Integrated Care System Board

Thursday 11 April 2019, 09:00 – 12:00

Rufford Suite, County Hall, Nottingham

AGENDA

	Time	Agenda Items	Paper	Lead	Action
1.	09:00	Welcome and introductions – Chairs vision and ambition for the ICS	Paper A1-2	Chair	To note
2.	09:15	Conflicts of interest	Verbal	Chair	To note
3.	09:20	Minutes of 15 March and 1 April ICS Board meeting and action log	Paper B1-3	Chair	To agree
4.	09:25	Patient story from ICS Cancer workstream	Paper C1-2	Simon Castle	To discuss
Outcomes Framework, Prevention and Inequalities					
5.	09:40	ICS MOU prevention priority – alcohol	Paper D	Alison Challenger & Chris Packham	To discuss
6.	10:10	ICS Outcomes framework	Paper E1-2	Wendy Saviour & Chris Packham	To discuss
7.	10:25	Embedding Personalised Care in Nottinghamshire	Paper F1-2	Jane North & Roz Howie	To agree
Short break					
Strategy and System Planning					
8.	10:55	Agree the approach to June 2019 NHSI/E Estates Strategy Assessment	Paper G	Helen Pledger	To agree
9.	11:05	Receive an overview of the 2019/20 operational plan submission	Verbal	Helen Pledger	To discuss
Oversight of System Resources and Performance Issues (including MoU)					
10.	11:15	ICS Integrated Performance Report - Finance, Performance & Quality. Escalated issues: • Finance • A&E • Mental health	Paper I	Wendy Saviour & Helen Pledger	To discuss
11.	11:30	Receive a report on the delivery of MOU National and Local priorities and deliverables	Paper J	Wendy Saviour	To discuss

	Time	Agenda Items	Paper	Lead	Action
12.	11:40	Update from the Mid Nottinghamshire ICP	Paper K to follow	Richard Mitchell	To discuss
Governance					
13.	11:50	ICS Board Terms of Reference	Paper L	Chair	To agree
12:00 Close					

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

Integrated Care System
Nottingham & Nottinghamshire

Nottingham City Council | Nottinghamshire County Council | NHS

ENC. A1

Meeting:	ICS Board
Report Title:	Welcome and introductions – scene setting from the Chair
Date of meeting:	Thursday 11 April 2019
Agenda Item Number:	1.
Work-stream SRO:	David Pearson
Report Author:	David Pearson
Attachments/Appendices:	Enc. A2. Annex A vision and ambition for our ICS. Annex B - Presentation for the Introduction to the National ICS/ STP Leaders Event on the 6 March 2019

Report Summary:

This is a report from the Chair with two annexes. Annex A shares the Chair's vision and ambition for the ICS which was used as part of the appointment process. Annex B shares a speech given on 6 March to introduce the national ICS and STP Leaders day.

The Board are asked to note and discuss the contents of the report.

Action:

☒ To note
☐ To agree
☐ To agree the recommendation/s (see details below)

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	Greater Nottingham ICP	-
☐	☐	☐	☐	☐

Contribution to delivering the ICS:

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.

Annex B: Presentation for the Introduction to the National ICS/ STP Leaders Event on the 6th March 2019

This is start of day 2 for me as the independent chair of the Nottingham and Nottinghamshire ICS having been the STP or ICS lead since 2016 alongside my responsibilities as the Director of Adult Social Care and Deputy Chief Executive of the County Council.

In starting on this new role yesterday I reflected on why I applied for the non-exec chair role after nearly three years as the lead.

I remembered the experience of people who as a result of the move towards integrated care in Nottingham and Nottinghamshire are experiencing improvement in their experience and outcomes despite the challenges we all face in managing the increasing and changing need.

1. The people who have been able to remain at home or in hospital as a result of the work of multidisciplinary team working and use of technology in primary care - identifying those most at risk and working with them to keep more people at home and out of hospital than otherwise would have been the case.

2. The work to combine information systems that has resulted in being able to join up data between primary, secondary care, mental health and social care which has resulted in times for referral from health to social care arranging an assessment being down to 32 seconds in two of our hospitals.

3. The comments of Helen when she enthused about the huge change for her family when her adult son Carl had a personal health and care budget - which led her to say that the “difference was immense we went from being done to being done with. We work so that Karl’s needs are met on a personal level rather than one size fits all.”

4. The Call for Care scheme and the ability to get urgent help to people within two hours to better manage and de - escalate crises.

5. The housing with health and care scheme which has rapidly increased the speed and effectiveness of ensuring that people are able to return safely from hospital.

You will have your own examples of great things that are happening in your area that are inspiring.

Of course the today is an opportunity to share these things and understand the ways in which we can further unlock potential. In a way the agenda is a reflection of the job of leaders - which is to focus on the longer term solutions and building these whilst making sure that today the public experience the best performance, most effective use of the money and the best quality through the extraordinary workforce in health and social care.

The long term plan does provide clarity on expectations and the funding available. As someone who one of the advisers to the government on the Green Paper I am remain optimistic that we can establish a greater degree of certainty about the plans for social care that deal with sustainability of the service alongside further reforms building on the Care Act.

In the build up to NHS 70 we were all reminded of the privilege we have had arising from the extraordinary innovation in the NHS which has helped many to live longer. When in a sustainable position social care provides person centred coordinated care for those who need it encouraging independence. In 2019 people need the best health, social care and wider public and community services in a coordinated way at a local level.

There are things we know work - but we also know they only work with the commitment of leaders from across all the organisations through the quality of relationships.

At the end of October at one of these events Don Berwick an international adviser around integrated care said:-

“ICS are not based on structures but relationships - the life blood is affection, reflection, dialogue and problem solving.”

How far do our systems reflect this advice

ICS Board, 11 April 2019 Item 1, Enc. A2

The vision and ambition for our Integrated Care System

My personal outlook, style and motivations

Passionate and sustained commitment to Nottingham and Nottinghamshire – with a strong record of leadership nationally and locally. Have led effective and high performing services and change at scale with strong and deep partnerships. Deep understanding of the health and care landscape. Credibility nationally and locally. Ability to work with and influence national and regional government and organisations.

Our ambition for the future:

Population health

- Responding to changing demography, technology and use of resources
- Understanding needs of population groups and priorities
- Ensuring the information, structures and enablers support the ambition
- Clear identification of the outcome measures that drive improvement

Integration

- Of health, health and care, health, care and wider public services
- Based around groups of people with particular needs
- Identifying those who need proactive, coordinated care to manage need and risk
- Helping people to be in control
- Improved outcomes, cost and quality

Building the coalition

- Relationship building and trust across ICS – shared influence
- Partnerships with mutual accountability and honest debate
- Focus on the population – we are in a privileged position, here to serve
- Deal with our own issues – balance pace and ownership for change
- Governance, transparency and communication

Innovation and transformation

- Evidence based change
- Coherent, resourced and clear programmes of work
- Integrated work on enablers workforce, finance ,technology and data analysis and production
- Standardisation and integration

Engagement and co-production

- Systematic engagement of clinicians and the wider workforce in creating the future
- Ensuring the public have the ability to engage, comment and design service responses
- Communicate widely with all stakeholders

ICS MoU

- Continue to implement and address milestones for key service priority areas of urgent care, mental health and finances
- Celebrate and communicate the successes – new service models and their impact for the system and citizens

Delivering the ICS – My contribution as Non Executive Chair

My personal outlook, style and motivations

Experience and skills in successfully chairing and leading Boards, statutory bodies, large partnerships, and non statutory organisations. Includes non exec chairing roles for Mansfield and Ashfield CCG and as President of Association of Directors of Adult Social Services. Experience, ability and skills in creating the conditions for success. Building momentum and communicating. Identifying progress and challenges. Removing barriers and unlocking potential

My contribution to making it happen:

Governance

- Building shared purpose, cohesion, coordination, hope for the future
- Clear accountability and structures
- Acting within legal parameters
- Quality of board papers and discussion
- Making sure the right people are around the table and the voices are heard
- Living up to the Nolan principles

Assurance

Ensuring Board, structures and leaders are delivering on:-

- Strategy
- Performance
- Quality
- Budget

Holding a mirror to the Executive and the system. Knowing when to support and challenge

Strong relationships and trust

- Relationship building and trust - shared influence.
- Promote mutual accountability and honest debate
- Focus on the population – we are in a privileged position, here to serve
- Deal with our own issues – balance pace and ownership for change

Ambassadorial role

- Clear and relevant narrative for different audiences – particularly public and the workforce
- Help to manage interface with national bodies – everyone in the Nottingham and Notts tent
- Local health and care scrutiny, interest groups and Healthwatch engaged

System architecture

- Fully formed and effective functioning of ICS, ICP's and Primary care Networks
- Clarity on objectives and outcomes
- Population health management – roadmap of practical next steps

Holding the MD to account

- Clear personal objectives
- Sufficient capacity, skill and experience available to deliver
- The evidence is there to support the assurance
- Evidence based constructive support and challenge

The Nottingham and Nottinghamshire Integrated Care System

Item 3. Enc. B1

Shadow Integrated Care System Board

15 March 2019
09:00 – 12:30
Rufford Suite, County Hall

DRAFT MINUTES

Present:

ICS Board members	ORGANISATION
Anthony May	Chief Executive, Nottinghamshire County Council
David Pearson	ICS Chair
Dean Fathers	Chair, Nottinghamshire Healthcare NHS FT
Eric Morton	Chair, Nottingham University Hospitals NHS Trust
John Brewin	Chief Executive, Nottinghamshire Healthcare NHS FT
John MacDonald	Chair, Sherwood Forest Hospitals NHS FT
Jon Towler	Lay Member, Nottinghamshire CCGs (ICS Vice Chair)
Lucy Dadge *on behalf of Amanda Sullivan*	Chief Commissioning Officer, Mid Nottinghamshire CCGs
Richard Mitchell	Chief Executive, Sherwood Forest Hospitals NHS FT
Stuart Wallace	Councillor and Chair of the Adult Social Care and Health Committee, Nottinghamshire County Council
Wendy Saviour	Managing Director, Nottinghamshire ICS

In Attendance:

Alex Ball	Director of Communications and Engagement, Nottinghamshire ICS
Andy Haynes	Clinical Director, Nottinghamshire ICS
Helen Pledger	Finance Director, Nottinghamshire ICS
Jo Simmonds	Head of Governance and Assurance, Greater Nottingham CCGs (minutes)
Richard Stratton	Clinical Lead from Greater Nottingham GP, Belvoir Health Group
Stephen Shortt	Clinical Lead from Greater Nottingham Clinical Chair, NHS Rushcliffe CCG
Thilan Bartholomeuz	Clinical Lead from Mid Nottinghamshire Clinical Chair, Newark and Sherwood CCG

Apologies:

Amanda Sullivan	Accountable Officer, Nottinghamshire CCGs
Gavin Lunn	Clinical Lead from Mid Nottinghamshire Clinical Chair, Mansfield and Ashfield CCG
John Doddy	Councillor and Chair of the Nottinghamshire Health and Well Being Board, Nottinghamshire County Council
Tracy Taylor	Chief Executive, Nottingham University Hospitals Trust

1. Welcome and introductions

DP welcomed colleagues to the meeting and introductions were given.

Apologies received as noted above.

2. Conflicts of Interest

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

3. Minutes of 15 February ICS Board meeting and action log

It was requested that page 5 of the minutes of the 15 February meeting be amended to state that Nottingham University Hospitals Trust voted against the proposal to move to three ICPs.

Subject to the above amendment being made, the minutes of the ICS Board meeting on 15 February were agreed as an accurate record of the meeting by those present.

The action log was noted and the following updates were provided:

- B108 – WS advised that a meeting to discuss this further was scheduled for the following week.
- B109 – DP advised that slides would be available at a future meeting.

Matters arising - update from organisation boards/committees on ICP decision

JB, RM and LD confirmed that their organisation's boards/governing body had supported the decision to have three ICPs. AM explained that agreement was secured in principle but formal approval is needed from the Adult Social Care and Public Health Committee meeting for Nottinghamshire County Council. EM advised that the Nottingham University Hospital Board meet on 28 March to consider the matter. Wendy Saviour (WS) stressed the importance of progressing this and requested confirmation of everyone's position by the end of March 2019.

ACTIONS:
AM to confirm in writing the position of Nottinghamshire County Council ahead of the meeting of the Adult Social Care and Public Health Committee.
EM / TT to confirm the position of Nottingham University Hospitals with regard to the move to three ICPs by 31 March 2019.

4. Patient story from Connected Nottinghamshire

Terry Locke (TL) and Andy Evans (AE) were welcomed to the meeting to present this item and the following points were highlighted:

- The purpose of the presentation was to explain how work to develop the Medical Interoperability Gateway (MIG) was enabling access to medical records across different systems.
- TL provided members with a brief overview of his own medical history, explaining how use of the MIG had saved valuable time during a pre-operation check; thus, saving valuable time for both clinicians and patients.
- There were numerous examples of where use of the MIG had made a positive impact and it was important that work continued to dispel any myths around information sharing so that the benefits of this work continue to be realised.

TL and AE were thanked for the informative presentation and the following points were raised and discussed:

- It was queried as to whether all community pharmacists had access to the MIG and AE advised that this was not in place currently but that plans were in place to explore this further.
- Members agreed that the ability for primary care and secondary care to access each other's patient records was extremely important. It was discussed as to whether the ICS would be able to mandate the use of the MIG across the system; however, AE advised that the initial challenge to this would be that different systems are currently in operation.
- In terms of supporting frontline paramedics, it was explained that East Midlands Ambulance Service had started using MIG and that this had successfully been trialled as part of the Rushcliffe Vanguard.
- It was noted that the new GP contract set out that patients will have access to their own records by April 2020. AE advised that work is ongoing to encourage online access.

DP thanked TL and AE for attending the meeting.

Outcomes Framework, Prevention and Inequalities

5. Strategic discussion on the draft ICS Outcomes Framework

Tom Diamond (TD), Alison Challenger (AC) and Jonathan Gribbin (JG) were in attendance to present this item:

- WS introduced the item by explaining that a key task for the ICS was to agree a system-level outcomes framework that provided a clear view of the success of the ICS in improving the health, wellbeing and independence of people and transforming the way the health and care system operates.

- TD explained that feedback provided by the Board following its review of the initial draft system-level outcomes framework in November 2018 had been incorporated into the revised framework, which included re-framing the outcomes to provide a more succinct approach based on the triple aim and aligned with the Health and Wellbeing Board strategies.
- The Board was asked to agree that the ambitions and outcomes set out in the revised framework are used to continue to move the ICS towards establishing a prototype system-level outcomes reporting dashboard as soon as possible.

The Board discussed the system-level outcomes framework and raised the following for further consideration:

- Where possible outcomes should be described as 'increases' rather than 'reductions' so they are described in a positive frame.
- It was queried as to whether the system-level outcomes framework could potentially supersede some of the performance frameworks and measures currently being worked to. WS responded there may be the opportunity to consider this but it had to be recognised that there were national 'must-do's' that could not be replaced.
- It was identified the framework also offered the opportunity to clarify the relationship and principles for reporting at ICS, ICP and PCN levels.
- It was suggested that one of the ambitions should focus on the workforce, given their critical role in delivery. This should encompass recruitment and up-skilling as well as ensuring strong engagement.
- AB welcomed the fact that the outcomes of the Long Term Plan patient engagement work would be reflected in the outcomes.
- It was queried as to whether the framework might drive resource to deprived areas which may have an impact on other areas. WS responded that this would need to be thought through; adding that reducing inequalities may mean spending differently.
- It was stressed that the framework should ensure the right balance between health and social care. It was confirmed that the Local Authorities had been involved in the work and the framework did this.
- In terms of next steps, it was agreed that input from other organisations would be helpful and DF, JM, TB and RS volunteered to be involved.

The Board agreed that the ambitions and outcomes set out in the system-level outcomes framework should be used to continue to move the ICS towards establishing a prototype system-level outcomes reporting dashboard as soon as possible, giving consideration to the points it had made.

TD, AC and JB were thanked for their work on the System Level Outcomes Framework and for their informative presentation.

ACTIONS:
TD to consider the Board's comments on the System Level Outcomes Framework and bring back developments on the framework to 9 May ICS Board meeting.

Strategy and System Planning

6. Received the draft 2019/20 operational plan and overview

HP presented the paper, explaining that this provided a progress update for the 2019/20 planning, the latest draft system plan (key messages & supporting information) and the system plan overview/narrative document.

The Board discussed the key messages and next steps:

- The system has a finance do nothing gap of £157 million (5.6%). Despite receiving 3.4% real growth, the scale of the challenge is at a similar level to 2018/19 due to the underlying recurrent deficit and non-recurrent mitigations in 2018/19.
- To address the financial and operational challenges the system needs to focus on how services are transformed to be delivered within available resources (finance, workforce and capacity).
- The draft system financial plan submitted on 19 February included a forecast in-year deficit of £82.7 million, compared to the notified system control total of £67.7 million in-year deficit. It was noted that, to date, NUH have not accepted their organisational control total. A regional escalation meeting is scheduled for 21 March to review the financial position of the Greater Nottingham system.
- Work is ongoing across the system to continue to develop and strengthen ICP transformational plans, existing schemes need to be rapidly developed to implementation stage and further plans need to be identified to meet the do nothing challenge for 2019/20. The ICP Transformation plans are being reviewed weekly, including the level of savings identified, position on contract negotiations and risk assessment. The system needs to main a strong focus on this for the remainder of the planning timetable and into April.
- With regard to the ICS Financial Framework, a national working group is in place supported by the national team. Work is underway to understand issues and look for opportunities to further develop the 2018/19 scheme. A Joint Advisory Group meeting is scheduled on 21 March and it is expected that the framework will be published in March. Further updates will be provided to the ICS Board as information becomes available.
- ICS Planning Group has implemented a weekly contract tracker to provide oversight and assurance.
- Operational performance trajectories for urgent care and mental health are being reviewed to ensure that the system can demonstrate ambitious improvement and realistic/credible recovery plans.

HP also presented the System Plan Overview document, it was explained that the report is intended as an assurance document produced in line with guidance and reviewed by the ICS Planning Group.

Work will continue over the next two weeks to develop the final plan, with organisational plans submitted on the 4 April and system plan on the 11 April. Further update will be provided at an extraordinary meeting of the ICS Board on 1 April.

RM flagged that the paper did not include the latest position on the 52WW target for Sherwood Forest Hospitals.

The Board acknowledged the significant work across the system to agree contracts and develop plans.

ACTIONS:
RM to send latest position on 52WW performance for Sherwood Forest Hospitals to HP.

7. Agree the Mental Health Strategy

JB and LD presented the Mental Health Strategy and highlighted the following key points:

- Members were reminded that the strategy had originally been presented at the August 2018 meeting and whilst it had been agreed in principle, significant further work was requested to streamline the document and ensure more focus on key deliverables to improve outcomes for service users and reduce inequalities.
- Prevention and self-care were intrinsic throughout the strategy, as well as an integrated approach towards physical and mental health.
- There were clear challenges around the workforce required to successfully deliver the strategy; both in up-skilling staff and due to the recognised national issues around recruitment.
- Nationally, there remained a focus on reducing the discrepancy around life expectancy for people with mental health issues.

The following points were discussed:

- TB commented that the transition between services from children to adults was a vulnerable area and that patients caught in this group often defaulted to Primary Care. JB advised that a move from focussing on age and criteria was needed. LD advised that commissioners were already discussing a separate pathway for 18-25 year olds.
- It was highlighted that c. 90% of mental health provision occurred in Primary Care; therefore the pathways were extremely important.
- Members agreed that there were clear steps set out within the document and queried as to whether these had been costed. LD confirmed that the immediate steps were being considered within the current contracting round.
- Members discussed how the strategy would be operationalised and implemented within the ICS governance framework. WS advised that the

strategic commissioner and providers need to work together to develop the implementation plan, then the ICPs and PCNs are responsible for implementation. In terms of monitoring progress, this would be the role of the ICS board along with the emerging assurance arrangements for ICSs. WS highlighted that it was important for the ICS workstream to handover delivery to the Strategic commissioner, ICPs and PCNs to signal the way the new architecture would work in practice in the future state.

- It was agreed that the implementation plans for the Mental Health Strategy would come back to the Board. WS advised that clarity around resources to support this was needed from the strategic commissioner and providers.
- In summary, members agreed that the strategy was much clearer than previous versions and thanks were extended to those who had contributed to the work.

The Board approved the Mental Health strategy.

ACTIONS:
JB and LD to meet with system planning leads to agree the approach to developing the implementation plans for the MH Strategy that are to be delivered by ICPs working with PCNs. These need to reflect the requirements of the long term plan. . These implementation plans are to be reviewed at the Board's strategic planning session in June.
JB and LD to identify resources available to support the development of the implementation plans to deliver the Mental Health Strategy.

8. Consider approach to developing and implementing ICS Strategy

TD presented this item and highlighted the following key points to the Board:

- Since the last meeting of the ICS Board, further conversations regarding the ICS strategy have been held with Board members. These discussions highlighted varying views on the need for a specific ICS strategy; however, everyone supported the need for the Board to dedicate time to agree the strategic direction of the ICS and how it would be delivered.
- Two half day sessions were proposed to develop and agree the ICS's strategic direction and to consider this alongside the ICS's response to the national requirements as set out in the NHS Long Term Plan (pending Spring 2019).
- A core focus of the half day sessions will be the priority areas identified by Board members during the conversations with them: urgent and emergency care, mental health, finance & efficiency, proactive care management and prevention & self-care.
- The Board was also asked to support plans to utilise the proposed strategy development and planning process to continue to test and align members of the contribution of the ICS, ICPs and PCNs in terms of operational, accountability and assurance arrangements.

The following comments were made in discussion:

- Members agreed that it was important to focus on strategy and that it would be difficult to get into the detail of what was needed solely at Board meetings.
- There was recognition of the need to balance the short-term requirements and 'must-do's' with the long-term strategic aims.

The Board agreed to the following recommendations.

ACTIONS:
TD to arrange ICS Board strategic planning workshops.

Oversight of System Resources and Performance Issues (including MoU)

9. ICS Integrated Performance Report

The Board noted the contents of the ICS Integrated Performance Report. Key areas of concern are highlighted in the report summary along with actions being taken to address the performance issues. The red-rated performance areas remain urgent and emergency care, mental health transformation delivery and finance.

The Board discussed the format of the IPR report and the role of the ICS Board. It was agreed that report would be developed further to give a high level overview, with a deep dive in to specific areas at the Board. JT offered that this work could be taken forward through the CCGs.

ACTIONS:
AS and JT to ensure that CCGs lead the development of the IPR report and deep dive process, working with the Performance Oversight Group.

Governance

10. Resourcing the ICS team for delivery

The Board were presented with a proposal to continue with the current interim team for 2019/20, recognising that system architecture continues to develop. The following points were discussed:

- It was agreed that further discussions were needed at the Board about resource for developing the ICPs and PCNs; with the possibility of accelerating the transfer of CCG capacity to support this work. However, it should be recognised that whilst the CCGs remained operating as six statutory organisations, there may be some challenge around this and a need to accept that the resource may not be available immediately. It was also stressed that 20% of CCG running costs needed to be saved for 20/2021.

- It was agreed that the pace of discussions around resource for ICPs and PCNs needs to be accelerated and it was agreed that this should be developed for May 2019.
- Members noted that discussions were ongoing nationally around Commissioning Support Units, further information will be shared as it becomes available.

The Board approved organisational contributions to continue at the same level as in previous years (£80,000 per statutory body member of the ICS) and noted that this funding will not support proposed posts for ICS Officers for workforce or public health.

ACTIONS:
WS and ICP Leads to present a review of the resource available for ICP and PCN development at the 9 May 2019 meeting.

11. Agreeing arrangements for the ICS Board meetings being held in the public

AB presented the proposal and protocol for the ICS Board to meet in public from 11 April 2019.

The following points were discussed:

- All members were supportive of meeting in public; however, the logistics of holding the meeting in different venues was raised. It was agreed that as County Hall was set up for public use, the meetings would continue there for the foreseeable future.
- Considering the proposal for allowing questions from the floor, the Board discussed the various options for balancing the need for openness whilst also making progress on the business of the meeting.
- Following discussion, members agreed that no questions would be permitted as part of the initial meetings in public but members of the public with an interested would be invited to write to the appropriate members of the Board with their question.

The Board agreed to meeting in public from 11 April 2019 meeting and agreed to the proposed meeting protocol, subject to the comments made above.

ACTIONS:
AB to update the meeting protocol reflecting the changes to the proposals for meeting location and questions from the floor.
ALL to provide a brief biographical summary and photograph for the 'Who Are the Board Members' pack

12. Governance of ICS Groups

The Board received the updated ICS Board Terms of Reference and the following points made:

- It was requested that legal advice be sought on how the decision-making and accountability arrangements were defined. In particular, this should ensure clarity that decisions made by the Board are not binding on the membership organisations.
- The possibility of a tie in voting was discussed. It was agreed that a process needs to be agreed to cover the event of a tie in any voting. The usual process is for the Chair to have a casting vote.
- It was expected that there would eventually be a PCN representative on the Board's membership.

The Board also received an update on the revised approach to managing ICS risk and noted that a number of individuals across the system were contributing to the ongoing development of this work. In addition, the Board:

- Received the ICS Risk Register;
- Ratified the ICS Risk Management Policy; and
- Noted the actions in place to support further development work.

ACTIONS:
DJ to seek legal advice as to how decision-making and accountabilities should be defined within the Terms of Reference.

13. Feedback from the inaugural ICS Partnership Forum

WS reported that the inaugural meeting went well. Members of the Forum welcomed the chance to contribute to the work of the ICS. Discussions at this first meeting included the developing of the local system plan in response to the NHS Long Term Plan and also the work around Population Health Management. Members of the Partnership Forum were keen to contribute further and given the amount of change currently underway in the system raised concerns about the frequency of meetings. DP suggested attending the next meeting as the ICS Lead.

14. Plans for EU Exit

The Board received the Nottinghamshire ICS combined EU exit risks exception report and noted that the NHS England regional team were currently obtaining the updated positions.

15. Receive feedback from the 16 January ICS Stocktake meeting

The Board received the letter from the 16 January ICS Stocktake meeting and DP advised that this meeting had gone well.

DP thanked everyone for attending the meeting. DP will be meeting with individual Board members as part of induction to the role.

