Integrated Care System
Nottingham & Nottinghamshire

Nottingham City Council | Nottinghamshire County Council | NHS

Integrated Care System Board
Meeting held in public

Thursday 13 June 2019, 09:00 – 12:00
Rufford Suite, County Hall, Nottingham

AGENDA

	Time	Agenda Items	Paper	Lead	Action
1.	09:00	Welcome and Introductions: • Official Welcome to new members	Verbal	Chair	To note
2.	09:05	Conflicts of Interest	Verbal	Chair	To note
3.	09:10	Minutes of 9 May 2019 ICS Board meeting and action log	Paper A1-2	Chair	To agree
4.	09:15	Patient story – Persistent Physical Symptoms. Primary Care Psychological Medicine	Paper B	Chris Schofield / Sajidah Munir / Nick Page / Helen Smith	To discuss
Outcomes Framework, Prevention and Inequalities					
5.	09:30	Personalised care – lessons learnt and sustainability	Verbal	Amanda Sullivan	To discuss
Strategy and System Planning					
6.	09:35	ICS and East Midlands Academic Health Science Network – innovation and research	Paper C1-2	Wendy Saviour	To discuss
7.	09:55	Draft Acute, Community and Primary Care Clinical Services Strategy	Paper D1-2	Tracy Taylor	To agree
8.	10:15	Draft Primary Care Strategy	Paper E1-3	Nicole Atkinson	To discuss
Short break					
9.	10:30	Confirmation of the Primary Care Network Configurations for Nottingham and Nottinghamshire	Paper F	Nicole Atkinson	To note

	Time	Agenda Items	Paper	Lead	Action
10.	10:40	Local priorities for inclusion in the 19/20 MoU with NHS England & Improvement	Paper G	Tom Diamond	To agree
11.	10:50	CCG Merger Plan	Paper H1-2	Amanda Sullivan	To discuss
12.	11:00	Update from Mid Nottinghamshire ICP	Paper I	Richard Mitchell	To discuss
13.	11:05	2019/20 System Operational Plan (NHS)	Paper J1-2	Helen Pledger	To note
Oversight of System Resources and Performance Issues (including MoU)					
14.	11:15	ICS Integrated Performance Report - Finance, Performance & Quality. Escalated issues: • Finance • A&E • Mental health	Paper K1-2	Wendy Saviour / Helen Pledger	To discuss
15.	11:20	Mental Health Deep Dive	Paper L1-2	Amanda Sullivan / John Brewin	To discuss
Governance					
16.	11:40	ICS Board Revised Governance Arrangements	Paper M1-2	Chair	To agree
12:00 Close					

Date of the next meeting:
12 July 2019, 9:00 – 12:00, Rufford Suite, County Hall

Integrated Care System Board meeting
Thursday 9 May 2019 – 13:30 – 17:00
Rufford Suite, County Hall, Nottingham
Meeting held in public

Draft minutes **Item 3. Enc. A1**

Present:

ICS Board members	ORGANISATION
Amanda Sullivan	Accountable Officer, Nottinghamshire CCGs
David Pearson	ICS Chair
Dean Fathers	Chair, Nottinghamshire Healthcare NHS FT
Eric Morton	Chair, Nottingham University Hospitals NHS Trust
Ian Curryer	Chief Executive, Nottingham City Council
John Brewin	Chief Executive, Nottinghamshire Healthcare NHS FT
John MacDonald	Chair, Sherwood Forest Hospitals NHS FT
Jon Towler	Lay Member, Nottinghamshire CCGs
Melanie Brooks	Corporate Director Adult Social Care and Health, Nottinghamshire County Council
Richard Henderson	Chief Executive, East Midlands Ambulance Service
Richard Mitchell	Chief Executive, Sherwood Forest Hospitals NHS FT
Tracy Taylor	Chief Executive, Nottingham University Hospitals Trust

In Attendance:

Alex Ball	Director of Communications and Engagement, Nottinghamshire ICS
Andy Haynes	Clinical Director, Nottinghamshire ICS
Deborah Jaines	ICS Deputy Managing Director
Elaine Moss	Chief Nurse, Nottinghamshire CCGs and ICS
Helen Pledger	Finance Director, Nottinghamshire ICS
Joanna Cooper	Assistant Director, Nottinghamshire ICS
Lucy Dadge (item 6)	Director of Sustainability, Nottinghamshire CCGs
Lyn Bacon (item 5)	Chief Executive, Nottingham Citycare Partnership
Nicky Hill (item 5)	Director of HR, Nottingham University Hospitals NHS Trust
Nicole Atkinson	Clinical Lead from Greater Nottingham Clinical Chair, Nottingham West CCG
Richard Stratton	Clinical Lead from Greater Nottingham GP, Belvoir Health Group
Thilan Bartholomeuz	Clinical Lead from Mid Nottinghamshire Clinical Chair, Newark and Sherwood CCG
Tom Diamond	ICS, Director of Strategic Planning

Apologies:

Gavin Lunn	Clinical Lead from Mid Nottinghamshire Clinical Chair, Mansfield and Ashfield CCG
Cllr. John Doddy	Councillor and Chair of the Nottinghamshire Health and Well Being Board, Nottinghamshire County Council
Cllr. Sam Webster	Executive Member for Adult Social Care and Health
Cllr. Stuart Wallace	Councillor and Chair of the Adult Social Care and Health Committee, Nottinghamshire County Council
Wendy Saviour	ICS, Managing Director

1. **Welcome and introductions**

Apologies received as noted above.

2. **Conflicts of Interest**

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

3. **Minutes of 11 April 2019 and Action log**

Minutes of ICS Board meeting on 11 April 2019 were agreed as an accurate record of the meeting by those present. The action log was noted.

4. **Patient story on smoking in pregnancy**

EIM presented a patient story to the ICS Board on smoking at time of delivery and the Love Bump campaign. A dedicated website for the campaign and supporting posters are available here https://lovebump.org.uk/nottinghamshire/

EIM highlighted the need for a consistent approach engaging with ICS partners and wider partners such as schools. It is important to galvanise support from mothers in a similar position to act as champions and promote smoking cessation during pregnancy.

ACTIONS:
JC to circulate the patient story presentation to the Board with the minutes.

Outcomes Framework, Prevention and Inequalities

No items on the agenda.

Strategy and System Planning

5. Local Workforce Action Board – update

Lyn Bacon and Nicky Hill attended the meeting to present the circulated papers on workforce. A revised People and Culture Strategy has been developed across partner organisations. LB and NH highlighted two key areas for further consideration:

1. Governance and connections across the system to the Local Workforce Action Board (LWAB). In future LWAB will be more ICS led and rather than no longer a joint endeavour with Health Education England (HEE).
2. Resources to deliver the workforce strategy are at risk.

The Board discussed the presentation and noted the following aspects:

- Recognised workforce as one of the biggest challenges for the system.
- Further consideration needs to be given to how to connect strategic imperative to the AHSN and the rest of the NHS system.
- A need to demonstrate the right role modelling behaviours around recruitment and retention.
- Further consideration to be given to where it might be possible to create shared HR services across ICS partners.
- Further information needed on the impact that implementing the People and Culture Strategy will have.
- Multiskilling of the workforce.
- Further insight needed on how workforce implications will fit at ICS / ICP and PCN level.

The ICS Board endorsed the revised People and Culture Strategy and asked for further detail on what the impacts of the initiatives delivered to date have been. Further consideration to be given to how the LWAB links to the ICS and resource requirements to support the workstream.

ACTIONS:
LB and NH to provide further detail to the ICS Board on the impact of the initiatives in the People and Culture Strategy.
WS to work with LB and NH to give further consideration to how the LWAB links to the ICS and the resource requirements for the workforce workstream.

6. ICS approach to Best Value Decision Making

DP presented the circulated paper on Best Value Decision Making further to the discussion at the 18 January ICS Board meeting. The paper summarises the legal parameters and proposed a set of guiding best practice principles for all partners, and highlights the importance of transparency and coherence at a strategic level.

ICS Board members welcomed the report and asked that the following be given further consideration:

- That it be made clear that the approach applies to commissioners within the ICS to retain a focus on what can be directly influenced. The report should be amended to include reference to the impact of other commissioners currently outside of the ICS, e.g. specialised commissioning. JB to keep the Board appraised of developments in relation to specialised commissioning.
- The report should read best value for the population (as opposed to the system) not individual organisations. Any implications for individual organisations needs to be considered and addressed by the whole ICS.
- That when Foundation Trusts take major items with wider implications for decision from their governors that the ICS Board is asked for endorsement.
- That consideration needs to be given to the consequences of holding a competitive procurement process for part of a pathway.

The ICS Board agreed the approach to Best Value Decision Making and best practice principles with the proviso that comments made by the Board are reflected. The ICS Board agreed that an annual item on commissioning intentions would be added to the future workplan.

ACTIONS:
DP and Lucy Dadge to make the required amendments to the approach to Best Value Decision Making.
JC to add an annual item on commissioning intentions to the ICS Board workplan.

7. ICS Strategy / 5 Year Plan - Outputs of ICS Board Strategy Session 24 April 2019

TD attended the meeting to present the circulated paper following key discussion points and agreement from the 24 April ICS Board development session. The paper was agreed as an accurate record of the discussion and the priorities agreed.

The Board discussed the item and made the following points:

- The ICS Board should give consideration to how urgent care services will function in the future, whether that be managing demand or creating alternative options in the community
- The same day urgent care model options appraisal will draw upon work already complete or underway.
- Leads for urgent and emergency care, and any other relevant subject mater experts, to be invited to the July development session to support discussions.
- The importance of stating an ambition for transformation in quantitative terms and robustly measuring to understand progress.
- That further emphasis needs to be given to broader work across the system including social care.

TD to address points made and build into the next ICS Board strategy development session.

ACTIONS:
TD to address points made and build into the next ICS Board strategy development session.

8. Local priorities for inclusion in the 2019/20 MoU with NHS England and Improvement

TD attended the meeting to present an early proposal of local priorities for inclusion in a 2019/20 Memorandum of Understanding (MoU) with NHS England and Improvement. Paragraph 8 of the report proposes four priorities.

Board members asked that the following be addressed:

- More emphasis be given to priorities which will demonstrate tangible changes rather than an emphasis on structure and governance. Suggested that structure and governance priorities could form one overarching priority to reflect this.
- Red rated performance issues such as urgent care should be stated as local priorities for the system.
- Further work is needed to cross reference with the ICP priorities.
- Emphasis on system architecture should be to conclude rather than to develop further.
- Implementation of the mental health strategy and its impact should be incorporated.
- Priorities should be ordered as “big ticket” items, how the system is organised, and local priorities.
- Priorities should be reflected in the ICS Board workplan.

Board agreed that a proactive approach to decide system priorities was welcome.

ACTIONS:
TD to develop the local priorities for inclusion in a 2019/20 Memorandum of Understanding (MoU) with NHS England and Improvement to be agreed by the ICS Board at a future meeting.

9. NHS Long Term Plan engagement plan and system narrative

AB presented the circulated papers on the NHS Long Term Plan engagement plan and system narrative following the meeting on 15 February. The papers provide:

- An update on the progress to date on the Engagement activities regarding the NHS Long Term Plan.
- An update on the deployment of the ICS System Narrative.
- A summary of the insights regarding the priorities and attitudes of the citizens and staff.
- An outline of the further engagement activities due to be delivered over the coming weeks.

Board members made the following points:

- That the engagement is focussed on NHS rather than the wider system. MB to support AB on incorporating social care.
- That the findings to date reinforce current system priorities.
- The importance of engaging with staff from across the system.

ACTIONS:
AB to give further consideration to engagement activity focussed on wider system issues.

10. Developing the roles and functions at ICS, ICP and PCN level

DJ presented the circulated paper on the roles and functions at ICS, ICP and PCN levels.

Board agreed the following recommendations:

- Endorse section 10 as an agreed description of how each part of the new system will relate to one another (the 'Operating Behaviours').
- Agree to receive a future report on how relationships are working out in practice and how provider partnerships are overcoming potential inconsistencies of approach. This will be incorporated into a review of ICPs in 12 months time.
- That Board members will ensure that the organisations they represent use Annex B as the basis for the establishment of the ICPs and PCNs.
- JT highlighted that Annex B was a good starting point but that it might be too simplistic – some parts of the system have a role (albeit less dominant a role) in areas that are not indicated in Annex B.
- JM welcomed the report and found Figure 2 especially helpful and asked whether more worked examples could be produced.

Work that AS is undertaking following the 24 April ICS Board development session will build on this approach to specifically make clear what needs to be done at each level where functions are multifaceted.

11. Development of the Model for Primary Care Networks

NA presented the circulated paper on the development of the model for Primary Care Networks (PCNs) following the approach agreed in November 2018. Paper provides an overview of the process undertaken and progress to date.

NA clarified that whilst the lower limit on the size of PCNs is fixed at 30,000, there is likely to be more flexibility with the upper size parameter of 50,000 stated in guidance in order to address local issues and work within established neighbourhoods. RS highlighted that there may be one PCN larger than the values stated in the paper.

TT noted the work that had gone in to getting to this point and the importance of the final agreed configuration of PCNs not undermining the decision-making principles that has been used to establish the ICPs.

Board approved the vision and aspirations for PCNs. Progress to date on configurations was endorsed and final approval of the submission to NHSE&I was delegated to the ICS Managing Director on behalf of the Board. Paper to be presented to the CCG joint PCC Committee for approval on the 23 May.

Oversight of System Resources and Performance Issues (including MoU)

12. ICS Integrated Performance Report - Finance, Performance & Quality.

HP presented the circulated Integrated Performance Report. Key messages are as follows:

- Consistent position for high and emerging risks.
- Cancer performance further deterioration in month.
- Significant improvement in children's wheelchairs performance.
- Comparison to other STP/ICS has been refreshed in this report and is broadly consistent with previous reports.

As discussed at the 11 April meeting, deep dives into red rated areas have been incorporated into the forward workplan for the Board. A report on Mental health performance will be presented to the Board at the 13 June meeting.

