further embed the ICS System Level Outcomes Framework across all parts of the system by focussing on two or three of the System Level Outcomes Framework indicators to:
   a. Identify a set of process and output measures that align to the chosen system level indicators and drive action
   b. Establish / quantify a baseline for the process and output measures and quantify potential targets
   c. Engage with ICPs and PCNs on the measures and agree how this approach can be embedding and operationalised
   d. Assess to what extent the measures are included in current service and provider specifications and contracts (or reported elsewhere) and options for how this could be strengthened.

## System Outcome Indicators: Alcohol and Smoking

8. Following the ICS Board meeting the ICS System Outcomes Task and Finish Group met to review the next steps ask of the Board and agreed to focus the next stages of work on the 'Reduction in illness and disease prevalence' System Level Outcome and the associated indicators for:
   a. Admission episodes for alcohol-related conditions (rate per 100,000 population); and
   b. Smoking prevalence in adults (18+)

9. To support the work to be completed and in line with the discussions at the ICS Board a 'golden thread' schematic was developed to frame the work and articulate the relationship between PCN and ICP measures and system level indicators.

***ICS System Outcomes Indicators 'golden Thread'***



10. Work has progressed in both areas (Alcohol and Smoking), however due to a number of challenges the work has not progressed as far as anticipated:
    a. A change in Programme Lead combined with the summer holiday period has impacted on the pace of progress. These have now resolved.
    b. The requirements on systems in relation to the Long Term Plan and submission/publication of local plans towards the end of November is ever growing and consuming a significant amount of capacity. These demands will not change over the next three months and the LTP area of work will need to be a priority.
    c. Analytical capacity continues to be an ongoing challenge to support this work (and other key areas of work). There is no plan currently in place to address this.

**Admission episodes for alcohol-related conditions**

11. Consultants in Public Health from the County Council and City Council working with the Programme Lead for the ICS Prevention workstream led the work in this area.

12. Seven process and output measures have been identified at an ICP level and two measures at a PCN level (with overlap between them). These are set out below.

| | |
|---|---|
| **Ambition** | Our people and families are resilient and have good health and wellbeing |
| **Outcome** | Reduction in illness and disease prevalence |
| **Measure** | Admission episodes for alcohol-related conditions |

| **ICS – System** | **ICP – Place** | **PCN – Neighbourhood** |
|---|---|---|
| **Indicator**<br>• Admission episodes for alcohol-related conditions (narrow measure)<br>*Cut at ICP and PCN level where appropriate*<br>• *Alcohol-related mortality**<br>• *Alcohol-specific mortality**<br>**Not currently included in System Level Outcomes Framework* | **Measure**<br>• Proportion/number of affected people (appropriately) referred to specialist services and proportion/number of people completing support from specialist services *(definition of success required)*<br>• Proportion/number of affected people (appropriately) referred to alcohol support programmes and proportion/number completing alcohol support programmes<br>• Proportion/number of staff trained in Alcohol Identification and Brief Advice (IBA)<br>• Proportion/number of (appropriate) people given intervention advice<br>• Attendance at Emergency Dept for High Volume Service Users (alcohol related)<br>• Claimants of benefits due to alcoholism<br>• Qualitative – comms campaigns (links into HWB) focused on areas with high prevalence | **Measure**<br>• Proportion/number of affected people (appropriately) referred to alcohol support programmes and proportion/number completing alcohol support programmes<br>• Proportion/number of (appropriate) people given intervention advice (greatest focus on high need areas) |

See Appendix One for more detail on the actions to support and challenges/considerations faced.

**Smoking prevalence in adults**

13. Once again Consultants in Public Health from the County Council and City Council working with the Programme Lead for the ICS Prevention workstream led the work in this area. Seven process and output measures have been identified at an ICP level and five measures at a PCN level (with overlap between them). These are set out below.

| | |
|---|---|
| **Ambition** | Our people and families are resilient and have good health and wellbeing |
| **Outcome** | Reduction in illness and disease prevalence |
| **Measure** | Smoking prevalence in adults (18+) |

| ICS – System | ICP – Place | PCN – Neighbourhood |
|---|---|---|
| **Indicator**<br>• Smoking prevalence in adults (18+)<br>*Cut at ICP and PCN level where appropriate* | **Measure**<br>• Proportion/number of smokers referred to smoking cessation services and proportion/number of smokers completing smoking cessation programme that have successfully quit at 4 weeks<br>• Proportion/number of patients with smoking status recorded in secondary care<br>• Proportion/number of smokers who receive smoking cessation support in hospital/achieve temporary abstinence<br>• Mental health community services – rate/number of referrals to smoking cessation services<br>• Proportion/number of staff signed up to smoking staffing compact (front line staff to identify and signpost to smoking cessation services where relevant)<br>• Proportion/number of staff trained in Very Brief Advice (VBA)<br>• Qualitative – comms campaigns, tobacco declaration (links into HWB) focused on areas with high prevalence | **Measure**<br>• Proportion/number of smokers referred to a smoking cessation service and proportion/number of participants successfully completing smoking cessation programme that have successfully quit at 4 weeks<br>• Proportion/number of people who smoke referred to smoke cessation programme ahead of planned surgery<br>• Proportion/number of VBA delivered (greatest focus on high need areas)<br>• Proportion/number of pharmacotherapy prescriptions issued to smokers<br>• Proportion/number of smokers converting to e-cigarettes/vaping |

See Appendix Two for more detail on the actions to support and challenges/considerations faced and an initial analysis of smoking prevalence by ICP and PCN.

14. Across both areas further work is required to:
    a. Establish / quantify a baseline for the process and output measures and quantify potential targets; and identify where data is not readily available
    b. Engage with ICPs and PCNs on the measures, agreeing how this approach can be embedding and operationalised

c. Assess to what extent the measures are included in current service and provider specifications and contracts (or reported elsewhere) and options for how this could be strengthened.

## Next Steps

15. In line with discussions at the July ICS Board and work completed to date the proposed next steps are set out below.

### 16. System Level Indicators

a. Baseline the system level indicators (cut on an ICP and PCN basis as appropriate) on a population health segment basis (the segmentation agreed by the ICS Board is Healthy, Maternal and Child Health, Disability, LTCs and End of Life) and on outcomes specific features such as age, gender and deprivation – to continue to move towards a health and care system underpinned by a population health management approach a segmentation view of system indicators is required.
b. Establish an approach and governance mechanism to establish forecast improvement trajectories for system indicators.
c. Establish a reporting mechanism and approach for system level indicators and identify what it would take for data to be reported on a 'near-time' basis.
d. Ongoing engagement with ICP leads on the System Level Outcomes Framework to ensure alignment and ongoing adoption into operations.

17. **ICP and PCN Measures**

a. Engage with ICP leads on proposed indicators and measures, including approach and governance mechanisms to establish forecast improvement trajectories, and approach ICPs are adopting to engage with PCNs on this.
b. Discuss with ICP leads their plans and approach to analytics (baselining and reporting) to ensure work on ICP and PCN indicators and measures is owned and embedded.
c. Working with ICP and PCN leads establish / quantify baselines for the key process and output measures including:
    - Identifying what data is readily available on an ICP and PCN footprint to baseline measures on a whole population health segment basis (all segments) and assess feasibility of baselining on a population segment basis and other outcome specific features.
    - Where data is not readily available identify how will it be obtained and what is the timeline for doing so.
    - Identifying what it would take for data to be reported on a 'near-time' basis.
d. Engage with contract leads to identify provider and service contracts that currently contain the identified process and output measures (or similar) and identify options for further strengthening contracts to align to and deliver system level outcomes.

18. Over the past couple of months there has also been a number of developments at a national level that could have a bearing on the ICS's System Level Outcomes Framework:
    a. A set of metrics has been published that all systems are expected to include as part of their Long Term Plan submission; and

b. The national team working on ICS Outcomes and Performance measures have released their early thoughts on what this could look like.

19. Therefore, it is also proposed that the ICS's approach to its System Level Outcomes Framework is reviewed against these developments.

## Recommendations

20. The ICS Board is asked to:
    1. Note the progress to date to further refine and develop the System Level Outcomes Framework and establish a 'golden thread' through the system.
    2. Note the proposed next steps to further develop and embed the System Level Outcomes Framework at ICS, ICP and PCN level.
    3. Note the challenges faced in progressing this work over the coming months, in particular the draw on capacity of the Long Term Plan requirements and available analytical capacity to support.

## Appendix One – Alcohol related admissions Indicators and Measures

| | |
|---|---|
| **Ambition** | Our people and families are resilient and have good health and wellbeing |
| **Outcome** | Reduction in illness and disease prevalence |
| **Measure** | Admission episodes for alcohol-related conditions |

**What is the potential impact of the work on alcohol:**

- If the ICS had the same admission rate as England for alcohol related conditions (narrow definition), then up to 4,600 admissions would have a reduced acuity or length of stay. In total an equivalent of 630 admissions to hospital would be prevented, which have an indicative cost of £1.4m at 2019/20 National Tariff
- An additional 10,000 Alcohol Identification and Brief Advice sessions (IBA) each year would reduce the health burden attributable to alcohol by an average of 220 QALYs per year. This represents 6.9% of the health burden attributable to alcohol in the ICS population and 1.3% of the burden attributable to risk factors that contribute to Healthy Life Expectancy (HLE).

| | **ICS – System** | **ICP – Place** | **PCN – Neighbourhood** |
|---|---|---|---|
| **Indicators and measures** | **Indicator**<br>• Admission episodes for alcohol-related conditions (narrow measure)<br>*Cut at ICP and PCN level where appropriate*<br>• *Alcohol-related mortality**<br>• *Alcohol-specific mortality**<br>**Not currently included in System Level Outcomes Framework* | **Measure**<br>• Proportion/number of affected people (appropriately) referred to specialist services and proportion/number of people completing support from specialist services *(definition of success required)*<br>• Proportion/number of affected people (appropriately) referred to alcohol support programmes and proportion/number completing alcohol support programmes<br>• Proportion/number of staff trained in Alcohol Identification and Brief Advice (IBA)<br>• Proportion/number of (appropriate) people given intervention advice<br>• Attendance at Emergency Dept for High Volume Service Users (alcohol related)<br>• Claimants of benefits due to alcoholism<br>• Qualitative – comms campaigns (links into HWB) focused on areas with high prevalence | **Measure**<br>• Proportion/number of affected people (appropriately) referred to alcohol support programmes and proportion/number completing alcohol support programmes<br>• Proportion/number of (appropriate) people given intervention advice (greatest focus on high need areas) |
| **Actions / impactful interventions** | There is a well-established clinical and commissioning network across Nottingham and Nottinghamshire that is already working to identify ways in which services and organisations could work together to reduce alcohol related harm. The Nottinghamshire Alcohol Pathways Group have the ownership of delivering the actions required for the ICS's alcohol priority and have developed an 8-point action plan.<br><br>The Nottinghamshire Alcohol Harm Reduction Plan was approved by the ICS board in August 2018.<br><br>There is ongoing work through the Nottinghamshire Alcohol Pathways Group to develop outcome and process measures for the 8-point action plan, at all system levels. However, some possible actions are described below: | | |

<table>
<tr><td></td><td colspan="3">ICS Level<br>• All ICS partners agree strategic commitment to the Nottinghamshire Alcohol Pathways Group by providing a representative and hence ensure collective delivery across the eight themes of the Nottinghamshire Alcohol Harm Reduction Plan.<br>• The ICS's overall communications campaign for Prevention will seek to increase population level understanding of risk and harm from alcohol consumption.<br>• Annual participation in a communications campaign for National Alcohol Awareness week in November.<br><br>ICP Level<br>• Work is completed to identify priorities in relation to alcohol measures, notably health inequalities and local population, before then defining and implementing targeted action plans.<br>• Agreement to and plans defined for full implementation of Alcohol IBA, including data sharing.<br><br>PCN Level<br>• Implementation of a targeted approach to IBA relevant to PCN population cohorts and level of risk. Proactive management through PHM. Defining programme with local voluntary sector and support groups.<br>• Proactive case management of high-volume service users.</td></tr>
<tr><td>Considerations</td><td>• A baseline of current and historical measures is required<br>• As well as a baseline of the system level indicator at whole population level (all segments) a baseline of on a population health segment basis and on outcomes specific features such as age, gender and deprivation is required to determine the level of aspiration and subsequent pace at which it can be realistically achieved<br>• An approach and governance mechanism to establish forecast improvement trajectories is required<br>• A reporting mechanism is required together with an understanding of what it would take to be 'near-time'<br>• Engagement required with ICP and PCN leads to ensure work is not duplicate and discuss how the outputs fit in with their operations</td><td>• Engagement with ICPs required on proposed measures and their refinement<br>• Need to identify what data is readily available on an ICP footprint to baseline measures on a whole population health segment basis (all segments) and assess feasibility of baselining on a population segment basis and other outcome specific features.<br>• Where data is not readily available how will it be obtained and what is the timeline for doing so?<br>• An approach and governance mechanism to establish forecast improvement trajectories is required<br>• What analytical capacity is available to lead on analysis and reporting?<br>• What provider and service contracts currently contain these measures and how could they be strengthened further to align to and deliver system level outcomes?</td><td>• ICPs to lead on engagement with PCNs regarding measures and their refinement<br>• Need to identify what data is readily available on an PCN footprint to baseline measures on a whole population health segment basis (all segments) and assess feasibility of baselining on a population segment basis and other outcome specific features.<br>• Where data is not readily available how will it be obtained and what is the timeline for doing so?<br>• An approach and governance mechanism to establish forecast improvement trajectories is required<br>• What analytical capacity is available to lead on analysis and reporting?<br>• What provider and service contracts currently contain these measures and how could they be strengthened further to align to and deliver system level outcomes?</td></tr>
</table>

## Annex Two – Smoking prevelance Indicators and Measures

| | |
|---|---|
| **Ambition** | Our people and families are resilient and have good health and wellbeing |
| **Outcome** | Reduction in illness and disease prevalence |
| **Measure** | Smoking prevalence in adults (18+) |

**What is the potential impact of the work on smoking:**

- Across all providers in Nottingham and Nottinghamshire, in one year, approximately 8100 emergency and planned admissions are tobacco attributable. The ambition of reducing smoking prevalence by 2023 in Nottingham City to 14.8% and to 13.8% in Nottinghamshire County will impact on the current £54.1 million spent on smokers by the NHS in Nottingham City and Nottinghamshire County.

- Temporary abstinence can have an impact on the health burden attributable to tobacco. NICE scenarios have shown that temporary abstinence such as 'stop before your op' can be cost effective with savings ranging from an estimated £765 per QALY to £8,464 per QALY[1].

| | ICS – System | ICP – Place | PCN – Neighbourhood |
|---|---|---|---|
| **Indicators and measures** | **Indicator**<br>• Smoking prevalence in adults (18+)<br>*Cut at ICP and PCN level where appropriate* | **Measure**<br>• Proportion/number of smokers referred to smoking cessation services and proportion/number of smokers completing smoking cessation programme that have successfully quit at 4 weeks<br>• Proportion/number of patients with smoking status recorded in secondary care<br>• Proportion/number of smokers who receive smoking cessation support in hospital/achieve temporary abstinence<br>• Mental health community services – rate/number of referrals to smoking cessation services<br>• Proportion/number of staff signed up to smoking staffing compact (front line staff to identify and signpost to smoking cessation services where relevant)<br>• Proportion/number of staff trained in Very Brief Advice (VBA)<br>• Qualitative – comms campaigns, tobacco declaration (links into HWB) focused on areas with high prevalence | **Measure**<br>• Proportion/number of smokers referred to a smoking cessation service and proportion/number of participants successfully completing smoking cessation programme that have successfully quit at 4 weeks<br>• Proportion/number of people who smoke referred to smoke cessation programme ahead of planned surgery<br>• Proportion/number of VBA delivered (relevance to high and low need areas)<br>• Proportion/number of pharmacotherapy prescriptions issued to smokers<br>• Proportion/number of smokers converting to e-cigarettes/vaping |
| **Actions / impactful interventions** | Across the County and City there are well-established links across the NHS and Local Authority in the commissioning of smoking cessation services. Through the Health and Wellbeing Boards Local Authorities and NHS organisations signed up to the Tobacco Declaration. Nottinghamshire County and City Councils are carrying out a review against standards of good practice. A continued | | |

| | | | |
|---|---|---|---|
| | systematic, co-ordinated, proportionate approach with additional investment is required across the NHS aligning with Local Authorities.<br>Tackling tobacco harm requires a systematic and proportionate approach at all levels and some of the actions are described below:<br>**ICS Level**<br>• All ICS partners revisit the Tobacco declaration and supporting action plans (organisational level) – commitment to include as a priority including at an organisational level<br>• Review options for integrated commissioning of smoking cessation services<br>• The ICS overall communications campaign for Prevention will seek to promote smoking cessation and will include a targeted approach to children and young people and manual workers<br>• To establish relevant requirements for data sharing to improve the conversation with the patient and citizen on smoking cessation, linked to PHM<br><br>**ICP Level**<br>• Identify and agree highest risk areas and population cohorts in order to target smoking cessation activities including alignment across organisations (commit to actions to increase smoking cessation rates)<br>• ICPs to develop clear, aligned pathways for citizens and GP registered population to access smoking cessation in primary care, acute and mental health settings and community cessation services<br>• Promotion and implementation of employee health and wellbeing programmes<br><br>**PCN Level**<br>• Implementation of a targeted approach to Very Brief Advice relevant to their local knowledge about their PCN population and level of risk (aligning with ICS level priority groups) – supported by ICP aligned pathways and commissioning at the ICS level.<br>• Pro-active care by working with local community assets on opportunities to promote smoking cessation | | |
| **Considerations** | • A baseline of current and historical measures is required<br>• As well as a baseline of the system level indicator at whole population level (all segments) a baseline of on a population health segment basis and on outcomes specific features such as age, gender and deprivation is required to determine the level of aspiration and subsequent pace at which it can be realistically achieved<br>• An approach and governance mechanism to establish forecast improvement trajectories is required<br>• A reporting mechanism is required together with an understanding of what it would take to be 'near-time'<br>• Ongoing engagement on the System Level Outcomes Framework with ICP leads to discuss how the outputs fit in with their operations | • Engagement with ICPs required on proposed measures and their refinement<br>• Need to identify what data is readily available on an ICP footprint to baseline measures on a whole population health segment basis (all segments) and assess feasibility of baselining on a population segment basis and other outcome specific features.<br>• Where data is not readily available how will it be obtained and what is the timeline for doing so?<br>• An approach and governance mechanism to establish forecast improvement trajectories is required<br>• What analytical capacity is available to lead on analysis and reporting?<br>• What provider and service contracts currently contain these measures and how could they be strengthened further to align to and deliver system level outcomes? | • ICPs to lead on engagement with PCNs regarding measures and their refinement<br>• Need to identify what data is readily available on an PCN footprint to baseline measures on a whole population health segment basis (all segments) and assess feasibility of baselining on a population segment basis and other outcome specific features.<br>• Where data is not readily available how will it be obtained and what is the timeline for doing so?<br>• An approach and governance mechanism to establish forecast improvement trajectories is required<br>• What analytical capacity is available to lead on analysis and reporting?<br>• What provider and service contracts currently contain these measures and how could they be strengthened further to align to and deliver system level outcomes? |

**Registered Patients Aged 15 and over (15+) with smoking status recorded GP Systems (GPRCC) - August 2019**

**Public Health England Smoking Prevalence in Adults (18+) Current Smokers (2018)**

| | | | | | Number | | | | % | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ICP | CCG Code | PCN Code | PCN Name | PCN Neighbourhood | Previous Smoker | Current Smoker | Not recorded | Total Patients 15+ | Current Smoker (%) | Smoking Prevalence | Lower CI | Upper CI |
| **Mid Notts ICP** | **04E** | AN | **Ashfield North** | Ashfield North PCN | 10,772 | 8,431 | 1,900 | 42,585 | 19.8% | 16.6% | 11.0% | 22.2% |
| **Mid Notts ICP** | **04E** | AS | **Ashfield South** | Ashfield South PCN | 7,992 | 6,134 | 1,588 | 32,192 | 19.1% | 16.6% | 11.0% | 22.2% |
| **Mid Notts ICP** | **04E** | MN | **Mansfield North** | Mansfield North PCN | 11,969 | 9,570 | 2,617 | 48,419 | 19.8% | 23.1% | 15.7% | 30.4% |
| **Mid Notts ICP** | **04E** | MS | **Mansfield South** | Mansfield South PCN | 8,485 | 8,475 | 2,512 | 38,923 | 21.8% | 23.1% | 15.7% | 30.4% |
| **Mid Notts ICP** | **04H** | NK | **Newark** | Sherwood PCN | 16,651 | 10,092 | 4,066 | 64,143 | 15.7% | 16.5% | 9.0% | 24.0% |
| **Mid Notts ICP** | **04H** | SW | **Sherwood** | Newark PCN | 12,960 | 8,393 | 3,015 | 50,350 | 16.7% | 16.5% | 9.0% | 24.0% |
| **Mid Notts ICP Total** | | | | | **68,829** | **51,095** | **15,698** | **276,612** | **18.5%** | | | |
| **Nottingham City ICP** | **04K** | NC1 | **City PCN 1** | Bulwell and Top Valley PCN | 7,909 | 8,880 | 2,702 | 35,223 | 25.2% | 20.6% | 17.9% | 23.3% |
| **Nottingham City ICP** | **04K** | NC3 | **City PCN 3** | BACHS PCN | 9,109 | 11,239 | 4,140 | 46,463 | 24.2% | 20.6% | 17.9% | 23.3% |
| **Nottingham City ICP** | **04K** | NC4 | **City PCN 4** | Radford and Mary Potter PCN | 5,289 | 8,270 | 2,670 | 39,741 | 20.8% | 20.6% | 17.9% | 23.3% |
| **Nottingham City ICP** | **04K** | NC5 | **City PCN 5** | Bestwood and Sherwood PCN | 9,179 | 7,993 | 2,762 | 40,691 | 19.6% | 20.6% | 17.9% | 23.3% |
| **Nottingham City ICP** | **04K** | NC6 | **City PCN 6** | Nottingham City East PCN | 9,944 | 13,298 | 4,891 | 54,281 | 24.5% | 20.6% | 17.9% | 23.3% |
| **Nottingham City ICP** | **04K** | NC7 | **City PCN 7** | City South PCN | 5,776 | 4,129 | 1,832 | 30,235 | 13.7% | 20.6% | 17.9% | 23.3% |
| **Nottingham City ICP** | **04K** | NC8 | **City PCN 8** | Clifton and Meadows PCN | 5,787 | 6,036 | 1,932 | 25,520 | 23.7% | 20.6% | 17.9% | 23.3% |
| **Nottingham City ICP** | **04K** | NCU | **City PCN U** | University PCN | 3,582 | 4,023 | 1,405 | 46,121 | 8.7% | 20.6% | 17.9% | 23.3% |
| **Nottingham City ICP Total** | | | | | **56,575** | **63,868** | **22,334** | **318,275** | **20.1%** | | | |
| **South Notts ICP** | **04L** | NNE1 | **NNE PCN 1** | Hucknall PCN | 7,682 | 5,241 | 1,817 | 30,275 | 17.3% | 16.6% | 11.0% | 22.2% |
| **South Notts ICP** | **04L** | NNE2 | **NNE PCN 2** | Arnold and Calverton PCN | 7,602 | 3,981 | 2,083 | 28,042 | 14.2% | 15.2% | 8.2% | 22.2% |
| **South Notts ICP** | **04L** | NNE3 | **NNE PCN 3** | Carlton and Villages PCN | 8,555 | 4,995 | 1,793 | 34,805 | 14.4% | 15.2% | 8.2% | 22.2% |
| **South Notts ICP** | **04L** | NNE4 | **NNE PCN 4** | Nottingham North and East 4 PCN | 6,345 | 4,294 | 1,294 | 24,397 | 17.6% | 15.2% | 8.2% | 22.2% |
| **South Notts ICP** | **04M** | NW2 | **Nottingham West** | Eastwood and Kimberley Neighbourhood | 9,072 | 4,580 | 1,341 | 31,506 | 14.5% | 13.4% | 7.2% | 19.7% |
| **South Notts ICP** | **04M** | NW1 | **Nottingham West** | Beeston Neighbourhood | 8,120 | 5,365 | 2,261 | 39,643 | 13.5% | 13.4% | 7.2% | 19.7% |
| **South Notts ICP** | **04M** | NW3 | **Nottingham West** | Stapleford Neighbourhood | 4,832 | 2,972 | 978 | 17,799 | 16.7% | 13.4% | 7.2% | 19.7% |
| **South Notts ICP** | **04N** | RU1 | **Rushcliffe** | Central Neighbourhood | 8,882 | 3,421 | 2,802 | 39,621 | 8.6% | 3.6% | 0.8% | 6.4% |
| **South Notts ICP** | **04N** | RU2 | **Rushcliffe** | North Neighbourhood | 8,956 | 3,924 | 1,499 | 33,224 | 11.8% | 3.6% | 0.8% | 6.4% |
| **South Notts ICP** | **04N** | RU3 | **Rushcliffe** | South Neighbourhood | 8,578 | 3,434 | 1,950 | 34,497 | 10.0% | 3.6% | 0.8% | 6.4% |
| **South Notts ICP Total** | | | | | **78,624** | **42,207** | **17,818** | **313,809** | **13.4%** | | | |
| **Total ICS** | | | | | **204,028** | **157,170** | **55,850** | **908,696** | **17.3%** | | | |

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| | |
|---|---|
| **Meeting:** | ICS Board |
| **Report Title:** | 2019/24 Five Year System Plan |
| **Date of meeting:** | Thursday 12 September 2019 |
| **Agenda Item Number:** | 6 |
| **Work-stream SRO:** | Wendy Saviour |
| **Report Author:** | Tom Diamond/Helen Pledger |
| **Attachments/Appendices:** | Appendix One – 2019/24 Five Year System Plan Approach High Level Timeline |

**Report Summary:**

This report updates the ICS Board on the approach to developing and approving the 2019/24 five-year system plan.

**System Planning Approach:**

A system planning approach is in place to move towards a bottom up single system plan with a clearly articulated 'do nothing' position and 'do something' plan. The planning approach has been discussed with the ICS Planning Group, the ICS Finance Directors Group and the ICS Board during a number of Board development sessions.

The ICS Planning Group continues to meet fortnightly to provide oversight and support for the development of the plan. A first draft of the case for change and system sustainability model have been completed and eight workshops with care areas have taken place to support development of the first draft of the 'do something' plans.

The existing planning governance structure put in place to escalate and address issues for the 19/20 Operational Plan will be used for the development of the 5 year plan (Organisations -> ICP Planning Group -> ICS Planning Group -> ICS Board).

**Long Term Plan, Guidance and Supporting Information:**

The system has received:

- The Long Term Plan Implementation Framework
- CCG allocations
- The main technical supporting guidance
- An early draft of the system metrics definitions and returns

However, the template for the supporting technical return is yet to be issued. The system is also awaiting further information from the regional team on funding, the future financial framework and confirmation of specific requirements for performance trajectories.

**2020/21 Commissioning Intentions:**

The system has requested confirmation of what is required for 2020/21 commissioning intentions, recognising the move towards system planning and is awaiting a response. An update will be provided at the ICS board meeting.

**Issues (section 3)**

There are three issues identified in the approach update, along with the actions being taken to address these.

| **Action:** | |
|---|---|
| ☒ To receive<br>☒ To approve the recommendations | |
| **Recommendations:** | |
| 1. | The ICS Board is asked to continue to NOTE the challenging timeframe within which the ICS's five year plan is to be developed, particularly given guidance continues to be released and the exact ask of systems is not clear yet. |
| 2. | The ICS Board is asked to continue to NOTE that in light of this uncertainty a phased process to developing the plan is being adopted to put the necessary building blocks in place whilst enabling a fluid and reactive response as specific planning requirements are confirmed. |
| 3. | The ICS Board is asked to continue to NOTE that a balance will need to be struck between ensuring the necessary building blocks are in place and stakeholder engagement at the right time in the process. |
| 4. | The ICS Board is asked to NOTE the need for ongoing engagement on the development of the five-year system plan through ICS Board development sessions and the ICS Planning group, and that statutory organisations' Boards are kept fully engaged in the lead up to the final submission. |
| 5. | The ICS Board is asked to NOTE that ensuring the right individuals from constituent organisations who can act as the conduit to ICPs and constituent PCNs is key to ensuring the plan is owned across the ICS. A lead has been identified for Mid Nottinghamshire ICP, awaiting confirmation for South Nottinghamshire and City ICPs. |
| 6. | The ICS Board is asked to NOTE that an extraordinary ICS Board meeting is scheduled for the 14 November to endorse the five year system plan, following approval of the individual statutory organisations that constituent the ICS (as agreed at the August ICS Board). |

| **Key implications considered in the report:** | | |
|---|---|---|
| Financial | ☒ | |
| Value for Money | ☒ | |
| Risk | ☒ | |
| Legal | ☐ | |
| Workforce | ☒ | |
| Citizen engagement | ☐ | |

| | | |
|---|---|---|
| Clinical engagement | ☐ | |
| Equality impact assessment | ☐ | |

**Engagement to date:**

| Board | Partnership Forum | Finance Directors Group | Planning Group | Financial Sustainability Group |
|---|---|---|---|---|
| ☒ | ☐ | ☒ | ☒ | ☐ |
| Performance Oversight Group | Clinical Reference Group | Mid Nottingham-shire ICP | Nottingham City ICP | South Nottingham-shire ICP |
| ☐ | ☐ | ☐ | ☐ | ☐ |

| **Contribution to delivering the ICS high level ambitions of:** | |
|---|---|
| Health and Wellbeing | ☒ |
| Care and Quality | ☒ |
| Finance and Efficiency | ☒ |
| Culture | ☒ |

**Is the paper confidential?**

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

Integrated Care System
Nottingham & Nottinghamshire

Nottingham City Council | Nottinghamshire County Council | NHS

# SYSTEM PLAN 2019/24 – APPROACH UPDATE

## SEPTEMBER 2019

## Introduction

1. In January 2019 the NHS published the Long Term Plan (LTP), which sets out a 10-year practical programme of phased improvements to NHS services and outcomes, and provides a framework for local planning for the next five years and beyond.

2. This was followed by the publication of the NHS Long Term Plan Implementation Framework in June 2019 that set out the approach Sustainability and Transformation Partnerships (STPs)/Integrated Care Systems (ICSs) are to take to create their five-year strategic plans by November 2019, covering the period 2019/20 to 2023/24.

3. These plans should be based on realistic workforce assumptions and deliver all the commitments within the Long Term Plan.

4. Some of the commitments in the LTP are described as critical foundations to wider change. The expectation is all systems must deliver on these foundational commitments in line with nationally defined timetables or trajectories, including the Government's five financial tests.

5. Systems have greater flexibility to prioritise and define the pace for the remainder of the commitments in the LTP, but will need to ensure the end points as set out in the LTP are met.

6. Systems are expected to prioritise actions that improve quality of, and access to, care for local populations, with a focus on reducing health inequalities and unwarranted variation.

7. It is expected plans will be aligned to the following principles:

- Clinically-led
- Locally owned
- Realistic workforce planning
- Financially balanced
- Delivery of all commitments in the Long Term Plan and national access standards
- Phased based on local needs
- Reduce local health inequalities and unwarranted variation
- Focussed on prevention
- Engaged with Local Authorities
- Drive innovation

8. Publication of the LTP Implementation Framework is described as the start of the process for strategic system planning, with an initial submission in September 2019 and a final submission by mid November 2019. Plans should fully align

across the organisations within a system so they can subsequently be translated into organisational plans for 2020/21, which will be required in early 2020.

9. The milestones as set out in the LTP Implementation Framework are:

| | |
|---|---|
| **3 June 2019** | Interim People Plan published |
| **June 2019** | Publication of the Long Term Plan Implementation Framework |
| **July 2019** | Main technical and supporting guidance issued |
| **27 September 2019** | Initial system planning submission |
| **15 November 2019** | System plans agreed with system leads and regional teams, in consultation with National Programme Directors |
| **December 2019** | Further operational and technical guidance issued |
| **December 2019** | Publication of the national implementation programme for the Long Term Plan |
| **Early February 2020** | First submission of draft operational plans |
| **End of March 2020** | Final submission of operational plans |

10. The main technical and supporting guidance has now been issued, however a functioning template for the technical element of the return is not expected until the 2 September at the earliest (with an initial system planning submission on the 27 September). Information and guidance continues to be issued on an ongoing basis from the various national programme teams in terms of their expectations.

11. Originally systems were asked to provide two elements at both the September and November submission milestones:

- **Strategy Delivery Plan:** A document that sets out what the system plans to deliver over the next five years. There is no template for this document, however systems have been encouraged to ensure that their plan reflects the principles set out above and includes a description of local need; what service changes will be taken forward and how; how the local system infrastructure will be developed – including workforce, digital and estates; how efficiency will be driven through all local activity, how local engagement has been undertaken to develop the plan and how financial balance will be delivered.

- **Supporting Technical Material:** System plans need to be underpinned by realistic plans for workforce and activity, which must be delivered within the local financial allocation. Templates and tools will be provided to support systems in this.

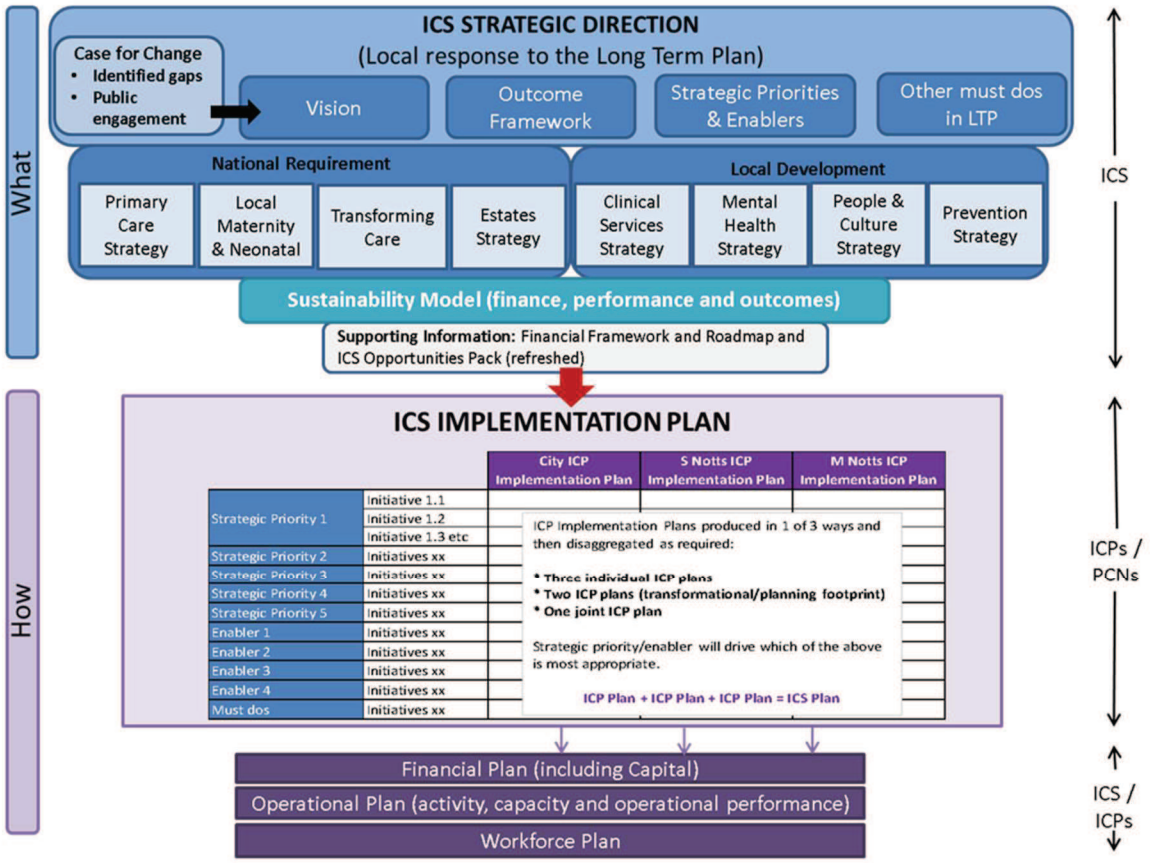
12. Systems have now also been asked to submit a set a metrics:
    - **System Metrics:** Two sets of metrics are required to be submitted; Long Term Plan headline metrics and programme metrics. These two sets of metrics are to be reported in three places; the Strategy Delivery Plan, the technical submission templates and a specific metrics template.

13. The ask of the Strategy Delivery Plan continues to be informed by both national and regional teams, including Programme Leads. As such, there is not a clear articulation of what is required for this component at this stage.

14. This paper provides an update on the system planning approach agreed to develop the ICS's five year plan.

## Approach to developing system plan 2019/24

15. The intention of the system planning approach is to move the system towards a fully bottom up system plan with a focus on key areas where the system faces challenges, but that also delivers all of the commitments set out in the LTP. This overall approach is set out in the diagram below.



16. Given the relatively short timescales to develop the five-year system plan and that guidance is still being issued in a number of areas, the system planning process to deliver this approach will need to be fluid and reactive.

17. Based on the information received to date and through discussions with the ICS Board, ICS Planning Group and ICS Finance Directors Group a process comprised of four phases has been developed to deliver the approach set out above.

18. Given all the guidance has not been released and the exact asks of systems isn't absolutely clear yet, these phases are designed to ensure the necessary building blocks are in place to develop the five year plan and balance this with engagement at the appropriate time to ensure the best use of input. These phases and their progress are outlined below (see Appendix One for timeline).

| Phase | Focus | Lead | Timeline | Progress |
|---|---|---|---|---|
| **One** | ICS Strategic direction<br>• Case for change<br>• Vision<br>• System Outcomes<br>• Strategic Priorities & Enablers<br>• Other LTP Must dos | • LTP core team | Now - 30 Aug | **Completed** |
| **Two** | ICS Sustainability model<br>• Financial sustainability<br>• Outcomes<br>• Performance/KPIs | • LTP core team | Now - 30 Aug | **Final stages to be completed by 11 September** |
| **Three** | 1st draft do something plans<br>• Collective bottom up development to get an initial view of five year plan<br>• Based on LTP and associated implementation guidance<br>• Develop based on a set of four workshops over August | • LTP core team<br>• Organisation and ICP planning leads<br>• Care area leads | 22 Jul – 30 Aug (6 weeks) | **1st round of workshops completed** with all areas. Further information requested by early September. |
| **Four** | Final do something plans<br>• Further refinement of do something plans based on wider engagement<br>• Reflect different approaches by ICPs as required | • Organisation and ICP planning leads<br>• Care area leads<br>• Wider clinical/professional and patient/public stakeholders | 16 Sep – 25 Oct (7 weeks) | |
| **Ongoing** | Development of required outputs<br>• Strategy delivery plan<br>• Supporting technical | • LTP core team | 05 Aug – 01 Nov | |

| | | | | |
|---|---|---|---|---|
| | submissions | | | |

***Lead Roles and Responsibilities:***

***LTP core team***

- *Hold the ring on the national ask*
- *Co-ordinate and the align the inputs*
- *Produce the required outputs*

***Organisation and ICP planning leads***

- *Inform and shape 1st draft of 'do something' plans based on LTP guidance*
- *Engage and be the conduit with the ICPs*
- *Engage and be the conduit with relevant stakeholders in their organisations*

***Care area leads***

- *Provide subject matter expertise input to plans*
- *Link with National Programme Directors*
- *Engage with relevant wider stakeholders*

***Wider clinical/professional and patient/public stakeholders***

- *Provide clinical oversight*
- *Lead on the further development and refinement of the 1st draft of do something plans*

19. In previous years Clinical Commissioning Groups have issued annual commissioning intentions by the 30 September. However, for 2020/21 it is expected that this process will be aligned with the production of the five-year plan. There has been no specific guidance issued on this to date, the system has requested confirmation of what is required for 2020/21, recognising the move towards system planning and is awaiting a response. An update will be provided at the ICS board meeting.

## ICS Board Approval

20. The Long Term Plan Implementation Framework requires that all systems agree their plans by the 15 November and publish them shortly after.

21. Following discussions at the August ICS Board meeting it was agreed an extraordinary ICS Board meeting is required to endorse the approvals of the individual statutory organisations that constituent the ICS, ahead of the system's submission on 15 November.

22. An extraordinary ICS Board meeting to endorse the approvals of the individual organisations is scheduled for the 14 November, and if an organisation is unable to attend the meeting any amendments to the plan made by the Board will be shared with the Chair and Chief Executive of the organisation(s) that cannot attend for confirmation ahead of final submission.

23. Each ICS partner has been asked to ensure that appropriate organisational approval process is in place to ensure the ICS Board is in a position to endorse the approvals of individual statutory organisations at the extraordinary Board meeting on the 14 November, prior to submission on the 15 November.

24. Each ICS partner has been asked to put forward by the end of September when they anticipate signing off the ICS's five year plan so they can all be consolidated and a final plan and process put in place in line with the agreed timeline (as set out in previous section) for completing the five year system plan.

25. Ensuring regular engagement and communication on the development of the five year plan with organisation leads so they can keep their Boards up to date will be key in the run up to the sign off of the submission. Key milestones for facilitating this are:

    a. **16 September:** ICS Board development session. A working draft of the Strategy Delivery Plan Submission will be shared together with other key supporting documentation. The discussion at this session will focus on key decisions needed for the plan, in line with the national LTP guidance. Immediately following the development session a Board cover paper will be produced for individual organisations that reflects the conversations during the day, sets out the steps to the 27 September and enables the working draft of five year plan to be taken to individual statutory Boards.

    b. **10 October:** ICS Board agree the process and plan for individual organisations to agree the system's five year plan ahead of it coming to the ICS extraordinary Board meeting on the 14 November.

    c. **October:** ICS Board development session. This will provide another opportunity for the Board to discuss and agree the key components of the system's five year plan, in line with national guidance, and take these back to their constituent organisations. Outputs of the Clinical Services Strategy will also be discussed at this session together with how they are reflected in the five year plan.

    d. **6 November:** ICS Board receive an update on feedback from individual statutory organisations five year plan sign off process.

26. The regulatory assurance process will commence following the first submission on 27 September, 2019. This will continue until early November, with regulators providing feedback up to 8 November 2019, the system will be expected to reflect all feedback in the final submission on 15 November 2019.

27. The ICS Planning Group will be used for ongoing engagement and discussion on the five year plan with organisational and ICP planning leads, as it was for the 19/20 planning round. This will include any updates to organisational boards from the regulatory assurance process.

## Issues

### Timeline and guidance

22. Co-ordinating planning across the ICS, ICPs and individual organisations in the planning timeframe will be challenging for all partners given:
    a. The breadth of the Long Term Plan commitments
    b. Not all the planning guidance has been released yet and the technical submission template isn't expected until the 2 September – and an interim submission is due on the 27 September

c. Good progress will be required over August when a large number of people will be on leave
d. The actual ask of the strategy delivery plan and supporting technical material is not clear
e. Aligning submissions dates with statutory organisation and ICS Board dates is a challenge.
f. Impact of reorganizational changes of NHSE and I.

23. To seek to mitigate these challenges the process for developing the five year plan is phased to get the necessary building blocks in place to draw on as further guidance is released and the ask becomes clearer whilst allowing for it to be fluid and adapt to changing requirements.

**Clinical and professional input and ownership**

24. Ensuring clinical and professional input and ownership will be critical to developing a successful plan. Given not all the guidance has been received yet and the ask is not clear, the system will need to ensure it makes the best use of clinical and professional input. This will be achieved through a phased process to ensure this input is requested when there is clarity on the ask of systems and ensuring clinical oversight of the plans through forums such as the ICS Clinical Reference Group and the ICP Clinical Reference Groups.

25. A number of clinicians and professionals attended the first round of workshops and all the care areas leads at the workshop were asked to engage with their clinical and professional colleagues in the development of their material to inform the plan. Care area leads will continue to be the conduit to the relevant clinical leads as plans are developed.

**ICP and PCN ownership**

26. Ensuring ICPs engage with the development of the plan to inform and shape it is key. Having the right individuals from constituent organisations who explicitly have that role and can act as that conduit with the ICP and its constituent PCNs is vital. ICP Leads need to ensure these people are in place and have been asked to do so. A lead has been identified for Mid Nottinghamshire ICP, awaiting confirmation for South Nottinghamshire and City ICPs.

**Recommendations**

27. The ICS Board is asked to note:
    a. The challenging timeframe within which the ICS's five year plan is to be developed, particularly given not all the guidance has been released and the ask of systems is still not clear
    b. In light of this uncertainty a phased process to developing the plan is being adopted to put the necessary building blocks in place whilst enabling a fluid and reactive response as specific planning requirements are confirmed

c. A balance will need to be struck between ensuring the necessary building blocks are in place and stakeholder engagement at the right time in the process
d. The need for ongoing engagement on the development of the five-year system plan through ICS Board development sessions and the ICS Planning group and this is taken back to individual statutory organisations Boards so they are fully engaged in the lead up to the final submission
e. Ensuring the right individuals from constituent organisations who can act as the conduit to ICPs and their constituent PCNs is key to ensuring the plan is owned across the system. A lead has been identified for Mid Nottinghamshire ICP, awaiting confirmation for South Nottinghamshire and City ICPs
f. An extraordinary ICS Board meeting is scheduled for the 14 November to endorse the five-year system plan, following approval of the individual statutory organisations that constituent the ICS (as agreed at the August ICS Board)

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Integrated Care System
Nottingham & Nottinghamshire

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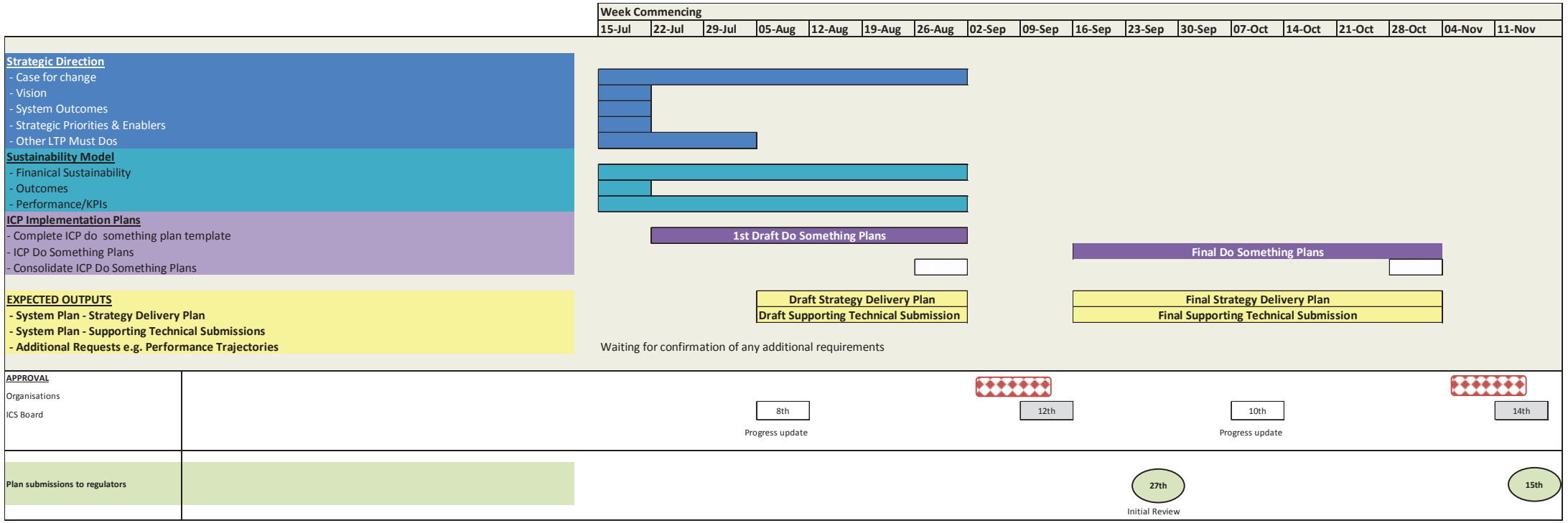
# Appendix One



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|---|---|
| **Meeting:** | ICS Board |
| **Report Title:** | Communications and Engagement for the Five Year System Plan |
| **Date of meeting:** | Thursday 12 September 2019 |
| **Agenda Item Number:** | 7 |
| **Work-stream SRO:** | David Pearson, Independent Chair, Integrated Care System |
| **Report Author:** | Jenny Goodwin, Head of Communications, Integrated Care System |
| **Attachments/Appendices:** | Appendix 1: Plan on the Page for the Long Term Plan Communications and Engagement<br>Attachment E2: Insights Report Executive Summary |

**Report Summary:**

This report updates the ICS Board on the approach to communications and engagement activity to support the system wide Long Term Plan.