Time and place of next meeting:
11 April, 2019
09:00 – 12:00
Rufford Suite, County Hall

The Nottingham and Nottinghamshire Integrated Care System

ICS Board membership

Role	John Brewin	Dean Fathers	Richard Mitchell	John Macdonald	Eric Morton	Lucy Dadge	Anthony May	Stuart Wallace	Wendy Saviour	David Pearson	Jon Towler	Not represented at this meeting
ICS Chair										X		
Chief Executive Nottinghamshire Healthcare NHS FT	X											
Chair or nominee Nottinghamshire Healthcare NHS FT		X										
Chief Executive Sherwood Forest NHS FT			X									
Chair or nominee Sherwood Forest NHS FT				X								
Chief Executive Nottingham University Hospitals NHS Trust												X
Chair or nominee Nottingham University Hospitals NHS Trust					X							
Chief/Accountable Officer, CCGs						X						
CCG Chair											X	
EMAS Chief Executive												X
Nottinghamshire County Council CEO or nominee							X					
Nottinghamshire County Council elected member								X				
NHSE/I representative									X			

In attendance:

	Wendy Saviour	Helen Pledger	Alex Ball	Richard Mitchell	Stephen Shortt	Richard Stratton	Thilan Bartholomeuz	Andy Haynes	Not represented at this meeting
ICS Managing Director	X								
The ICP lead from Greater Nottingham ICP									X
The ICP lead from Mid Nottinghamshire ICP				X					
Two clinical leads from Greater Nottingham ICP with one to represent primary care providers					X	X			
Two clinical leads from Mid Nottinghamshire ICP with one to represent primary care providers							X		
ICS Officer - finance director lead		X							
ICS Officer - Clinical director								X	
ICS Officer - Nursing/Quality director									X
ICS Officer – Public Health Director									X
ICS Officer - Director of Communications and Engagement			X						

The Nottingham and Nottinghamshire Integrated Care System

Item 3. Enc. B2

Shadow Integrated Care System Board – Extraordinary Meeting

1 April 2019
15:30 – 16:30
Rufford Suite, County Hall

DRAFT MINUTES

Present:

ICS Board members	ORGANISATION
Amanda Sullivan	Accountable Officer, Nottinghamshire CCGs
David Pearson	ICS Chair
Eric Morton	Chair, Nottingham University Hospitals NHS Trust
John Brewin	Chief Executive, Nottinghamshire Healthcare NHS FT
John Doddy	Councillor and Chair of the Nottinghamshire Health and Well Being Board, Nottinghamshire County Council
Richard Mitchell	Chief Executive, Sherwood Forest Hospitals NHS FT
Stuart Wallace	Councillor and Chair of the Adult Social Care and Health Committee, Nottinghamshire County Council
Tracy Taylor	Chief Executive, Nottingham University Hospitals Trust
Wendy Saviour	Managing Director, Nottinghamshire ICS

In Attendance:

Alex Ball	Director of Communications and Engagement, Nottinghamshire ICS
Andy Haynes	Clinical Director, Nottinghamshire ICS
Elaine Moss	Chief Nurse, Nottinghamshire CCGs and ICS
Gavin Lunn	Clinical Lead from Mid Nottinghamshire Clinical Chair, Mansfield and Ashfield CCG
Helen Pledger	Finance Director, Nottinghamshire ICS
Joanna Cooper	Assistant Director, Nottinghamshire ICS
Nicole Atkinson	Clinical Lead from Greater Nottingham Clinical Chair, Nottingham West CCG
Tom Diamond	Director of Strategy, Nottinghamshire ICS

Apologies:

Anthony May	Chief Executive, Nottinghamshire County Council
Dean Fathers	Chair, Nottinghamshire Healthcare NHS FT
Jon Towler	Lay Member, Nottinghamshire CCGs
Richard Stratton	Clinical Lead from Greater Nottingham GP, Belvoir Health Group
Thilan Bartholomeuz	Clinical Lead from Mid Nottinghamshire Clinical Chair, Newark and Sherwood CCG
John MacDonald	Chair, Sherwood Forest Hospitals NHS FT

1. Welcome and introductions

DP welcomed colleagues to the meeting.

Apologies received as noted above.

2. Conflicts of Interest

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

3. 2019/20 System Operational Plan and Overview

HP introduced the circulated papers and key messages. HP iterated that 2019/20 has been a challenging planning round for all ICS partners with a number of issues prior to organisations plan submission on 4 April, and system plan submission on 11 April, still to be resolved.

System control total

NHS England and Improvement regional escalation process in place for the Greater Nottingham part of the ICS, this is in relation to the delivery of the control total, contract agreement and QIPP and CIP plans. Following the escalation meeting on the 21st March, the system received a letter from NHS England and Improvement requiring further information and confirmation of what will be submitted in the 4th April plan submissions. A response has been agreed and submitted by the ICS.

The agreement of the 2019/20 contract between Nottingham University Hospitals (NUH) and Greater Nottingham CCGs has resolved the contract triangulation gap. Following this agreement NUH are developing a plan to meet the required organisational total, this includes discussions with NHS England and Improvement on capital and MRET funding.

Therefore, the system is expecting to submit an operational plan in line with the system control total of £67.7 million in year deficit (before provider sustainability funding, financial recovery fund and marginal rate emergency threshold).

The national ICS Financial Framework is to be published shortly and will outline the incentive scheme. Once published, HP will produce options for the Board to consider at a future meeting.

Contracts

There are a number of contracts not yet agreed with actions underway this week to agree a final position.

EMAS contract is in mediation, this is being taken forward by the lead commissioner (Derbyshire CCG).

Transformation Plan

Latest position is that the do nothing gap is £145 million (5.2%). The ICS Planning Group meets on 2 April to review the latest ICP Transformational Plans.

Latest QIPP and CIP plan opportunities are outlined in the circulated paper. Significant risk identified with unidentified schemes (14.9%) and schemes identified as high risk (33.0%).

Work is ongoing across the system to continue to develop and strengthen ICP Transformational Plans, existing schemes need to be rapidly developed to implementation stage and further plans need to be identified to meet the do nothing challenge. Organisational leads to ensure that opportunities are being fully exploited to contribute to the delivery of system plans by end of April.

The ICP Transformational Plans continued to be reviewed weekly by the ICS Planning Group, including the level of savings identified, position on contract negotiations and risk assessment.

Activity and Capacity Plan

Activity and capacity plans developed jointly with a fully aligned do nothing position. Key remaining issue to address is the alignment of the activity reductions in relation to transformational schemes.

Operational performance

Operational performance queries have been addressed in latest iteration of the plan..

The NUH A&E trajectory is to be approved by the Greater Nottingham A&E Delivery Board 2 April prior to submission as part of the NUH organisational plan.

Narrative document

Draft narrative overview circulated. Further work to take place to add an additional section on health inequalities, and to strengthen links to the estates strategy.

The Board queried whether further information was available on PSF and Transformation Funding and considered the possibility of making the best use of available funding to support system development. HP confirmed that this would be issued as part of the national ICS Financial Framework.

Further opportunities for efficiencies to be identified and discussed at the Financial Sustainability Group meeting in April. This will include comparing the latest ICP Transformational Plans to the ICS Opportunities pack and a focus on back office opportunities. Work is underway to develop priorities and options as part of the five-year plan and will be completed by the end of July.

JB and AS raised that system opportunities need to be developed to fully realise opportunities across organisations. Discussions are taking place within ICPs to progress this work. To be discussed at the Financial Sustainability Group meeting on in April, with an overview provided to the ICS Board on 9 May 2019.

The Board requested that opportunities be identified and developed in granular detail in order for the Board to make early decisions when needed and allow sufficient time for opportunities to be realised.

The ICS Board agreed to delegate the sign off of the system operational plan and system operational plan overview submission on the 11 April to the ICS Chair, ICS Managing Director and ICS Finance Director. HP to produce an updated pack for the ICS Board and circulate with the draft narrative overview on 10 April for final review by the Board. HP to highlight any significant amendments from the discussion at the ICS Board meeting 1 April.

ACTIONS:
HP to produce an overview of the national ICS Financial Framework and options for the Board to consider at a future meeting.
Organisational leads to ensure that CIP / QIPP opportunities are being fully exploited to contribute to the delivery of system plans by end of April.
HP to provide the Board with an update at the 9 May meeting on system opportunities considered at the Financial Sustainability Group.
HP to produce an updated pack for the ICS Board and circulate with the draft narrative plan on 10 April for final opportunity for the Board members to review to submission on 11 April.

Time and place of next meeting:
11 April, 2019
09:00 – 12:00
Rufford Suite, County Hall

The Nottingham and Nottinghamshire Integrated Care System

ICS Board membership

Role	John Brewin	Dean Fathers	Richard Mitchell	John Macdonald	Tracy Taylor	Eric Morton	Amanda Sullivan	Anthony May	Stuart Wallace	John Doddy	Wendy Saviour	David Pearson	Jon Towler	Not represented at this meeting
ICS Chair												X		
Chief Executive Nottinghamshire Healthcare NHS FT	X													
Chair or nominee Nottinghamshire Healthcare NHS FT														X
Chief Executive Sherwood Forest NHS FT			X											
Chair or nominee Sherwood Forest NHS FT														X
Chief Executive Nottingham University Hospitals NHS Trust					X									X
Chair or nominee Nottingham University Hospitals NHS Trust						X								
Chief/Accountable Officer, CCGs							X							
CCG Chair														X
EMAS Chief Executive														X
Nottinghamshire County Council CEO or nominee														X
Nottinghamshire County Council elected member									X	X				
NHSE/I representative											X			

In attendance:

	Wendy Saviour	Helen Pledger	Alex Ball	Richard Mitchell	Nicole Atkinson	Gavin Lunn	Andy Haynes	Elaine Moss	Not represented at this meeting
ICS Managing Director	X								
The ICP lead from Greater Nottingham ICP									X
The ICP lead from Mid Nottinghamshire ICP				X					
Two clinical leads from Greater Nottingham ICP with one to represent primary care providers					X				
Two clinical leads from Mid Nottinghamshire ICP with one to represent primary care providers						X			
ICS Officer - finance director lead		X							
ICS Officer - Clinical director							X		
ICS Officer - Nursing/Quality director								X	
ICS Officer – Public Health Director									X
ICS Officer - Director of Communications and Engagement			X						

Integrated Care System
Nottingham & Nottinghamshire

Nottingham City Council | Nottinghamshire County Council | NHS

Item No 3. Enc. B3

ICS Board Action Log (April 2019)

ID	Action	Action owner	Date Added	Deadline	Action update
B142	To provide a brief biographical summary and photograph for the 'Who Are the Board Members' pack	ALL Members	15 March 2019	03 April 2019	A draft pack has been produced with further work needed to collate outstanding information.
B138	To arrange ICS Board strategic planning workshops.	Tom Diamond	15 March 2019	11 April 2019	First session to be incorporated to the planned development session on 24 April. A further session will be arranged.
B139	To ensure that CCGs lead the development of the Integrated Performance Report and deep dive process, working with the Performance Oversight Group.	Amanda Sullivan and Jon Towler	15 March 2019	11 April 2019	The CCGs will be combining their integrated performance reports as part of the CCG alignment process. The CCGs will work with the ICS team on a revised format by the end of Q1.
B137	To identify resources available to support the development of the implementation plans to deliver the Mental Health Strategy.	John Brewin and Lucy Dadge	15 March 2019	30 April 2019	
B124	To lead on the development of a consistent set of principles, objectives and behaviours for the operation of the ICPs by the 31 March	Wendy Saviour	15 February 2019	09 May 2019	Workshop held on 20 March. Paper to be drafted and circulated for agreement at the 9 May meeting

ID	Action	Action owner	Date Added	Deadline	Action update
B130	To provide an update at the 9 May meeting on short term learning and how the narrative or deployment plan need to be refined for the system narrative.	Alex Ball	15 February 2019	09 May 2019	
B134	To consider the Board's comments on the System Level Outcomes Framework and bring back developments on the framework to 9 May ICS Board meeting.	Tom Diamond	15 March 2019	09 May 2019	
B140	To present a review of the resource available for ICP and PCN development at the 9 May 2019 meeting.	Wendy Saviour and ICP Leads	15 March 2019	09 May 2019	
B103	To discuss and develop the structures at ICS and ICP level to ensure that duplication is avoided, and develop a set of principles for system posts. Proposal to be brought to a future meeting	Tracy Taylor/Richard Mitchell/Wendy Saviour/Amanda Sullivan	14 December 2018	31 May 2019	Draft principles considered at the 15 February meeting. Tom Diamond and Deborah Jaines to lead work to develop further
B109	To present slides used at ICS Chair interview to the Board at the March meeting to share vision as the ICS progresses	David Pearson	18 January 2019	01 June 2019	

ID	Action	Action owner	Date Added	Deadline	Action update
B121	To provide an update at the 13 June 2019 meeting on what lessons have been learnt from the You Know Your Mind Project and how sustainability can be addressed longer term linked to the wider us of PHBs	Amanda Sullivan/Wendy Saviour	15 February 2019	13 June 2019	
B136	To meet with system planning leads to agree the approach to developing the implementation plans for the MH Strategy that are to be delivered by ICPs working with PCNs. These need to reflect the requirements of the long term plan. These implementation plans are to be reviewed at the Board's strategic planning session in June.	John Brewin and Lucy Dadge	15 March 2019	30 June 2019	

Integrated Care System
Nottingham & Nottinghamshire

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ENC. C1

Meeting:	ICS Board
Report Title:	Patient Stories from Cancer Workstream
Date of meeting:	Thursday 11 April 2019
Agenda Item Number:	4.
Work-stream SRO:	Richard Mitchell
Report Author:	Simon Castle
Attachments/Appendices:	Enc C2 ICS Board Cancer Patient Stories

Report Summary:

The ICS is a significant outlier in terms of two key cancer outcome metrics: low one year survival rates and % of cancers diagnosed at an early stage (1&2).

The ICS Cancer Strategy is implementing a number of initiatives centred around earlier diagnosis, in particular lung and colorectal cancer. The attached presentation focuses on patients stories related to implementation of a targeted lung MOT programme within Nottingham City (to be expanded to Mansfield and Ashfield in 2019/20), and implementation of a new colorectal cancer test in primary care (FIT - faecal immunochemical test).

Action:

☒ To note
☐ To agree
☐ To agree the recommendation/s (see details below)

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**	**Greater Nottingham ICP**	-
☐	☒	☒	☒	☐

Contribution to delivering the ICS:

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.

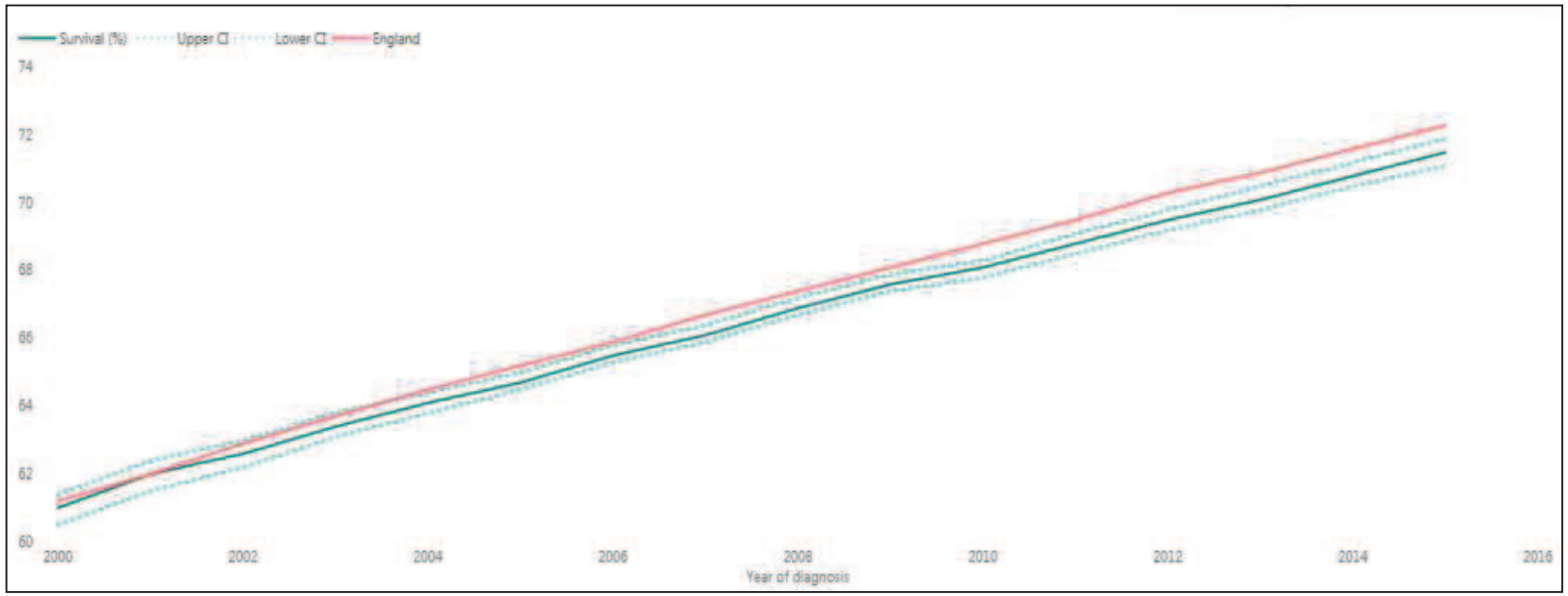
ICS Board 11 April 2019
Item 4. Enc C2

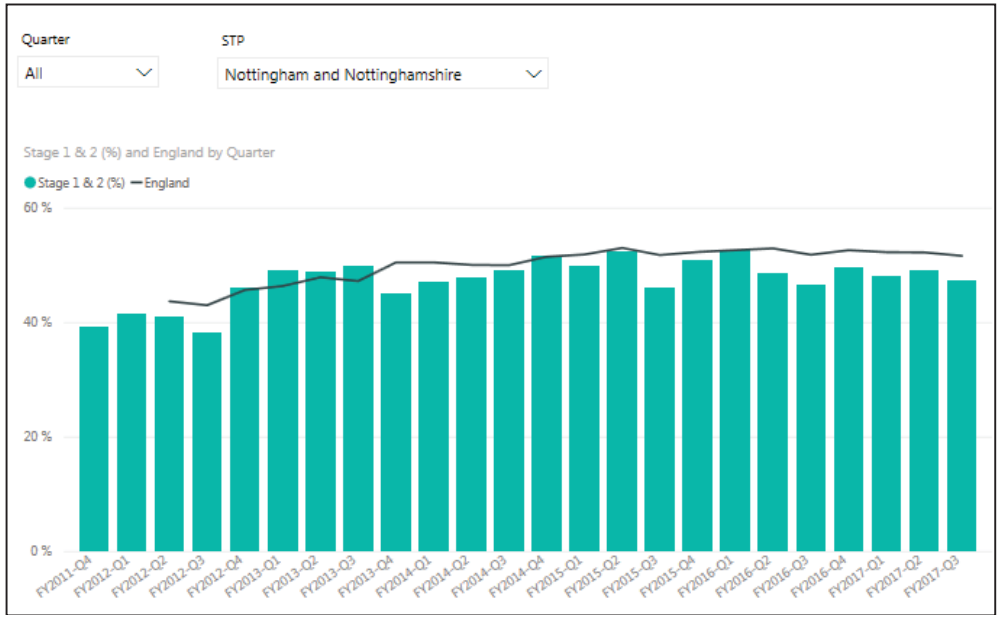
ICS Cancer Workstream

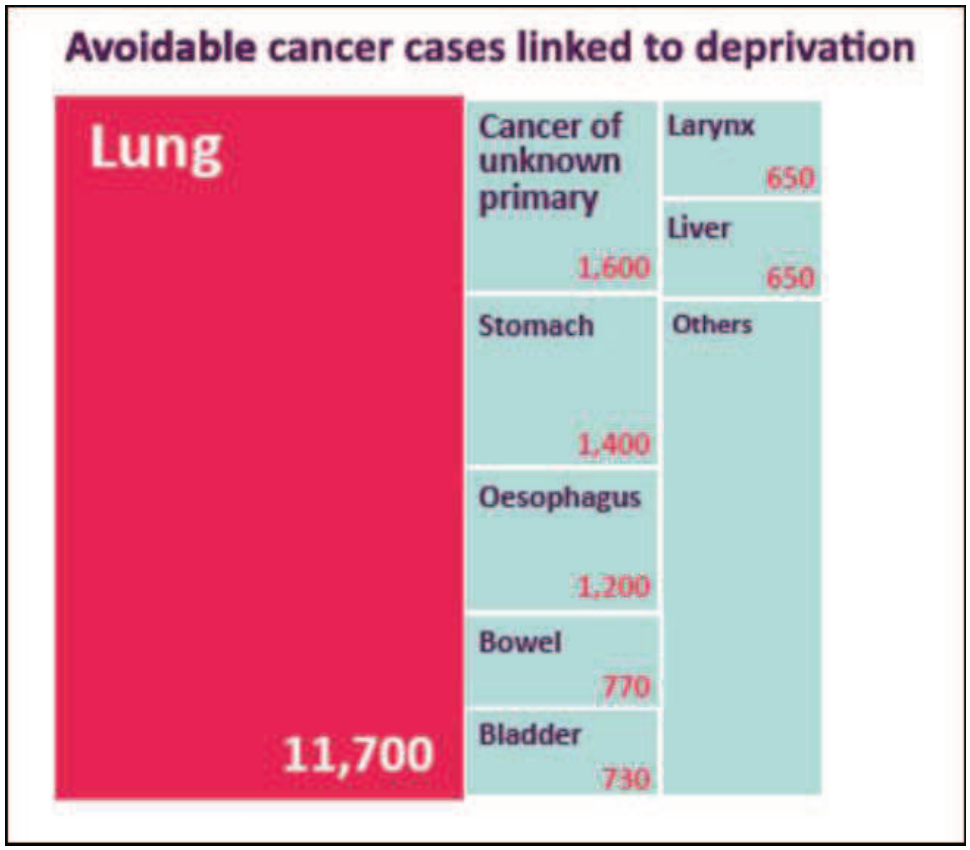
Patient Stories

Simon Castle
Programme Director
Cancer and EOL

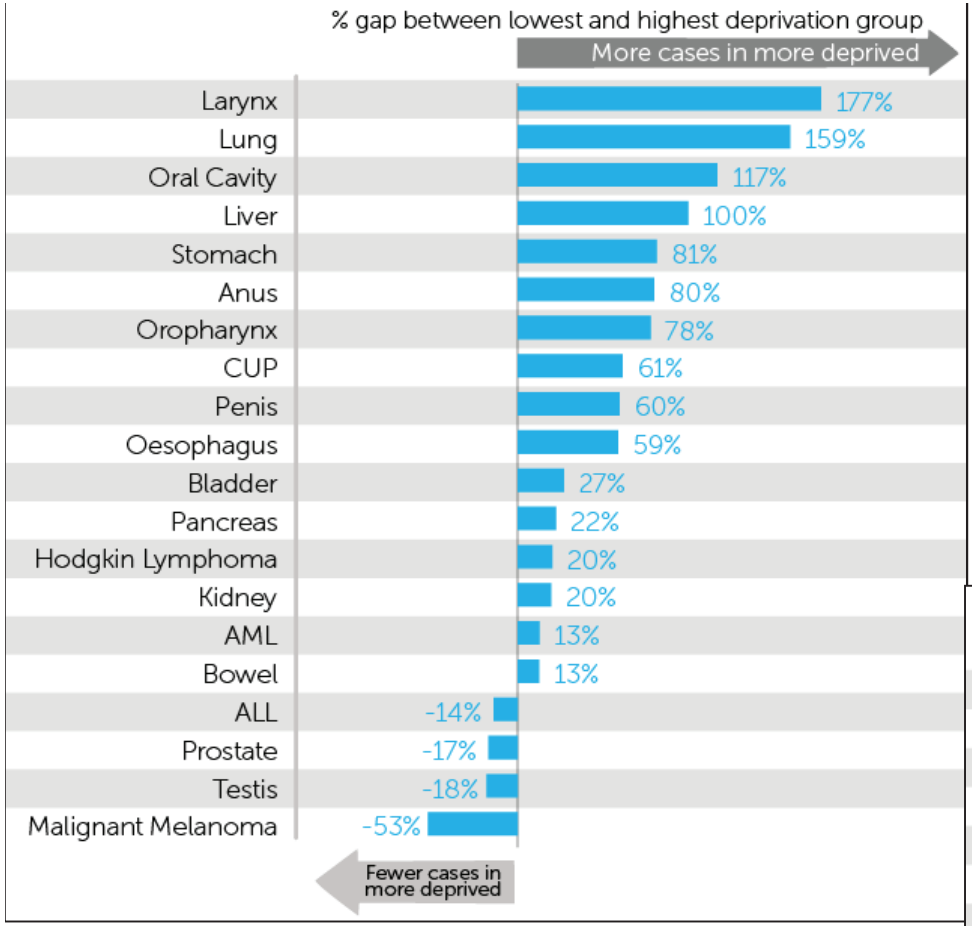
ICS has significantly lower one year survival rates & % of cancers diagnosed early






Avoidable cancer cases linked to deprivation
Lung
11,700
Cancer of unknown primary
1,600
Stomach
1,400
Oesophagus
1,200
Bowel
770
Bladder
730
Larynx
650
Liver
650
Others


4 IN 10 CANCERS CAN BE PREVENTED
These are proven ways to reduce the risk of cancer.
Larger circles indicate greater impact on cancer risk.
LIFESTYLE
KEEP A HEALTHY WEIGHT
BE SMOKE FREE
EAT FRUIT & VEG
5+ a day or more
DRINK LESS ALCOHOL
BE SUNSMART
Use clothing, shade and sunscreen. Avoid sunbeds
EAT LESS PROCESSED & RED MEAT
EAT A HIGH FIBRE DIET
BE ACTIVE
EAT LESS SALT
OTHER
MINIMISE ANY TIME SPENT ON HRT
BREASTFEED IF POSSIBLE
MINIMISE RADIATION
such as radon and unnecessary x-rays
MINIMISE CERTAIN INFECTIONS
HPV, H. Pylori, EBV, HIV, Hepatitis B & C
MINIMISE RISKS AT WORK
such as asbestos
Let's beat cancer sooner
cruk.org/health
CANCER RESEARCH UK


% gap between lowest and highest deprivation group
More cases in more deprived
Larynx 177%
Lung 159%
Oral Cavity 117%
Liver 100%
Stomach 81%
Anus 80%
Oropharynx 78%
CUP 61%
Penis 60%
Oesophagus 59%
Bladder 27%
Pancreas 22%
Hodgkin Lymphoma 20%
Kidney 20%
AML 13%
Bowel 13%
ALL -14%
Prostate -17%
Testis -18%
Malignant Melanoma -53%
Fewer cases in more deprived