RH asked that the local performance information for ambulance response times be incorporated into the report, this was agreed. Consideration to be given to a Board development session on ambulance performance.

JB asked that the report be amended for mental health to ensure that performance reflects population and provider appropriately.

ACTIONS:
HP to ensure that the Integrated Performance Report is developed to incorporate local ambulance response times and mental health.

13. Mid Nottinghamshire ICP

RM presented the circulated paper from Mid Nottinghamshire. Board members to note the visit to Wigan and how Wigan have come together as a system and created a sense of identity. To discuss at Mid Nottinghamshire ICP Board meeting on 14 May 2019.

JM emphasised the strong relationships with Local Authorities and political support in Wigan and positive impact on transformation. DP highlighted the upcoming ICS workshop for Elected Members and NHS Non-Executives on 25 June and asked that Board members circulate this invitation within their organisation.

ACTIONS:
RM to share messages and learning from the visit to Wigan with members of the Board.
Board members to circulate the invitation to the ICS workshop for Elected Members and NHS Non-Executives on 25 June within their organisation.

Governance

No items on the agenda.

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

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ICS Board membership

Role	John Brewin	Dean Fathers	Richard Mitchell	John Macdonald	Tracy Taylor	Eric Morton	Amanda Sullivan	Melanie Brooks	David Pearson	Jon Towler	Richard Henderson	Ian Curryer	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						

Role	John Brewin	Dean Fathers	Richard Mitchell	John Macdonald	Tracy Taylor	Eric Morton	Amanda Sullivan	Melanie Brooks	David Pearson	Jon Towler	Richard Henderson	Ian Curryer	Not represented at this meeting
CCG Chair										X			
EMAS Chief Executive											X		
Nottinghamshire County Council CEO or nominee								X					X
Nottinghamshire County Council elected member													X
Nottingham City Council CEO or nominee												X	
Nottingham City Council elected member													X
NHSE/I representative													X

In attendance:

	Deborah Jaines	Helen Pledger	Alex Ball	Richard Mitchell	Nicole Atkinson	Richard Stratton	Thilan Bartholomeuz	Andy Haynes	Elaine Moss	Not represented at this meeting
ICS Managing Director	X									
The ICP lead from Nottingham City ICP										X
The ICP lead from South Nottinghamshire ICP										X
The ICP lead from Mid Nottinghamshire ICP										
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							

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ICS Board Action Log (June 2019) **Item 3. Enc. A2**

ID	Action	Action owner	Date Added	Deadline	Action update
B159	To make the required amendments to the approach to Best Value Decision Making.	David Pearson/Lucy Dadge	09 May 2019	30 May 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	
B158	To work with Lyn Bacon and Nicky Hill to give further consideration to how the LWAB links to the ICS and the resource requirements for the workforce workstream	Wendy Saviour	09 May 2019	30 June 2019	Discussions underway.
B161	To address points made in ICS Strategy / 5 Year Plan discussion and build into the next ICS Board strategy development session.	Tom Diamond	09 May 2019	22 July 2019	

ID	Action	Action owner	Date Added	Deadline	Action update
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	31 July 2019	Item on the Board workplan for the 12 July meeting.
B157	To provide further detail to the ICS Board on the impact of the initiatives in the People and Culture Strategy.	Lyn Bacon/Nicky Hill	09 May 2019	30 September 2019	Item to be presented at the September Board.

ENC. B

Meeting:	ICS Board
Report Title:	Patient Story – Persistent Physical Symptoms. Primary Care Psychological Medicine
Date of meeting:	Thursday 13 June 2019
Agenda Item Number:	4
Work-stream SRO:	N/A
Report Author:	Helen Smith
Attachments/Appendices:	Appendix 1: Patient Story

Report Summary:

The patient story is presented to illustrate the impact on outcomes of a patient with complex persistent physical symptoms of:

- A person centred approach
- Assessment and formulation based on a biopsychosocial model
- The equal acknowledgement of mental and physical health components to the person's presentation

Recommendations for a service to address this group of patients' needs are made by the Joint Commissioning Panel for Mental Health (2017) and is highlighted as one of the ten priorities for change by the Kings Fund in their report 'Bringing together physical and mental health' (2016).

The patients seen by the service become not only more independent in managing their condition, using healthcare services less frequently, but have been able to return to purposeful and meaningful roles at home and work, reduce carer burden and reliance on benefits.

These patients were seen by the Primary Care Psychological Medicine service, developed to address a need identified within Principia Multispecialty Community Provider Vanguard to provide an intervention for people with complex persistent physical symptoms that were too complex to be managed by Improving Access to Psychological Therapies (IAPT) providers and whose symptoms were not responding to intervention from physical health input.

Nottinghamshire Healthcare Foundation Trust provided the team to test this model of delivering liaison psychiatry in the community for this group of people within Rushcliffe CCG, funded by Vanguard monies.

In the first two years the service saw 211 patients who presented with significant physical symptoms (96th centile on PHQ-15), moderate to severe depression (PHQ 9) and moderate to severe anxiety (GAD 7).

To understand the impact of the service patient reported and clinician reported outcomes measures were recorded. Actual patient level primary care and secondary care activity was also analysed. The findings were independently evaluated by the Centre for Mental Health and showed significant improvement in

patient and clinician reported outcome measures and a reduction in use of secondary physical health care services and primary care attendance equating to annualised savings of £222k for a service whose staffing costs are £140k.

As the service does not see people in a specific diagnostic care pathway it can be difficult to understand the patients seen by the service. The patient story is intended to illustrate this.

Action:

☒ To receive
☐ To approve the recommendations

Recommendations:

Key implications considered in the report:

Financial	☒	The report summarises the financial and activity impacts
Value for Money	☒	Independent evaluation shows value for money
Risk	☐	
Legal	☐	
Workforce	☐	
Citizen engagement	☒	To engage patients who have benefitted from the service in sharing their experience where until now there has been a gap in their treatment and management
Clinical engagement	☒	To engage clinical leaders across the ICS in acknowledging the need for parity of esteem. It reinforces the wider ICS work around personalisation.
Equality impact assessment	☒	A full EQIA has been completed and is available. It shows a positive impact on health outcomes and access.

Engagement to date:

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

Contribution to delivering the ICS high level ambitions of:

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

Is the paper confidential?
☐ Yes ☒ No Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

BACKGROUND PAPER FOR PATIENT STORIES – PERSISTENT PHYSICAL SYMPTOMS, PRIMARY CARE PSYCHOLOGICAL MEDICINE

13 June 2019

The Service

1. The Principia Multispecialty Community Vanguard identified a gap in service provision for people with complex persistent physical symptoms and so developed and tested a service model for the patient group. Those consulted in the development of the model were GPs and local CCGs, Department of Psychological Medicine (DPM) staff, Nottinghamshire Healthcare NHS Foundation Trust, Nottingham University Hospital colleagues, the Centre for Mental Health (CMH), the Royal College of Psychiatrists Liaison Faculty and, most importantly, several DPM patients who shared the index diagnoses. Primary Care Psychological Medicine Service was initiated and funded by the Vanguard in Rushcliffe and commenced in September 2016.

2. The service offers a holistic, integrated service to improve the management of patients identified by the primary care clinician falling within the following:

   - Complex Persistent Physical Symptoms
   - Diagnosis of complex mixed medical and psychiatric morbidity such as patients with complex persistent physical symptoms for example (but not limited to), patients with multiple sclerosis or motor neurone disease where the physical health intervention has not produced results; in this case exploration of psychological aspects of the illness may well lead to symptom improvement
   - Multiple referrals to secondary services
   - Distress and functional impairment
   - Patients who have frequent admissions as inpatients where a clear diagnosis has not been made
   - Patients with negative diagnostics which have failed to show a cause for the symptoms being presented
   - Polypharmacy

3. This group of patients has a wide variety of presentations that are seen across all areas of health services. It should therefore follow that by managing this diverse group of people's symptoms in a more systematic and holistic way, capacity would be realised within primary care, outpatients and inpatient facilities.

4. Due to the wide range of services these people can be in contact with, it is difficult to appreciate the complexity of the group of patients as they do not fit into a NICE guideline or simple diagnostic treatment pathway. Also as the combination of health presentations can make it challenging for their care to be met by a mental health or physical health service alone.

5. The team providing the service, delivered in a primary care/community setting, are 2.0 WTE experienced mental health liaison nurses and 2 sessions of a liaison psychiatrist who also work in the local acute trust. The team are supported by admin and data analyst staff.

6. As part of the Vanguard, the service was required to be evaluated for impact. The Centre for Mental Health was commissioned to independently evaluate the service using actual patient service utilisation data; patient reported outcome measures and clinician rated outcome measures.

7. Patient reported outcome measures used were :

   - Patient Health Questionnaire 15-Item Somatic Symptom Severity Scale (PHQ-15) is used to assess the impact of physical symptoms
   - Patient Health Questionnaire-9 (PHQ-9): A measure of depression
   - Generalized Anxiety Disorder 7 (GAD-7): A measure of anxiety
   - EQ-5D-5L: A measure of physical and mental well-being
   - Thermometer: A measure of general well being

   Statistically significant improvements were seen in these measures.

8. The headline figures based on **actual** secondary care patient activity showed:

   - 33.3% reduction in hospital admissions,
   - 38.9% reduction in emergency admissions,
   - 31.7% reduction in ED attendances,
   - 32.4% reduction in outpatient appointments

9. Primary care actual activity showed:

   - contacts -2.4%
   - referrals -20.5%
   - investigations -2.7%
   - acute appointments +29.9%
   - sick notes issued -31.3%
   - ambulance usage -71.5%

10. The Centre for Mental Health's analysis found that prior to intervention the cost per month of each patient was £175.41. After discharge these reduced to £86.38 per patient per month. This was calculated to equate to annualised savings of £222k for a service whose staffing costs are £140k (18/19 pay rates). It should be noted that costs related to investigations, prescriptions and nationally commissioned services are **not** included.

11. As well as delivering savings and releasing capacity in primary care, the service improves the quality of care received by reducing the potential risks associated with unnecessary treatment or investigations.

12. Acknowledgment of the service is reflected in being a finalist in both the Health Service Journal and British Medical Journal awards. It is also referenced in the Kings Fund Mental Health and New Models of Care: Lessons from the Vanguards (Kings Fund, 2017) and is featured in the mental health and primary care resources from the Kings Fund Learning network on Integrated care (https://www.kingsfund.org.uk/courses/integrating-physical-mental-health-care/resources).

Patient Stories

13. It can be difficult to describe the patient cohort the service sees due to the variety of diagnoses and presentations of the patients. The purpose of sharing this story is to articulate the clinical impact, system impact and wider impact on the participation of people seen by the service in work and life roles, reducing their care and needs on their network of support.

14. In her own words one of the patients describes her experience. See Appendix 1. She will present her story within the meeting.

15. Another patient, who wanted to remain anonymous, has recorded a video describing the significant improvement in her condition and functioning with this approach which is available on request. Consent has been provided to share this to support commissioning processes.

Key Messages and Learning

16. The pilot has shown that treating people holistically to meet physical and mental health needs is having a positive impact on patients' symptoms, function and their families and carers.

17. It has demonstrated:

- Improved patient outcomes
- Integrated mental health and physical health
- Integrated hospital care and brought it into primary care
- Reduced secondary care attends
- Reduced primary care attendances
- Savings based on CCG Healthcare Resource Group (HRG) 4+ code individual level patient data.

18. There are opportunities in the future configuration of the system for this model to be rolled out with a phased approach at PCN level if tailoring to meet the needs of particular populations. Extrapolated annualised savings including proportionate decay =

£1,200 net saving (after staff costs accounted for) per suitable patient per year

Net savings of this rollout, once steady state is achieved, (staffing costs accounted for) would be £520k per annum.

It should also be taken into account that unmeasured direct costs, e.g. prescription costs and investigation costs would multiply this by a factor of 1.5 = £780K

Indirect service costs would increase this further, e.g. clerical, telephone calls, waiting lists etc.

Next Steps

19. The service is currently funded until 31 March 2020 to continue delivering the service in Rushcliffe. Activity is underway locally to secure financial sustainability for April 2020 onwards. The original business case is being further refined to support this process.

20. Spread of the service beyond Rushcliffe was agreed in principle during Greater Nottingham Clinical Commissioning Executive group in December 2018.

21. The roll out of this service could pilot the ambition of the ICS Mental Health strategy of a service that is commissioned in an integrated way, rather than from a solely mental or physical health commissioning perspective.

22. A pathway with local IAPT providers and secondary care providers will be developed to ensure the right people are seen by the right service.

Conclusion

23. This service is demonstrating beneficial health outcomes for patients who hitherto have not had their health needs adequately addressed and whose GPs have struggled to manage. Furthermore it is showing promising financial benefits and an impact of releasing primary care time and resource. The patient stories demonstrate the significant impact a relatively modestly resourced service can have on patients and their lives.

Appendix 1

Patient Story
History and background of symptoms

In October 2015, my whole life changed. I woke up unable to communicate. My face muscles seemed droopy. My jaw muscles were involuntarily contracting, thus making me bite my tongue and cheeks. Mentally and emotionally, I was a wreck due to the 24-hour pain of biting my tongue and cheeks, which was deeply cut, bleeding and blistered. (Scars can be seen from this to date). I could not stop clenching my jaw shut. I could not open my mouth. I had constant pain on the left side of my head, especially just above my ears. I felt frustrated and lonely, as if no-one really cared about me. I have dextrocardia situs inversus to complicate matters.

What was your quality of life and how were you functioning day to day?

I couldn't eat, sleep, do housework, cook, shop, have a shower, drive a car or even look after my little 4-year-old. I also suffered from insomnia. I couldn't go out of my home. I couldn't stop crying. My poor son had thought he done something wrong. Communication was very difficult for me, due to the jaw spasms. I could only communicate by wedging my mouth open with something (E.g. pen, pen lid, lollipop stick, lipstick, etc.), so that my jaw would not snap shut. It was difficult to open my jaw without using a spoon or fingers to do so. My brother even bought me a boxing glove, as my fingers were extremely sore from biting on them and trying to prise my jaw open. It just clenched shut and continuously kept pushing against my teeth. I was even having problems with my memory. I could not remember simple things. I also started wetting myself.
What hurt the most, was not being able to take care of my son; simple things like reading to him, playing with him or even taking him to school.