Following papers presented at the ICS Board meetings in February and May 2019 and the July Board Development session that detailed a three phased approach to the communications and engagement, the ICS Board is requested to note that the insights phase of the work is now complete and the executive summary of the outputs can be seen in the Attachment.

This paper sets out:

- Phase Two of the plan which focusses on sharing the findings with patients, citizens and staff
- Phase Three and our approach to the NHSE and NHSI guidance to launch our plan to all stakeholders on 28 November 2019. This will expand into a 12 month campaign, predominantly targeted at staff, to support their understanding of our system priorities and the changes we all need to make.

A timeline setting out the high level plan for Phase Three, covering the launch and 2020 campaign, can be seen in Appendix 1.

A budget of £25,000 (from within existing ICS team resources) has been allocated to the delivery of the launch and the 12 month communications and engagement approach which involves and relies upon the support of communications and engagement teams from across the ICS system.

**Action:**

☒ To receive
☒ To approve the recommendations

**Recommendations:**

| | |
|---|---|
| 1. | The ICS Board is asked to NOTE Executive Summary of the insights outputs in the Attachment. |
| 2. | The ICS Board is asked to NOTE that the full insights report and supporting material will shortly be published on the ICS website. |

| | |
|---|---|
| 3. | The ICS Board is asked to APPROVE the proposed approach for Phase Three of the communications and engagement plan to support the Long Term Plan and also NOTE the requirement for the ICS system wide Communications and Engagement teams to support the delivery of this work. |

| **Key implications considered in the report:** | | |
|---|---|---|
| Financial | ☐ | |
| Value for Money | ☐ | |
| Risk | ☒ | The Engagement on the Long Term Plan will help mitigate the risk that stakeholders feel uninformed or disengaged with proposed changes. |
| Legal | ☐ | |
| Workforce | ☒ | The focus on Engagement with our workforce will support embedding our system wide priorities |
| Citizen engagement | ☒ | The Engagement will ensure that the voice of citizens, patients and staff is strongly reflected in the development of the local system response to the Long Term Plan |
| Clinical engagement | ☐ | |
| Equality impact assessment | ☐ | |

**Engagement to date:**

| Board | Partnership Forum | Finance Directors Group | Planning Group | Financial Sustainability Group |
|---|---|---|---|---|
| ☒ | ☒ | ☐ | ☐ | ☐ |
| **Performance Oversight Group** | **Clinical Reference Group** | **Mid Nottingham-shire ICP** | **Nottingham City ICP** | **South Nottingham-shire ICP** |
| ☐ | ☐ | ☐ | ☐ | ☐ |

| **Contribution to delivering the ICS high level ambitions of:** | |
|---|---|
| Health and Wellbeing | ☒ |
| Care and Quality | ☒ |
| Finance and Efficiency | ☒ |
| Culture | ☒ |

**Is the paper confidential?**

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

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# Update on NHS Long Term Plan Communications and Engagement Activity and Plans

**September 2019**

## Introduction

1. To support the development of the Nottingham and Nottinghamshire five year plan a paper was presented to the ICS Board in February 2019 covering the communications and engagement plan and set out:

a) A three phased approach to support the development of the system strategic plan due for publication in Autumn through the production of insights and intelligence from patients, public and staff in Nottingham and Nottinghamshire.
b) How it would ensure that the system strategic plan had widespread support when published through building confidence in the way that it has been developed and tested with patients, public and staff.

2. The first phase of the plan which involved gathering insights with Healthwatch and the research company Britain Thinks from our patients, public and staff is now complete. A paper on the initial findings was brought to the ICS Board meeting on 9 May 2019 and a further update was presented at the ICS Board Development Session on 12 July 2019.

3. The Executive Summary of these insights can be found in the Appendix and the full reports will shortly be published on the ICS website.

4. This paper provides an update on:

    a) Phase Two of the plan which focusses on sharing the findings with patients, public and staff.
    b) Phase Three and our approach to the NHSE and NHSI guidance to launch our plan to all stakeholders on 28 November 2019 and expanding this into a 12-month campaign, predominantly targeted at staff across the system, to support their understanding of our system priorities and the changes we all need to make.

## Activity taking place for Phase 2 of the Long Term Plan communications and engagement

5. As part of Phase 2 the insight reports are now being shared to ensure we build confidence with partners that the insights gathered are informing our plans. Reports are being shared:

a) All stakeholders for example Health and Well Being Board, ICS Partnership Forum and CCG Public, Patient and Engagement Committees.
b) Via the ICS and Healthwatch websites, system wide Communication and Engagement teams (web and intranets).

6. Work is now underway and will continue to embed the findings from the insights into the system wide Long Term Plan, utilising these insights to inform how we plan to transform services for people in Nottingham and Nottinghamshire and a 'You Said, We Did' approach in our communications activities

## Phase 3 – Plan for the Launch of the Long Term Plan and ongoing campaign

7. The launch of the Long Term Plan provides us with an opportunity to further embed our approach of having a single, clear and coherent voice for health and care in Nottingham and Nottinghamshire.

8. As a system at the forefront of truly integrating health and social care for our one million population, we need a bold, striking campaign that clearly shows our workforce and public that we are all spearheading the change that is needed to join up our health and care system.

9. Phase 3 of the communication and engagement approach for the Long Term Plan will be broken down into two actions:

    - Launch of the plan on 28 November 2019.
    - A 12 month campaign predominantly for our staff and also citizens will run January to December 2020 focussed on the five key priorities of the system Long Term Plan.

10. The campaign being developed is informed by the insights gathered and has been developed with communication and engagement colleagues from across the system. It will use real people from across our system wide organisations and focus on real examples of how we are transforming our health and care system. Inspiring and positively evoking an emotive response to motivate people to make changes at work or for themselves.

11. The campaign uses the Outcomes Framework five priorities as its topics to focus on throughout the 12 months. How this is broken down can be seen in the plan timeline in the Appendix.

12. The five main priority areas are:

    - Prevention
    - Proactive Care
    - Urgent Care
    - Mental Health

- Value, Resilience and Sustainability (woven into the work of the four priority areas above)

## Objectives of the launch and overall campaign

13. Communicate and publicise the objectives and outcomes of the plans clearly to our staff and public and make them real for people.

- Support staff in all our organisations to understand they are the people who will enable the change that is needed to work differently/together across health and social care to improve the outcome for our population.
- Support staff to understand how their role, wherever they work, contributes to supporting our system wide vision to help people stay healthier for longer.

14. Engage our citizens in how they can support delivering those objectives

- Support citizens in understanding the importance of staying well and healthy (protecting their own health)
- Being looked after at home rather than in hospital is often better for them and their family
- Getting better does not always mean being referred to a clinician it could be non-medical interventions that help the most.

## Audience

15. Our audience:

a) Primary – our system wide workforce e.g. GPs, secondary care doctors, nurses, AHPs, other clinicians, care assistants, social workers, social prescribing link workers

b) Secondary – Citizens (taking into account that our workforce are also our citizens)

16. To support the workforce approach, demographic data has been analysed to understand the breakdown of basic information such as age and sex in the workplace.

17. The demographic data of staff shows that it is predominantly female: 76% female and 24% male. Much of this workforce falls into the 50 – 54 and 25 – 29 age bracket and we will therefore carry out targeted work to reach this audience for example:

    - Understanding what social media they use to share information
    - What organisations do they belong to?
    - Identifying Peer to Peer influencers
    - Where and how do they want us to talk to them?

## Approach

18. In preparation for the launch of the Local Long Term Plan on 28 November 2019 a series of products are being produced. These include:

    - Short video
    - Two two-page summaries of the plan for staff and citizens
    - Social media content including using the video content
    - Website content including blogs and articles
    - Press (local and trade)

19. The video will be produced by a professional company to ensure it makes the impact to the standard needed to invoke a response from our workforce. The content will be emotive and cover what the system is already doing to make a change and be a 'calling' to people to make changes at work and protect our own health. For example: sharing stories from the new Link Workers and people from the community to describe social prescribing and promoting the fibroscan units being used to test people's liver health and alcohol consumption.

20. The content is informed by feedback received that people need to 'feel' the change that is needed. People relate to people and feeling what we are trying to do will make it real. As part of the video development process we will be testing the approach and first edits of the video with staff, in line with best practice.

21. It is intended that this video can also be used at inductions for new starters at organisations across the system to help them understand the potential and impact for system-working as they start to be part of the Nottingham and Nottinghamshire family.

22. The video and call to action and for staff and public will be used in the video and throughout the 12 month campaign:

    "I will do something differently…"
    "I will take charge of my own health by…"

23. A review of what has worked well across the country has been carried out and informed our approach. The call to action on what can be achieved at work and for the individual has worked well in Wigan. Providing system leaders/managers with materials and products encouraged staff in all areas of the system to have the conversation and support people to act and do something differently at work or for themselves and make a pledge.

24. Dissemination of the products for the launch will be to all staff and stakeholders through the established channels in our system. Specifically the insights informed us that staff prefer to get information from their line manager or their professional body. In addition we are linking in with professional bodies e.g. the LMC to support the roll out of the information.

25. November onwards is when our workforce is focussed on winter pressures and this has been taken into account in the campaign planning, which can be seen in the timeline in the Appendix. After the intensive winter period a full staff re launch of the plans objectives will follow in March and the campaign will run to December 2020.

26. A system wide communication and engagement meeting for all communications and engagement colleagues in the system is planned for 11 October 2019 to have a wider conversation about how all teams can work together and support the activity on the Long Term Plan. Quarterly meetings will be planned and monthly phone calls will follow to support the ongoing development of the 12 month campaign.

## Products and Activity being planned for the 12 month campaign

1. Video case studies for the five priorities highlighting the great work taking place.
2. Working with ICS workstream leads to support the key areas of work over the next 12 months and enhancing or developing ideas to promote the great work taking place and deliver against KPIs.
3. A strong hashtag and social media takeovers using key influencers highlighting the great work taking place and the challenges often faced when making a change.
4. Connecting with our wider partners in Police and Fire, District Councils, Third Sector to share our messages and products and look at opportunities to work together.
5. Staff ambassadors supporting the priorities, for example Nottinghamshire Healthcare has 300 Health and Wellbeing Champions.
6. Integrating the communications and engagement work already planned in the priority areas across the system to ensure this is seen to be linked to the system Long Term Plan by our workforce.
7. Mapping of all relevant staff and stakeholder events that system wide communication and engagement colleagues believe we can use to highlight our priorities to staff either through the products we are developing or further ideas e.g. the Nottingham City ICP Launch in October, AGMs throughout the year

## Ideas being researched:

1. Celebrity involvement from local sports clubs and also the arts to create eye-catching endorsement.
2. Staff survey to include a question in 2021 on what our system wide priorities are to check if the messages have landed.
3. Inquiring into local cinema, libraries and schools using the videos to support getting the call to action in front of our citizens.
4. Requesting support from our six district councils to use their channels for no cost to get the messages, specifically their publications which reach every household.

## Considerations:

1. A £25,000 budget allocated for all Communications and Engagement activity split into.
2. Video costs planned will be £15,000 (maximum spend).
3. Additional products including design, social media advertising, incentives to encourage workforce engagement - £10,000.

## Measuring Success

We will measure success by evaluating how we meet our objectives.

1. How many staff from across the system are reported to have viewed and seen the video and materials.
2. How many staff and citizens make a pledge following the call to action?

## Evaluation

1. Quality of pledges made as part of the call to action.
2. Digital engagement – views of the video; other interactions to be measured (shares, likes, retweets etc.).
3. Web – visits to landing page.
4. Coverage through the media – hits, views, comments made on articles.

## Reporting progress to the ICS Board

1. To inform the Board a quarterly short report on activity will be provided.

The reports will be:

- Published on the ICS website
- System communication and engagement leads will also be requested to share the information through their appropriate channels.
- Stakeholder partners will be kept informed through the reports e.g. Health and Wellbeing Boards, Partnership Forum

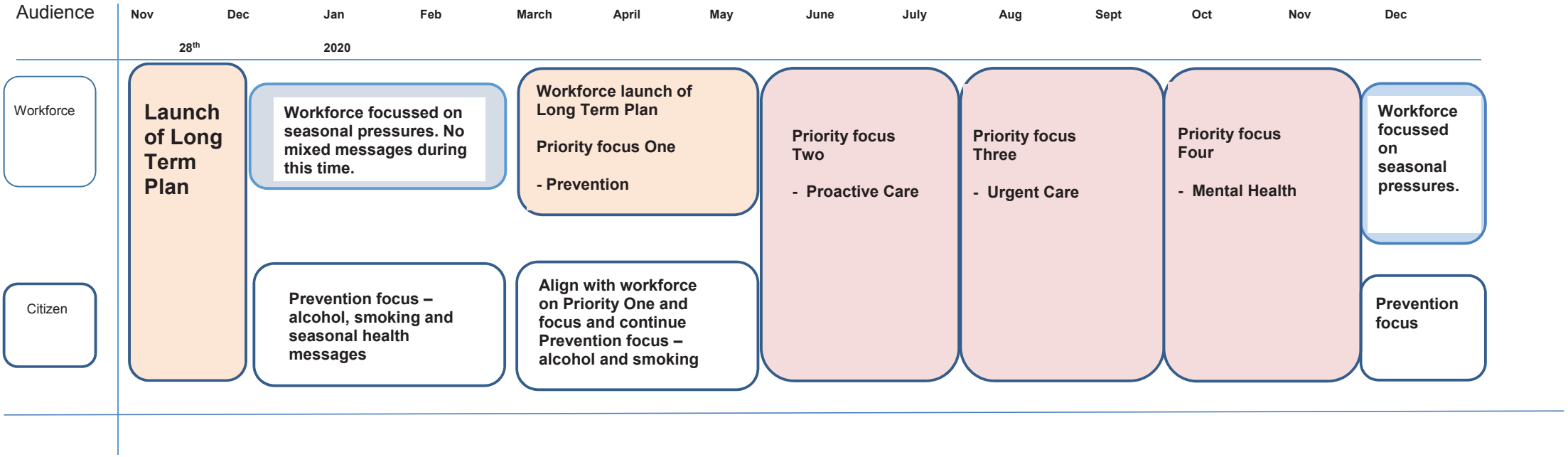
Alex Ball
Director of Communications and Engagement
August 2019
**Alex.Ball1@nhs.net**

Jenny Goodwin
Head of Communications and Engagement
August 2019
**Jenny.Goodwin2@nhs.net**

**Appendix 1**

## Communications and Engagement – Nottingham and Nottinghamshire Long Term Plan campaign

An at glance plan on the page of the launch for the Long Term Plan and ongoing communications and engagement campaign through 2020



ICS Board Meeting 12 September 2019
Item 7. Enc. E2

# Long Term Plan Engagement
# Integrated Insights Report

# Executive Summary Report

**Nottingham and Nottinghamshire Integrated Care System**

**August 2019**

## 1 Background

1.1 On 7 January 2019 the new Long Term Plan for the NHS was published. This plan sets out the ambitions of the NHS in England for the next ten years and received widespread support upon its publication.

1.2 Following the publication of the plan, each local area has been asked to develop their own local plan setting out how they will implement the national strategy. In Nottingham and Nottinghamshire this is being led by the Integrated Care System (ICS) in partnership with the local Clinical Commissioning Groups (CCGs), the hospital and provider Trusts and Local Authorities.

1.3 The NHS Long Term Plan was developed with a high level of engagement with clinical experts and other stakeholders, patients and the public.

1.4 To support the implementation of the Long Term Plan, each local area was asked to undertake engagement with their populations to understand what matters to local people in their health services and to inform the development of a local system plan.

1.5 Healthwatch England, the organisation that supports local Healthwatch organisations, worked closely with the NHS to coordinate a programme of national engagement. In Nottingham and Nottinghamshire we have worked in partnership with Healthwatch Nottingham and Nottinghamshire (HWNN) to undertake an extensive programme of engagement with local people. This engagement has explored some of the key themes in the NHS Long Term Plan and sought to understand what matters to people in their health and health services. This report details the findings of that engagement and sets out how we will ensure that they inform our local system plan.

1.6 We have spoken to over 1,000 people across Nottingham and Nottinghamshire in our engagement about topics such as mental health, urgent care, health prevention and more. These conversations with local people have given us a wealth of insight that will help us improve local services and deliver the national NHS Long Term Plan in a way that reflects what matters to people.

## 2 Our approach

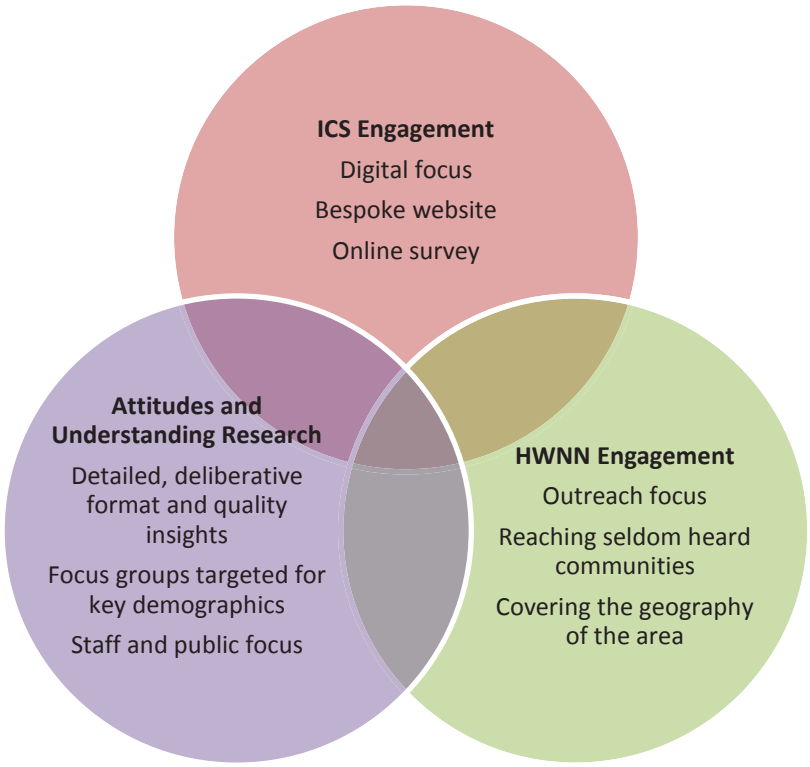
2.1 The Nottingham and Nottinghamshire ICS has worked in partnership with HWNN Nottinghamshire to deliver an extensive programme of public engagement on the NHS Long Term Plan.

2.2 Our approach includes:

a) Public engagement by the ICS communications and engagement team, through digital and face-to-face channels
b) Public engagement by HWNN through face-to-face channels
c) Understanding and Attitudes Research by social research agency Britain Thinks, delivered through a series of focus groups with staff and members of the public.

2.3 The elements above form the key parts of our engagement approach. While each element includes a different focus, the programme is underpinned by core themes and questions. This model is summarised below in figure 1.

*Figure 1 – model for engagement*



2.4 The core theme underpinning each element of our engagement was exploring what matters to local people, in the context of the NHS Long Term Plan ambitions. Each element focused engagement around the priorities within the NHS Long Term Plan.

2.5 Within all of our engagement we have discussed the priorities within the NHS Long Term Plan in three ways:

a) Understanding how important each priority is to people;
b) Understanding what matters most to people within each priority
c) Discussing the priorities in terms of hypothetical 'trade-offs' e.g. investment in prevention versus investment in treatment, to generate debate.

2.6 We also asked people 'What do you think is the best thing about the NHS?' to understand people's priorities without prompting or context.

2.7 We talked to a wide range of partners and stakeholders to gain input into our engagement approach. This included conversations with our engagement partner HWNN; our ICS Board members; neighbouring systems; local voluntary and community sector (VCS) partners; NHS Confederation; local MPs and Local Authorities.

2.8 Table 1 below summarises the delivery of engagement across all elements.

*Table 1 – summary of engagement by approach*

| Focus of engagement | Engagement activity/outputs | Value added |
|---|---|---|
| **ICS Team Engagement** | | |
| Engagement through digital channels<br><br>Campaign focus | Bespoke website with 3,200 visitors over the engagement period<br><br>Online survey with 405 responses<br><br>Outreach engagement at 7 community events<br><br>Social media reach of >70,000 | High number of responses to survey across digital channels<br><br>High level of engagement with campaign through digital channels<br><br>Numbers reached by Long Term Plan conversation far in excess of engagement respondents |
| **HWNN Engagement** | | |
| Outreach engagement targeting seldom heard communities | Outreach engagement with 610 survey responses<br><br>40 community events attended | Reach into communities across Nottingham and Nottinghamshire<br><br>Trusted engagement partner enabling the ICS to reach into communities<br><br>Expertise in engagement design |

| Focus of engagement | Engagement activity/outputs | Value added |
|---|---|---|
| **Attitudes and understanding Research** | | |
| In-depth research targeting professionals, heavy service users and light service users | 27 tele-depth interviews with GPs; nurses; consultants; junior doctors; allied health professionals; public health professionals; social care staff<br><br>10 at-home interviews with heavy service users with complex long-term conditions<br><br>4 focus groups with light service users | In depth conversations with staff and the public enabling detailed insights to be generated<br><br>Adding context and depth to the survey findings |
| **Summary** | | |
| 1015 Survey responses<br><br>47 Community events<br><br>58 in-depth interviews/focus groups participants<br><br>3,200 website visitors<br><br>Social media reach of >70,000 | | |

## 3 Summary of findings

3.1 There were clear and common themes that emerged from all these sources of input. The key insights drawn collectively are summarised below.

### 3.2 Public views about priorities and pressures within the system are strongly influenced by the national media narrative on the NHS or on personal experience of services

3.2.1 Alongside a significant amount of pride in the local NHS, there is a perception that services are under pressure. This explains the widespread public support identified for urgent and emergency care and mental health. Even those with no experience of these services rank them as important or very important.

3.2.2 The public also see their experience of one service as indicative of the whole NHS, so experiences of long waits for GP services or urgent and emergency care are interpreted as indicators of pressure across the whole system.

### 3.3 People mostly value having a free at the point of need healthcare model, frontline staff and the accessibility of services within the NHS

3.3.1 Both the ICS and HWNN elements of the engagement opened with the question ‘What do you think is the best thing about the NHS?’ This has provided useful insight into public

perceptions about the NHS, which have been reinforced in the Understanding and Attitudes Research.

3.3.2 Overwhelmingly, people value the free at the point of need model as the best thing about the NHS.

3.3.3 Where the workforce are cited as the best thing about the NHS, this is usually focused on front-line staff with compassion, dedication and helpfulness the qualities that people value.

3.3.4 Many people also cite the accessibility of services as the best thing about the NHS, in particular equity of access and fairness e.g. 'it's for everyone'.

3.3.5 It should be noted that the free at the point of need model does not, of course, apply to much of social care and therefore care needs to be taken when emphasising this strength of feeling when talking about integrated care.

**3.4 There is widespread support for urgent and emergency care and mental health, which are among the system's top priorities**

3.4.1 The public are highly supportive of prioritising urgent and emergency care and mental health. There is a perception among both staff and the public that more focus is needed on mental health.

**3.5 While there is public support for a focus on finance and efficiency, this is not as significant as support for other areas**

3.5.1 While many people rated finance and efficiency as important or very important, support for other system priorities was significantly higher. Support for focusing on finance and efficiency also needs to be considered alongside public and staff concerns about system pressures and perceptions of diminishing resources and cutbacks.

3.5.2 This can be seen in wider national research including this from the King's Fun (https://www.kingsfund.org.uk/blog/2019/05/public-and-nhs-funding) where 83% of survey respondents felt that there was a major or severe funding problem in the NHS. The majority (58%) said they would be willing to accept an increase in taxes to fund the NHS and 75% opposed means testing.

**3.6 People are broadly supportive of a focus on preventative activity, with some reservations**

3.6.1 There is widespread support for focusing on prevention of ill health among both staff and the public. Among the public however, there are some reservations. People still view

Treatment for health problems as a priority and would be concerned if resources were viewed to be being taken away from this area. People also highlight the limits of preventative interventions, citing that not all health problems are preventative and that people cannot always be encouraged to change their behaviour.

**3.7 There are mixed and ambiguous views about personalisation, choice and control**

3.7.1 In being asked to consider personalisation, choice and control in health people felt that these things were highly dependent on context. This is reinforced by previous engagement carried out by HWNN on shared decision making. Both engagement on the Long Term Plan, and previous work by HWNN highlights that people do not always understand these terms – particularly those who are not 'health literate'.

**3.8 There is only lukewarm support for digital innovation in healthcare and a lack of understanding of the value of digital technology to improve access**

3.8.1 Of all the areas of healthcare covered within the engagement there was the least understanding of, and support for, digital innovation to improve access. While there is a correlation between respondents age and their level of support for digital innovation in healthcare, with those over working age less likely to be supportive, it remains the least supported and least understood of all areas covered among all groups.

**3.9 The public are mostly uninterested in hearing about system change**

3.9.1 The public have little appetite for hearing about system change and transformation, unless it directly affects how they access care. They perceive the biggest challenges to the NHS to be difficulty accessing services, a loss of high performing services and hit-and-miss quality of care. For access to services people are mostly referring to A&E and their GP.

**3.10 Staff are concerned about diminishing resources and increasing demand**

3.10.1 Staff see an increasing demand for healthcare alongside diminishing resources. They highlight short-term thinking and pressure on staff as the net effects of this. Staff are interested in seeing investment in more effective and efficient ways of working.

3.10.2 Where staff are particularly interested in knowing more about system change they will be very proactive in seeking out information. For those with limited interest in these matters, they want to hear about what it means for them directly in their job and expect to hear it from their line manager or professional association.

ENC. F1

| | |
|---|---|
| **Meeting:** | ICS Board |
| **Report Title:** | People and Culture Delivery Plan and Impact |
| **Date of meeting:** | Thursday 12 September 2019 |
| **Agenda Item Number:** | 8 |
| **Work-stream SRO:** | Lyn Bacon |
| **Report Author:** | Jackie Hewlett -Davies |
| **Attachments/Appendices:** | Enc. F2. People and Culture Delivery Plan and Impact |

**Report Summary:**


The ICS board approved the People and Culture Strategy in May 2019. The board requested an update on the impact of the key initiatives.

This presentation aligns with the paper on system staff engagement and OD and aims to;

- Update the board on key developments since the May Board Meeting
- Provide assurance that the Nottinghamshire People and Culture Strategy is aligned to the National Interim People Plan and the Long Term Plan Implementation Framework
- Provide examples of impact as a result of key initiatives and highlight risks and mitigations
- Share the delivery plan priorities


**Action:**

☒ To receive
☐ To approve the recommendations

**Recommendations:**

| | |
|---|---|
| 1. | Note the developments since the May ICS Board |
| 2. | Note the impact of initiatives to date |
| 3. | Agree the delivery plan priorities |
| 4. | Agree to support future activity within the work stream |

**Key implications considered in the report:**

| | | |
|---|---|---|
| Financial | ☐ | |
| Value for Money | ☐ | |
| Risk | ☒ | Workforce supply and demand |
| Legal | ☐ | |
| Workforce | ☒ | |
| Citizen engagement | ☐ | |
| Clinical engagement | ☐ | |
| Equality impact assessment | ☐ | |

**Engagement to date:**

| Board | Partnership Forum | Finance Directors Group | Planning Group | Workstream Network |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☒ |
| Performance Oversight Group | Clinical Reference Group | Mid Nottingham-shire ICP | Nottingham City ICP | South Nottingham-shire ICP |
| ☐ | ☐ | ☐ | ☐ | ☐ |

| **Contribution to delivering the ICS high level ambitions of:** | |
|---|---|
| Health and Wellbeing | ☐ |
| Care and Quality | ☒ |
| Finance and Efficiency | ☐ |
| Culture | ☒ |

**Is the paper confidential?**

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

Integrated Care System
Nottingham & Nottinghamshire

ICS Board Meeting
12 September 2019
Item 8. Enc. F2

# Nottingham and Nottinghamshire Integrated Care System (ICS)

## People and Culture

## Delivery Plan & Impact

Lyn Bacon, CEO CityCare & SRO

12 September 2019

Integrated Care System
Nottingham & Nottinghamshire

# Objectives

- Update following May Leadership Board
- Impact of programme to date
- Share strategy delivery plan priorities

Integrated Care System
Nottingham & Nottinghamshire

# Update

- Since LTP Implementation Framework & Interim People Plan published, we have aligned our existing People & Culture priorities
- System agreed provider contributions to Talent Academy & Nurse Associate programmes from HEE workforce development funds (LBR)
- August HEE system allocation £250,000
- Successful ESF funding bid to recruit 50 Digital Workforce Champions
- Creation of new Nottinghamshire People & Culture Board replacing the LWAB

Integrated Care System
Nottingham & Nottinghamshire

| ICS Strategic Priority (P&C) | National Interim People Plan (IPP) Themes | | | | |
|---|---|---|---|---|---|
| | Making the NHS a better place to work | Improving Our Leadership Culture | Addressing Urgent Workforce Shortages in Nursing | Delivering 21st Century Care | A New Operating Model for Workforce |
| Planning, attracting and recruiting people to work in our health and care system | X | X | X | X | |
| Retaining staff and trainees, promoting career paths & talent management | X | X | X | X | |
| Role redesign and embedding new roles | X | | X | X | |
| Developing & preparing people to work in new ways, including digital skills development | X | X | X | X | X |
| Enabling cultural change & leadership development to maximise system effectiveness | X | X | | X | X |

Integrated Care System
Nottingham & Nottinghamshire

# Examples of High Impact Delivery

- Primary Care
  - GP: Ahead of trajectory through Phoenix recruitment & retention programme
  - Led to increase in GP Registrar applications to our schemes (now over subscribed)
  - Practice Nurses: Recruited 13 additional for PCNs using GPFV funds
  - Additional roles: Recruitment of Clinical Pharmacists & Social Link Prescribing workers into PCNs underway
  - Training Hub: secured resource to strengthen infrastructure to support development of future workforce across primary & community, including care homes

Integrated Care System
Nottingham & Nottinghamshire

# Examples of High Impact Delivery

- Nursing
  - Nursing Associate role implemented through Nottinghamshire wide training programme 3rd cohort of trainees (250 qualified and working in the system)
  - Successful experienced nurse retention scheme (Legacy Mentor proof of concept pilot) across all sectors, now extending
  - Advanced Clinical Practice implementation: Competence framework in place to support single approach to ACP across the system through new work-based learning programme delivered by NTU
  - Engaged widely with nursing, midwifery and AHP colleagues on developing key priorities for action
  - Increased quality and capacity for student nursing placements through roll out of new NMC standards
  - Increased supply pipeline for nursing through local training programmes with NTU

Integrated Care System
Nottingham & Nottinghamshire

# Examples of High Impact Delivery

New & Extended Roles

- Increased number of peer support workers in mental health settings
- Upskilling of care home/nursing home staff in partnership with Optimum
- Medical Team Administrator pilots leading to training hub leading on national development programme
- Personalisation, prevention, integration: 125 people from a range of settings trained in holistic working

  - Upskilling existing health & social care staff with additional competences in function & mobility, MH awareness, observations, equipment & safety has reduced frequency of visits of more senior staff, improved quality of life
- One stop shop work experience hub established as shared service co-ordinating 1200 placements per year attracting young people into careers
- Implemented an integrated workforce information system
- Organisational Development – see separate paper

Integrated Care System
Nottingham & Nottinghamshire

# Strategy Delivery Plan Development

- Review the outputs from the Clinical Services Review, the Long Term Plan submissions and the final People Plan requirements to inform our detailed planning for 20/21 and beyond
- Produce workforce development plans to meet population health & care needs aligned to ICP and PCN population need
- Build on and strengthen our workforce information systems and analysis to inform our future planning and provide the wider system with good quality evidence for decision making
- Ensure system transformation & targeted funds are allocated to support workforce development priorities

Integrated Care System
Nottingham & Nottinghamshire

# Strategy Delivery Plan Priorities

- Addressing shortages in our nursing workforce
  - Build nursing careers e-platform & link to health careers resources
  - Develop attractive career options including research, projects, rotational & integrated roles
  - Embed evidence based nursing retention programme
  - Programme of events as part of Nursing Now Nottinghamshire & Year of the Nurse
  - Continue expansion of clinical placement capacity across all sectors
  - Widening participation plan to attract applicants from under represented/disadvantaged groups
- Develop workforce productivity programme to deliver system efficiencies based on Carter recommendations
- Establishing system-wide Talent Academy with programmes to attract young people & under represented groups into jobs and careers in health & care (apprenticeships, career frameworks, careers activity, school engagement, ambassador development, volunteer expansion).

Integrated Care System
Nottingham & Nottinghamshire

# Strategy Delivery Plan Priorities

- Investment in upskilling Urgent & Emergency Care teams
  - Embed & increase Urgent Care Practitioner roles, work based learning & assessment through UC Faculty
- HR & OD Work Plan:
  - Flexible employment & deployment models
  - reducing reliance on agency usage
  - portability of training between employers
  - embedding prevention & personalisation skills & practice
  - staff health & wellbeing
  - integrated workforce dataset, analysis of risks & challenges to develop mitigation

Integrated Care System
Nottingham & Nottinghamshire

# Strategy Delivery Plan Priorities

- Enhanced skills in care homes – development of champions to build capacity & capability to support system ambitions
- Upskilling Learning Disability nursing teams and supporting delivery of TCP
- Continue with work to deliver MHFV workforce expansion trajectories
- Roll out of training programmes to support personalisation and prevention

ENC. G

| | |
|---|---|
| **Meeting:** | ICS Board |
| **Report Title:** | Update on System Staff Engagement and OD |
| **Date of meeting:** | Thursday 12 September 2019 |
| **Agenda Item Number:** | 9 |
| **Work-stream SRO:** | Lyn Bacon, Chief Executive, Nottingham City Care |
| **Report Author:** | Alex Ball, Director of Communications and Engagement, Nottingham and Nottinghamshire ICS; Julian Eve, Associate Director of Learning and Organisational Development, Nottinghamshire Healthcare NHS Trust |
| **Attachments/Appendices:** | None |

**Report Summary:**

In May 2019 the ICS Board approved the ICS's People and Culture Strategy. One of the five strategic priorities of this strategy is "**enabling cultural change and leadership development to maximise system effectiveness**". The deliverables that come from this priority are designed to enable cultural change across the system.

The themes of this priority include engagement, communications, leadership development at all levels, quality improvement and organisational development support for redesign of services and systems.

This paper provides an update to the ICS Board of system staff engagement and organisational development since January 2019 and outlines the plans and opportunities for the balance of 2019 and into 2020.

**Action:**

☐ To receive
☒ To approve the recommendations

**Recommendations:**

| | |
|---|---|
| 1. | NOTES the strong progress to date on leadership development and OD including the positive feedback from the Leadership Conference in June 2019. |
| 2. | NOTES the strong collaboration across all system partners including between the OD Collaborative and the ICS Communications function in pulling this programme together. |
| 3. | NOTES the dates for the Leadership Conferences on 8th November 2019 and 10th June 2020 and prioritises these in their diary |
| 4. | NOTES the proposed Leadership Development Programme to commence in autumn 2019 and commit to support nominated leaders in their participation in this programme. |
| 5. | AGREES to support the future activities including the QI programme and the PCN development activities. |
| 6. | AGREES to continue to support the coordination of this activity between the OD Collaborative and the ICS Communications team. |
| 7. | AGREES to consider future ad-hoc requests for funding to deliver these activities as required, assuming that national funding opportunities and local resources have been maximised. |

| Key implications considered in the report: | | |
|---|---|---|
| Financial | ☐ | |
| Value for Money | ☐ | |
| Risk | ☐ | |
| Legal | ☐ | |
| Workforce | ☒ | |
| Citizen engagement | ☐ | |
| Clinical engagement | ☒ | |
| Equality impact assessment | ☐ | |

| Engagement to date: | | | | |
|---|---|---|---|---|
| Board | Partnership Forum | Finance Directors Group | Planning Group | Workstream Network |
| ☐ | ☐ | ☐ | ☐ | ☐ |
| Performance Oversight Group | Clinical Reference Group | Mid Nottingham-shire ICP | Nottingham City ICP | South Nottingham-shire ICP |
| ☐ | ☐ | ☐ | ☐ | ☐ |

| Contribution to delivering the ICS high level ambitions of: | |
|---|---|
| Health and Wellbeing | ☐ |
| Care and Quality | ☐ |
| Finance and Efficiency | ☐ |
| Culture | ☒ |

**Is the paper confidential?**

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

# UPDATE ON SYSTEM STAFF ENGAGEMENT AND ORGANISATIONAL DEVELOPMENT

## 12 SEPTEMBER 2019

## Introduction

1. In May 2019 the ICS Board signed up to the five elements of the People and Culture Strategy for the Nottingham and Nottinghamshire system. The fifth element of this strategy is 'enabling cultural change and leadership development to maximise system effectiveness'.

2. The organisational development (OD) deliverables that come from this section are designed to enable cultural change across the system. The themes of this section include engagement, communications, leadership development at all levels, quality improvement and organisational development support for redesign of services and systems.

3. These elements form the agreed OD and system effectiveness plan that has driven cultural change activity and managed output and outcomes to be reviewed.

## OD and System Effectiveness Deliverables

4. The stated OD and System Effectiveness deliverables within the People and Culture Strategy are:

- Developing and sustaining systems leaders; guiding and aligning collaborative leadership development across health and social care wherever possible
- Building a culture of continuous quality improvement
- Establishing facilitative support for the ICS Board; building strong, supportive and trusting relationships among very senior leaders across the Integrated Care System (ICS)
- Authentic engagement with multi-professional leaders and teams across health and care across the ICS footprint
- Facilitative OD support for the Urgent Care agenda across the Nottingham and Nottinghamshire ICS

## Work to Date

5. Significant progress has already been made in the delivery of these ambitions and some key achievements include:

## ICS Leadership Conference

6. In June 2019 the Nottingham and Nottinghamshire ICS welcomed 250 leaders from across the county to a whole system leadership conference with opportunities to network, to meet and hear from the ICS leaders and to learn more about the ambition of the ICS and about leadership expectations and challenges.

7. Delegates reported positively on their experience at the conference. It was seen to be symbolic of collaborative progress with a request from participants to continue the momentum of getting together in this way. The conference welcomed the Director of the National NHS Leadership Academy who in follow up conversation had been impressed by the conference and the ICS ambition and stressed the importance (and the evidence base) of the pillars of system leadership:

- An inspirational vision of high quality care
- Clear aligned goals at every level with helpful feedback
- Good people management and employee engagement
- Continuous learning and quality improvement
- Enthusiastic team working, co-operation and integration

8. Delegates at the conference were keen to hear more about the detail of system integration and to maintain and expand the leadership networks of the whole system (ICS) to keep whole system continuity as well as understanding the growth within each ICP.

9. Equally the number of requests and appetite for 'what next' were a significant proportion of the feedback; an encouraging position being stated by a community who want to see and be part of the future

## Quality Improvement (QI)

10. In March 2019 the third cohort of system wide quality improvement training took place for 80 senior system leaders across the ICS. On this occasion the five training days were facilitated by a complete team of local trainers accredited as Quality, Service Improvement and Redesign (QSIR) Associates with the NHSEI.

## ICS Board Development

11. The ICS Board has received independent facilitation throughout 2019 and Board members have participated in individual meetings and Board Development sessions which have led to strong discussions about principles of working together and behavioural commitments required.

12. It is acknowledged that to ensure the ICS's effectiveness, credibility, cohesion, and advancement toward common goals that further work needs to

be undertaken and the next stage of independent facilitation identified to continue system leadership development at this level.

**ICS Senior Leadership Development Programme**

13. The ICS will deliver a senior leadership programme for the whole system for 60 senior leaders in the autumn 2019. Resource to deliver has been identified through a specific NHSE programme. Delivery of the programme is a co-production between Nottingham Trent University and the local Leadership Academy with planned input from senior leaders across the ICS.

14. Starting in November 2019, the programme will respond to feedback taken from the ICS Leadership Conference and guided by contemporary leadership thinking from the identified partners. The programme will be centred around the following six seminars:

    i. System vision and systemic context
    ii. Approaches to leadership in complex systems and adaptive leadership styles
    iii. Managing Change, understanding cultural context, and overcoming resistance
    iv. Leading change through uncertain futures and stakeholder perspectives
    v. Delivering change initiatives and enabling cultures of innovation and creativity
    vi. Shaping our future with collaborative innovation

15. These seminars will be augmented by workshops, online coaching sets and individual mentoring. There will be opportunity for leaders of the ICS and ICPs to meet the group as they develop their leadership skill set

16. We will specifically seek attendees to spend a limited but focused amount of time working in other organisations, shadowing and working with others to get a strong feel of walking in others shoes

17. In early September 2019 the provisional list of nominees for the programme will be reviewed in discussion with ICS and ICP leads before confirmation of attendance

**ICP and PCN Facilitator Support**

18. Acknowledging the need to bring the PCN Clinical Directors together at the earliest opportunity whilst also anticipating a national OD and Leadership approach to PCN development would be forthcoming, the Primary Care Network Clinical Directors met for the first time on the 4 July for an inaugural development session; to meet each other, build relationships and to start the conversation about future function and priorities.

19. The session was organised and facilitated by the OD Collaborative and was seen to be a successful start by all parties involved. A further two meeting of all clinical directors have been set up for the end of August and end of September where the National PCN Development Support Prospectus (released on the 12 August 2019) will be discussed and OD priorities identified.

20. Locality Directors for the three ICP areas have been engaged in conversation about the support available for PCN Clinical Directors including the best approach for engaging with local communities and stakeholders. This includes the development of a programme of media training for PCN CDs and also a set of workshops supporting ICPs and PCNs in engaging with local authority (District and Top-Tier) Councillors.

**Simple Guide to the ICS**

21. Following the conference referenced in 3.1 above, a PowerPoint deck explaining the ICS in simple terms for a workforce audience was developed and distributed to delegates as well as leaders from across the ICS. This offered a common set of words to describe the ICS and its work along with some visual prompts – for use by leaders across the system with their teams. Response to this deck has been positive

**Summary of Next Steps**

22. In order to build on these successes and continue the positive momentum, it is proposed that the following activities and products are delivered throughout the remainder of 2019 and into 2020.

**Conferencing**

23. Building on the success of June's conference, it is planned to bring together middle managers and leaders from across the system at an ICS Team Leader Conference. This event will also include ICP and PCN leaders and be action oriented around delivery of the local response to the Long Term Plan. There will be opportunities for the ICPs and PCNs to work in geographic breakout groups as well as a full schedule of plenary sessions. The date for this is set as 8 November 2019.

24. In addition, it is planned to hold a second ICS Leadership Conference (to repeat the success of the first) with date held for 10 June 2020.

**Quality Improvement (QI)**

25. We will build on the success of whole system delivery of training and support of quality improvement methodology. We are starting to collect the information related to the impact of this input of delivery in 2018 and earlier this year. As such the OD Collaborative will sponsor two further cohorts of system wide Quality, Service Improvement and Redesign (QSIR) training to take place

before the end of March 2020. At this point we will have taken 250+ senior leaders through this training.

## ICS Website

26. Launched in August 2019, the ICS's new website at www.healthandcarenotts.co.uk will be the central point for accessing all the public and staff facing information about the work of the ICS. As part of that, there will be a specific section housing the emerging whole system OD offer with specific focus on the emerging Talent Academy and shared management and leadership development opportunities.

## Local Response to Long Term Plan

27. The ICS is due to publish its local response to the NHS Long Term Plan in mid-November. As part of this publication, there will be a concerted effort to 'launch' the plan with members of the public and, as a primary audience, staff members from across the system. The strategic intent of this launch activity is to enable staff members from across the system to better understand the work of the ICS and for them to be empowered and supported to contribute to it. There will be many elements to this communication activity but it will include the creation of a film that can also be used for induction to the ICS for all new employees when they join the system.

28. The delivery of this activity within the system will need to be led by the individual organisations as staff have indicated that they expect to hear news of this type through their direct management line.

## OD Support of the Primary Care Networks

29. Nationally and locally it is understood that the emerging Primary Care Networks will require significant support to enable the named clinical directors to operate with strong leadership collegiality.

30. The national programme of OD for the Primary Care Networks alongside funding allocation will be considered in the next PCN Clinical Directors meeting. The Nottingham and Nottinghamshire ICS Primary Care Networks will continue to receive OD support from the OD Lead for the ICS. Monthly meetings of the Clinical Directors as well as other events are being managed as a collaborative between the SRO for Primary Care, the CCG and the PCN Clinical Directors.

## ICS Leadership Programme

31. It is anticipated that there will be demand for a second and third cohort of delegates for the ICS Leadership Programme following the first course in November. Learning from cohort one will be key to future delivery but the intentional flexible design of the offer will enable the programme to be

adapted into a thematic (e.g. all colleagues working on frailty across the system) and geographic (e.g., all leaders at a certain level in a locality) offer.

32. The programme will be thoroughly evaluated at mid- point and will inform the design and next steps of future delivery.

**Resourcing and Funding**

33. Delivery of these activities have all so far been achieved within existing resources (human and financial) or through the use of external funding streams. Going forward this will be the intention but it may be that to achieve truly transformative delivery that further investment will be required. The Board is asked to consider those requests when they arise.

**Recommendations**

34. It is recommended that the Board:

- NOTES the strong progress to date on leadership development and OD including the positive feedback from the Leadership Conference in June 2019
- NOTES the strong collaboration across all system partners including between the OD Collaborative and the ICS Communications function in pulling this programme together
- NOTES the dates for the Leadership Conferences on 8 November 2019 and 10 June 2020 and prioritises these in their diary
- NOTES the proposed Leadership Development Programme to commence in autumn 2019 and commit to support nominated leaders in their participation in this programme
- AGREES to support the future activities including the QI programme and the PCN development activities
- AGREES to continue to support the coordination of this activity between the OD Collaborative and the ICS Communications team
- AGREES to consider future ad-hoc requests for funding to deliver these activities as required, assuming that national funding opportunities and local resources have been maximised

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| | |
|---|---|
| **Meeting:** | ICS Board |
| **Report Title:** | Developing an ICS Strategy for Data, Analytics, Information and Digital Technology |
| **Date of meeting:** | Thursday 12 September 2019 |
| **Agenda Item Number:** | 10 |
| **Work-stream SRO:** | Andrew Haynes |
| **Report Author:** | Andrew Haw, Tom Diamond |
| **Attachments/Appendices:** | None |

**Report Summary:**

The ICS Board agreed in July to take forwards the development of a strategy for Data, Analytics, Intelligence and Digital Technology (DAIT). This paper provides a brief update on progress and proposes a new timetable for completion of the strategy and proposes new governance arrangements for oversight of the DAIT agenda.