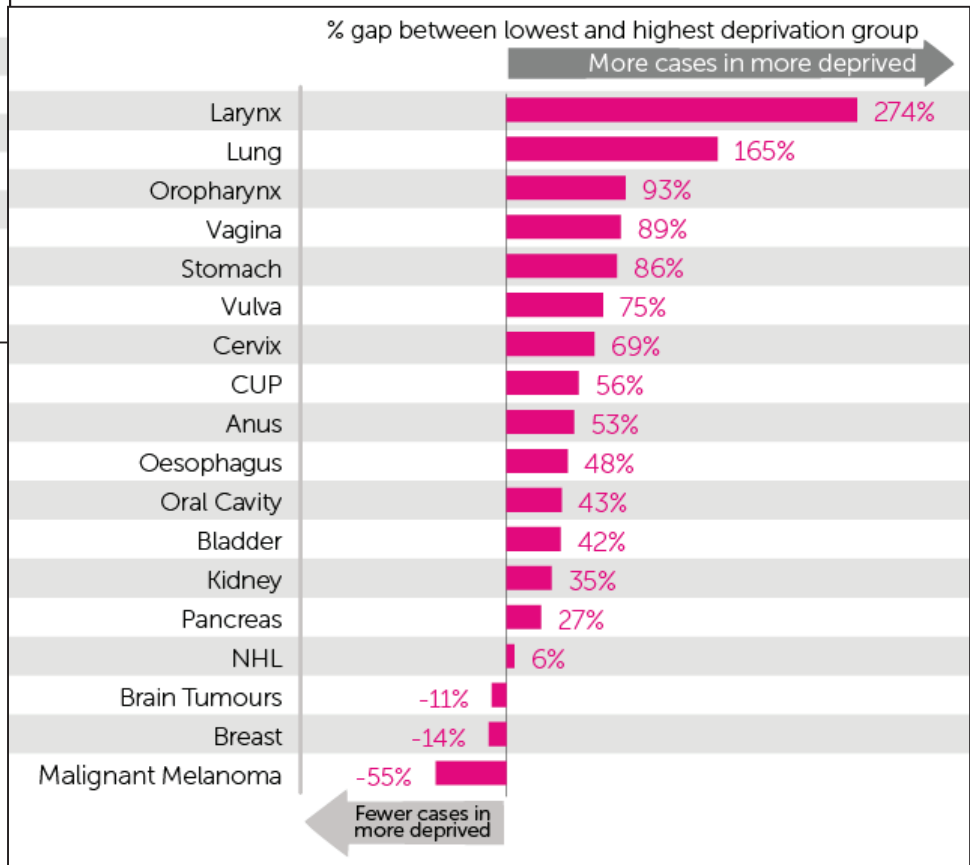
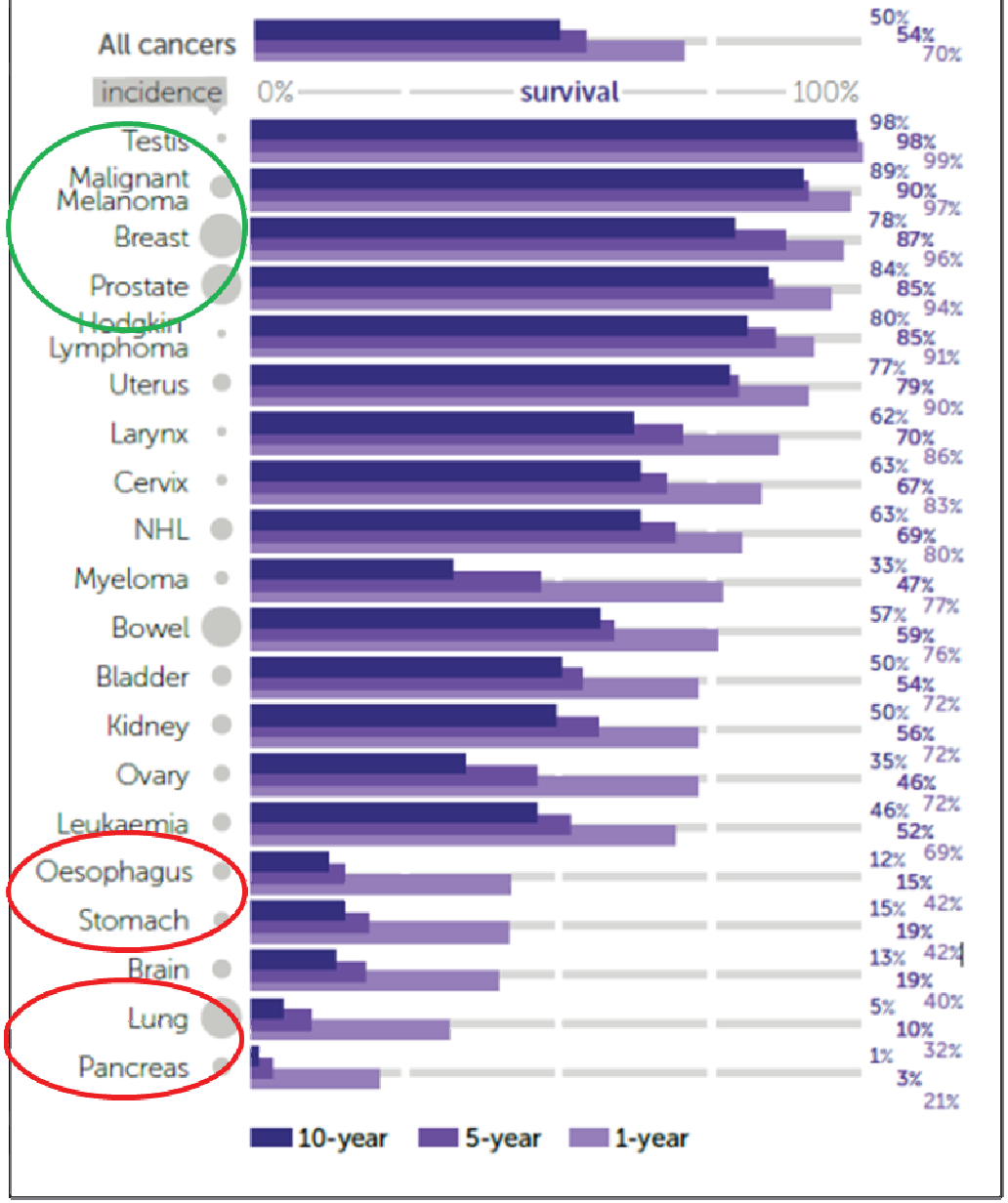
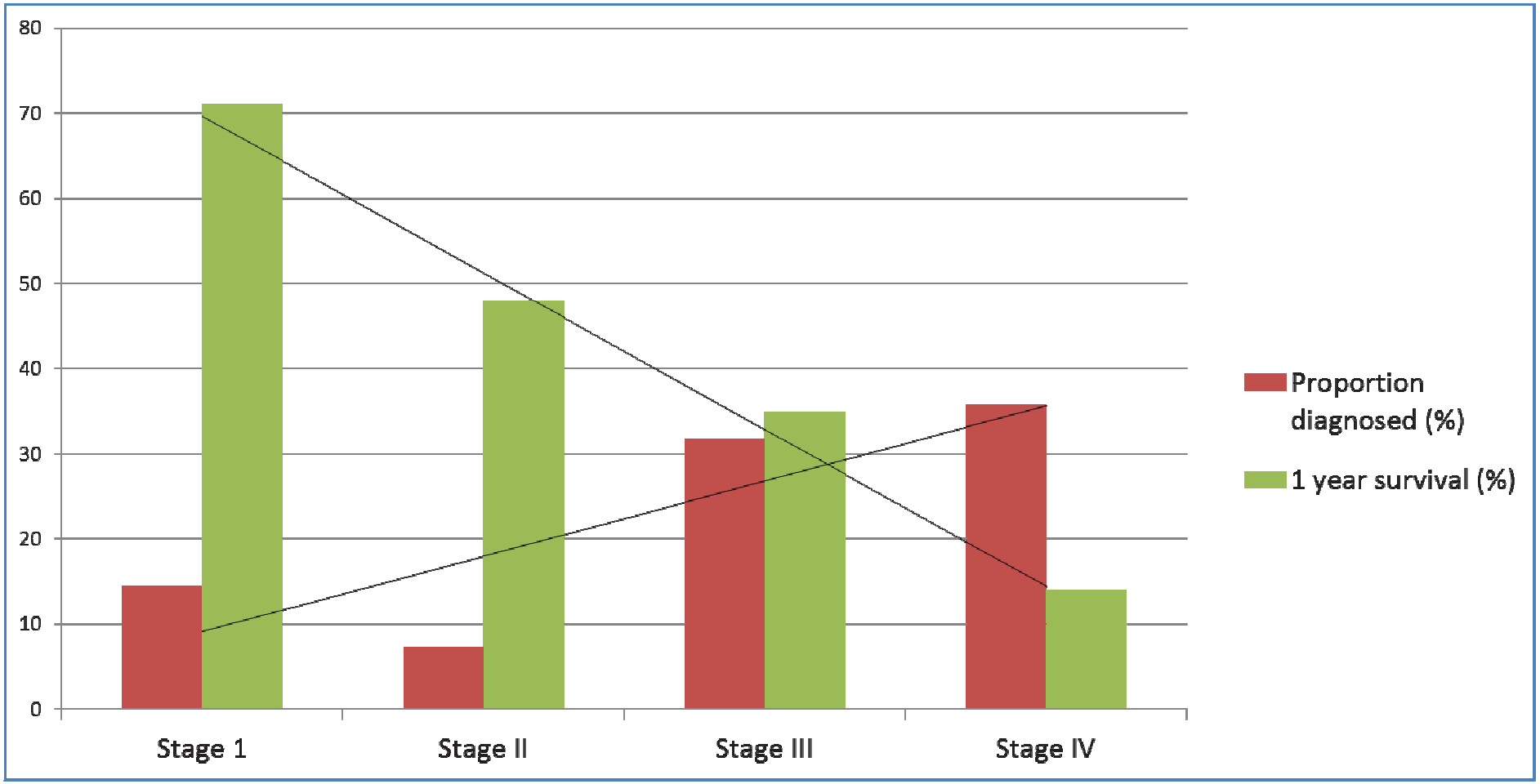

% gap between lowest and highest deprivation group
More cases in more deprived
Larynx 274%
Lung 165%
Oropharynx 93%
Vagina 89%
Stomach 86%
Vulva 75%
Cervix 69%
CUP 56%
Anus 53%
Oesophagus 48%
Oral Cavity 43%
Bladder 42%
Kidney 35%
Pancreas 27%
NHL 6%
Brain Tumours -11%
Breast -14%
Malignant Melanoma -55%
Fewer cases in more deprived

Figure 5: One-, Five- and Ten-Year Survival by Cancer Type



Relationship between stage and survival



The Nottingham and Nottinghamshire Sustainability and Transformation Partnership

Summary of Cancer Workstream

Themes and activities in WORKSTREAM

1 Preventing Cancer – by addressing risk factors, especially smoking.

1. NHS Provider Trusts to fully implement NICE PH48 guidance Smoking: acute, maternity and mental health services (https://www.nice.org.uk/guidance/ph48)
2. Pilot use of e-cigarettes within Stop Smoking Services. Make widely accessible within provider trusts.

2 Earlier Diagnosis – increasing % of cancers diagnosed at stage 1/2, reducing emergency presentations, leading to improved survival rates

3. Implement Non-specific symptoms pathway across STP footprint (https://www.cancerresearchuk.org/sites/default/files/ace_vague_symptoms_report_final_v1.1.pdf)
4. Commission services to deliver earlier diagnosis of cancer in areas of the STP with high incidence and / or late presentation e.g . Lung Health MOT service where high smoking rates, Community Prostate Cancer Clinics in Afro-Caribbean communities
5. Increase cancer screening rates in areas of the STP with low performance. Commission service to contact non-responders on-behalf of practices. Commission local awareness campaigns.
6. Address clinical variation in GP cancer metrics – 2WW referrals, emergency presentations, referral conversion, % of cancers detected via 2WW. Identify via GP cancer profiles. (https://fingertips.phe.org.uk/profile/cancerservices/data#page/0) Discuss and agree actions via practice visit programmes. Provide educational support via Cancer Support UK facilitators.
7. Implement full suite of GP Direct Access Diagnostics as per NICE Guidance NG12: Suspected cancer: recognition and referral (https://www.nice.org.uk/guidance/ng12)
8. Roll out use of decision support tools within primary care across the STP including Qcancer (https://www.emisnug.org.uk/using-cancer-symptom-checker-emis-web) and F12 project (http://www.rushcliffeccg.nhs.uk/media/4488/takeaway-f12-pathfinder.pdf)

3 Improving Cancer Treatment and Care – achieve cancer waiting time targets including new 28 day referral to diagnosis metric. Implement all aspects of recover package. Implement risk stratified follow up.

9. Implement National Timed Cancer pathways (Lung, Colorectal and Prostate), utilising Cancer Alliance Transformational funds.(https://cancervanguard.nhs.uk/wp-content/uploads/2017/09/Best-practice-cancer-pathways.pdf)
10. Commission all parts of the Recovery Package (https://www.macmillan.org.uk/about-us/health-professionals/programmes-and-services/recovery-package0) – Holistic Needs Assessment, Treatment Summary, Cancer Care Reviews, Health and Wellbeing Events. Commission Community Cancer Services across the STP
11. Commission personalised risk stratified follow up pathways of care (https://www.england.nhs.uk/wp-content/uploads/2016/04/stratified-pathways-update.pdf)
12. Evaluate Cancer Integrated IAPT Pilot in Nottingham City, with the intention to roll out across the STP (https://www.england.nhs.uk/mental-health/adults/iapt/mus/wave-two-integrated-iapt-sites/)
13. Nutrition innovation in Cancer Project (NiiCproject). http://niicproject.nuh.nhs.uk - Develop a system wide approach to the nutritional care of cancer patients at NUH

Enablers and interdependencies

- **Workforce**: Vacancies across the cancer pathway particularly in endoscopy, radiology and specific tumour sites e.g. Head and Neck. Use of EMRAD (http://emrad.org/) to utilise imaging workforce flexibly across the East Midlands. National Cancer Workforce plan (https://hee.nhs.uk/our-work/planning-commissioning/workforce-planning/cancer-workforce-plan)
- **IM&T**: Use of cancer dashboards to monitor progress. Use of decision support tools integrated into primary care systems to aid referral. 2WW referral pathways built into F12 project. Cancer Care Review templates integrated into GP Systems
- **Estates**: Commission Rapid Diagnostic and Assessment Centre
- **Mental health**: Integrated IAPT being piloted with Cancer pathways. https://www.england.nhs.uk/mental-health/adults/iapt/mus/wave-two-integrated-iapt-sites/
- **Prevention**: See theme 1. Work with Prevention workstream to reduce other lifestyle impacts on cancer incidence e.g. diet, alcohol, exercise etc.

2 **Earlier Diagnosis –** increasing % of cancers diagnosed at stage 1/2, reducing emergency presentations, leading to improved survival rates

3. Implement Non-specific symptoms pathway across STP footprint (https://www.cancerresearchuk.org/sites/default/files/ace_vague_symptoms_report_final_v1.1.pdf)
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LUNG Health Checks

Ages 60-75
Smokers and ex-smokers

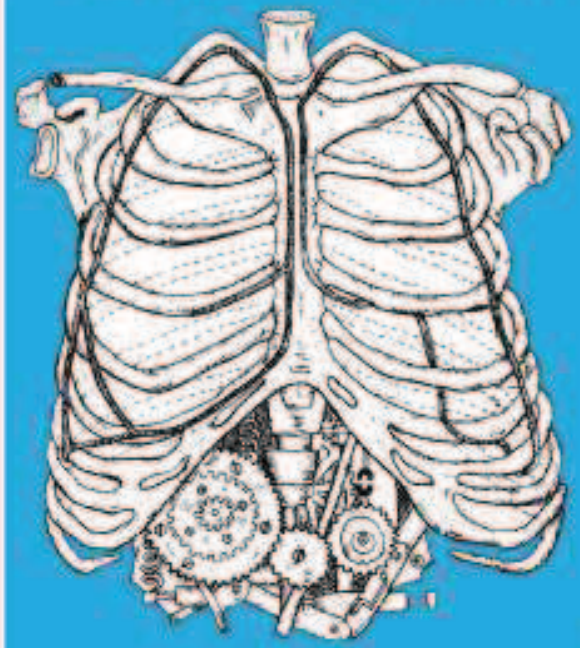
"I would never have gone to the doctors by myself because I didn't feel ill." *Bill from Bulwell*

NHS Nottingham City Clinical Commissioning Group

Expect Better

An MOT for all models of lung owners

Smokers and ex-smokers between the ages of 60 and 75, registered at:



- Aspley Medical Centre
- Melbourne Park Medical Centre
- RHR Medical Centre
- Lime Tree Surgery
- Strelley Health Centre
- Beechdale Surgery
- Bilborough Surgery
- Boulevard Medical Centre
- Grange Farm Medical Centre

will receive an invitation through the post to attend.

www.nottinghamcitycare.nhs.uk
www.roycastle.org

THESE LUNG HEALTH CHECKS HAVE ALREADY SAVED PEOPLE'S LIVES - PEOPLE LIKE BILL

Bill attended the health check at his GP surgery last year and was diagnosed with early stage lung cancer. Within six weeks, he had surgery to remove the cancer and is feeling great. He wants everyone to have the same chance as he did:

"I would never have gone to the doctors by myself, I know that, because I didn't feel ill.

"I had a cough but didn't think too much about it. I never thought for a second it could be lung cancer but a few days after the check I got a phone call saying they had found an abnormality and I had lung cancer. Fortunately, they had caught it early and it hadn't spread.

"You're operated on and a couple of days later you can go home, you're fixed, you're mended. You feel great!

"The doctor when I went said, it's probably given you 10 more years of your life.

"That's the thing, if they find it you can be fixed so please attend the health check.

"If I hadn't had gone for that scan, I could have been dead in a year's time."

ROY CASTLE LUNG CANCER FOUNDATION

Expect Better

Reg. Charity Eng & Wales 1046854 Scot. SC037596

Bill's story

- Bill from Bullwell - In his 60s
- Smoked since teenager.
- Persistant cough for some time – smokers cough, felt well, didn't want to bother GP.

- https://vimeo.com/263768448
- https://www.roycastle.org/news/lung-health-check-the-results

Linda’s Story

News › Local News › NHS

Mobile cancer check up in car park saved my life, says 70-year-old

- A pensioner from Bulwell said she feels 'incredibly lucky' to be alive after a scan inside a mobile truck in a car park saved her life.
- Linda Salter, 70, who smoked around 10 cigarettes a day since she was a teenager until the diagnosis, is now encouraging other people to do the test.
- Mrs Salter, whose husband died of lung cancer in 2002, was invited to a health check at her local GP when the scheme originally launched in Bulwell in 2017.
- At the appointment Linda was diagnosed with chronic obstructive pulmonary disorder (COPD) and was prescribed medication as well as referred for a CT scan at a mobile scanner located at the Bulwell Riverside Centre.
- The scan discovered two small nodules inside her right lung and she was referred to a specialist at the City Hospital the same week.
- Clinicians recommended they monitor the nodules to make sure they were not growing. It was only after nine months and Linda’s third follow-up scan that the nodules had shown signs of growth.
- On June 6, 2018 Mrs Salter had one third of her lung removed after cancerous cells were found during the biopsy.
- She said: "That original health check may have saved my life. The most important thing is that I had no symptoms and felt absolutely fine.
- "So, I would have never known I had cancer until maybe it was too late. When my husband found out he had cancer it was too late”. “When they told me I had nodules in my lungs that was it. I never smoked again."

Colorectal FIT test

- New poo test for colorectal cancer (low risk symptoms)
- Nottingham first to implement for symptomatic patients
- Current diagnostic test is colonoscopy
- Unpleasant, expensive, risks
- FIT non invasive, simple, cheap and highly sensitive
- 30% reduction cancer colonoscopies
- Increase in cancers detected.
- More importantly increase in early stage cancers
- Rolled out in Mid Notts

Wendy’s story

A mother-of-three says a self-testing kit for bowel cancer saved her life.

Wendy Lyons, lives in Eastwood, Nottinghamshire, a county leading the way in the use of Faecal Immunochemical Tests or FIT.

The kit can tell doctors whether a more expensive and uncomfortable colonoscopy is needed.

Hospital bosses hope they can use it to find cancer earlier in people who would not normally be tested for the disease.

Clinical commissioning groups (CCGs) in Nottinghamshire said in November 2017, Nottingham GPs were the first in England to offer tests to patients with symptoms of bowel cancer other than spots of blood in their faeces or an obvious lump.

The test, which costs the NHS about £15 per person compared with £400 for a colonoscopy, is this year being sent to everyone over 60 as part of the national screening programme and is already widely used in Scotland.

But in Nottinghamshire, doctors can recommend the test to anyone with unexplained bowel problems, even if they think there is only a slim chance they have cancer, meaning they can pick it up in younger people too.

'Luckiest survivor alive'

Miss Lyons, 46, thought she was going through the menopause when she started getting headaches and pains.

Her GP initially reassured her it was unlikely to be cancer, offering her the test as a precaution.

It showed up positive and as a result her cancer was picked up so early she avoided both chemotherapy and major side effects from her operation.

"I feel like the luckiest cancer survivor alive - I can't thank the NHS enough," she said. "That FIT test saved my life."

According to Ayan Banerjea, a bowel cancer consultant in Nottingham, GPs can be reluctant to recommend colonoscopies unless it is necessary.

Using the kit, you collect small samples of your faeces and post them to a lab which then checks them for tiny amounts of blood, which could be caused by cancer.

A small number of places now follow Nottingham's example, such as hospitals in Hertfordshire and Leicester, but most are waiting to see how well it works first, according to Mr Banerjea.

Mr Banerjea said medics were now "picking up more cancers at an earlier stage".

https://www.bbc.co.uk/news/uk-england-nottinghamshire-47792829

ENC. D

Meeting:	ICS Board
Report Title:	Progress against the one year prevention priority
Date of meeting:	Thursday 11 April 2019
Agenda Item Number:	5
Work-stream SRO:	Alison Challenger & Chris Packham
Report Author:	Jane Bethea & Alison Challenger
Attachments/Appendices:	Appendix 1: Update on progress against the alcohol plan.

Report Summary:

The purpose of this report is to provide an update on progress against the ICS one year prevention priority around reducing alcohol related harm. Alcohol related harm is a significant issue across the ICS, costing at least £17.4 million a year in hospital admissions alone.

The previous report to the ICS Board on 14 December 2018 outlined the ICS alcohol plan and provided background information on need and estimated costs of alcohol related and specific hospital admissions. This report provides a summary of progress against the eight areas of the alcohol plan, describes related commissioning intentions and also provides an update of the most recent alcohol related and specific hospital admissions data.

In summary:

- The most recent data for 2017/18 reports a reduction in hospital admission episodes for alcohol related conditions (narrow measure) for both city and county residents, and a reduction in admission episodes for alcohol specific conditions for city residents whilst the county has remained stable.

- Commissioning intentions for Greater Nottingham Clinical Commissioning Partnership for 2019/20 reflect the alcohol plan and include intentions to provide consistent alcohol Identification and Brief Advice (IBA), ensuring appropriate pathways for people with co-existing substance misuse and mental health issues and upskilling staff in relation to brief interventions, including alcohol IBA.

- We continue to look for opportunities to learn from other areas. Members of the Nottinghamshire Alcohol Pathways Group have worked with the Faculty of Public Health and Public Health England to host an alcohol learning event that will take place in Nottingham on 29th April. This has attracted a number of national experts in the field of alcohol harm reduction, including those working in implementation of alcohol IBA.

- Progress against the plan includes:

    - funding has been secured through a Public Health England capital grant to support alcohol harm reduction initiatives at NUH and to also enable Framework to provide supported 'Housing First' accommodation for people with alcohol dependency;

- funding has been identified to widen access to alcohol IBA training and work is underway to develop online IBA training resources for staff working in non-healthcare settings;
- a high volume service user business case has been considered and is now being developed further to ensure a consistent approach across NUH and SFHT;
- a pathway to support people with co-existing mental health and substance misuse issues has been developed and will be presented to the ICS Mental Health Partnership Board in May 2019;
- work is underway through the ICS workforce work stream to embed alcohol harm reduction as part a wider prevention offer in staff training, job specifications and HR policy.

The ICS Board is asked to note the progress made to date and to provide continued support to this prevention priority.

Action:

☒ To note
☐ To agree
☒ To agree the recommendation/s (see details below)

Recommendations:

1.	That the Board provide ongoing support for this prevention priority
2.	That the Board note progress made to date and ongoing work relating to implementation of the alcohol plan
3.	To consider the alcohol plan and provide suggestions on further development and/or effective implementation

Key implications considered in the report:

Financial	☒	Financial resources have not been identified for all aspects of the alcohol plan. Since the last report, additional funding has been identified for IBA implementation across some but not all of the ICS geography. It is also possible that increased identification of those with a need for treatment will require additional capacity within community alcohol services.
Value for Money	☒	Alcohol care teams and alcohol IBA both have evidence for return on investment. Alcohol treatment reflects a return on investment of £3 for every £1 invested, which increases to £26 over 10 years, and alcohol IBA in primary care is estimated to save the NHS £27 per patient per year
Risk	☒	There is some risk of inconsistency across the ICS geography in relation to implementation of the plan. This includes an inconsistent offer around IBA training should a bid for funding being considered for Nottingham City not be successful.

Legal	☐	
Workforce	☐	The plan includes a requirement for consistent staff training as well as an ambition to embed alcohol harm reduction into HR policy and processes.
Citizen engagement	☐	
Clinical engagement	☒	Ongoing clinical engagement is pivotal to the full implementation of the alcohol plan.
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	Greater Nottingham ICP	-
☐	☐	☐	☐	☐

Contribution to delivering the ICS:

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 progress against the one year prevention priority.

April 2019.

Introduction

1. In 2018 the ICS identified reducing alcohol harm as the one year prevention priority. Alcohol harm represents a significant burden at local level across the footprint and nationally, with a need for renewed national focus on reducing alcohol related harm outlined in the 10 Year Plan for the NHS. An eight point ICS wide plan has been developed by the Nottinghamshire Alcohol Pathways Group and implementation of this plan began in mid-2018. In summary the plan aims to:

    - Increase population level understanding of risk and harm
    - Prevent alcohol harm through wider related local/national policy
    - Embed a systematic approach to Alcohol Identification and Brief Advice (IBA)
    - Identify 'alcohol champions' in key organisations across the system
    - Include alcohol as a priority for employee health and wellbeing
    - Ensure better communication of identified alcohol risk between some key parts of the system
    - Case manage Emergency Department (ED) High Volume Service Users (HVSU)
    - Agree and embed pathways for service users with co-existing mental health and substance misuse issues.

2. At the 14 December 2018 ICS Board a report was presented that summarised early progress against the plan, including areas that required further focus. A further update was requested for discussion at the 11 April 2019 ICS Board and this report provides that update and also outlines the most recent data on alcohol related and specific hospital admissions.