What was the treatment and management approach prior to your referral to PCPM?

The first time I went to the doctor, I was asked to see my dentist. My dentist referred me back to my doctor, who then referred me back to the dentist! For quite some time I visited my doctor every other day. All I was given was strong painkillers. My doctor also suggested counselling. She referred me to a health visitor because she was concerned about my weight and diet.
I was then seen by the Maxillofacial Team at the QMC and then the Pain Management Team instead.
I had spent a lot of money on prescriptions, trying different painkillers and trying herbal remedies. My sister even paid for me to go to hypnotherapy, cranial massage and head massage.
At this point, I had just about had enough. I had this condition with no name for a year now and going from one department to another within the NHS was really not helping me mentally or physically. I decided to write a letter to my doctor regarding how fed up I was and that I had enough with the NHS. I was then referred to

psychological medicine. By now I had lost 3 of my teeth from clenching already. 1 front tooth and 2 back teeth.

What approach did PCPM take and how did it help?

I was very dubious about the Psychological Medicine Team. Their care was very different to that of GPs, Doctors, Counsellors and Health Visitors. It's difficult to explain in terms of words, but it was more as if nurturing my way of thinking; my outlook on why I woke up like this.
I had appointments every week and sometimes twice a week with them. Mainly, I was visited at home by the Mental Health Liaison Nurse. She helped me in various ways such as; trying to encourage me to get out of the house for a short walk; mindfulness; The Psychological Medicine Team Doctor had prescribed me with some psychological medicine that could only be prescribed by them and not the GP. The medicine helped ease some of my symptoms by directing my mind away from the pain but was not a full cure.
I felt they listened to me and talked to me like no other professional did; they seemed more concerned for my well-being; they seemed to take part in my sadness and worries; I did not feel alone anymore; they were sympathetic to my needs; helped me feel more relaxed; I felt they gave me the information I needed to help me get better and understand why and what was happening to me ; They agreed plans with me on short terms goals to take one step at a time and also ensured my GP were aware of these; I felt they fully engaged with my management; They made me realise the cause of my symptoms and how I could help myself; They helped me build my self-esteem and self-confidence. I did not feel worthless anymore; They helped to direct my doctors in contacting the speech therapist, who has helped me with better communication. I now just need to focus on managing to eat: Throughout my time with them, nearly 2 years, I have felt reassured by them, as I was taken seriously; I felt they understood my concerns more than anyone else.
I am able to communicate better and not clenching or biting my tongue or cheek anymore.
I was prescribed a better anti-depressant by them and slowly, but surely was on the mend. I could not have done it without the help of the Psychological Medicine Team.

Patient Reported Rating scales

	Initial assessment	Last
EQ-5D-5L	11	7
GAD 7	15	3
PHQ 9	8	4
Thermometer	0	80

What was the impact on your family and carers of how you were?
My neighbour, whose son was in the same School and class as my son, kindly took him to school and back home every day for a year for me. My parents and sister helped look after my son. They also helped by doing the grocery shopping and housework. My family supported me financially, although they were not well off themselves. I lost my livelihood and my home.

How are you now? Quality of life, day to day functioning and frequency of health appointments

I am now working part time and have bought a new property. I can care for my son independently and we have been on holidays. My mood is good and I sleep well. I hardly see the GP and have occasional appointments with the liaison nurse from PCPM. I no longer need to see the psychiatrist. I manage my own health and have a better understanding of how to cope and function in day to day life. I am positive in my outlook. I can communicate and I'm in less pain in my jaw.

What has this meant to your family and carers?

I am less dependent on my family to help me with shopping and day to day activities. I can take my son to school and do activities with him. We have recently been to Morocco on holiday and people worry about me less.

References:

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Kings Fund (2016) Bringing together physical and mental health: A new frontier for integrated care [online] available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Bringing-together-Kings-Fund-March-2016_1.pdf Accessed May 2019

Kings Fund (2017) Mental health and new models of care Lessons from the Vanguards [online] available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/MH_new_models_care_Kings_Fund_May_2017_0.pdf Accessed October 2018

Helen Smith
Programme Manager – Integration
03 June 2019

ENC. C1

Meeting:	ICS Board
Report Title:	Embedding innovation within the ICS strategy
Date of meeting:	Thursday 13 June 2019
Agenda Item Number:	6
Work-stream SRO:	Wendy Saviour
Report Author:	Alex Ball and Mike Hannay
Attachments/Appendices:	Enc. C2. Menu of Innovations available to the ICS

Report Summary:

This report outlines an opportunity to collaborate with the East Midlands Academic Health Science Network (EMAHSN) to embed a more consistent and strategic approach to research and innovation, by:

1. **Rapidly implementing existing 'off the shelf' evidenced-based innovations** from EMAHSN's project portfolio that address ICS strategy / 5 year plan priorities

2. **Putting in place a process** for ICS priorities not addressed by EMAHSN's existing portfolio, to identify proven solutions to support the delivery of the local strategy

This paper and recommended actions are part of a wider set of activities being developed to maximise the impact of the research and innovation community of Nottingham and Nottinghamshire. This wider set of activities will include exploring the potential of partnering with a standing research partner to better understand drivers of demand for urgent and emergency care and also seeking solutions to other longstanding issues.

Action:

☐ To receive
☒ To approve the recommendations

Recommendations:

1.	Review the list of 'off the shelf' innovations at the appendix and agree to seek full deployment within the ICS
2.	Identify key ICS priority areas / themes that could benefit from an innovation exchange process to identify other proven solutions (i.e. for ICS priorities not addressed by the existing EMAHSN portfolio)
3.	Identify ICS colleagues to co-develop and run the innovation exchange process alongside the EMAHSN
4.	Agree timescales, review and sign-off process for the above.

Key implications considered in the report:

Financial	☐	It is not anticipated that there will be any cost to the ICS to running an innovation exchange process
Value for Money	☐	All innovations considered for adoption would focus on improving outcomes for patients / service users and enabling efficiencies

Citizen engagement	☐	All AHSN-supported innovations are developed in liaison with patient / service user representation
Clinical engagement	☐	Clinical engagement will be key to successful deployment and must be built into any plans to adopt existing / identify potential new innovations
Equality impact assessment	☐	All EMAHSN-supported innovations are subject to an equality impact assessment coordinated by the organisations Public and Patient Leadership team

Engagement to date:

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

Contribution to delivering the ICS high level ambitions of:

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

Is the paper confidential?

☐ Yes
☒ No

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

Integrated Care System
Nottingham & Nottinghamshire

Nottingham City Council | Nottinghamshire County Council | NHS

Embedding innovation within the ICS strategy

13 June 2019

Background:

1. EMAHSN (hosted by Nottingham University Hospitals NHS Trust) is one of 15 Academic Health Science Networks across England, licensed by NHS England to operate as the innovation arm of the NHS.

2. Each AHSN works in its region to develop and spread evidence-based solutions to local STP and ICS priorities, and via their national network the 15 AHSNs share what works best so the innovations can be spread across wide geographies.

3. The AHSNs all operate local 'innovation exchanges: these processes take a priority highlighted by an STP / ICS and bring together health partners with innovators to match solutions to challenges. As the AHSNs work across sectors – NHS, social care, higher education, third sector and industry – they can broker connections between health systems and innovators / entrepreneurs with proven solutions.

4. Once solutions against the challenge have been identified, the AHSN may be able to provide support, expertise and seed funding to deploy and embed the selected innovations; the intention is to prove their value so they become sustained as 'business as usual'.

5. Innovations identified by this process could be from within the AHSN's local area or from another AHSN region, and could be devices, diagnostics, systems, processes or pathways.

6. All 'off the shelf' innovations are evidence-based (i.e. they have been tested in a 'real world' setting and proven to work) or are new initiatives established as demonstrator projects that are deployed within an NHS or social care setting for evaluation to establish their potential for wider spread.

7. Hence, by collaborating with the EMAHSN (and by leveraging their wider connections with the other 14 AHSNs) there is potential for Nottingham and Nottinghamshire ICS to quickly identify, evaluate and adopt existing, proven innovations to support the delivery of key strategic priorities.

8. AHSNs have an established track record at spreading innovation: they were relicensed by the NHS in 2018 based on their impacts during their first period (2013-2018) which saw them collectively spread 330 innovations across 11,000 health and social care locations throughout England.

9. In its 2019-2020 business plan the EMAHSN's targets are focusing on supporting the priorities of East Midlands STPs / ICSs.

10. **The appendix lists EMAHSN's current innovation portfolio.** Of the 18 innovations listed, six are fully deployed within the ICS: however a number not yet deployed / partially deployed align closely to the ICS strategy and 5 year plan. For ease of reference the appendix lists the innovations by ICS priority with an indication of the level of adoption within Nottingham / Nottinghamshire.

Issues for consideration:

11. The Board is invited to review the appendix that lists the existing EMAHSN innovations

12. Of those not deployed / not fully deployed locally, the Board is invited to commit to roll out across the ICS footprint those that address ICS priorities. Any issues or barriers subsequently identified that could limit their adoption, will be reported back to the Board

13. The Board is invited to indicate any ICS priorities not addressed by the existing EMAHSN innovation portfolio, which could form the basis for a bespoke 'innovation exchange' process. Supported by the EMAHSN, this process would use the organisation's local and national connections to identify proven innovations in line with the priorities identified for local adoption.

14. The Board is asked to commit to support the bespoke innovation exchange process (summarised at 3.) in collaboration with the EMAHSN, and to identify ICS colleagues who would be tasked with shaping the design to ensure it addresses ICS priorities.

Timescales:

15. Timescales are suggested below. These are indicative and will depend on a range of factors including the size / complexity of the projects, sign-off processes of delivery partners, availability of 'seed' funding required for some projects and capacity of the EMAHSN to deploy multiple new projects concurrently. However:

    a) For adoption of existing EMAHSN projects selected by the Board:

    - Scoping and evaluation / feasibility - two months approx.
    - Deployment – a further four to six months

    b) To run a bespoke innovation exchange process:

    - Identification of solutions against ICS priorities: six to eight weeks
    - Organisation of event / workshop: a further six to eight weeks
    - Further timelines to be developed (deployment / evaluation of solutions).

Recommendations

16. The Board are asked to note the following recommendations:
    - Review the list of 'off the shelf' innovations at the appendix and agree to seek full deployment within the ICS
    - Identify key ICS priority areas / themes that could benefit from an innovation exchange process to identify other proven solutions (i.e. for ICS priorities not addressed by the existing EMAHSN portfolio)
    - Identify ICS colleagues to co-develop and run the innovation exchange process alongside the EMAHSN
    - Agree timescales, review and sign-off process for the above.

Integrated Care System
Nottingham & Nottinghamshire

East Midlands Academic Health Science Network
Igniting Innovation

East Midlands Academic Health Science Network Programmes

Support for Nottinghamshire Implementation

The tables in the following document summarise the East Midlands AHSN's portfolio of innovations against the indicated and emerging priorities of the Nottingham and Nottinghamshire Integrated Care System (ICS):

- Redesign of the urgent and emergency care system
- Improve the care of people with single and multiple long term conditions through greater proactive management and self management to reduce crises
- Re-shape and transform services and other interventions so they better respond to the mental health and care needs of the population
- Reduce waste and improve efficiency and value across the system
- More action on and improvements in the upstream prevention of avoidable illness and its exacerbations

Many of our programmes span more than one of these priority areas, but are demonstrated under the most appropriate priority for ease.

England's 15 Academic Health Science Networks (AHSNs) operate as the innovation arm of the NHS. We work across all sectors involved in health and care - NHS organisations, social care, public health, universities, third sector and industry - to broker innovative solutions and support NHS transformation.

Each AHSN works with its partners to develop, test and then spread proven solutions that respond to local NHS challenges. By operating as a national network we can both export home-grown innovations and import solutions proven to work elsewhere that address the needs of our region.

- ✓ Deployed in Nottinghamshire
- ? Partially deployed in Nottinghamshire
- ✗ Not deployed in Nottinghamshire
- ★ Limited deployment while in demonstrator / testing phase
- £ Savings information

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Office for Life Sciences

East Midlands Patient Safety Collaborative

NHS

Nottingham and Nottinghamshire ICS Priority 1:
Redesign of the urgent and emergency care system

Project Summary	Why?	Nottinghamshire Adoption
Atrial Fibrillation - East Midlands AF Advance Programme Part of a major AHSN / NHS national initiative to detect and treat Atrial Fibrillation (AF), by distributing mobile electronic testing devices to GP practices along with more effective prescribing of anti-coagulation medication and testing of patients in their local community.	AF is a leading cause of stroke, accounting for one in every five cases - there are over 36,000 undiagnosed patients in the East Midlands. Latest figures show 6,175 more East Midlands' patients at high risk of AF are now being anti-coagulated - a 9.7% increase over 12 months and the highest treatment rate in England.	? Deployed across four of the six Nottinghamshire CCGs (devices not currently in use in Mansfield and Ashfield CCG and Newark and Sherwood CCG). £ As a result of the 4,400 additional people who will have AF diagnosed, this will save the East Midland's NHS over £2.5m.
Emergency Laparotomy Collaborative Reducing deaths associated with Emergency Laparotomy (complex emergency abdominal surgery). It uses collaborative working to embed quality improvement - bringing together dozens of staff from Emergency Departments, radiology, acute admission units, theatres, anaesthetics and intensive care.	Emergency Laparotomy is a high risk procedure - up to 25% of patients die within 30 days. Up to 50,000 are performed every year in the UK and over 25% of surviving patients remain in hospital for more than 20 days after surgery, costing over £200m a year and leading to big variations in care.	✓ Deployed across all hospitals in Nottinghamshire where Emergency Laparotomy procedures are performed.
Falls prevention and management Multi-agency collaboration (NHS, social care, third sector and technology providers) to develop a service model to reduce falls through early identification of risk, early intervention and proactive management - improving patient management and supporting self-management by patients.	55,000 people over 65 are at risk of falling in the area currently covered by this project (Leicester, Leicestershire and Rutland). Once a fall occurs there is a higher probability of falling again with a year. Understanding why falls happen reduces the likelihood - causes range from faulty footwear to medication and poor visibility.	★ Currently in demonstrator phase in Leicester, Leicestershire and Rutland. Full evaluation will be available Q2 20/21.