**Action:**

☐ To receive
☒ To approve the recommendations

**Recommendations:**

| | |
|---|---|
| 1. | To receive an update on progress with developing the strategy |
| 2. | To approve a proposed revised timetable for strategy development |
| 3. | To approve the proposed governance arrangements for the DAIT agenda including the strategy development |

**Key implications considered in the report:**

| | | |
|---|---|---|
| Financial | ☐ | |
| Value for Money | ☐ | |
| Risk | ☐ | |
| Legal | ☐ | |
| Workforce | ☐ | |
| Citizen engagement | ☐ | |
| Clinical engagement | ☐ | |
| Equality impact assessment | ☐ | |

**Engagement to date:**

| Board | Partnership Forum | Finance Directors Group | Planning Group | Workstream Network |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |
| **Performance Oversight Group** | **Clinical Reference Group** | **Mid Nottingham-shire ICP** | **Nottingham City ICP** | **South Nottingham-shire ICP** |
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Contribution to delivering the ICS high level ambitions of:**

| | |
|---|---|
| Health and Wellbeing | ☒ |

| | |
|---|---|
| Care and Quality | ☒ |
| Finance and Efficiency | ☒ |
| Culture | ☒ |

**Is the paper confidential?**

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

# DEVELOPING A SYSTEM-WIDE STRATEGY FOR DATA, ANALYTICS, INTELLIGENCE AND DIGITAL TECHNOLOGY FOR HEALTH AND CARE IN NOTTINGHAM & NOTTINGHAMSHIRE: AN UPDATE

## 12 SEPTEMBER 2019

## Purpose and Background

1) At the ICS Board in July, the Board agreed to progress the development of a system wide strategy for Data, Analytics, Intelligence and Digital Technology (DAIT.) The August ICS Board allocated £100,000 to support the development of the strategy.

2) This paper provides the Board with an update on:
   a) The common themes running through the initial workshops held during the summer;
   b) Progress on evaluating the need for external support to the strategy;
   c) A proposed revised timetable for strategy development;
   d) Proposed governance arrangements for the DAIT agenda including the strategy development.

## Common Themes from the summer workshops

3) A total of 57 people from across all sectors of the health and care system attended one of the 5 workshops. A longer document is being prepared that will form a comprehensive record, but Table 1 below describes the 10 most frequently mentioned themes or observations from the workshops.

Table 1: Common themes mentioned or observed

| | Common themes mentioned or observed at the summer workshops |
|---|---|
| 1 | Knowledge of the NHS Long Term Plan was low |
| 2 | There are currently 2 locally configured shared health and care records, we ought to have only 1 |
| 3 | The existing strategic initiatives such as the Health and Care Portal and a Public Facing Digital Service are welcome, but comms activity is patchy and greater awareness of the implications is required |
| 4 | The analytical communities are disparate and are not aware of new initiatives that are technological in nature, but which could create valuable new sources of data |
| 5 | All of the data about the wider determinants of health that are available to support Population Health Management is not together in one place with all of the health and care data and it needs to be |
| 6 | There are many good local initiatives but relatively few are system wide |
| 7 | There is a shortage of change management expertise and it is often regarded as optional when introducing new technology, leading to under-achievement of planned benefits |
| 8 | The IT barriers between our organisations should be broken down so that IT is not a barrier to working either wirelessly or wired, so that health and care professionals can work anywhere |
| 9 | There is good appetite for 'doing it once' across the system and that local variations (eg in choice of outcome indicators) while often justifiable should be the exception not the norm |
| 10 | There needs to be a compelling vision for the use of analytics and digital technology that the whole system can agree on, before the necessary support and investment are obtained |

## Evaluating the need for external support

4) Limited progress has been made in the last month. Meetings have been held with both local universities to explore their interest in collaborating with us on strategic developments, particularly the concept of a possible Nottingham Institute of Data Analytics modelled along the lines of the Leeds Institute of Data Analytics[1]. The Leeds Institute for Data Analytics brings together applied research groups and data scientists from all disciplines (principally health, local government and academia), opening up opportunities to understand health and human behaviour and casting light on the action required to tackle a range of social and environmental problems.

5) Initial meetings have been held with Boots and Experian and a further meeting has been arranged with Boots for the end of September.

6) Experian have unique intellectual property in profiling populations that is already being used in local government and further exploration is required as to what their offer to us comprises and how we can learn from their greater expertise in data science.

7) Two meetings have been held with Gartner. Gartner are not a traditional consultancy company. They work with 82% of the Global 500 company list such as Amazon, Google, Facebook, Walmart, Unilever, BMW, Tesla, Apple and also the leading consultancy firms including McKinsey, KPMG, EY, Deloitte and Accenture. The leading consultancies obtain insights and guidance from Gartner to help them execute work for their clients, as do the executives and digital teams of the more advanced, digitally mature organisations around the globe. Gartner's pitch is that they claim that they can help guide and advise us on a safe passage journey through digital challenges, helping us to understand what works and what doesn't work. They do this by pointing out global best practice across the digital healthcare transformation spectrum, and would seek to advise us on the digital business elements of Leadership, Culture, Talent, Workforce, Operating Models and Strategy as well as the digital healthcare elements ( new patient care models, data, analytics etc.), providing an all-encompassing knowledge base.

8) Gartner's claim is that they would partner with us to help us deliver on closing the gap between reality and ambition while upskilling and educating our organisations in the process.

9) However, the majority of their experience is with single organisations not a heterogenous grouping such as the ICS and it is not yet clear that their delivery model would be applicable to us.

[1] https://lida.leeds.ac.uk/

## Revised Work Plan for strategy development

10) To take account of the uncertainty around who if anyone we should choose as external support partners, a revised outline plan has been developed, see Figure 2.

Figure 2 Proposed timetable for development of strategy

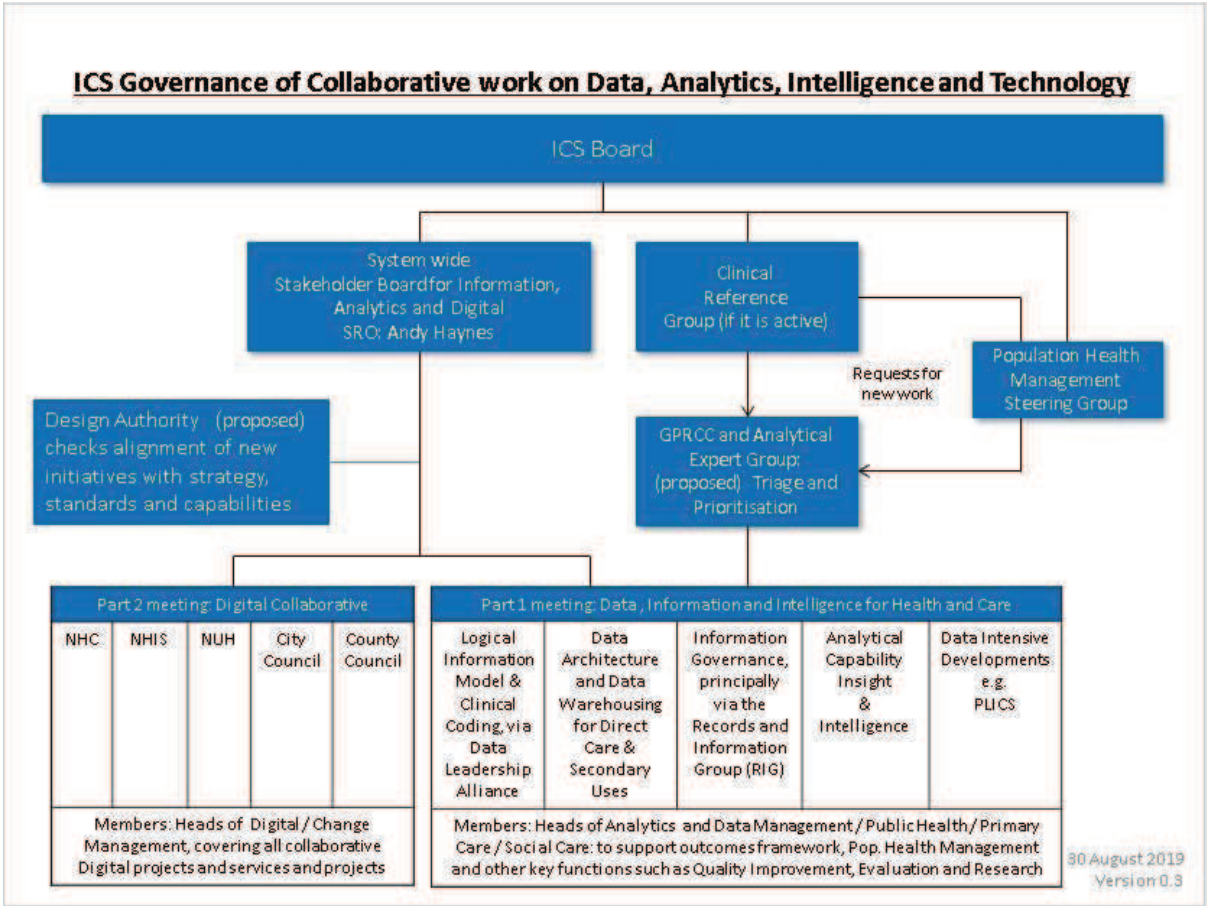
| **Timetable for Developing the Strategy** | **v0.2** | **1 Sept 2019** |
|---|---|---|
| **Activity** | Milestone | **Output** |
| | | |
| Summarise ICS response to the National Plan | 6 Sept | Material for ICS Plan draft 1; revise in period to November |
| Describe projected spend both committed and required over the 5 year period. | 6 Sept | |
| Identify key gaps in strategy development capabilities and make a proposal to fill those gaps with one or more external partners using the non-recurrent resources made available | 6 Nov | Paper to Stakeholder Board & ICS Board |
| Assuming the ICS Board confirm proposed new Governance arrangements on 12 September, establish first meeting of new Stakeholder Group | mid to end Nov | |
| Propose collaboration arrangements with local universities and other partners to Stakeholder Group | 30 Nov | |
| Stakeholder Group agrees strategic principles, priorities for investment and any implied changes needed to the 5 year plan | 31 Dec | |
| Produce draft strategy document | 14 Feb 2020 | Draft 0.1 strategy |
| Present to Stakeholder Board and revise as necessary | Feb 2020 | |
| Share with PCNs, ICPs, all statutory bodies and key working groups in the manner in which they want to do so and revise as required | Mar 2020 | Draft v0.2 |
| Present strategy to ICS Board for adoption | Apr 2020 | Draft v1.0 |
| Formal adoption by ICPs, PCNs and statutory bodies | After Apr 2020 | |

## Proposed new governance arrangements for DAIT

11) Taking observations about governance from the summer workshops, it is proposed to establish a new stakeholder board for DAIT. An attempt has been made to broaden out the previous membership to include representatives from Public Health, Social Care and the analytical communities.

12) Terms of Reference are set out at Appendix 1. In summary a two part meeting is proposed with a small overlap to discuss matters that are germane to the development of both analytics and digital technology, to allow heads of function to attend only one part if that was all that they needed to do. Task and finish groups and / or project teams will be created as required by the Group to progress specific new pieces of work, such as the strategy development. Figure 3 summarises the governance arrangements below.

Figure 3 Proposed Governance Arrangements for DAIT




## Recommendations

13) Board members are asked to:
   a) Note the progress made in developing the strategy
   b) Agree the new timetable for developing the strategy
   c) Agree the new governance arrangements.

# Appendix A: Nottingham and Nottinghamshire Stakeholder Board for Data, Analytics, Intelligence and Digital Technology: Terms of Reference

## Introduction

Connected Nottinghamshire has had an IT Management Board or a similar stakeholder group for over 6 years and it has overseen a number of improvements in digital maturity across the health and care system in Nottinghamshire. Active consideration should be given to the ongoing retention of the Connected Notts brand as it has meaning and a reputation with many people.

As we work through developing a system wide strategy for Data, Analytics, Intelligence and Technology as described in the paper to the July 2019 ICS Board[2], we need to make some adjustments to both broaden the scope of matters discussed so as to include analytics and also to bring in some stakeholders who have previously not been present.

In recognition of the different way in which portfolios are arranged in the larger organisations, a two part meeting is proposed so that individuals who only own either the Technology brief or the Analytics brief can limit the amount of time spent in meetings. Such a structure would allow those functional heads who are responsible for both portfolios (City Council, Notts Healthcare and the single CCG) to go to only one meeting.

## Purpose

The Stakeholder Board will be a senior decision making board which will have oversight of multi-organisational programmes for Data, Analytics, Intelligence and Digital Technology (DAIT) in both health and care sectors, and significant individual organisational system changes or procurements which could impact on other stakeholder organisations across Nottingham and Nottinghamshire.

The Board will be responsible for the development and oversight of implementation of the strategy for Data, Analytics, Intelligence and Digital Technology, setting the overall ambition and strategic direction for the use of digital technology and analytics across Nottingham and Nottinghamshire. The Board will establish a project team to develop the strategy. It will align the programme with key business and transformation agendas of the ICS, the ICPs and PCNs and will monitor, review and report overall progress of the programme capabilities and deliverables through the SRO to the ICS Board and the Health and Wellbeing Boards.

The Board will translate the strategy into tangible projects and have oversight on project delivery and benefits realisation management across the clinical, care and business requirements across the health and social care community.

[2] https://mk0healthandcary1acq.kinstacdn.com/wp-content/uploads/2019/07/12-july-board-papers.pdf

It will ensure that Data, Analytics, Intelligence and Digital Technology contribute towards the overall strategic direction of individual organisations and that qualitative and quantitative benefits are realised to improve the quality and productivity of clinical and care services. It will also decide how each of Data, Analytics, Intelligence and Digital Technology will underpin and enable the 5 ICS priorities of:

- Prevention and wider determinants of health;
- Proactive care, Self-management and Personalisation;
- Urgent and Emergency Care;
- Mental Health; and
- Value, Resilience and Sustainability.

Through the Digital Collaborative it will also explore how the cost effectiveness of IT service providers can be improved by working in collaboration.

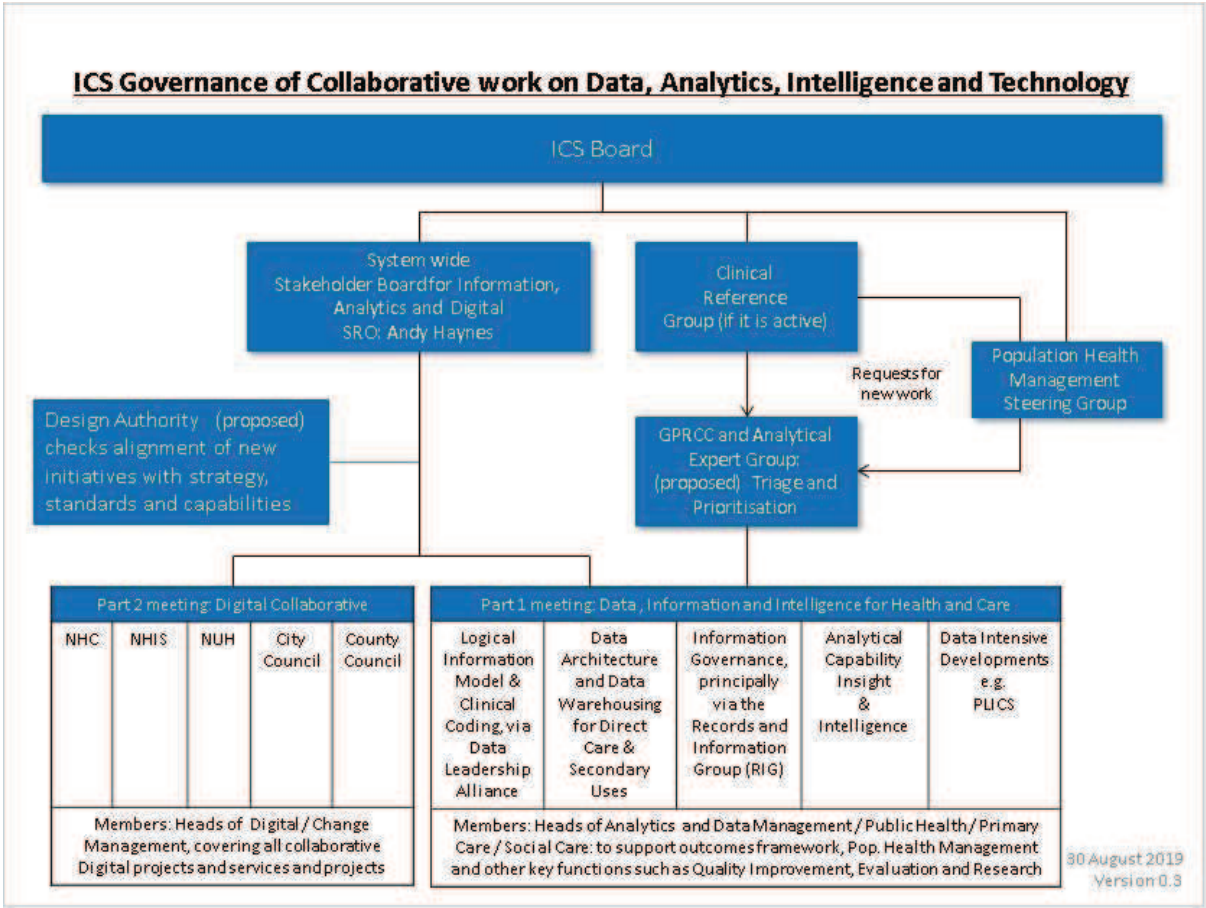
It is also proposed to establish a GPRCC and Analytics Expert Group to help to prioritise the demand for work on the GPRCC and analytical teams and to resolve any issues that are impeding progress. Separate terms of reference have been prepared for the Expert Group.

The board will also have oversight of programme delivery assurance such as Information Governance and Data Quality. A number of subordinate groups will report into the Board, be they business as usual groups such as the Records and Information Group and the Data Leadership Alliance or task and finish groups such as may be established from time to time by agreement, e.g. for the development of the strategy. Key risks and issues will be raised to the board through these subordinate groups.

## Accountability

The Board will be accountable to the Nottingham and Nottinghamshire ICS Board and will also report progress and issues to the City and County Health and Well Being Boards. It will ensure lines of assurance and reporting meet the requirements of the various transformation groups and workstreams that have dependencies on the work managed through the Board.

**Figure 1 – Governance Arrangements**




## Responsibilities

The Stakeholder Board will:

1. Set the overall ambitions and strategic direction of Data, Analytics, Intelligence and Digital Technology in Nottingham and Nottinghamshire (excluding Bassetlaw) through the production of a collaborative system wide Strategy for Data, Analytics, Intelligence and Digital Technology.
2. Ensure that the Strategy for Data, Analytics, Intelligence and Digital Technology and its annual business plans are congruent with the strategies of the statutory organisations that comprise the membership and with National Informatics Policy and Strategy, and local Transformation Programmes and Business Plans. Assessment of these plans will be on a regular basis to reflect any necessary changes resulting from shifts in national and local policies, prioritise, funding and timescales.
3. Through the membership organisations, ensure that appropriate priority is given to the investment profile for Data, Analytics, Intelligence and Digital Technology for both the strategic Commissioner and the subsequent investment into provider organisations.
4. Ensure the Nottinghamshire Data, Analytics, Intelligence and Digital Technology community has the appropriate level of engagement with clinicians, care providing

staff, public health and other management in order to maximise benefits to services, citizens and patients.

5. Sign-off the strategic plans for Data, Analytics, Intelligence and Digital Technology for Nottingham and Nottinghamshire at such times as required.
6. Oversee the work of the Nottinghamshire Health and Social Care Records and Information Group (RIG) and liaise with other appropriate information governance forums to contribute to the data/information sharing agenda. Support the implementation of local policies with the development of technical infrastructure to facilitate the successful implementation of record sharing for direct care (including clinical audit, population health management and service improvement) and for secondary purposes such as performance management, planning and research.
7. Oversee the work of the Nottinghamshire Data Leadership Alliance (DLA), which aims to standardise on how clinical and other terms are recorded across those systems that are used across health and care providers.
8. Maintain links at the strategic level of the informatics agenda across local, regional and national stakeholders for health and care including but not limited to NHS England / Improvement, NHS X, NHS Digital, the Local Government Association and the Information Governance Alliance.
9. Oversee the development of specific projects to translate the strategic intent of the health and social care community into deliverable schemes which contain clear objectives, milestones and resource implications.
10. Oversee the application and implementation of National Policy and changes in legislation which may impact the strategic delivery of the programme.
11. Monitor the delivery, utilisation, and system wide benefits realisation through the agreed Work-streams and programmes.
12. Maximise the opportunities for cost improvement by the joint utilisation of scarce specialist resources and expertise across organisations whilst supporting sharing of best practice and learning.
13. Highlight opportunities where the quality, productivity and efficiency of health and care services could be increased by the exploitation of existing technologies.
14. Provide programme assurance to the Nottingham and Nottinghamshire ICS Board (in addition to ensuring lines of assurance and reporting meet the requirements of the various transformation programmes and work streams such as Population Health Management that have a dependency on the work managed through the Board).
15. Provide good communication channels and maintain close links with key stakeholders and other appropriate groups whilst ensuring wider stakeholder groups are kept informed.
16. Oversee the work of individual programmes and work-streams providing mandates and approvals to undertake projects and specific pieces of work.
17. Oversee and address risks raised through supporting assurance groups.

## Membership

To ensure that the Board has both influence and authority members should be drawn from key business areas that rely heavily of Data, Analytics, Intelligence and Digital Technology services such as Public Health, Social Care, health care providers and commissioning.

Other members will be those that have the responsibility for leading either the Analytics / Information Management portfolio or the Digital / IT portfolio in their respective organisations and have delegated authority to make decisions on behalf of their organisation.

By including clinical, social care, Public Health, transformation representation together with the specialist leaders of the Analytical and Digital portfolios, members should have the executive authority to commit resources. The Board should be chaired by the SRO nominated by the Integrated Care System Board.

| **Role** | **Name** |
|---|---|
| *Permanent Membership* | |
| Chair (Programme SRO) | Andy Haynes |
| Director of Public Health, Nottingham City Council or their nominee | Dr Alison Challenger |
| Representative from the Clinical Reference Group or one of the Provider CCIOs | Dr Ian Trimble |
| Director of Public Health, Nottingham County Council or their nominee | Jonathan Gribbin |
| Director of Strategy (owner of IM&IT portfolios) Nottingham City Council | Colin Monckton |
| Group Manager, IT Architecture and Technical Design, Nottinghamshire County Council | Adam Crevald |
| Performance, Intelligence and Policy Team Manager, Nottinghamshire County Council | Matt Garrard |
| Social Care or Business Transformation Lead, Nottingham City Council | TBA |
| Social Care Transformation Manager, Nottinghamshire County Council | Wendy Lippmann |
| Chair of the Data Leadership Alliance / GPRCC Architect | Dr Mike O'Neil |
| Strategic Commissioner / CCG IM&T Lead | Andy Hall |
| City of Nottingham ICP representative or one of the PCN Clinical Directors in the City | TBA |
| South Nottinghamshire ICP representative or one of the PCN Clinical Directors in the South | TBA |
| Mid Nottinghamshire ICP representative or one of the PCN Clinical Directors from the South | TBA |

| | |
|---|---|
| Director or Senior Manager with IM&T portfolio, East Midlands Ambulance Service NHS Trust | Steve Bowyer |
| Senior Manager with Informatics (IM&T) portfolio, Nottinghamshire Healthcare NHS Trust | Kathy Fulloway |
| Senior Manager with Digital portfolio, Nottingham University Hospitals (NUH) NHS Trust | Andrew Fearn |
| Senior Manager with Information portfolio, NUH | Andrea Race |
| Senior Manager with IM portfolio, Sherwood Forest Hospitals NHS FT | Philip Harper |
| Director of Nottinghamshire Health Informatics Service | Jaki Taylor |
| Director with IM&T portfolio, CityCare | Louise Bainbridge |
| NEMS representative | TBA |
| PICS representative | Nicky Render |
| Chair of the Records and Information Governance Group or a nominated representative | Dr Chris Packham |
| Population Health Management Programme Lead | Maria Principe |
| Connected Nottinghamshire Programme Director | Andy Evans |
| Connected Nottinghamshire Head of Strategy and Transformation | Alexis Farrow |
| Interim lead for Information and Analytics, ICS | Andrew Haw |
| *Co-opted Membership* | |
| Representative from :<br>➢ other significant providers or commissioners such as Derbyshire health, Bassetlaw CCG<br>➢ other significant workstreams or programmes such as Public Facing Digital Services etc. | (as required) |

Additional membership will be allowable dependent upon the agenda and may be extended for particular points in the year and at the approach of milestones in the programme.

Whilst suppliers will not be formal co-opted members of any of the identified boards they will attend necessary boards, by invitation, where there is a requirement to obtain supplier input or to raise concerns directly with them.

Deputies are allowed with prior notification to the Chair.

Administrative support will be provided by Connected Nottinghamshire.

## Meetings

Although there will be one Stakeholder Board it is proposed that the Board meetings are divided into two back to back meetings on the same afternoon. The first half of the meeting would be for the Information and Analytics business, to include heads of function from each organisation plus business and other key people from Social Care and Public Health. That meeting would end with a 15 minutes overlap with the second part, made of Digital / Technology heads and business change people.

In the overlap session the Information and Analytics people would be able to escalate issues to the Technology people such as those things that they needed doing that were not happening quickly enough, or to share new requirements with their technology counterparts at an early stage. Also some topics like Longitudinal Health and Care Records would of necessity straddle the two halves of the Board, as indeed would Information Governance, who could sit in either half of the meeting or in both.

## Quoracy

To be deemed quorate meetings shall consist of a minimum of 60% of core member organisations represented with at least one commissioner representative. Core member organisations are the CCG, NUH, SFHFT, NHCT, Nottingham City Council, Nottinghamshire County Council and NHIS.

## Voting

In such cases where the Programme Board needs to take a vote each permanent member has an equal vote. In the event of members not being present designated deputies may attend and vote.

A vote is deemed to be carried if a simple majority of votes has been observed. In the event of equal votes the chairman has the casting vote.

## Pattern of Business

The Board meets on a monthly basis (via telephone conference and a physical meetings alternately) with additional meetings scheduled to coincide with any additional key decision dates.

Meetings will take place at convenient venues across the County such as the Home Brewery, Arnold; however, meetings may take place at other locations within the county dependant on the availability of accommodation or for the needs of specific meetings or presentations.

## Review and reporting

The Terms of Reference will be reviewed and a report produced against achievement of the objectives on an annual basis.

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| | |
|---|---|
| **Meeting:** | ICS Board |
| **Report Title:** | The Development of Primary Care Networks for Nottingham and Nottinghamshire |
| **Date of meeting:** | Thursday 12 September 2019 |
| **Agenda Item Number:** | 11 |
| **Work-stream SRO:** | Nicole Atkinson |
| **Report Author:** | Helen Griffiths/Lucy Dadge |
| **Attachments/Appendices:** | Enc. I2. Appendix 1 – National PCN Maturity Matrix |

**Report Summary:**


At the13 June 2019 ICS Board meeting, members considered a paper on the final configurations of Primary Care Networks (PCN) across Nottingham and Nottinghamshire. This included the NHSE governance process for approval of the PCN registrations; the rationale for the configurations and the recruitment to the Clinical Director positions.

At the ICS Board meeting the members confirmed the support for the PCN configurations, as well as the newly appointed Clinical Directors for each PCN, and noted the next steps for the development of the PCNs for Nottingham and Nottinghamshire.

This paper will:

- Outline the NHSE national offer for the development of PCNs which includes the PCN Development Support - Guidance and Prospectus and the NHSE Maturity Matrix
- Discuss the approach to utilise the national allocation of PCN Support Funding
- Provide a briefing on the development of the PCNs to date.


**Action:**

☒ To receive
☐ To approve the recommendations

**Recommendations:**

| | |
|---|---|
| 1. | To consider the report. |
| 2. | Note the NHSE National Prospectus and Maturity Matrix for the development of PCNs. |
| 3. | Confirm support for the development to date for each PCN for Nottingham and Nottinghamshire. |
| 4. | Recognise the significant requirement to support and develop the PCNs across the system, being pragmatic in the expectations of delivery at the start of the 5 year journey. |
| 5. | To note the next steps for the ongoing development of the PCNs. |

**Key implications considered in the report:**

| | | |
|---|---|---|
| Financial | ☐ | |

| | | |
|---|---|---|
| Value for Money | ☐ | |
| Risk | ☐ | |
| Legal | ☐ | |
| Workforce | ☐ | |
| Citizen engagement | ☐ | |
| Clinical engagement | ☒ | |
| Equality impact assessment | ☐ | |

**Engagement to date:**

| Board | Partnership Forum | Finance Directors Group | Planning Group | Workstream Network |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |
| Performance Oversight Group | Clinical Reference Group | Mid Nottingham-shire ICP | Nottingham City ICP | South Nottingham-shire ICP |
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Contribution to delivering the ICS high level ambitions of:**

| | |
|---|---|
| Health and Wellbeing | ☒ |
| Care and Quality | ☒ |
| Finance and Efficiency | ☒ |
| Culture | ☒ |

**Is the paper confidential?**

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

**The Development of the Primary Care Networks for Nottingham and Nottinghamshire**

**12 September 2019**

## Introduction

1. The purpose of this report is to provide the ICS Board with an overview of the NHSE national offer to support the development of Primary Care Networks (PCNs) for Nottingham and Nottinghamshire, including the national PCN maturity matrix, and the PCN Support Fund. The paper will also detail the work to date to develop and establish the PCNs across the ICS, as well as outline the next steps for the ongoing development of the PCNs.

## Background

2. At the 13 June 2019 ICS Board meeting, members considered a paper on the final configurations of Primary Care Networks (PCN) across Nottingham and Nottinghamshire, which included the NHSE governance process for approval of the PCN registrations; the rationale for the configurations and the recruitment to the Clinical Director (CD) positions. All 20 PCNs went live on 1 July 2019 with all relevant contracts and schedules agreed and signed with NHSE.

3. It is recognised that the successful implementation of the NHS Long Term Plan requires the development of effective PCNs. It is expected that to help all PCNs to mature and thrive, every ICS/STP will need to put in place high quality support.

4. A PCN Development Support – Guidance and Prospectus was published on 9 August 2019. This has been a long awaited document to help inform local systems on the framework, timelines and expectations of delivery for the PCNs. Nationally, new dedicated PCN support funding has been allocated and a total of £43.5 million was released in July to all ICSs/STPs to support PCNs develop in 2019/20.

## NHSE National Offer for Primary Care Networks

5. The PCN Development Support - Guidance and Prospectus is structured in two sections which firstly set out the parameters that all ICS/STPs should work within, and a process which systems are intended to use to develop PCN support programmes. The second section sets out key components that should be used as the basis of any support offer. Systems are expected to build upon the key components, adding specific details and requirements to meet local need.

6. In the document NHSE outline ambitions for PCNs over the next 5 years:

   - Firstly, **stabilise general practice**, including the GP partnership model
   - Secondly, **help solve the capacity gap** and improved skill-mix by growing the wider workforce by over 20,000 wholly additional staff as well as serving to help increase GP and nurse numbers
   - Thirdly, become a **proven platform for further local NHS investment**

- Fourthly**, dissolve the divide between primary and community care**, with PCNs looking out to community partners not just in to fellow practices
- And fifth, systematically deliver new services to implement the Long Term Plan, including the seven new service specifications, and **achieved clear, positive and quantified impacts** for people, patients and the wider NHS.

7. The prospectus also states what is expected to be achieved by PCNs by March 2020:

   - **Understand their own journey**: know where they are aiming to get to over the next five years. By using a diagnostic process to establish their development needs, for example, using a maturity matrix or similar tool, and putting a development plan in place
   - Functioning increasingly well as a **single team**
   - Being part of a '**network of PCNs**' that helps shape the STP/ICS plan to implement the Long Term Plan
   - Formed clear and agreed **multi-disciplinary teams** with community provider partners
   - Building on existing relationships, forming **links with local people and communities** to understand how to work most effectively for their benefit
   - Have made 100% use of emerging roles funding entitlement in line with national guidance
   - Have started work on at least one **service improvement project** of some kind, linked to Long Term Plan goals
   - Have started thinking about their **future estate needs**, jointly with community partners
   - Be ready to **deliver the new national service specifications from April 2020.**

8. The publication also outlines the expectations and role for ICS/STPs in developing and supporting PCNs. This includes:

   - To have a Director lead for PCN development, and proactively make PCN CDs aware of appropriate contact points
   - To partner with PCNs to support them to identify their level of development and support needs, forming an aggregate view across the system
   - To identify and deploy PCN support funding and associated support to meet PCNs' collective development needs, making use of system, wider NHS and external expertise and holding suppliers to account for delivery
   - To understand PCN progress and impact of support, and gather and share learning for subsequent years
   - To deliver the primary care requirements set out in the LTP

9. NHSE describes the PCN support process as:

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| **Step 1** | PCNs go live 1 July 2019. Established membership; appointed CDs; completed Network DES registration; completed and signed schedules 1 – 7. |

| | |
|---|---|
| **Step 2** | ICS/STP facilitates conversations with each PCN to help build relationships; sense of identity; purpose and identify areas of initial focus.<br>PCNs to self-assess against PCN Maturity Matrix.<br>Each PCN to identify a specific service improvement priority as a means of closer collaboration with wider system partners. |
| **Step 3** | ICS/STP and PCN CDs agree specific development support needs for 2019/20<br>PCN development support prospectus used to identify areas<br>To consider 2020/21 service specifications and wider system strategy. |
| **Step 4** | ICS/STP to deploy PCN development support funding to implement agreed development programme.<br>PCNs to come together individually as well as a collective.<br>To use system resources; wider NHS resource and external expertise. |
| **Step 5** | Support delivered to enable PCNs to develop. |
| **Step 6** | ICS/STP and CCGs support PCNs to review progress against priorities and self-assessment.<br>Areas for additional support identified.<br>Learning and best practice shared. |

10. The prospectus sets out a co-produced consensus view of six development support domains:

    1. PCN set up and support
    2. Organisational development and change
    3. Leadership development and support
    4. Supporting collaborative working
    5. Population health management
    6. Social prescribing and asset based community development

    The development domains are the agreed essential elements that systems will need to use as the basis of the support offer. It is expected that systems will wish to build on this framework and tailor the development needs in line with local requirements.

## The PCN Support Funding

11. Additional funding has been allocated to each ICS/STP for in year delivery of the PCNs. This money is ring-fenced new monies over and above that set out in the GP contract agreement.

12. The national funding is expected to be used for two purposes:

    i) PCN development, and

ii) A specific Clinical Director development programme in each ICS/STP.

The funds are intended to help PCNs make early progress against their objectives –for example supporting much closer practical collaboration between PCNs and their community partners, including preparatory activity for the forthcoming national service specifications.

13. The total value of the funding for 2019/20 for Nottingham and Nottinghamshire is £791,000 – (approx. 0.72p per patient). Early guidance suggests that this funding is "intended to be recurrent for five years dependent on need and effective use, with funding being confirmed on an annual basis".

14. The guidance outlines that systems use the funding to deliver support according to the following parameters:

- A universal offer, with all PCNs and CDs receiving support matched to their needs.
- Support designed alongside and agreed with PCNs and CDs through local conversation, promoting collaboration between PCNs and with other partners, including community service providers at both the neighbourhood and place level of the system.
- LMCs to be engaged in the allocation process.
- Alignments as set out in the NHS Long Term plan and the Network Contract DES, and supporting delivery of system strategies.
- Alignment with the approach in the NHSE national offer for PCNs prospectus. This includes:
  - Based on self-assessment of development in each PCN
  - Making use of the development of domains for PCN development support
  - Ensuring all key components are covered in the CD development offer
- Adequate resourcing and sponsorship in place at a system level, with a Director lead in every ICS/STP, who is known to all PCN CDs.
- System plans for PCN development being agreed with NHSE/I regional teams
- Outputs from use of monies monitored and shared.

**The 2019/20 PCN Maturity Matrix – see appendix 1**

15. The PCN Maturity Matrix outlines core components that underpin the successful development of networks. It sets out a progression model that evolves from the initial steps and actions that enable networks to begin to establish through to growing the scope and scale of the role of networks in delivering greater integrated care and population health for neighbourhoods.

16. The matrix can be developed and tailored to meet local circumstances and is designed to support system and network leaders, working in collaboration with

commissioners and other local leaders within neighbourhoods, to work together to:

- Identify where PCNs are now in their journey of development –and how PCNs can build on existing improvements such as those that may have been enabled by the GP Forward View and other local integration initiatives.
- Develop plans for further development – that help networks to continue to expand integrated care and approaches to population health.
- Identify support needs – using the PCN Development Support Prospectus as a guide for framing support plans and coming together to form links with their new team.

## Work to date for the development of the PCNs

17. Over the last two months work has been underway to support the development of the newly formed PCNs. This has included:

- Establishment of a **PCN Clinical Directors Network** across the ICS.
  An initial meeting was held 4 July 19 which was well attended and allowed an opportunity to bring all PCN leads together to discuss the opportunities, challenges and experiences to date in the context of the newly emerging system architecture. The second session was held on 29 August 19. The main use of the session was to hold table discussions on the PCN Support Prospectus, the Maturity Matrix, and gain initial thoughts on the approach and needs of the PCNs and the use and allocation of the PCN Support Funds.
  A programme of monthly meetings has been scheduled until March 20 covering a range of topics to support the operational delivery of the PCNs in line with national priorities.

- In July **diagnostic development sessions** were held in each ICP footprint with each of the 'PCN of Networks'. Development advisers from the Time for Care NHSE/I national programme team led and facilitated the sessions. All 3 sessions were well attended by representatives from system partner organisations. The sessions provided the opportunity for team building and getting a shared consensus of what a PCN is. Consideration was given to the PCNs current state of readiness and priorities for future development.

- Discussions are ongoing with the Time for Care National Team regarding how this programme will be best utilised locally; initial thoughts are to target the support with PCNs who are a newly formed collective of general practice to enhance their team building and pace in their development.

- Initial meetings have been taking place with colleagues from the Nottingham and Nottinghamshire **HR/OD collaborative** to explore the resources available and expectations in line with the CCGs Organisational Development Strategy. The strategy specifically notes the need for the development and enhanced leadership at the PCN Clinical Director level,

with the associated action to jointly develop a Clinical Director Leadership Programme with the newly appointed CDs.

- Meetings have also been held with colleagues from East Midlands Leadership Academy to discuss resources available to support the development of the Clinical Directors and the PCNs. A briefing is currently being developed to describe a comprehensive programme to support at an individual level, PCN level and a system level.

- A meeting was held on 22 August 19 with a 'hosted colleague' from The Kings Fund, Martin Hefford, CEO of Tū Ora Compass Health, a Primary Health Organisation in New Zealand. The meeting was attended by GP clinical leads from across the ICS to discuss and debate the opportunities and challenges for general practice in an emerging integrated system.

- A summary record of all local and national offers for PCN organisational development is being gathered centrally to support the PCNs to determine the most appropriate offer to support local needs.

18. Supporting the development of PCN Clinical Directors so that they are able to create thriving PCNs is a significant priority. It is expected that the offer of the CD programme will need to cover:

    i) development of the individual,
    ii) leadership of PCNs, and
    iii) leadership within an ICS.

    The offer and range of support locally, specifically for PCN CDs includes:

| Resource | Scheduling | Notes |
|---|---|---|
| Nottingham and Nottinghamshire PCN CD Network | Monthly meetings | Supported by the CCG and HR/OD Collaborative To support the development of a 'network of networks' to share best practice and operational delivery of PCNs. Self-determined agenda |
| Nottingham and Nottinghamshire ICS leadership programme | To commence Autumn 19 | Ran by HR/OD collaborative; East Midlands Leadership Academy; Trent University |
| National Primary Care Leadership programme | To commence Autumn 19 | Ran by NHSE One representative from each ICP |

| | | |
|---|---|---|
| Phoenix Programme | Currently being developed | Ran by LMC<br>Develop offer of practical support/skills for all PCN CDs, as well as succession planning for GP new leaders |
| Individual Coaching and mentoring<br>Action learning set model across PCNs | Currently briefing offer being developed | East Midlands Leadership Academy |
| Three Triumvirate Development Programme for Primary Care | Ongoing offer | Ran by East Midlands Leadership Academy<br>Brings together any three people in different roles within an organisation (or across the system) to work on a primary care change project |
| National PCN support offer | To commence Autumn 19 | Range of NHS body providers as well as national organisations and private providers<br>Change Management<br>Use of data and information to support decision making<br>Managing finances and budgets<br>Establishing and developing a good team<br>Influencing and engaging staff and stakeholders<br>Public engagement<br>Building the workforce – OD and operational management<br>Understanding emerging roles. |

## Next steps for the organisational development of the PCNs

19. Work is underway to plan and enable the PCNs to develop both in the immediate term and over the next 5 years. It is recognised that the 'ask' and ambitions for PCNs for the system is significant and yet at the same time it is important the ICS are pragmatic about the pace of progress across all 20 PCNs. It is important that PCNs are not set up to fail by being expected to take on too many tasks too quickly and that, as a system they are supported to develop and evolve to support

overall general practice resilience in the first instance, as they mature to deliver population health management alongside their system partners.

20. The next steps include:

- A meeting will be set up for September 19 to discuss and agree the use of the PCN Support monies. This will be determined around an agreed set of principles which will support adequate resourcing and sponsorship in place at ICS, place and PCN level. Representation at the meeting will be clinically led from both the PCN CDs, as well as the CCG clinical chairs, with support from the CCG independent GP. The LMC will also be invited to the meeting in accordance with the NHSE guidance.

- Discussions will be held with the CCG's Locality Directors, week of 2 September 19, to agree and determine the timelines for PCNs to discuss the Maturity Matrix and develop their local PCN development plan. It is anticipated that this work will be completed by the end of Quarter 3 to enable a system wide PCN development plan to be formalised.

- To determine at the earliest opportunity the organisations and/or providers to deliver the organisational development. The Framework of Providers to support this programme is currently being finalised by NHSE. As soon as this information is available the PCNs will be able to confirm their organisational development offer and approach.

- The NHSE PCN Maturity Matrix is being developed into a local work book to support individual PCN discussions to complete a baseline self-assessment and devise an annual plan. It is anticipated that this work will be carried out over the next 2-3 months which will help inform the priority areas of for each PCN. Once each PCN has completed their baseline assessments an aggregated system plan for PCN development will be established which will demonstrate individual PCN requirements as well as development to establish a 'network of networks' at both a place and system level.

- An individual coaching and mentoring offer is being determined as a priority to support the CDs. sought through East Midlands Leadership Academy.

- Discussions are underway with The Kings Fund to support an ICS PCN development whole day event this autumn, in a similar vein to the ICS leadership event. It is anticipated that system leaders will be able to discuss and debate the opportunities and challenges for the newly formed PCNs, as well as showcase service models to be delivered through PCNs as part of the NHSE New Models of Care Programme.

- Work is underway to develop a local PCN dashboard which will assist in informing and supporting the PCN development requirements in advance of the national dashboard becoming available in April 20.

## Recommendations

The Board are asked to:

- Consider this report
- Note the National Offer for the development of PCNs
- Confirm support for the development to date for each PCN for Nottingham and Nottinghamshire
- Recognise the significant requirement to support and develop the PCNs across the system, being pragmatic in the expectations of delivery at the start of a 5 year journey.
- Note the next steps for the ongoing development of the PCNs

**Helen Griffiths**
**Associate Director of Primary Care Networks**
**Mid Notts and Greater Notts CCGs**
**September 2019**

# Primary Care Network Maturity Matrix

August 2019

NHS England and NHS Improvement

# Primary Care Network Maturity Matrix

**What is the PCN Maturity Matrix?**

The Primary Care Network (PCN) Maturity Matrix outlines components that underpin the successful development of networks. It sets out a progression model that evolves from the initial steps and actions that enable networks to begin to establish through to growing the scope and scale of the role of networks in delivering greater integrated care and population health for their neighbourhoods.

The matrix was built through learning from the initial wave of Integrated Care Systems who commenced early work on the design and development of PCNs during 2017/18. It has since been refreshed in light of the NHS Long Term Plan and the GP Contract Framework. A number of systems have developed their own version of the maturity matrices to meet local need.

**Purpose of the Maturity Matrix**

The PCN maturity matrix is not a binary checklist or a performance management tool. It is designed to support network leaders, working in collaboration with systems, places and other local leaders within neighbourhoods, to work together to understand the development journey both for individual networks, and how groups of networks can collaborate together across a place in the planning and delivery of care. Using the matrix as a basis for these discussions will allow networks to:

- Come together around a shared sense of purpose, identify where PCNs are in their journey of development and consider how they can build on existing improvements such as those that may have been enabled by the GP Forward View and other local integration initiatives.

- Make plans for further development that help networks to continue to expand integrated care and approaches to population health, and that can best meet the health and care needs of the population served by the network.

- Identify support needs using the PCN Development Support Prospectus as a guide for framing support plans

**A development journey for PCNs**

Across England, PCNs will be at varied stages of development. A number of networks will be building on already established integrated ways of working and emerging population-health based new care models, with GP practices, other primary care providers, community services, secondary care, mental health, local authorities, the voluntary sector, local people and communities already collaborating on existing transformation schemes and initiatives. It is important the momentum of these existing ways of working is retained where that is already adding value for patients, staff and the wider population

*Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan* sets out a trajectory for how networks can build over time, for example with the planned introduction of the contract service specifications. The matrix is designed to complement that framework and to set out the wider supportive development journey in how networks can grow their capabilities to support local priorities. It will help STPs and ICSs to work with providers within networks to enable those journeys in a way that also reflects the priorities systems identify in their 5 year delivery strategies. As for the prospectus support domains, the PCN maturity matrix covers areas that may, from April 2020, be part of PCN service specifications.

General practices are central to the successful development of PCNs but the matrix is intended to support a holistic multi-agency view of the development of networks. 'Neighbourhoods' are the cornerstone of integrated care, served by groups of GP practices working with NHS community services, social care, mental health, other providers, voluntary organisations, local people and communities to deliver more coordinated and proactive services. It is important that development discussions framed around the matrix are able to bring together the insights and expertise of a range of local stakeholders who will be working together to provide improvements in integrated care.

# How to use the matrix

**Components of the matrix**

The matrix is set out as a table of components for the development of PCNs and is organised as follows:

- There are four columns showing a development journey over time – organised into 'Foundation', Step 1, Step 2 and Step 3
- The columns are subdivided in to components that PCNs may find it helpful to consider as part of their development journey and components that ICSs and STPs will also want to consider as part of the wider supporting infrastructure that enables network development
- There are five rows which organise the components into the following
    - Leadership, planning and partnerships
    - Use of data and population health management
    - Integrating care
    - Managing resources
    - Working in partnership with people and communities

**A basis for development discussions**

Experience from the initial community of Integrated Care Systems shows that the matrix was most effectively used when it provided the basis for local development discussions. Practices within a network came together with their CCGs and other local organisations – for example local authorities and community services – for a shared discussion on current progress and future plans for integrated care and networks. The output of these discussions was typically a shared set of priorities and actions for how the network would evolve. There is no 'one size fits all' approach on how best to organise and hold these discussions. System primary care leaders, CCG primary care directors and PCN clinical directors should come together to agree an approach that works best locally – which could, for example, inform the development of system and place level priorities and actions to support networks. The PCN Development Support Prospectus and the funding available to systems for PCN development can be utilised to support these local development discussions.