Progress to date

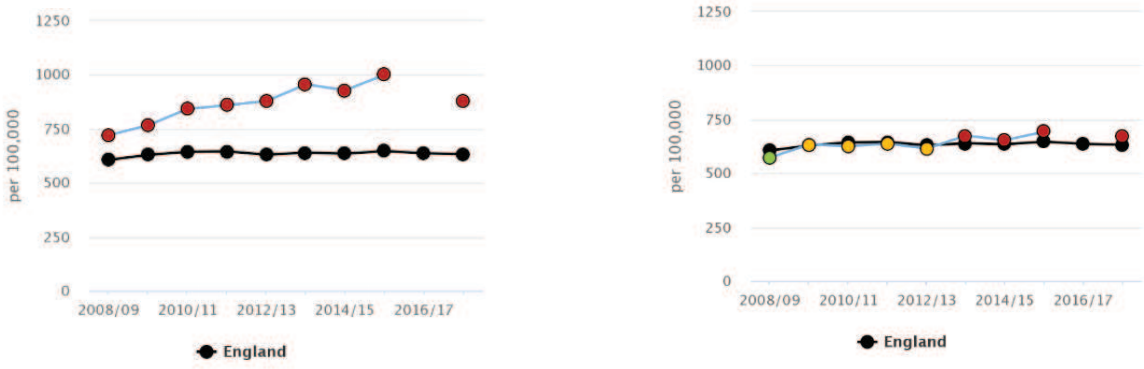
Update on key alcohol outcomes

3. The headline indicator that has been adopted by the ICS for this prevention priority is the narrow measure for alcohol related hospital admissions. This is a measure reported in the Public Health Outcomes Framework and the most recent data is for the period 2017/18. As shown in Figure 1, reductions have been reported for this indicator for both Nottingham City and Nottinghamshire County residents. This has fallen from 1000 per 100,000 for city residents in 2015/2016, to 881 per 100,000 in 2017/18. A smaller reduction is reported for Nottinghamshire County residents, from 693 per 100,000 in 2015/2016 to 670 per 100,000 in 2017/18.

4. As shown in Figure 2, a reduction in alcohol specific hospital admission episodes has also been reported, from 990 per 100,000 for the period 2015/16 to 818 per 100,000 in 2017/18. Rates of alcohol specific hospital admission episodes for the county have remained stable during this period. Although it is not possible to

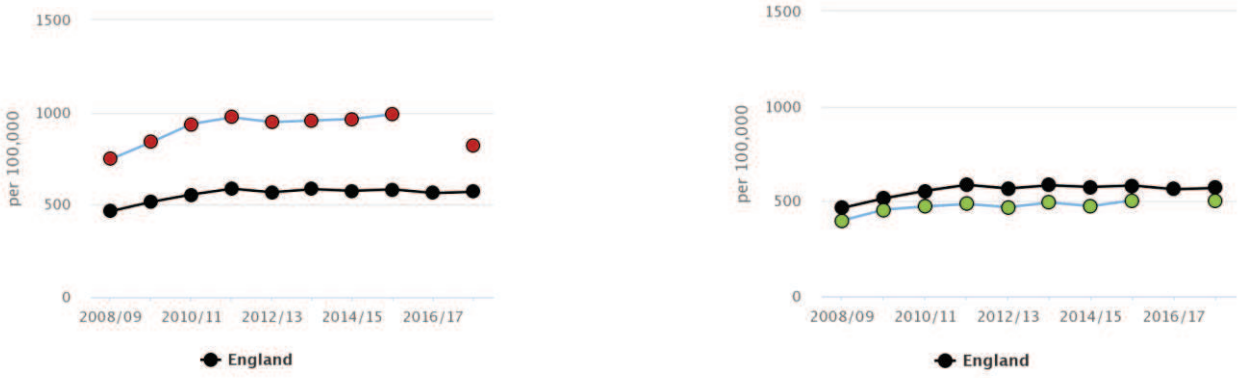
ascribe any change in alcohol related and specific admission episodes data to the activity ongoing across the ICS as part of the alcohol plan, this most recent data is encouraging and ongoing monitoring will determine if this is sustained into the next reporting period.

Figure 1: Hospital admission episodes for alcohol related conditions (narrow measure) for Nottingham City and Nottinghamshire County residents 2008/9 to 2017/18



Nottingh Nottinghamshire County Residents

Figure 2: Hospital admission episodes for alcohol specific conditions for Nottingham City and Nottinghamshire County residents 2008/9 to 2017/18.



Nottingham City Residents

Nottinghamshire County Residents

Source for Figures 1&2: Public Health England. Local Alcohol Profiles for England. Note: Data for 2016/17 is missing due to data quality issues

Update on progress against the alcohol plan

5. Appendix one provides an update of progress against the eight areas of the alcohol plan. In summary, good progress has been made across the eight areas of the plan, with successful funding bids supporting specific aspects. In the county, Public Health staff have successfully applied for funds to support roll out from April 2019 of alcohol IBA in a number of key settings. In the city Public Health staff have applied for funds to support a similar approach and are also

working with Nottingham Recovery Network to develop online training tools for staff working in non-health settings that can be used across the ICS geography

6. A recent successful bid to Public Health England's capital fund will also support delivery of IBA in the Emergency department (ED) setting at NUH and will support work to ensure information on alcohol risk is shared appropriately across the system. This will include the introduction of mobile fibro-scanning into the ED setting, with the aim of reinforcing delivery of IBA and providing additional motivation to those with a need for treatment and support to engage with community alcohol services. This intervention is simple and quick and gives immediate results in relation to liver stiffness and fatty change. It is similar to receiving an ultrasound scan and is non-invasive. Dr Steve Ryder (Consultant Physician in Hepatology and Gastroenterology and NUH alcohol lead) believes that this can act as a behavioural lever for patients, encouraging them to access support from treatment services. This will also help to further embed alcohol IBA in this setting, giving staff a clear pathway for those patients identified as being at risk of alcohol harm. Providing this in the ED setting is novel and the impact will be assessed through robust evaluation. A robust evaluation will run alongside this work to determine associated impact and also learning for the wider footprint. This funding will also support Framework to provide eight units of 'Housing First' supported accommodation to people with alcohol dependency. This will provide stable housing and intensive support to clients to encourage and support successful engagement with treatment.

7. Work is underway to develop a service to support case management of high volume service users. SFHT are currently advertising a post that will aim to support a reduction in Emergency Department attendances and emergency admissions by high volume service users. The role will support and also engage with clinicians, patients and their carers to implement long term care and support plans, ensuring that a patient is fully aware of and in agreement with the arrangements made for them. This role is not specifically around alcohol but a significant number of clients are likely to report problematic alcohol use. A business case for a similar service at NUH has been written and this is now being further developed using learning from SFHT and also from evaluation of the HVSU post previously provided by NUH in the ED setting.

8. Work is also continuing within both Local Authorities in relation to licensing. This has included public health staff in both the city and county providing input to the development of the most recent Statement of Licensing Policy and reviewing alcohol licensing applications, raising questions or concerns where appropriate.

9. A pathway for service users with co-existing mental health and substance misuse issues has been developed and will be presented to the ICS Mental Health Partnership Board in April 2019. Plans are also being developed to launch an awareness raising campaign that will coincide with national alcohol awareness week in November 2019.

Ensuring consistency and sharing learning

10. The alcohol pathways group was until 2018, working only across the Greater Nottingham area. In the last six months there has been work underway to ensure

that this group is representative of the wider ICS geography. This has included identifying representation from both primary care and SFHT as well as community based substance misuse services. This has also provided opportunities to share good practice and to identify models of working that could be applied more widely.

11. In terms of learning from other areas, members of the pathways group have developed an alcohol learning event that will take place on 29th April 2019 where work underway in other areas will be presented and shared, including the most recent work undertaken by Newcastle University on effective implementation of alcohol IBA. A project undertaken locally around barriers and enablers associated with delivery of alcohol IBA in the ED setting will also be shared at this event.

Commissioning intentions

12. Commissioning intentions produced by Greater Nottingham Clinical Commissioning Partnership in collaboration with Mid Nottinghamshire CCGs have identified reducing alcohol harm as a priority and plan to commission for this by:

- Agreeing system actions to reduce alcohol related harm, including communication to public and consistent provision of alcohol identification and brief advice across primary care and ED
- Exploring different ways of working with people with alcohol abuse, including Co-morbidities between physical, mental health and substance misuse, to integrate care at an individual level
- Agreeing pathways between service users with co-existing mental health and substance misuse issues.
- Ensuring training and support is delivered to service staff to upskill on brief intervention in alcohol and smoking and embed this within service delivery across the system

Issues

13. Although there has been progress against all areas of the plan, there is further work to do and this includes:

- *Alcohol IBA:* Funding to expand and embed IBA in health and wider settings has been sourced for the county but this has not yet been secured for the city. A bid to a charitable funding body has been submitted but should this not be successful then an alternative source of funding will be required. Work is also required to determine how best to embed IBA in the primary care setting. The Local Medical Council have offered support and ways of developing this important area of work are being considered by the pathways group.

- *Impact of increased identification of need*: Work is still underway to determine the impact of increased IBA on penetrance of community based substance misuse services. This is being completed by Public Health and will provide an estimate of how many additional clients city and county services could see as a result of up-scaled and consistent alcohol IBA provision. Additional capacity within substance misuse services may be required as a result of increased identification of alcohol related risk and harm.

Next steps

14. The next steps are to further develop and implement the alcohol plan, with a focus on:

1) Ensuring activity and progress is consistent across the ICS footprint
2) Implementation of IBA across the system, including primary care
3) Implementing plans associated with the recently awarded PHE capital funds
4) Developing system understanding of the impact a system wide approach to IBA is likely to have on current capacity within substance misuse treatment services
5) Ensuring that alcohol as part of a wider prevention offer is embedded within workforce initiatives

Recommendations

15. The Board are asked to approve / note the following:

1. That the Board provide ongoing support for this prevention priority
2. That the Board note progress made to date and ongoing work relating to implementation of the alcohol plan
3. To consider the alcohol plan and provide suggestions on further development and/or effective implementation

Jane Bethea/Alison Challenger
Consultant in Public Health/Director of Public Health
29th March 2018
jane.bethea@nottinghamcity.gov.uk

Appendix 1: Update on progress against the ICS alcohol plan

Action	Progress to date	Next steps
1. Increase population level understanding of risk and harm	Public understanding of guidance around alcohol consumption and also associated harms is known to be poor. As such the plan identified a need to undertake some awareness raising work, both at individual level through embedding alcohol IBA in key settings (see action 3) and through population level awareness raising. Discussions are taking place around use of existing alcohol harm materials and linking to other awareness raising campaigns across the footprint. Discussions with the ICS communications team are also taking place to determine how a consistent roll out of key information and messages can be achieved. A visible campaign is likely to be strengthened by launching it during national alcohol awareness week, running this year in mid-November.	To agree a named lead for this element of the plan and to then agree key messages and identify any associated costs. To agree timing of release of materials with consideration given to coinciding this with national Alcohol Awareness Week (November 2019).
2. Prevent alcohol harm through wider related local/national policy	Initial work to influence national strategy development has been paused as the draft national alcohol strategy that was expected to be released in January 2019 appears to have been delayed. Alcohol licensing work continues in both the city and county council and has included providing input to recent Statements of Licensing Policy and review of licensing applications.	The Nottinghamshire Alcohol Pathways Group will be formally responding to consultation on the national alcohol strategy once that is released.
3. Embed a systematic approach to Alcohol Identification and Brief Advice (IBA)	Funding has been identified to support roll out of IBA in a number of health and non-health settings in Nottinghamshire County. Public Health in the county are working with their substance misuse provider (CGL) to roll out training starting from April 2019. In the city a bid has been submitted jointly by Public Health and Nottingham Recovery Network to ensure a consistent offer. In March 2019 Nottingham City Council, NUH and Framework successfully applied for £540,000 to support alcohol related projects. This includes introducing liver fibro-scanning into the ED setting at NUH, training for ED staff and also the development of IT systems to ensure appropriate sharing of information on alcohol risk	To monitor roll out and feedback progress/issues to the Nottinghamshire Alcohol Pathways Group. To look for alternative funding should the city be unsuccessful. To implement fibro-scan pathway and develop work around IT system changes. To be discussed at the next Nottinghamshire Alcohol Pathways Group and then as a

	and harm between key parts of the system, including between ED and primary care. This will strengthen provision of IBA in this key setting and robust evaluation is planned to identify associated patient and system outcomes and learning.	standing item until fully implemented.
	Nottinghamshire County Council and CGL also submitted a bid for capital funds that would enable roll out of a novel technology that would support alcohol IBA delivery. This was not successful but alternative ways of supporting this are being pursued.	To pursue other avenues for funding. To be discussed at Nottinghamshire Alcohol Pathways Group.
	On-line training has been identified for staff working in health-care settings but there is a gap for staff in key non-health settings. Public Health in Nottingham City are working with Nottingham Recovery Network to develop appropriate online training resource that can be utilised across the footprint. This will be piloted and then rolled out to key non-health settings.	Online package to be completed by 30th April 2019 and piloted May 2019. To be made available to the wider system in June 2019.
	Alcohol 'scratch cards' will be used to support alcohol IBA. The cards will be made available to staff in key settings following positive feedback on their use in augmenting discussions around alcohol harm. Currently any additional cost associated with including contact details of community alcohol treatment services is being identified as this would be a useful addition.	Cards to be available 2019. Priority groups and distribution to be agreed by Nottinghamshire Alcohol Pathways Group.
	Nottingham City Council have identified alcohol IBA training as a priority for staff working in key citizen facing roles. Training is being rolled out from June 2019 and will be supported by the on-line training package described above.	Roll-out from June 2019 to priority groups. Progress and issues to be reported back to the Nottinghamshire Alcohol Pathways Group.
	Work is underway across the workforce and prevention work stream of the ICS to embed prevention (including alcohol IBA) into job roles, training and appraisal processes.	Progress to date to be discussed at the next Nottinghamshire Alcohol Pathways Group in April 2019.

Identify 'alcohol champions' in key organisations across the system	Alcohol champions have been identified in some organisations but not all. Some organisations are considering broader 'prevention champions' with alcohol as a consideration within that. The Nottinghamshire Alcohol Pathways Group welcome either approach.	To ensure champions have been identified and named in key organisations. To identify who will lead this area of the plan. This could be taken on by a project manager within the workforce work stream currently providing support for workforce elements of the alcohol plan.
Include alcohol as a priority for employee health and wellbeing	Discussions are taking place with ICS work force leads around a consistent approach to employee health and wellbeing. It is unclear what is currently provided across organisations and some are looking to undertake staff surveys to determine level of need.	To map activity across the footprint. This will require support from project managers working in the work force element of the prevention work stream.
Ensure better communication of identified alcohol risk between some key parts of the system	NUH will shortly receive funding via the PHE capital bid to develop their ICT systems so that information can be shared appropriately between the trust and other key parts of the system, including primary care. This funding will also help ensure that information collected on alcohol at patient level can be used to inform service development.	Implement ICT processes in line with capital funds and evaluate to determine impact. Share learning with wider footprint. Current information sharing processes at SFHT will be discussed at the pathways group to ensure a consistent approach across the footprint.
Case manage Emergency Department (ED) High Volume Service Users (HVSU)	A business case for a HVSU service based at NUH has been developed and work is now underway to develop this to ensure consistency between NUH and SFHT. SFHT has a permanent post currently out to advert that will support and also engage with clinicians, patients and their carers to implement long term care and support plans, ensuring that a patient is fully aware of and in agreement with the arrangements made for them. How this could work with and support community based HVSU services is also being considered as part of this development.	This is being taken forward by GN CCP with progress reported to the Nottinghamshire Alcohol Pathways Group.

Agree and embed pathways for service users with co-existing mental health and substance misuse issues	A pathway has been developed by a multi-agency group that represents mental health and substance misuse commissioners and providers across the ICS footprint. Currently the group are working to identify financial costs associated with the proposed pathway. This will be presented to the ICS Mental Health Partnership Board in 2019 for discussion and support.	To present the pathway for discussion at the ICS Mental Health Partnership Board. To include any cost implications and any potential return on investment associated with the proposed approach.

ENC. E1

Meeting:	ICS Board
Report Title:	The Nottingham and Nottinghamshire ICS System Level Outcomes Framework
Date of meeting:	11 April 2019
Agenda Item Number:	6.
Work-stream SRO:	Wendy Saviour
Report Author:	Chris Packham/Tom Diamond/Elaine Varley
Attachments/Appendices:	Annex A – ICS System Level Outcomes Framework April 2019

Report Summary:

The purpose of this paper is to update Board members on the continued development of the Nottingham and Nottinghamshire ICS System Level Outcomes Framework against the identified next steps and in accordance with feedback received from ICS Board members at the March Board meeting.

The key areas of developments have been around the ambitions, outcomes, measures and engagement with stakeholders across the system. Feedback from ICS Board members and subsequent wider engagement has underpinned the developments.

Two additional ambitions have been developed to capture 'quality of life' within the 'independence, care and quality' domain of the framework and 'workforce' within the 'effective resource utilisation' domain. The establishment of a 'quality of life' ambition and subsequent outcomes and measures, was as a result of engagement with clinical leads and the Population Health & Population Health Management Steering Group. The establishment of a 'workforce' ambition was in direct response to ICS Board member feedback. Development of the ambition and subsequent outcomes and measures has been undertaken with expert people and culture leads from across the system.

Where possible outcomes seeking a reduction have been reframed to focus on delivering improvements and they will continue to be subject to engagement and appropriate refinement. Initial measures have been identified against each outcome. The expectation is that all partners across the system have a responsibility and duty to contribute to the delivery of all ambitions, outcomes and measures identified within the framework.

Core stakeholders for engagement have been identified and will be continually reviewed to ensure the right people across the system are appropriately sited of the framework to ensure it is suitably shaped and owned by all partners.

In the short term solutions have been identified to secure capacity to work with the System Outcomes Framework Task and Finish Group to assess the quality of measures and propose suitable baselines, benchmarks and trajectories. It is recognised that in order for the framework to be operationalised across the system a long term approach and solution should be captured through a system wide IM&T and analytics strategy.

The Board is asked to note the progress and support the current iteration of the System Level Outcomes Framework.

Action:

☐ To note
☐ To agree
☒ To agree the recommendation/s (see details below)

Recommendations:

1.	To note the progress to further refine and develop the System Level Outcomes Framework.
2.	To agree the updated ambitions and outcomes – recognising the framework will continue to refine and develop over time and to provide any additional feedback.
3.	To agree the proposed next steps.

Key implications considered in the report:

Financial	☐	*The system-level 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**	**Greater Nottingham ICP**	-
☐	☐	☐	☐	☐

Contribution to delivering the ICS:

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 ICS System Level Outcomes Framework

11 April 2019

Background

1. The purpose of this paper is to update Board members on the continued development of the Nottingham and Nottinghamshire ICS System Level Outcomes Framework against the identified next steps and in accordance with feedback received from ICS Board members in March 2019 and subsequent engagement with wider system partners.

2. The Nottingham and Nottinghamshire ICS System Level Outcomes Framework April 2019 can be found in Annex A. This document will be the basis of the framework going forward to ensure there is a single master version where all developments will be captured.

Progress to date

Ambitions

3. Two additional ambitions have been developed to capture 'quality of life' within the 'independence, care and quality' domain of the framework and 'workforce' within the 'effective resource utilisation' domain:
   - Our people with care and support needs and their carers have good quality of life.
   - Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population.

4. The establishment of a 'quality of life' ambition and subsequent outcomes and measures, was as a result of engagement with clinical leads and the Population Health & Population Health Management Steering Group. It was identified that this should be a core stand alone ambition for all service delivery to capture care management and treatment optimisation, particularly for those with long term conditions or at end of life.

5. The establishment of a 'workforce' ambition was in direct response to ICS Board member feedback. Development of the ambition and subsequent outcomes and measures has been undertaken with expert people and culture leads from across the system including the workstream SRO, Programme Director and Workforce Transformation Programme Manager.

6. The updated ambitions and framework structure can be found in page 9 of Annex A.

7. The framework now identifies a total of ten ambitions.

Health and Wellbeing
- 4 ambitions
- 12 outcomes

Independence, care and quality
- 3 ambitions
- 8 outcomes

Effective resource utilisation
- 3 ambitions
- 8 outcomes

Outcomes measurable at year 1 to 5+ years

Outcomes measurable monthly/quarterly in year 1 through to 5+ years

Outcomes

8. In direct response to ICS Board feedback, where possible outcomes seeking a reduction have been reframed to focus on delivering improvements or an increase. Following a review of all outcomes that sought a reduction it is proposed that there are exceptions to reframing all outcomes and that the need to deliver a reduction is maintained to ensure the purpose and clarity of the outcome intention is specific and measurable. This relates to outcomes that are associated with mortality, potential life years lost, disease prevalence and hospital admissions. The system level outcomes will continue to be subject to engagement and appropriate refinement.

9. Intentionally the system-level outcomes identified are limited in number, however it is recognised and acknowledged that there is currently a requirement through the various mandatory frameworks for health, social care and public health for the system to report on and deliver against a much larger number of outcomes. Opportunities to reduce reporting across the various frameworks to allow a greater focus on the System Level Outcomes Framework will be continuously explored.

Measures

10. Initial measures have now been identified against each outcome. They refine the long list of measures presented to Board members in March and have been refined with relevant experts across the system. The measures are set out from page 11 of Annex A. The measures will continue to be refined as we engage further with stakeholders across the system.

11. Analytical expertise will be drawn upon to determine the relevant quality of the measures. Baselines, benchmarking and trajectories for each measure will be undertaken as part of the next phase of the framework development. The System Outcomes Task and Finish Group members will review the analytical work undertaken and present the assessment of the measures back to the ICS Board Members, along with recommendations for benchmarks and trajectories in July 2019.

12. The expectation is that all partners across the system have a responsibility and duty to contribute to the delivery of all ambitions, outcomes and measures identified within the framework.

Engagement

13. An initial discussion has taken place with the ICS Director of Communications and Engagement to explore how the ambitions within the System Level Outcomes Framework might suitably be incorporated within the public engagement that will take place on the Long Term Plan. The intention is that the public will be asked to tell us what our ambitions really mean to them and in turn what they want us to achieve for them, their families and communities. Mapping of the ambitions against the national 'I statements' is also underway.

14. Engagement with partners across the system continues to take place via Board members and the established Population Health & Population Health Management Steering Group and System Outcomes Framework Task and Finish Group, they provide expert and organisational diverse representation. This has underpinned the development outlined above.

15. A formal structure to the Outcomes Framework approach to engagement over the summer will be established to ensure there is consistency in how that engagement takes place and to ensure the Framework is consistently and efficiently shaped.

16. The Outcomes Framework Task and Finish Group have identified the following core routes of engagement at this stage:

Organisation/Group	Route
Public	ICS Communications Team
ICS statutory organisations	Chief Executives / Accountable Officer Relevant executive level meeting
City Care	Chief Executive Relevant executive level meeting
PICS (Primary Integrated Care Services)	Chief Executive Relevant executive level meeting
Integrated Care Partnerships (ICPs)	Identified SRO and Clinical Lead
Primary Care Networks	Via ICPs Clinical Leads
ICS Finance Directors Group	Chair
ICS Planning Group	Chair
Clinical Reference Group	Chair
ICS workstreams	Workstream network Programme Directors

Key risks and solutions

Information Management and Analytics Capacity and Capability

17. Informatics and analytic capacity continue to pose a core risk to the ongoing operationalisation of the System Level Outcomes Framework. In the short term solutions have been identified to secure capacity to work with the System Outcomes Framework Task and Finish Group to assess the quality of measures and propose suitable baselines, benchmarks and trajectories.

18. The long term approach and solution to information management and analytics capacity and capability needs to be captured through a system wide IM&T and analytics strategy that considers not just the needs of system level outcomes but also the wider Population Health Management approach and how it will be suitably scaled up in order for the benefits to be fully realised.

Next Steps

19. The following next steps will be undertaken to develop a prototype of the System Level Outcomes Framework dashboard:

Table two: ICS System Level Outcome Framework Development

Action	By When
Assessment of the quality of measures	April 2019
Establish an engagement plan to consistently and effectively refine the outcomes framework	April 2019
Establishment of baselines, benchmarking and trajectories	April – June 2019
Undertake further engagement with partners across the system to ensure it is fit for purpose	May – June 2019
System Level Outcomes Framework prototype dashboard	June 2019
Report back to the Board against the above steps and present the prototype	July 2019

20. The System Outcomes Task and Finish Group will continue to meet every three weeks and report into the monthly Population Health & Population Health Management Steering Group.

21. Board members are reminded that the Framework is a blueprint that will evolve and refine over time. It is recognised that the System Level Outcomes Framework is a core component of the ICS's strategy and will form a core part of the strategic planning to be undertaken by the Board in the coming months.

Recommendations

The ICS Board is asked to note and agree the following:

1. To note the progress to further refine and develop the System Level Outcomes Framework.

2. To agree the updated ambitions and outcomes – recognising the framework will continue to refine and develop over time and to provide any additional feedback.

3. To agree the proposed next steps.

Integrated Care System
Nottingham & Nottinghamshire

The Nottingham and Nottinghamshire Integrated Care System System Level Outcomes Framework

v1.1

April 2019

Version Control

Version	Modifications	By Who
V1.1	Document development based on March 2019 ICS Board paper, updated to reflect board feedback and additional comments from wider engagement	Elaine Varley

Contents

1. Introduction

The Nottingham and Nottinghamshire ICS has developed a system level outcomes framework that all partners across the system will work together to jointly deliver, in recognition that such a framework is a core component of a successful Integrated Care System.

When done well, measuring success:

- Shows that outcomes for citizens are being achieved across the system;
- Focuses plans and inform priorities through clearly articulated key performance indicators; and
- Supports organisations to work as one health and social care system to deliver impact and continually improve

Dr Nick Goodwin, CEO, International Foundation for Integrated Care

2. Purpose

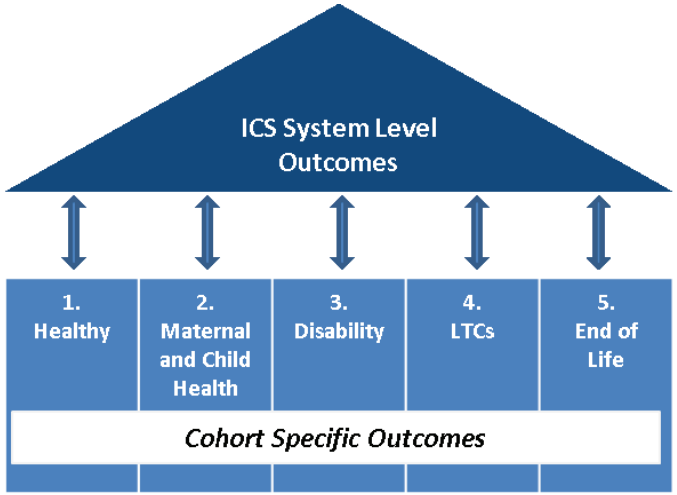
The purpose of the Nottingham and Nottinghamshire ICS System Level Outcomes Framework is to provide a clear view of our success as an Integrated Care System in improving the health, wellbeing and independence* of our residents and transforming the way the health and care system operates (quality and efficiency).