Nottingham and Nottinghamshire ICS Priority 2:

Improve the care of people with single and multiple long term conditions through greater proactive management and self management to reduce crises

Project Summary	Why?	Nottinghamshire Adoption
Safety in Care Homes (LPZ) LPZ (Landelijke Prevalentiemeting Zorgkwaliteit) is an audit tool developed in the Netherlands to measure common care problems in nursing and residential homes such as falls, pressure ulcers and hydration. East Midlands care homes have taken part in the audit providing consistent recording of data to support and measure improvements in quality of care, and enable cost savings.	Care home providers in the UK use different indicators and metrics for care quality. With no nationally agreed benchmarking tool it is impossible to know the true incidence or prevalence of common problems such as pressure ulcers. LPZ offers a benchmark to drive quality improvement, improve patient safety and reduce unnecessary admissions to hospital.	? Deployed across 27 care homes in Nottinghamshire. £ If deployed across the East Midlands care home sector, this programme would result in an annual cost saving of £4.58m.
The 'Scarred Liver' programme This innovative diagnostic pathway is proven to more effectively detect chronic liver disease at an early stage, when it can be halted or even reversed. It combines identification of patients who are at risk (as a result of their lifestyle) with a diagnostic test using a mobile scanner that highlights the degree of scarring to the liver.	Liver disease is the third leading cause of premature death in the UK and deaths have increased in each of the last four decades. Deaths in the East Midlands have increased by over 60% in the last 20 years - but as most cases result from lifestyle-related factors (such as alcohol and obesity) they can be prevented as long as they are detected early enough.	? Deployed in Nottingham City and South Nottinghamshire CCGs. £ Reduces one consultant outpatient appointment per patient with risk factors for liver disease.

Nottingham and Nottinghamshire ICS Priority 2:

Improve the care of people with single and multiple long term conditions through greater proactive management and self management to reduce crises

Project Summary	Why?	Nottinghamshire Adoption
ESCAPE-Pain NICE-approved programme provides group rehabilitation for people with chronic joint pain. It uses self-management to help people cope, with exercise tailored to each person. It is delivered via physiotherapists or health trainers away from clinical settings such as leisure centres and work places.	One in four GP appointments are estimated to be related to joint pain. ESCAPE-Pain participants experience a marked improvement in mobility and pain reduction and are better able to cope with everyday activities. There is also a reduction in anxiety and depression.	? Currently in deployment phase in four community settings in Nottinghamshire (including Bulwell Riverside Centre, King's Mill Hospital, Mary Potter Health Centre and Newark Hospital). £ Every £1 spent gives a £5.20 return to the health system.
COPD Discharge Bundle This programme focuses on the facilitation and spread of the British Thoracic Society, Chronic obstructive pulmonary disease (COPD) discharge bundle, which outlines high impact actions with the aim of improving care and reducing re-admissions.	COPD has a large impact on quality of life and can result in unplanned hospital admissions. The condition narrows the airways throughout the lung, reducing capacity and leads to breathlessness. It affects the lung's ability to transfer oxygen to the blood and can lead to respiratory failure.	★ To be rolled out in the city / county during 2019 via the East Midlands respiratory network.

Nottingham and Nottinghamshire ICS Priority 3:

Re-shape and transform services and other interventions so they better respond to the mental health and care needs of the population

Project Summary	Why?	Nottinghamshire Adoption
ChatHealth Safe and secure text messaging service that puts secondary school pupils in touch with a school nurse using their own mobile phone.	School nursing capacity is stretched and young people may want to avoid face-to-face appointments on highly sensitive issues. Chathealth is highly effective at reaching this hard-to-reach audience using technology they are familiar and comfortable with.	✓ Available across Nottinghamshire.
Transforming ADHD Care In the East Midlands over 76,000 young people have Attention Deficit Hyperactivity Disorder (ADHD). QbTest uses technology to assess core symptoms of ADHD, supporting faster and more effective diagnosis.	ADHD assessment can be lengthy and relies heavily on interpretation of subjective reports. QbTest reduces the number of clinician consultations needed to confirm diagnosis and speeds up diagnosis.	✗ Not currently deployed in Nottinghamshire. Originally pioneered in Nottinghamshire. £ Estimated savings for 2019-20 across the three areas currently using QbTest is £191,000.
Group Psychoeducation for Bipolar Disorder NICE-approved group therapy for people with bipolar disorder delivered in mental health provider organisations. Patients receive information on their illness and work with family members to develop personalised coping strategies.	Few adults with bipolar disorder access appropriate psychological interventions because of capacity and training issues within mental health services. These structured group sessions are highly successful in treating patients in the early stages of bipolar disorder compared to standard peer-support offered by the NHS and voluntary sector.	✓ Deployed in Nottinghamshire via Nottinghamshire Healthcare NHS Foundation Trust, which was the lead site for the intervention.

Nottingham and Nottinghamshire ICS Priority 3:

Re-shape and transform services and other interventions so they better respond to the mental health and care needs of the population

Project Summary	Why?	Nottinghamshire Adoption
Serenity Integrated Mentoring (SIM) Integrates mental health care and policing, focusing on patients with complex mental health needs. It trains a police officer in high intensity behaviour, risk management and basic clinical theory and parachutes them into a community mental health team to help with the most challenging cases.	Public services are struggling to manage a small number of callers with highly complex behaviour, placing pressures on police, emergency and healthcare teams. SIM makes the connection between emotional trauma and offending, providing joined up support across health and justice systems. It is proven to significantly reduce crisis calls to emergency services, admissions to A&E for false or malicious and abusive behaviour.	✕ Not currently deployed in Nottinghamshire. £ Combined cost savings to police, ambulance, Emergency Department and mental health services of £950 per calendar month, per patient.

Nottingham and Nottinghamshire ICS Priority 4:
Reduce waste and improve efficiency and value across the system

Project Summary	Why?	Nottinghamshire Adoption
Digital outpatient appointment management This project is currently at testing phase and will put in place a digital outpatient management system across a number of acute NHS trust clinical specialities, integrating with the trust's existing IT systems. It will help move scheduling of outpatient appointments to a needs, rather than time, basis.	Tailoring care to individuals can cut costs by reducing unnecessary appointments, and it also improves patients' experiences and supports them to live well, for example by helping them manage side-effects of medication.	★ Currently in demonstrator phase within Nottingham University Hospitals NHS Trust across three clinical specialties. Full evaluation will be available Q4 2019/20.
PINCER **P**harmacist-led **IN**formation technology intervention for Reducing **C**linically Important **ER**rors) is software that helps GPs review patient caseloads and highlight risk of prescribing errors - particularly for people with complex combinations of medicines. This enables action to reduce risk of errors.	Errors are rare but expensive to resolve and lead to patient harm, hospitalisation and deaths. Error rates are around 5% and serious errors affect 1 in 500 prescriptions. Mistakes happen for many reasons such as knowledge gaps, ignoring warnings, lack of monitoring and breakdown of systems. PINCER helps to prevent these mistakes.	✓ Deployed within all Nottinghamshire CCG areas. Currently used in 100 out of 134 GP practices (74%).
Unit Dose Close Loop Medicines Management Uses robotics to individually package medicines for patients in acute NHS hospitals. The system coordinates the entire process - cutting, bagging and labelling with unique barcodes for each patient. Automated storage cabinets on wards automatically fill medicines trolleys.	It is a challenge for hospital staff to get the right medicines to the right patients at the right time - resulting in waste and risking patient safety from mistakes in the combination or quantity of medicines prescribed. This end-to-end high-tech solution enables over 80% of medicines to be tracked and traced from order to patient administration at a unit dose level - saving money and improving the safety of patients.	★ Under evaluation in University Hospitals of Leicester NHS Trust.

Nottingham and Nottinghamshire ICS Priority 4:
Reduce waste and improve efficiency and value across the system

Project Summary	Why?	Nottinghamshire Adoption
Transfers of Care Around Medicines (TCAM) When people move between care providers or are discharged from hospital, mistakes can be made about medication. TCAM ensures ongoing local pharmacist support, so they have the right medicines and take them appropriately. It leads to significant reductions in hospital length of stay and re-admissions.	Patients don't always remember everything they are told in hospital; having a pharmacist go through their medicines - discussing side effects and checking they understand -keeps them safe and means they are less likely to be readmitted to hospital.	✓ Deployed in Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS foundation Trust. £ Estimated saving of over £2m for current trusts through avoided admissions and shorter hospital stays.
Polypharmacy Polypharmacy (where people are prescribed many medicines) can lead to errors and unintended side effects. This project reviews people's medicines and provides information and advice for clinicians to identify patients at risk, and for people to understand their conditions.	Polypharmacy is common for elderly people - around 40% of older adults living in their own homes are prescribed more than 10 medicines. It can lead to a number of problems, for example patients who are prescribed more medicines than they actually need, or take the wrong medication for their condition.	★ Frailty pathway in demonstrator phase at Nottingham University Hospitals NHS Trust and a new Social Prescribing Tool will be available in Nottinghamshire in late 2019.

Nottingham and Nottinghamshire ICS Priority 5:

More action on and improvements in the upstream prevention of avoidable illness and its exacerbations

Project Summary	Why?	Nottinghamshire Adoption
Maternal and Neonatal - PReCePT (**PR**eventing **C**erebral Palsy in **P**re-**T**erm labour) Prescribes magnesium sulphate to mothers in pre-term labour.	Magnesium sulphate significantly reduces infant mortality and prevents cerebral palsy.	✓ Deployed across all of the maternity units in Nottinghamshire (about to commence at Nottingham University Hospitals NHS Trust). £ In 2018-19, based on the average lifetime healthcare cost for an individual with cerebral palsy, this programme saved the region's NHS over £4m.
Diabetic foot service digital solution Hand-held 3D camera assesses diabetic foot ulcers over time. The system shares wound imaging, measurements and electronic clinical notes in real time across care teams. Patients can have follow up appointments in the community, which is more convenient and reduces waiting times.	Around £650m is spent on foot ulcers and amputations each year in the NHS, but there is massive variation in the practice of prevention and management. This system helps clinicians keep track of healing progress, ensures patients receive appropriate care and treatment and reduces the risk of foot amputations - saving NHS time and money.	✓ Deployed in Nottingham University Hospitals NHS Trust.

Integrated Care System
Nottingham & Nottinghamshire

East Midlands Academic Health Science Network
Igniting Innovation

Supporting Health and Care Transformation

We provide advice and expertise to assist East Midlands health and care organisations with their transformation work - our support is summarised below, please get in touch to discuss how we can help:

Innovation Exchanges - these structured processes bring together partners across sectors to develop, test and spread solutions to major challenges identified within East Midlands STP and ICS plans. We are keen to get your views on themes for future Innovation Exchanges.

Patient and Public Leadership and inclusion - we provide expertise and resources including 'top tips' guides, training events and masterclasses. We also host the East Midlands Patient and Public Involvement Senate, a group of patients and carers with 'lived experience' that provides independent advice. As well as offering access to events, resources and the PPI Senate we may be able to provide bespoke support for STPs and ICSs.

Navigating and signposting - through our local and national networks we bring together organisations across sectors and identify opportunities to work on shared priorities. In particular we connect health and industry partners and can support STPs and ICSs to identify proven solutions to existing challenges.

Analytics, business cases and procurement - we can provide STPs and ICSs with access to expert and independent specialist advice.

Digital Transformation - we host the East Midlands digital transformation forum that brings together digital leads from across East Midlands NHS organisations. Please get in touch to access this Network.

Clinical entrepreneurship - we support NHS clinical innovators to assess and develop their ideas, understand the environment and navigate the health system, and advise NHS organisations on issues such as protecting Intellectual Property. We are inviting applications for our next intake of clinical entrepreneur training - please get in touch.

emahsn@nottingham.ac.uk | www.emahsn.org.uk | @EM_AHSN

Office for Life Sciences

East Midlands Patient Safety Collaborative

NHS

ENC.D1

Meeting:	ICS Board
Report Title:	Acute, Community and Primary Care Services Clinical & Community Services Strategy
Date of meeting:	Thursday 13 June 2019
Agenda Item Number:	7
Work-stream SRO:	Tracy Taylor and Dr Nicole Atkinson
Report Author:	Duncan Hanslow and Angela Potter
Attachments/Appendices:	Enc. D2 Clinical & Community Services Strategy

Report Summary:

1. The ICS Board commissioned this clinical strategy in recognition that we need to clearly define our longer term vision for service delivery. There is a compelling case for change in terms of the changing demographics and needs of our population, workforce recruitment and retention challenges along with the need to develop new roles and ways of working and the clear financial challenge that the system faces. This strategy has been developed to support the delivery of the triple aim identified in the NHS Five Year Forward View and reiterated in the NHS Long Term Plan – *improving health and well-being; care and quality and financial sustainability.*
2. The Clinical & Community Services Strategy has been developed through an open and inclusive process that brings together the expertise of both clinicians and care professionals with patients and citizens in determining the future shape of services across the system. To date over 250 clinicians, professional staff, patients and citizens have been engaged in the work. Citizen and patient engagement is a key part of the service reviews detailed in point 5 below and the numbers involved will grow as this work develops.
3. It was presented as a working draft to the Clinical Services Strategy Board in May 2019 and is now presented as a working document to the ICS Board for further engagement and development prior to being re-presented for sign off.
4. This strategy document does not sit in isolation. It is a key piece of work that sits alongside the ICS Mental Health Strategy, Population Health Management work, development of an Outcomes Framework and the developing ICS Five year Strategic plan which is due for submission later this year.
5. The next phase of the overall strategy development process has already commenced with a programme of detailed service reviews being commissioned. A process of prioritisation has been undertaken by the Clinical Services Strategy Board which has supported an overall programme of approximately 20 service reviews with the first six commencing from April 2019. These include – CVD (Stroke); Respiratory (Asthma and COPD); Frailty; Children and Young People; Colorectal services and Maternity and Neonates.