The matrix should be used pragmatically and flexibly, with networks viewing PCN development as a multi-year journey, and one that can build on progress that has already been made in improving and transformation care and services for patients and populations. **Initial discussions may want to reference the maturity matrix and focus on the following questions: Where are you now? Where do you want to be in a year? How will you get there and what do you need? Within this discussion networks will need to think about the time needed, the capacity required, the support needed to build sustainable skills and confidence to deliver.** This will enable PCNs to identify where the network wants to focus its development activity during the remainder of 19/20 and subsequent years. Network development should be a continuous improvement process, which enables plans to grow and mature, and therefore systems and their networks should consider holding further periodic reviews using the matrix – for example on an annual or bi-annual basis.

Conversations between providers operating across the network's footprint are crucial for building, trust and confidence and helping develop partnerships. Where any ICSs or STPs are confident that they have already undertaken a level of local development discussions against previous or locally developed versions of the matrix, it is expected those systems will apply a proportionate approach in how any further discussions are taken forward. In these cases, systems should assure themselves through appropriate local governance channels (including in dialogue with PCN Clinical Directors) that there is sufficient existing intelligence on network development to inform support activities during 19/20, including for the deployment of any transformation funding, and there is an understanding of local PCN level priorities that can in turn inform the development of system primary care strategies.

There is also an important role for systems in support the development of PCNs. The maturity matrix draws out how systems can do this across each theme of the matrix, ensuring that PCNs have the infrastructure, resources and relationships to thrive operationally and financially and make an important strategic contribution.

To complement the maturity matrix, there is a simple diagnostic spreadsheet tool that can support systems to understand local PCN maturity, target support and inform any local development plans. The tool enables PCNs to put the matrix 'into action'.

# PCN Maturity Matrix

| | Foundation | Step 1 | Step 2 | Step 3 |
|---|---|---|---|---|
| **Leadership, planning and partnerships**<br><br>**Prospectus Domains:** Leadership, OD, Change management, CD leadership | For PCNs:<br>• The PCN can articulate a clear vision for the network and actions for getting there. GPs, local primary care leaders, local people and community organisations, the voluntary sector and other stakeholders are engaged to help shape this.<br><br>• Clinical directors are able to access leadership development support.<br><br>For Systems<br>• Systems are actively supporting GP practices and wider providers to start establishing networks and integrated neighbourhood ways of working and have identified resources (people and funding) to support PCNs on their development journey.<br><br>• Systems have identified local approaches and teams to support PCN Clinical Directors with the establishment and development of networks and for clinical directors in their new roles. | For PCNs:<br>• The organisations within the PCN have agreed shared development actions and priorities.<br><br>• Joint planning is underway to improve integration with broader 'out of hospital' services as networks mature. There are developing arrangements for PCNs to collaborate for services delivered optimally above the 50k footprint.<br><br>• There are local arrangements in place for the PCN (for example through the PCN Clinical Directors) to be involved in place/system strategic decision-making that both supports collaboration across networks and with wider providers including NHS Trusts/FTs and local authorities.<br><br>For Systems:<br>• Primary care is enabled to have a seat at the table for system and place strategic planning.<br><br>• As set out in the LTP, there is a system level strategy for PCN development and transformation funding, with support made available for PCN development. System leaders supports PCN clinical directors to share learning and support development across networks. | For PCNs:<br>• The PCN has established an approach to strategic and operational decision-making that is inclusive of providers operating within the network footprint and delivering network-level services. There are local governance arrangements in place within networks to support integrated partnership working.<br><br>• The PCN Clinical Director is working with the ICS/STP leadership to share learning and support other PCNs to develop.<br><br>For Systems:<br>• Primary care is enabled to play an active role in strategic and operational decision-making, for example on Urgent and Emergency Care. Mechanisms in place to ensure effective representation of all PCNs at the system level.<br><br>• PCN Clinical Directors work with the ICS/STP leadership to share learning and work collaboratively to support other PCNs. | For PCNs:<br>• PCN leaders are fully participating in the decision making at the system and relevant place levels of the ICS/STP. They feel confident and have access to the data they require to make informed decisions.<br><br>For Systems:<br>• Primary care leaders are decision making members of the ICS and place level leadership, working in tandem with partner health and care organisations to allocate resources and deliver care. |
| **Use of data and population health management**<br><br>**Prospectus Domain**: Population Health Management | For PCNs:<br>• The PCN is using existing readily available data to understand and address population needs, and are identifying the improvements required for better population health.<br><br>For Systems:<br>• Infrastructure is being developed for PHM in PCNs including facilitating access to data that can be used easily, developing information governance arrangements & providing analytical support. | For PCNs:<br>• Analysis on variation in outcomes and resource use between practices and PCNs is readily available and acted upon.<br><br>• Basic population segmentation is in place, with understanding of key groups, their needs and their resource use. This should enable networks to introduce targeted interventions, which may be initially focussed on priority population cohorts<br><br>• Data and soft intelligence from multiple sources (including and wider than primary care) is being used to identify interventions.<br><br>For Systems:<br>• Basic data sharing, common population definitions, and information governance arrangements have been established that supports PCNs with implementation of PHM approaches.<br><br>• There is some linking of data flows between primary care, community services and secondary care. | For PCNs:<br>• All primary care clinicians can access information to guide decision making, including identifying at risk patients for proactive interventions, IT-enabled access to shared protocols, and real-time information on patient interactions with the system.<br><br>• Functioning interoperability within networks, including read/write access to records,.<br><br>For Systems:<br>• There is a data and digital infrastructure in place to enable a level of interoperability within and across PCNs and other system partners, including wider availability of shared care records<br><br>• Analytical support, real time patient data and PHM tools are made available for PCNs to help understand high and rising risk patients and population cohorts, and to support care design activities. | For PCNs:<br>• Systematic population health analysis allows the PCN to understand in depth their population's needs, including the wider determinants of health, and design interventions to meet them, acting as early as possible to keep people well and address health inequalities. The PCN's population health model is fully functioning for all patient cohorts.<br><br>• Ongoing systematic analysis and use of data in care design, case management and direct care interactions support proactive and personalised care<br><br>For Systems:<br>• Full interoperability is in place across the organisations within PCNs, including shared care records across providers.<br><br>• System partners work with PCNs to design proactive care models and anticipatory interventions based on evidence to target priority patient groups and to reduce health inequalities. |

# PCN Maturity Matrix

| | Foundation | Step 1 | Step 2 | Step 3 |
|---|---|---|---|---|
| **Integrating care**<br><br>**Prospectus Domain:** Collaborative Working (MDTs) | For PCNs:<br>• The PCN is starting to build local plans for improving the integration of care for their populations, informed by the Long Term Plan, GP contract framework and locally agreed system/place priorities.<br><br>• The PCN is aware of the organisations they need to engage to develop multi-agency approaches to integrated care and are beginning to make initial approaches.<br><br>For Systems:<br>• Systems support the PCNs to build relationships across physical and mental health service providers and social care partners to facilitate the delivery of Integrated care. | For PCNs:<br>• Integrated teams, which may include social care, are working within the network and supporting delivery of integrated care to the local population. Plans are in place to develop MDT ways of working, including integrated rapid response community teams and the delivery of personalised care.<br><br>• Components of comprehensive models of care are defined for all population groups, with clear gap analysis and workforce plans.<br><br>For Systems:<br>• Systems support the building of relationships across providers of physical and mental health services, and social care partners.<br><br>• System workforce plans supports the development of integrated neighbourhood teams. | For PCNs:<br>• Early elements of new models of care defined at Step 1 now in place for most population segments, with integrated teams including social care, mental health, the voluntary sector and ready access to secondary care expertise. Routine peer review takes place.<br><br>• The PCN and other providers have in place supportive HR arrangements (e.g. formalised integrated team governance and operational management) that enable multi-agency MDTs to work together effectively.<br><br>For Systems:<br>• There is continued development of partnerships across primary care, community services, social care, mental health, the voluntary sector and secondary care that are enabling on-going MDT development. Workforce sharing protocols in place. | For PCNs:<br>• Fully integrated teams are in place within the PCN, comprising of the appropriate clinical and non-clinical skill mix. MDT working is high functioning and supported by technology. The MDT holds a single view of the patient. Care plans and co-ordination in place for all high risk patients.<br><br>• There are fully interoperable IT, workforce and estates across the PCN, with sharing between networks as needed.<br><br>For Systems:<br>• Systems have developed and implemented integrated care models that meet with objectives of the LTP. |
| **Managing resources** | For PCNs:<br>• Primary care, in particular general practice, has the headroom to make change<br><br>• There are people available with the right skills to make change happen.<br><br>For Systems:<br>• System plan in place to support managing collective financial resources that includes PCNs.<br><br>• PCN development support funding is being used to address PCN development needs. | For PCNs:<br>• Steps taken to ensure operational efficiency of primary care delivery, such as delivering the Time to Care programme, and support general practices experiencing challenges in delivery of core services.<br><br>For Systems:<br>• Systems have put in place arrangements that support PCNs with improvements in the efficiency of primary care delivery and enable PCNs to make optimum use of their resources. | For PCNs:<br>• The PCN has sight of resource use and impact on system performance and can pilot new incentive schemes where agreed locally.<br><br>For Systems:<br>• Systems support networks to have sight of resource use and impact on system performance and that can enable piloting of new incentive schemes. | For PCNs:<br>• The PCN takes collective responsibility for managing the resource flowing to the network. Data is used in clinical and non-clinical interactions to make best use of resources.<br><br>For Systems:<br>• Systems support PCNs to take collective responsibility for managing the resource flowing to the network and use data in clinical and non-clinical interactions to make best use of resources. |
| **Working in partnership with people and communities**<br><br>**Prospectus Domain:** Asset based community development & social prescribing | For PCNs:<br>• Approach agreed to engaging with local communities.<br><br>• Local people and communities are informed and there are routes for them contribute to the development of the PCN.<br><br>For Systems:<br>• Systems are providing PCNs with expertise to support local involvement of people and communities. | For PCNs:<br>• The PCN is engaging directly with their population and are beginning to develop trusted relationships with wider community assets.<br><br>• The PCN has undertaken an assessment of the available community assets that can support improvements in population health and greater integration of care.<br><br>• The PCN has established relationships with local voluntary organisations and their local Healthwatch.<br><br>For Systems:<br>• Systems have put in place arrangements to support PCNs to develop local asset maps in partnership with their local community to enable models of social prescribing for personalised care. | For PCNs:<br>• The PCN is routinely connecting with and working in partnership with wider community assets in meeting their population's needs.<br><br>• Insight from local people and communities, voluntary sector is used to inform decision-making.<br><br>• Community networks are understood and connected to the PCN.<br><br>For Systems:<br>• Systems are facilitating effective partnerships with local community assets within PCN footprints.<br><br>• The system is developing a strategy to support communities to develop and build particularly in those areas that face the greatest inequalities. | For PCNs:<br>• The PCN has fully incorporated integrated working with local Voluntary, Community and Social Enterprise (VCSE) organisations as part of the wider network.<br><br>• Community representatives, and community voice, are embedded into the PCN's working practices, and are an integral part of PCN planning and decision-making.<br><br>• The PCN has built on existing community assets to connect with the whole community and codesign local services and support.<br><br>For Systems:<br>• The community assets and partnerships developed by PCNs are being connected in to strategic planning at place and system level. |

ENC. J1

| | |
|---|---|
| **Meeting:** | ICS Board |
| **Report Title:** | Update from the Mid-Nottinghamshire Integrated Care Partnership |
| **Date of meeting:** | Thursday 12 September 2019 |
| **Agenda Item Number:** | 12 |
| **Work-stream SRO:** | |
| **Report Author:** | Richard Mitchell |
| **Attachments/Appendices:** | None |

**Report Summary:**

To update on Mid-Nottinghamshire Integrated Care Partnership progress over the last month.

**Action:**

☒ To receive
☐ To approve the recommendations

**Key implications considered in the report:**

| | | |
|---|---|---|
| Financial | ☒ | |
| Value for Money | ☒ | |
| Risk | ☒ | |
| Legal | ☐ | |
| Workforce | ☒ | |
| Citizen engagement | ☒ | |
| Clinical engagement | ☒ | |
| Equality impact assessment | ☒ | |

**Engagement to date:**

| Board | Partnership Forum | Finance Directors Group | Planning Group | Workstream Network |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |
| **Performance Oversight Group** | **Clinical Reference Group** | **Mid Nottingham-shire ICP** | **Nottingham City ICP** | **South Nottingham-shire ICP** |
| ☐ | ☐ | ☒ | ☐ | ☐ |

**Contribution to delivering the ICS high level ambitions of:**

| | |
|---|---|
| Health and Wellbeing | ☒ |
| Care and Quality | ☒ |
| Finance and Efficiency | ☒ |
| Culture | ☒ |

**Is the paper confidential?**

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

## Mid-Nottinghamshire Integrated Care Partnership Board Update – August 2019

1. Below is a summary of the key discussions and decisions taken at the latest Mid-Nottinghamshire ICP Board which met on 13 August 2019.

## Approaches to Engagement

2. The Board was reminded about the five engagement principles which had been agreed at the previous meeting and were updated on the work undertaken by the task and finish group looking at a proposed engagement model.

3. Following discussion, the Board agreed to meet in public from September 2019 and to hold meetings in different venues across Mid-Nottinghamshire.

## ICP Vision Summary and Identity

4. Members were thanked for their comments and input into the ICP Vision Summary which is an aspirational high level document. It was explained that the detail of the ICP Vision will appear once the ICS response to the Long Term Plan and work on the outcomes framework had been finalised. The Board approved the ICP Vision Summary and agreed that the full ICP Vision would come back in November so that it would be aligned to the ICS response to the NHS Long Term Plan.

5. The final version of the proposed ICP identity logo [at top of page] was also approved, reflecting the Board's heritage from the Better Together programme and its place within the Nottingham and Nottinghamshire ICS.

## Q1 System Status Report

6. This was the first quarterly report received by the ICP Board from the Transformation Board. The Transformation Programme's core aim is to reduce demand for secondary care services (for mental and physical health) by enabling robust and resilient primary, community and social care. Key points were:

    - There continues to be strong and effective collaboration between ICP partners, together with demonstrable success on a range of transformation initiatives, but this success is undermined by high and growing levels of demand, particularly for urgent and emergency care. Sherwood Forest Hospital's Emergency Department attendances are 5.8% above plan year-to-date and emergency admissions are 7.6% above plan year-to-date.

- The main planned care focus is on outpatient process re-design. Whilst plans are well advanced, it was noted that first outpatient activity is above plan.
- The Board received and noted the report and agreed that quarterly updates were appropriate.

**Seasonal Plan and Update on Drivers of Demand**

7. The seasonal plan was presented by Helen Drew from the Mid-Nottinghamshire A&E Delivery Board. It articulates how the Mid-Nottinghamshire urgent care system will proactively and reactively manage demand and surges in activity. It provides both strategic and operational detail on how services will remain safe and responsive. It is a live document, and will continue to evolve as plans develop and outputs of work streams/projects are quantifiable. Helen explained this was now referred to as a Seasonal Plan as the same principles were being used to respond to urgent demand throughout the calendar year rather than just in winter. The Board discussed and received the report. It noted that the depth of detail and hard work gave a high level of assurance and thanked Helen Drew for her efforts in pulling it together.

8. Lorraine Palmer from the ICP team then presented the Drivers of Demand data. The Board was told how demand was definitely increasing but that there appeared to be a number of factors that could be contributing to that. Seven key areas of focus to be taken forward are:

    - Understanding and interrogating the changes to the community contract and GP demand to determine if there is an emerging gap.
    - The Integrated Rapid Response System (IRRS) model which will focus on two stages: pre ED (with the development of the CAS and the ability to stream patients earlier to prevent conveyance/instruction to attend ED) and the development of the IRRS clinic model to provide an additional streaming route within ED.
    - Reviewing the Directory Of Service (DOS) for Newark Urgent Treatment Centre and Call for Care (C4C) for 111 access.
    - Reviewing NEMS capacity from a 111 response and within PC24 to increase streaming into the service
    - Newark GPs are looking to consolidate duty GP cover into a single place (Newark Hospital) to facilitate booked in patients and walk ins. Consider if this could be done in Mansfield and Ashfield with the GP duty cover provided within PC24 to increase walk in capacity.
    - Understanding the increasing EMAS and 111 conveyance rates.

- Considering if there are greater opportunities to support patients attending with drug and alcohol related conditions (circa 175 patients per month).

9. Rob Mitchell from Ashfield District Council and Hayley Barsby from Mansfield District Council agreed to work with Lorraine Palmer to understand who were using NHS and council services and how partners could work together to support these citizens. The Board discussed and received the report.

## Rural Health and Care Alliance

10. The Board discussed an offer to join the Rural Health and Care Alliance which had been received by several partners. Deborah Jaines, Deputy Managing Director, ICS, agreed to take this to ICS colleagues to see if an agreement could be reached which covered the whole ICS.

## Thanks Given

11. Angela Potter from Nottinghamshire Healthcare NHS Foundation Trust and Deborah Jaines from the Nottingham and Nottinghamshire ICS confirmed that the August Board would be their last meeting. ICP Chair Rachel Munton recorded the Board's thanks to them for their contributions to the Board to date and wished them well.

12. The next ICP meeting will take place on September 9 and the key issue for discussion will be neighbourhood working approaches across the ICP.

**Richard Mitchell**
**Mid-Nottinghamshire ICP Lead**
richard.mitchell2@nhs.net
**12 September 2019**

ENC.J2

| | |
|---|---|
| **Meeting:** | ICS Board |
| **Report Title:** | South Nottinghamshire Integrated Care Provider Update |
| **Date of meeting:** | Thursday 12 September 2019 |
| **Agenda Item Number:** | 12 |
| **Work-stream SRO:** | N/A |
| **Report Author:** | John Brewin |
| **Attachments/Appendices:** | None |

**Report Summary:**

To update on South Nottinghamshire Integrated Care Provider progress over the last month.

**Action:**

☒ To receive
☐ To approve the recommendations

**Recommendations:**

| | |
|---|---|
| 1. | The Board is asked to NOTE the South Notts ICP work to date. |

**Key implications considered in the report:**

| | | |
|---|---|---|
| Financial | ☒ | |
| Value for Money | ☒ | |
| Risk | ☒ | |
| Legal | ☐ | |
| Workforce | ☒ | |
| Citizen engagement | ☒ | |
| Clinical engagement | ☒ | |
| Equality impact assessment | ☒ | |

**Engagement to date:**

| Board | Partnership Forum | Finance Directors Group | Planning Group | Workstream Network |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |
| **Performance Oversight Group** | **Clinical Reference Group** | **Mid Nottingham-shire ICP** | **Nottingham City ICP** | **South Nottingham-shire ICP** |
| ☐ | ☐ | ☒ | ☒ | ☒ |

**Contribution to delivering the ICS high level ambitions of:**

| | |
|---|---|
| Health and Wellbeing | ☒ |
| Care and Quality | ☒ |
| Finance and Efficiency | ☒ |
| Culture | ☒ |

**Is the paper confidential?**

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

Integrated Care System
Nottingham & Nottinghamshire

Nottingham City Council | Nottinghamshire County Council | NHS

# UPDATE FROM SOUTH NOTTINGHAMSHIRE INTEGRATED CARE PROVIDER

## 12 SEPTEMBER 2019

## Background

1. The South Nottinghamshire ICP has focused on progressing stakeholder engagement and establishing the appropriate governance structures to support the on-going development of the ICP this month.

## Developing the ICP's goals and identity

2. The East Midlands Leadership Academy (EMLA) facilitated a development session on 31 July 2019 with over 20 attendees from Primary Care Networks, District and Borough Councils, providers and commissioners.

3. The development session focused on identifying what is working well within South Notts and should be built on; the areas we can work on collectively to improve outcomes for our population; and who else we should engage with going forward.

4. The group recognised that there are positive relationships that can be built on to strengthen our impact, with District and Borough Councils successfully collaborating on key areas such as domestic violence, knife crime and drug and alcohol misuse.

5. The output of the session is being used to develop an action plan which will be discussed at the ICP meeting on 6 September.

## ICP planning

6. The ICP's system partners have been participating in the ICS Long Term Plan workshops during August.

7. An ICP Planning Group has been established and will be considering its response to the Long Term Plan on 11 September. This group will meet monthly to support the work of the ICP.

## ICP transformation projects

8. Mobilisation of the ICP funded transformation projects is underway, with the ICP to receive regular updates on progress against delivery.

9. The first update report was shared with the ICS following discussion at the CCG's Strategic Commissioning Committee meeting on 14 August, where the

Committee confirmed and approved the implementation next steps ('the how') following assurance in relation to compliance with CCG procurement process and scheme of delegation.

**John Brewin**
**South Nottinghamshire ICP Lead**
**john.brewin@nottshc.nhs.uk**
**2 September 2019**

ENC. J3

| | |
|---|---|
| **Meeting:** | ICS Board |
| **Report Title:** | Update from the Nottingham City Integrated Care Partnership |
| **Date of meeting:** | Thursday 12 September 2019 |
| **Agenda Item Number:** | 12 |
| **Work-stream SRO:** | |
| **Report Author:** | Ian Curryer |
| **Attachments/Appendices:** | None |

**Report Summary:**

To update on Integrated Care Provider progress over the last month.

**Action:**

☒ To receive
☐ To approve the recommendations

**Recommendations:**

| | |
|---|---|
| 1. | The Board is asked to note the Nottingham City ICP work to date. |

**Key implications considered in the report:**

| | | |
|---|---|---|
| Financial | ☐ | |
| Value for Money | ☐ | |
| Risk | ☐ | |
| Legal | ☐ | |
| Workforce | ☐ | |
| Citizen engagement | ☐ | |
| Clinical engagement | ☐ | |
| Equality impact assessment | ☐ | |

**Engagement to date:**

| Board | Partnership Forum | Finance Directors Group | Planning Group | Workstream Network |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |
| **Performance Oversight Group** | **Clinical Reference Group** | **Mid Nottingham-shire ICP** | **Nottingham City ICP** | **South Nottingham-shire ICP** |
| ☐ | ☐ | ☐ | ☒ | ☐ |

**Contribution to delivering the ICS high level ambitions of:**

| | |
|---|---|
| Health and Wellbeing | ☐ |
| Care and Quality | ☐ |
| Finance and Efficiency | ☐ |
| Culture | ☐ |

**Is the paper confidential?**

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

# NOTTINGHAM CITY INTEGRATED CARE PROVIDER UPDATE

## 12 SEPTEMBER 2019

1. The interviews for the Nottingham City ICP Programme Director Post have been conducted and a preferred candidate chosen. Further update to be shared once the usual employment contract processes have been undertaken by CityCare who will be hosting the post.

2. The planning for the ICP Launch Event continues. As this event is aimed at frontline staff, the ICP want to make this as accessible as possible, and are looking to offer a different approach with a mixture of standard and rolling programme throughout the event to allow staff to 'drop in'. The ICP Launch planning team are working closely with the Director of Communications and Engagement, Nottinghamshire ICS, to align to ICS plans and approaches.

3. Mental health and wellbeing is an agreed priority for the Nottingham and Nottinghamshire ICS and for the Nottingham City ICP. A paper was received in relation to supporting the delivery of the ICS Mental Health Strategy priorities in the City. Recognising the diversity of the population, and prevalence of mental health issues and wellbeing challenges within the City means that care needs to be given to how services are structured and developed. The ICP supported this approach and will be hosting a stakeholder workshop in November to develop an integrated approach to all age mental health in the City.

4. The CCG City Locality Team alignment to the ICP is recognised as a clear and positive step forwards for the ICP. Further assessment will need to be undertaken to fully understand the resource need for the ICP and how all partners can contribute to this.

5. The ICP is keen to explore links with EMAS in relation to developing much closer working between paramedics and PCNs, supporting the vision shared by Richard Henderson at the recent ICS Board. A meeting between Richard Henderson and Ian Curryer is being arranged to take this forward.

6. Citizen Engagement is recognised as a key principle for the City ICP going forwards and work is being undertaken in conjunction with the ICS Communication and Engagement (C&E) Team to develop a model for citizen involvement. An update was very positively received from the work undertaken to date and a recommendation supported to form a task and finish group whose membership included a small cohort of Nottingham City CCG People's Council members, Healthwatch, the Academic Health Science Network (AHSN) Patient and Public Involvement Lead, ICS C &E team member, Nottingham City Council member, and Mid Notts C&E Lead. The output of this task and finish group will be the model for citizen involvement for the City ICP.

7. The ICP received an update from the ICS Planning Team on the work underway to support the completion of the response to the NHS Long Term Plan. The ICP acknowledged that the timescales involved have not facilitated full involvement of the ICP in the work undertaken to date but were supportive of the approach taken by system partners in this endeavour. It was agreed that the full engagement of the ICP to enact the plan was crucial, and that development of the approach to support this will need to be undertaken shortly.

**Ian Curryer**
**Nottingham City ICP Lead**
**Ian.curryer@nottinghamcity.gov.uk**

ENC. K1

| | |
|---|---|
| **Meeting:** | ICS Board |
| **Report Title:** | September 2019 Integrated Performance Report |
| **Date of meeting:** | Thursday 12 September 2019 |
| **Agenda Item Number:** | 13 |
| **Work-stream SRO:** | Wendy Saviour |
| **Report Author:** | Sarah Bray |
| **Attachments/Appendices:** | Enc. K2. Integrated Performance Summary<br>Enc. K3. ICS SRM Q1 Letter |

**Report Summary:**

This report supports the ICS Board in discharging the objective of the ICS to take collective responsibility for financial and operational performance as well as quality of care (including patient/user experience). Key risks and actions are highlighted to drive focus and strategic direction from across the system to address key system performance issues.

Current key risk areas are outlined below, with a summary of key performance enclosed.

**Main areas of current risk:**

- Urgent Care System delivery – significant pressures through August
- Cancer Performance – low performance continues (mid 70%)
- Financial Sustainability
- Mental Health – OAPs (National outlier on volumes despite Q1 reductions)

Emerging & Continuing Risks:

- *Planned Care – diagnostics performance and waiting list increases, however the system remains in the upper quartile performance nationally for RTT.*
- Quality, due to performance across Maternity and risks within the Transforming Care Programme.
- Activity – 'other referrals' and elective day-case are over planned levels. Non-electives are under planned levels due to Same Day Emergency Care not being reported as expected. Demand has continued to increase in line with unmitigated growth trends.

| Service Delivery Area | 2019/20 ICS Performance | | |
|---|---|---|---|
| | No. KPIs | % Not Achieved | % Achieved |
| Mental Health | 10 | 30% | 70% |
| Urgent & Emergency Care | 11 | 91% | 9% |
| Planned Care | 5 | 42% | 58% |
| Cancer | 8 | 25% | 75% |
| Nursing & Quality | 5 | 40% | 60% |
| Finance | 8 | 50% | 50% |
| Workforce | 12 | tbc | tbc |
| Overall Performance Delivery | 47 | 48% | 52% |

Nottingham and Nottinghamshire ICS - Performance Overview - as at 29th August 2019

***Areas of Progress and Achievement*** – the ICS has made good progress with the personalisation policy and supported 38,491 people during 2018/19 against a target of 23,740.

**Assurance Frameworks**

The new NHS Oversight Framework 2019/20 has been published during August. This updated oversight framework now replaces the Single Oversight Framework and Integrated Assurance Framework and will be a focal point for joint work and support dialogue between NHS E, NHS I, CCGs, Providers and Systems.

The new approach to oversight outlines how regional teams will review performance at a system and organisational level, and identify support needs across ICSs. The changes are characterised by several key principles, which include single regulatory voice, emphasis on system performance, working with and through system leaders, progressive earned system autonomy.

Organisational support decisions should be taken having regard to the views of the ICS leadership, of which there are three levels of support, universal, targeted or mandated. These will determine the segment/ category which the organisation will be assigned, which are Maximum autonomy, targeted support, mandated support or Special Measures/ Legal Directions.

The Oversight Metrics for 2019/20 are aligned to priority areas in the NHS Long Term Plan, covering 5 areas

1. New Service Models
2. Preventing Ill Health and reducing Inequalities
3. Quality of Care and Outcomes
4. Leadership and Workforce
5. Finance and Use of Resources

**Quarter 1 2019/20 System Review Meeting**

To support the national policy direction of system leadership, changes have been made within the regulatory system, through the single NHS Oversight Framework, and the alignment of NHS England and NHS Improvement responsibilities. As such any discussions on the delivery of the ICS MOU and operational NHS performance and delivery, will now in the first instance, be undertaken at the system level. The first Quarterly System Review Meeting, utilising this new approach to system performance, took place on the 16 August. The review focused on finance, quality, performance, workforce and ICS Maturity. Areas of focus were:

- Finance – system control total and underlying positions
- Performance – urgent care, waiting lists, cancer, diagnostics and Mental Health Out of Area Placements
- Quality – clostridium difficile and antimicrobial stewardship, maternity
- Workforce – community nursing and AHP

The feedback letter is provided for information – Enc. K3.

**Action:**

☒ To receive

| | | |
|---|---|---|
| ☐ To approve the recommendations | | |
| **Recommendations:** | | |
| 1. | That the board note the contents of the report | |
| **Key implications considered in the report:** | | |
| Financial | ☒ | Delivery against forecast and year to date |
| Value for Money | ☐ | |
| Risk | ☒ | Service delivery and performance risks |
| Legal | ☐ | |
| Workforce | ☒ | Delivery against workforce plans |
| Citizen engagement | ☐ | |
| Clinical engagement | ☐ | |
| Equality impact assessment | ☐ | |

| **Engagement to date:** | | | | |
|---|---|---|---|---|
| Board | Partnership Forum | Finance Directors Group | Planning Group | Workstream Network |
| ☐ | ☐ | ☒ | ☐ | ☐ |
| Performance Oversight Group | Clinical Reference Group | Mid Nottingham-shire ICP | Nottingham City ICP | South Nottingham-shire ICP |
| ☒ | ☐ | ☐ | ☐ | ☐ |

| **Contribution to delivering the ICS high level ambitions of:** | |
|---|---|
| Health and Wellbeing | ☒ |
| Care and Quality | ☒ |
| Finance and Efficiency | ☒ |
| Culture | ☒ |

**Is the paper confidential?**

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

# INTEGRATED PERFORMANCE OVERVIEW

## 30TH JULY 2019

| Red Risks to System Delivery | | |
|---|---|---|
| *RAG* | ***Performance Issues*** | ***Actions to Address*** |
| **A: Mental Health** | ***Performance*** concerns relating to:<br>CYP Access & data capture issues ongoing relating to Kooth, being supported nationally. EIP Concordant compliance & Data – Level 2 assessment May 2019. Further improvements potentially at risk due to CBTp training issues<br><br>***5YFV Transformation Areas*** issues:<br>Out of Area Inappropriate placements – remain national outlier on volumes of placements. Revised trajectories were agreed for 2019/20, system has achieved Q1. National clinical support and regulatory deep dive overview is in place.<br><br>IPS – Service not currently delivered across the ICS. Wave 2 funding has been received to progress the service across the ICS<br>.<br>Physical Health Checks are currently not progressing in line with requirements, the system is reviewing alternative service models. | A number of performance and 5YFV transformation area concerns remain for Nottinghamshire. As a result the system has Service Improvement plans for IAPT, EIP, CYP, Out of Area Placements (including Liaison & Crisis) and Physical Health Checks which include phased performance improvements to deliver requirements planned for 2019/20.<br><br>ICS Executive Mental Health monthly oversight remains in place to progress the actions required through the service improvement plans.<br><br>Discussions are ongoing with Health Education England to progress potential barriers to success, including CBT and IAPT training programmes.<br><br>Funding requests have been approved for IPS, Crisis & Liaison transformation, Perinatal and CYP School Trailblazer (Nottingham City expansion, and Mansfield & Ashfield) |
| **B: Urgent Care** | ICS A&E performance remains below target and has reduced to 88.9% however this now only includes SFHT. NUH are trialling the new UEC metrics.<br><br>There were 1 twelve hour ED waits. 1 mental health extended wait at NUH.<br><br>Urgent care attendances and admissions continue on the growth trajectory seen during 2018/19 (3.4% A&E, 9.1% NEL), however are under the ICS plan (-3.7% A&E, -5.8% NEL). There are differential positions within the ICP areas and between providers & commissioners, with Mid-Notts being over plan (SFHT & CCGs), whilst and City and South Notts are under plan and reduced volumes year-on-year, however NUH are over year-on-year (5.9% A&E, 8% NEL).<br><br>EMAS has struggled to achieve category 2, due to increased volumes. Performance is more positive across Nottinghamshire, than EMAS as a whole. | Mental Health 12 Hour Breach RCA meeting July 2019, recommendations are being progressed through the A&E boards.<br><br>NUH remains in regional escalation for urgent care performance as service difficulties continue. Significant volume increases have continued. Actions to address acute and community bed capacity gaps and front door service redesign continue to be implemented. Weekly executive calls continue to be in place to respond to the pressures across the system. Daily patient review processes and 'pull teams are now in place. ECIST support is being provided and the Trust are participating in the Same Day Emergency Care accelerator programme.<br><br>Due to continuing activity increases, the ICS has undertaken an activity driver deep dive into urgent care activity, which has completed analytical analysis and clinical challenge and review. Actions include reviews with 111 and EMAS on conveyancing and triage protocols, as well as audits on the increased volumes of A&E attendances with no subsequent interventions (40% increase Nottm City Type 1 Attendances), and audits on ambulatory care activity. |

| | | |
|---|---|---|
| D:Cancer | Cancer 62 performance has remained at a low level for June 2019, 77.87%. (SFHT 71.52% / NUH 73.51%, Circle 82.93%). Breaches have increased during July with performance expected between 64%-70%.<br><br>62 day and 104 day Backlogs have increased during July and into August. | The trusts expected performance for Aug 19 to Sept 19 is 70-72%, which is maintaining current low levels of performance. The trusts continue to work through the increased demand, and capacity constraints from revised pathways and workforce issues. Alternative capacity is being sourced, through workforce, alternative providers and additional equipment / clinical capacity. However, recovery is not now expected to be achieved before the end Q3 2019/20. |
| G: Financial Sustainability | There is no reporting of the City Council due to information not being received.<br><br>The NHS & Local Authority system has not delivered against the system financial plan for July 2019, due to continuing pressures (activity/demand, staffing pressures and non-delivery of savings & efficiency programmes).<br><br>The NHS has not delivered on the system control total for July 2019 and therefore reporting a shortfall at Month 4 against the System Provider Sustainability Funding though forecast to receive all available by the end of the financial year. | The system is forecasting to deliver against the financial plan and system control total by year-end. However, this is a very challenging position with key risks the under delivery of savings/efficiency programme and activity pressures across the system.<br><br>The ICS Financial Sustainability Group are monitoring the year-to-date and forecast position and identifying where further actions are necessary. |
| **Amber Risks To System Delivery** | | |
| C: Planned Care | RTT has not achieved at ICS 91.4% June 2019. (SFHT 89.37% / NUH 92.79% / Circle 92.08%)<br><br>Waiting lists have increased further to 8% over March 2019 levels, and 6.8% over June trajectory. There has been an increase in 'Other Referrals' by consultants and A&E departments, which is being investigated.<br><br>NUH 52 week waits reductions are in line with planned trajectories.<br><br>Children's wheelchair waits have continued to achieve at Q1 19/20 98.6%. | The ICS has expanded the Drivers of Demand review to include planned care activity.<br><br>SFHFT and the CCG are monitoring recovery plans at speciality levels, which include staffing and additional capacity, for recovery September 2019. Actions include staged implementation of Medefer Virtual Hospital Model, June-August. NUH are investigating causal factors of growth in specific specialties during August.<br><br>52+ waits recovery to nil at NUH is expected by Q2 2019/20 due to patient choice factors. This is being actively managed |
| E. Nursing & Quality | Transforming Care achieved July 19 trajectory -3 over planned levels.<br><br>CHC: ICS achieved both QP standards for July 19, however Nottingham West CCG did not achieve (predominantly due to low patient numbers)<br><br>LeDeR – There has been an increase in the number of completed reviews to 41% (55) June in line with trajectory. 79 reviews are remaining.<br><br>Maternity did not achieve the continuity of carer 20% requirement, reducing from 2.4% May 2019, which was the lowest in the Region, to 1.4% June 2019, with only | TCP remains in regional escalation. Recovery plans are in place, focus on admission avoidance, with refreshed targets having been agreed for 2019/20.<br><br>CHC performance has reduced, CCGs and Local Authorities are identifying immediate actions to be taken. Virtual MDTs to be progressed.<br><br>LeDeR – Improvement trajectory is in place supported by NHSEI. ICS is on track to clear the backlog by the end of Q2, as additional review capacity has been sourced, and achieve national standard by Nov 2019.<br><br>Maternity recovery plan is in place, revised trajectories are expected for June 2019, to progress towards the 35% requirement for March 2020, expect achievement Q1 20/21. Pilots commenced march, April, July and |

| | | |
|---|---|---|
| | 15/1103 women booked onto CoC pathway. The ICS is assessed by NHSE as 'Requiring Some Support' because of delayed implementation of Savings Babies Lives Care Bundle, CoC and higher than average rates of Smoking at the Time of Delivery. | September, with proposals for dedicated resource within each provider to lead the implementation. NUH: 1 pilot in place commenced July with 195 women joining the pathway. A bespoke support offer is currently being co-produced with the National and Regional NHSEI teams. |
| **H. Workforce** | Delivery of primary care workforce plans is a raising concern. | Primary Care and delivery of increased workforce is at risk of delivery against the planned trajectory, due to overseas recruitment not being as successful as planned. Contingencies including reviewing skill mix and further retention are being developed. |

## Integration of services, improving health of the population

While healthy life expectancy has increased both nationally and locally over recent years, Nottingham and Nottinghamshire remain below both national and core city averages. Additionally, there is a significant downward trend in female healthy life expectancy across the previous four rolling averages.

Performance measures for the ICS relating to social care and population health are being developed by the respective teams. The three priority areas are alcohol, smoking & diet.

The ICS performed well against the Personalisation agenda, and achieved all targets.

| Activity Data (number of people) | 2017/18 | Target 2018/19 | Actual 2018/19 | 2019/20 Target |
|---|---|---|---|---|
| **Person** | | | | |
| Personalised Care and Support Plans | 3709 | 10840 | 18519 | 16680 |
| Personal Health Budgets & Integrated Personal Budgets | 1743 | 2060 | 2320 | 2900 |
| **Community** | | | | |
| Self-Management Support or Health Coaching | 493 | 10840 | 17652 | 31615 |
| Community Based Approaches | 3352 | | | |

## Strengthened Leadership

ICS Governance arrangements are continuing to be strengthened, with on-going work programmes related to management of risk, organisational and system arrangements, and workstream oversight. This includes development of the ICS Outcomes Framework. A governance review is to be undertaken during Q2 2019/20.

The performance report will continue to be developed during 2019/20 to reflect the emerging governance of the ICS and ICPs and the establishment of the ICS Outcomes Framework.

CCG joint management arrangements are progressing.

## Recommendations

1. The Board/Group are asked to note the report:

   a. Integrated Performance Report and
   b. Key risk areas:

   - Urgent Care System delivery

- Mental Health OAPs
- Financial Sustainability
- Cancer Services Delivery

c. Areas of Emerging Risks:

- Local Maternity & Neonatal Services Transformation
- Planned Care – continual rising waiting lists

**Sarah Bray**
**Head of Assurance & Delivery**
**30 August 2019**
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# Nottinghamshire ICS
# System Integrated Performance Summary
# September 2019

ICS Board Meeting Item 13. Enc. K2

12 September 2019

| | Key Performance Indicator | 19/20 ICS Basis | National 19/20 Required Performance | 19/20 Reporting Period | 2019/20 ICS Performance: Latest Period | 2019/20 ICS Performance: National Month RAG | 2019/20 ICS Performance: Month Delivery Trend | 2019/20 ICS Performance: Forecast Delivery Risk | Exception Narrative |
|---|---|---|---|---|---|---|---|---|---|
| **A. Mental Health**<br>Deliver the MHFV, with a focus on Children and Young Peoples services (CYP), reductions in Out of Area Placements, improved access to mental health services (EIP / IAPT / Crisis and Liaison services) | CYP Access Rate | CCG | 34% | Q4 18/19 | 17.2% | 🔴 | ↑ | 🔴 | Due to concerns relating to performance and plans to progress the 5YFV requirements, ICS Exec level oversight remains in place. Joint Recovery plans are in place.<br>**CYP** - ICS reported 17.3% against 32% access standard in Q4 (based on national dataset). Local data indicates a Q4 position of 25% against the 32% target. Data issues continue with national reporting, expect to be fully resolved for Q3 reporting.<br>**IAPT** - ICS exceeded the target of 4.94% for April 19, all except Mansfield & Ashfield 4.74%.<br>**EIP** - Exceeded target in June 2019, achieving 77.9%. Actions are ongoing to improve service delivery against NICE standards, including access to CBTp accredited training.<br>**OAPs** – Continuing reduction in number of inappropriate out of area bed days (OBDs). Q1 trajectory was achieved (23% less than Q4 18/19), as the system was able to bring forward some Q2 actions. |
| | CYP Eating Disorders Urgent 1st <1 weeks | CCG | 95% | Q1 19/20 | 100.0% | 🟢 | ↑ | 🟢 | |
| | CYP Eating Disorders Routine 1st <4 weeks | CCG | 95% | Q1 19/20 | 75.0% | 🔴 | ↓ | 🟢 | |
| | IAPT Access - 22% (4.94% Q1% min, to 5.5% Q4)<br>2/3 of increase in IAPT-LTC | CCG | 4.94% | Apr-19 | 5.28% | 🟢 | ↑ | 🟢 | |
| | IAPT Waiting Times - 6 weeks (Rolling Quarter) | CCG | 75% | May-19 | 73.5% | 🔴 | ↓ | 🟢 | |
| | IAPT Waiting Times - 18 weeks (Rolling Quarter) | CCG | 95% | May-19 | 100.0% | 🟢 | ↑ | 🟢 | |
| | IAPT Recovery Standards (Rolling Quarter) | CCG | 50% | May-19 | 54.1% | 🟢 | ↓ | 🟢 | |
| | EIP NICE Concordant Care within 2 Weeks | CCG | 56% | Jun-19 | 77.9% | 🟢 | ↑ | 🟢 | |
| | Inappropriate Out of Area Placements (bed days)<br>Q1 3432, Q2 2024, Q3 1748, Q4 1440 | CCG | 3432 | Jun-19 | 2555 | 🟢 | ↓ | 🟡 | |
| | Maintain Dementia diagnosis rate at 2/3 of prevalence | CCG | 66.7% | Jun-19 | 76.6% | 🟢 | ↑ | 🟢 | |
| **B. Urgent & Emergency Care**<br>Improved A&E performance in 2018/19, reduce DTOCs and stranded patients, underpinned by realistic activity plans.<br>Implementation of NHS 111 Online & Urgent Treatment Centres. | Aggregate performance of 4 Hour A&E Standard<br>(SFHT performance only as NUH trialing new metrics) | Provider | 95% | Jul-19 | 88.9% | 🔴 | ↑ | 🔴 | Activity pressures continues with attendances and admissions up year on year. Although the activity across the ICS is below plan.<br>**A&E** - NUH ED are part of the new NHSE reporting pilot and will no longer be reporting against the 4 hour target. SFHFT failed to achieve national standard and planned trajectory performance with 88.95% for July 19.<br>**12 Hour Wait** - 1 x NUH patients - 1x mental health, lack of inpatient bed locally.<br>**DTOCs** - NUH failed with 3.73% in June. SFHFT also failed to achieved target in June with 4.69%<br>**Ambulance** – The ICS non conveyance group are reviewing ambulance activity with an ambition to reduce by -3% across Nottinghamshire County.<br>**111** – performance against "answered in 60 seconds" failed to achieve target in July. |
| | 12 Hour Breaches | Provider | 0 | Jul-19 | 1 | 🔴 | ↓ | 🔴 | |
| | NHS 111 50% population receiving clinical input | Provider | 50% | Jul-19 | 47.6% | 🔴 | ↓ | 🟢 | |
| | Ambulance (mean) response time Category 1 Incidents (Notts Only) | Provider | 00:07:00 | Jul-19 | 00:06:47 | 🟢 | ↓ | 🟢 | |
| | Ambulance (mean) response time Category 2 Incidents (Notts Only) | Provider | 00:18:00 | Jul-19 | 00:27:29 | 🔴 | ↑ | 🔴 | |
| | Manage Optimal Length of Stay - reduction in >21 days | Provider | 279 | Jun-19 | 317 | 🔴 | ↓ | 🟡 | |
| | Reduce DTOCs across health and social care- NUH | Provider | 3.5% | Jun-19 | 3.81% | 🔴 | ↑ | 🟢 | |
| | Reduce DTOCs across health and social care- SHFT | Provider | 3.5% | Jun-19 | 4.96% | 🔴 | ↑ | 🟡 | |
| | A&E Attendances - Variance to Plan | CCG | ±2% of plan | Jun-19 | -3.70% | 🔴 | ↓ | 🔴 | |
| | NEL - Variance to Plan | CCG | ±2% of plan | Jun-19 | -5.80% | 🔴 | ↓ | 🔴 | |
| | NEL Short Stay - Variance to Plan | CCG | ±2% of plan | Jun-19 | -12.50% | 🔴 | ↑ | 🔴 | |
| **C. Planned Care** | RTT Incomplete 92% Standard | Provider | 92% | Jun-19 | 91.4% | 🔴 | ↓ | 🟡 | **RTT** – ICS just missed the June target by 0.6% and achieved 91.4%. SFHT failed the target with performance at 89.37%.<br>**Waiting list** – ICS has grown +8% in Q1, and is +6.8% over the planned trajectory in June 19, with NUH +5.1% and SFHT +4.4% over trajectory.<br>**52 Week Waits** - NUH reported 2 breaches for Jun-19, both due to patient choice, there are no future breaches predicted<br><br>**Diagnostics** - The ICS failed to meet the standard for the third month in a row. However SFHT did achieve this target. The majority of NUH breaches have been within audiology, urodynamics, cystoscopy and gastroscopy. Additional capacity sourced from independant sector and internal process issues have been addressed. Expect performance to recover from September. Capacity risks remain relating to tax / pension issues<br><br>**Wheelchairs** – performance has been maintained for Q1. |
| | RTT Waiting List - March 2020 incomplete pathway < March 2019 | Provider | 56,751 | Jun-19 | 63,169 | 🔴 | ↑ | 🔴 | |
| | +52 Week Waits - to be halved by March 2019, and eliminated where possible | Provider | 2 | Jun-19 | 1 | 🟢 | ↓ | 🟢 | |
| | Diagnostics +6 weeks | Provider | 0.9% | Jun-19 | 1.92% | 🔴 | ↓ | 🟢 | |
| | Children's Wheelchair Waits < 18 Weeks | CCG | 92% | Q1 19/20 | 98.60% | 🟢 | ↓ | 🟢 | |
| | E-Referrals increased coverage 100% | CCG | 100% | May-19 | 105% | 🟢 | ↑ | 🟢 | |
| | GP Referrals - Variance to Plan | CCG | ±2% of plan | Jun-19 | 1.70% | 🟢 | ↑ | 🟢 | |
| | Other Referrals - Variance to Plan | CCG | ±2% of plan | Jun-19 | 4.50% | 🔴 | ↓ | 🟡 | |
| | Total Referrals - Variance to Plan | CCG | ±2% of plan | Jun-19 | 2.70% | 🔴 | ↑ | 🟡 | |
| | Outpatient 1st - Variance to Plan | CCG | ±2% of plan | Jun-19 | -0.90% | 🟢 | ↓ | 🟢 | |
| | Outpatient F/U - Variance to Plan | CCG | ±2% of plan | Jun-19 | 1.60% | 🟢 | ↑ | 🟢 | |
| | Total Elective - Variance to Plan | CCG | ±2% of plan | Jun-19 | 1.00% | 🟢 | ↓ | 🟢 | |