The Framework sets out the short, medium and long term outcomes the whole ICS will work together to achieve, and supports strategic planning by ensuring system improvement priorities and investment enable achievement of the outcomes. Our framework reflects a commitment that everyone should have the opportunity to make choices that support independence and wellbeing.

As our ICS continues to move away from a system based on an individual's service utilisation at a point in time to one based on delivering outcomes for segments of the population with similar needs (as being developed through the population health management workstream), the ICS System Level Outcomes Framework will also act as the 'anchor point' for shaping what the outcomes for each of the population segments should be. This is highlighted in the diagram below.

** 'Health, wellbeing and independence' reflects physical, emotional, mental and social aspects*

Figure one: Alignment between ICS System Level Outcomes and Population Segment Outcomes



The ICS System Level Outcomes Framework does not replace existing frameworks and indicator sets that will still need to be monitored and delivered e.g. the ICS System Integrated Performance Report, the CCG Improvement and Assessment Framework, Quality Outcomes Framework, Adult Social Care Outcomes Framework and Public Health Outcomes Framework. However, it is recognised that the ICS System Level Outcomes Framework development cannot be in isolation from these and the relationships and any interdependencies need to be explicit. Longer term the aim is to reduce the number of outcome frameworks used within the system, where possible, to increase focus and streamline monitoring and reporting.

3. Principles

To help guide the identification of which outcomes should be included in the ICS System Level Outcomes framework a set of principles have been developed.

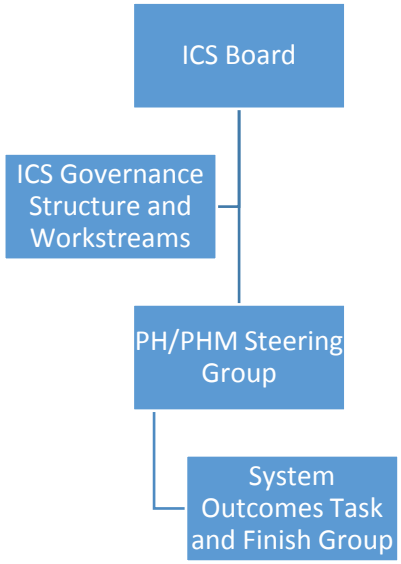
Principle The ICS System Level Outcomes Framework....	What does this mean for the Framework?
Can and will be routinely measured, and used to hold the system to account	• The quality of our measures will be assessed • Available metrics will be drawn upon where possible, without constraining transformation • The system level outcomes selected are those that the system can influence • Holding to account is within the context of demonstrating progress towards achievement (or not) of our outcomes and frequency of data reporting.
Will focus on improving the health and wellbeing for the population overall as well as reducing inequalities across the population	• Outcomes and measures are whole population (physical, mental, emotional and social) and are therefore purposefully generic • Outcomes are not designed to be population or condition / service user specific but may draw on some population or condition / service user specific measures to demonstrate progress.
Will provide a clear foundation for programmes of change to assess their impact against	• Demonstrating progress (or not) will highlight key transformation activity for areas of improvement and their impact – by proxy against the selected outcomes and measures • Recognition that there are number of outcomes frameworks system partners are working to and reporting against.
Should be based on best practice, local need and co-produced with local citizens	• The framework draws on national frameworks and best available evidence and good practice • Engagement and review with local people and partners is integral to the framework development.
Will take into account the statutory duties of the ICS's constituent organisations	• The framework is not designed to capture statutory outcomes • The framework is designed to support the achievement of statutory duties through shared working across the system.
Are not static, and may change and evolve over time	• Engagement with partners across the system is integral to the frameworks design and in turns it evolution.

Principle The ICS System Level Outcomes Framework....	What does this mean for the Framework?
Will focus on unmet need and the prevention of poor health and wellbeing as well as health and care outcomes	• The framework is all age and its design focuses on the maintenance and achievement of good health and wellbeing and keeping our population healthy from the onset for longer.
Recognises that prevention is critical to delivering a fair and affordable ICS, and is central to the achievement of the outcomes framework	• A shift towards prevention activity and interventions is essential.

4. The Outcomes Framework Design and Structure

The ICS System Level Outcomes Framework has been developed within a governance model (figure two) that enables different perspectives, expertise and experience from key partners from across the ICS to come together to design and develop the framework structure. The framework is built on good practice following a review of outcomes frameworks in existence across Nottingham and Nottinghamshire, nationally and internationally, and engagement with colleagues across the system. A small task and finish group has been established to lead the development.

Figure two: Nottingham and Nottinghamshire Outcomes Framework Design Governance Model



The Framework design is based on four core components:

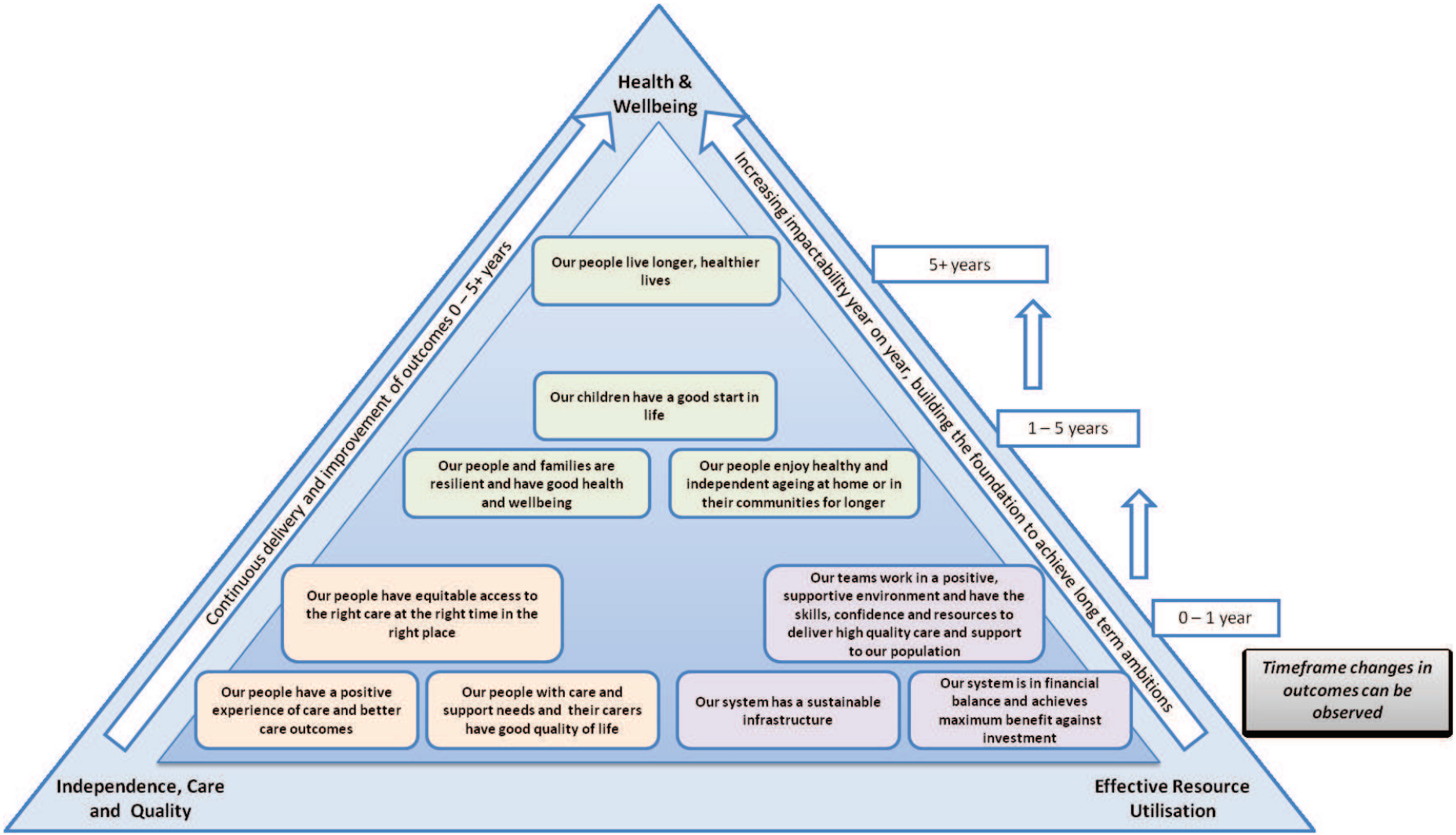
<table>
<tr><td>Domain</td><td>3 domains
High level grouping or classification based on the triple aim:

<table><tr><td>Health and Wellbeing</td><td>The impact of health and care services on the health of our population</td></tr><tr><td>Independence, care, quality</td><td>The overall quality of care and life our service users are able to have and their experiences of our health and care services</td></tr><tr><td>Effective resource utilisation</td><td>The state of our health and care infrastructure and its ability to deliver quality care and improve health and wellbeing long term</td></tr></table></td></tr>
<tr><td>Ambition</td><td>10 ambitions
High level aspiring ambitions for our Nottingham and Nottinghamshire population mapped against the 3 domains</td></tr>
<tr><td>Outcome</td><td>28 outcomes
System level outcomes and results our health and care system will aim to achieve to deliver our ambitions</td></tr>
<tr><td>Measure</td><td>Maximum of 84 measures
Indicators to demonstrate progress towards or achievement (or not) of our outcomes</td></tr>
</table>

The ICS System Level Outcomes Framework is based on the triple aim (improved health and wellbeing, transformed quality of care, and sustainable finances) and the priorities within the Health and Wellbeing Board Strategies, as described in figure three. The Health and Wellbeing Board strategies are informed by the need of our population and have undergone consultation and engagement with local health and social care stakeholders and the public.

The framework structure reflects the different timeframes over which system level outcomes relating to these ambitions can be tracked and improvements observed, and is based on the assumption that improvements in outcomes that can be measured in the short and medium term will build a strong foundation to drive achievement and deliverability of our long term ambitions.

Figure three: ICS System Level Outcomes Framework



The ICS System Level Outcomes Framework identifies a total of ten ambitions in accordance with the aims and priorities of the ICS and Health and Wellbeing Boards, against which 28 outcomes have been defined to demonstrate delivery and achievement towards these ambitions.

Health and Wellbeing

- 4 ambitions
- 12 outcomes

Independence, care and quality

- 3 ambitions
- 8 outcomes

Effective resource utilisation

- 3 ambitions
- 8 outcomes

Outcomes measurable at year 1 to 5+ years

Outcomes measurable monthly/quarterly in year 1 through to 5+ years

These outcomes will be underpinned by a small number of proxy system level measures (limited to 3 per outcome in the first instance) – identified in table one.

Table one: ICS System Level Ambitions, Outcomes and Measures

Health and Wellbeing

Ambitions	System Level Outcomes	Measures
Our people live longer, healthier lives	• Increase in life expectancy	• Life expectancy at birth (Male) • Life expectancy at birth (Female)
	• Increase in healthy life expectancy	• Healthy life expectancy at birth (Male) • Healthy life expectancy at birth (Female)
	• Increase in life expectancy at birth in lower deprivation quintiles	• Inequality in life expectancy at birth (Male) • Inequality in life expectancy at birth (Female)
Our children have a good start in life	• Reduction in infant mortality	• Stillbirth rate • Infant mortality – rate of deaths in infants aged under 1 year per 1,000 live birth
	• Increase in school readiness	• Percentage of children at or above expected level of development in all give areas of development at 2-2.5 years • Percentage of children achieving a good level of development at the end of reception
	• Reduction in smoking prevalence at time of delivery	• Smoking status at time of delivery • Smoking at booking (not currently available but expected that this will be added to PHOF during 19/20)

Ambitions	System Level Outcomes	Measures
Our people and families are resilient and have good health and wellbeing	• Reduction in illness and disease prevalence	• Smoking prevalence in adults • Admission episodes for alcohol-related conditions • Percentage of adults (aged 18+) classified as overweight or obese
	• Narrow the gap in the onset of multiple morbidities between the poorest and wealthiest sections of the population	• Smoking prevalence in adults – socio-economic gap in current smokers (APS) (not currently available but expected to be added to PHOF during 19/20) • Comorbidity rates
	• Increase the number of people who have the support to self-care and self-manage and improve their health and wellbeing	• People referred for self-management support, health coaching and similar interventions • Self-reported wellbeing (people with a low satisfaction score) • Hospital admissions as a result of self-harm (10-24 years)
Our people will enjoy healthy and independent ageing at home or in their communities for longer	• Reduction in premature mortality	• Under 75 mortality rate: all causes (Persons) • Mortality rate from causes considered preventable • Suicide rate
	• Reduction in potential years of life lost	• Potential years of life lost due to smoking related illnesses • Years of life lost due to alcohol-related conditions (Persons) • Years of life lost due to suicide

Ambitions	System Level Outcomes	Measures
	• Increase in early identification and early diagnosis	• Number of people completing an assessment tool • Number of people who benefit from community signposting/social prescribing • Diagnostics rates

Independence, care and quality

Ambitions	System Level Outcomes	Measures
Our people will have equitable access to the right care at the right time in the right place	• Reduction in avoidable and unplanned admissions to hospital and care homes	• Permanent admissions of older people (aged 65 and over) to residential and nursing care homes directly from a hospital setting per 100 admissions of older people (aged 65 and over) to residential and nursing care homes – implement Discharge planning on admittance • Identify % of avoidable unplanned admissions and increase evidence based interventions • Increase % of self-management techniques, consider the impact of socio-economic deprivation and other socio-demographic factors among people with long-term conditions
	• Increase in appropriate access to primary and community based health and care services	• Number of delayed transfers of care for medically fit patients • Proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement/ rehabilitation services • % improvement in waiting times and waiting for treatment

Ambitions	System Level Outcomes	Measures
	• Increase in the number of people being cared for in an appropriate care settings	• Permanent admissions of older people (aged 65 and over) to residential and nursing care homes • Discharge planning undertaken on admittance • % Improvement in delayed transfer of care
Our services meet the needs of our people in a positive way	• Increase in the proportion of people reporting high satisfaction with the services they receive	• The proportion of adults with learning disabilities and/or mental health needs who have been supported into paid employment • Patient Reported Outcome (PROMS)Measures • % of safeguarding service users who were satisfied that their outcomes were achieved
	• Increase in the proportion of people reporting their needs are met	• % of patients that have been identified and involved in shared decision making • Number of people who have a personal health budget • Improved systematic process for collating people's personal requirements for their care
	• Increase in the number of people that report having choice, control and dignity over their care and support	• Number of people who receive a personal health budget and people who have a personalised care and support plan • % of safeguarding service users who were satisfied that their outcomes were achieved • Carer feedback

Ambitions	System Level Outcomes	Measures
Our people with care and support needs and their carers have good quality of life	• Increase in quality of life for people with care needs	• Health related quality of life for older people • Gap in the employment rate between those with a long-term health condition and the overall employment rate • Adjusted social care quality of life – impact of social care services
	• Increase in appropriate and effective care for people who coming to an end of their lives	• % of people who have three or more emergency hospital admissions during the last 90 days of life • % of people on GP palliative care register per 100 people who died • % of people at end of life whose needs are met in accordance with their priorities and preferences about when, how and where their care is delivered

Effective Resource Utilisation

Ambitions	System Level Outcomes	Measures
Our system is in financial balance and achieves maximum benefit against investment	• Financial control total achieved	• Monthly performance against system control total • System PSF received • Underlying Financial position

Ambitions	System Level Outcomes	Measures
	• Transformation target delivered	• CIP/QIPP performance • Performance against ICS opportunities pack
Our system has a sustainable infrastructure	• Increase in the total use and appropriate utilisation of our estate	• Utilisation figures of all Acute and Community PFI and LIFT facilities i.e. Non-Clinical Space, Carter Metric and Unoccupied Floor Space • Proportion of estate that is in a poor or unusable state
	• Alignment of capital spending for new and pre-existing estate proposal with clinical and service improvement objectives	• Audit of capital planning spend against 'spending objectives'
	• Increase in collaborative data and information systems	• % of organisations providing regular data for analytics use and records available to share digitally (by organisation) • % of staff using digital records as primary record keeping method (by organisation) • % of transfers of care (by organisation)and referrals to social care from acute settings being conducted electronically
Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population	• Sustainable teams with skill mix designed around our population and mechanisms to deploy them flexibly to respond to care & support needs	• System workforce tracker: vacancies, agency reliance & turnover - monitored 6 monthly from March 2018 baseline • Teams representative of the population we serve (diversity measures, impact of widening participation measures via Talent Academy) • Availability & take up of flexible employment option

Ambitions	System Level Outcomes	Measures
	• Increase in skills, knowledge and confidence to take every opportunity to support people to self-care and take a flexible, holistic approach to people's needs with a strong focus on prevention and personalised care	• MECC & personalisation embedded in HR processes: recruitment, induction, essential learning, appraisal • Number of people trained in relevant skills & knowledge & evidence of impact from appraisal • Referrals to lifestyle & support services
	• Increase in the number of people reporting a positive and rewarding experience working and training in the Nottinghamshire health and care system	• Staff survey measures & CQC for non NHS employers: job satisfaction, access to learning & development, health, wellbeing & safety, sickness absence due to anxiety & stress • Retention of staff & trainees/students in Nottinghamshire (flow tool) • Trainee & student survey outcomes (learning environment)

For each measure in the framework baselines, benchmarking and trajectories will be identified and a dashboard developed for reporting performance. These measure will be continually reviewed for data quality and appropriateness, and iterated as appropriate.

Enc. F1

Meeting:	ICS Board
Report Title:	Memorandum of Understanding for Personalised Care Demonstrator Sites 2019/20
Date of meeting:	Thursday 11 April 2019
Agenda Item Number:	7
Work-stream SRO:	Dr Chris Packham and Alison Challenger
Report Author:	Jane North, Transformation Programme Director, Nottinghamshire County Council and Roz Howie, Associate Managing Director of Integrated Care System (ICS)
Attachments/Appendices:	Enc. F2. Memorandum of Understanding for Personalised Care Demonstrator Sites 2019/20 Appendix 1: MOU

Report Summary:

The Nottingham and Nottinghamshire ICS has a longstanding commitment to personalised care. In May 2018, the ICS agreed to seek to deliver personalised care at scale as a demonstrator site for the NHSE Comprehensive Model of Personalised Care, signing a MOU for deliverables in 2018/19. The comprehensive model establishes:

1. Whole-population approaches to supporting people of all ages and their carers to manage their physical and mental health and wellbeing, build community resilience and make informed decisions and choices when their health changes.
2. A proactive and universal offer of support to people with long-term physical and mental health conditions to build knowledge, skills and confidence and to live well with their health conditions.
3. Intensive and integrated approaches to empowering people with more complex needs to have greater choice and control over the care they receive.

The model requires six key elements to be embedded in the ICS, that is, across the NHS and the wider health and social care system. These include:

- Shared decision making
- Personalised care and support planning
- Enabling choice, including legal rights to choice
- Social prescribing and community-based support
- Supported self-management
- Personal health budgets and integrated personal budgets

Purpose of the report

1. Provide an update on progress against the 2018/19 Memorandum of Understanding (MOU) with NHS England (NHSE) and Nottinghamshire Integrated Care System on Universal Personalised Care
2. Set out the requirements for Personalised Care Demonstrator Sites in 2019/20 and request the ICS Board agree a further one-year MOU with NHSE as an advanced Personalised Care Demonstrator site. This will require:
    a. a commitment by different levels of the system, including Integrated Care System (ICS), Integrated Care Providers (ICPs) and Primary Care Networks (PCN).
    b. a jointly developed and delivered universal personalised plan between Integrated Care System (ICS), Integrated Care Providers (ICPs) and Primary Care Networks (PCN).
3. Consider future funding beyond 2020 for resources to deliver on the personalised care commitments made in the NHS Long Term Plan.

Action:

☐ To note
☐ To agree
☒ To agree the recommendation/s (see details below)

Recommendations:

1.	Consider progress against the 2018/19 Memorandum of Understanding (MOU) with NHS England (NHSE) and Nottinghamshire Integrated Care System
2.	Agree a further one-year MOU with NHSE as an advanced Personalised Care Demonstrator site for 2019/20
3.	Support the commitments as set out in paragraph 5.3 – 5.15 to deliver on the 2019/20 MOU and make good progress against the 21 requirements for personalisation, as set out in the NHS Long Term Plan (Universal Personalised Care: Implementing the Comprehensive Model[1])
4.	Jointly develop a plan between the ICS, ICPs and PCNs for 2019/20 on universal personalised care and support a resource plan on future funding to deliver our commitments under the NHS Long Term Plan

Key implications considered in the report:

Financial	☐	
Value for Money	☐	
Risk	☐	
Legal	☐	

[1] https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/

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	Greater Nottingham ICP	-
☐	☐	☐	☐	☐

Contribution to delivering the ICS:

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.

Memorandum of Understanding for Personalised Care Demonstrator Sites 2019/20

11 April 2019

Purpose of the report

1. Provide an update on progress against the 2018/19 Memorandum of Understanding (MOU) with NHS England (NHSE) and Nottinghamshire Integrated Care System on Universal Personalised Care
2. Set out the requirements for Personalised Care Demonstrator Sites in 2019/20 and request the ICS Board agree a further one-year MOU with NHSE as an advanced Personalised Care Demonstrator site this will require:
    a. a commitment by different levels of the system, including Integrated Care System (ICS), Integrated Care Providers (ICPs) and Primary Care Networks (PCN)
    b. a jointly developed and delivered universal personalised plan between Integrated Care System (ICS), Integrated Care Providers (ICPs) and Primary Care Networks (PCN)
3. Consider future funding beyond 2020 for resources to deliver on the NHS Long Term plan

Background

What is personalised care?

4. The Nottingham and Nottinghamshire ICS has a longstanding commitment to personalised care. In May 2018, the ICS agreed to deliver this at scale as a demonstrator site for the NHSE Comprehensive Model of Personalised Care, signing a MOU for deliverables in 2018/19. The comprehensive model establishes:

- Whole-population approaches to supporting people of all ages and their carers to manage their physical and mental health and wellbeing, build community resilience and make informed decisions and choices when their health changes
- A proactive and universal offer of support to people with long-term physical and mental health conditions to build knowledge, skills and confidence and to live well with their health conditions
- Intensive and integrated approaches to empowering people with more complex needs to have greater choice and control over the care they receive

5. The model requires six key elements to be embedded in the ICS, that is, across the NHS and the wider health and social care system. These include:

   - Shared decision making
   - Personalised care and support planning
   - Enabling choice, including legal rights to choice
   - Social prescribing and community-based support
   - Supported self-management
   - Personal health budgets and integrated personal budgets

6. There is an ICS overarching portfolio of work, 'Prevention, Person and Community Centred Approaches,' and this is responsible for the coordinated delivery of the NHSE Model for Personalised Care.

7. In addition, the programme is one of three sites (alongside Gloucestershire and Lincolnshire) to pilot taking a proactive and joined-up approach to health and social care, including:
   - Assessments for people with health and social care needs
   - Personalised care and support planning for health and social care outcomes
   - Offering of more integrated personal budgets for health and social care funding (where beneficial)

National context

8. Personalised care is one of the five major, practical changes to the NHS that will take place over the next five years, as set out in Chapter One of the NHS Long Term Plan[2]

9. Universal Personalised Care: Implementing the Comprehensive Model[3] (UPC) sets out how we will do this by 2023/24. It is the delivery plan for personalised care across England, introducing the Comprehensive Model for Personalised Care and the standard models for the six elements (see paragraph 2.2). This work follows several years of evidence-based research and local approaches, working with people with lived experience, community groups and a wide range of stakeholders

10. UPC sets out 21 actions to be delivered with partners from across national and local government, and organisations from across health, care, voluntary and community-

[2] www.longtermplan.nhs.uk
[3] https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/

based sectors including clinicians, professionals and people with lived experience. These actions build on progress made in areas, such as Nottinghamshire.

11. The key commitments and actions by 2023/24 are:

- That we deliver universal implementation of the Comprehensive Model for Personalised Care[4] across England, which fully embeds the six standard elements
- Personalised Care will benefit up to 2.5 million people, ensuring they have the same choice and control over their mental and physical health that they have come to expect in every other aspect of their life
- Shared Decision Making will be embedded in 30 high value clinical situations in primary care, secondary care and at the primary/secondary care interface where it will have the greatest impact on experience, outcomes and cost
- Over 1,000 trained social prescribing link workers will be in place by 2020/21 rising further by 2023/24, with the aim that over 900,000 people are able to be referred to social prescribing schemes by then. Social prescribing link workers connect people to wider community support which that can help improve their health and well-being and to engage and deal with some of their underlying causes of ill health
- 200,000 people will have a personal health budget, so they can control their own care, improve their health experiences and experience better value for money services
- 750,000 people will have a personalised care and support plan, including people with long term health conditions, people at the end of life, and pregnant women
- 75,000 clinicians and professionals will be enabled to develop their skills and behaviours through practical support to use personalised care approaches in their day-to-day practice

Local context

12. In order to achieve the scale committed to in the NHS Long Term Plan, Demonstrator sites are required to build on the good work that has come before and demonstrate how Personalised Care can be delivered at scale across Nottinghamshire.

13. Locally, overall the ICS has over achieved against the 18/19 MOU targets see figure 1. The target for personal health budget is projected to be slightly below target, but action is being taken to mitigate this. To date, however, the approach to Personalised Care has been largely opportunistic in health settings and builds upon pilot activity in pockets of the ICS geography.

[4] https://www.england.nhs.uk/personalisedcare/comprehensive-model-of-personalised-care/

Figure 1: MOU targets and progress

Measure	Basis of counting	Total MOU required activity 2018-19	Q3 performance	Target status
Patient activation measure (or equivalent)	People completing the Patient Activation Measure OR an equivalent tool	10,840	15,638	44% above target
Self-management	People referred for self-management support, health coaching and similar interventions			
Community –based support	People referred for social prescribing community groups, peer support and similar activities			
Personalised care and support plans	Number of plans or reviews	10,840	12,497	15% above target
Personal health budgets	Number of people with a personal health budget	2,060	1696	Projected year end figure is 1,926, but steps being taken to meet target

14. In Nottinghamshire Personal Health Budgets have, on average, reduced the direct care costs for NHS Continuing Healthcare by 17% whilst maintaining or improving outcomes for people. Where people have higher levels of need, personal health budgets are associated with a £3,100 total cost saving per person per year.

MOU for 19/20

15. The twin challenge for Personalised Care in 19/20 is: to achieve scale and pace and embed the approach within our core business and strategic planning.