6. The Board is asked to discuss and provide comment to help continue to shape this strategy prior to approval.

Action:
☒ To receive ☐ To approve the recommendations

Recommendations:	
1.	To discuss and provide comment on the development of the strategy

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

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

Contribution to delivering the ICS:	
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.

Item 7. Enc. D2

ACUTE, COMMUNITY AND PRIMARY CARE SERVICES

CLINICAL & COMMUNITY SERVICES STRATEGY

DRAFT

Contents

1. EXECUTIVE SUMMARY

In Nottinghamshire we have made great progress in improving people's health and wellbeing. Today, we can treat diseases and conditions we once thought untreatable: cancer survival rates, for instance, have increased dramatically in just twenty years.

However, with great improvements come new challenges. While we now live longer, for many these additional years are not lived in good health. The growing prevalence of long-term health conditions, for instance, places new strains on our health and care services. There is inequality evident in both the location of challenges and in access to services. In some areas, it is easier to access a GP than in others, or to find things to do to keep you active and fit.

As the challenges our health and care system faces change, so must our services. In this endeavour, we start with a simple goal: to ensure everyone in Nottinghamshire has the best possible health and wellbeing they can. This means more people able to live full and independent lives in their homes, more care provided for them near those homes, better local access to health and care services, and a greater focus on the prevention of illnesses, not just their treatment.

Our vision for the ICS is ambitious.

Across Nottinghamshire, we seek to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age.

The Need for an ICS Clinical & Community Strategy

The NHS Long Term Plan is clear that to meet the challenges that face the NHS it will increasingly need to be:

- More joined up and coordinated in its care
- More proactive in the services it provides
- More differentiated in its support offer to its individuals.

Explicit within this is the recognition that some of the service changes necessary may not be in the interests of individual organisations but are required to maximise what can be achieved for the individual patient and the whole system.

Nottingham and Nottinghamshire has the benefit of long established relationships and partnerships and these are the basis on which our new models of care and clinical strategy are being developed.

The Strategy Development Process

This Strategy has been developed through an open and inclusive process which weaves together the expertise of both clinicians and care experts with citizens in determining the future shape of services across the system.

This Clinical and Community Services Strategy does not sit in isolation, it is an integral part of the components that

will be necessary to make our new system function effectively and deliver the desired outcomes.

The strategy provides the framework for future service model development and to help understand what services will be delivered where.

The Case for Change

We have made great strides in improving the health and care that our population receive, but to continue to improve outcomes and stay within the funding allocated by the Government we recognise we need a major transformation programme which will require all sectors – NHS, social care, local authority, private and voluntary to work collaboratively with our citizens to radically redesign the way we deliver our services.

Delivering the NHS Five Year Forward View Triple Aims is a major driver of our case for change. The Triple Aims are;

Improving Health & Well-being

There are currently 1.1m people in the Nottingham and Nottinghamshire ICS which is set to increase by 3% by 2024 and by 10% by 2039.

Depending on where you live in Nottingham and Nottingham, people have different overall life expectancy and healthy life expectancy (i.e., the number of years a person lives in 'good health'). This variation is significant and is a key outcome that the ICS wishes to make improvements in to close the gap.

Deprivation and socio-economic factors are key drivers of this inequity - unemployment, lower qualifications and less healthy lifestyle choices (healthy eating, smoking, overweight/obesity, low physical exercise) consistently result in poorer health and wellbeing outcomes.

Transforming the Quality of Care

Our citizens want to be able to receive services in a very different way to that which their parents and grandparents did. They have told us they want easier access to services closer to home, increased use of technology, such as options of web based consultations and other ways that enable them to take greater control of their health and well-being whilst still being able to see a doctor face-to-face when it's really needed.

Clinical Sustainability

The current healthcare system is clinically unsustainable driven by demand pressures, insufficient levels of out of hospital services and staff shortages.

From an activity perspective all modes of service delivery have increased year on year such that A&E attendances have seen a 4% increase in the last 3 years with a 17% increase in those aged 70+. Inpatient episodes have also increased by 7% over the last 3 years.

Circulatory disease (including stroke, coronary heart disease), Cancers and

Respiratory diseases currently account for 60% of the diseases that cause the gap in life expectancy between the most and least deprived areas in Nottinghamshire and these are set to rise. Evidence has confirmed that these diseases can be prevented by improving lifestyle choices.

The pressures on our current services are unsustainable and require a significant transformation in not only how and where services are delivered, but also how we shift to a more proactive model of care that focuses on preventing the population developing the disease burden in the first place.

Workforce Challenges

Workforce is a key driver for change within our system. We employ a wide range of talented and dedicated staff across our services who provide excellent care and support to our populations.

However, it is becoming increasingly difficult to recruit staff with the right skills and expertise in the right locations as there are national shortages of staff entering training places or wanting to join these professions. We know that measures such as trying to recruit more staff or increasing wages alone are not going to solve this issue so we need to consider different options of how we recruit and retain the necessary workforce.

We face a number of challenges across our ICS in relation to workforce related issues. These include aspects such as high sickness and turnover rates; high reliance on agency staff and high vacancy rates. Our local estimates indicate that based on current demand trajectories we will have a shortage of at least 1500 clinical staff over the next five years. This is exacerbated by a reduced supply of graduates and an ageing workforce with a significant number of staff reaching retirement age.

Our People and Culture strategy outlines a range of initiatives and actions that need to be taken for us to address this significant workforce challenge. These are aligned to four strategic workforce objectives;

1. Recruitment & retention supporting our current workforce;
2. Supporting and retaining our students;
3. Developing and supporting new roles;
4. Preparing the workforce for new ways of working.

Sustainable Finances

The ICS currently spends £3.2bn annually on health and care services and for a number of years has been spending more money than it receives from the Government. Without change, the situation will get worse.

Key challenges are growth in activity/demand (health and social

care), provider pay pressures and non-delivery of efficiency programmes.

The system faces a gap of £159.6m in 2019/20 representing 4.9% of the total system resources – this gap is expected to increase to in excess of £500m by 2023/24 for NHS services alone if we do not change the way in which we design services and work with our populations to improve their health and well-being to prevent them entering ill-health in the first place.

To a large extent these cost increases are driven by projected increases in demand for healthcare services. If there was no projected increase in demand for services the financial gap would actually narrow to £50m due to the funding increases expected.

Current services are not set up to enable our staff to work as efficiently or as effectively as they could or to deliver as much health care as could be provided if services were better organised. It is therefore imperative that we drive forward our transformational change in order that we will be able to deliver services and meet the needs of our local populations within the available resources.

We can only spend the money that the Government has allocated to us – to do otherwise is unfair on other areas and other parts of the public sector. But this isn't simply about reducing spend – by doing things differently, we can change the way that we deliver services that mean people get treatment when it is needed and are supported to stay well whilst spending less money.

Developing the Clinical Model

We have held a series of clinically led workshops in which over 200 clinicians and health and care professionals from a wide range of disciplines and all parts of our system were represented and developed the following set of design principles have been agreed with the Programme Board to build on the vision and system challenges;

- Principle 1 – Care and support will be provided as close to home as is both clinically effective and most appropriate for the patient, whilst promoting equality of access
- Principle 2 – Prevention and early intervention will maximise the health of the population at every level and be supported through a system commitment to 'make every contact count'
- Principle 3 – Mental health and well-being will be considered alongside physical health and wellbeing
- Principle 4 – The model will require a high level of engagement and collaboration both across the various levels of the ICS and with neighbouring ICSs
- Principle 5 – The models of care to be developed will be based on evidence and best practice, will ensure that pathways are aligned and will avoid un-necessary duplication.
- Principle 6 – They will be designed in partnership with local people and

will operate across the whole healthcare system to deliver consistent outcomes for patients through standardised models of care except where variation is clinically justified.

The Clinical Model Framework

Our aspiration is that we want people to live healthy and fulfilling lives. However, we also recognise that at times throughout their life, people will become unwell and that they will need different services at different points in their lives.

Our clinical model is based around a life continuum – recognising that people will move both up and down the continuum in terms of the support and intervention that they need. This model is supported by some key cross cutting aspects such as population health management and 100% risk stratification, prevention being everybody's responsibility and a focus on personalisation and self-care.

A recognised progression of care needs has therefore been utilised within the development of this clinical and care strategy. These include;

- **Staying Healthy**
  - Primary Prevention & Education
  - Wider determinants of health
- **Living well**
  - Primary & secondary prevention
  - Maternity and Children's Services
  - Universal Personalised care
  - Living with a Long-term health or care need (including mental ill health)
- **Care in a Crisis**
  - Care that is needed on an emergency or same day/ urgent basis
- **Managing Illness**
  - Planned acute or specialist care (including cancer care) and support with the aim to return back to living well.
- **End of Life**
  - Patient centred with joint decision making

Delivering Our New Models of Care

To support this clinical model there is an ongoing process of clinically and professionally led service reviews. These reviews are utilising a systemic approach to consider where and how we currently deliver services and compare these against benchmarking data, national and international models of best practice and ongoing developments in technology and infrastructure. This will enable us to determine;

- Size and configuration of future estate
- Shared and inter-connected IT systems
- Skills, configuration and requirements for our future workforce models

Our system is developing across 3 levels of collaboration;

- Primary Care Networks (PCNs) consisting of integrated health and care teams linking with wider local authority housing and community services across neighbourhood localities
- Integrated Care Providers (ICPs) facilitating the integrated provision and delivery of outcomes for the population. Three ICPs have been agreed - Mid Notts, South Notts and Nottingham City
- Integrated Care System (ICS) for the whole of Nottingham and Nottinghamshire

Conclusion

This Clinical and Community Services Strategy starts to define what needs to be delivered and to some extent, where and when that care needs to be delivered in our future vision. This will continue to be developed further during the next stage of the strategy development. However, its success is dependent on the 3 levels of our system continuing to collaborate, develop and mature into effective commissioning and integrated delivery structures. We have a compelling need for change, driven by the changing needs of our local population, financial and workforce drivers and by the need to ensure we are consistently offering the best evidence based services for all of our citizens.

2. INTRODUCTION

The Need for an ICS Clinical Strategy

The NHS Long Term Plan is clear that to meet the challenges that face the NHS it will increasingly need to be:

- More joined up and coordinated in its care
- More proactive in the services it provides
- More differentiated in its support offer to its individuals.

At the heart of this approach is working as an integrated health and care system to achieve the best outcomes for our citizens. Explicit within this is the recognition that some of the service changes necessary may not be in the interests of individual organisations but are required to maximise what can be achieved for the individual patient and the whole system.

As such, the vision for the ICS is to deliver sustainable joined up, quality health and social care and broader community services that maximise the health and well-being of the people of Nottingham and Nottinghamshire.

Each individual partner in the Integrated Care System (ICS) has their own Service Strategies in relation to the delivery of their core services. This ICS Clinical and Community Services Strategy provides a long term (five year plus) overarching vision for our health and care delivery system and provides a strategic direction and framework for which future service development and reconfiguration will be considered against.

Nottingham and Nottinghamshire has the benefit of long established relationships and partnerships and these are the basis on which our new models of care and clinical strategy are being developed.

A separate, but inter-related mental health strategy has also been developed across the ICS. There are inevitably a considerable number of overlapping and integrated outcomes and actions that need to be taken to deliver the holistic needs of our population. Therefore, the ICS Board will ensure that there are single, integrated implementation plans where appropriate.

The Strategy Development Process

This Strategy has been developed through an open and inclusive process which weaves together the expertise of both clinicians and care experts with citizens in determining the future shape of services across the system.

This Clinical Services Strategy does not sit in isolation, it is an integral part of the components that will be necessary to make our new system function effectively and deliver the desired outcomes. The strategy provides the framework for future service model development and to help understand what services will be delivered where.

This will be informed by a greater understanding of the needs of our population through Population Health Management data.

Stakeholder Engagement

As part of the development process there has been a wide range of stakeholder engagement events and opportunities for input. These include;

- 3 design workshops including over 200 local clinicians, care professionals and system leaders from across statutory, voluntary, and commissioning organisations
- Technology and Innovation workshop with 35 experts from a range of fields
- The third strategy design workshop included citizen representatives and a number of citizens groups from across the system have also been engaged in the production of the strategy
- Citizens are now involved in each of our service reviews (see section 7) through attendance at workshops and through specific focus groups for the different areas of care. Voluntary sector organisations are also involved in each of the reviews. The numbers of citizens involved in the work will grow as the service reviews are extended.

The System level Outcomes Framework

This Clinical and Community Services Strategy has been developed alongside other key workstreams across the ICS. The need to align the strategy with the emerging system-level Outcomes Framework is essential. The ICS Board recently confirmed that the ICS Outcomes Framework is being based on the triple aims (improved health and wellbeing, transformed quality of care, and sustainable finances) whilst increasing healthy life expectancy remains the overarching system outcome.

The purpose of the Framework is to provide a clear view of our success as an ICS in improving the health, wellbeing and independence of our citizens and transforming the way the health and care system operates. The Framework sets out short, medium and long term outcomes the whole ICS will work together to achieve based on eight ambitions. These remain in draft but are currently outlined as follows;

Outcome Ambitions
Our people live longer, healthier lives
Our children have a good start in life
Our people and families are resilient and have good health and wellbeing
Our people enjoy healthy and independent ageing for longer, at home or in their community
Our people have equitable access to the right care at the right time in the right place
Our services meet the needs of our people in a positive way
Our system is in financial balance and achieves maximum benefit against investment
Our system has a sustainable infrastructure

This Clinical and Community Services Strategy focuses on what future services will look like to deliver this outcomes framework over the long term.