# Nottinghamshire ICS
# System Integrated Performance Summary
# September 2019

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|---|---|---|---|---|---|---|---|---|---|
| | | | | | Latest Period | National Month RAG | Month Delivery Trend | Forecast Delivery Risk | |
| **D. Cancer**<br>Delivery of all eight waiting time standards, implementation of nationally agreed radiotherapy specifications and diagnostic pathways, progress risk stratified scanning and follow-up pathway | Cancer 2 weeks - Suspected Cancer referrals | Provider | 93.0% | Jun-19 | 95.0% | | | | **NUH Performance** - June 73.51%. Breeches decreased to 39.5, – Urology 12.5, LGI 7.5, Lung 4. 62 day backlog increased to 133 at 12-08-19 (from 120 as of 01-07-19), with 49 confirmed cancers. LGI, (42) accounts for nearly third and is increasing due to longer than normal surgical wait driven by demand and complexity. Head and Neck backlog is still unusually high (13). Urology has improved hitting the target of 18. Treatment numbers slightly lower than last month at 151.5 (May 160). Number of patients over 104 days at the end July 36 (June 28). Un-validated July data for NUH is concerning, with forecast of 68%. Lack of surgical capacity, complexity and increased volumes are the key causal factors.<br><br>**SFHFT Performance** - June 71.52% with 26.5 breaches, compared to 16.5 breaches in May. 12 breaches were in Urology (prostate). A third of breaches were due to provider initiated delay to diagnostic or treatment planning. The number of patients who have exceeded 62 days in the backlog remains high at around 65. |
| | Cancer 2 weeks - Breast Symptomatic Referrals | Provider | 93.0% | Jun-19 | 99.5% | | | | |
| | Cancer 31 Days - First Definitive Treatment | Provider | 96.0% | Jun-19 | 96.6% | | | | |
| | Cancer 31 Days - Subsequent Treatment - Surgery | Provider | 94.0% | Jun-19 | 79.1% | | | | |
| | Cancer 31 Days - Subsequent Treatment - Anti Can | Provider | 98.0% | Jun-19 | 100.0% | | | | |
| | Cancer 31 Days - Subsequent Treatment - Radiothy | Provider | 94.0% | Jun-19 | 98.9% | | | | |
| | Cancer 62 Days - First Definitive Treatment - GP Referral | Provider | 85.0% | Jun-19 | 77.9% | | | | |
| | Cancer 62 Days - Treatment from Screening Referral | Provider | 90.0% | Jun-19 | 94.4% | | | | |
| | Cancer 62 Days - Treatment from Consultant Upgrade | Provider | | Jun-19 | 89.2% | | | | |
| **E. Nursing & Quality** | | | | | | | | | **LeDeR**: Current performance continues to demonstrate improvements. Increase in number of completed reviews increasing from 36% (42) to 41% (55) . Of the remaining 79 reviews, 45 have been allocated to reviewers leaving a total of 32 unallocated. 2 reviews are outwith and 5 reviews are CDOP cases.<br>**Maternity**: LMNS not achieving national or local trajectory for CoC with a cumulative YTD position of 6.69%. Nottingham and Nottinghamshire LMNS assessed by NHSE/I as 'Requiring Some Support' as a result of delayed progress in implementing the Saving Babies Lives Care Bundle, Continuity of Carer ambition, and higher than national average rates of Smoking at Time of Delivery (SATOD). Bespoke support offer is currently being coproduced with National and Regional Teams.<br>**CHC**: During this reporting period the ICS achieved both Quality Premium Standards: 92% of assessments completed outside of hospital setting, and 88% of decisions made within 28days. All CCGs achieved DSTs and 5/6 CCGs achieved the 28 days QP target. Nottingham West was 7% below the expected standard. |
| **Transforming Care**<br>Continued reduction of inappropriate hospitalisation of people with Learning Disabilities | Reductions in patients against Local planning trajectories - Total for Nottinghamshire | CCG | 49 | Jul-19 | 46 | | | | |
| | Learning Disability Mortality Reviews (LeDeR) 85% Mar 2020 | CCG | 40% | Jun-19 | 42% | | | | |
| **Continuing Health Care** | Fewer than 15% of Continuing Health Care Full Assessments undertaken in acute setting | CCG | <15% | Jul-19 | 10% | | | | |
| | More than 80% eligibility decisions undertaken within 28 days from receipt of checklist | CCG | 80% | Jul-19 | 88% | | | | |
| **Maternity**<br>Deliver improvements in safety for maternity services, and improve personal and mental health service provision | Continuity of Carer | Provider | 20% | Jun-19 | 1.40% | | | | |
| **Quality Measures** | Mixed Sex Breaches | | | Jul-19 | TBC | | | | CQC inspection at SFHT in April has improved overall rating to good.<br>HCAI (Hospital Aquired Infections) have action plans to address the increased rates |
| | MSSA Breaches | Provider | | Jul-19 | 0 | | | | |
| | MRSA | Provider | | Jun-19 | 0 | | | | |
| | C-Difficile | Provider | | Jun-19 | 23 | | | | |
| | E Coli | Provider | | Jun-19 | 85 | | | | |
| **F. Prevention & Public Health** | | | To be developed and populated by public health and social care | | | | | | Nottingham and Nottinghamshire remain below both national and core city averages. Additionally, there is a significant downward trend in female healthy life expectancy across the previous four rolling averages |

# Nottinghamshire ICS
# System Integrated Performance Summary
# September 2019

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|---|---|---|---|---|---|---|---|---|---|
| | | | | | Latest Period | National Month RAG | Month Delivery Trend | Forecast Delivery Risk | |
| **G. Finance & Efficiency**<br><br>***Note: Nottingham City Council and Nottinghamshire County Council information not provided and therefore is not included in finance & efficiency reports*** | **Overall Revenue Financial Position** (excluding Provider Sustainability Funding, Marginal Rate Emergency Threshold and Financial Recovery Fund) | ICS - Health & Social Care | Nil variance to the system financial plan of £65.7m in year deficit | Jul-19 | -£1.4 | 🔴 | ↓ | 🔴 | Year-to-date deficit higher than planned due to Local Authority pressures as a result of staffing issues and growth pressures on external residential placements, commissioner pressures arising for acute activity & non-delivery of QIPP and provider pressures arising from non-delivery of CIP.<br><br>FORECAST - NHS forecast to deliver against £65.7m in-year deficit (control total £67.7m deficit) with the Local Authority forecasting a £2.6m over-spend. This is a very |
| | **Overall Revenue Financial Position** (including Provider Sustainability Funding, Marginal Rate Emergency Threshold and Financial Recovery Fund) | ICS - Health & Social Care | Nil variance to the system financial plan of £8.3m in year deficit | | -£1.6 | 🔴 | ↓ | 🔴 | Year-to-date deficit higher than planned due to the pressures above & shortfall at M4 on PSF system monies due to the YTD financial position.<br><br>FORECAST - to deliver £8.3m in-year deficit. This is a very challenging position with key risks the delivery of savings/efficiency programmes and activity pressures across the system. This could impact on the receipt on provider sustainability funding in year. |
| | **NHS Revenue System Control Total** (excluding Provider Sustainability Funding, Marginal Rate Emergency Threshold and Financial Recovery Fund) | NHS | Deficit does not exceed System Control Total of £67.7m in year deficit | | -£0.6 | 🔴 | ↑ | 🟡 | Year-to-date the NHS system was off plan & therefore showing a PSF system shortfall at Month 4.<br><br>FORECAST - to deliver £65.7m in-year deficit (control total £67.7m deficit). This is a very challenging position with key risks the delivery of savings/efficiency programmes and activity pressures across the system. |
| | System Capital Control Limit | NHS | Spend does not exceed system capital control limit of £70.5m | | £0.0 | 🟢 | → | 🟢 | All provider organisations are within the System Capital Control Limit year-to-date plan. YTD spend is £13.4m.<br><br>FORECAST - to deliver. |
| | Savings & Efficiency Programme | ICS - Health & Social Care | Nil variance to plan - £159.7m (4.9%) | | £0.4 | 🔴 | ↑ | 🔴 | Delivered £33.8m of savings year-to-date, under delivery across the NHS offset by over-achievement of Local Authority savings plans.<br><br>FORECAST - NHS organisations are forecasting £124.6m (£145m plan) & Local Authority £17.6m (£14.9m plan) |
| | Provider Sustainability Funding (PSF) | NHS | Nil variance to available PSF of £27.5m | | -£0.1 | 🟢 | → | 🟡 | The system is reporting to be off plan at Month 4 & therefore a shortfall on PSF System monies.<br><br>FORECAST - All provider organisations are forecasting to receive full provider |
| | Mental Health Investment Standard (MHIS) | NHS | MH spend (exc LD & Dementia) is at least £165.1m | | £0.2 | 🟢 | ↓ | 🟢 | MHIS is forecast to be above target at the end of July 2019. |
| | Agency Ceiling | NHS | Agency Spend is within the ceiling limit of £45.4m | | £0.0 | 🟢 | → | 🟢 | All provider organisations are within the agency spend ceiling year-to-date.<br><br>FORECAST - to deliver, low risk. |

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|---|---|---|---|---|---|---|---|---|---|
| | | | | | Latest Period | National Month RAG | Month Delivery Trend | Forecast Delivery Risk | |
| **H. Workforce** | Substantive WTEs | ICS (NHS) | 25748.26 | Aug-19 | 187.00 | | | | Excludes Primary and Social Care and Nottingham City Care |
| | Agency/Bank WTEs | | 1608.28 | | -226.74 | | | | Excludes NUH actual data as not included in NHSi return |
| | Working in A&E WTEs | | 438.24 | | -256.69 | | | | Taken from NHSi monthly returns excludes NUH planned figures |
| | Transformational Roles WTEs | | TBC | Aug-19 | n/a | | | | Plan & Actual exclude primary and social care. Data accurate for 2018-2019 above plan by 56 apprentices. |
| | Apprenticeships WTEs | | TBC | | n/a | | | | |
| | Vacancy Rates | | 10.0% | Aug-19 | 10.00% | | | | . |
| | 12m Rolling Sickness Absence Rate % | | 3.0% | | 3.00% | | | | |
| | 12m Rolling Staff Turnover % | | 10.0% | | 10.00% | | | | |
| | Primary Care Workforce - GPs | | 554.19 | Apr-19 | 568.53 | | | | Data taken from Primary Care Census - March 2019 |
| | Primary Care Workforce - Clinical | | 532.00 | | 491.11 | | | | Data taken from Primary Care Census - March 2019 |
| | Primary Care Workforce - Non-Clinical | | 1273.13 | | 1205.65 | | | | Data taken from Primary Care Census - March 2019 |
| | Primary Care Workforce - Direct Patient Care | | | | 209.00 | | | | Data taken from NHS General Practice Workforce Statistics - March 2019 |
| | TBC | | | | | | | | |

Sent via email

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**Wendy Saviour**
ICS Managing Director
Nottingham and Nottinghamshire ICS

21 August 2019

Dear Wendy,

**System Review Meeting – 16 August 2019**

Thank you to you and system colleagues for attending the System Review Meeting (SRM) on 16 August 2019.

As you are aware, we are in the process of reframing our approach to regulation to best support systems to deliver the commitments of the NHS Long Term Plan. We are therefore moving away from direct regulation with individual commissioners and providers and looking to engage at a system level. Over the coming months we will continue to work with you to develop our new oversight model and welcome feedback on this emerging approach.

It was confirmed that the system has been placed into regional escalation due to poor performance in urgent and emergency care.

A summary of our discussion and actions is outlined below.

**1. Operational delivery and in-year plan**

**1.1 Finance**

At month 3 the system has reported a year to date deficit of £31.3m (excluding PSF/CSF/MRET/FRF); this results in a £0.5m adverse variance to plan, which is predominantly being caused by the performance of the Mid-Notts CCGs due to over-performance on non-elective activity.

The system confirmed its promise to meet the aggregate financial plans submitted by the ICS and its constituent members in May 2019. In conjunction with the ICS, we will continue to review this position at the system Directors of Finance meetings which have been scheduled for 16 and 18 September 2019 for Greater Nottingham and Mid-Nottinghamshire respectively. Sessions will focus on financial delivery including in-year recovery plans and the underlying financial positions of organisations and the ICS.

## 1.2 Performance

### Urgent Care

Nottingham University Hospitals Trust (NUH) is not currently reporting against the 4-hour standard as it is one of 14 pilot sites for the new clinical standards. As part of the trial, the trust reports against a mean average time in ED and although some improvement was seen in July, this has deteriorated again in August. Key challenges relate to a significant demand increase year on year.

Detailed actions relating to urgent care are discussed and reviewed at the monthly system urgent care stocktake meeting. However, some general points of discussion are noted below:

- You reported that the ICS has undertaken a piece of work to look at drivers of demand across Nottingham and Nottinghamshire. The report identifies a number of causal factors including NHS111 disposition, EMAS conveyances, and pathway and protocol changes. You confirmed that there is a programme of work in place to address demand, including changes to services outside hospital.

- We expect every system to develop a comprehensive frailty strategy to support management of urgent care and you confirmed that you will review the system strategy at the next ICS Board. It was noted that the system did not sign up to the first phase of the frailty programme within the Midlands region, however you have committed to be involved in phase two.

- The Greater Nottingham system is failing to make sustained progress on its Long Length of Stay target which remains at an average of 245 and around 18% of the bed base. The Mid-Nottinghamshire system has previously made good progress with meeting its target but numbers have increased again in recent weeks. It is important that progress is made and sustained in this area to maximise available bed capacity.

**Action 1: System to provide its frailty strategy following review at ICS Board**

### RTT

At the end of Quarter 1, the waiting list at NUH is 5.1% (1500) above trajectory and SFH is 4.4% (1147) above trajectory. In total, the waiting list is 4.7% (2647) above trajectory. However, you are confident that you will recover against the trajectory. You also confirmed that your 52-week trajectory will be zero for the remainder of the year.

### Cancer

Cancer 62-day performance across the system is significantly below standard at 77.9% in June. The backlog is increasing overall and 104-day waits have more than doubled in recent months, with the most recently reported combined figure at 44.

There are a number of challenges relating to workforce and capacity and the ICS has undertaken a 'deep dive' resulting in a clear action plan being agreed across constituent organisations. The plan enables the standard to be recovered in October 2019 as planned.

**Diagnostics**

Performance across the system did not meet the 1% standard in June, driven by poor performance of 2.7% at NUH. The key issue is MRI capacity due to significant growth but mitigating actions have been taken and recovery is forecast in September.

**Out of Area Placements**

We discussed the ongoing issue of high numbers of out of area placements. Although good progress has been made against the trajectory target in Quarter 1, the system is an outlier nationally. You helpfully outlined the plans already in place and some future options for increasing capacity in the system

**1.3 Quality**

We highlighted concerns around the rising levels of clostridium difficile and discussed the system's approach to antimicrobial stewardship. You reported that the PCNs are reviewing the data to drill down to practice level to understand what is driving this position. You also outlined the system work which continues to address the challenges of out of hospital E Coli. The system is also currently working on improvements with the NHSEI national IPC team.

We discussed maternity services and the system's plan to improve the traction on the work of the local maternity system which is being led by the CCG chief nurse, reporting to the local maternity board (and subsequently to the Regional Maternity Board). You confirmed that both provider boards have declared full compliance against the ten NHS Resolution CNST maternity safety actions, which includes the implementation of the Savings Babies Lives Care Bundle. In terms of the Public Health dimension you highlighted smoking cessation services in mid Nottinghamshire as being a key area of focus. You also described the system's plans to review the strategy for neonatal services.

**1.4 Workforce**

You recognise the need to strengthen workforce planning and workforce leads are involved in the ongoing clinical strategy and LTP work. You outlined the strategy for workforce, and there was a specific discussion around the need to address risks around the availability and skill set of the community workforce in order to deliver new models of care.

We discussed community nursing and AHP roles and the importance of further developing the specialist practitioner role, advanced clinical practitioners and community matrons who can undertake a range of diagnostic testing and prescribe. It was recognised that these roles are key to the success of the frailty work across the system and nationally recognised as a targeted area for future support and investment.

You confirmed that the ICS SRO for workforce would sit on the ICS Board going forward.

## 2. Strategy, Long Term Plan and ICS development

### 2.1 Clinical services strategy and Long Term Plan

You reported that the clinical services strategy was agreed by the ICS Board in June 2019. It identifies the top twenty areas based on demand, and an initial five will be prioritised, with clear implications for finance and activity, as the basis of the outline Long Term Plan (LTP).

You confirmed that the development of PCNs is progressing well and that the cornerstone of the LTP will be the provision of strong, integrated neighbourhood care.

You reported that work with Local Authorities has evolved more quickly in the Nottingham and Nottinghamshire system, particularly with population health management and the wider determinants of health. The ICS Board has agreed an outcomes framework which also includes early indicators of health and work continues with Public Health England to refine this approach.

The timeline and process for LTP development is agreed and there has been a high level of engagement across the system.

### 2.2 ICS development

The ICS MOU for 2019/20 was signed off at the August ICS Board.

The recent Maturity Matrix assessment categorised the ICS as ‘maturing’ in four out of five domains, with the ‘track record of delivery’ domain categorised as ‘developing’.

You are planning to undertake a governance review as a next step.

## 3. Any other business

### 3.1 National Rehabilitation Centre

You provided an update on progress against the assurance process for the national rehabilitation centre (NRC). The proposal has been reviewed by the Clinical Senate which has resulted in some further issues to be addressed. The PCBC has been reviewed by commissioners this week and there remains an outstanding revenue gap to be closed. The system is meeting with Professor Stephen Powis on 23 August to review the proposal.

### 3.2 Treatment Centre

You gave an update on the Treatment Centre following the transfer of the contract to NUH on 29 July 2019. Mobilisation is complete and the majority of staff have transferred to NUH. There is a programme of data quality and validation work underway resulting from the transfer of data from the previous IT system into NUH’s Medway system.

I would like to express my thanks to you and the system for providing a slide pack in support of the discussion, and for your participation in the session which I found extremely helpful. I look forward to working with you to further develop the relationship with NHSEI in order that we can work collectively to enable the ICS to continue to progress.

Yours sincerely

Fran Steele
Director of Strategic Transformation, North Midlands
NHS England and NHS Improvement

Cc:
Dale Bywater, Regional Director, Midlands Region, NHSE/I
Jeff Worrall, Director of Performance and Improvement, Midlands Region, NHSE/I
Mark Mansfield, Midlands Region, NHSE/I
Siobhan Heafield, Chief Nurse, Midlands Region, NHSE/I
David Pearson, ICS Chair

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| **Meeting:** | ICS Board |
| **Report Title:** | 2019/20 Financial Sustainability - NHS System Control Total and NHS Financial Plan |
| **Date of meeting:** | Thursday 12 September 2019 |
| **Agenda Item Number:** | 14 |
| **Work-stream SRO:** | Wendy Saviour, ICS Managing Director |
| **Report Author:** | Helen Pledger, ICS Finance Director |
| **Attachments/Appendices:** | Appendix 1 – Financial Performance (Month 4)<br>Appendix 2 – ICP Transformational Schemes |

**Report Summary:**


The ICS Integrated Performance Report reports the financial performance of the system and outlines that there are significant risks to the delivery of the 2019/20 NHS system control total and financial plan. The key NHS system pressures are increasing activity/demand and delivery of the savings programme of 5.2% (QIPP and CIP/FEP).

Work is underway across the system to strengthen the 2019/20 financial plan and mitigate risk. This is focussed across three areas:

- **Organisational recovery actions**
- Strengthening delivery of **system wide transformational schemes (ICPs)**, supported by flexible transformational funding
- **System wide recovery actions** (Mid Nottinghamshire and Greater Nottingham)

The latest position has been reviewed by the ICS Financial Sustainability Group (August) and ICS Finance Directors Group (September). An initial assessment of NHS organisational risks and mitigations has identified a potential risk to delivery of the financial plan of up to £41 million (1.5%) at this stage.

This paper updates the ICS Board on the progress to further develop mitigating actions and outlines next steps.


**Action:**

☒ To approve the recommendations

**Recommendations:**

| | |
|---|---|
| 1. | The ICS Board is asked to **DISCUSS** the progress update on 2019/20 Financial Sustainability (NHS) and identify any further actions needed at this stage. |
| 2. | The ICS Board is asked to **AGREE** to the proposed next steps identified in this paper, with an update to the ICS Board in October. This requires all system partners to continue to take forward the actions during September and to provide updated plans by the end of September. |

**Key implications considered in the report:**

| | | |
|---|---|---|
| Financial | ☒ | *Progress update on elements of Financial Plan to support board discussion.* |
| Value for Money | ☒ | |
| Risk | ☒ | |

| | | |
|---|---|---|
| Legal | ☐ | |
| Workforce | ☐ | |
| Citizen engagement | ☐ | |
| Clinical engagement | ☐ | |
| Equality impact assessment | ☐ | |

**Engagement to date:**

| Board | Partnership Forum | Finance Directors Group | Planning Group | Financial Sustainability Group |
|---|---|---|---|---|
| ☐ | ☐ | ☒ | ☐ | ☒ |
| **Performance Oversight Group** | **Clinical Reference Group** | **Mid Nottingham-shire ICP** | **Nottingham City ICP** | **South Nottingham-shire ICP** |
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Contribution to delivering the ICS high level ambitions of:**

| | |
|---|---|
| Health and Wellbeing | ☒ |
| Care and Quality | ☒ |
| Finance and Efficiency | ☒ |
| Culture | ☒ |

**Is the paper confidential?**

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

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# 2019/20 FINANCIAL SUSTAINABILITY – NHS SYSTEM CONTROL TOTAL

## 3 SEPTEMBER 2019

## Introduction

1. The NHS is implementing a new financial framework for providers and commissioners and it is expected that in future years we will move away from control totals and sustainability funding. However, for 2019/20 control totals remain in place, for individual organisations and ICSs.

2. The ICS has been issued a system control total of a £67.7 million in-year deficit, before provider sustainability funding (PSF), provider financial recovery fund (FRF) and marginal rate emergency threshold (MRET).

3. The NHS Providers have been allocated £27.5 million of provider sustainability funding (PSF) in 2019/20; this is paid quarterly in arrears dependent of delivery of control totals (£22.5 million on delivery of individual organisation control totals and £5 million on delivery of the overall system control total).

### 2019/20 Financial Plan (NHS)

4. The system submitted a financial plan in May 2019, following the assurance process and discussions with regulators. This requires the NHS organisations within the system to deliver an in-year financial position of £65.7 million deficit for 2019/20, as per the table below:

| In Year Financial Plan (£ millions) | |
|---|---|
| Mid Nottinghamshire CCGs | £1.1 million surplus |
| Greater Nottingham CCGs | £1.2 million surplus |
| Nottinghamshire Healthcare | £0.4 million surplus |
| Nottingham University Hospitals | £26.9 million deficit |
| Sherwood Forest Hospitals | £41.5 million deficit |
| **Total ICS (NHS Organisations)** | **£65.7 million deficit** |

5. The ICS Board receives updates on 2019/20 Financial Sustainability (NHS) and in-year delivery through the ICS Integrated Performance Report. This has highlighted that there are significant risks to the delivery of the NHS system control total and financial plan; the key NHS system pressures are activity/demand and delivery of the savings programme of 5.2% (QIPP and CIP/FEP).

6. Work is underway across the system to strengthen the 2019/20 financial plan and mitigate risk. This paper updates the ICS Board on the progress to date, including the latest position on developing mitigating actions.

## Progress to date

### Latest Financial Performance (Month 4)

7. For the period April – August 2019 (Month 4), the ICS is reporting the following NHS financial position (before PSF, FRF and MRET):

| | |
|---|---|
| **Year-to-date** | **£34.6 million deficit**<br>• £1.4 million worse than year-to-date plan<br>• £0.6 million worse than year-to-date system control total |
| **Forecast Year-end** | **£65.7 million deficit**<br>• Break-even against annual plan<br>• £2.0 million better than system control total<br><br>At month 4 NHS organisations are forecasting to deliver the plan at year-end but have highlighted that they are two significant risks to delivery: activity/demand pressures and delivery of the savings & efficiency programme (5.2%). |

Appendix 1 provides further detail by NHS organisation.

### Risk Assessment – Delivery of Financial Plan (NHS)

8. The latest NHS financial position has been reviewed at the ICS Financial Sustainability Group (August) and ICS Finance Directors Group (September).

9. As part of this review it was agreed to assess the risks and mitigations across the system in upside, downside and likely scenarios. This is informed by working that is already taking place in each of the individual NHS organisations, based on organisational assessment of risks and mitigations and latest discussions with boards/governing bodies and regulators.

10. **This initial assessment has identified a net risk to delivery of the NHS financial plan of up to £41 million (1.5% of NHS resources).** Further detail of the initial assessment is provided in the table below:

| | |
|---|---|
| **Gross Financial Risk (before mitigations)** | Individual organisations have identified a number of risks which impact on the delivery of the financial plan including:<br><br>• Activity/demand and capacity pressures<br>• Delivery of savings & efficiency programme (5.2%)<br>• Continuing Healthcare<br>• Prescribing<br>• Delivering outpatient transformation<br>• Clinical and other income |

| | |
|---|---|
| | The significant risks are activity/demand and delivery of the savings & efficiency programme which equate to 75% of assessed risk at this stage. |
| **Potential Mitigations** | Mitigations are being developed across all levels of the system as follows:<br><br>• **Organisational recovery actions**<br>• Strengthening delivery of **system wide transformational schemes (ICP)**, supported by flexible transformational funding<br>• **System wide recovery actions** (Mid Nottinghamshire and Greater Nottingham)<br><br>*Paragraphs 12 –18 provide further detail on each of these areas.* |
| **Net risk to delivery of Financial Plan** | Based on the development of the initial assessment of likely, upside and downside scenarios, the **ICS Finance Directors Group have assessed that the potential net risk to delivery of the financial plan is up to £41 million.**<br><br>*Note: this is based on current risks identified and does not include exceptional events.* |

11. Risk and mitigations, including scenarios, will be reviewed monthly by the ICS Finance Directors Group, which will include developing a standard ICS report and approach for system-wide risk and mitigation scenarios. A consolidated report will be provided to the ICS Financial Sustainability Group.

## Organisational Recovery Actions

12. All organisations have been working to strengthen the delivery of savings and efficiency programmes (QIPP and CIP/FEP) and identify further recovery actions. This includes:

- Improving the delivery of the savings & efficiency programmes by strengthening existing schemes and developing further schemes (Sherwood Forest Hospitals, Nottingham University Hospitals and CCGs have commissioned additional capacity to support this work)
- A full review of in-year budget and expenditure positions
- A review of financial controls and approach to financial governance
- Targeted work through PMOs
- A review of activity/demand and capacity pressures. This links to the drivers of demand work led by the ICS Medical Director, which will identify targeted

actions to address the emerging pressures. Initial focus has been non elective, the same process has now commenced for planned care.

## System Wide Transformational Schemes (ICPs)

13. The ICS Board approved the ICP proposals for use of the flexible transformational funding at the July meeting (see Appendix 2).

14. ICPs are implementing the approved schemes and all ICPs have confirmed that **implementation is on track and in-year delivery is forecast in line with approved plans**.

15. Key progress from July 2019 is summarised below:
    - Detailed implementation plans have been developed for each of the schemes.
    - CCG Strategic Commissioning Committee has agreed the approach for deploying funding; in line with CCG financial governance processes (City CCG holds the flexible transformational budget on behalf of the ICS).
    - Funding is released as the scheme commences and in line with actual spend.
    - Robust monitoring and evaluation processes are in place to review delivery against the plans. This includes the development of additional KPIs at ICP level. The CCG Turnaround Team PMO will monitor delivery and KPIs on a monthly basis and report this to the ICPs and ICS.
    - Recognising that this is non-recurrent funding, exit strategies are also in place should a return on investment not be demonstrated.

## System Wide Recovery Actions

16. The development of system wide recovery actions is being taken forward at a planning footprint level (Mid Nottinghamshire and Greater Nottingham). The recovery actions are focussing on four areas:

    - **Access and eligibility** e.g. review implementation of existing policies, providers of choice
    - **Corporate and estates** e.g. review utilisation of estate, minimise agency costs
    - **Service benefit reviews** e.g. review of all clinical contracts, opportunities to work with voluntary and third sector
    - **Service transformation** e.g. fast tracking developments in Long-Term Plan – outpatient transformation

17. Following the completion of an initial opportunity analysis further work has taken place to quantify the likely range of financial benefit that may be delivered. The Mid Nottinghamshire system is in the process of working up detailed delivery plans.

18. Progress on developing system wide recovery actions was discussed at the ICS Financial Sustainability. It was agreed that during September each planning footprint would consolidate the latest position and would prioritise which actions could be taken forward in 2019/20, ensuring that all agreed actions have commitment from all partners.

## Financial Assurance

19. As part of the move towards integrated assurance, joint financial assurance meetings have been established with NHS England & Improvement and the ICS Finance Director. Initial financial deep dive meetings were held with Mid Nottinghamshire and Greater Nottingham Finance Directors at the end of August. Further meetings are scheduled for mid-September to review the outcome of agreed actions and the expected impact on financial risk and year-end delivery.

## Next steps

20. The system needs to maintain pace and focus on strengthening the current financial plans and continuing to develop financial recovery actions. The following actions are required:

- **Organisational Recovery Actions:** All organisations to continue to strengthen the QIPP and CIP/FEP plans and provide the ICS Finance Director with an updated risk and mitigations position by 30 September.
- **System-wide Transformational Schemes:** CCG Turnaround PMO Team to provide monthly reports outlining financial and activity impact and KPIs for each scheme. Monthly report to be issued to all ICPs and ICS (ICS Financial Sustainability Group).
- **System-wide Recovery Actions:** Planning footprints to consolidate latest position and agree prioritised actions, ensuring commitment from all partners. Final actions to be shared with ICS Finance Director by end of September.

The ICS Financial Sustainability Group will continue to have oversight, escalating issues as required to the ICS Board.

## Recommendations

21. The ICS Board is asked to:

a) **DISCUSS** the progress update on 2019/20 Financial Sustainability (NHS) and identify any further actions needed at this stage.

b) **AGREE** to the proposed next steps identified in this paper, with an update to the ICS Board in October. **This requires all system partners to continue to take forward the actions during September and to provide updated plans by the end of September.**

**Helen Pledger**
**ICS Finance Director**
**3 September 2019**
**Helen.Pledger@nhs.net**

## Appendix 1 – NHS Financial Performance

## Year-to-date: April – August 2019 (Month 4)

| | Year-to-date (Month 4) | | | | | |
|---|---|---|---|---|---|---|
| | Mid Notts CCGs £Ms | Greater Nottm CCGs £Ms | Notts Healthcare £Ms | Nottingham University Hospitals £Ms | Sherwood Forest £Ms | NHS Total £Ms |
| Financial Position (before PSF, FRF and MRET) | -0.6 | 0.4 | -1.6 | -16.1 | -16.7 | -34.6 |
| Financial Plan | 0.5 | 0.4 | -1.6 | -16.3 | -16.2 | -33.2 |
| Variance to Plan: Surplus / (Deficit) | -1.1 | -0.0 | 0.0 | 0.2 | -0.5 | -1.4 |
| NHS System Control Total | 0.3 | 0.0 | -1.8 | -16.3 | -16.2 | -34.0 |
| Variance to Control Total: Surplus / (Deficit) | -0.9 | 0.4 | 0.2 | 0.2 | -0.5 | -0.6 |

## Year-end Forecast

| | Forecast Outturn | | | | | |
|---|---|---|---|---|---|---|
| | Mid Notts CCGs £Ms | Greater Nottm CCGs £Ms | Notts Healthcare £Ms | Nottingham University Hospitals £Ms | Sherwood Forest £Ms | NHS Total £Ms |
| Financial Position (before PSF, FRF and MRET) | 1.1 | 1.2 | 0.4 | -26.9 | -41.5 | -65.7 |
| Financial Plan | 1.1 | 1.2 | 0.4 | -26.9 | -41.5 | -65.7 |
| Variance to Plan: Surplus / (Deficit) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| NHS System Control Total | 0.9 | 0.0 | 0.0 | -27.0 | -41.5 | -67.7 |
| Variance to Control Total: Surplus / (Deficit) | 0.2 | 1.2 | 0.4 | 0.1 | 0.0 | 2.0 |

*Note: Forecasting to deliver at month 4 but this is a challenging position with high risk on activity/demand and delivery of savings & efficiency programme.*

# Appendix 2 – ICP Transformational Schemes

The ICS Board approved the following ICP schemes at the July meeting:

| ICS Strategic Priority | ICP Scheme | ICP Scheme Description | ICP | £Ms |
|---|---|---|---|---|
| Urgent and Emergency Care | Integrated Rapid Response Service (IRRS) | Strengthened rapid response service to provide urgent community based assessment and/or individualised intervention for patients at immediate risk of admission | MN | 0.4 |
| | Home First Integrated | Implementation of an integrated discharge function | MN | 0.3 |
| | Community beds and intensive at home care | The scheme aims to right size the community capacity - both home based services and community beds - in Greater Nottingham to enable delays to discharge from NUH due to waits for community/home packages to be minimised | City/SN | 1.1 |
| | Community beds and intensive at home care | Home based services in Nottingham City to enable GPs to keep people at home delivering with provision to overnight care and a new delivery model of care at home, including a 2 hour response time. | City | 0.4 |
| Pro-active care, self-management and personalisation | End of life | Development of an end of life care system that is co-ordinated and personalised through care plan discussion. | City/SN | 0.3 |
| | High Intensity Service User (HISU) | Implement high intensity service users scheme to reduce ED attendance and admissions | All | 0.3 |
| | Let's Live Well in South Notts | Provides integrated social prescribing service for the population of South Notts. | SN | 0.1 |
| Mental Health | Primary Care Psychological Medicine | Service for people with complex persistent physical symptoms (PPS) which includes people with Complex Long Term Conditions and Medically Unexplained Symptoms | SN | 0.4 |
| Value, resilience and sustainability | Outpatient transformation | Transformation of elective pathways and the current through: working collaboratively, following best practice and adopting technology, supporting care closer to home, reducing unwarranted clinical variation and improving access. | MN | 0.4 |
| | Targeted support to improve efficiency | Targeted support to delivery of SFH and NHC workstreams to improve efficiency | MN | 0.3 |
| | | | | **4.0** |

Schemes are funded from the ICS flexible transformational funding for 2019/20.

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| **Meeting:** | ICS Board |
| **Report Title:** | Urgent and Emergency Care Deep Dive |
| **Date of meeting:** | Thursday 12 September 2019 |
| **Agenda Item Number:** | 15 |
| **Work-stream SRO:** | Amanda Sullivan |
| **Report Author:** | Amanda Sullivan |
| **Attachments/Appendices:** | None |

**Report Summary:**

ICS partners work very closely together to deliver urgent and emergency care (UEC) services across a range of settings. Rising demand and the complexities of patient flows mean that operational processes and liaison need to be effective. All partners have an essential role to play.

UEC gives rise to a number of key risks for the ICS, including clinical, operational, reputational and financial. Performance is managed through two A&E Delivery Boards, serving both hospital trusts. The ICS also has an established work programme to implement national standards that integrate access points into services.

Achievement of ED waiting times standards are differential across Greater Nottingham and mid-Nottinghamshire, with the Greater Nottingham system being in regional escalation. Delayed transfers of care is another key measure. This standard is achieved in Greater Nottingham, but not in mid-Nottinghamshire.

Although the ICS standardised ED attendance and admission rates are not high when compared nationally, demand for UEC services is rising to a level that is not clinically or financially sustainable. The ICS undertook an analysis of the drivers of demand locally. There are some common findings concerning increased 111 dispositions and ambulance conveyances to hospital, although similar increases have not been seen in ED primary care streaming services.

We are undertaking significant service improvements in order to adapt to our population needs. Whilst there are some different starting points for these service changes across mid-Nottinghamshire and Greater Nottingham, the aim is to achieve a standard core offer across the ICS. PCNs will also have an increasingly important role to play.

ICS partners will need to work more closely together to fully understand inter-dependencies across the wider public sector. Further research and understanding of how best to inform the public and influence behaviours in terms of urgent care access will also be required across the ICS.

**Action:**

☒ To receive
☐ To approve the recommendations

**Recommendations:**

| | |
|---|---|
| 1. | To NOTE the findings of the report |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

| **Key implications considered in the report:** | | |
|---|---|---|
| Financial | ☐ | Management of demand and proactive care management will be required for financial sustainability across the ICS |
| Value for Money | ☐ | |
| Risk | ☐ | UEC confers reputational, operational and clinical risk, so remains a key ICS priority |
| Legal | ☐ | |
| Workforce | ☒ | Workforce retention, recruitment and development are a priority for the workforce enabling work stream |
| Citizen engagement | ☐ | |
| Clinical engagement | ☐ | |
| Equality impact assessment | ☐ | |

**Engagement to date:**

| Board | Partnership Forum | Finance Directors Group | Planning Group | Workstream Network |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |
| Performance Oversight Group | Clinical Reference Group | Mid Nottingham-shire ICP | Nottingham City ICP | South Nottingham-shire ICP |
| ☐ | ☐ | ☐ | ☐ | ☐ |

| **Contribution to delivering the ICS high level ambitions of:** | |
|---|---|
| Health and Wellbeing | ☒ |
| Care and Quality | ☒ |
| Finance and Efficiency | ☒ |
| Culture | ☒ |

**Is the paper confidential?**

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

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# URGENT AND EMERGENCY CARE DEEP DIVE

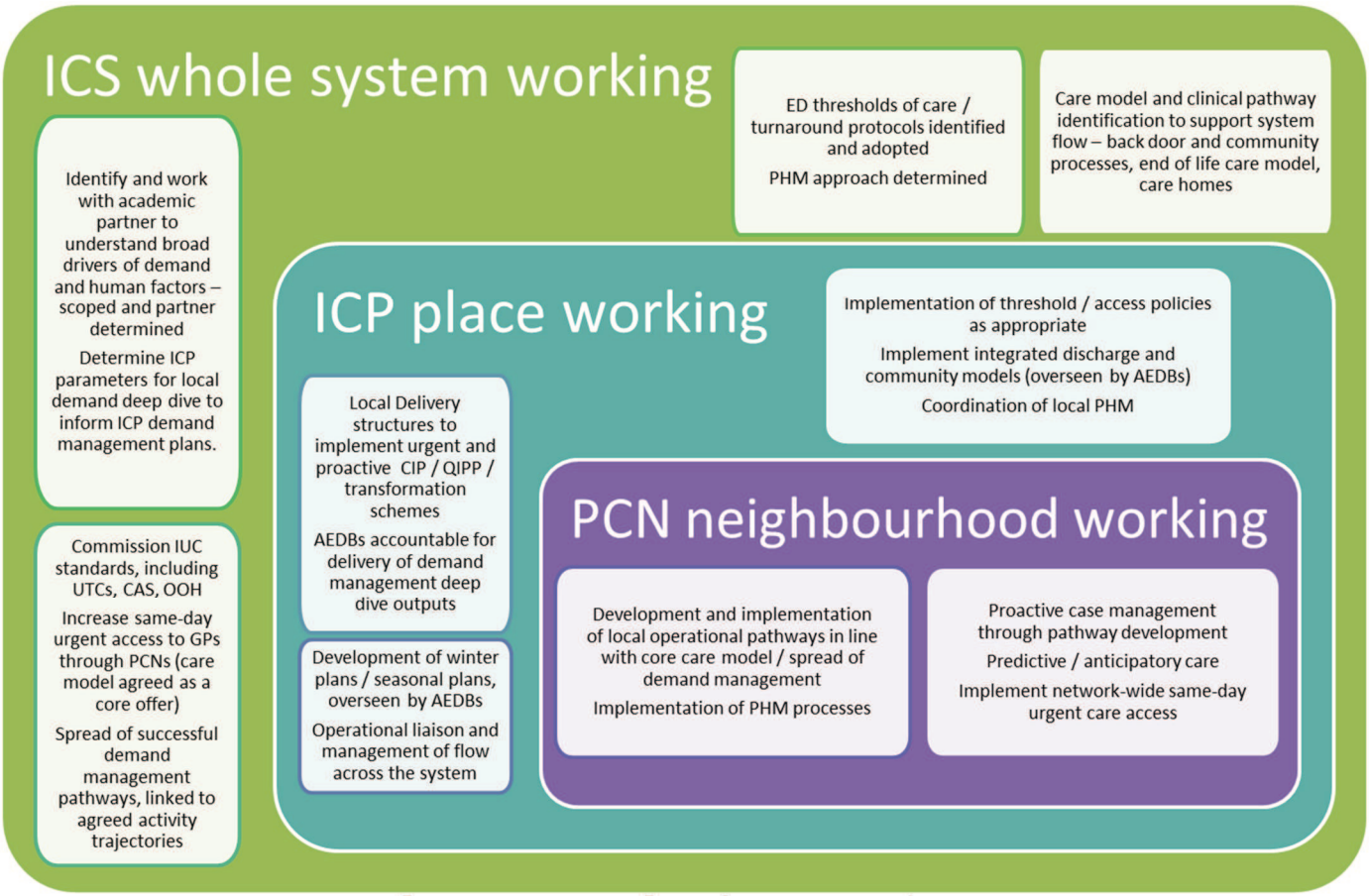
## URGENT AND EMERGENCY CARE (UEC) IS A KEY AREA OF FOCUS FOR THE ICS

1. ICS partners work very closely together to deliver urgent and emergency care services across a range of settings. Rising demand and the complexities of patient flows across different parts of the system mean that operational processes and liaison have to be robust and efficient across all constituent organisations.

2. UEC gives rise to a number of strategic risks for the ICS, including clinical, reputational, operational and financial risks. Day-to-day performance and operational liaison is managed through two A&E Delivery Boards, serving KMH and NUH catchments respectively.

3. The ICS has also established a UEC work programme, which complements the work of the Delivery Boards by taking forward work that is best done once across the ICS as a whole. This includes the implementation of the national Integrated Urgent Care (IUC) standards across the ICS, ambulance non-conveyance and the roll out of best practice schemes that support UEC patient flows. IUC will join up 111 with clinical triage services and navigation to a range of appropriate local services.

4. All partners within the ICS have a critical role to play in the development and delivery of UEC, as shown in the schematic below:



5. There are a number of potential UEC entry points for people who live in Nottingham and Nottinghamshire. These include GP urgent appointments in hours and out-of-hours, 111, 999, ED, pharmacies, Newark Hospital UCC and the Nottingham Walk-in Centre. This can be very confusing for residents, so a key priority is to join up services and to give greater clarity and consistency about appropriate access points for different types of illness or injury.

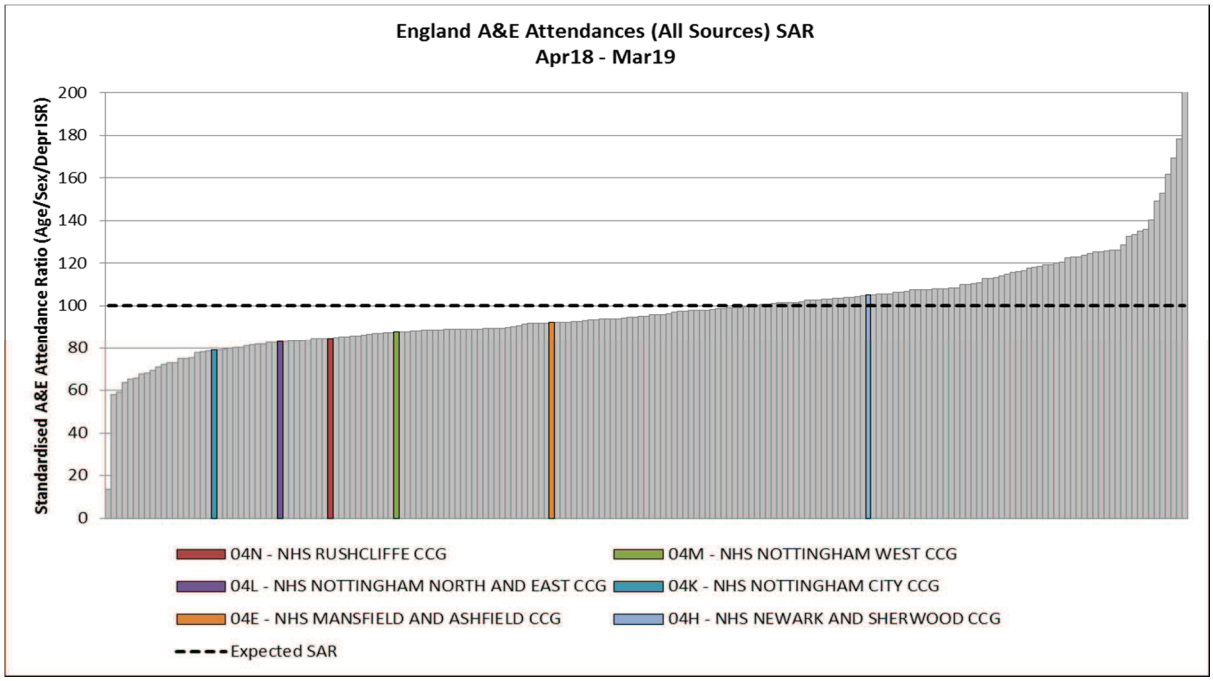
6. UEC access is most commonly measured through a performance target requiring 95% of people being seen and treated in ED within 4 hours. There are differential levels of performance across the two ICS ED departments. In 2018/19, SFH average performance was 94.23% and NUH average performance was 77.89%. The NUH / Greater Nottingham system is in regional escalation for UEC access. Currently, NUH is one of the national pilot sites testing a range of new performance standards. UEC access time is a key issue for the ICS and is multi-faceted.

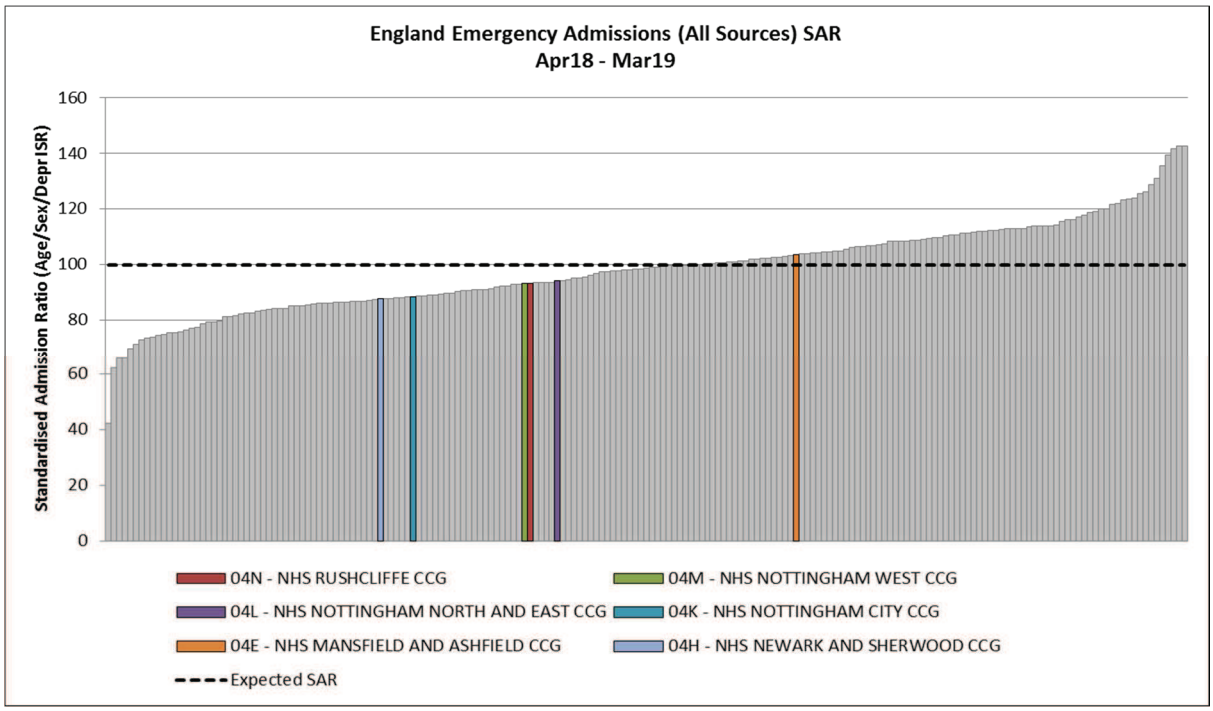
7. Another key measure is the rate of delayed transfers of care from hospital, including both health and social care delays. The standard is that no more than 3.5% of beds should be occupied by delayed patients. Over the previous year, NUH has met this standard, with an average rate of 3.03%, whilst this has been 4.3% at SFH. Action plans to reduce length of stay and delays in care are in place at both hospitals, supported by system partners.