16. To achieve this, NHSE has set out a series of expectations in the 19/20 MOU. See appendix 1 for draft MOU and figure 2 below sets out the targets. The funding attached to the delivery of the requirements is £225k for the universal personalised care. There is a further £100k ring-fenced for the delivery of the joined-up approaches to assessment and support planning, as set out in paragraph 2.4.

Figure 2: MOU targets for 2019/20

Measure	Basis of counting	How collected	2019/20 target
A. Patient activation measure (or equivalent)	People completing the Patient Activation Measure	NHSE PAM team	1615
B. Self-management	People referred for self-management support, health coaching and similar interventions	NHSE activity data collection	15,000
C. Community – based support	People referred for social prescribing community groups, peer support and similar activities.	NHSE activity data collection	15,000
D. Personalised care and support plans (total)	Number of plans or reviews	NHSE activity data collection	19,580
D.2 Personalised care and support plans (excl those from PHBs)	Number of plans or reviews	NHSE activity data collection	16,680
E. Personal health budgets	Number of people with a personal health budget (includes integrated personal budgets)	NHS Digital collection	2,900
			Total: 51,195

17. The expectations are summarised under the following themes:
    - Leadership, planning and governance
    - Achieving scale and spread
    - Finance, contracting and commissioning

18. Below are the key features to draw the ICS leadership attention to:

Leadership, Planning and governance

19. Embed Personalised Care into the local Five-Year Plan due to be submitted to NHS England in the autumn.
20. The Local Five-Year Plan must be underpinned by a plan at ICP level that articulates a clear vision and actions to be taken, including at Primary Care Network level.
21. Embed Personalised Care across the whole of Nottinghamshire ICS, Integrated Care Providers (ICPs) and Primary Care Networks (PCNs), building on the local Population Health Management and integrated care approaches.
22. Ensure named leads for personalised care within the ICS and ICPs are identified.

23. Identify named leads for delivering for strategic co-production, workforce, digital and finance, commissioning, and contracting requirements.

24. Ensure clarity about the roles of ICS, ICPs and PCNs. The table below sets out a proposal outlining the commitments at different levels across the system:

Figure 3: Proposed responsibility at different levels of the system

Component	Personalised Care
ICS	• Defining health and care outcomes to be delivered • Defining care model principles, frameworks and core components of care; • Ensuring consistency in approach that allows for some flexibility in implementation. • Leading transformational and cultural change, including identifying new cohorts of people, and addressing finance and commissioning issues • Strategic planning and monitoring performance of the ICS against NHSE MOU targets and progression towards meeting the 21 requirements in the NHS Plan • Reporting back to NHSE, including quarterly 'sustainability assessments'
ICP	• Implementation of personalisation • Allocation of resources to deliver personalised care within the ICP based on local data and population need • Performance monitoring and management of personalised care outcomes and performance delivery at ICP level • Accountable for delivery of personalised care outcomes and performance levels/measures agreed with commissioner
PCN	• Provide local intelligence and input to implementation of personalised care • Operationalise and deliver agreed model day to day • Leading a multi-disciplinary team approach • Feedback to ICP on how the model is working • Community development

25. Link workers: Under the NHSE plan to implement universal personalised care, NHSE has committed to an extra 1,000 link workers by April 2021 as part of plans to personalise care. The funding for the link workers will be given to primary care networks (PCNs), within which the link workers will be based. There is a NHSE requirement under the MOU to 'bring local partners together at a placed-based level in Q1 to develop shared local social prescribing plans for 19/20.' These plans should include:
    - How additional link workers will be recruited locally, using the new national Primary Care Network Direct Enhanced Service link worker funding and

embedded in every local Primary Care Network multi-disciplinary team across the ICS.

- How Primary Care Networks will be supported to use the Systematised Nomenclature of Medicine -- Clinical Terms (SNOMED) codes and implement the Common Outcomes Framework for measuring the impact of social prescribing on people and community groups.
- How the VCSE sector will be supported to receive social prescribing referrals and how local community assets will be nurtured.

26. Therefore, it is imperative that there is an ICP led discussion to agree local social prescribing and community signposting plans, as part of the development of the PCNs.

27. Resources: a significant amount of the resources to run this programme of work are currently funded for centrally by NHSE from the delivery of the MOU. This source of funding from NHSE is being tapered down on the basis universal personalisation is embedded in business as usual in the ICPs from 2019/20. The Strategic Commissioner will need to develop a resource and sustainability plan for 2020 with the identified leads from the ICPs.

Figure 3: Roles and funding sources

Roles	Costs	Funding Source
8b post	73K	CCG
3xB7 (1 per ICP)	144K	MOU
1 x B8a PHBs	60K	CCG
1 x B6	41K	CCG
2x band 4	70K	MOU
1 B7 Integrated Pilot	48K	MOU
Workforce Role B7	48 K	HEE plus MOU
Total	484K	

Achieving scale and pace

28. Challenging targets have been set for Nottinghamshire based on good performance to date and to reflect national ambitions as set out in the NHS Long Term Plan. We will need to show that the geographical spread of personalised care within their site is expanding in 19/20 and that the model is being used to improve outcomes for new cohorts and services where this makes sense locally. A crucial vehicle for spread of Personalised Care will be Primary Care Networks.

29. Following negotiations between NHSE and the ICS Directors about challenging but achievable targets, there is an expectation ICS activity will increase by over 50% in 2019/20 (based on projections of performance for year-end).

Finance, contracting and commissioning

30. To achieve the necessary scale and pace, Personalised Care needs to be embedded within all service specifications as part of contracting and commissioning. To date, targets on Personal Health Budgets have been largely been met through using people's budget where a package or individual funding stream exists. There are expectations that the right to a Personal Health Budget is extended to other cohorts and earlier this year the legal right to a Personal Health Budget was extended to wheelchair users.

31. The MOU expects all service specifications for community contracts to include the requirements to deliver Personalised Care, aligned with the requirements in the 2019/20 NHS Standard Contract. Further it is expected that commissioning plans include approaches to capitation and the percentage of contract value or population to be released for expansion of Personal Health Budgets. Good practice would see Demonstrators expanding their Direct Payment PHB offer to a cohort or service area previously tied up in block contract arrangements, ensuring sustainable contractual arrangements to underpin the releasing of the resource.

Recommendations

32. The Board are asked to approve and note the following:
    a. Consider progress against the 2018/19 Memorandum of Understanding (MOU) with NHS England (NHSE) and Nottinghamshire Integrated Care System
    b. Agree a further one-year MOU with NHSE as an advanced Personalised Care Demonstrator site for 2019/20
    c. Support the commitments as set out in paragraphs 17-31 to deliver on the 2019/20 MOU and make good progress against the 21 requirements for personalisation, as set out in the NHS Long Term Plan (Universal Personalised Care: Implementing the Comprehensive Model[5])
    d. Jointly develop a plan between the ICS, ICP and PCNs for 2019/20 on universal personalised care and support a resource plan on future funding to deliver our commitments under the NHS Long Term Plan

[5] https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/

Memorandum of Understanding for Personalised Care Demonstrator Sites

Between

NHS England

And

Nottinghamshire Integrated Care System

This Memorandum of Understanding (MOU) sets the terms and understanding between the following parties:

National Health Service Commissioning Board (NHS CB), operating under the name of NHS England

And Nottinghamshire Integrated Care System (ICS)

This Memorandum of Understanding covers the period 1 April 2019 – 31 March 2020

Background

Personalised care is one of the five major, practical changes to the NHS that will take place over the next five years, as set out in Chapter One of the NHS Long Term Plan[1]. Universal Personalised Care: Implementing the Comprehensive Model[2] (UPC) sets out how we will do this by 2023/24. It is the delivery plan for personalised care across England, introducing the Comprehensive Model for Personalised Care and the standard models for the six, evidence-based, interlinked components, together with four enablers. This work follows several years of evidence-based research and local approaches, working with people with lived experience, community groups and a wide range of stakeholders.

UPC sets out 21 actions to be delivered with partners from across national and local government, and organisations from across health, care, voluntary and community-based sectors including clinicians, professionals and people with lived experience. These actions built on progress made in areas already delivering the Comprehensive Model for Personalised Care and include introducing quality standards and building on metrics to demonstrate impact; developing workforce skills and working with Royal Colleges to update their curricula.

[1] www.longtermplan.nhs.uk

[2] https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/

The key commitments and actions by 2023/24 are:

1. That we deliver universal implementation of the Comprehensive Model for Personalised Care[3] across England, which fully embeds the six standard components - shared decision making; personalised care and support planning; enabling choice; social prescribing and community based support; supported self-management; and personal health budgets and integrated personal budgets - across the NHS and the wider health and care system. This includes demonstrating early, full delivery of the Comprehensive Model and its enablers across a number of Integrated Care Systems (ICSs) and Sustainability and Transformation Partnerships (STPs) (action 2 of UPC).

2. Personalised Care will benefit up to 2.5 million people, ensuring they have the same choice and control over their mental and physical health that they have come to expect in every other aspect of their life;

3. Shared Decision Making will be embedded in 30 high value clinical situations in primary care, secondary care and at the primary/secondary care interface where it will have the greatest impact on experience, outcomes and cost.

4. Over 1,000 trained social prescribing link workers will be in place by 2020/21 rising further by 2023/24, with the aim that over 900,000 people are able to be referred to social prescribing schemes by then. Social prescribing link workers connect people to wider community support which that can help improve their health and well-being and to engage and deal with some of their underlying causes of ill health.

5. 200,000 people will have a personal health budget so they can control their own care, improve their health experiences and experience better value for money services;

6. 750,000 people will have a personalised care and support plan, including people with long term health conditions, people at the end of life, and pregnant women;

7. 75,000 clinicians and professionals will be enabled to develop their skills and behaviours through practical support to use personalised care approaches in their day-to-day practice

Purpose

[3] https://www.england.nhs.uk/personalisedcare/comprehensive-model-of-personalised-care/

In order to achieve the scale committed in the Long Term Plan, Demonstrator sites are required to build on the good work that has come before and demonstrate how Personalised Care can be delivered at scale across Nottinghamshire ICS geographies including Primary Care Networks and Health and Wellbeing board areas. This will show how the model brings the six components of Personalised Care together and will demonstrate how the model:

- improves people's health and wellbeing, joins up care in local communities, reduces pressure on the health and care system and drives efficiency;

- helps people with multiple physical and mental health conditions make decisions about managing their health, so they can live the life they want to live based on what matters to them, as well as the evidence-based, good quality information from the health and care professionals who support them;

- recognises that, for many people, their needs arise from circumstances beyond the purely medical, and will support them to connect to the care and support options available in their communities.

This Memorandum of Understanding sets out the expectations and deliverables for sites and roles and responsibilities of all parties to work together to continue to scale and spread Personalised Care within Demonstrator sites and beyond, in order to realise the ambitious commitments described above.

Responsibilities

All Personalised Care Demonstrator Sites will make a commitment to implement and evaluate the Comprehensive Model for Personalised Care at scale as a core business embedded in, and aligned to other local strategic plans.

General conditions on Demonstrator Sites

Personalised care is a system leadership and integration model and so participating in the programme comes with expectation that each site will:

1. **Leadership, Planning and governance**

- Commit to embedding Personalised Care into the local Five-Year Plan due to be submitted to NHS England in the Autumn. This must include or be underpinned by a plan that articulates a clear vision and actions to be taken at neighbourhood, place and system level to ensure Personalised Care is embedded across the ICS to include enablers – Strategic Coproduction, workforce, digital and finance and commissioning/contracting requirements.
- Fully implement & spread the whole Comprehensive Model for Personalised Care across the whole of Nottinghamshire ICS, complementing and building on

the local Population Health Management/integrated care approach as well as the sustainability and expansion plans developed by the site in 2018/19

- Ensure there is cross system (i.e. NHS, Local Authority, VCSE, and people with lived experience) leadership for personalised care, through named Senior Responsible Officers (SROs) – both clinical and commissioning, who will sponsor and drive the work locally.
- Ensure sufficient Programme Management capacity to deliver Personalised Care as described herein in addition to identifying named leads already embedded in the system who are responsible for delivering/enabling Strategic Coproduction, workforce, digital and finance, commissioning and contracting requirements and evidence/evaluation.
- Ensure clear governance for Personalised Care, including senior sponsorship for the work across the ICS and including people with lived experience.

- Central to the delivery of the Long Term Plan is the continued development of Integrated Care Systems. They are a practical way to deliver on the "triple integration of primary and specialist care, physical and mental health services, and health with social care". The demonstrator programme for 2019/20 will focus on integrated system change with the Integration Accelerator Pilot sites identifying what is needed to join up around health and social care assessments. As integration is fundamental to the Long Term Plan, it is expected that all demonstrators will add to the integration narrative, including highlighting local examples of integrated approaches to assessment, planning and personal budgets to embed Personalised Care.

2. Engaging with the NHSE programme

- Work with their NHS England Personalised Care Team to complete the Personalised Care self-assessment for each 'place' within the ICS/STP, develop delivery plans, review progress and identify support needs, and engage with support requested and made available as a result of this. This is to include regular communication with site programme managers, and SROs as set out below.
- Share their learning with NHS England, other demonstrators and wider systems through:
    - participating in the 'National Personalised Care Collaborative', which will meet approximately five times a year;
    - participating in programme manager meetings;
    - contributing to an online network;
    - Promoting the work they are undertaking, through:
        - One 800 word blog to engage new people to personalised care and reach to the parts demonstrator programmes cannot reach.

        - One hour long webinar showcasing the work of the area;
        - Three examples of practice which could be a link to a video, a document that helps others to implement a component/enabler, a personal story, some raw material entered onto a case study template.
    - In addition to the requirement to embed the whole Personalised Care Model across the whole ICS, Demonstrators are required to facilitate geographical spread of Personalised Care through mentorship of non-demonstrator sites. This includes supporting national and regional collaboratives and offering bespoke support to non-demonstrators on elements of the model and leadership for change on a national and regional basis – this may be through webinars, sharing documents and resources or through direct conversations with other areas.
    - Where implementing the model for new groups such as carers or exploring different enablers such as utilising the Better Care Fund to implement Personalised Care, share this information and learning with NHS England to further inform policy development and national roll-out.
    - Support national work to understand the impact on health inequalities through sharing stories and case studies that demonstrate how this can be done

- Promote attendance of relevant senior people from across the system at Finance, Commissioning and Contracting Regional Networks, the Royal College of General Practitioner's Person Centred Approaches Network of Champions, PHB regional networks, Social Prescribing regional networks, and any other relevant Communities of Practice that are identified as facilitating development and transformation in relation to embedding Personalised Care.

3. Understanding progress

- Provide quarterly reporting against key activity projections (see Schedule 3). Engage in quarterly 'structured conversations' with the Personalised Care team, to understand local progress with implementing personalised care and adjust support arrangements accordingly.

Deliverables by end of March 2020:

Achieving scale: All Personalised Care Demonstrators will agree levels of activity for people experiencing personalised care which reflect local and national ambitions for the programme. For Nottinghamshire ICS this has been agreed at:

- 6% of population to experience Personalised Care by March 2020 – see Schedule 3 for breakdown of numbers by component

- Nottinghamshire ICS must meet their IAF trajectories for the year in relation to Personal Health Budgets as a minimum. However, we would like to see sites who are able, working to exceed IAF trajectories and engaging with national support to do so.

The component specific deliverables to achieve scale are that sites must:

- Complete the Shared Decision Making Self-Assessment Checklist in one or more of the 30 high priority clinical situations and deliver actions in one or more of the four key Shared Decision Making foundations based on a quality improvement plan;

- Achieve 100% Compliance with all 9 Choice Standards using the Quality Assurance Framework developed by the National Choice Team;

- Ensure consistent delivery of supported self-management programmes that seek to increase the knowledge, skills and confidence of people to better self manage their long term conditions including health coaching, self-management education and peer support;

- Agree a CCG/NHS Provider/Local Authority site within the Demonstrator to be the lead site for ICS that can deliver additional PAM licences via partnership agreements;

- Bring local partners together at a placed-based level in Q1 to develop shared local social prescribing plans for 19/20. These plans should include:

    - How additional link workers will be recruited locally, using the new national Primary Care Network Direct Enhanced Service link worker funding and embedded in every local Primary Care Network multi-disciplinary team across the /STPICS.
    - How Primary Care Networks will be supported to use the SNOMED social prescribing codes and implement the Common Outcomes Framework for measuring the impact of social prescribing on people and community groups.
    - How the VCSE sector will be supported to receive social prescribing referrals and how local community assets will be nurtured.

- Build sufficient and sustainable capacity locally to deliver Personalised Care and Support Plans in line with trajectories in Schedule 3 for this year and to increase this number in subsequent years. Capacity must be suitably trained and

resourced to ensure that Personalised Care and Support Plans meet the NHS England Key Features.

- In relation to Personal Health Budgets, deliver the following:
    - At least 85% of CHC home care packages in a local area are delivered through a PHB
    - Development and implementation of a Personal Wheelchair Budget offer.
    - Aim to ensure that by March 2020 PHB/Integrated Personal Budgets are available to at least four groups (to include s.117 eligible patients) by each CCG, moving to a position where no single group make up more than 50% of all PHB/IPB recipients in a local area
    - Aim to ensure that at least 40% of PHBs in a local area are managed as a direct payment or third-party budget (note that this excludes personal wheelchair budgets). This is good practice to ensure a mix of approaches in a local area but all individuals still have the choice to manage the money as a notional, third party or direct payment.

Achieving 'spread': Demonstrators will need to show that the geographical spread of personalised care within their site is expanding in 19/20 and that the model is being used to improve outcomes for new groups of people and services where this makes sense locally. A crucial vehicle for spread of Personalised Care will be Primary Care Networks. Spread of Personalised Care beyond demonstrators will also be supported through the shared learning ask of sites above to promote the work but also in particular the mentorship requirements detailed above.

Demonstrating impact: All Personalised Care Demonstrators will actively engage with all reporting and evaluation activity associated with the programme, providing robust and timely information on outcomes, user experience, costs etc in order to continue to develop the local and national business case/evidence base. This will include:

- reporting activity as agreed towards the Personalised Care minimum dataset
- use of the social prescribing common outcomes framework
- supporting national work to build the financial business case for personalised care by engaging as above with information but also by developing local datasets based on national templates on service use for people taking up personalised care (initially in secondary healthcare).
- sharing case studies which show the impact of personalised care for people and for the system, including standardised content and utilising templates provided by the programme

[INSERT FOR ACCELERATOR SITES Integration Accelerator Pilot sites are asked to meet the following targets (see annex for more detail):

Sustainability planning: There are some key sustainability deliverables that relate to enablers to the Personalised Care model, namely that each site must**:**

Strategic Coproduction:

- Actively promote the NHS England Peer Leadership Academy and online equivalent or any other Personalised Care development programme that the Personalised Care Group may develop.

- Ensure sustainable approach to supporting people with Lived Experience to increase their knowledge, skills and confidence to contribute in equal partnership with the system.

Workforce:

- Ensure that training, development and support for the workforce to deliver Personalised Care across the six components of the Personalised Care model are included in the ICS Workforce/Organisational Development Strategy.

- Engage with workforce work taken forward by the Personalised Care Group to facilitate spread and scale of the model locally and nationally

Digital:

- Understand digital requirements for Personalised Care and ensure these are included in local and strategic digital developments.

Finance, Commissioning and Contracting:

- Commit to ensuring that 100% of service specifications for community contracts include the requirements to deliver Personalised Care, aligned with the requirements in the 2019/20 NHS Standard Contract.

- In relation to the above requirement to commit to Personalised Care explicitly in the Five Year Strategic Plan for the ICS submitted in the Autumn, ensuring that operational plans that underpin this commitment take account of commissioning/contractual implications including approaches to capitation and the percentage of contract value or population to be released for expansion of the PHB offer in line with local priorities.

- Good practice would see Demonstrators expanding their Direct Payment PHB offer to a group or service area previously tied up in block contract arrangements, ensuring sustainable contractual arrangements to underpin the releasing of the resource (sites should identify the amount of resource to release that meets locally identified needs).

- Actively explore with NHS England the opportunity to identify money within the system and through Long Term Plan financial planning that can be invested in Personalised Care to demonstrate ongoing commitment to the model beyond the Demonstrator Programme and to facilitate sustainability going forward.

- Work collaboratively with the local voluntary and community sector and other relevant partners including the wider public sector to develop finance contracting and commissioning approaches that support sustainable models of delivery and scaling of innovative provision by the local voluntary and community sector to ensure a broad range of community-based approaches is available to their population.

- Contribute to development of a personalised care dashboard as per Action 19 in UPC

Responsibilities of NHS England

The NHS England delivery programme will support sites in the following way,:

- a Personalised Care Site Lead who will be the main person supporting sites to deliver their objectives. They will ensure good communication between the national programme and the site, and access to timely and effective support. They will be responsible for supporting sites to review progress, providing direct support and coordinating input from the 'team around the site'.
- a 'team around the site' – a coordinated approach bringing relevant expertise from areas of work across PCG to support Nottinghamshire ICS. This will include access to support from Shared Decision Making, Finance, Commissioning and Contracting, Information Governance, Lived Experience, PHBs, Supported Self-Management, Personalised Care and Support Planning, Social Prescribing and Choice.
- access to the 'National Personalised Care Collaborative' which will meet five times a year and will build confidence and capability to lead large scale change.
- access to programme manager calls, workshops, webinars, events and action learning opportunities, and the offer of in-site workshops
- bespoke local support on priorities identified between the site and Site Lead, including from a range of national voluntary partners and suppliers.
- access to an online network to share good practice, hear about events and discuss emerging issues with colleagues from across the programme
- support for the local area to connect into national and regional system leaders and policy working groups to escalate key issues.

NHS England will agree a personal support plan with individual sites.

£225,000 will be made available from NHS England in 2019/20 to support this work.

This will be spent as follows:

What	Amount
Programme management costs	

VCSE organisation engagement	
Co-production with people with lived experience and families	
Finance and analytical support	
Evaluation support (including comparison groups)	
Investment in development of personalised care approaches (choice, shared decision making, social prescribing, supported self-management, health coaching and peer support, personalised care and support planning and personal health budgets and integrated personal budgets) in line with this MOU	
Staff training and development	
IT	
Travel, expenses, overheads	
Total	

Each site will agree arrangements for payment of the support funding with NHS England. In line with normal practice, funding will be supplied at point of need, specifically in regular payments through the year rather than as a one-off lump sum. It is proposed that this is as two payments, 70 per cent on the signing of the MOU, and 30 per cent in October 2019, subject to delivery of the deliverables listed above. It is proposed that Nottinghamshire ICS payment is made Nottingham City CCG and NHS England will set up a purchase order to enable this, and inform the site of the reference number so they can invoice as agreed.

Governance and reporting

National governance for the programme will be through the Personalised Care Advisory Board, which will oversee the governance of Personalised Care Demonstrator Sites and Integration Accelerator sites. Operational management of the programme will be overseen by the NHSE Personalised Care Group's Senior Management Team. The Personalised Care Programme Board will be co-chaired by NHSE and the LGA. It will receive a quarterly report on progress in the sites.

Intellectual property

Any materials developed as part of this project and information gathered will remain the property of NHS England. Apart from published personal stories where consent has been obtained, any confidential and sensitive information will be made anonymous.

Legal basis of this MOU and liability

This MOU is not intended to be contractually binding in a court of law or to give rise to any other legally enforceable rights or obligations, nor does this document constitute an offer to purchase or to supply services or goods on the terms set out in this document or at all.

No Party shall be deemed to be an agent of any other Party and no Party shall hold itself out as having authority or power to bind any other Party in any way.

Neither Party shall have any liability to the other Party for any redundancy costs arising either from delivery of the services or by the termination of the MOU, whether by the passage of time or any earlier termination.

Duration, variation and termination

There will be 'gateway' points in the programme when Demonstrator sites' ongoing participation in the programme will be reconfirmed and the MOU refreshed through the change control procedure following this to cover the next period in more detail. These gateway points will be:

- October 2019 – following review of Quarter 2 data and progress toward trajectories and following submission of Five Year Plan to NHS England, to include the vision and plan to embed the whole Personalised Care model across the whole system

The decisions above will be made by the Personalised Care Advisory Board following recommendations from PCG Delivery Leads. This MOU may be terminated early by the Demonstrator Site's Programme Board making a decision to leave the national programme, upon return of any appropriate programme management funds as agreed between the parties.

This MOU may be modified in accordance with the change control procedure detailed in the Appendix, schedule 2 by mutual consent by authorised officials from the NHSE Personalised Care Group and those of the Demonstrator site listed in Schedule 1.

If, during the course of 2019/20, separate MoUs are agreed between NHS England and Nottinghamshire ICS or individual CCGs within it, in relation to the personalised care programme, those MoUs will be added as annexes to this agreement, to facilitate coordination of all related activities in the locality.

This MOU shall become effective upon signature by the authorised officials from NHS England, and the Demonstrator site, and will remain in effect until modified or terminated by either the Personalised Care national programme or the Demonstrator Site, as agreed at either's Programme Board. For NHSE this is the Personalised Care Programme Board. In the absence of termination by the authorised Programme Boards this MOU shall end on 31/03/20.

Signed for and on behalf of

Name and Title:	
Signature:	
Date:	

Signed for and on behalf of

Name and Title:	
Signature:	
Date:	

Signed for and on behalf of

Name and Title:	
Signature:	
Date:	

Signed for and on behalf of

Name and Title:	
Signature:	
Date:	

Schedule 1

Nominated representatives

NHS England: James Sanderson (Director of Personalised Care NHS England)

_____ CCG: [Please insert name of lead CCG and nominated representative here]
_____ Local Authority: [Please insert name of LA and nominated representative here]

Schedule 2, see page 11 of main body of MOU

Change Control Procedure

[insert]

MoU Change Note (MCN)

Sequential Number	[insert]
Title	[insert]
Originator	[insert]
Date change first proposed	[insert]
Number of pages	[insert]

Reason for proposed change

{Please insert, using examples below:
- Continuation of the duration of the MoU term, from _____ to _____},

{- changes to pricing as follows: _____}

Full details of proposed change

{Please insert full details of the proposed change}

Details of likely impact, if any, of proposed change on other aspects of the MoU

{Please insert details or "None"}.

Date of Proposed Change

[insert]
Save as herein amended, all other terms and conditions of the MOU inclusive of any previous CCNs shall remain in full force and effect.

Signed for and on behalf of [insert]:

Name and Title:	
Signature:	
Date:	

Signed for and on behalf of [insert]:

Name and Title:	
Signature:	
Date:	

Signed for and on behalf of [insert]:

Name and Title:	
Signature:	
Date:	

Signed for and on behalf of [insert]:

Name and Title:	
Signature:	
Date:	

MOU schedule 3

You have agreed the following projections for the number of people that you expect to take part in your programme in 2019/20. You have agreed to provide activity data to enable progress against these projections to be monitored.