3. THE CASE FOR CHANGE

The populations of Nottingham and Nottinghamshire's require health and care services that are of the highest quality and delivered as locally as possible. Our citizens have told us that they want to be supported to take more responsibility for their own health and that if they become ill they want to be cared for at home where-ever possible with a proactive support system wrapping services around them.

We have made great strides in improving the health and care that our population receive, but to continue to improve outcomes and stay within the funding allocated by the Government we recognise we need a major transformation programme which will require all sectors – NHS, social care, local authority, private and voluntary to work collaboratively with our citizens to radically redesign the way we deliver our services.

There are a number of reasons why our services need to be radically re-focused to ensure we can maximise the health and well-being of our population and deliver the triple aims identified in the Five Year Forward View and the NHS Long Term Plan. These include improving health and well-being, transforming the quality of care and delivering sustainable finances.

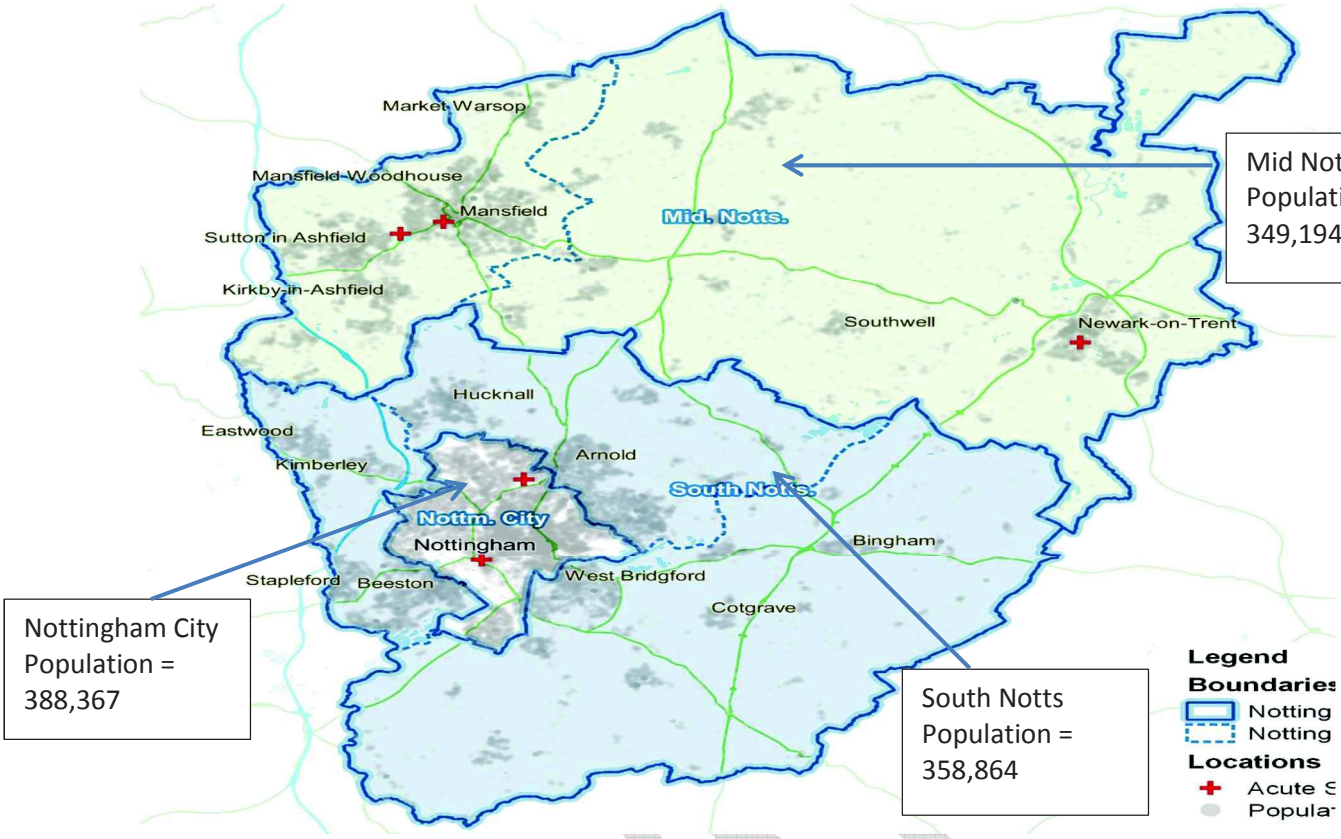
Improving Health & Well-being

There are currently 1.1m people in the Nottingham and Nottinghamshire ICS which is set to increase by 3% by 2024 and by 10% by 2039.

The age profile of our populations in Mid Notts and South Notts are relatively similar to that of the England average, whilst our Nottingham City population has a smaller proportion of those aged 50+ and a higher proportion of younger people even when we discount for its large student population. People are also living far longer with 13% of the ICS population currently aged 70+ which is set to rise to 18% by 2039.

Deprivation is a strong driver of illness and poor levels of health. Our ICS has large variations in the levels of deprivation, for example Nottingham City and Mansfield and Ashfield are some of the most deprived districts in England compared to Rushcliffe which at 318th is one of the least deprived in the country.

Deprivation and socio-economic factors significantly affect a person's life expectancy. Nottingham City and Mansfield & Ashfield are affected by higher unemployment, lower qualifications and less healthy lifestyle choices (healthy eating, smoking, overweight/obesity, low physical exercise) resulting in poorer health and wellbeing outcomes. Across the ICS we have a differential pattern in overall life expectancy with male life expectancy ranging between 77yrs – 80.7yrs and females ranging between 81.1yrs - 83.4yrs.



The healthy life expectancy i.e. the number of years a person lives in 'good health' also shows a pattern of inequity – a male in Nottingham City lives 57 years in good health compared to a male in the rest of Nottinghamshire who lives 62.5 years. The patter is similar for females with 53.3 years compared to 61.6 years.

Around 20% of our lives are spent in poor health, and evidence suggests that the past gains in life expectancy may be becoming harder to achieve. We are now living with more complex illnesses for longer. This trend is set to continue as the proportion of those aged 65 and over with four or more diseases is set to double by 2035, with around a third of these people having a mental health problem.

Therefore improving healthy life expectancy is essential to creating a sustainable system and securing this improvement requires change in every part of the system.

Childhood obesity is a further key indicator of the impact our lifestyle choices have on the health of our population. It is associated with a higher chance of premature death and disability in adulthood. Overweight and obese children are more likely to stay obese into adulthood and to develop long term health (LTC) conditions such as diabetes and cardiovascular diseases at a younger age.

At the age of 4-5yrs Nottingham City children are already significantly less likely to be a healthy weight than those in Nottinghamshire and the rest

of England. By age 10-11yrs the gap has grown further with only 57.8% of Nottingham City children being a healthy weight compared to 64.3% in England.

Transforming the Quality of Care

Changing Public Expectations

We have a growing population with increasingly complex care needs that are placing different demands on the health and care services. However, they also want to be able to receive services in a very different way to that which their parents and grandparents did. Our citizens tell us they want easier access to services closer to home, increased use of technology, such as options of web based consultations and other ways that enable them to take greater control of their health and well-being whilst still being able to see a doctor face-to-face when it's really needed.

Many of our health facilities were established over 50 years ago to meet a very different health need. Our health and care services need to adapt and change to provide high quality care for people at home or in the community (where clinically appropriate) and to ensure everyone can benefit from modern day medicine and technological advances.

Clinical Sustainability

The current healthcare system is clinically unsustainable driven by demand pressures, insufficient levels of out of hospital services and staff shortages.

From an activity perspective we have seen:

- **Outpatient appointments** have increased by 15% in the last 3 years (17/18 vs 14/15) with a 20% increase in age 70+ Outpatient appointments.
- **A&E attendances** have seen a 4% increase in the last 3 years (17/18 vs 14/15) with a 17% increase in age 70+ A&E attendances in last 3 years.
- **Inpatient episodes** have increased by 7% over the last 3 years but we have seen a corresponding decrease in bed days by 9% and an increase in daycase activity of 10%. There has been a 17% increase in inpatient episodes in those aged 75+.

Currently 13% of the ICS population is aged 70+ and this population accounts for;

- 20% A&E attendances,
- 27% outpatient appointments,
- 31% of emergency inpatients,
- 33% of elective and 33% of daycases

Circulatory disease (including stroke, coronary heart disease), Cancers and Respiratory diseases currently account for 60% of the diseases that cause the gap in life expectancy between the most and least deprived areas in Nottinghamshire and these are set to rise. For example over the next 20 years Stroke will increase to

84%, respiratory diseases to 101% and Cancer to 179%.

Evidence has confirmed that these diseases can be prevented by improving lifestyle choices. For example;

- 9 out of 10 strokes are caused by risk factors that can be modified
- 40 - 45% of Cancers are caused by risk factors that can be modified

Current data suggests that we still have significant areas of unhealthy lifestyle choices as demonstrated below;

Smoking	• Mansfield & Ashfield > 1 in 5 people • Rushcliffe 1 in 12 people
Exercised for 30 mins for 12 out of 28 days	• Nottingham City/ Mansfield and Ashfield - 1 in 3 people • Rushcliffe - 1 in 2 people

With the population growing, ageing and spending a higher proportion of time in poor health, there will be an ever increasing need for carers. Informal carers need more support, they are 2.5 times more likely to experience psychological distress than non-carers; working carers are two to three times more likely to suffer poor health than those without caregiving responsibilities. Dementia carers particularly struggle and dementia is due to increase 86% in the next 10 years.

The pressures on our current services are unsustainable and require a significant transformation in not only how and where services are delivered, but also how we shift to a more proactive model of care that focuses on preventing the population developing the disease burden in the first place.

Clinical sustainability also requires us to review and consider how and where we deliver services from. Treatments are becoming increasingly specialised offering the potential to improve quality of care further by enabling access to the latest treatments and techniques. However, this does require more specialised services to be based around larger centres. This will enable specialist staff to build their skills and capabilities, and to ensure all patients have access to specialist skills and equipment.

Workforce Challenges

Workforce is a key driver for change within our system. It is becoming increasingly difficult to recruit staff with the right skills and expertise in the right locations as there are national shortages of staff entering training places or wanting to join these professions. We know that measures such as trying to recruit more staff or increasing wages alone are not going to solve this issue so we need to consider different options of how we recruit and retain the necessary workforce.

The ICS has developed a 10 year People and Culture strategy which will fully articulate the challenge and put forward some of the mitigations in terms of recruiting and retaining high quality staff to deliver the care needs of our population. We employ a wide range of talented and dedicated staff across our system who provide excellent care and services to our populations. The profile of staff is as follows;

- 35,436 Full time equivalent members of staff are employed across the Nottinghamshire system
- 18,318 of our staff are based in our hospitals
- 11,949 of our staff are based within a community setting
- 2,171 of our staff are based out of hospital but work system wide
- 2,965 of our staff are based out of the ICS

We face a number of challenges across our ICS in relation to workforce related issues. These include aspects such as;

- We have a system wide reliance on agency staff which is both a financial issue and a clinical risk. The three NHS providers in Nottinghamshire spent approximately £40m on agency staff in 2018/19.
- There is a requirement in the GP Forward View and the Mental Health Forward View to increase the numbers of staff in these areas, e.g. 77 more GPs by 2020, 30 Children & Young People MH workers, and 23 Mental Health crisis workers
- Sickness absence is higher than the national NHS average
- Vacancy rates higher than the national NHS average (12.1% vs 9.1%) and we have a high turnover rate at 11.4%
- Nursing vacancy rates are also extremely high – 18.9%, which equates to a vacancy figure of 1,412 FTE.

Our local estimates indicate that based on current demand trajectories we will have a shortage of at least 1500 clinical staff over the next five years. This is exacerbated by a reduced supply of graduates and an ageing workforce with a significant number of staff reaching retirement age.

Some of the key staffing impacts on the delivery of our strategy include a shortage of General Practitioners (77 FTE short by 2020) along with a general shortage of primary care based staff. Certain hospital based specialities including Health Care of the Elderly, Stroke, Paediatrics, Emergency Medicine and Radiology are all struggling to meet the growing demand.

Additionally, there are 2000 (9%) social care/ residential care vacancies with turnover in Nottingham in line with the England average for this sector of 30.1%.

Our People and Culture strategy outlines a range of initiatives and

actions that need to be taken forward for us to address this significant workforce challenge. These are aligned to four strategic workforce objectives;

1. Recruitment & retention supporting our current workforce;
2. Supporting and retaining our students;
3. Developing and supporting new roles;
4. Preparing the workforce for new ways of working.

Staff engagement is a key enabler to delivery of both our People and Culture strategy and to this Clinical and Community Services Strategy. It is essential that we listen and respond to our workforce to shape the delivery of our priorities. Evidence tells us that an engaged and committed workforce leads to improved patient outcomes and increased staff satisfaction which will assist with recruitment and retention challenges.

Developing our Clinical and Community Services Strategy will also identify where we will deliver services differently and how we can use enablers such as technological advances to mitigate some of the workforce challenges. We need to ensure that staff are empowered to work at the top of their licence and that we maximise their valuable contribution by developing new and innovative roles where appropriate to ensure we continue to focus on high quality patient outcomes.

Additionally, we recognise that the current roles and workforce structures are not fit for purpose. We need to develop a flexible workforce that is not constrained by organisational or professional boundaries. In order to achieve this we will need to link with education providers and review the approach to training our future workforce to focus on the skills we need rather than the roles themselves.

Sustainable Finances

The ICS currently spends £3.2bn annually on health and care services and for a number of years has been spending more money than it receives. Without change, the situation will get worse. In 2018/19 the financial position of the system deteriorated, with a forecast in-year deficit of £87 million, this is £19 million worse than the position agreed with national NHS leaders. Key challenges are growth in activity/demand (health and social care), provider pay pressures and non-delivery of efficiency programmes.