**Demand for UEC is increasing significantly, both locally and nationally. This needs to be understood and addressed if the system is to be clinically and financially sustainable**

8. In 2018/19, there were 261,335 Greater Nottingham UEC attendances (daily average 716, including QMC and London Road Walk-In Centre with 150-200 attendances per day). There were 159,097 UEC attendances in mid-Nottinghamshire (daily average 436, including KMC and Newark Hospital with 50-90 attendances per day).

9. Unplanned hospital attendances and admissions are not high when compared nationally. However, significant increases in demand are evident and are not clinically or financially sustainable.




10. The drivers of demand are multiple and not fully understood. The ageing population, with increased prevalence of multiple long-term conditions, is a contributory factor but does not fully explain rising patterns of demand. Some pathway changes and capacity increases appear to have driven some changes in service usage and thresholds for hospital attendance / admission may also be reducing. For example, significantly increased demand for hospital services is

evident through the 111 and ambulance services. Primary care streaming is also in place within EDs.

11. The impact of changes to services across the public sector is also thought to impact on demand for hospital services, most notably social care, drug and alcohol services and third sector support for specific vulnerable groups.

12. The ICS Board commissioned work to understand what is driving demand in more detail. There were some interesting system-wide insights when looking at data over the last two years:

    12.1. EMAS ambulance conveyance increased by 5% at SFH and 3.1% at NUH.
    12.2. There has been a 2-3% increase in the 111 disposition to convey calls, with a step change in July 2018 above the national average.
    12.3. Primary care streaming has not increased the number of people seen in the ED primary care streams.

13. There are some findings that are specific to either mid-Nottinghamshire or Greater Nottingham areas.

    13.1. At KMH, there has been a 10% increase in admissions, which is a variant to the national picture. There has been a 15% increase in local walk-ins and an 8% increase in out-of-area patients. 45% of the increase is minor injuries. There have been significant increases in presentations associated with mental health and drug misuse. There has also been an 11.6% increase in admissions, mainly with increased same day emergency care.
    13.2. ED attendances have also increased at QMC, although in line with national trends. There was a spike in quarter 1 of 2019/20, which caused pressures. There is a 16% increase in people who attend and are discharged without needing an intervention. Admissions have increased by 7.1%, with a rise in the rate of admissions in the last few months of 2018/19. There has been significant building and service redesign at the front door of QMC, so direct comparisons over time are difficult to measure.

**We are adapting and changing the way that services work to accommodate demographic and behavioural changes in the use of health and care services**

14. In order to manage changing demands on local services, we are re-designing and integrating the way that services work. In addition to the ICS-level implementation of the national IUC standards and EMAS non-conveyance work, we are also developing and improving local care pathways.

15. The service transformation that we are instigating is critical for a number of reasons. First and foremost, people need timely access to urgent and emergency care when necessary, but should only be in an acute hospital when they are

acutely unwell and benefit from hospital interventions. It is estimated that 10 days of best rest for healthy older people can equate to 10 years of muscle ageing with attendant loss of function. This is something that we need to avoid through timely discharge and efficient care coordination, both in hospital and across hospital and community boundaries.

16. In addition, pressures on hospital beds and systems reduce the quality of care. Moving patients to outlier wards that are not appropriate for their medical needs increases length of hospital stay and is associated with increased mortality rates. NUH have undertaken internal analysis that shows the impact of flow through the hospital on bed capacity requirements. If there were no changes in practice and planned increases in demand, there would be a bed gap of 235 in quarter 4, peaking at 259 in December. However, internal NUH measures to prevent admissions and improve flow will bridge this gap by an estimated 183 beds. Community-based schemes to avoid admissions and improve discharge further improve the position by 77 beds overall, with 73 in December. Appendix 1 shows the analysis that underpins this position.

17. An overview of local community developments in 2019/20 is shown in the table below. The schemes that aim to avoid admissions and to reduce discharge delays broadly tackle the same issues across mid-Nottinghamshire and Greater Nottingham. However, there are different starting points in each area. A standard core offer will be developed and implemented as part of our Long-Term Plan. More detail about assumptions and scheme tracking as shown in Appendix 2.

| Scheme Name | Scheme Description | Start Date |
|---|---|---|
| **High Intensity Service Users** | GN: Employment of 4 mental health nurses to manage patients that frequently attend ED. Funding has been requested from IC P Transformation Funds<br><br>MN: Develop a High Intensity User Service (HIUS), building on learning from existing models. The service will focus on reducing ED attendances and emergency admissions for high intensity service users with a priority focus on mental health and alcohol related attendances and admissions. | September 2019<br><br>April 2019 |
| **End of Life** | GN: Improve identification of patients at end of life and ensure they have robust care plans to avoid unnecessary admissions and interventions in the last year of life.<br><br>MN: Integration of End of Life services across Mid Nottinghamshire (health, social care and third sector organisations) to support and care for people nearing end of life (and their families) – continuation and embedding of integrated care model. | September 2019<br><br>April 2019 |

| Scheme Name | Scheme Description | Start Date |
|---|---|---|
| | | |
| **Frailty Pathway** | GN: Introduction of in reach services into ED from the HCOP team to identify frail patients and support, if appropriate, discharge from ED. Service to be extended 8-8 7 days.<br><br>MN: Roll out and embedding of the Frailty MDTs in GP practices in order to reduce unplanned secondary care activity of 65+ population, review and relaunch existing frailty/falls pathways targeting outlying practices. Embed GPRCC frailty functionality into the MDT process. Engage EMAS on using the appropriate pathways/Call for Care to reduce inappropriate conveyances to ED. | August 2019<br><br>April 2019 |
| **Hospital to Home Respiratory** | GN: Employment of three specialist nurses on the Respiratory wards in NUH to improve the discharge pathway for patients with COPD and ensure appropriate community support is provided. | April 2019 |
| **Pulmonary rehabilitation** | GN: Improve uptake of pulmonary rehabilitation courses and ensure a greater number of patients complete the course. | August 2019 |
| **Integrated Community Respiratory Service** | GN: Strengthening of the community respiratory service to avoid admissions to secondary care. | October 2019 |
| **Significant 7 and care homes** | GN: Training of care home staff to recognise changes in 7 key areas that may indicate a deterioration the can be managed outside hospital if identified early.<br><br>MN: Nurse-led service proactively supporting patients in rolling cohorts of 13 care homes with highest A&E attendances and NELs admissions. Decommissioning of local care home duplicate services. Alignment of GP practices to care homes.<br><br>(Significant 7 is a new 19/20 project aimed at care homes; training package which supports Care Assistants to spot the earliest signs of deterioration in order to respond to residents needs quicker thereby reducing acute emergency care.) | October 2019<br><br>April 2019 |

| Scheme Name | Scheme Description | Start Date |
|---|---|---|
| **Housing to Home** | The Housing to Health scheme has been in place in Nottingham City since April 2016. The aim of the project is to support patients who are inappropriately housed either:<br>- where the impact of their housing situation on their health and wellbeing is deemed to be such that they are at risk of admission to hospital or<br>- at the point of discharge, where recovery from hospital care would be impossible at home and readmission or a lengthy stay in a high demand community bed would be the likely result. | April 2019 |
| **Call for Care** | Implementation of the Call for Care model in Greater Nottingham which will allow more patients to benefit from a 2 hour response to care needs that will avoid a hospital admission | October 2019 |
| **Integrated discharge** | MN: Redesign transfer of care pathways bringing together health and social care colleagues into a single system model for the discharge of patients. Phase 1 - Partnership Operating Model (D2A pathways). Phase 2 - Community hospital beds provision and re-configuration. Community Rehabilitation. Phase 3 - Remote PCN provision and ANP led model, aligned with the Acute Home Visiting service and the Integrated Rapid Response service to provide clinical responsibility for the beds in MCH and NH and spot purchased beds.<br><br>GN: Integration of IDT, hubs into an integrated discharge process. | August 2019<br><br>October 2019 |
| **Integrated Rapid Response Service (IRRS)** | MN: Clinical triage and short term interventions based on an acute medical health condition within the patients' usual place of residence. The new model will provide: A community facing, single integrated discharge team in ED. A single point of access for an urgent community assessment and/or intervention. A rigorous 'Pull' function combined with discharge to assess pathway navigation. A short term rapid response service to bridge the gap in social Packages of Care (POC). | October 2019 |
| **Community bed redesign** | GN: Re-specification of beds and development of Intensive Home Support (IHS) service. | Phased approach from October 2019 |

**PCNS will have an increasing role to play in urgent care and demand management across the ICS**

18. A General Practice Enhanced Delivery Scheme is in place for 2019/20, which has been rolled out to all GP practices. This ensures consistent delivery of primary care access standards to support reductions in demand for ED. The scheme also promotes peer review of referrals and adoption of good practice in population health management. Multi-disciplinary team meetings will be in place across all areas, with care co-ordination and population risk stratification. Social prescribing services to support high intensity users are also being put into place in each PCN.

**Capacity and flow through the system have to be understood across all partners – there are a high number of variables and inter-dependencies that impact on performance, individually and collectively**

19. In addition to the schemes to develop admissions avoidance and timely integrated discharge, it is important that flow across all parts of the system is understood and does not incur inappropriate delays and bottle necks. For example, NUH has an internal transformation programme to improve flow through the hospital. Key work areas are shown in the table below:

| Workstream 1 | Workstream 2 | Workstream 3 |
|---|---|---|
| Front Door & Assessment | Internal Flow | External Flow (Discharge) |
| Project:<br>• Process capacity UECC Front Door pathways UTU, Majors and LJCDU<br>• Workforce review UECC<br>• Remodelling B3/D57 Assessment Units<br>• HCOP in reach and senior review in ED<br>• Frailty pathway redesign collaborative system review<br>• ED/HCOP handover process review | Project:<br>• Portering and bed management satellite HUB<br>• Radiology standards and processing capacity<br>• Therapies senior review and home first risk assessments<br>• Therapy processing capacity<br>• Ambulance QMC to City pathway<br>• Live flow capacity and control centre | Project:<br>• Excellence in Discharge – Long stay<br>• Criteria for Discharge<br>• IDT system collaborative<br>• Discharge Lounge<br>• Board rounds (culture and leadership)<br>• Weekend discharge process<br>• Transport process review<br>• TTO process review |

20. The management of demand, capacity and flow across the system is necessarily a whole-ICS endeavor, since so many factors impact on each component. It is imperative that system partners have visibility on impacts across different areas and work together to address issues in an evidence-based and collaborative manner.

21. There are seasonal variations in the patterns of demand, which are reflected in seasonal capacity plans and are overseen by the A&E Delivery Boards.

**UEC will be an on-going and significant area of focus for the ICS. Some strategic choices will need to be made in order to address operational, clinical and financial pressures arising from changing patterns of population demand**

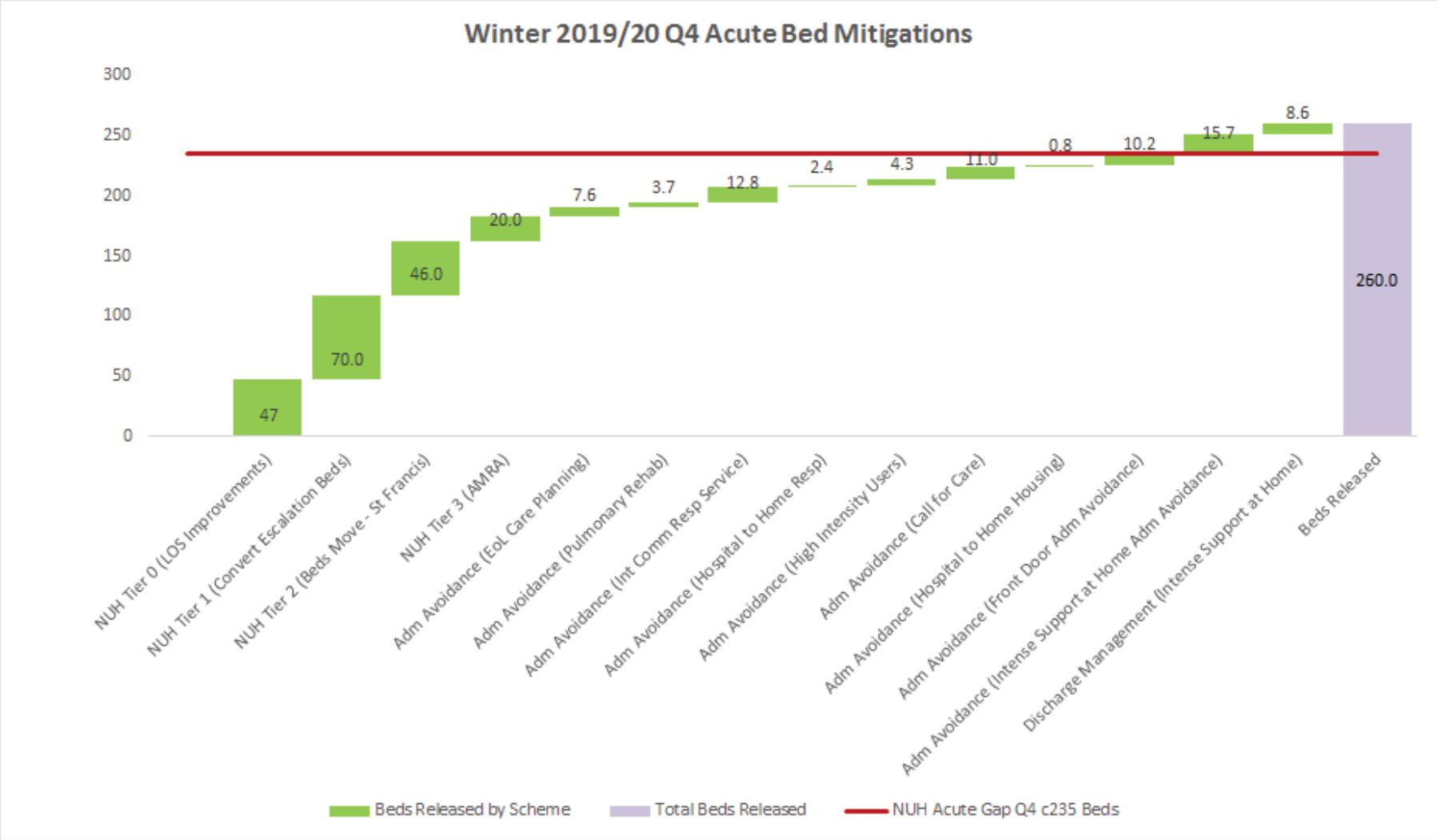
22. The drivers of demand are multi-faceted and the interdependencies of decisions taken across the public sector are not yet fully understood. The ICS will need to undertake further work with wider partners if this is to be understood in more detail. It is evident that drivers include social, demographic, pathway and wider system influences.

23. The impacts of public messaging on decisions about how to access urgent and emergency care services are complex and may increase demand in some areas. Some parts of the country are exploring whether more explicit sign-posting into appropriate community services and re-directing from ED where clinically appropriate / making appointments in other settings may be required on a larger scale to help manage demand in ED. This will be an area for further discussion across the ICS as part of the Long-Term Plan development.

24. Challenges concerning workforce recruitment, retention and development will be critical for the ICS. This work will be linked to the workforce enabling work stream for the ICS.

25. Further integration of pathways and working across settings and teams will also be required in order to embed the new pathways and schemes that are described in this paper.

## Appendix 1 NUH bed modelling – impact of internal and community schemes on bed requirements



## Monthly profile

| | | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
|---|---|---|---|---|---|---|---|
| | Acute Core beds | 1222 | 1222 | 1222 | 1222 | 1222 | 1222 |
| | Acute Forecast beds | 1384 | 1418 | 1481 | 1470 | 1437 | 1463 |
| | ***Bed gap*** | -162 | -196 | -259 | -248 | -215 | -241 |
| Mitigations | Tier 0 (Bed efficiencies LOS) | 44 | 44 | 44 | 47 | 47 | 47 |
| | Tier 1 (Convert escalation beds) | 39 | 39 | 70 | 70 | 70 | 70 |
| | Tier 2 (St Francis) | 46 | 46 | 46 | 46 | 46 | 46 |
| | Tier 3 (AMRA) | 20 | 20 | 20 | 20 | 20 | 20 |
| | End of Life Care Planning | 8 | 8 | 8 | 8 | 8 | 8 |
| | Improved uptake and completion of Pulmonary Rehabilitation Programmes | 4 | 4 | 4 | 4 | 4 | 4 |
| | Integrated Community Respiratory Service (Back to Basic) | 0 | 0 | 13 | 13 | 13 | 13 |
| | Hospital to Home Respiratory Service | 2 | 2 | 2 | 2 | 2 | 2 |
| | High Intensity Service Users | 1 | 1 | 1 | 1 | 6 | 6 |
| | Call for Care | 7 | 8 | 10 | 11 | 11 | 11 |
| | Hospital to Home Housing Scheme | 1 | 1 | 1 | 1 | 1 | 1 |
| | Front Door Admission Avoidance Scheme | 10 | 10 | 10 | 10 | 10 | 10 |
| | Intensive Support at Home Avoidance Scheme | 16 | 16 | 16 | 16 | 16 | 16 |
| | Intensive Support at Home Discharge (Reduce Acute LOS) scheme | 9 | 9 | 9 | 9 | 9 | 9 |
| | ***TOTAL*** | **207** | **208** | **253** | **257** | **261** | **261** |
| | ***Residual gap*** | 45 | 12 | -6 | 9 | 46 | 20 |

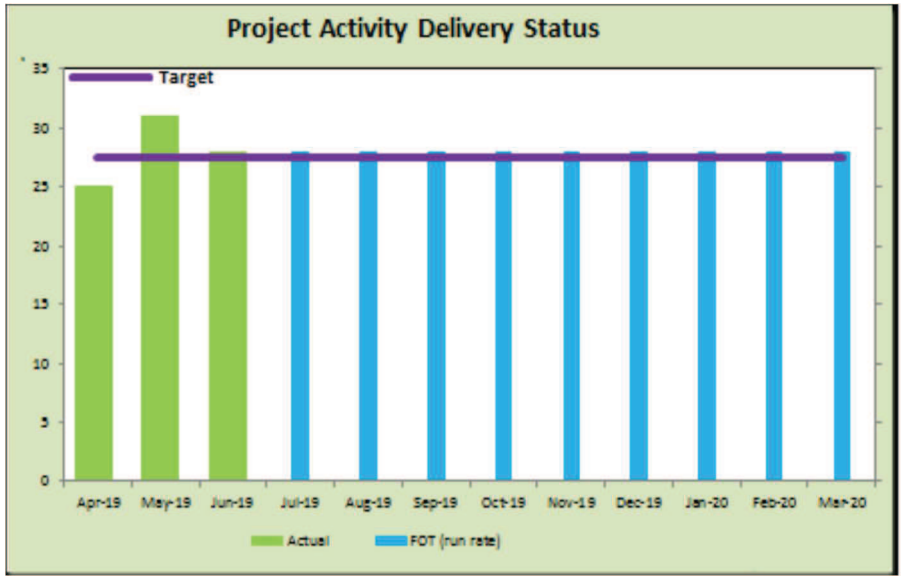
## Appendix 2 Greater Nottingham scheme activity and capacity assumptions against a do nothing scenario

| Scheme | Details and Assumptions | Start Date | Winter Activity Reduction | Avg LOS for Cohort | Potential Bed Days Saved for Winter | Potential Beds Saved for Winter - 183 days at 100% occupancy |
|---|---|---|---|---|---|---|
| 1 - Frailty in reach into ED | Already transacted in NUH activity plan, so exclude from calculations to avoid duplicate count. | Apr-19 | - | - | - | - |
| 2 - End of Life Care Planning | End of Life Planning, use Avg LOS for Emergency Admissions under Respiratory Medicine & Geriatric Medicine in 18/19 where discharge method was 4 (died) and patients aged 65 years and above. PID plan gives 115 NEL spell avoided for Winter Period. | Jul-19 | 115 | 12.1 | 1392 | 7.6 |
| 3 - Improved uptake and completion of Pulmonary Rehabilitation Programmes | PLT in City in Sept when info will be circulated to GPs re Pulmonary Rehab, and same info circulated to south ICP at the same time. Patient group is COPD. Scheme will impact from October. Using Avg LOS for 18/19 at NUH for Emergency patients with Diagnosis of J44-J47 for COPD | Oct-19 | 125 | 5.38 | 673 | 3.7 |
| 4 - Integrated Community Respiratory Service (Back to Basic) | Back to Basic – Flu vac being pushed so some assumption re small drop in flu admissions, plus impact of Vitamin D approved at CEC last week, marketing info being distributed so phase in impact from December. Mid Notts CCGs implemented similar scheme and impacted on pneumonia admissions. Original Scheme due to deliver 293 avoided admissions from October but reduced down to reflect likely December delivery. Avg LOS for 18/19 Emergency adult Influenza and Pneumonia Admissions applied. (J09-J18) | Dec-19 | 189 | 8.25 | 1557 | 8.5 |
| 5 - Hospital to Home Respiratory Service | Scheme is already active so full impact expected to deliver. Focus is on COPD patients so use Avg LOS for 18/19 Emergency patients with Diagnosis of J44-J47 for COPD. Expected to deliver 150 avoided admissions for full year, seasonally adjusted to deliver 83 admissions in winter period. | Apr-19 | 83 | 5.38 | 447 | 2.4 |
| 6 - High Intensity Service Users | HISUs – target group is patients who are frequent attenders/admissions; often people with mental health/alcohol misuse issues. To be delivered by 4 staff. Staffing is yet to be fully resourced, full staffing from January 2020. Planned activity reduction has been amended to reflect this. | Sep-19 | 90 | 5.74 | 518 | 2.8 |
| 7 - Call for Care | Call for Care will impact on admissions for social reasons, over 75s where no procedure and chronic ambulatory care sensitive conditions. May see impact build from start point rather than equal profile across all months. Expected delivery of 248 avoided admissions. This scheme is for South County patients. | Oct-19 | 248 | 7.19 | 1783 | 9.7 |
| 8 - Hospital to Home Housing Scheme | To deliver 41 avoided admissions, running from April 2019, activity amended to reflect the winter period. Avg NUH 18/19 Emergency Adult LOS for General & Acute specialties applied. | Apr-19 | 28 | 5.53 | 155 | 0.8 |

| Scheme | Details and Assumptions | Start Date | Winter Activity Reduction | Avg LOS for Cohort | Potential Bed Days Saved for Winter | Potential Beds Saved for Winter - 183 days at 100% occupancy |
|---|---|---|---|---|---|---|
| 9 - Front Door Admission Avoidance Scheme | Similar to the Call for Care scheme, will impact on admissions for social reasons, over 75s where no procedure and chronic ambulatory care sensitive conditions. May see impact build from start point rather than equal profile across all months. Expected to delivery 260 avoided admissions, 10 per week. This scheme is for Nottingham City patients. | Oct-19 | 260 | 7.19 | 1869 | 10.2 |
| 10 - Intensive Support at Home Avoidance Scheme | Plan for 10 spells per week to be avoided through this scheme by providing services at home for patients who require significant support that are not commissioned through community beds. Cohort estimated to be those aged 75 years and over with frailty and dementia diagnoses. Use Avg LOS for patients with Diagnosis F00 - F03, and F05 where age is 75 years and more for NUH Emergency activity in 2018/19. | Oct-19 | 260 | 11.03 | 2868 | 15.7 |
| 11 - Intensive Support at Home Discharge Scheme | Plan for 10 spells per week to have a reduced LOS in acute bed with provision of Intensive Support at Home Service (ISaH). This cohort of patients estimated to be those aged 75 years and over with frailty and dementia or delirium diagnosis. Use Avg LOS for patients with Diagnosis F00 -F03 or F05, where age is 75 years and more for NUH Emergency activity in 2018/19 but reduce Agv LOS by 5 days to reflect that patients will still be admitted, but discharge will be quicker. | Oct-19 | 260 | 6.03 | 1568 | 8.6 |

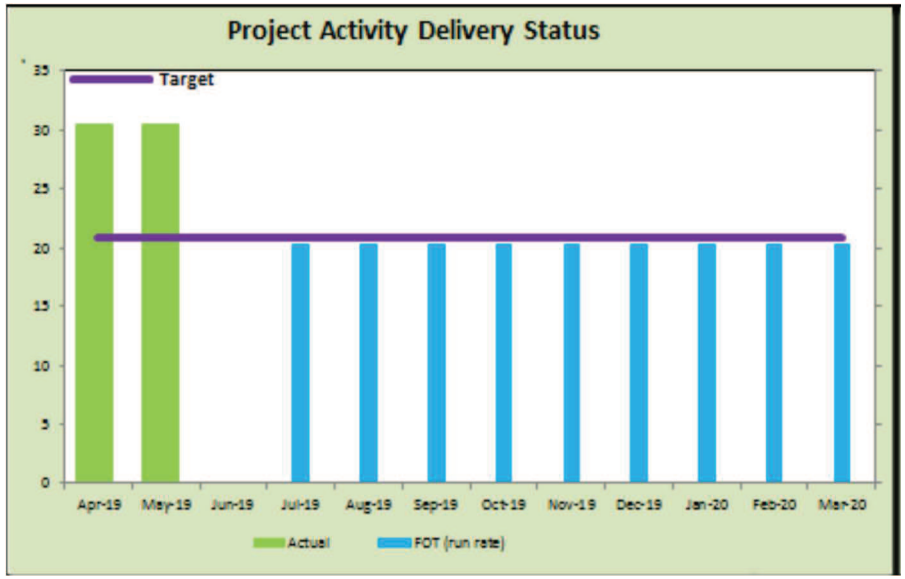
## Mid-Nottinghamshire scheme tracking examples

### End of life admissions avoidance




**Success Measure:** Reduction in admissions against a 'Do Nothing' position for patients dying in hospital
within four days
**Technical Definition** Emergency admission (admeth 2%), died in hospital within 4 days.
Also receive local data direct from Trust based on reduction in admissions at SFH for patients on EPACCS

### Frailty




**Success Measure:** Reduced emergency admissions with primary diagnosis of falls, tendency to fall , dementia, arthropathy and respiratory.**Technical Definition** Emergency admission (admeth 2%), primary diagnosis of falls (W01-W19), tendency to fall (R296), dementia (F00-F03), arthropathy (M01-M19) and respiratory (J%)

ENC. N1

| | |
|---|---|
| **Meeting:** | ICS Board |
| **Report Title:** | Understanding the drivers of urgent care demand in Mid-Nottinghamshire |
| **Date of meeting:** | Thursday 12 September 2019 |
| **Agenda Item Number:** | 16 |
| **Work-stream SRO:** | Andy Haynes |
| **Report Author:** | Ryan Cope |
| **Attachments/Appendices:** | Enc. N2. Attached presentation – Drivers of Demand<br>Andy Haynes to present |

**Report Summary:**


The rising demand to the ED department at King's Mill Hospital has led to an increased pressure on the urgent care system in Mid-Nottinghamshire.

This report summarises the findings of a targeted piece of work to understand the main causes behind this increase in demand. This work involved a clinically led multi-organisational data analysis exercise investigating significant changes in activity trends.

Interspersed throughout the data analysis exercise were three clinical panels which were key in reviewing the outcomes of the analysis and refocusing the key lines of enquiry.

The report summarises the main finding of this work and details the next steps to tackle the underlying causes of increased ED demand.

Seven key areas of focus to be taken forward are:

- Understanding and interrogating the changes to the community contract and GP demand to determine if there is an emerging gap.
- The Integrated Rapid Response System (IRRS) model which will focus on two stages: pre ED (with the development of the CAS and the ability to stream patients earlier to prevent conveyance/instruction to attend ED) and the development of the IRRS clinic model to provide an additional streaming route within ED.
- Reviewing the Directory Of Service (DOS) for Newark Urgent Treatment Centre and Call for Care (C4C) for 111 access.
- Reviewing NEMS capacity from a 111 response and within PC24 to increase streaming into the service
- Newark GPs are looking to consolidate duty GP cover into a single place (Newark Hospital) to facilitate booked in patients and walk ins. Consider if this could be done in Mansfield and Ashfield with the GP duty cover provided within PC24 to increase walk in capacity.

- Understanding the increasing EMAS and 111 conveyance rates.
- Considering if there are greater opportunities to support patients attending with drug and alcohol related conditions (circa 175 patients per month).

(Please note that a full report detailing all of the findings of the data analysis exercise is also available HERE).

| **Action:** | |
|---|---|
| ☒ To receive<br>☐ To approve the recommendations | |
| **Recommendations:** | |
| 1. | To note the report, the key findings and the next steps |

| **Key implications considered in the report:** | | |
|---|---|---|
| Financial | ☒ | |
| Value for Money | ☒ | |
| Risk | ☒ | |
| Legal | ☐ | |
| Workforce | ☐ | |
| Citizen engagement | ☐ | |
| Clinical engagement | ☐ | |
| Equality impact assessment | ☐ | |

**Engagement to date:**

| Board | Partnership Forum | Finance Directors Group | Planning Group | Workstream Network |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |
| **Performance Oversight Group** | **Clinical Reference Group** | **Mid Nottingham-shire ICP** | **Nottingham City ICP** | **South Nottingham-shire ICP** |
| ☐ | ☐ | ☒ | ☐ | ☐ |

| **Contribution to delivering the ICS high level ambitions of:** | |
|---|---|
| Health and Wellbeing | ☒ |
| Care and Quality | ☒ |
| Finance and Efficiency | ☒ |
| Culture | ☐ |

**Is the paper confidential?**

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

# Mid Nottinghamshire Drivers of Demand Report

## A&E Delivery Board 7th August 2019

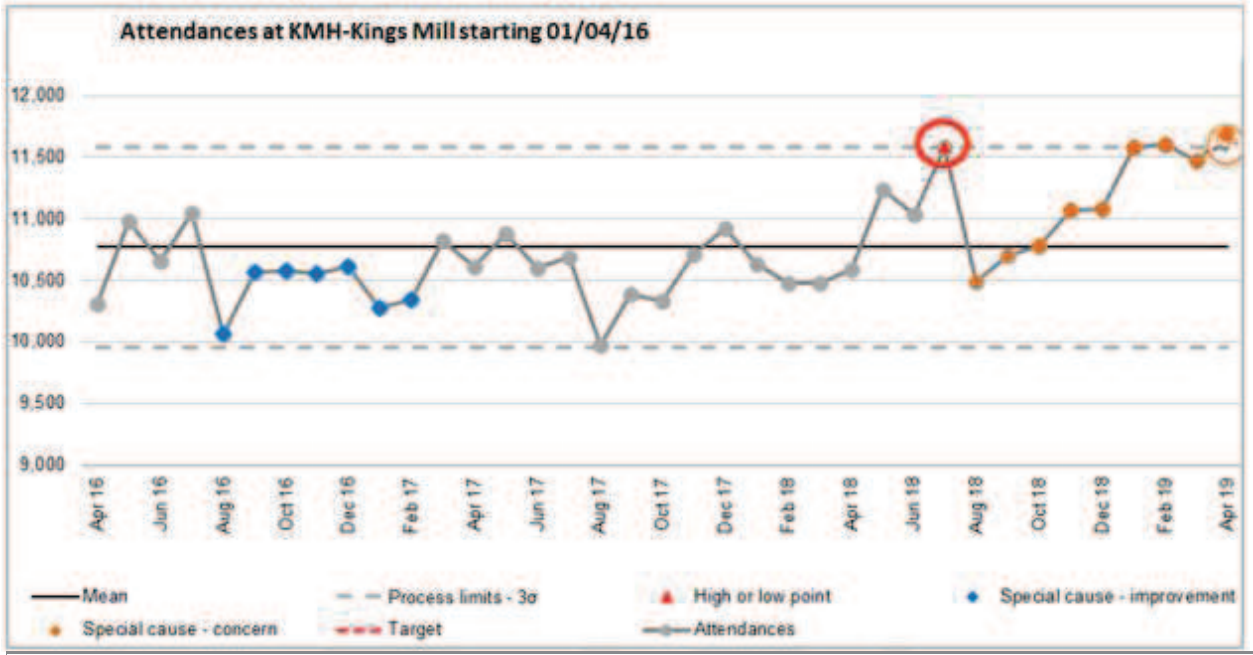
Produced by Mid-Nottinghamshire ICP
Version 4.4

ICS Board meeting
12 September 2019
Item 16. Enc. N2

# Content

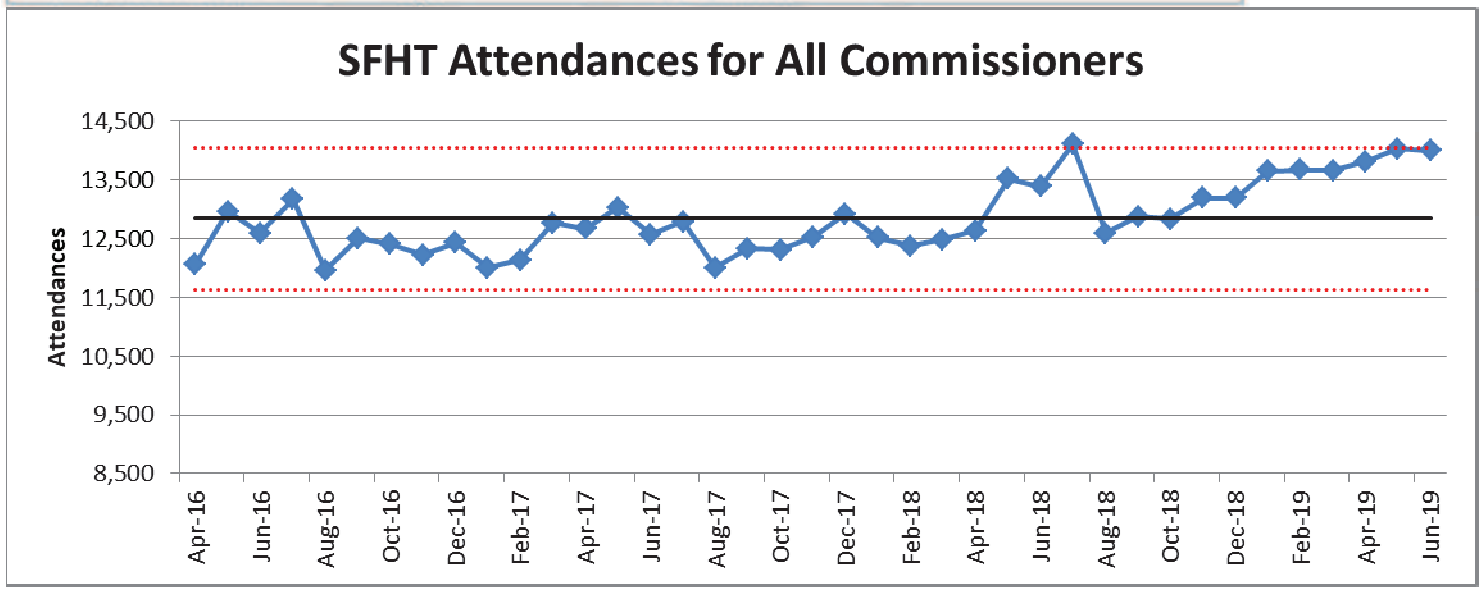
- Background and Process undertaken
- Key Themes and Summary Findings
- Areas of Focus and Opportunity
- Summary and Next Steps

# Background and Process Undertaken




The rising demand through A&E was the critical factor underpinning the Drivers of Demand work.

Month on month rises in Front Door attendances since August 18 drove the requirement to understand what was contributing to the increases



# Background and Process Undertaken

- Metrics for analysis were set by the ICS and spanned a three year period 16/17, 17/18 and 18/19

- Clinical Panel convened over 3 occasions which included attendance from Andy Haynes, Simon Barton, Ben Owens, Thilan Bartholomuez, David Ainsworth, Greg Cox, Faye Nicholls, Lisa Dinsdale, Peter Wozencroft and Helen Drew (on behalf of Liz Cowley), supported by Lorraine Palmer, Simon Draycon, Pui-Shan Tang and Ryan Cope

- Panel reviewed the analysis and identified and indicated other areas of enquiry for review

- Single master document of analysis has been developed as a single version of the overall analysis undertaken

- Contributors to the analysis included EMAS, SFH, NHCT physical and mental health, CCG, NEMS, 111, and Primary Care

# Key Themes

- Analysis of demand demonstrated that demand was fairly stable in 16/17 and 17/18, however between April and June 18 something changed and resulted in Front Door attendances increasing month on month

- There appears to be no single reason for the increasing demand into ED however key themes include;

    - Stretched Primary Care Services. More extended hours/access with a possible unintended consequence of less Out of Hours support.
    - Increased calls to 111 and Ambulance Service which has been driven by a number of factors and subject the EMAS non conveyance work
    - Reduction in Community Care services with less referrals, a drop in first patient contacts and a reduction in patient LOS.

- As a result we have seen increases in EMAS conveyance and in walk in patients as well as higher attendances from Out of Area patients (non Mid-Notts) which has contributed to an overall increase of 10%, 37 more patients per day compared to 12 months ago.

# Summary of Findings

- There has been a steady increase in patients attending with the condition recorded as mental health from circa 100 patients per month in March 18 peaking at 160 patients per month in April 19, with mental health colleagues referencing difficulties in having the capacity to meet the rising demand (NHSE funding will aim to support the rising demand)

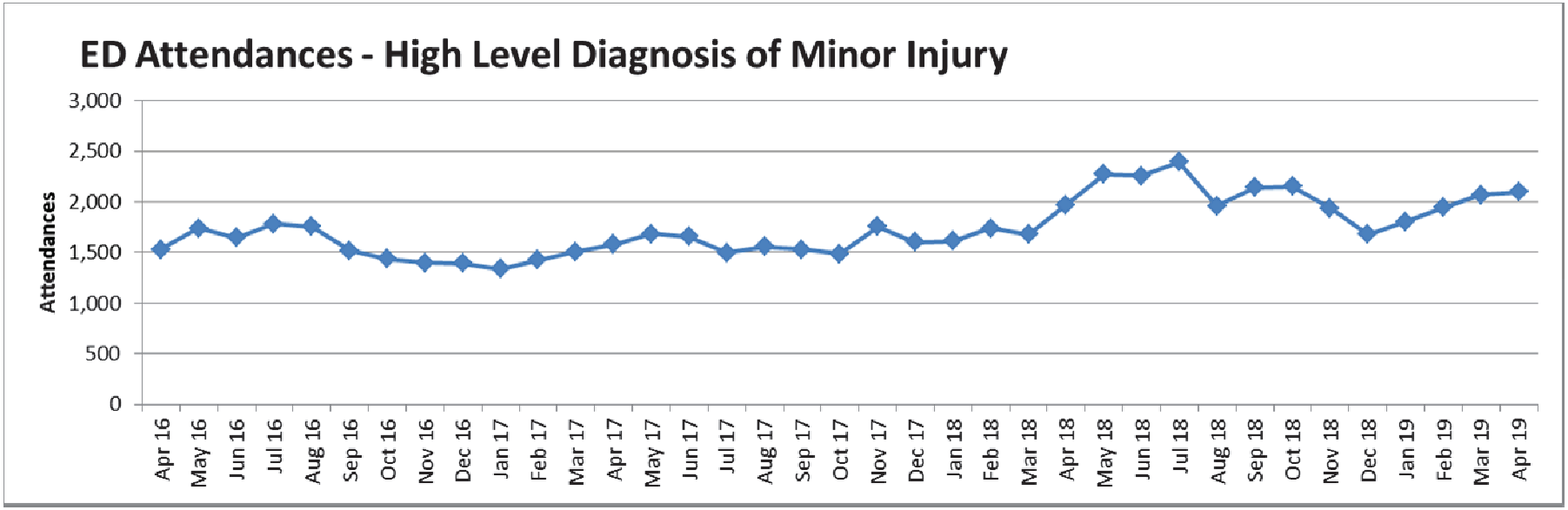
- Patients attending with drug and alcohol related conditions has been steadily increasing by circa 100 patients per month than Sept 17

- There are a number of changes which may have led to unintended consequences that contributed to the rising ED demand.
  - the change in the Sepsis algorithm for 111 June 2018 – EMAS conveyances/ED attendances
  - The merging of C4C and IHS and a reduction in the LoS for patients accessing those services

- There has been a steady increase in patients leaving the ED department after being streamed into ED rising from circa 8 patients in June 18 to 200 patients in April 19

# Summary of Findings

- Since March 18 there has been a marked increase in patients attending ED with a minor injury category, circa 500 patients per month which equates to 43% of the identified increase in demand (this cohort could be larger as minor injury may be contained within specialty specific coding)

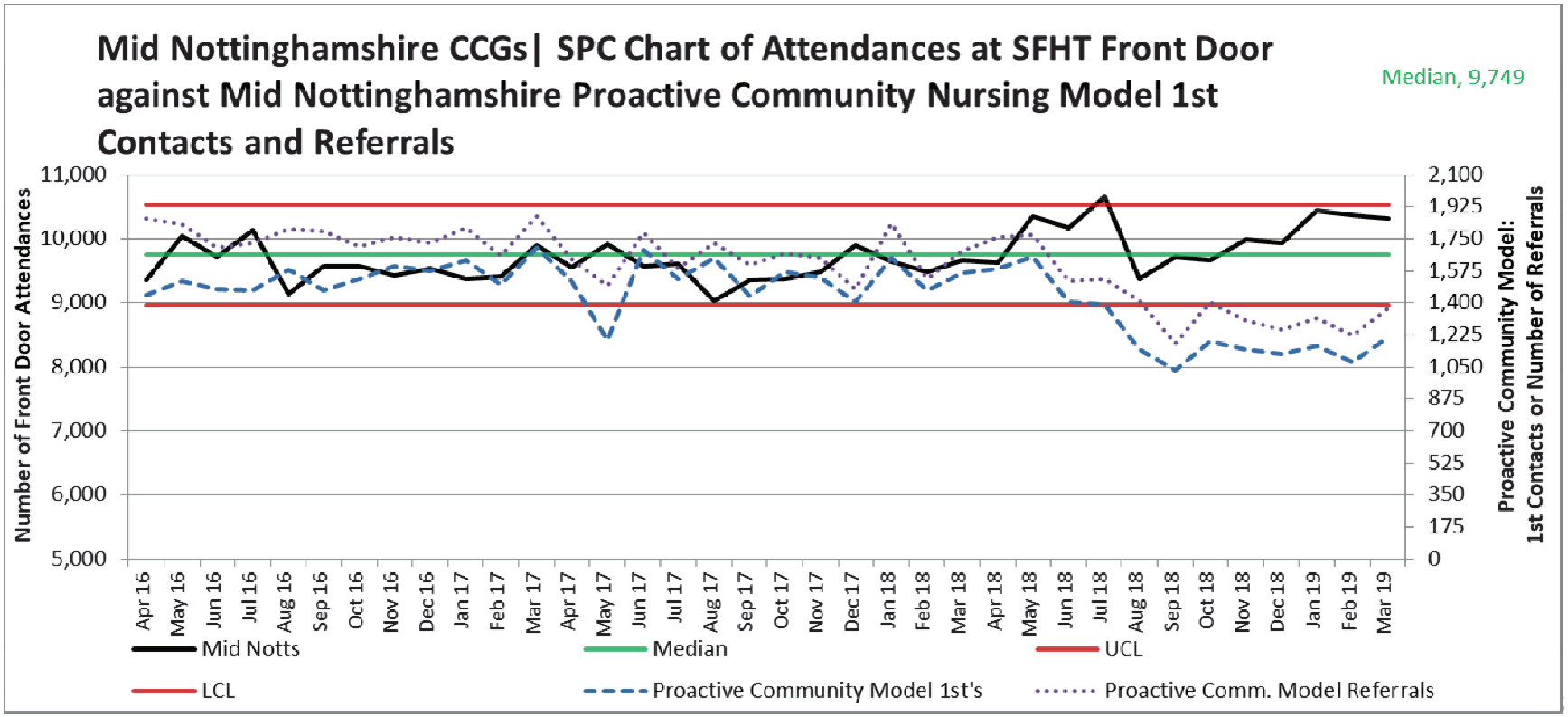



- With no single area of focus the Clinical Panel have had to identify a number of areas to conclude some final detailed analysis to determine if there has been an actual impact and to look for areas of opportunity ahead of winter 19/20

# Key Areas of Focus and Opportunity

**1. Understand and interrogate the changes to the community contract and GP demand to determine if there is an emerging gap**

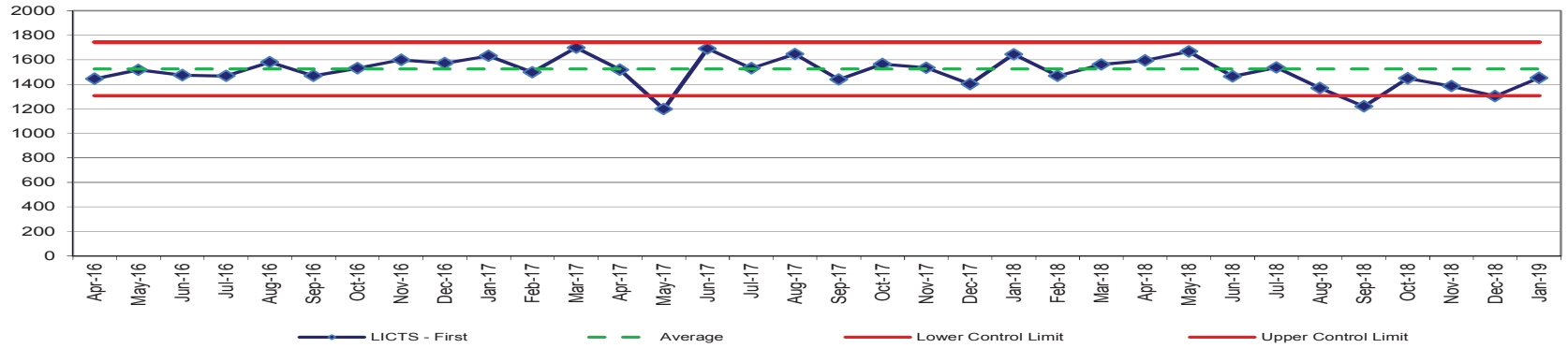
There have been a number of changes in way services are delivered which may have impacted the capacity within community services and therefore has identified the need to understand if those changes have contributed to the rising demand.