2019/20 PC total	51,195	2019/20 % Pop	4.9%

Measure	Basis of counting	How collected	2019/20 target
A. Patient activation measure (or equivalent)	People completing the Patient Activation Measure	NHSE PAM team	1615
B. Self-management	People referred for self-management support, health coaching and similar interventions	NHSE activity data collection	15000
C. Community – based support	People referred for social prescribing community groups, peer support and similar activities.	NHSE activity data collection	15000
D. Personalised care and support plans (total)	Number of plans or reviews	NHSE activity data collection	19580
D.2 Personalised care and support plans (excl those from PHBs)	Number of plans or reviews	NHSE activity data collection	16,680
E. Personal health budgets	Number of people with a personal health budget (includes integrated personal budgets)	NHS Digital collection	2,900

ENC G

Meeting:	ICS Board
Report Title:	Process for submission of the ICS Estates Strategy
Date of meeting:	11 April 2019
Agenda Item Number:	8
Work-stream SRO:	Simon Crowther
Report Author:	Mike Simpson and Marcus Pratt
Attachments/Appendices:	None

Report Summary:

The report provides the ICS Board with an update on the national estates strategy and capital prioritisation process as per the following timetable.

1. 1st April 2019 to the 28th June 2019 – Pull together the estates and supporting capital planning response to feedback received – Regulators will be providing a template for completion.
2. July 2019 - NHSE/I light touch assessment of June submission and further feedback to inform the autumn response.
3. Autumn 2019 – submission of estates strategy and prioritised capital plans (pending national agreement of available capital funds) alongside long-term plan.

The Nottinghamshire ICS estates strategy has been assessed as **Improving**. Feedback has been received which is being reviewed.

A task and finish group with key individuals from the ICS team and partner organisations will be put in place reporting into the ICS Planning group. This group will address the feedback and refine the estates strategy accordingly.

For the purposes of the initial submission in June 2019, the ICS Board is asked to delegate responsibility to ICS Planning Group.

The final estates strategy will be received by the ICS Board as part of the five-year plan 2019-24.

Action:

☒ To note
☒ To agree
☒ To agree the recommendation/s (see details below)

Recommendations:

1.	The ICS Board is asked to NOTE the update on the national process for responding to and improving the estates strategy.
2.	The ICS Board is asked to AGREE the approach to progressing the development of the estates strategy
3.	The ICS Board is asked to DELEGATE the sign-off of the ICS estates strategy submission and feedback response on 28th June 2019 to the ICS Planning Group.
4.	The ICS Board is asked to NOTE that the final estates strategy will be received by the Board as part of the five-year plan 2019-24.

Key implications considered in the report:		
Financial	☒	Ensure limited capital resources are invested appropriately to address key system risks and achieve best value
Value for Money	☒	
Risk	☒	
Legal	☐	
Workforce	☐	
Citizen engagement	☐	
Clinical engagement	☒	The estates strategy will require clear alignment with the clinical services strategy
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	Greater Nottingham ICP	-
☐	☒	☐	☐	☐

Contribution to delivering the ICS:	
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.

ICS Estates and Capital Planning
April 2019

Introduction

1. As part of a national bidding process between March and July 2018 (Wave 4), the ICS submitted seven prioritised capital bids and an ICS Estates Strategy to NHS Improvement and England (NHSE/I) in July 2018. In preparation for this work, a task and finish group was created, involving planning, finance and estate leads. As part of the preparation, the ICS prioritised capital bids using a framework developed to assess each partners' bid against a set of key criteria set by the DHSC, NHSE and NHSI;

    - *Deliverability*
    - *Patient benefit and demand management*
    - *Service need and transformation*
    - *Financial sustainability (ability of the ICS or organisation to absorb the additional capital)*
    - *Value for money*
    - *Strength of estates strategy (including level of stretch on disposals)*

2. The Estates Strategy and results of the prioritisation were approved by the STP Leadership Board in July 2018.

3. Each of the national STPs or ICSs received feedback on their estate's strategies, ranging from Fair, Improving through to Good and Strong. Nottinghamshire estates strategy received an **Improving** status with feedback on next steps to improve to Good/Strong.

4. The ICS is now expected to implement a plan to address recommendations within their estate's strategy feedback provided and submit an updated estates strategy on the 28th June 2019. The template for this will be issued by region during April 2019. The ICS will be expected to ensure the following points are clear in their response;

    - How estates plans support the Long Term Plan submission (Autumn 2019).
    - Alignment between clinical priorities and estates plans, clearly defining how capital funds deliver system objectives.
    - To support the drawdown of funds for NUH as part of their STP Wave 4 award's Full Business Case requirement, the system needs a ROBUST i.e. GOOD Estates Strategy banding, and be able to clearly demonstrate progress on key elements of their award through the Estates Strategy, taking into account feedback
    - Respond to the feedback from NHSI/E which was provided on the July 2018 estates strategy and demonstrate that the strategy is being developed to take into account the feedback, and disposal plans are up to date and of sufficient quality

5. All systems will be subject to a Light Touch assessment which will focus on the updated slide pack provided by Region to enable progress to be tracked and understood.

6. Assessment will be undertaken within the Strategic Estates Planning Service (SEP), with a robust process in place to ensure impartiality. Full assessment of Strategy updates from **Fair and Improving** systems will also be supported with input and Quality Assurance from the Office for Government Property (OGP).

7. As a follow on to June's 2019 response, all systems will be asked to submit an updated Estates Strategy during Autumn 2019 to align with five-year planning requirements. This will provide further opportunity to update following the period between 1st July and early September.

Progress to date

8. The Estates Workstream SRO has written to NHS ICS partners to inform them of the preparatory steps, with a key request for up-to-date estates data and capital scheme updates. This will include system prioritised capital (Wave 4 bids) as well as new capital plans/surplus land proposals. Data is due back on the 12th April 2019.

9. The Finance Director's Group in April will focus on the process to maximise appropriate utilisation of the Nottinghamshire estate.

10. A small task and finish group will be implemented consisting of one representation from each NHS ICS partners, to work with ICS estates, finance and clinical service strategy leads in bringing the production of the detail together.

11. Regular progress reports to be provided to the ICS Planning Group through April and May 2019 with final delegated sign-off 19 June 2019.

Issues

12. The lack of availability of transformational capital funds is a national issue with STPs/ICSs seen as the route for allocating capital resources.

13. Locally, capital solutions are seen as critical to the delivery of the clinical services strategy but in order to access funds any plans must be underpinned by a 'good' estates strategy.

14. In order to do this links must be strengthened between clinical service plans and estates utilisation, and further consideration to primary care estate requirements. Plans are in place to do this but it will need full support of partner organisations.

Next steps

15. ICS Planning Group to agree and implement estates task and finish group w/c 1 April ensuring it has appropriate representation from each partner organisation.

16. Estates task and finish group to review data provided by each partner during April 2019 and produce a response. Issues to be escalated through to the Planning Group to ensure gaps are closed prior to submitting the plan.

17. Develop estates strategy and prioritised bids in line with the national timetable with regular progress reports to the ICS Planning Group. Timetable below:

    - 1st April 2019 to the 28th June 2019 – Pull together the estates and supporting capital planning response to feedback received – Regulators will be providing a template for completion.
    - July 2019 - NHSE/I light touch assessment of June submission and further feedback to inform the autumn response.
    - Autumn 2019 – submission of estates strategy and prioritised capital plans (pending national agreement of available capital funds) alongside long-term plan.

Recommendations

18. The Board are asked to approve and note the following:
    1. The ICS Board is asked to NOTE the update on the national process for responding to and improving the estates strategy.
    2. The ICS Board is asked to AGREE the approach to progressing the development of the estates strategy
    3. The ICS Board is asked to DELEGATE the sign-off of the ICS estates strategy submission and feedback response on 28th June 2019 to the ICS Planning Group.
    4. The ICS Board is asked to NOTE that the final estates strategy will be received by the Board as part of the five-year plan 2019-24.

Mike Simpson/Marcus Pratt
NHS Improvement Strategic Estate Planning/Programme Director Finance and Efficiencies
March 2019
mike.simpson1@nhs.net and marcuspratt@nhs.net

ENC. I

Meeting:	ICS Board
Report Title:	April 2019 Integrated Performance Report
Date of meeting:	11th April 2019
Agenda Item Number:	Item 11
Work-stream SRO:	Wendy Saviour
Report Author:	Sarah Bray
Attachments/Appendices:	Enc. I. *Integrated Performance Summary*

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 risk:

- Urgent Care System delivery
- Mental Health services and service transformation delivery
- Financial Sustainability

Emerging Risks:

- Cancer performance due to the longevity and sustained level of below-target performance.
- Quality, due to performance across Transforming Care and Maternity.

Service Delivery Area	2018/19 ICS Performance		
	No. KPIs	% Not Achieved	% Achieved
Mental Health	10	40%	60%
Urgent & Emergency Care	5	80%	20%
Planned Care	6	50%	50%
Cancer	8	50%	50%
Nursing & Quality	7	14%	86%
Finance	7	100%	0%
Overall Performance Delivery	43	53%	47%

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

Assurance Framework Overview

Q2 2018/19 ICS Integrated Assurance Framework aggregated to ICS level, top 4 best and worst performing areas are.

Best Performing areas out of the 42 ICSs are: - GP Extended Access (1/42) - E-Referral Utilisation (2/42)	**Worst Performing** areas out of the 42 ICSs are: - MH Out of Area placements (40/42)

- RTT (3/42) - Dementia Diagnosis (4/42)	- Maternal Smoking at time of delivery (40/42) - A&E 4 hour wait (39/42) - Diabetes patients achieving NICE treatment targets (36/42)

Action:

☒ To note
☐ To agree
☐ To agree the recommendation/s (see details below)

Recommendations:

1.	That the Board note the contents of the report

Key implications considered in the report:

Financial	☒	*Off plan against forecast and year to date*
Value for Money	☐	
Risk	☒	*Service delivery and performance risks*
Legal	☐	
Workforce	☐	
Citizen engagement	☐	
Clinical engagement	☐	
Equality impact assessment	☐	

Engagement to date:

Board	Partnership Forum	Advisory Group	Planning Group	Programme Delivery Group
☐	☐	☐	☐	☐
Performance Oversight Group	**Clinical Reference Group**	**Finance Directors Group**	**Mid Nottingham-shire ICP**	**Greater Nottingham ICP**
☒	☐	☒	☐	☐

Contribution to delivering the ICS:

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

29th March 2019

Red Risks to System Delivery		
RAG	***Performance Issues***	***Actions to Address***
A: Mental Health	***Performance*** concerns relating to: IAPT Access M&A CCG CYP Access & data capture issues EIP Condordant compliance & Data – Level 1 in Mid-Notts CCGs, as well as overall service delivery performance across the ICS ***5YFV Transformation Areas*** issues: Out of Area Inappropriate placements – outlier on volumes of placements, national data continues to increase Liaison –service model at NUH Crisis – 24/7 CRHT service is not currently offered IPS – Service not delivered across the ICS Physical Health Checks are not in line with requirements	There are a significant number of performance and 5YFV transformation area concerns relating to Nottinghamshire. As a result the system has developed recovery plans for IAPT, EIP, CYP, Out of Area Placements (including Liaison & Crisis) and Physical Health Checks. Delivery of key requirements is not expected until 2019/20 for CYP and IAPT, with EIP aiming to achieve level 2 by the end of March 2019. Following the ICS Mental Health workshop in January, mental health leaders have linked in with areas of good practice, to enhance local service improvements. Executive Mental Health monthly oversight is in place across the ICS, to progress the actions required through the recovery plans.
B: Urgent Care	ICS A&E performance remains below target and has reduced to 76.43% February 2019 (NUH 59.42%/ SFHT 90.33%) EMAS performance plateaued at current levels, with small improvements seen over the last 2 months. Performance is more positive across Nottinghamshire, than EMAS as a whole.	NUH remains in regional escalation for performance as service difficulties continue. Significant volume increases have continued, including increases for over 75s. The performance has continued to deteriorate through January and February. Actions to address capacity gaps and front door service redesign continue to be implemented. Daily executive calls continue to be in place to respond to the pressures across the system. Both A&E Delivery Boards have provided focus on DTOCs and are aligning to Length of Stay actions, focusing on Admission avoidance, flow and reducing delays, improvements in D2A processes, with focus on Newton 'Home First' approach, and specific actions to review mental health patient care pathways. Daily patient review processes and 'pull teams are now in place. ECIST support is being provided.
G: Financial Sustainability	The year-to-date health & social care financial position (before receipt of PSF) is £87 million deficit (£21.2m million worse than plan). This is a deteriorating position and the key pressures are non-delivery of savings programme, activity/demand, social care costs and premium staffing costs. The year-to-date position for the NHS System Control Total is £71.3million deficit (£22.5 million worse than plan).	The system has received £15.7 million of Provider Sustainability Funding, which is less PSF than planned due to non-delivery of A&E at NUH (months 1-11), SFHT A&E (month 10-11) and financial position (months 4-11). *Note: A&E PSF is not recoverable and finance PSF is recoverable* Additional actions have been put in place, monitored through the Financial Sustainability Group. The system is forecasting to under-deliver on the year end position for the NHS System Control by £18.9m.
Amber Risks To System Delivery		

C: Planned Care	RTT failed to achieve for the ICS 91.6%. Waiting lists are over March 2018 levels, however have decreased to 4.6% (Jan 19). (NUH -1.5%, SFHT 10.2%). SFHT +52 weeks values are in line with trajectory, planning for nil at March 19. NUH have had sustained levels of breaches over recent months, which are being actively managed by the system. Children's wheelchair waits have significantly improved over the year to 90% delivery Q3. Performance recovery was achieved Q2 for Greater Notts and expected during Q4 for Mid-Notts.	SFHFT expected recovery of the 92% target by November 2018, however there is low confidence in achieving the standard before March 2019. SFHFT and the CCG are monitoring recovery plans at speciality levels, which include staffing and additional capacity. SHFT Waiting lists recovery back to March 18 levels is unlikely to be achieved by March 2019, due to data validation and activity increases. Additional activity has been directed through to the independent sector for certain specialties. 52+ waits recovery to nil is expected by Q2 2019/20 due to patient choice factors.
D:Cancer	Cancer 62 performance reduced slightly to 83.09% January 2019. (SFHT 84.46% / NUH 78.11%). Pressures from increased urology referrals and convergence rates have impacted upon both trusts.	The trusts expected performance for Jan 19 & Feb 19 is 78-82%, as the trusts work through the increased demand, and capacity constraints during the winter period. Recovery is not expected to be achieved before March 19, but Q2 2019/20.
E. Nursing & Quality	Transforming Care did not achieve Q3 trajectory +10 over planned levels, however there has been a significant improvement since Q1 reducing the variance by 4 CHC: ICS achieved both QP standards for Q3 maintaining an improved position. Mid Notts are unlikely to achieve Q3 28 day standard. Maternity did not achieve the continuity of carer 20% requirement, for 2018/19. Q3 performance was 0%.	TCP remains in regional escalation. Recovery plans are in place, focus on admission avoidance. The Mid Notts CCGs are working with the IDAT and Home First Pathway Team to ensure appropriate discharge/transfers. A clinical lead with LD expertise has commenced. Recovery is expected by the end Q4, improvements are noted for January 19. Maternity recovery plan is in place, revised trajectories are expected for June 2019, to progress towards the 35% requirement for March 2020. Pilots are commencing March and April 2019.
Primary Care	Delivery of 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.

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.

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

CCG joint management arrangements are progressing.

1. Recommendations

The Board/Group are asked to note the report:

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

- Urgent Care System delivery
- Mental Health service and service transformation delivery
- Financial Sustainability

Name of Report Author: Sarah Bray
Job Title: Head of Assurance & Delivery
Date: 29th March 2019
E-mail: sarah.bray6@nhs.net

Nottinghamshire ICS
System Integrated Performance Summary
April 2019

	Key Performance Indicator	18/19 STP Basis	18/19 Required Performance	18/19 Reporting Period	2018/19 ICS Performance				Exception Narrative
					Latest Period	Month RAG	Month Delivery Trend	Forecast Delivery Risk	
A. Mental Health 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	32%	Q3 18/19	16.2%		↑		Due to a range of concerns relating to performance and plans to progress the 5YFV requirements, Executive level oversight has been established in the ICS. Joint Recovery plans are in place. CYP Performance is improving, however the access standards were not met in Q2, data issues continue to be addressed. IAPT access target not achieved as an ICS for Dec 18. EIP - focus remains on improving service compliance. OAPs – Continued reduction in out of area placement (OAP) occupied bed days (OBDs). 29% reduction in OAP OBDs from the end of Q1 to the end of Q3 2018/19. However, the local trajectory was not achieved.
	CYP Eating Disorders Urgent 1st <1 weeks	CCG	95.0%	Q3 18/19	50.0%		-		
	CYP Eating Disorders Routine 1st <4 weeks	CCG	95.0%	Q3 18/19	100.0%		↑		
	IAPT Access	CCG	4.61%	Dec-18	4.47%		↓		
	IAPT Waiting Times - 6 weeks (Rolling Quarter)	CCG	75.0%	Dec-18	80.8%		↑		
	IAPT Waiting Times - 18 weeks (Rolling Quarter)	CCG	95.0%	Dec-18	99.3%		↓		
	IAPT Recovery Standards (Rolling Quarter)	CCG	50.0%	Dec-18	55.2%		↑		
	EIP NICE Concordant Care within 2 Weeks	CCG	53.0%	Jan-19	66.7%		↓		
	Inappropriate Out of Area Placements (bed days)	CCG	1698	Dec-18	2815		↓		
	Maintain Dementia diagnosis rate at 2/3 of prevalence	CCG	66.7%	Feb-19	75.8%		↓		
B. Urgent & Emergency Care Improved A&E performance in 2018/19, reduce DTOCs and stranded patients, underpinned by realistic activity plans. Implementation of NHS 111 Online & Urgent Treatment Centres.	Aggregate performance of 4 Hour A&E Standard	Provider	90% Sept /95% Mar	Feb-19	76.4%		↓		Activity pressures continued into Q3, year on year ED attendances continue to rise. A&E – NUH performance remained low at 59.42%, demand had increased further with increased ED attends and ambulance arrivals. SFHFT failed to achieve national standard and local trajectory at 90.33% in Feb-19, with 10 12 hour breaches. Length of Stay continues to be an issue, Greater Notts RAP aims to recover by Mar-19, Mid Notts will not meet the target. DTOCs – NUH achieved and SFHFT failed in Jan-19.
	12 Hour Breaches	Provider	0	Feb-19	10		↓		
	NHS 111 50% population receiving clinical input	Provider	50.0%	Feb-19	52.8%		↑		
	Ambulance (mean) response time Category 1 Incidents	Provider	00:07:00	Oct-18	00:07:39		↓		
	Ambulance (mean) response time Category 2 Incidents	Provider	00:18:00	Oct-18	00:30:27		↓		
	Reduce DTOCs across health and social care- NUH	Provider	3.5%	Jan-19	2.97%		↓		
	Reduce DTOCs across health and social care- SHFT	Provider	3.5%	Jan-19	4.30%		↓		
Primary Care Delivering extended access, additional workforce, upgrading primary care facilities, and active engagement in primary	Extended Access GP Services (evenings & weekends, holiday periods) 100% population by October 2018	CCG	100%	May-18	100.0%				Mid Notts CCG's have 100% population coverage since October 2018. National reporting is now reflective of this position.
	Invest balance of the £3 / head for general practice transformation support	CCG							
C. Planned Care Improvements in planned elective activity, reductions in patients waiting over 52 weeks as well as reductions in overall waiting lists	RTT Incomplete 92% Standard	Provider	92%	Jan-19	91.6%		↓		RTT perfomance missed 91.6%, as previous month, however waiting lists have decreased to 4.6% overall as ICS compared to previous month. 52 Week Waits – SFHT list validation has now concluded. Breaches expected into Q4 due to patient choice for both trusts. Wheelchairs – Mid Notts has improved significantly but
	RTT Waiting List - March 2019 incomplete pathway < March 2018	Provider	<March 18 56511	Jan-19	59,115		↓		
	+52 Week Waits - to be halved by March 2019, and eliminated where possible	Provider	15	Jan-19	11		↓		
	Diagnostics +6 weeks	Provider	0.9%	Jan-19	0.72%		↓		

Nottinghamshire ICS
System Integrated Performance Summary
April 2019

	Key Performance Indicator	18/19 STP Basis	18/19 Required Performance	18/19 Reporting Period	2018/19 ICS Performance				Exception Narrative
					Latest Period	Month RAG	Month Delivery Trend	Forecast Delivery Risk	
	Children's Wheelchair Waits < 18 Weeks	CCG	92%	Q3 18/19	90.00%		↑		Wheelchairs – Mid Notts has improved significantly but remain under target at Q3 90%.
	E-Referrals increased coverage 100% 1819	CCG	100%	Dec-18	104%				

Nottinghamshire ICS
System Integrated Performance Summary
April 2019

	Key Performance Indicator	18/19 STP Basis	18/19 Required Performance	18/19 Reporting Period	2018/19 ICS Performance				Exception Narrative
					Latest Period	Month RAG	Month Delivery Trend	Forecast Delivery Risk	
D. Cancer 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%	Jan-19	95.0%		↓		62 Day wait times in oncology continue to be an issue across a number of tumour sites at NUH. Urology continues to be an issue at SFHFT, with 9/15 breaches in Urology in Jan. NUH expected to meet 80% by Feb-19 however, recovery by Mar-19 is unlikely. SFHFT recovery expected in Feb-19.
	Cancer 2 weeks - Breast Symptomatic Referrals	Provider	93.0%	Jan-19	98.1%		↓		
	Cancer 31 Days - First Definitive Treatment	Provider	96.0%	Jan-19	93.8%		↓		
	Cancer 31 Days - Subsequent Treatment - Surgery	Provider	94.0%	Jan-19	83.9%		↓		
	Cancer 31 Days - Subsequent Treatment - Anti Can	Provider	98.0%	Jan-19	98.3%		↓		
	Cancer 31 Days - Subsequent Treatment - Radiothy	Provider	94.0%	Jan-19	97.5%		↓		
	Cancer 62 Days - First Definitive Treatment - GP Referral	Provider	85.0%	Jan-19	83.1%		↓		
	Cancer 62 Days - Treatment from Screening Referral	Provider	90.0%	Jan-19	84.0%		↓		
E. Nursing & Quality									
Transforming Care Continued reduction of inappropriate hospitalisation of people with Learning Disabilities focusing on long	Reductions in patients against Local planning trajectories - Total for Nottinghamshire	CCG	36	Jan-19	54		↓		TCP: The Nottinghamshire TCP collectively (Specialised Commissioning & CCG) did not achieve the 2018/19 Q3 trajectory (+10) this was across NHSE areas. CHC: Provisional data shows Nottingham & Nottinghamshire ICS achieved both QP standards for Q3 maintaining an improved position. Maternity: Baselines & Trajectories (B&T) aligned to LMS Transformation Plan were agreed (June 2018). The requirement for 20 continuity of carers by March 2019 is not expected to be achieved. Data capture and definitions continue to be agreed. Smoking in pregnancy continues to be a concern.
Continuing Health Care	Fewer than 15% of Continuing Health Care Full Assessments undertaken in acute setting	CCG	<15%	Jan 19	8%		↑		
	More than 80% eligibility decisions undertaken within 28 days from receipt of checklist	CCG	80%	Jan 19	89%		↑		
Maternity Deliver improvements in safety for maternity services, and improve personal and mental health service provision	Local planning trajectories agreed								
Quality Measures	Mixed Sex Breaches			Dec-18	TBC				CQC inspection at SFHT in April has improved overall rating to good. HCAI (Hospital Aquired Infections) have action plans to address the increased rates
	MSA Breaches	Provider		Dec-18	0		↓		
	MRSA	Provider		Jan-19	0		↓		
	C-Difficile	Provider		Jan-19	17		↓		
	E Coli	Provider		Jan-19	85		↑		
F. Prevention & Public Health			To be developed and populated by public health and social care						Healthy life expectancy has increased both nationally and locally over recent years, however 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
April 2019

	Key Performance Indicator	18/19 STP Basis	18/19 Required Performance	18/19 Reporting Period	2018/19 ICS Performance				Exception Narrative
					Latest Period	Month RAG	Month Delivery Trend	Forecast Delivery Risk	
G. Finance & Efficiency	Overall Financial Position (Health & Social Care): **Pre-PSF**	ICS	Nil Variance to Plan (£millions)	Feb-19	-£24.4		↓		YTD £87.0m deficit (Plan £65.8m deficit) and forecast £92.6m deficit (Plan £67.7m deficit). In year position is deteriorating, key pressures are non delivery of savings programme, activity/demand, social care costs and premium staffing costs.
	Provider Sustainability Funding (PSF)	ICS (NHS)			-£23.1		↓		YTD received £15.7m (Plan £43.3m) and forecast £17.0m (Plan £49m). Variances due to non delivery of A&E performance at NUH & SFH (months 9-12 only), the months 4-11 actual & months 4-12 forecast financial position.
	Overall Financial Position (Health & Social Care) : **Post-PSF**	ICS			-£47.5		↓		YTD £71.3m deficit (Plan £22.5m deficit) and forecast £75.6m deficit (Plan £18.7m deficit).
	NHS System Control Total	ICS (NHS)			-£19.6		↓		YTD £81.4m deficit (Plan £65.8m deficit) and forecast £86.6m deficit (Plan £67.7m deficit) - excluding Provider Sustainability Funds. Significant risks to delivery of the NHS System Control Total, additional actions have been put in place, monitored through Financial Sustainability Group.
	Savings Programme (6%)	ICS			-£10.5		↓		YTD £145.5m (Plan £153.7m) and forecast £163.2m (Plan £170.1 m). Key areas of under delivery are elective care transformation and pay efficiencies.
	Mental Health Investment Standard (MHIS)	ICS	£148.8 (Plan)	Feb-19	£126.8		-		MHIS is forecast to deliver at M11.
	Agency Ceiling	ICS	£45.4 (Plan)	Feb-19	£37.7		-		The Agency Ceiling is delivering YTD against the plan of £41.5m
H. Workforce									To be developed and populated by workforce propgramme lead

ENC. J

Meeting:	ICS Board
Report Title:	Receive a report on the delivery of Integrated Care System Memorandum of Understanding (ICS MOU) National and Local priorities and deliverables
Date of meeting:	11 April 2019
Agenda Item Number:	11
Work-stream SRO:	David Pearson
Report Author:	Joanna Cooper
Attachments/Appendices:	None

Report Summary:

A Memorandum of Understanding (MOU) between the Nottinghamshire ICS and NHS England and NHS Improvement was agreed for 2018/19. The agreement outlines key objectives and deliverables for the Integrated Care System (ICS). This paper provides an overview of progress made in 2018/19 against the key deliverables, and asks for support to accelerate progress in key areas. In order to maintain progress the Board are asked to consider the following:

1. Whilst the resilience of the system was improved, challenges remain with the overall system priority of achieving the 4 hour target in Greater Nottingham.
2. At the 15 March ICS Board meeting the ICS mental health strategy was agreed. Commissioners and ICPs have now commenced the development of delivery plans to implement the strategy.
3. An interim oversight model has been agreed between the ICS and Regional Team for 2018/19. However, further consideration will need to be given to this in 2019/20 as the ICS, ICP and PCN structures become more established. A progression model and oversight framework is in development, by the ICS and regulators, which will include transitional progression steps for integrating oversight as the system matures and develops, under the combined joint regulatory processes.