The system faces a gap of £159.6m in 2019/20 representing 4.9% of the total system resources – this gap is expected to increase to in excess of £500m by 2023/24 for NHS services alone if we do not change the way in which we design services and work with our populations to improve their health and well-being to prevent them entering ill-health in the first place.

The improved NHS Long Term Plan funding settlement will result in system resources increasing by circa 20%

over the next five years but this will not keep pace with cost increases which are projected at 35% for the same period if we don't do anything differently. To a large extent these cost increases are driven by projected increases in demand for healthcare services. If there was no projected increase in demand for services the financial gap would actually narrow to £50m due to the funding increases expected.

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

Current services are not set up to enable our staff to work as efficiently or as effectively as they could or to deliver as much health care as could be provided if services were better organised. It is therefore imperative that we drive forward our transformational change in order that we will be able to deliver services and meet the needs of our local populations within the available resources.

These features of the financial position of the ICS show that while it is unrealistic to expect no increase in demand for services, improving the health of the population with better prevention, earlier intervention and more developed self-care, is at least as important to a sustainable healthcare system as the improving the efficiency of service provision.

National Drivers

There are a range of national policy drivers that we remain committed to as a wider system that this strategy has taken account of. In particular:

- The Five Year Forward View and the refreshed guidance in February 2018 reaffirmed national priorities and set out five challenges for the NHS and care system to respond to.
- General Practice Forward View in April 2016 which was supplemented by Investment and Evolution; a five year framework for GP Contract reform to implement *The NHS Long Term Plan*
- Prevention is Better than Cure – Our vision to help you live well for longer - Department of Health & Social Care (Nov 2018)
- Universal personalised care: Implementing the comprehensive model – NHSE (Jan 2019)
- Our understanding of the implications of the imminent 'Green Paper' on Social care

Local Drivers - Fixed Points in the System

Given the challenges and expectations of the people of Nottingham and Nottinghamshire we are being ambitious in our proposed changes. But there are some things that we are not proposing to change in order to create a small number of fixed

reference points to support service and capital planning. These are set around core areas of urgent access and interdependency of services in those locations. These have been confirmed as;

Agreed Fixed Points of Delivery	
Kingsmill Hospital	Accident & Emergency for all patients; and Antenatal and postnatal obstetrician led services;
QMC Nottingham	Accident & Emergency for all patients; Major Trauma & associated services; Antenatal and postnatal obstetrician led services; Neonatal Intensive Care; Nottingham Children's Hospital;
Newark Hospital	Designated range of Commissioner Requested Services which includes high volume/low complexity elective care and diagnostics plus Urgent Care services
Rampton Hospital	High secure mental health facilities
Wells Road Centre Nottingham	Low secure adult mental health facilities
LIFT and PFI Facilities	All the LIFT and PFI healthcare facilities will be effectively used

These fixed points are important as they set the foundations to construct where future service provision will be delivered from across the system.

They will be used to build other services around and enable the focus to be on how these are maintained in the future rather than whether they are required. While many services not on this list will not change location, their future planning will be undertaken by reference to these fixed points through the service review process and engaging with patients and the public (Section 7).

Estates & Infrastructure

A further key constraint and opportunity is the quality of the estate and infrastructure of current service provision. There is £168m of backlog maintenance required across the key NHS provider organisations much of it critical for ongoing service delivery.

The healthcare estate infrastructure in the ICS costs circa £172m p/a of which £78m p/a is Private Finance (PFI) or LIFT payments.

It is also the case that there is significant opportunity to better use estate capacity in the system either through effective reuse or disposal. Some areas for improvement include;

- 33% of the acute hospital estate is used for non-clinical purposes and 2.55% of the estate is unoccupied
- Across the health community there are 316 healthcare buildings including 115 owned by GPs
- The ICS has been set a land disposal target for Nottinghamshire of £12.2m to support the reinvestment in modern facilities

It is therefore essential that the future clinical services models enable

- Improved use of our quality estate, especially PFI and LIFT building where we are tied into a long term contractual commitment
- Reduction in the acute service estate footprint, currently envisaged to be predominantly at the City Hospital campus, to enable investment in better quality estate both on that site and elsewhere
- Use the estate more effectively for the whole health and care system looking beyond traditional organisational boundaries.

Conclusion

We have a compelling need for change, driven by the changing needs of our local population and by the need to ensure we are consistently offering the best evidence based services for all of our citizens.

We are faced with a current health and care system that has a number of challenges ranging from an inability to recruit and retain the key skills and personnel that we require to deliver care and rising costs that mean that our current services are costing more than the income we receive.

These issues are very real and we need to address them in a way that will improve outcomes for individuals, our communities as well as all of our staff working across the system.

Figure 1 overleaf provides a summary of how the development of the Clinical and Community Services strategy will support the ICS to deliver the NHS Long Term Plan 'Triple Aims';

DRIVING CHANGE ACROSS THE ICS 'TRIPLE AIMS' GAP

Improved Health and Wellbeing

- The clinical and community services strategy will support people to live longer, healthier lives
- Our children will have a good start in life
- Reduce avoidable admissions and managing conditions amenable to healthcare
- Reducing outcomes gap so that our populations enjoy healthier and independent ageing for longer
- Improving workplace health and reducing long term unemployment

Transforming Care and Quality

- Shifting from a reactive hospital based treatment model to pro-active approaches of prevention and early intervention
- Variation in primary care access and outcomes will be reduced
- Inconsistent clinical pathways and outcomes removed
- Improve self-care and management
- Developing new models of care in priority pathways
- Our populations will have equitable access to the right care at the right time in the right place

Sustainable Finances

- Nottinghamshire currently spends £3.2bn on health and social care services
- Health and Care system faces a **£156.9m Do Nothing gap** in 2019/20 representing 4.9% of system resources
- Projected gap of **£500m for NHS alone** by 2023/24
- System resources expected to increase by 20% over next five years but this will be outstripped by cost increases of 35% if we don't do anything different
- New Clinical Service Models will be a key contributor to bridging this gap alongside increasing efficiency and reducing waste

NB – Figures currently exclude Nottingham City Council

4. OUR SHARED VISION

Our Vision

Across Nottinghamshire, we seek to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age.

The aim of our strategy is to support the system to achieve this by shifting the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention, delivered in people's homes or in community locations where this is appropriate.

By working in partnership across our different providers of care and all our sectors of care – acute, community, general practice, local authorities and wider community services including voluntary and private providers, we aim to ensure our citizen's experience is less fragmented and is integrated via a single patient held, patient record.

This requires a high level of trust both at an organisational level and individual clinician level to enable the necessary culture change that will support positive risk taking to become the norm.

The NHS Long Term Plan articulated the gap around delivery of the 'triple aims' and identified five major practical changes necessary to achieve closure of these gaps. The ICS has undertaken a process to align our system priorities to the Long Term Plan and confirmed five priorities that must be delivered. This strategy will make a step change in supporting the delivery of these priorities which include;

- Redesign the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting
- Improve the care of people with single and multiple long term conditions through greater proactive management and self-management to reduce crises
- Re-shape and transform services and other interventions so they better respond to the mental health and care needs of our population
- Reduce waste and improve efficiency and value across the system (including estates)
- More action on and improvements in the upstream prevention of avoidable illness and its exacerbations.

5. APPROACH TO STRATEGY DEVELOPMENT

Our clinical strategy fully recognises that we cannot continue with the current 'illness' models of healthcare that the NHS has traditionally delivered.

Tangible benefits can be achieved if we fully embrace the opportunities provided by utilising population health management data to risk stratify the population. This will allow us to identify who is most at risk of developing preventable conditions or whose health may deteriorate and then identifying the 'what and where' health and care services will be delivered to pro-actively target those most at risk.

The Clinical Design Principles

Through engagement at the workshop events the following set of design principles have been agreed with the CSS Programme Board to build on the vision and system challenges;

- Principle 1 – Care and support will be provided as close to home as is both clinically effective and most appropriate for the patient, whilst promoting equality of access
- Principle 2 – Prevention and early intervention will maximise the health of the population at every level and be supported through a system commitment to 'make every contact count'
- Principle 3 – Mental health and well-being will be considered alongside physical health and wellbeing
- Principle 4 – The model will require a high level of engagement and collaboration both across the various levels of the ICS and with neighbouring ICSs
- Principle 5 – The models of care to be developed will be based on evidence and best practice, will ensure that pathways are aligned and will avoid un-necessary duplication.
- Principle 6 – They will be designed in partnership with local people and will operate across the whole healthcare system to deliver consistent outcomes for patients through standardised models of care except where variation is clinically justified.

Public Engagement

Nottingham and Nottinghamshire have a long history of service transformation and throughout each of these programmes of work there have been numerous consultation and engagement events with patients, carers and the public. These were then supplemented by public engagement at the outset and during the development of the Strategic Transformation Partnership work.

The output from this wide range of engagement events has created an overwhelming case for change in terms of the way that health and care services have been traditionally delivered across Nottingham and

Nottinghamshire and have been the foundation of the case for change for the Clinical and Community Services Strategy.

The Clinical Services Strategy Programme Board acknowledged that this work remains valid and demonstrates a strong consensus as to what the public would like to see from our clinical and community services. The following key factors from the feedback were considered during the strategy development;

- Joined up health and care to enable a seamless approach for the individual
- Prevention and self-care are essential components
- Less reliance and demand on acute hospitals – and ultimately smaller facilities
- Strengthened and integrated primary and community care services with new models of care able to meet the needs of individuals in their own homes where ever possible
- Evidence based planning and streamlining to reduce inefficiency and unwarranted clinical variation

The Clinical Model Framework

Our aspiration is that we want people to live healthy and fulfilling lives. However, we also recognise that at times throughout their life, people will become unwell and that they will need different services at different points in their lives.

It is also acknowledged that people will move both up and down the continuum in terms of the support and intervention that they need. For example, an individual's life may suddenly be impacted by a significant trauma that has life changing consequences or a family may have a child born with extremely complex health and care needs that will stay with them throughout their lives. Others may have complex needs that following intervention allow them to live independently with support from their GP or community team.

A recognised progression of care needs has therefore been utilised within the development of this clinical strategy. These include:

- **Staying Healthy**
  - Primary Prevention & Education
  - Wider determinants of health
- **Living well**
  - Primary & secondary prevention
  - Maternity and Children's Services
  - Universal Personalised care
  - Living with a Long-term health or care need including mental ill health
- **Care in a Crisis**

    - Care that is needed on an emergency or same day/ urgent basis.

- **Managing Illness**
    - Planned acute or specialist care (including cancer care) and support with the aim to return back to living well.

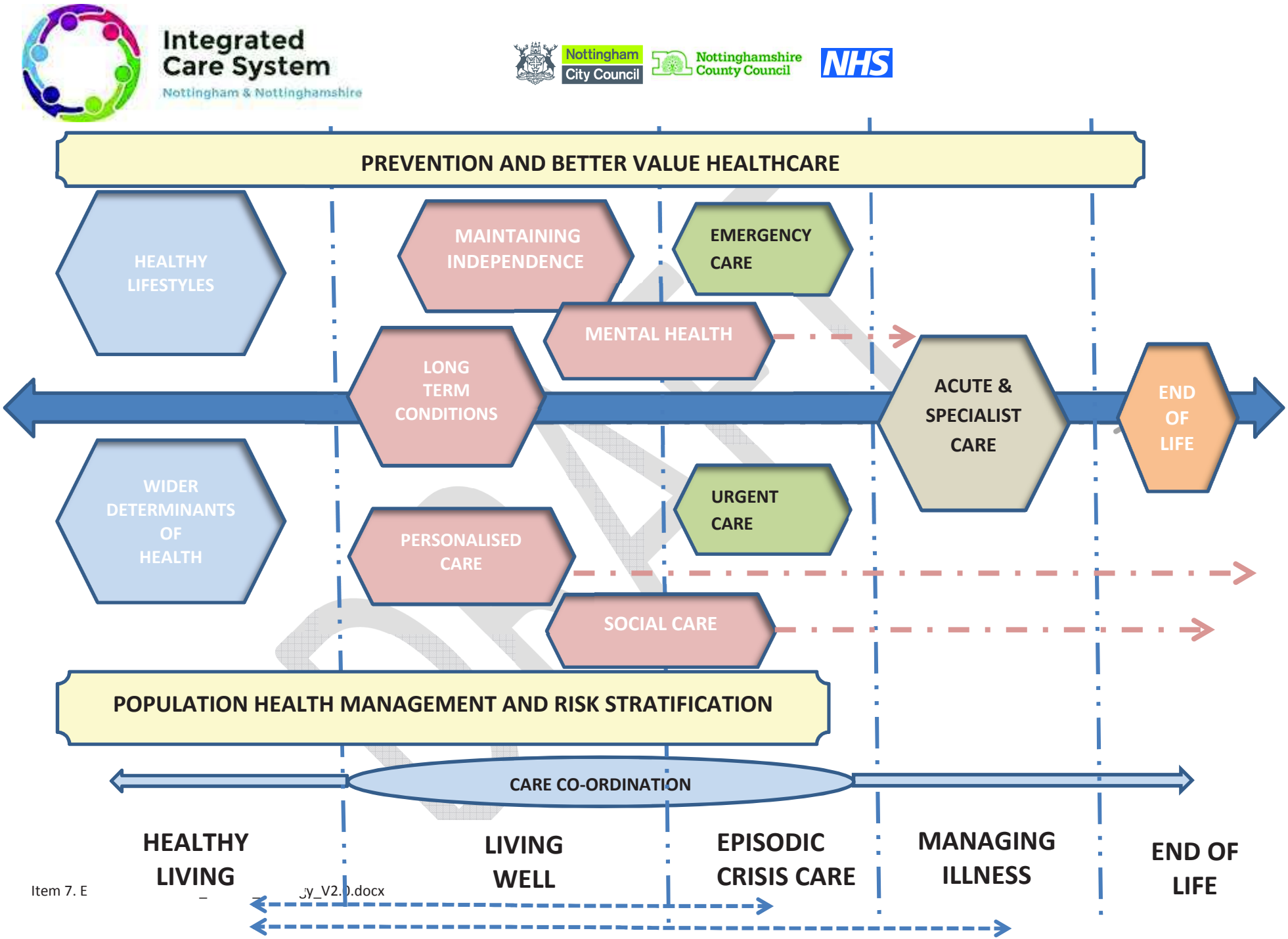
- **End of Life**
    - Patient centred with joint decision making

Using this consistent approach across our service reviews will enable the aggregate changes and impact to be determined for;

- Size and configuration of future estate
- Shared and inter-connected IT systems
- Skills, configuration and requirements for our future workforce models
- Ongoing organisational development and culture changes

Overleaf provides a schematic representation of our approach to developing the Clinical and Community Services Strategy whilst the next section explores the dimensions of care for the high level clinical model in more depth.