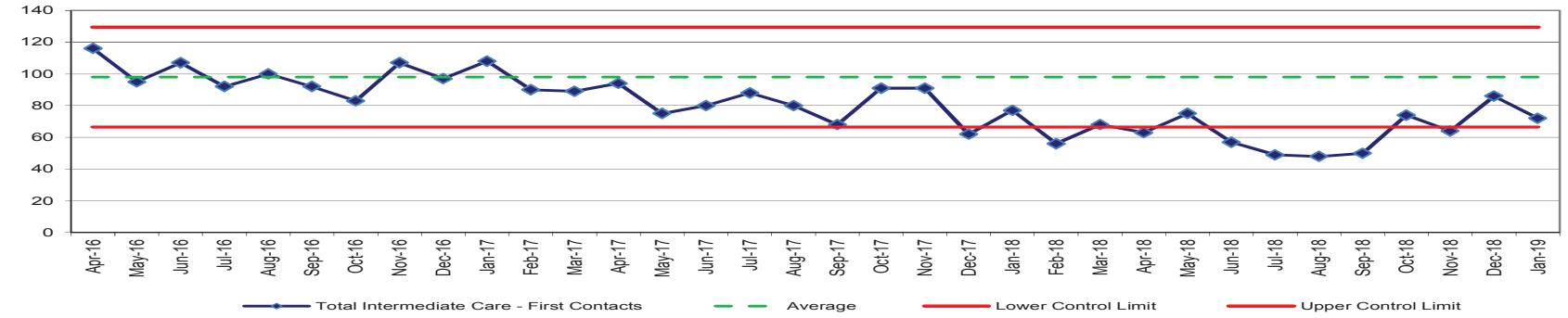
# Key Areas of Focus and Opportunity

Below are examples of Services, LICTs and Total Intermediate Care, where the number of first contacts within the service have seen a reduction in in 18/19 against previous levels and require further detailed work with NHCT to understand referrals in and patients accessing the services.

**LICTS - First**
**Contracted Activity - SPC Analysis**
**Total Mid Notts Registered Population**
**April 2016 - March 2019**




**Total Intermediate Care - First Contacts**
**Contracted Activity - SPC Analysis**
**Total Mid Notts Registered Population**
**April 2016 - March 2019**



# Key Areas of Focus and Opportunity

To determine of these changes are contributing to the step change seen from Q1 18/19, the following actions were agreed by the clinical panel

- Understand the changes and construction of the community services to determine and understand which patients are accessing the services and whether they are known/receiving services from the community teams. Revised data provided Monday 5th August requires building into the deep dive review
- Deep dive of a patient cohort pre and post the service change to determine of there are unintended consequences of the streamlining of the services (change from 20 days to 10 days LoS as an example)
- NHCT and Primary Care leads to undertake a review and sensor check to determine how patients are being referred into the service and understand any constraints affecting referral rates
- GP demand analysis being undertaken to determine if the reduction in community services is being delivered by GPs/Practice nursing. If there is a corresponding increase then no gap impacting rising demand, if demand has not increased are we as a system facing a gap that is contributing to the rising demand

# Key Areas of Focus and Opportunity

**2. IRRS model will provide a model focusing on two stages, pre ED with the development of the CAS and the ability to stream patients earlier to prevent conveyance/instruction to attend ED and the development of the IRRS "clinic" model to provide an additional streaming route within ED "pulling" patients from ED**

The Clinical Panel confirmed that the IRRS model was likely to provide mitigation of the rising demand and that the development of the model was under development. It had been subject to a multi-organisational workshop and a Steering Group was now set up to take the service forward

**3. Immediate actions to review the DOS for Newark UTC and Call for Care for 111 access**

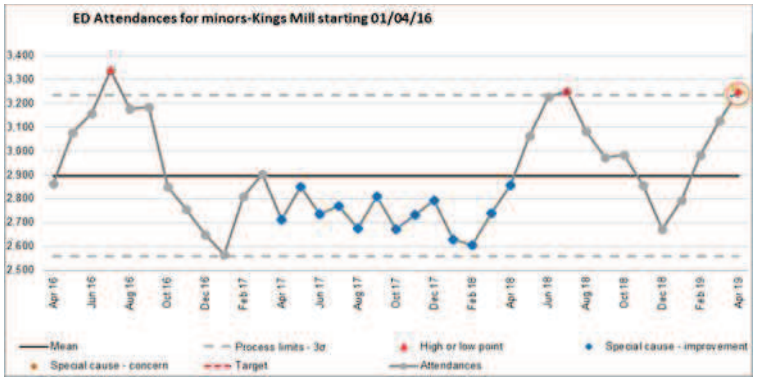
- **Newark DOS more limited than other similar facilities**
- **C4C only profiled for Diabetes, Constipation and Falls or Faints without injury are there others that could be added to increase 111 access**

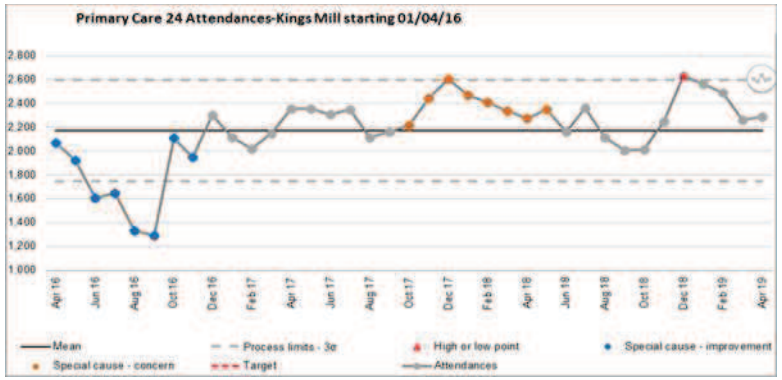
CCG Urgent Care Team picking this up and taking forward

# Key Areas of Focus and Opportunity

**4. Review NEMS capacity from a 111 response and within PC24 to increase streaming into the service**

- **Consider agreeing increased target of activity required to be seen within PC24 to support the system demand and measure against this, prevent bounce back to ED, patients seen in the most appropriate place not a default of ED**




Clinical Panel agreed that further discussions with NEMs are required to understand the capacity and demand issues

NEMS will be an integral part of the developing IRRS service to determine if there are other opportunities

ICP working with NEMS to analyse demand and capacity over the last 3 years, initial meeting 5th August

Opportunity to complete a review of why streaming to PC24 is reducing, understand the cohorts involved and potential other opportunities

# Key Areas of Focus and Opportunity

**5. Newark GPs looking to consolidate duty GP cover into a single place, Newark Hospital. Patients to be signposted to the service and to provide walk in capacity.**

- **Consider if this could be done at pace in M&A with the GP duty cover provided within PC24 to increase walk in capacity and potentially to support the IRRS "clinic" being developed**

Consideration to be given as to whether there is opportunity for a similar service to be delivered in Mansfield and Ashfield to improve capacity at PC24 and provide a walk in service signposted by other GP practices

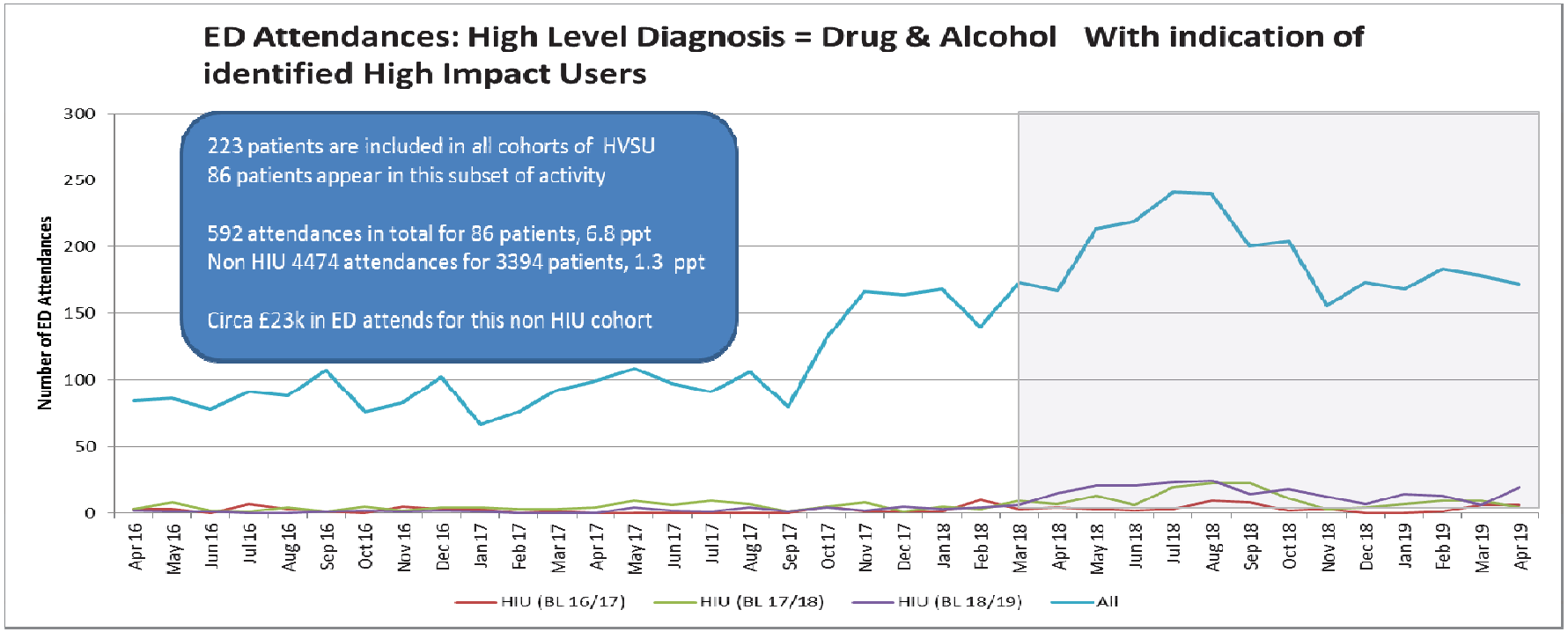
Opportunity for GP to be an integral part of the IRRS "clinic" and provide another streaming pathway away from ED

**6. Further work to understand the increasing EMAS and 111 conveyance rates linking to work already being undertaken to work with EMAS on non-conveyances rates.**

Work continues with EMAS to understand conveyance rates and already part of the AEDB work plan

# Key Areas of Focus and Opportunity

**7. Consider if there are greater opportunities to support patients attending with drug and alcohol related conditions – current demand circa 175 patients per month, with 11% of these captured by HISU, no admission or 0-1 day LoS man outcome for this patient group**




Clinical Panel considered if the implementation of a dedicated drug and alcohol service would mitigate demand, including nurse specialist pulling before booked into A&E and potential observation area to monitor patients

# In Summary

- The Drivers of Demand work has identified that the rising demand has no single contributing factor

- The work has identified the need to explore in more depth the changes to the community services to rule out any impact those changes are having to rising demand, as the analysis has clearly shown that the time the community services were restructured that an unintended consequence in the rising demand in ED needs to be investigated

- Key factors affecting demand are mental health, drugs and alcohol, minor injury and increasing demand on EMAS services

- The IRRS service is already in development and with two stages of streaming included in the model should have an impact to demand through ED. Crucial to the pre-streaming is the implementation of the new CAS model

- Seven key areas of focus have been identified by the Clinical Panel and should form the basis of key plans for implementation ahead of winter 19.

- Clinical Panel 4 may be required to consider the findings of the community services review and NEMs capacity and demand exploration

# Ownership

| Key Opportunity | Project Lead | Lead SRO | Timeframes | Comments |
|---|---|---|---|---|
| Community Services Review and GP demand profiling | Lorraine Palmer | Lisa Dinsdale | Report prepared to co-incide with the Drivers of Demand being issued to the ICS Board and September Transformation Board | Discussions on finding will require the Clinical Panel to sit for a 4th time to analyse the findings and agree next steps |
| IRRS Model | IRRS Steering Group | Lorraine Palmer | As per the HFID/IRRS Governance structure | Phase 1 to be developed and implemented for Winter 19 |
| Review of the DOS for 111 | CCG Urgent Care Team | Helen Drew | As soon as possible | Report back to September AEDB |
| NEMS Capacity and Streaming | Mid Notts ICP team | Lorraine Palmer/Arwel Griffiths | Analysis completed in the next two weeks | Build into the IRRS project and may require a 4th sitting of the Clinical Panel |
| GP Duty Cover and potential to deliver from ED | Steph Haslam | David Ainsworth | Within CCG planning timeframes | Mid-Notts ICP will support and could be built into the IRRS project for governance structure |
| Intervention for Drugs and Alcohol | IRRS Steering Group | Lorraine Palmer | As per the HFID/IRRS Governance structure | Developed within the IRRS and HFID Programme |

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| | |
|---|---|
| **Meeting:** | ICS Board |
| **Report Title:** | First draft of winter plans – Mid-Nottinghamshire |
| **Date of meeting:** | Thursday 12 September 2019 |
| **Agenda Item Number:** | 17 |
| **Work-stream SRO:** | |
| **Report Author:** | Helen Drew |
| **Attachments/Appendices:** | Enc. O2. Mid-Nottinghamshire ICP/A&E Delivery Board Winter Plan 19/20<br>Appendices: Further documents exist and are available upon request to Helen Drew or the ICS Admin Team. |

**Report Summary:**

The 18/19 winter de-brief session which took place at the April 2019 A&E Delivery Board meeting concluded that winter 18/19 was a success against the system-wide winter plan, despite some significant challenges experienced by the network as a whole and some individual providers more than others. Poor weather and a severity of flu were noticeable by their absence and senior system leaders and staff surveys agreed that winter planning was more robust than in previous years, which is largely attributable to an earlier enactment of plans creating additional resource, capacity, and a cohesive system approach to escalation and de-escalation.

This 19/20 winter plan attempts to build upon the successes of 18/19 to offer a significantly more sophisticated response and to meet the continued demands of increased urgent care activity across the footprint. Because the seasonal and calendar boundaries and associated peaks and troughs in demand are no longer as defined as in previous years, this winter plan forms part of an overarching system-wide seasonal plan, which offers a high level overview of thematic challenges to and responses from the mid-Nottinghamshire system.

It is acknowledged that as a live plan, this document will continue to evolve as further information becomes available from provider planning rounds, as work streams progress towards targets and trajectories, and as the system continues to identify examples of best practice and lessons learned. Two crucial elements of this will be the final outputs of the ICS Drivers of Demand analysis and the NHIS led Demand and Capacity work streams, both of which have made a commitment to enable key system improvements ahead of the winter period.

**Action:**

☐ To receive
☒ To approve the recommendations

**Recommendations:**

| | |
|---|---|
| 1. | That the Board NOTES the proposed plan and offers comments as appropriate |

**Key implications considered in the report:**

| | | |
|---|---|---|
| Financial | ☐ | |

| | | |
|---|---|---|
| Value for Money | ☐ | |
| Risk | ☐ | |
| Legal | ☐ | |
| Workforce | ☒ | |
| Citizen engagement | ☐ | |
| Clinical engagement | ☒ | |
| Equality impact assessment | ☐ | |

**Engagement to date:**

| Board | Partnership Forum | Finance Directors Group | Planning Group | Workstream Network |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |
| **Performance Oversight Group** | **Clinical Reference Group** | **Mid Nottingham-shire ICP** | **Nottingham City ICP** | **South Nottingham-shire ICP** |
| ☐ | ☐ | ☒ | ☐ | ☐ |

**Contribution to delivering the ICS high level ambitions of:**

| | |
|---|---|
| Health and Wellbeing | ☐ |
| Care and Quality | ☒ |
| Finance and Efficiency | ☒ |
| Culture | ☐ |

**Is the paper confidential?**

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

NHS Mansfield and Ashfield Clinical Commissioning Group

NHS Newark and Sherwood Clinical Commissioning Group

NHS Sherwood Forest Hospitals NHS Foundation Trust

DHU Derbyshire Health United

NHS East Midlands Ambulance Service NHS Trust

NHS Nottinghamshire Healthcare NHS Foundation Trust

Nottinghamshire County Council

NEMS Community Benefit Services Limited

# The Mid-Nottinghamshire ICP/A&E Delivery Board Winter Plan 19/20

**Contents Page**

**Executive Summary**

This document articulates the manner in which the mid-Nottinghamshire urgent care system and partners will respond to the anticipated and significant pressures of the winter 19/20 period. System partner flu and organisational winter plans have been embedded where these are available, and these have been reviewed and cross-referenced to avoid duplication and contra-indicative plans and actions.

The plan is a live working document, and as such will continue to be updated as further information, plans and outputs of work streams become available. The intention of this plan is that it should be read as an iterative 'updated to a point' in time document, the efficacy of which will be reviewed on an ongoing basis in monthly A&E Delivery Board meetings.

The plan details both business as usual and transformational schemes which will help to mitigate and proactively manage the demands of the period. The 3 main system-wide schemes which have been identified as having the biggest impact are summarised below.

Home First Integrated Discharge Scheme –

This project, currently in phase one, will further streamline and improve advanced discharge planning processes and timelines from a Home First – 'why not home, why not today?' ethos and discharge to assess (D2A) model.

Fundamental to this project is the HFID discharge hub; the hub underpins the HFID model with the following aims and objectives of the HFID model

- A daily system MDT meeting which identifies the appropriate discharge pathways for medically optimised and complex patients.
- A trusted decision making and pull approach to ensure patients are supported home first or as soon as medically fit for discharge
- The hub ensures that the admissions criteria principles for community bed stock are appropriately utilised,
- A dedicated system lead of the hub that can hold system parties to account for the delivery of the agreed principles within the Partnership Operating Model developed in collaboration. Currently this resource is provided by the CCG
- The hub will be supported by dedicated administration to track, monitor and manage patients being managed by the hub.

Phase 2 implementation of the model has already begun ahead of the August 2019 timeline will aim to re-configure the community bed base within the SFHFT bed stock.

Non-Conveyance Project Manager –

The 19/20 work plan for reducing conveyances includes the appointment of a dedicated Project Manager who will drive the work stream forward on behalf of the Nottinghamshire ICS. The post-holder, in a 12 month term will be employed by EMAS, but deliver non-conveyance service improvements and reductions on behalf of the two delivery systems. It is envisaged that this role, which is crucial to the success of the workstream will work closely with a number of organisations across the Nottinghamshire urgent care system and deliver transformational change.

Respiratory STOP FLU work stream

The STOP FLU campaign is based on promoting 5 key messages to patients, clinicians and their carers.

1. Flu Vaccination works and is safe
2. Stop Smoking
3. Hygiene stops the spread - wash hands, catch sneezes, do not touch your face
4. Eat healthily take Vitamin D everyday
5. Exercise regularly

The message is to be given to patients in all health care settings and social care. A fact sheet will be created and a video for call boards. Fact sheets will be issued with Flu invitations.

**The Mid-Nottinghamshire ICP/A&E Delivery Board System Winter Plan 19/20.**

**Background –**

This document articulates the mid-Nottinghamshire urgent care system's proactive and reactive planning response to the anticipated seasonal surge in demand in winter 19/20. Wherever possible lessons learned from previous seasonal surges and other system experiences are clearly identified. The format of the document follows the patient flow through the local healthcare system and it is acknowledged that business as usual activities will continue to deliver a positive impact on the delivery of services and mitigation of risk during the period. Specific winter management schemes will be identified in individual partner organisational plans, which can be found as an appendix to this document. These plans have been considered individually, and as part of a mid-Notts ICP and Nottinghamshire ICS approach to the period. Care has been taken to ensure that all system partner plans demonstrate an awareness of the key interdependencies between pathways and work streams, and that no obvious cross-organisational contra-indicative actions are evident. For clarity and transparency, narrative which relates to service improvements and transformation schemes which are new to the system for winter 19/20, but not specific to winter, are denoted in blue text. This is in response to feedback received on the 18/19 system winter plan.

**Aims & Objectives**

The aims and objectives of the plan are as follows –

- Ensuring that patients can continue to access safe and timely services during times of demand, system pressure and escalation throughout the winter period.
- Ensuring that providers are able to pre-empt, predict, identify, prepare for and respond to periods of escalation and de-escalation accordingly to ensure the robust and safe delivery of services.
- Ensuring that delivery and performance against national standards and trajectories continues to be maintained during these times.
- Providing Commissioners and regulators with assurance that individual organisations and as a system-wide network, the health and social care providers across Mid-Nottinghamshire are prepared to meet and can quickly recover from, the demands and pressures of winter 19/20.
- Ensuring that transparent system capacity is available across the network
- Ensuring that the Mid-Nottinghamshire system can strive towards a clear understanding of true urgent care demand, in order to fully comprehend both core and escalation capacity, and is subsequently aware of any gaps and has plans to address this.

**A&E Delivery Board –**

The ownership, governance and monitoring of the successful enactment of this plan sits with the executive health and social care system leaders who make up the mid-Nottinghamshire A&E Delivery Board (A&EDB), covering all system partners, regulators and CCG representatives. This membership allows for the senior level engagement, buy in and commitment required to drive and sustain the delivery of a system-wide plan of this nature. Members have the opportunity to hold each other to account on the delivery of the operational and strategic content which contributes to the deliverables that the system will be measured against. A key addition to the board membership during 18/19 was CCG Primary Care representation. The voice of Primary Care around the table has enabled more rounded and whole system conversations and planning to take place.

Winter 19/20 will remain a standing agenda item for Board meetings to gain assurance that the system performance and stability is being enabled and supported by the plan & its contents. There will also be a focus on continuous improvement to ensure that the plan is delivering the overarching aims and objectives of the plan in-year. Where there is a lack of assurance that the plan is providing sufficient resilience to winter pressures (either based on provider/system performance, or the operational experiences of staff) recovery actions will be delegated to the relevant organisation(s) & followed up for assurance virtually, to ensure a timely recovery is possible. System partners are committed to engaging in and recognising the urgency of these actions and any other necessary steps (e.g. Task & Finish Groups) that

may be required to remedy the position, and give full commitment on behalf of their organisation, to deliver this.

These conversations will be enabled by the new approach of the board to review performance by scrutinizing the previous month's data and performance in comparison to the month prior, and the same period in the previous year.

**Membership of the Mid-Notts A&E Delivery Board**

| Organisation | Representative | Designation |
|---|---|---|
| SFHFT | Richard Mitchell | Chief Executive & A&E Delivery Board Chair |
| Mid-Notts CCGs | Amanda Sullivan | Chief Officer and A&E Delivery Board Deputy Chair |
| Mid-Notts CCGs | Elizabeth Cowley | Head of Urgent & Proactive Care |
| Mid-Notts CCGs | Helen Drew | Emergency Care Network Manager |
| Mid-Notts CCGs | Cathy Quinn | Deputy Director of Primary Care |
| SFHFT | Simon Barton | Chief Operating Officer |
| SFHFT | Andy Haynes | Medical Director |
| NEMS | Arwel Griffiths | Chief Executive |
| EMAS | Greg Cox | Divisional General Manager |
| Social Care | Mark McCall | Service Director |
| NHSE/I | Diane Gamble/Kerry Rainford | Regulator Assurance |
| Notts Healthcare Trust | Julie Hankin | Clinical Lead |
| Notts Healthcare Trust | Lisa Dinsdale | Director |
| DHU/111 | Jenny Doxey | Clinical Director |
| DHU/111 | Pauline Hand | Managing Director |
| DHU/111 | Asif Khan | NHS 111 Service Delivery Manager |
| Mental Health – Mental Health Services for Older People (MHSOP) | Jo Horsley and John Burton | General Managers |

| | | |
|---|---|---|
| and Adult Mental Health (AMH) | | |

19/20 A&E DB work plan & UEC Deliverables -

In 18/19 the mid-Nottinghamshire A&E DB had sight of the UEC deliverables via the NHSE monthly assurance return. This was populated by system leaders and the CCG collated the information, completed the return & submitted this to NHSE. The Urgent and Proactive Care Programme Board monitored and assured delivery of the plan with delegated authority from the A&E Delivery board, who received the completed template under the standing agenda item of 'NHSE Returns/Submissions'

In 19/20 this process will become significantly more robust as the UEC deliverables will form an integral part of the new 19/20 A&E Delivery Board work plan. A proposed draft plan including the deliverables indicators has been circulated to members with the ambition of plan and baseline position has been agreed. The inclusion of the UEC deliverables into the wider over-arching A&E DB work plan ensures that board members are clearly sighted on system-wide interdependencies between projects, and the impact upon the ultimate objective for the board of delivering performance against the national 4 hour A&E target, and ensuring system flow.

The CCG Urgent Care Teams will ensure that progress; risks and mitigations around deliverables are understood and clearly articulated to the board. The Board will review the progress of UEC deliverables projects via the monthly NHSE return. This will avoid duplication and ensure that all partners are signed up to one single version of the truth. The Boards will hold themselves and system partners to account.

Each of the developments within the programme maintains a monthly risk log detailing mitigations and actions taken to reduce risks. All high level risks are reported to A&E delivery board on the AEDB risk register

The Emergency Care Network (ECN) Manager will be a key conduit between work streams and the Delivery Board. In 19/20 as part of the new governance structure an Operational Delivery Group (ODG) has been established which will provide the system forum for the oversight of the performance of all intervention and pathways being delivered, tracking performance against the agreed KPI's and providing an additional escalation point for mitigation and management of risks.

An ICS response to the recently received Jeffrey Worrall letter which sets out regulator expectations around the delivery of the UEC deliverables has recently been signed off by the Board, and the documentation around this can be found as an appendix to this document.

**The Urgent Care System: Resilience function**.

The CCG's ECN Manager and Urgent Care team have oversight of system performance and resilience across mid-Notts. System-wide urgent care resilience teleconferences take place weekly on Mondays throughout the year, regardless of system escalation, with the opportunity to increase the frequency of calls if individual provider/system escalation requires this. These calls also take place ahead of national or local events which may impact the local system if not prepared for effectively, for example Bank Holiday weekends. Daily system resilience calls will be proactively scheduled between October and Easter but will be stood down if not required, to ensure the best utilisation of system resources. Representatives from all system partner organisations attend the call including Adult Mental Health (AMH) and Social Care colleagues which provides a holistic approach to services across the localities. As in winter 18/19 system calls will continue to take place following periods of de-escalation, but will be more sophisticated in their understanding of 'what worked well' by implementing a real time PDSA approach to actions undertaken. This will directly inform future escalations and enables system clarity on anticipated issues which may jeopardise recovery.

The CCG continues to adopt a much more strategic operational role with OPEL reporting ahead of winter 19/20, as OPEL processes and reporting are significantly embedded in business as usual resilience processes and are pivotal to daily activities of the team who will ensure that those partners whose OPEL position escalates as a result of supporting other partners are sufficiently supported to successfully de-escalate.

CCG On-call function

During the winter period weekend and Bank Holiday OPEL reporting is undertaken by the CCG on-call Manager. The urgent care team takes responsibility for training to ensure a consistent and measured response to in-hours and out of hours reporting, and there are plans to include specific OPEL reporting and system resilience training in the official Nottinghamshire ICS on-call Manager training, which urgent care team members will be involved in delivering. Currently across the ICS a slightly different approach is taken to reporting routes and processes.

The imminent CCG restructure, the formulation of a single ICS footprint urgent care team, and within that an ICS resilience hub offering has the opportunity to strengthen, streamline and simplify OPEL, resilience operational processes and on-call functions moving forward and further updates will be provided when these are available.

Resilience Demand Forecasting –

The sharing of individual organisational demand and capacity intelligence across the system in 18/19 allowed proactive resilience conversations to take place ahead of periods of surge. For example, on days where EMAS had forecasted a high number of ambulance arrivals at SFHFT several key actions were taken by system partners to prevent escalation, as opposed

to reacting to it afterwards to de-escalate. Whilst it's generally accepted that these activities were met with limited success due to the variance in forecasted vs. actual arrivals, it is hoped that lessons can be learned for 19/20 and a slightly more measured response can be instigated. Conversations are currently taking place around the availability of demand data and planning task and finish group meetings will be arranged. The outputs of these will be updated in this plan and the ambition is to utilise the task and finish group meetings as a means of undertaking a desk top test of the winter plan for efficacy.

Peaks in demand over weekends and Bank Holidays -

In readiness for peaks in demand at Bank Holiday periods, providers with bedded capacity and patient facing caseloads plan to expedite the safe discharge of patients as early as possible, including the community bed base and wrap around virtual ward bases. This is done via pre-planned MDT meetings. The acute trust will continue to adopt a 'Home First' focus to discharges to ensure that patients who are ready to be discharged from acute beds are not inappropriately transferred to another provider, which causes a bottle-neck elsewhere in the system.

Lessons learned from previous Bank Holiday periods would suggest that greater knowledge is required across the system as to what services are actually available during these times. A Make Every Contact count approach to promoting the utilisation of Call for Care will take place prior to the Christmas Bank Holidays periods to ensure that Healthcare professionals are aware of who to contact for service availability. System providers will also ensure that the DoS accurately reflects the services that are available to 111 for the onward dispositioning of patients.

Direct messages to patients will be picked up by the Comms and Engagement plan, and will include the publication of Pharmacy opening times across the localities. GP practices will be encouraged as always, to publically display their opening hours and appointment availability to patients, both in practices, via SMS messages and on their websites.

The CCG collates staffing and capacity information from system partners for the Christmas and New Year Bank Holiday periods, which has usually surpassed the requirements of the regulator return which is disseminated nationally. Pharmacy and Dentistry information will be shared across the system and with wider partners for example libraries, supermarkets etc.

**OPEL reporting -**

OPEL reporting and action cards are an integral element of the Mid-Notts Surge & Escalation plan. This plan forms a key element of the wider overarching winter plan and has also been amended following the experiences of 18/19. It was felt that the action cards should continue to address individual provider OPEL levels, as opposed to system OPEL levels, because addressing provider escalations can in effect, prevent system escalation. For example, if the 111 service reported OPEL 3 because staffing difficulties were preventing calls to be answered

in time, this could trigger NEMS to take calls from 111 as a contingency, and could trigger SFHFT to deploy additional admissions avoidance staff at the front door.

Individual provider OPEL levels will continue to be collated by the CCG and a system-wide report and OPEL level will be produced. Work has taken place to review organisational OPEL triggers, thresholds and corresponding mitigating actions, acknowledging an alignment to Greater Nottinghamshire processes wherever possible. A significant development in the OPEL actions prepared for winter 19/20 is shared resources and cross-organisational boundary working amongst health partners. This commitment will be key to the delivery of a successful plan and once again demonstrates the positive and cohesive system approach across the mid-Notts footprint. The review has also taken account of system leader feedback from 18/19, and remedial actions have been brought forward to lower OPEL escalations and provide distinct step up response to previous years.

In winter 18/19 the overall system OPEL level was signed-off by a CCG Director with A&E Delivery Board delegated authority, however it is hoped that in winter 19/20 the newly formed system OPEL matrix process which provides a consistent automated approach to the system level will be signed off in advance by regulators to alleviate demand on CCG Execs on a daily basis. The CCG urgent care team will continue to engage with Execs and on-call Managers around OPEL reporting, risks and mitigations.

Nottinghamshire Healthcare Trust colleagues have successfully engaged AMH and MSHOP services in OPEL reporting and system resilience functionality and are in the process of developing OPEL reporting for wider services, for example CAHMS. Urgent and Primary Care teams within the CCG are currently considering the possibility of operationalising Primary Care and care home OPEL reporting via PCN functionality. Whilst this may not result in deployment of resources, it will develop the local demand and capacity analysis and reporting on key triggers may allow the advance identification of increased urgent care demand.

Regulator & System reports –

The morning OPEL report will be shared with NHSE/I colleagues as per the daily requirement and for transparency, the same report will be shared across the system as part of a wider daily consolidated report which has evolved to include Greater Nottinghamshire system OPEL reporting, system partner service capacity, care home closures and more recently temperature and weather alerts in a bid to provide the network with a suite of valuable resilience intelligence. Receipt of this report by partners is the call to action to invoke OPEL action cards and respond accordingly to reports of escalation and de-escalation.

In 18/19 provider colleagues elected to submit an afternoon OPEL return which was solely for the use of the local system and has enabled organisations to better prepare evening/night services as to the pressures/issues that they may face. Discussions are underway as to

whether or not this process will continue in 19/20 as there is a need to balance the benefits of the reporting with the additional burden on providers during peak times.

It is acknowledged that in addition to this narrative report, regulators will send out an assurance template which requires specifics on resource and staffing levels of the relevant patient facing service teams across contracts, along with on-call/escalation arrangements and other key elements. The CCG will co-ordinate this return which will be signed off by the board.

Ad-hoc regulator reporting –

Any responses to ad-hoc requests in winter 19/20 will be co-ordinated and submitted by the CCG urgent care team to prevent duplication and to ensure consistency of reporting information. Ad-hoc winter reporting requests were much less frequent in winter 18/19 than in winter 17/18 and during the 18/19 period the mid-Notts system was deemed to be a system which 'consumed its own smoke' by regulators and Winter Room colleagues. Positive, trusting relationships were developed between the CCG urgent care team and regulators, which continue to evolve and it is felt that this regular dialogue and exchange prevented a high volume of ad-hoc information requests, enabling operational teams to continue to focus on service delivery.

**Managing Demand – keeping patients out of hospital**

Drivers of Demand Workstream –

The Nottinghamshire healthcare systems have experienced an unprecedented increase in demand in urgent care activity over the last 12 to 18 months. In response to this, the Nottinghamshire ICS has undertaken a deep-dive into the causes, and drivers of this demand. An initial piece of work has identified that there is not one single attributable driver, but has uncovered 9 key areas which require either immediate remedial action or further deep dives into activity. The deep dives will either rule out lines of enquiry or provide a granular focus for an ongoing piece of work. These actions are expected to be delivered at pace in order to deliver maximum impact for the winter period. The action plan for Drivers of Demand will form part of the 19/20 mid-Nottinghamshire workplan and will be monitored alongside the UEC deliverables programme. It is anticipated that initial analysis will be repeated as an ongoing exercise in order to monitor for efficacy and residual risk.

Comms and Engagement –

Both the winter and seasonal plans are accompanied by robust ICS Comms and Engagement plans which centre on proactive key messaging to the public ahead of and during the winter period. These include seasonal self-care messages (colds & flu) driven by the Self Care work stream and can help patients to make the most appropriate choice of healthcare access point for their condition. A flexible and reactive approach also exists, and as in previous years activities can be implemented immediately and flexed to address local demand surges.

A key change and improvement to this work ahead of winter 19/20 is the evolution of the ICS-wide comms and engagement function. This will enable a robust and consistent system response to messaging across health and social care partners, along with wider system colleagues, for example District Councils. This enables a Make Every Contact Count approach to local messaging and presents a unified single version of the truth across the system, which presents a greater opportunity for messages to be effective.

Self-Care Workstream –

The CCG Self-Care working group is made up of Pharmacists and Pharmacy Technicians whose objectives are to identify seasonal and proactive self-care themes and messages for dissemination to the public via a strategic comms plan, which forms an integral part of the seasonal plan. These messages align to the national guidance identified on the Area Prescribing Committee (APC) website and are reinforced by a whole system approach. These messages aim to direct patients to the lowest level medical care thresholds appropriate for their condition. For example, posters in GP surgeries which ask the question "Do you need a GP appointment, or could your local Pharmacist help? Also posters in secondary care venues asking the question "Do you need A&E or could your GP help?" The ambition of this is that patients at each point make better more appropriate choices for their healthcare which creates capacity in all services in the round.

Comms messages include how to self-treat coughs, colds, sore throats and other ailments that are common during the winter period, and recommend key first aid kit items that patients should purchase themselves and keep at home, in-line with paracetamol prescribing policies.

**General Practice**

Access to appointments in general practice is a key topic during any period of surge and demand and winter is no exception. Extended hours has 100% coverage across mid-Notts on a 1 hour per 1000 patient population PCN basis, allowing patients greater access to Primary Care services for longer and during weekends. The ambition of this is to reduce the numbers of patients attending PC24 due to exacerbations of conditions, or from convenience. Utilisation of appointment slots and DNAs are actively monitored as a pre-bookable service and the CCG Primary Care Team continues to work with practices to maximise utilisation and reduce wasted resource.

The Acute Home Visiting Service continues to be successful and is now delivered by one single provider across the mid-Notts footprint, with additional capacity for more appointments. This allows for greater economies of scale and consistency of service application. With this service GPs can ensure that patients with acute episodes receive home visits, while they themselves can prioritise the patients with long-term conditions who may benefit from the consistency of treating clinician.

Social Prescribing Link Workers (SPLW) will be in post by October 2019, with one member of staff in each PCN. This role will identify and work with patients face to face, whose use of the local health and social care system is driven by a social need and sign-posted/supported into relevant services, for example, Citizens Advice Bureau. The SPLW will link closely with the Network Navigators who will assist in the identification of patients using risk stratification tools, and the High Intensity Service User (HISU) lead at SFHFT. It is anticipated that secondary care discharge teams will be in a position to refer into this role in an attempt to expedite discharges of patients who are medically fit for discharge (MFFD) but have a social blockage to their discharge (hoarding etc.)

Clinical Pharmacists will be in place in each PCN during winter and will support practices with the medicines management of patients. Patient discharge letters from secondary care, e-healthscope exception reporting and GP referral are some of the methods of referral into these posts. These roles will ensure that prescribing and de-prescribing is appropriate in-line with best practice guidelines.

Flu vaccination remains a Primary Care QoF for the 19/20 period and practices will manage this process in a variety of ways. Early indications from Australia suggest that 19/20 flu patterns should align to those of 18/19, although leading strains and the start of the official flu season continue to be unknown variables which will be closely monitored. Potential issues with availability and supply of the vaccines remains a cause for concern. However the CCG and Primary Care Networks will aim to vaccinate maximally with specific focus on traditional at risk cohorts.

STOP FLU campaign

New for winter 19/20, the STOP FLU campaign is based on promoting 5 key messages to patients, clinicians and their carers.

1. Flu Vaccination works and is safe
2. Stop Smoking
3. Hygiene stops the spread - wash hands, catch sneezes, do not touch your face
4. Eat healthily take Vitamin D everyday
5. Exercise regularly

The message is to be given to patients in all health care settings and social care and a fact sheet will be created along with a video for call boards. Fact sheets will be issued with Flu invitations.

The following specific tasks are key to the successful delivery of the programme;

- FLU vaccinations will be offered in outpatient settings including ED for High intensity users, on discharge from hospital, paediatric out patients and maternity.

- PCNs will coordinate out-reach nurses to visit preschools and care homes.

- PCNs will provide a single email contact for community/SFHFT flu vaccination providers so all vaccinations are recorded on the patient record.
- Clinicians will visit schools and pre-schools in the week before vaccination visits to deliver the STOP FLU message.
- 'Fluathon' coordinated across Nottinghamshire for a single Saturday flu clinic.
- Standard consent forms and invitations will be re-written to account for the Mid Notts reading age.

Direct Booking -

The Mid Notts Primary Care Team and Urgent Care Team are working collaboratively to implement 111 direct booking into GP practice slots during extended hours and in-hours. This is an NHSE directive and the timelines for implementation are as follows;

- Direct Booking into extended hours by October 2019
- Direct Booking in-hours by March 2020

Mid Notts are on track with both trajectories as follows;

Extended hours

Direct Booking configuration is taking place in each of the PCN areas. During July 2019 the Newark Primary Care Network (PCN) went live with 3 appointment slots a week during extended hours (6.30pm – 8pm). Early indication shows that 75% of the slots were used and all referrals were appropriate and potentially diverted patients away from urgent care services. The next phase will be to roll out across the remainder 3 PCN areas, with all areas to be covered by October 2019.

In-hours

In-hours direct booking will require configuration in each GP Practice. The 6 practices across Mid Notts (3 M&A, 3 N&S) with the highest 111 calls during in-hours will be targeted first and will go live with in-hour direct booking by autumn (ahead of deadline) in order to make impact during winter.

It is acknowledged that whilst the slots made available to 111 during in-hours and extended hours is initially low this will expand over time and as a consequence will divert patients away from urgent care services during winter.

**Care Homes and the Enhanced Health in Care Homes Framework**

The Enhanced Health in Care Homes Framework (EHCH) was launched in 2016, and became a formalised mandated national must do in 2019. The ambitions of the framework which feature in the NHS Long Term Plan and 2019 GP contracts, stipulate 8 core elements and 18 sub-elements designed to provide support, development and stability to care homes for the benefits of staff, residents and the wider healthcare system. The 8 core elements range in

topic from MDT in-reach support to workforce developments and technological capabilities. Given the system interdependencies all of the 8 elements are applicable to system planning and the programme spans the 19/20 period. The framework is an indicator on the A&E DB work plan for 19/20 and some key projects have already been delivered.

- Red Bags for Care Homes was launched by the mid-Notts CCGS in 18/19, however this project will be fully embedded by winter 19/20, with evaluation metrics in place to evidence the national ambition of a reduced LoS after admission.
- NECS Care Home Bed Tracker was implemented after winter 18/19, is now fully live in mid-Nottinghamshire and is embedded within SFHFT. This tool is designed to offer a 'shop window' service to care homes when updated regularly and supports DToCs and LoS reduction by supporting families and carers through patients choice decisions. Sign up from Care Homes is continuing to increase with over 70% of homes in Mid Nottinghamshire engaged. Homes are now updating the system on at least a weekly basis and the tracker is now the SFHFT discharge teams' main method of identifying Care Home availability. Phase 2 plans to roll out the system wider including other hospital and continuing healthcare teams. Discussions are currently taking place around mechanisms to monitor the success of the scheme which will include measures such as a reduction in DTOCs and LOS.
- Significant 7 is a scheme which supports homes to monitor 7 observation elements of residents, record these holistically and identify early warning signs of deterioration, which may result in an emergency or acute episode of care if not addressed early enough. Crucially, conversations are taking place with community partners to offer an alternative referral route for residents who are identified as having a worsening condition, to avoid an increase in front door activity. This is as a result of learning the lesson from other areas that have identified increased attendances as an unintended consequence of rolling out the tool.
- Re-alignment of GP Practices to care homes to ensure a consistent offer and better patient experience is under way, with 3 of the 6 PCN areas currently aligned.
- Care Home Contracts were amended in 18/19 to include mandated reporting on the numbers of staff and resident flu vaccinations. Uptake rates were monitored by the A&E Delivery Board and Make Every Contact Count conversations took place amongst health partners to myth bust and promote the benefits of vaccination. In 19/20 PHE funding is enabling training to take place with the 10 homes identified in mid-Notts to require support around increasing flu vaccination rates.
- Rapid flu testing by SFHFT on care home swabs for flu last year enabled outbreaks to be identified or dismissed at pace, resulting in shorter care home closures and reduced delays in returning care home patients back to their usual place of residence. It is hoped that this service offer will continue in winter 19/20.
- The Proactive Care Homes Team continues to work with care homes which have the highest non-elective attendances (NELS), with additional homes having recently been

taken into the portfolio. This team are Significant 7 trained to achieve a MECC approach to the train the trainer scheme.

- Care homes across Nottinghamshire continue to have access to the 111 *6 service which provides access directly to a clinician, rather than a non-clinical call handler.

Compliance with the BGS Guide on Care Home Medicine -

As in previous years, all staff from the Mid-Nottinghamshire Healthcare system who are responsible for supporting Care Homes (Meds Management, Care Homes Leads, Community Providers, GPs) are strategically working to the NICE Guidance standards for Medicines in Care Homes and the Royal Pharmaceutical Guidance. The CCG policy for Care Homes Medicines references these sources in-line with CQC recommendations.

Nottinghamshire County Council are the Lead Commissioner for Care Homes, and the contract consistently requires substantial compliance and quality monitoring/reporting around the utilisation, storage, and administering of medicines within a Care Home setting.

111 –

DHU's resilience as an organisation and performance against national standards improved in winter 18/19, following a particularly challenging period in 17/18and the organisation has advised that there are no concerns around winter 19/20.

Derbyshire Health United (DHU 111) can book directly into PC24 through Adastra and to PC24 working with GP extended hours services to allow DHU 111 direct booking into both NEMS out of hours GP (PC24 and NEMS GP). Direct booking into appointment slots in the Newark Urgent Care Centre is also already in place. Work is currently taking place to enable 111 to book direct into Primary Care extended hours on a PCN basis and this will go live at the end of summer 2019.

DHU already deliver the Cat 3 re-triage pathway, whereby any Category 3 ambulance disposition is re-triaged and approximately 80% of conveyances are avoided using this method. There are a number of national Pathways changes since winter 18/19 which will

**EMAS –**

Non-conveyance

EMAS have access to pathways which offer an alternative to conveyance via Call for Care Community Pathfinder and the GP 10 minute call back protocol. The CCGs articulated their ambition of safely reducing type 1 ambulance conveyances in 18/19 via the local STP CQUIN for the Nottinghamshire division.

Whilst this project has proved fruitful in some areas, it is widely accepted that any reductions in conveyances have contributed to the stemming of activity growth, as opposed to reducing conveyances below the indicative activity and affordability plan baseline position.

This should be addressed in 19/20 with the introduction of a national non-conveyance CQUIN which will run alongside the local ICS CQUIN of the same ambition, and both will be supported by the contract mechanism which will see a proportion of the 19/20 contract value payment being dependent upon the reduction in conveyances (details still to be worked through). Moving forwards these conversations will form part of the 19/20 contract management meeting discussions to ensure a single strategic direction of travel.

The system ambition is to reduce the number of patients conveyed to Type 1 and Type 2 ED by ambulance, by at least 2% against forecast plan by April 2020. 17/18 target was 1.5% and achievement at December 18 was 2.4%. For Nottinghamshire this trajectory equates to a reduction in conveyance rate of 1% by Q3 and 1.5% by Q4. As the provider, EMAS are developing an associated action plan. In addition, Nottinghamshire have agreed a local CQUIN focusing on increasing use of demand management pathways to reduce conveyance.

To achieve this, the system will:

- Increase use of community pathfinder (paramedic clinical navigation system) by 12% against 17/18 baseline by April 2020
- Increase the % of care home calls directed to a clinical advisor from 111 from 22% to 50% by April 2020
- Implement a non-injured falls pathway by September 2020 to reduce ambulance dispatch to non-injured fallers (and therefore conveyance). In line with the Mid Nottinghamshire pathway outcomes, it is expected that 95% of referrals from EMAS will be managed though the non-injured falls pathway.
- Roll out access to Service Finder (next generation Directory of Services) by April 2020 to EMAS clinical triage teams and paramedics to support clinical navigation of patients to the correct service and enable an alternative to ambulance dispatch.
- The 19/20 UEC deliverables for ambulance digital developments will be delivered through national CQUIN 10. EMAS have advised that they are unable to deliver the requirements as set out in the national CQUIN document. On this basis, commissioners have agreed to receive an alternative proposal which sets out how EMAS will deliver the planned outcomes of the national CQUIN but in a different way. Regulators have agreed to a local variation to the national CQUIN on this basis. EMAS are responsible for formulating a proposal document which sets out the 19/20 plan for this CQUIN delivery and at the time of writing, this is due imminently. There is a timeline ambition to have this document agreed & CV'd into the EMAS 19/20 NHS Standard Contract by 30 July 2019. Further details will be available at this point.

Non-Conveyance Project Manager –

The 19/20 work plan for reducing conveyances includes the appointment of a dedicated Project Manager who will drive the work stream forward on behalf of the Nottinghamshire ICS. The post-holder, in a 12 month term will be employed by EMAS, but deliver non-conveyance service improvements and reductions on behalf of the two delivery systems. It is envisaged that this role, which is crucial to the success of the workstream will work closely with a number of organisations across the Nottinghamshire urgent care system and deliver transformational change.

There is an expectation that the post holder will spend time working with the Urgent and Emergency Care System to understand the wider system and how best to contribute to the transformation of Urgent and Emergency Care, this will require the individual to work with a range internal and external stakeholders.

Handovers -

Ambulance handovers have been a standing agenda item for the A&E Delivery Board during 18/19 and in 19/20 will form part of the boards' work plans. Whilst an SFHFT action plan to reduce pre-handover delays has been signed up to by EMAS, commissioners are keen that this evolves into a true joint organisational action plan which includes the ambulance provider actions required to address post-handover delays to deliver the ambition of handovers within 30 minutes.