We anticipate that a further MOU will be required for the financial year 2019/2020.

Action:

☐ To note
☐ To agree
☒ To agree the recommendation/s (see details below)

Recommendations:

1.	To note the progress to date and year end position on ICS MOU priorities and deliverables and identify priority actions that need to be put in place to address the issues raised.

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	Greater Nottingham ICP	-
☐	☐	☐	☐	☐

Contribution to delivering the ICS:

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.

Performance Report on the Delivery of Integrated Care System Memorandum of Understanding (ICS MOU) National and Local Priorities and Deliverables

11 April 2019

1. Introduction

A Memorandum of Understanding (MOU) between the Nottinghamshire ICS and NHS England and NHS Improvement was agreed for 2018/19. The agreement outlines key objectives and deliverables for the Integrated Care System (ICS). This paper provides an overview of progress made in 2018/19 against the key deliverables outlined in Annex 1.

2. Progress to date

Progress against the ICS MOU has been tracked as part of the quarterly ICS stocktake meetings between the ICS representatives and NHS England and NHS Improvement. Annex 1 provides an overview of progress against the key 2018/19 deliverables. In summary, good progress is being made against the national and locally determined priorities. A summary is presented in the table below:

Priority #	Description of priority	Overseeing Group	BRAG rating March 2019
National NHS priorities and deliverables			
NO1.1	Reaching 100% coverage of self-identified primary care networks (PCNs) by the end of 2018/19.	PCN Task and Finish Group	B
NO1.2	Enhancing resilience of systems before next winter.	A&E Delivery Boards	A
NO1.3	Working in partnership with the National Mental Health Team to develop and implement actions to improve system-level working across all local partners for Mental Health delivery in 2018/19.	Mental Health, Urgent Care and OAP Taskforce	A
NO1.4	Working through, and as an active member of your Cancer Alliance, and in partnership with the National Cancer Programme, to implement the National Cancer Taskforce's recommendations.	Cancer Alliance	G
Integrating care			
NO2.1	With support from the national team make significant progress towards full maturity of the three population health management capabilities and develop a system-wide plan setting out locally determined population health priorities.	Population Health Management Coordination Group	G
Oversight			
NO3.1	Regional teams will agree with ICSs how this oversight model will operate, taking into account the maturity of system working, including governance and financial management.	Performance Oversight Group	A

Priority #	Description of priority	Overseeing Group	BRAG rating March 2019
NO3.2	After six months there will be a clearly agreed plan about how oversight will be provided in Nottingham and Nottinghamshire in conjunction with regional and national teams.	Performance Oversight Group	A
NO3.3	Performance activity and finance will be transparent across the Nottingham and Nottinghamshire system and where necessary there will be joint discussions between ICS Leaders and Regional regulatory teams.	Performance Oversight Group	G
NO3.4	Single regional team to work with the ICS Leadership Board to develop the accountability framework for ICS delivery issues.	Performance Oversight Group	B
Local priorities and deliverables			
NO4.1	Develop a Nottinghamshire Clinical Services Strategy focused on acute, primary and community services. This work will lead to a reduction in unwarranted variation, improve the use of the estate and improve workforce resilience.	Clinical Services Strategy Programme Board	A
NO4.2	Develop a comprehensive mental health services strategy ensuring delivery of service planning requirements including Out of Area Placements reductions, and alignment to physical health strategies.	Mental Health, Urgent Care and OAP Taskforce	B
NO4.3	Finalise the ICS organisational and governance architecture.	System Architecture Group	G
NO4.4	Remedial action related to core national priorities. A step-change in improvements to the urgent care pathway to bring A&E waiting times back in line with NHS Constitution standards by the end of 2018/19.	A&E Delivery Boards	R
NO4.5	Scaling up and wide scale adoption of specific care pathways and referral management protocols to implement best practice on a Nottinghamshire wide level.	Elective Care Group	G
NO4.6	In support of the ICS Prevention and Well-being plan, the ICS will agree a key short term priority for 2018/19 for preventing ill-health across Nottinghamshire.	Strategic Oversight Group for Prevention, Personal and Community Centred Approaches	B
NO4.7	To continue to develop local integrated care partnerships (LICPs).		Superseded through the development of PCNs
NO4.8	To implement the integrated MDT model supported by the revised risk stratification and population health approaches being developed across	Population Health Management	G

Priority #	Description of priority	Overseeing Group	BRAG rating March 2019
	Nottinghamshire, with early focus across Greater Nottingham.	Coordination Group	

3. Next steps

It is anticipated that the priorities identified in the ICS MOU will continue into 2019/20 and be complemented by the priorities identified in the NHS Long Term Plan published in January 2019. An MOU for 19/20 will be proposed and agreed with the system in due course.

In order to maintain progress the Board are asked to consider the following issues:

1. Whilst the resilience of the system was improved, challenges remain with the overall system priority of achieving the 4 hour target in Greater Nottingham.
2. At the 15 March ICS Board meeting the ICS mental health strategy was agreed. Further work is needed to develop a system-wide mental health investment strategy, and credible workforce plan.
3. An interim oversight model has been agreed between the ICS and Regional Team for 2018/19. However, further consideration will need to be given to this in 2019/20 as the ICS, ICP and PCN structures become more established. A progression model and oversight framework is in development, by the ICS and Regulators, which will include transitional progression steps for integrating oversight as the system matures and develops, under the combined joint regulatory processes.

4. Recommendations

The Board are asked to approve the following:

1. To note the progress to date and year end position on ICS MOU priorities and deliverables and identify priority actions that need to be put in place to address the issues raised.

Annex 1

Priority #	Type of Priority	Description of priority	Progress update from ICS
National NHS priorities and deliverables			
NO1.1	National NHS priorities and deliverables	Reaching 100% coverage of self-identified primary care networks (PCNs) by the end of 2018/19. We expect PCNs to be: functionally sharing assets and workforce and consistently delivering care through integrated teams to high risk groups; making use of data to understand their populations, identifying variation in resource use and outcomes, and guiding clinical decision making; acting as core partner in system decision making. We will work with each ICS in July and August to agree the level of primary care network maturity that systems expect to achieve by March 2019, and that would represent a step change in the delivery of integrated primary care during 2018-19. We will also co-produce with ICSs appropriate measures to assess progress and impact, aligned with the national Primary Care Network Programme.	System has a history of PCN working, therefore a good baseline in place. Working with each locality lead and comparing the practices against the NHS Primary care network maturity matrix, it was agreed that 90% of practices would self-assess themselves at a level 2, with 10% self- assessing themselves at a level 3. Following release of further guidance in relation to the GP Contract, there has been a review to ensure that all PCNs are in line with the 30k minimum population size and a process for the appointment of a Clinical Director has commenced across all localities. There have been a number of workshops with representatives from all sectors across the system to develop the vision, roles and responsibilities for the PCNs across the system and this will be taken forward in the ICS Primary Care Oversight Group. Work is underway to register the PCNs and ensure 100% coverage by the required May deadlines.
NO1.2	National NHS priorities and deliverables	Enhancing resilience of systems before next winter, for example by improving system-level working across urgent and emergency care and improving resilience in care homes through implementation of the Enhanced Health in Care Homes framework;	- Work has been progressing in the ICPs against all the workstream identified local and national objectives for 111 and EMAS. - Challenges remain with the overall system priority of achieving the 4 hour target in Greater Nottingham. - Care Homes bed state software rolled out over winter 18/19 and care home trusted assessors in post. - Greater Nottingham are going through a system wide exercise to improve and refine system and partner escalation actions and thereby OPEL reporting, ensuring that appropriate actions are taken at each stage to improve patient flow. - Long LOS review meetings, chaired by the system delivery director, happen on a weekly basis with all system partners to expedite discharge of patients from the acute, this has resulted in reduced long LOS patients at NUH.

Priority #	Type of Priority	Description of priority	Progress update from ICS
NO1.3	National NHS priorities and deliverables	Working in partnership with the National Mental Health Team to develop and implement actions to improve system-level working across all local partners for Mental Health delivery in 2018/19. This includes an ICS system-wide mental health investment strategy, and credible mental health workforce plan;	Governance structure in place and draft strategy developed with partners across Nottinghamshire. 5 key strategic pillars of work identified: System Infrastructure, Parity of Esteem, Prevention and person centred approaches, Workforce and Access. In addition robust governance framework in place to monitor actions to achieve 5 year forward view and constitutional standards. Regular urgent care / OAP task force meetings in place. Monthly ICS Mental Health Executive leaders meeting in place to progress in year performance and service improvement issues.
NO1.4	National NHS priorities and deliverables	Working through, and as an active member of your Cancer Alliance, and in partnership with the National Cancer Programme, to implement the National Cancer Taskforce's recommendations.	On track against long term objectives. £920K Transformation Funding secured. Lung MOT service to be expanded via National Programme CCG Cancer ratings published. STP overall rated good. Variation across STP largely due to deprivation. National Patient Experience Survey results released. Provider and CCGs above national average and improved on last year. Latest Cancer early diagnosis data released. Good proxy measure for outcomes. Significant improvement in City which had low rates.
Integrating care			
NO2.1	Integrating care	With support from the national team, ICSs will be required to make significant progress towards full maturity of the three population health management capabilities and develop a system-wide plan setting out locally determined population health priorities.	- Establishment of System Wide Population Health and Population Health Management Co-ordination Group (with representation from NHSE and PHE). - Initial Baseline assessment against the National PHM Framework. - Review of data and analytics underway with Local analytic leads, PHE and Directors of Public Health. - September meeting of the STP Leadership Board agreed that the system will have one agreed set of cohorts across the footprint. - Agreement of STP Clinical Reference Group to a system-wide

Priority #	Type of Priority	Description of priority	Progress update from ICS
			standardised set of Clinical Cohorts - Expert panels have been created to support and aid the development of risk algorithms, priorities and measures with initial focus on Long-Term Conditions Cohort. -November STP Leadership Board agreed principles, approach and headline population goals for a system-wide outcomes framework - Directors of Public Health updating system baseline needs assessment and JSNA process to provide updated insight of key population health priority areas
Oversight			
NO3.1	Oversight	Regional teams will agree with ICSs how this oversight model will operate, taking into account the maturity of system working, including governance and financial management. This will include: - establishing a single governance forum (led and hosted by the ICS, but with input from regional teams) to review both system performance and the performance of individual providers and CCGs. - agreeing an accountability framework setting out how oversight will work in practice. - agreeing a work programme and timetable which identifies specific and tangible changes that will be made to the relationship between NHS England, NHS Improvement, the ICS and local trusts and CCGs.	Performance oversight group established as a Sub-Committee of the ICS Board, supporting the local System in the delivery of, and improvements in, constitutional and other national requirements across Nottinghamshire. This includes identification of risks to delivery of Constitutional and MOU performance requirements, and ensuring triangulation with quality and finance performance as a whole system view. The accountability framework will be further developed to reflect the governance of ICS, ICP and PCN structures.
NO3.2	Oversight - specific additional agreements	After six months there will be a clearly agreed plan about how oversight will be provided in Nottingham and Nottinghamshire in conjunction with regional and national teams.	Facilitated workshop with Leadership Board held on the 20th July. Focused on the principles and policy objectives of local and integrated oversight within ICS.A progression model and oversight framework is in development, by the ICS and Regulators, which will include transitional progression steps for integrating oversight as the system matures and develops, under the combined joint regulatory processes.

Priority #	Type of Priority	Description of priority	Progress update from ICS
NO3.3	Oversight - specific additional agreements	Performance activity and finance will be transparent across the Nottingham and Nottinghamshire system and where necessary there will be joint discussions between ICS Leaders and Regional regulatory teams about action to deal with under performance in the NHS.	A single system, integrated performance report has been developed for the ICS Board to support the monitoring and management of system performance. Has been developed to support ICP reporting.
NO3.4	Oversight - specific additional agreements	Single regional team to work with the ICS Leadership Board to develop the accountability framework for ICS delivery issues.	A progression model and oversight framework is in development, by the ICS and Regulators, following the revised ICS architecture governance arrangements. This will include transitional progression steps for integrating oversight as the system matures and develops
Local priorities and deliverables			
NO4.1	Local priorities and deliverables	Develop a Nottinghamshire Clinical Services Strategy focused on acute, primary and community services. This work will lead to a reduction in unwarranted variation, improve the use of the estate and improve workforce resilience.	- Establishment of Programme Board and Clinical Design Advisory Group - Multiple engagement events on the 5 year vision for clinical services have now been completed with c. 150 clinicians across the ICS and outputs now being shaped to inform the clinical model and strategy - Agreement of fixed system elements and design principles to underpin the CSS design and the prioritisation process has been approved to identify the 6 initial service review areas which are now underway - Stroke, maternity and respiratory service reviews all commenced with strong clinical leadership and patient engagement - A draft operating model for PCNs is nearing completion which will be aligned with the CSS development - Draft Clinical Services strategy on track to be presented to Programme Board in May 2019
NO4.2	Local priorities and deliverables	Develop a comprehensive mental health services strategy ensuring delivery of service planning requirements including Out of Area Placements reductions, and alignment to physical health strategies.	All age ICS mental health and social care strategy developed. Strategy approved at the ICS Board meeting 15 March 2019.

Priority #	Type of Priority	Description of priority	Progress update from ICS
NO4.3	Local priorities and deliverables	Finalise the ICS organisational and governance architecture, to provide clarity on integrated oversight, integrated system strategy partnerships, integrated commissioning and integrated provider structures, with early actions to bring CCGs together across the system including committees in common and integrated management teams with a view to having a final form for the strategic commissioning function by 2020. The ICS will develop its governance structures to enable effective clinical and non-executive strategic input and scrutiny. See Section 7 also.	Fully engaged process with senior leaders and relevant boards. Dedicated workshops to agree future system configuration with ICS Board in place in shadow form. Now moved away from earlier ambition of LICP. Instead will focus on PCN development. Independent review of ICP options in Greater Nottingham concluded and decision reached at ICS Board on 15 February for three ICPs within Nottinghamshire: Mid, City and South.
NO4.4	Local priorities and deliverables	Remedial action related to core national priorities. A step-change in improvements to the urgent care pathway to bring A&E waiting times back in line with NHS Constitution standards by the end of 2018/19. This will require system wide working between all relevant partners.	- Work has been progressing in the ICPs against all the workstream identified local and national objectives for 111 and EMAS. - Challenges remain with the overall system priority of achieving the 4 hour target in Greater Nottingham. - Care Homes bed state software rolled out over winter 18/19 and care home trusted assessors in post. - Greater Nottingham are going through a system wide exercise to improve and refine system and partner escalation actions and thereby OPEL reporting, ensuring that appropriate actions are taken at each stage to improve patient flow. - Long LOS review meetings, chaired by the system delivery director, happen on a weekly basis with all system partners to expedite discharge of patients from the acute, this has re resulted in reduced long LOS patients at NUH. - ICS Managing Director taking personal responsibility to deliver performance improvement.

Priority #	Type of Priority	Description of priority	Progress update from ICS
NO4.5	Local priorities and deliverables	Scaling up and wide scale adoption of specific care pathways and referral management protocols to implement best practice on a Nottinghamshire wide level in order to maximise efficiencies and service improvement, as well as mitigating service pressures across the system (including the objectives delivered by the current schemes, MSK pathway, Call for Care and care homes support).	- Developed an ICS Nottinghamshire wide Not Routinely Funded Policy, Blueteq implemented as the single system for prior approval• Greater Nottingham going to procurement to implement the single model for Community Gynaecology that has been agreed; Mid Nottinghamshire are implementing using a virtual clinic/GPSI model - Single Consultant to Consultant policy adopted across the ICS - High level best practice surgical optimisation pathway agreed; phased implementation of pre-referral templates underway. Agreed to adopt single approach to high risk pre-operative assessments. - ICS pathway for women with gestational diabetes being implemented - Standardised haematuria pathway across ICS implemented - Standardised approach to implementation of single MSK model across ICS agreed currently being implemented

Priority #	Type of Priority	Description of priority	Progress update from ICS
NO4.6	Local priorities and deliverables	In support of the ICS Prevention and Well-being plan, the ICS will agree a key short term priority for 2018/19 for preventing ill-health across Nottinghamshire.	Alcohol agreed at the August STP Leadership Board as the one year prevention priority of the ICS MOU, with delivery being taken forward through the prevention, person and community approaches workstream. There is a need to work across the health and social care system to reduce alcohol related admissions, readmissions and repeat admissions through a multifaceted coordinated approach, including identifying potential ways to overcome current identified barriers. The Alcohol pathways group across Nottingham and Nottinghamshire have developed an eight point action plan: 1. Increase population level understanding of risk and harm 2. Prevent alcohol harm through wider related local/national policy 3. Embed a systematic approach to Alcohol Identification and Brief Advice (IBA) 4. Identify 'alcohol champions' in key organisations across the system 5. Include alcohol as a priority for employee health and wellbeing 6. Ensure better communication of identified alcohol risk between some key parts of the system 7. Case manage Emergency Department (ED) High Volume Service Users (HVSU) 8. Agree and embed pathways for service users with co-existing mental health and substance misuse issues. Progress has already been made in a number of these action areas. The ICS Board are giving further consideration to two areas where currently there are barriers to implementation; brief advice and case management of high volume service users.

Priority #	Type of Priority	Description of priority	Progress update from ICS
NO4.7	Local priorities and deliverables	To continue to develop local integrated care partnerships (LICPs) with general practice so that all localities within Nottinghamshire can reach a consistent baseline of maturity to enable integrated primary care at scale across Nottinghamshire, and that the more advanced LICPs are enabled to go further to test Nottinghamshire's ambitions for further transformation of primary care in 2019-20.	System-wide workshop held on 11 September. Decision taken at the 12-13 November workshop was to remove the layer referred to as LICPs from the system architecture. This work is therefore being undertaken within the remit of creating the Primary Care Networks (PCN). A task and finish group has been established to confirm the standard operating model for each PCN and undertake a mapping exercise alongside the maturity matrix for primary care development. Outstanding issue regarding City ICP option. To be concluded by end of March 2019.
NO4.8	Local priorities and deliverables	To implement the integrated MDT model that includes social care, mental health, community pharmacy and self-care, and supported by the revised risk stratification and population health approaches being developed across Nottinghamshire, with early focus across Greater Nottingham.	Cohorts and initial focus on LTC agreed by STP Leadership Board and paper at meeting on 16 November 2018. First expert panel met 12th December to define LTC scope. PHM Presentation at MN and GN transformation undertaken or booked in. All 23 PCN have integrated MDTs however variation exists. A new system specification will be developed through the PCN task and finish group to standardise delivery, supporting MDTs/PCNs to be strategically aligned, but locally tailored based on population intelligence.

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Meeting:	ICS Board
Report Title:	Mid Nottinghamshire Integrated Care Provider Update – April 2019
Date of meeting:	Thursday 11 April 2019
Agenda Item Number:	13.
Work-stream SRO:	
Report Author:	Richard Mitchell
Attachments/Appendices:	None

Report Summary:

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

Action:

☒ To note
☐ To agree
☐ To agree the recommendation/s (see details below)

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**	**Greater Nottingham ICP**	-
☐	☐	☒	☐	☐

Contribution to delivering the ICS:

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 Provider Update – April 2019

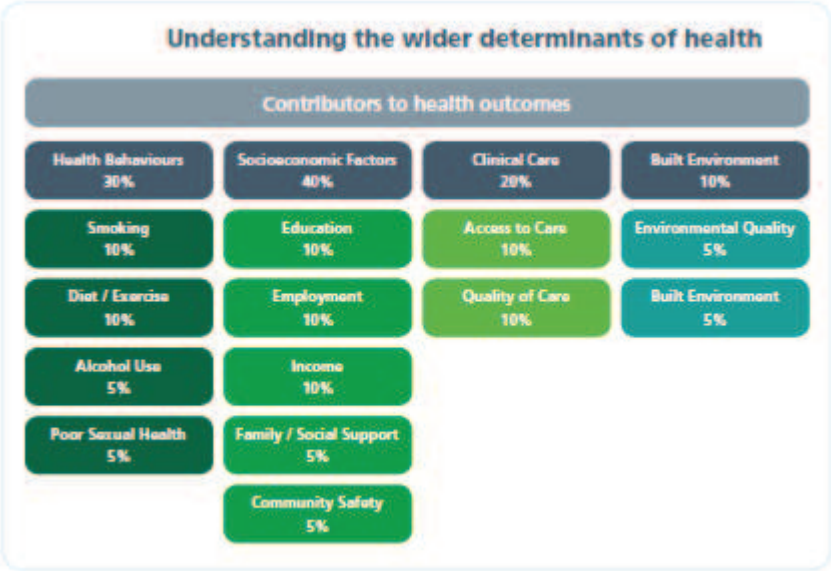
Independent Chair appointed

1. Professor Rachel Munton has been appointed as the independent chair of the mid Nottinghamshire (Mid Notts) ICP and will formally start in her new role on 1 May 2019. Rachel's previous roles include healthcare assistant, director of nursing, and director of the East Midlands Academic Health Science Network. We would like to take this opportunity to thank John MacDonald for chairing the Alliance Board over the last year and a half and we all recognise the improvements in culture and delivery that have occurred through his leadership.

ICP meeting on 4 April

2. We had an extended Mid Notts ICP workshop on 4 April with 27 colleagues representing commissioning, County Council, District Councils, Healthwatch, Nottinghamshire Healthcare NHS Trust, Nottingham University Hospital NHS Trust, Primary Care Networks, Sherwood Forest NHS FT, voluntary sector and the ICS and we discussed the following:
   - Life in Primary Care Networks - how can the ICP and PCNs work together?
   - How do we ensure equal balance between health and local authority?
   - How do we maximise the role of patients, public and the voluntary sector?
   - What sort of a board do we want this to be?
   - What do we want the ICP to focus on?
   - How we do focus on the wider determinants of health and wellbeing?

3. We were all clear and committed in the meeting to improve the lives of our residents in Mid Notts by working more closely together. The table below explains some of the wider determinants of health and provides further evidence that access to care only contributes circa 10% to overall health outcomes. For us to make a fundamental difference in Mid Notts we have agreed the ICP needs to be wider than just NHS services and social care. We will be developing the agreed approaches form this workshop in our future planned Board Meetings.



Secondments into the Mid Notts ICP

4. Peter Wozencroft (Director of Strategy Sherwood Forest Hospitals FT) and Kerry Beadling-Barron (Head of Communications Sherwood Forest Hospitals FT) will be seconded into the Mid Notts ICP, initially for 12 months, from 1 May. Key areas of focus for them in the first couple of months will be supporting the delivery of the actions that came out of the meeting on 4 April. From the beginning of May, Richard Mitchell (Chief Exec Sherwood Forest Hospitals FT) is committing a day a week to work solely on ICP business.

Contracts signed and aligned for 2019-20

5. The 2019/20 SFH CCG contract has been collaboratively developed in accordance with the following jointly agreed principles:

- Working together for the benefit of the system
- Aligning objectives and incentives to achieve system change
- A cost pressure causes a problem for the system
- A cost saving creates an opportunity for the system
- Openness and transparency and open book approach
- Risks shared and managed
- Contracts to reflect system objectives and incentivise delivery and enable transformation.

6. The contract has risk for all partners and the system and the two key risks are non-elective care growth beyond what we have planned for and outpatient transformation not occurring at the rate we need it to. We believe the contract agreed between commissioners and providers will support an improvement in joint working and transformational change in the next 12 months.

7. The table below captures the financial risks in Mid Notts (CCG, Notts Healthcare NHS Trust and Sherwood Forest Hospitals FT) accurate as of 29 March.

Identified schemes £43.2 million
Gap £6.3 million

	MC ICP	
	£ms	%
Identified		
Red	11.2	22.7
Amber	15.2	30.7
Green	16.8	33.9
Total Schemes	43.2	87.4
Unidentified	6.3	12.6
Control total not accepted	0	0
Total Savings Target	49.5	100

Visit to Wigan on 26/4

8. Seventeen colleagues from Mid Notts are visiting Wigan on 26 April to understand more about the Wigan Deal, which is "an informal agreement between the council and everyone who lives or works here to work together to create a better borough." We believe there is a lot we can learn from Wigan. Further details are here: https://www.wigan.gov.uk/council/the-deal/the-deal.aspx

Richard Mitchell
Chief Executive Officer, Sherwood Forest Hospitals NHS Foundation Trust
11 April 2019
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Meeting:	ICS Board
Report Title:	ICS Board Draft Terms of Reference
Date of meeting:	Thursday 11 April 2019
Agenda Item Number:	13.
Work-stream SRO:	David Pearson
Report Author:	Joanna Cooper
Attachments/Appendices:	None

Report Summary:

At the meeting on 15 March, the ICS Board considered amendments made to the draft ICS Board Terms of Reference (TOR). The Board agreed the recommendation that legal advice should be sought on the draft TOR in particular in relation to decision making, voting and accountability arrangements.

Independent legal advice has been obtained and an overview of the key points to be addressed is outlined below:

- The role and responsibilities of the Board are not as clearly set out as they could be and a clearer link to the ICS Memorandum of Understanding (MOU) is advised.
- Further work is needed to clarify the Board's ability to make decisions. This must distinguish between system related matters and matters set out in the MOU, and those which relate to a statutory duty and remain the responsibility of statutory bodies.
- As the Board is non-statutory and relies on consensus decision-making consideration needs to be given to the voting arrangements. The TOR should be strengthened in respect of decision making, dispute resolution and the role of the Chair in facilitating agreement

It is proposed that an independently facilitated session is arranged for some or all members of the Board to resolve the issues raised above. This short session could be arranged to form part of the development session (already in diaries) on 18 June OR a separate workshop could be convened by the end of May, if preferred.

Action:

☐ To note
☐ To agree
☒ To agree the recommendation/s (see details below)

Recommendations:

1.	To note the independent legal advice provided to the ICS Board on the draft TOR.
2.	To decide whether the Board will dedicate time to develop the ICS Board TOR during part of an independently facilitated workshop on 18 June or whether the option of a smaller group meeting in May is preferred.

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	Greater Nottingham ICP	-
☐	☐	☐	☐	☐

Contribution to delivering the ICS:

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

Is the paper confidential?

☐ Yes
☒ No

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