It is acknowledged that SFHFT have an NHSI agreed trajectory in place supported by a set of key actions and assumptions. This has meant that handovers at SFHFT have significantly improved in recent months, and SFHFT are currently prioritizing a 10% tolerance to pre-handovers above 15 minutes.

Performance -

EMAS' performance in the 17/18 and 18/19 winter periods was below target for the ARP standards across the regional contract. As a result patients experienced long waits with risk of harm a source of concern for commissioners. Following contract negotiations in 18/19, investment has been made in additional crews and resources, with EMAS undertaking its biggest ever recruitment drive. EMAS have committed to delivering national standard performance at a county level and during 18/19 some Nottinghamshire CCGs had started to receive national performance at a CCG level. At the time of writing, performance has significantly improved on previous years and whilst there is work to be done to understand the conveyance rate of impact of the additional resources, the risk of poorer outcomes from long patient waits is a vastly reduced risk for the winter 19/20 period.

Integrated Rapid Response Service (IRRS) –

The overall ambition of the IRRS model is designed to prevent admissions by bolstering alternative services available once the patient has reached the front door of A&E, for example Call for Care. To date a design work shop has been attended by over 40 wider system stakeholders and an operating model has been produced. A key focus of the group is to understand what can be implemented to support the front door and wider system ahead of the winter period and it is envisaged that this solution will be built upon the successes of the previous Pull Collaborative function which supported patients being turned around at the front door where clinically safe and appropriate to do so.

In the longer term, the multi-organisational front door IRRS model will form a key interdependency with the new Integrated Urgent Care (IUC) specification, which beyond winter will deliver a local Clinical Assessment Service (CAS) to form a holistic admissions avoidance pathway.

The 19/20 winter plan will be updated when further granular detail becomes available as to the expected deliverables and outputs which will specifically mitigate winter pressures.

**Integrated Urgent Care**

Implementation of the nationally mandated Integrated Urgent Care (IUC) pathway will occur across Nottinghamshire, aiming to provide care closer to people's homes and help tackle the rising pressures on all urgent care services (primary and secondary). This will be delivered by procuring a clinical assessment service available to 111 to ensure patients are directed to the right service first time. This model will also support EMAS to hear and treat, see and treat and reduce conveyance rates to hospital. There are currently two mobilisation options being considered by commissioners and key stakeholders; one of these will deliver beneficial changes to the system during winter 19/20 and this plan will be updated with further details once the outcome and next steps have been confirmed

**Call for Care**

Call for Care (CfC) is a single point of access and navigation hub for Mid Notts Adult Community services (physical healthcare) which includes Urgent Response (CURRT), End of Life together and Community Nursing services.

CfC Option 1 (Urgent response) provides care navigation for the entire system from a hospital avoidance perspective. Health and Social care professionals in primary care, EMAS crews and EMAS Clinical Assessment Triage, lifeline providers and SFHT can access a 2 hour face to face assessment to safety net people who have sub-acute health needs, where a hospital attendance would have previously been the only viable option. CURRT can provide ACP led care for patients with sub-acute health needs and intensive rehabilitation for those who have deconditioned functionally.

CfC responds to an average of 100 patients per week and this looks likely to increase as the Integrated Rapid Response service develops. CfC is the golden thread which runs through healthcare services in mid-Notts and aids the urgent care system from an admissions avoidance, flow and discharge perspective. The provider joins the weekly/regular system calls, attends flow meetings and contributes to system OPEL reporting, while sharing transparent capacity data.

**End of Life Care collaboration.**

End of Life Care Together was developed following a 2 year evaluation where services for end of life care were redesigned jointly following collaboration between partners, including Hospices, Notts Healthcare Foundation Trust, Primary Integrated Care Services, Sherwood Forest Hospitals Foundation Trust and Cruse Bereavement.

The service was built on a capacity and demand model with resources allocated dependent on need. Integral to the pathway is the Electronic Palliative Care Coordination Systems EPaCCS, a single point of access which identifies and registers patients in the community on end of life care. Whilst this is currently only available in the community in mid-Notts to view, extensive work is underway to ensure wider system partners can see this information moving forwards.

The pathway helps to prevent A&E attendances by advocating early identification of those patients with end of life needs in order that advance care planning can be undertaken. Patient leaflets have been produced to provide further information. Complementary to the pathway the ReSPECT form, an advanced care plan provide an opportunity to share future care needs.

Referrals are made through a single point of access (SPA) which is supported by clinical triage to assess patient needs with two separate numbers available, but these would be answered by the same service. The SFHFT A&E team have engaged with the service by introducing new protocols allowing EPaCCS to be triaged by a consultant.

2096 patients are currently registered on EPaCCS and there is an ambition that this will increase to 3000 by April 2020. According to available data, 80% of patients have passed away in their preferred place of death.

It is acknowledged that some patients are still referred too late and work is taking place to address this. This includes encouraging care homes to refer all patients in care homes and those who are moderately frail to have advanced care plans in place. Resources will be put in place collaboratively to improve access and navigation and the wider health and social care community will be trained to identify end of life care needs.

**Front Door – Admissions Avoidance**

**Front Door -**

ED-led streaming at the front door of SFHFT provides an effective and robust mechanism to protect against 4 hour breaches. This process is being supported by a focus within the department of assessing all patients within 30 minutes of attendance, enabling diagnostics/tests to be undertaken earlier, and clinical decision making to be completed sooner, and more conclusively. This in-turn will positively impact upon admissions & the subsequent flow of patients throughout the hospital. GP referrals into Specialties are currently being picked up by main front door protocols.

Ambulatory Care –

The availability and expansion of the Ambulatory Emergency Care Unit (AECU), and expanded ambulatory care pathways allows for the occurrence of patients who need further specialist test to be undertaken without admission, or opportunity to breach the 4 hour ED standard. Current front door protocols allow for certain patients to be streamed straight into AECU where appropriate in addition to the additional ambulatory care pathways, NEMS have opened a DVT pathway which will absorb a proportion of those patients requiring diagnostics & further testing and the protocols allow for patients to be exempt from breaching the 4 hour target where appropriate.

Clinical input from medicine and surgical specialties is provided under the current process of clinicians coming to the ward within 30 minutes of patient need being identified. This will both allow the Specialty consultants to better utilise their time in not having to move from one area of the hospital to another, and will allow for better flow within the ED. Specialty Hot Phones are in place where GPs can contact Specialty Consultants direct for advice on potential elective or non-elective referrals, or more general to feed into care plans which will ensure the ongoing management of patients within the community and primary care. Consultant Connect, a similar intervention is also available for other specialty disciplines. These services cover geriatrics and respiratory, which have been identified as the two main conditions where vulnerable cohorts of patients are at risk of admissions.

Available intelligence has indicated that the ED-led front door streaming processes continued to work effectively over the winter 18/19 period, with streaming protocols being maintained during busy periods, and the levels of admissions indicating successful admissions avoidance pathways are in place. The continuation of the Children's Assessment Unit (CAU) will continue to drive this activity in 19/20. A key risk for winter 19/20 is ongoing increased demand with front door attendances up by approximately 10%. The outputs of the system-wide Drivers of Demand analysis work will be crucial to implementing mitigating actions to reduce the risk of the unprecedented demand experienced by urgent care services over the last 6 months.

NEMS at PC24 -

NEMS deliver the co-located Primary Care service at the front door of A&E. They have been experiencing an increased number of breaches of the 4 hour standard in recent times and rapid deep dive work is taking place to put in remedial steps to resolve this situation ahead of winter. A number of breaches from PC24 have resulted from waits for diagnostics relating to the ambulatory care pathways which are in place as attendance avoidance tactics.

PC24 breaches are reported by exception to the CCG ECN Manager in the form of an RCA. Conversations are taking place to understand how streaming to Primary Care can be increased, enhanced and developed as data shows that PC24 attendances have not increased at the same rate as A&E attendances.

Wider initiatives delivered by NEMS which will continue during winter 19/20 include the Community Pathfinder service, which offers a clinical advice and support service for EMAS, designed to reduce conveyances to acute hospitals across Nottinghamshire. In addition, the successful ED Illness disposition pathway will continue. This service takes referrals from the 111 service when pathways produces an 'ED Illness – attend ED' disposition. NEMS re-triage the call and in 80% of cases avoid an attendance by either giving self-care advice or signposting to alternative services.

High Intensity Service Users (HISU) -

The SFHT HISU Service identifies the top 200 patients with 10 or more A&E attendances and has a priority focus on mental health and alcohol dependency related activity. Patients are identified via SFHT A&E data. HISU patients and their carers are supported through an integrated Multi-Disciplinary Team (MDT) process.

The service is delivered by two HISU Nurses located within A&E, with support from an A&E Consultant. Monthly HISU Integrated MDT meetings will take place in the acute trust and also within GP Practices, as appropriate. The Nurses have access to SystmOne and will enter patient place care plans directly onto SystmOne to ensure that GPs are aware of the plans in place. Wider A&E staff are also made aware of the HISU Care Plan to enable them to appropriately address attendances.

The acute HISU Nurses liaise with counterparts in other system partner organisations (for example, EMAS and 111) to ensure that approaches and plans are aligned to provide a co-ordinated response and joined up care offer.

Rapid Response Liaison Psychiatry Service (RRLP) –

This service, operated by Nottinghamshire Healthcare Trust (NHCT) offers a front door assessment service, designed to provide an early identification and proactive referral pathway for patients with a variety of mental health needs who present to the front door of SFHFT. The service work collaboratively with the HISU Nurses and are working to the ambitions of the Core24 standards. The service have identified that service demand does not fluctuate throughout the year and that they don't experience winter and Christmas period influxes. On-

call arrangements are in place for the escalation of issues during weekends and these details can be found in the Surge & Escalation Policy.

Mental Heath 12 hour breach Route Cause Analysis reviews –

In most cases a 12 A&E breach occurs at SFHFT because the patient is awaiting a mental health bed. Whilst NHCT are working on transformation plans which will improve bed availability and processes, a joint mental health breach route cause analysis meeting now takes place on a quarterly basis. These meetings review both the SFHFT and NHCT routs cause analysis documents, enabling themes and trends of breaches to be identified and shared learning conversations to take place.

Frailty -

Plans are underway to enhance the existing robust frailty pathway available at the front door, which will strengthen admissions avoidance practices & enhance the outcomes of patients beyond front door services. This is part of the UEC deliverables for 19/20 in the A&E DB work plan. Part of this work is in conjunction with the National Acute Frailty Network and steps are being undertaken to understand how other frontline services and PC24 can and are holistically addressing frailty as a service offering.

**Flow**

The Mid-Notts A&E Delivery Board acknowledges that patient flow impacts every touchpoint of our local healthcare system from GP attendances, telephone calls to 111 & EMAS, through to A&E attendances and demand on community providers who offer admissions avoidance alternatives, and step down facilities. As such patient flow is a system priority, and individual provider plans underpin this system process. Flow has been discussed regularly at A&E DB meetings and this will continue throughout winter 19/20 to ensure that plans are working effectively. This will be monitored on a daily basis from acute trust & community provider bed states and weekly data around LoS, DTOCs and occupancy information.

From a business as usual perspective the acute trust has previously implemented the SAFER bundles piece of work and is continuing to deliver the Red to Green initiative on ward bases. The ambition is for the HFID discharge hub to facilitate and expedite discharges which have been identified as complex, and work closely with CfC in relation to community resource availability and management.

Outcomes for patients will be further enhanced by the capacity of the START Re-ablement and Home First Response home care service, which will enable the earlier safe discharge of patients as soon as they are medically optimised to leave hospital.

Nerve Centre -

SFHFT are utilising the NerveCentre bed management tool as part of business as usual and there is further scope for this to be utilised to greater effect. However, as the only provider using the application across the system, it is hoped that the outputs of the Capacity and Flow workshop will assist with delivery of a system-wide solution, acknowledging that the starting point is existing good and shared practice across the patch.

In place of a live demand & capacity function across the localities the mid-Notts system is utilising shared dashboards, bed states and intelligence from system calls to inform flow discussions and negotiations. The Home First Integrated Discharge work stream has the ambition of providing a solution to any cross-organisational boundaries which may impact on flow with the development of 8 detailed pathways for each component of the model ensuring that patients are in the right pathway at the right time. This work is being supported by the advance planning within the OPEL action cards for 19/20.

**Hospital Discharge -**

Length of Stay (LoS) and Delayed Transfers of Care (DToCs)

Both national targets are indicators on the 19/20 A&E DB work plan. SFHFT have a combined LoS and DToC reduction action plan, which reflects the commonalities and interdependencies between the two patient groups. The current focus for LoS is on the reduction for patients with a stay of over 21 days which is delivering a marked reduction and will continue to work toward the standard required of a 40% reduction in long stay patients from the March 18 baseline by March 2020. The NHSI target for >21 days is 70 patients and in June 2019 SFHFT achieved this level. July fluctuated between 70 and 80 days, and it should be noted that these figures include the community bed bases with appropriate longer lengths of stay.

- SFHFT are working to deliver the national reduction in LoS bed days, in-line with national targets and timeframes. To ensure that this piece of work is managed strategically, both DToCs and LoS are indicators within the 19/20 mid-Nottinghamshire A&E Delivery Board work plan and progress will be monitored on a monthly basis.
- A recent version of the plan has also been included in the SFHFT 19/20 NHS Standard Contract as part of the Service Development & Improvement (SDIP) to ensure strategic alignment in objectives.

Actions from the plan include:

- Long Stay Wednesday – a national initiative designed to expedite patients with a hospital stay of 21 days and over, unblocks barriers to discharge and promotes the accountability of ward staff in the discharge process.

- SFHFT hold a weekly over 21 day meeting led by Medicine DGM, Medicine Clinical Lead and Head of Nursing where all stranded patients are reviewed. Information is presented from Matrons, IDAT members, Therapists and Medics. This meeting is attended by partner organisations as well. From this meeting a clinical peer review is conducted on the wards where required.
- A weekly executive forum where the Medicine DGM and Head of Nursing present a summary position to COO and any updates on complex patients where escalations are in progress. From here the COO may then discuss cases with partner executives for response/ action where required.
- An over 21 day DPTL is in development and this will be shadow monitored with the implementation date to be confirmed
- The revised SFHFT Discharge Policy is in the sign off stage with launch and training taking place during July 2019.Daily escalation to both Medicine DGM and Head of Nursing occur from the HFID Hub and actioned.
- Internal improvement actions, for example a criteria-led discharge pilot.

A LoS working group meets weekly to address internal issues with a monthly meeting with partner agencies on wider system related requirements with an action plan and risk log supporting this meeting.

Home First Integrated Discharge (HFID) Workstream –

A key deliverable on the LoS/DToC action plan is the delivery of the Alliance Transformation Board supported HFID programme by December 2019. This project, currently in phase one, will further streamline and improve advanced discharge planning processes and timelines from a Home First – 'why not home, why not today?' ethos and discharge to assess (D2A) model.

Fundamental to this project is the HFID discharge hub; the hub underpins the HFID model with the following aims and objectives of the HFID model

- A daily system MDT meeting which identifies the appropriate discharge pathways for medically optimised and complex patients.
- A trusted decision making and pull approach to ensure patients are supported home first or as soon as medically fit for discharge
- The hub ensures that the admissions criteria principles for community bed stock are appropriately utilised,
- A dedicated system lead of the hub that can hold system parties to account for the delivery of the agreed principles within the Partnership Operating Model developed in collaboration. Currently this resource is provided by the CCG

- The hub will be supported by dedicated administration to track, monitor and manage patients being managed by the hub.

Phase 2 implementation of the model has already begun ahead of the August 2019 timeline will aim to re-configure the community bed base within the SFHFT bed stock.

A key KPI for delivery of this is the acute discharge pathway of cohorts of patients who have previously been proven to impact upon LoS, e.g. Non-weight bearing, rehab and DST patients.

The system-wide escalation meeting forms part of the governance of the HFID hub, and provides a route to Exec level facilitation where patients who have been identified for a HFID pathway have not been discharged within 24 hours.

The outputs of the hub will feed into the urgent care network system resilience teleconferences, and both LoS and DToC levels have been proposed as indicators within the SFHFT OPEL reporting framework to ensure focus on key challenges to hospital and system flow.

A key interdependency of the HFID project and another action on the LoS action plan is the revision of the SFHFT Discharge Policy which underpins operational D2A processes and encourages staff to discuss discharge upon admission, while enabling and empowering actions where discharges are delayed due to patient choice.

Social Care

Social Care colleagues have been attending the HFID discharge hub to assist with expedited discharges of patients on agreed pathways out of the acute. It is anticipated that Social Care staff will continue to work additional hours in the evening and at weekends on a voluntary basis in recognition of the need to meet with families who can't visit relatives during the day time. There is ongoing work taking place in respect of patients who refuse interim care, or are self-funders in terms of the joint key messages that are given to these patients and when, to contribute to a timely discharge and flow from the acute. Joint meetings are taking place with families, Social Care and IDAT team members, and this will be further supported by the delivery of messages which set patients expectations from the point of admission.

Flu Plans –

The Notts CC flu plan is inclusive of care home staff and the target is for 51% vaccination rates in 19/20, an increase from 50% in 18/19 when 41% of all Notts County Council staff were vaccinated. A comprehensive electronic flu voucher system has been implemented for 19/20 and a programme of work place vaccine sessions is in place.

BCF Funding

BCF funding and associated schemes from 18/19 have been carried over into full year effect for 19/20 for both core BCF funding and the winter pressures grant spend which saw a £3.5m investment in Nottinghamshire in 18/19. It is hoped that this will offer a more robust timeline on which to implement additional supportive services and schemes which build upon the successes of 18/19.

Social Care IT Transformation –

Several technological developments between Social care and system partners will improve system and processes for winter 19/20. For example,

- The Social Care Viewer which allows Acute Trust staff in ED and discharge coordinators to view social care information 24/7 which has reduced the number of admissions,
- Automated Assessment Notices from Health to Social Care - saving time in the hospital discharge workflow process,
- The Nottinghamshire Health and Care Portal which shares GP, Acute and Mental Health data with social care staff to support better decision making
- Providing social care data into GPRCC – the system allows care coordinators to review and action care gaps for key cohorts of patients with chronic diseases or who are at risk of admission.

Placement without prejudice –

The Mid-Notts CCGs and wider system partners continue to be fully committed to the protocol of placement without prejudice. We acknowledge that where this is not in place, this presents delays to the process of discharging patients from the acute into either community provision or back home with wrap around care. We appreciate that a risk of such delays could arise from disputes between Health and Social Care over responsibility for payment, and so all efforts are made to ensure that this is not the case. For 19/20 the Home First Integrated Discharge (HFID) Workstream has alleviated some of these issues, as community beds have been identified as the main pathway for some of the patients who fit this criteria, and for all other cases there is an accepted approach which is reflected within the relevant protocols (e.g. CHC, D2A, etc.) that the discharge of the patient from the acute is the immediate priority, and funding decisions will not be a barrier to the delivery of this ambition. The full implementation of the HFID pathway during winter 19/20 will further support and enable the ambition of the Mid-Notts system.

Non-Emergency Patient Transport (NEPTS) –

Patient transport is a crucial element of successful and timely discharge processes during winter. Regional contracts and system interdependencies are complex for NEPTS and the

current provision has experienced long-standing challenges and difficulties in delivering a responsive service. A NEPTS working group chaired by SFHFT is in place with improvement actions for both the current provider - Arriva and SFHFT in terms of processes.

After a recent procurement, a new provider will commence service delivery in December 2019. Whilst going live with a new service in winter brings an element of risk, Commissioners have put mitigating steps in place to minimise this risk. Assurance has been gained on the stability and capability of the new provider from the competitive procurement process that was undertaken, and the provider currently runs successful services in an area with a similar demographic size to Notts. The CCGs have employed a Mobilisation Manager who will oversee the first 2 months of the new service and will be available to resolve and troubleshoot any potential issues. This Manager has been invited to attend future NEPTS meetings as the current plans for improvements will still be relevant and beneficial under the new contract.

Business Continuity plans, OPEL thresholds, triggers and actions have been requested from the new provider, and the CCG Urgent Care Team will work with the provider in advance of the go live date to ensure that there is little system impact from the new service, and to discuss system expectations for example, joining the system call and local key contacts. There are no concerns around the change of provider, given that mobilisation meetings between Arriva and the new provider are positive, proactive and productive.

**Wider considerations**

End to end call reviews –

End to end call reviews take place on a monthly basis and are attended by representatives from Commissioners, Primary Care, EMAS, DHU111, Healthwatch, NEMS, acute trusts and community partners. A different call theme is chosen each month (e.g. paediatrics, end of life) and attendees listen to each step in the patient journey from the initial call to 111, through to NEMS, EMAS and where applicable, an update from the relevant acute trust. Whereas previously the aim of this meeting has been to identify specific areas of improvement for DHU111, the revised focus for the 19/20 period is a system-wide lens on quality, pathways and patient experience. Recent call reviews have identified where information on the Directory of Services (DoS) has been absent for the new mid-Notts End of Life pathway, the results of which were an ICS-wide comms and engagement piece on the end of life service for existing pathway patients and a signposting addition will be added to the DoS for these patients. The call reviews are invaluable for allowing a timely review of current patient pathways and enable remedial actions to be undertaken rapidly for maximum effect.

**Bad Weather Operational Plans and Service Provision -**

Individual organisational winter and/or business continuity plans will contain specific plans around business continuity, bad weather readiness and operational details around how both staff and patients will be cared for during a bad weather period. Organisations with bedded

facilities will prepare for the eventuality that both patients and staff are unable to get into or leave the facility, in terms of both food and comfort. Social Media groups will be used in the eventuality that additional staff are needed at certain times, and most organisations have access to a pool of 4x4 vehicles, including Arriva, the PTS provider. The CCG urgent care team can provide a central function for operationalising shared resources across organisations where required.

It is generally accepted that urgent care services are quiet with low attendances during periods of bad weather, but that demand increases significantly once the bad weather has cleared. The desk top test of the winter plan will understand how this can be proactively addressed and overcome in advance of these occurrences.

Community services continue to be busy during bad weather periods, as ensuring that patient are cared for in their own homes is imperative to reducing avoidable urgent care activity, and day to day business as usual operations will dovetail into business continuity measures to ensure that services continue to be delivered.

The CCG will issue weather warning details as part of system comms and this intelligence will be cross-referenced with forecasted demand activity to ensure that the system response to periods of bad weather is as proactive and sophisticated as possible.

**Conclusion –**

In the spirit of continual improvement, the ambition of this document is to build upon the successes of the safe and timely service provision that was delivered and maintained by the mid-Nottinghamshire urgent care system during winter 18/19.

The plan articulates how the mid-Nottinghamshire ICP will retain its recognition of being a successful and resilient system through the trusted collaboration of system partners and the evolving, mature manner in which plans are shifting from reactive responses to proactive planning.

Lessons have been learned from the winter 18/19 period, including deep dive analysis into particularly challenging peaks in demand. The plan will continue to evolve as a live document which will respond to the challenges and successes of the season, in-season, following a PDSA review style which will triangulate intelligence from data analysis, system resilience teleconferences and A&E Delivery Board meeting outputs.

## Appendices

| Provider | Flu Plan | Winter Plan |
|---|---|---|
| SFHFT | Flu Plan SFHFT | |
| NEMS | | NEMs Winter Plan |
| EMAS | Notts Flu Plan 2019.docx | EMAS Hospital Predictions |
| 111 | | |
| Social Care | A&E Delivery Board Briefing July 2019.pdf | |
| Local Partnerships | download.pdf | |
| Arriva | | ATSL Winter Resilience Plan 2019 2 |
| | | |
| A&E Delivery Board workplan | A&EDB Workplan August 2019.xlsx | |
| OPEL calculation Matrix | MN System OPEL Calculation.xlsx | |
| 19/20 Surge & Escalation Plan | 1920 Surge & Escalation Plan | |
| 18/19 winter de-brief | | |

ENC. P1

| | |
|---|---|
| **Meeting:** | ICS Board |
| **Report Title:** | Greater Nottingham Transformation Steering Group Terms of Reference |
| **Date of meeting:** | Thursday 12 September 2019 |
| **Agenda Item Number:** | 18 |
| **Work-stream SRO:** | Amanda Sullivan, CCG Accountable Officer |
| **Report Author:** | Simon Gascoigne, NUH Integration Manager |
| **Attachments/Appendices:** | Enc. P2. Greater Nottingham Transformation Group Terms of Reference |

**Report Summary:**

**Background**

This paper sets out the background and rationale for the establishment of a Transformational Steering Group for Greater Nottingham. The Terms of Reference for the group are provided.

**Action:**

☐ To receive
☒ To approve the recommendations

**Recommendations:**

| | |
|---|---|
| 1. | To approve the GNTSG Terms of Reference. |
| 2. | ICP and Statutory Organisation leads to confirm appropriate membership of the group. |
| 3. | To agree to nominate suitable representatives as group members |

**Key implications considered in the report:**

| | | |
|---|---|---|
| Financial | ☐ | |
| Value for Money | ☐ | |
| Risk | ☐ | |
| Legal | ☐ | |
| Workforce | ☐ | |
| Citizen engagement | ☐ | |
| Clinical engagement | ☐ | |
| Equality impact assessment | ☐ | |

**Engagement to date:**

| Board | Partnership Forum | Finance Directors Group | Planning Group | Workstream Network |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |
| Performance Oversight Group | Clinical Reference Group | Mid Nottingham-shire ICP | Nottingham City ICP | South Nottingham-shire ICP |
| ☐ | ☐ | ☐ | ☐ | ☐ |

| Contribution to delivering the ICS high level ambitions of: | |
|---|---|
| Health and Wellbeing | ☒ |
| Care and Quality | ☒ |
| Finance and Efficiency | ☒ |
| Culture | ☒ |

**Is the paper confidential?**

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

# GREATER NOTTINGHAM TRANSFORMATION STEERING GROUP TERMS OF REFERENCE

## 12 SEPTEMBER 2019

## Progress

1. We are moving from a system that focuses on organisations to a way of working that is population focused. NHS organisations and local government will increasingly work across current boundaries for strategic planning and delivery of large-scale change (ICS), coordination and delivery at place level (ICPs) and very local neighbourhood networks (PCNs).

2. During this time of change and the development of new ways of working, it is essential to drive transformation and to execute changes at the level they are most likely to become embedded and operational – the right population scale for the task in hand.

3. When the ICS Board approved 2 ICPs in Greater Nottingham, some important operating principles were agreed at that time:

    - Whilst the ICPs will be best placed to work with their local populations to improve health, there are some programmes of work that are best executed once across Greater Nottingham. A joint transformation forum to take forward defined programmes and to share best practice will be of mutual benefit and will support coherence of effort.
    - Changes that impact on NUH entry and exit points would be developed and executed once at a Greater Nottingham level, in order to ensure operational coherence and consistency.

4. The development of a Greater Nottingham Transformation Steering Group will therefore oversee and drive transformation schemes that need to be executed once across Greater Nottingham. The focus will be on partnership working to

solve problems and tackle some wicked problems, such as emergency and planned care flows and financial deficits. Over time, it is envisaged that our approach to transformation will develop, ensuring a bottom-up care / clinical professional approach to service design. This group will provide a vehicle for development of our approaches, in line with partner views.

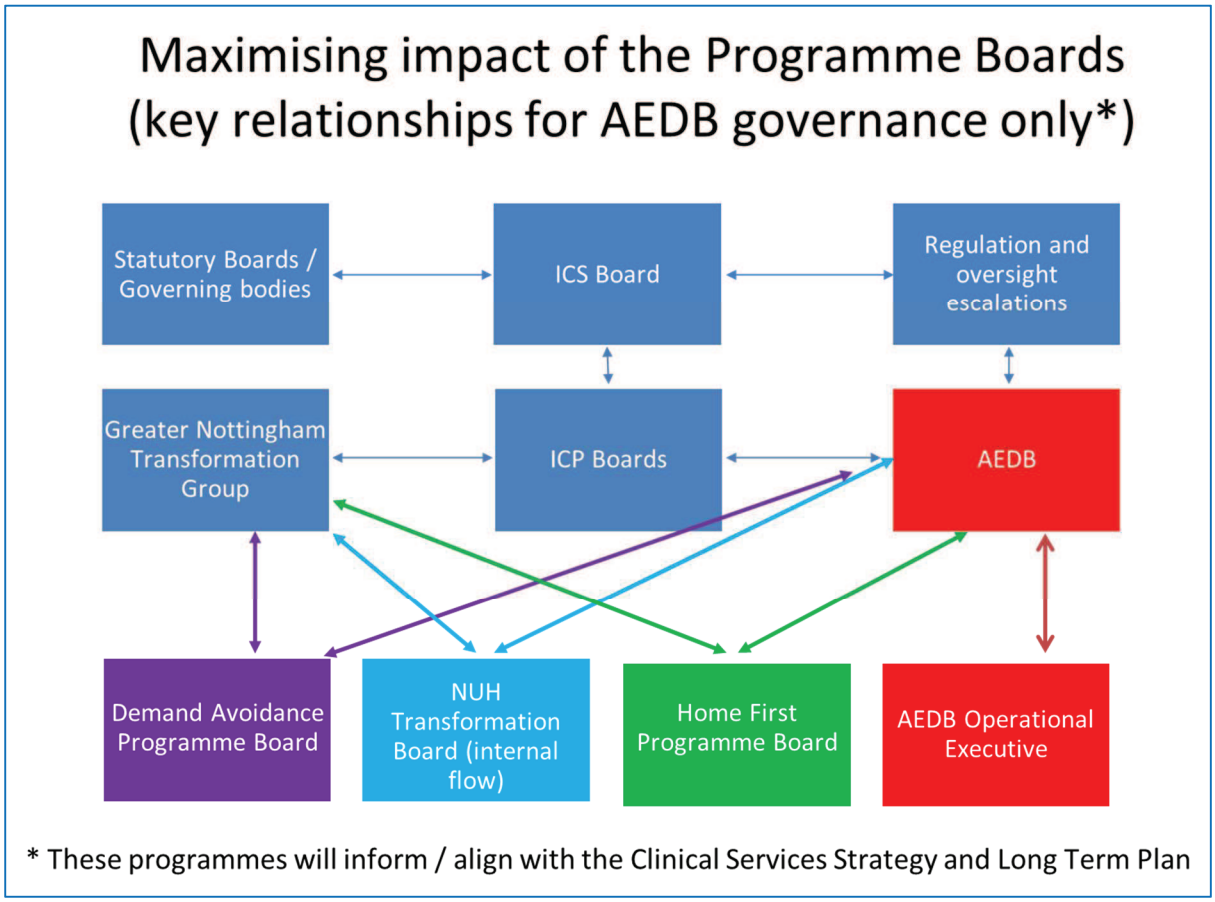
5. The Greater Nottingham Transformation Steering Group (GNTSG) has been established and has met on two occasions to date. The third meeting is planned for the 9th September.

6. A supporting working group has also been established that has representation from across GN. The working group has cross-representation with the ICP Boards and AEDB and has been progressing actions on behalf of the GNTSG as a virtual PMO.

7. Members of the GNTSG have discussed its purpose on a couple of occasions, which have resulted in the attached draft Terms of Reference. At a broad level, its contribution to system working is shown below:


8. The initial focus of the group has been on Urgent and Emergency Care, but this will expand across a range of care delivery areas.

9. Following work undertaken in partnership with Greater Nottingham A&E Delivery Board, it has been agreed that the GNTSG will have a focus on Urgent and Emergency Care transformation schemes allowing the A&E Delivery Board to focus on addressing current operational pressures and performance. Arrangements are being implemented to support the agreed governance. The diagram below summarises this:




**Recommendations:**

1. To approve the GNTSG Terms of Reference
2. ICP and Statutory Organisation leads to confirm appropriate membership of the group.
3. To agree to nominate suitable representatives as group members

**Simon Gascoigne**
**NUH Integration Manager**
**Simon.Gascoigne@nuh.nhs.uk**

# Greater Nottingham Transformation Steering Group

## Terms of Reference v0.6

# Version control

| Revision Date | Summary of Changes | Version | Author |
|---|---|---|---|
| 04/03/19 | First draft of ToR based on Mid Nottinghamshire Transformation Board | 0.1 | Jonathan Rycroft |
| 05/3/19 | Changes to proposed membership and reporting arrangements to recognise potential interim requirement for a joint executive group to have oversight whilst ICP arrangements are clarified in GN | 0.2 | Tim Guyler |
| 15/3/19 | Changes to reflect feedback from system colleagues on the phone call discussion on 7/3/19, particularly:<br>- Making this a transformation task and finish group<br>- Initial focus re identifying and agreeing the key areas of focus<br>- Inclusion of broader representation, including local authorities | 0.3 | Tim Guyler |
| May 2019 | General update to further thinking on the role of the group and to reflect comments from Sub-group. | 0.4 | Simon Gascoigne |
| 31st May 2019 | General update to reflect discussion at the May 2019 Steering Group | 0.5 | Simon Gascoigne |
| July 2019 | General update to reflect discussion at the July 2019 Steering Group and subsequent direction from ICS Board. | 0.6 | Simon Gascoigne |

# Approvals

| Date | Comments | Version | Approved by |
|---|---|---|---|
| July 2019 | ToR agreed in the interim whilst purpose of the GNTSG is agreed. | 0.5 | GNTSG |
| | | | |
| | | | |

## 1. Role of the Transformation Steering Group

As we move to a population based architecture there will be increasing opportunity to do things differently, working across organisational boundaries.

The Greater Nottingham Transformation Steering Group (South Nottinghamshire & Nottingham City ICPs in common) (GNTSG) has been established as a forum that allows health and social care partners to identify and work together to progress opportunities identified that require multi-organisation working to deliver benefits for the Greater Nottingham (GN) population (combined population of South Nottinghamshire and Nottingham City ICPs).

When the ICS Board approved 2 ICPs in GN, some important operating principles were agreed:

- Whilst the ICPs will be best placed to work with their local populations to improve health, there are some programmes of work that are best executed once across GN. A joint forum to take forward defined programmes and to share best practice will be of mutual benefit and will support coherence of effort.
- Changes that impact on NUH entry and exit points would be developed and executed once at GN level in order to ensure operational coherence and consistency.

The group will work closely with the developing ICPs.

The GNTSG has been established to support:

- The coming together of key partners to identify opportunities for joint working for the benefit of the representative population. The focus will be on partnership working to solve problems and tackle some wicked problems, such as emergency care flows and financial deficits.
- Progress identified opportunities arising from the work of the ICS Board and/or strategic commissioner.
- Work together to jointly support the resolution of any strategic risk issue raised by a partner that requires collective support to mitigate.
- Working together to explore identified opportunities, work up appropriate transformation proposals and jointly agree.
- Identify the collective resources that will support delivery of agreed transformation opportunities.
- Provision of oversight and tracking of delivery of agreed opportunities, providing a senior level forum to resolve any blockages pragmatically and in partnership for the benefit of the representative population.
- Take collective accountability for the benefits realisation of identified opportunities.

In fulfilling its purpose the GNTSG will not seek to duplicate work that is already being undertaken in another part of the system governance structure. The GNTSG may seek assurance that the work being undertaken in another part of the system to confirm it is sufficient to achieve the opportunity identified.

## 2. Greater Nottingham Transformation Steering Group Principles

It is proposed that the GN Transformation Steering Group should work consistently with the principles and behaviours agreed by the ICS Board.

Principles of Joint Transformation

- For the GN population we accept that there will be opportunities where it makes sense to come together and do things once.
- The overarching ambition is to do what is right for the GN population.
- Representative partner organisations will support the group with appropriate senior (Accountable Officer / Director) representation.
- Partner organisations accept that there may be times where support is required to provide a direct benefit to the population but not to their statutory organisation.
- Partners will learn together, will try new things, have success together and fail together. We will adopt the principles of continuous learning.
- Partners will adopt the expected behaviours as agreed in the ICS behaviours framework.
- Subject experts from partner organisations will engage in the transformation work.
- Each agreed programme will have an agreed Senior Responsible Officer (SRO) who will represent the needs of the GN population first.
- Programme objectives, baselines, milestones, KPIs and expected impacts will be agreed by the GNTSG.
- A standardised programme tracking and reporting mechanism will be established and adhered to ensuring consistency of message from agreed programme. This will be consistent with reporting to other governance forums.
- A Programme Management Office (PMO) business rhythm for monthly reporting will be established to track progress, identify highlights and escalations.

## 3. Membership

Core membership will include representatives from:

| |
|---|
| CCG |
| NUH |
| NHT |
| CityCare |
| Nottm City LA |
| Notts County LA |
| Primary Care Clinical Representatives |
| Representative from the South Notts ICP* |
| Representative from the Nottingham City ICP* |

*ICPs may feel they are represented through agreed organisational membership.

Additional members:

- Work stream SRO's and subject matter experts.

- Representatives from the virtual GN PMO i.e. those organisational officers co-ordinating progress on behalf of the group.
- Representation from NHS England, for any relevant items impacting activities that impact on specialised commissioning.

Other members, including public, patient and voluntary sector representatives may be co-opted as required according to the nature of business to be discussed.

Representatives will be required to be at executive level and to support decision making and resolution of escalated issues.

## 4. Accountability

The ICS Board has committed to the need for a transformation forum within GN, therefore, the GNTSG will initially be accountable to the ICS Board.

As the ICPs in South Notts and Nottingham City become more established, accountability arrangements for the GNTSG will be reviewed. The next review will take place after the 31st March 2020. It is expected that the ICPs will recognise the importance of the GNTSG and be active members in the groups work.

## 5. Chair

The Steering Group will be led by TO BE CONFIRMED.

The TO BE CONFIRMED, will deputise if the Chair is unavailable.

## 6. Quoracy/decision making

The Greater Nottingham Transformation Steering Group aims to bring partners together to promote collective working and problem solving. No formal quoracy or decision making rules are to be established at this time. There is an expectation that members or their deputies will attend each meeting to support the development of partnership working and have sufficient authority to support decision-making.

All members will be responsible for reporting through their respective organisational governance routes to ensure full participation and involvement.

## 7. Administration and Frequency

The Greater Nottingham Transformation Steering Group meetings will initially be held on a monthly basis.

## 8. Secretariat

The Greater Nottingham Transformation Steering Group secretariat will work with the Chair, where required, to develop the agenda contents and format. As much advance notice of business, as is reasonably possible, will be given.

The membership should ensure that responses to requests for papers and updates against actions are submitted in a timely manner.

## 9. Review of Terms of Reference

Terms of Reference will be considered after March 2020.

August 2019

ENC. Q1

| | |
|---|---|
| **Meeting:** | ICS Board |
| **Report Title:** | Governance Matters for Approval |
| **Date of meeting:** | Thursday 12 September 2019 |
| **Agenda Item Number:** | 19 |
| **Work-stream SRO:** | David Pearson, ICS Independent Chair |
| **Report Author:** | Joanna Cooper, Assistant Director, ICS |
| **Attachments/Appendices:** | Enc. Q2. Nottinghamshire Integrated Care System Architecture Working Group Terms of Reference |

**Report Summary:**

This report covers five governance matters for approval:

1. Board Membership

Board previously decided that there should be a more comprehensive review of the ICS Board terms of reference after a year of operation. In the meantime it is recognised that the Terms of Reference and composition of the Board may need to be adjusted to reflect the changing expectations of Integrated Care Systems, nationally and locally.

At the 8 August meeting, Board decided that CityCare should be represented on the Board as a major provider of community health services. In 2018, they successfully bid for the contract to provide community health services until 2028. The principle is that any major provider will need to work in an integrated way with the rest of the system as partners. At the same time this development has the advantage that Lyn Bacon (Chief Executive of CityCare) would be available to add the perspective of lead for the ICS on workforce. For other local system partner organisations, the non-Executive Chairs are also members of the Board. In order to be consistent it is recommended that the non-Executive Chair of the CityCare Board (Michael Williams) should also be invited to be a Member of the Board. The intention would be that the invitation would be until any re- procurement process for the services that CityCare provide.

In systems across the Country, it is recognised that the relationship with statutory Health and Wellbeing Boards (HWB's) is crucial. Indeed, in some systems HWB's form the basis for the governance of the ICS. Some of the responsibilities of the ICS overlap with those of the HWB's particularly for Prevention through the Health and Wellbeing Strategy and for population needs analysis. The two upper tier local authorities are represented by politicians as well as the Chief Executives (or their nominated representative). The Health and Wellbeing Boards have statutory responsibilities in their own right and whilst based in Councils, HWB's are made up of statutory and discretionary representation of partner organisations.

In view of the significance of Health and Wellbeing Boards it is recommended that the Chair of the Health and Wellbeing Boards become Members of the ICS Board with voting rights.

2. *Review of ICS Governance*

Board agreed at the 8 August meeting that the Independent Chair would lead the development of a governance review for the ICS to understand:

- Role and purpose of groups across the different levels of the system
- Strengths and weaknesses of the current configuration
- Topics which should be discussed at and owned by the ICS Board
- Membership of the groups within the ICS structure
- Consideration to an Executive Team layer within the system with NEDs and Chairs holding Executives to account for delivery.

A proposal will be shared with Board members for consideration by end of September with a view to completing the review by end of December 2019.

3. *Approach to sharing papers with the Board*

Members are asked to consider the use of an e-system for the distribution of papers. This would give members of the Board secure access to an online portal to download and annotate papers at their convenience.

A review of the programmes currently in place across the statutory organisations has taken place and shows that a number of programmes are in use to share papers internally. The most frequently adopted programme is Diligent, which is compatible with Microsoft and Apple. Diligent is available through NHIS and can be made available to all board members at no cost.

It is proposed to utilise Diligent for sharing papers with the Board. ICS Board members are asked to endorse this approach.

4. *Architecture Group Terms of Reference*

Terms of Reference (TOR) for the Architecture Group have been reviewed and amended. ICS Board are asked to approve these revised TOR / this group being stood down.

The terms of reference (TOR) of the System Architecture Group are due to be reviewed.

At its meeting on 3 September 2019, members of the System Architecture Group considered that the current TOR and purpose of the group had run their course.

Originally set up as a ‘task and finish’ group to steer the establishment of PCNs and ICPs, the principal objectives have been achieved.

All members present agreed that there was very limited value in continuing to meet in this way and the group should be ‘stood down’.

The Deputy Managing Director of the ICS has overseen the production of a comprehensive handover document to ensure that corporate memory is retained.

The ICS board will wish to give consideration in the future to how future collaboration (e.g. between ICPs) can be taken forward and to ensure oversight of progress against the ICS maturity matrix.

5. *The National Centre for Rural Health & Care and the Rural Health & Care Alliance*

This organisation approached the Mid-Nottinghamshire ICP with an opportunity to become a member of the Alliance. A system-wide (Nottingham and Nottinghamshire ICS) membership would be more cost-effective and a discounted membership fee has been negotiated (£700 for the remainder of this year and full year costs for next year). The cost could be met from ICS team non-pay expenditure. The Board is asked to note.

**Action:**

☐ To receive
☒ To approve the recommendations

**Recommendations:**

| | |
|---|---|
| 1. | Approve the recommendation to amend the membership of the ICS Board to include the non-Executive Chair of the CityCare Board and Chairs of the Nottingham City and Nottinghamshire County Health and Wellbeing Boards. |
| 2. | Note the requirement to input to the scope of the ICS governance review by the end of September |
| 3. | Approve the recommended approach to sharing papers with Board. |
| 4. | Review and agree the proposed changes to the Architecture Group Terms of Reference. |
| 5. | To approve ICS membership to the Rural Health Network. |

**Key implications considered in the report:**

| | | |
|---|---|---|
| Financial | ☐ | |
| Value for Money | ☐ | |
| Risk | ☐ | |
| Legal | ☐ | |
| Workforce | ☐ | |
| Citizen engagement | ☐ | |
| Clinical engagement | ☐ | |
| Equality impact assessment | ☐ | |

**Engagement to date:**

| Board | Partnership Forum | Finance Directors Group | Planning Group | Workstream Network |
|---|---|---|---|---|
| ☒ | ☐ | ☒ | ☐ | ☐ |

| Performance Oversight Group | Clinical Reference Group | Mid Nottingham-shire ICP | Nottingham City ICP | South Nottingham-shire ICP |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

| **Contribution to delivering the ICS high level ambitions of:** | |
|---|---|
| Health and Wellbeing | ☒ |
| Care and Quality | ☒ |
| Finance and Efficiency | ☒ |
| Culture | ☒ |

**Is the paper confidential?**

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

The Nottingham and Nottinghamshire Integrated Care System

Nottingham City Council | Nottinghamshire County Council | NHS

ICS Board Meeting
12 September 2019
Item 19. Enc. Q2

# TERMS OF REFERENCE

| | |
|---|---|
| **NAME OF GROUP:** | **Nottinghamshire Integrated Care System Architecture Working Group** |
| **PURPOSE** | The group's purpose is to advise and provide recommendations to the Integrated Care System Board on future arrangements for the governance and management of the emerging Integrated Care System (ICS) architecture, including the development of Integrated Care Providers (ICPs) and Primary Care Networks (PCNs). To ensure that, wherever possible, integrating commissioning and provision between health and social care partners is a key organising principle for the future system. Also, to develop, implement and manage the programme plan for moving from current state to future state. |
| **MEMBERSHIP** | **Chair:** Wendy Saviour, Nottinghamshire ICS<br><br>Members:<br>Deborah Jaines – Nottinghamshire ICS<br>Lucy Dadge – Mid-Nottinghamshire CCGs<br>Rebecca Larder – Greater Nottingham<br>Tim Guyler – Nottingham University Hospitals NHS Trust<br>Angela Potter – Nottinghamshire Healthcare NHS Foundation Trust<br>Peter Wozencroft – Sherwood Forest Hospitals NHS Foundation Trust<br>Sarah Bray – NHS England<br>Paul Johnson – Nottinghamshire County Council (role to liaise and engage with City Council as appropriate)<br>Stephen Shortt – GP commissioning representative<br>TBC – Director of Transition, Nottinghamshire CCGs<br>Tom Diamond – Nottinghamshire ICS and CCGs<br>Alex Ball – Nottinghamshire ICS and CCGs<br><br>**Other attendees**<br>ICS leads as required for specific subject matters e.g. enabling workstreams. Advisors as required. |
| **RESPONSIBILITIES** | • To synthesise and interpret the aims for the ICSs that are set out in the Long Term Plan on the future of commissioning and provision and how it enables effective integrated working. |

| | |
|---|---|
| | • To describe the critical actions and key roadmap milestones for establishing new ways of working, taking account of any key regulatory issues.<br><br>• To produce reports/framework proposals for the ICS Board for consideration as required, ensuring that feedback is incorporated in to final proposals.<br><br>• To ensure that all key stakeholders from providers and commissioners across the system have the opportunity to effectively input to developing the new arrangements.<br><br>• To identify and describe other key workstreams to support the re-alignment of commissioning and provision required (e.g. OD, communications) and propose timescales / arrangements for inputs.<br><br>• To identify and secure appropriate advisory support to inform proposals and ensure fit with best practice.<br><br>• Ensuring the system blueprint is iterated to reflect the elements and components that are agreed by the ICS Board.<br><br>• To actively oversee and manage the system programme plan on behalf of the ICS Board and escalate issues to the Board as appropriate. |
| **FREQUENCY OF MEETINGS** | The Group is a task and finish forum and will be subject to review after 6 months. It is proposed that the Group meets twice a month, and frequency will relate to achievement of key milestones. The Group may meet virtually through circulation of papers if required to deliver key outputs. |
| **REQUIRED ATTENDANCE:** | It is expected that members will prioritise these meeting and make themselves available.<br><br>Members of the Group to ensure that they engage within their sovereign and partner organisations outside of meetings to support pace of delivery and maximise input/insights. |
| **REVIEW DATE :** | These Terms of Reference will be reviewed on a six monthly basis to ensure continued fitness for purpose in the light of potential changes to the expectations of national requirements or local issue. |
| **DATE APPROVED :** | |