The schematic demonstrates that some aspects of our care model are needed throughout a person's life, for example we would see that there are opportunities for prevention and promotion of maximising the value from our health services pertain to all parts of our continuum whilst in other aspects, people will move through various stages for example, they may be in need of support in an emergency but then return back to healthy living.


Integrated Care System
Nottingham & Nottinghamshire
Nottingham City Council
Nottinghamshire County Council
NHS
PREVENTION AND BETTER VALUE HEALTHCARE
HEALTHY LIFESTYLES
MAINTAINING INDEPENDENCE
EMERGENCY CARE
MENTAL HEALTH
LONG TERM CONDITIONS
ACUTE & SPECIALIST CARE
END OF LIFE
WIDER DETERMINANTS OF HEALTH
URGENT CARE
PERSONALISED CARE
SOCIAL CARE
POPULATION HEALTH MANAGEMENT AND RISK STRATIFICATION
CARE CO-ORDINATION
HEALTHY LIVING
LIVING WELL
EPISODIC CRISIS CARE
MANAGING ILLNESS
END OF LIFE

HEALTHY LIVING

WHY PREVENTION & EDUCATION?

Prevention is about helping people stay healthy, happy and independent for as long as possible. This means reducing the chances of problems arising in the first place and, when they do, supporting people to manage them as effectively as possible. Prevention activities are key to keeping people independent and well at home and to avoid the escalation of needs that can result in crisis interventions. Prevention is important at all ages throughout life.

Around 20% of our lives are spent in poor health, and evidence suggests that the past gains in life expectancy may be becoming harder to achieve. We are now living with more complex illnesses for longer. This trend is set to continue as the proportion of those aged 65 and over with four or more diseases is set to double by 2035, with around a third of these people having a mental health problem.

The case for change has clearly identified that we can make a positive difference in our population's health if we focus on prevention as well as educating and supporting our populations to choose healthier lifestyle choices. In Nottingham and Nottinghamshire, the leading risks attributable to years of life lost due to premature mortality are tobacco, alcohol, dietary risks and high blood pressure.

It is estimated that currently only 3-5% of health spending is on public health activities, yet population health initiatives when evaluated usually have a far greater return on investment for every £1 spent.

For example, we know that 9 out of 10 strokes are caused by behaviours that could be modified. A key health intervention that would support this change is the NHS Health Check Programme. However, only 44% of those people who were invited to participate across our ICS during 2013-2018 for a coronary vascular disease check actually attended.

The case for change articulated the growing problem relating to LTCs resulting from obesity, especially obesity arising in childhood.

Obese children and adolescents suffer from both short-term and long-term health consequences. The most significant health consequences often do not become apparent until adulthood and these include cardiovascular diseases (mainly heart disease and stroke); diabetes; musculoskeletal disorders, especially osteoarthritis; and certain types of cancer (endometrial, breast and colon).

It is estimated around 50% of GP appointments, 64% of outpatient appointments, and 70% of hospital bed days are due to preventable ill health. Overall 40% of the burden on health

services in England may be avoidable through preventable action.

The evidence around smoking cessation is overwhelming. The World Health Organisation has clearly outlined the health benefits of quitting smoking. Within 2-12 weeks of quitting, circulation improves and lung function increases and within a year coronary heart disease is about half that of a smoker and within 5 years stroke risk has reduced to half that of a smoker.

Across Nottingham and Nottinghamshire, the move towards a smoke free generation would annually save lives (c. 1,823 early deaths are due to smoking), reduce hospital admissions for smoking related and directly attributable conditions (c.10, 992), reduce health inequalities and provide societal cost savings of £153m.

Another key area is the impact of alcohol on a wide range of conditions such as cancer, cardiovascular and alcohol related injuries. Alcohol related hospital admissions account for 1.1million admissions a year nationally.

The benefits that can be achieved from a focused reduction on preventable conditions such as tobacco and alcohol are significant. As such, a key part of our Clinical and Community Services Strategy will be that prevention and maximising future health is something that all partners are responsible for and will be considered throughout every stage of our clinical model.

As a system, we have a responsibility to make the environment and culture within which people live, work and play more supportive of enabling good health. We need to incentivise people to want to lead an active lifestyle and to have the knowledge, skills and confidence to take full control of their lives and making healthy choices as easy as possible.

We need open conversations at a population and individual level on how the health and social care system works jointly with the public to collectively support health and well-being. One such mechanism will be health promotion activities and a wide range of media need to be utilised to maximise public awareness and uptake. Technology will play an important and evolving role in preventative activity as well as a focus on factors such as housing and air pollution.

There is a growing body of evidence that health and care interventions are only able to address 10% of overall health benefit in terms of access to care and it is only by addressing the wider determinants of health that a real step change can be made in people's lives.

We need to:

- Ensure prevention activity is considered for all ages and takes a conception to grave approach that enables us to 'make every contact count' (MECC)
- Systematically tackle Nottingham and Nottinghamshire leading risks factors which impact on premature mortality - namely tobacco, dietary risks including obesity, alcohol, lack of exercise and high blood pressure
- Prevent or delay long term health and social care needs by identifying early risk factors that could impact on people's independence, health and well-being
- See a systematic culture change – moving to a system that takes a longer-term view and thinks about prevention rather than simply treatment
- Establish virtual clinics to access information, advice and guidance to prevent ill-health
- Establish links with education providers to pro-actively support children and their families to have the best start in life
- Ensure housing plans for the future support all communities that can meet the needs of people with all age disabilities and an ageing population
- Increase social prescribing for leisure activities to increase levels of physical activity at all ages

Key Outcomes

- A narrowing in the life expectancy gap and the healthy life years gap across our populations
- The overall demand for services is reduced as a result of work on prevention and the wider determinants of health

- In the longer term see a significant reduction in premature death from the main attributable risk factors
- Prevention activities are pro-actively and systematically funded and a longer-term view is taken to return on investment.
- Risk factors are identified and addressed at an earlier stage
- The interventions applied will be universal in their reach, but targeted according to need.
- An increasing number of people are supported in their own homes and local communities for longer

LIVING WELL

We want to increase the amount of years that people live in good health. To do this we need to support people to have a good start in life and then enabling them to live independent, fulfilling lives where they feel able to reach their full potential. This is a key outcome that the ICS wants to achieve.

We know that the number of people living with multi-morbidity prevalence will rise dramatically across our population over the coming years. The numbers of people with 4+ diseases will more than double in the next 20 years and this is significantly increasing the complexity of those people who do need health and care support.

Our current system is overly reliant on beds and care isn't provided in the right place. Our data suggests that in point prevalence studies, during the study period in 2017 50% of the patients in a hospital bed at Nottingham University Hospital could have been cared for more appropriately in a different setting and then when we reviewed CityCare beds in 2018 we found 60% of patients could have been cared for elsewhere.

In 2017/18, 335 elderly people aged over 65 were admitted to care homes in Nottingham (887/1,000 pop = 12th highest nationally out of 152 Local Authorities), and 987 in Nottinghamshire County (590/1,000 pop = 78th).

The evidence base for Personalised Care continues to grow – current statistics suggest that people who are confident to manage their health conditions (that is, people with higher levels of activation) have 18% fewer GP contacts and 38% fewer emergency admissions than people with the least confidence.

It is estimated that if we can provide greater proactive management and increase self- care activities then there is the opportunity to reduce our spend on Long Term Condition management by £12m in 2019/20 across the ICS. This would be achieved by reducing demand on acute hospital care and through re-investment of potential savings allow additional services to be developed in community based supporting infrastructure.

Community pharmacies could play a significant role in supporting people to live well and reduce the need for urgent assistance. Expansion of services such as supervision of medication compliance, medicines support including adjustments and prescribing support along with wider offers such as advice on minor ailments has shown that there are significant benefits to the NHS of cost efficiencies worth £1.1 billion and avoided treatment costs worth £242 million. In addition patients report time savings in reduced travel time and saved GP appointments.

Understanding the changing needs of our population and local communities is essential and will be informed by the use of population health management data. This work brings together health and social care factors and uses predictive analysis to help target interventions on a personalised basis.

MATERNITY, CHILDREN & FAMILIES

There has been a focus on transforming maternity care across our ICS for some time and we now need to increase the pace and focus on delivery.

We know that there is still a great deal to do to ensure that our children and their families have a great start in life. For example, we have high proportion of mothers who smoke at the time of delivery (14.7% compared to England average at 10.8%) and in addition there is a high still birth rate in Mansfield and Ashfield (5.1%) and in Nottingham City (5.2%) compared to the national average at (4.3%). With the right targeted interventions we can make a dramatic improvement in this area.

Maternity and family health will take a preconception-to-adulthood approach with the focus on 'teams around the family' operating largely through a community hub-based model, working to avoid cycles of poor health outcomes. This approach will work to deliver the best start in life and make the best use of all contacts to prevent poor health outcomes for the whole family.

Families will have a care navigator through their Primary Care Network who will pro-actively help to access the right support at the right time in the right place. This single point of contact is vital for providing a family with consistency throughout the early years.

Most services will operate best from a community hub where specialists can be co-located, rather than in the home, although home visiting will be an option where appropriate for the patient.

This pathway will be supported by consultant-led maternity services operating from the ICS' two acute trusts. Birth setting will be determined by patient choice, and the option of home birth (where clinically appropriate) will be presented alongside other options.

Due to the breadth of the reviews for both Maternity and Children & Young People further pathway work is ongoing in the next phase of service reviews and it has been agreed that the two aspects will initially be separated to enable a detailed understanding of the emerging models of care and challenges for each element of service provision.

PERSONALISED CARE

Personalised care will mean that our citizens have choice and control over

the way their care is planned and delivered, based on 'what matters' to them and their individual preferences. Personalised care is central to our new service models. Working through the Primary Care Networks we will ensure that people have more options, better support, and properly joined-up care at the right time in the optimal care setting.

Less than half of people in Nottinghamshire with a long term condition have had a conversation with a primary care Health Care Professional to discuss what is important to them, and a third don't have an agreed care plan.

This shift in focus therefore represents a new relationship between people, professionals and the health and care system. It provides a positive change in power and decision making that enables people to feel informed, have a voice, be heard and be connected to each other and their communities.

MANAGING LONG TERM (LTC) CONDITIONS

People with long term health and care needs want to live as normally and independently as they can. Despite the diversity of the range of conditions in terms of diagnosis and disease, people with a LTC progress through the same stages of intervention as other conditions.

An ever increasing proportion of the population are living with a multiple range of health and care needs. Whilst traditionally we may assume that this is isolated to older people, this is not the case. Older adults (65+) with functional needs i.e. Frailty are a major user of care services and have increasing risk of hospitalisation, increased length of stay and ultimately increased risk of needing long term care. However, there is an increasing proportion of children, young people and adults living with multiple long term conditions who require access to multiple services and specialities.

An individual's care needs will be met in the most appropriate place that their level of acuity dictates, but where-ever possible the default will be to provide holistic support services into a person's home.

Personalised health and care plans will be in place for every person who has a LTC and will be fully co-produced

recognising that the patient and their carers are often experts in their own condition and care needs.

Loneliness and social isolation are often associated with those with complex health care needs. 11% of people over 75 report feeling isolation and 21% report feeling lonely. Strategies that enable people to be socially engaged, remain in employment where appropriate and continue with activities that give their life meaning also need to be integral within our clinical and community models.

A key component of our Clinical and Community Strategy therefore needs to be a radical redesign of our approach to drive a proactive approach focusing on wellness and 'what matters to me' rather than an illness model of 'what is wrong with me'.

MENTAL HEALTH

An increasing number of people are now living with both physical LTCs such as respiratory or heart disease and mental health LTC's such as dementia and alzheimers. We need to clearly align our work in managing complex health needs with those contained with the mental health strategy to ensure system wide, integrated interventions that meet the needs of the whole person.

SOCIAL CARE

County, City and District Councils provide a wide range of community support to people, including preventative, housing, leisure and social care services. They are therefore integral to achieving the objectives of the ICS and key partners across the system.

Social care provides information and advice, short term reablement and long term support to enable the promotion of independence and well-being and to ensure that people understand the choices about how and where their ongoing care needs might be best met.

Both the City and County Council partners in the ICS have their own adult social care strategies and transformation programmes and this clinical and community services strategy fully acknowledges the essential interface between this strategy and those developed with a focus on the provision of social care.

We Need to:

- Ensure a single health and care record is available that is ultimately held by the patient and shared across all organisations
- Ensure an empowering, patient centred culture is in place that enables the conversations to be around 'what matters to me as a person'
- Change the skills of our workforce with a continued focus on multi-

skilled practitioners able to deliver first line interventions with knowledge of when to refer to specialised staff
- Support the community and voluntary sector to further extend its impact on outcomes through initiatives such as ending social isolation and self-care hubs
- Link with the Population Health Management work to ensure 100% of the population can be risk stratified by each PCN to proactively case manage those at risk of exacerbating LTC's and losing independence and wellbeing
- Ensure that care co-ordination is implemented in a standardised manner across all our PCNs to deliver clear support and sign-posting initially focusing on those with multiple co-morbidities
- Review the benefits to be achieved from telehealth and remote monitoring technologies in accordance with the Assistive Technologies Strategy
- Confirm our approach to developing a single point of access (SPA) model across both an ICS or if more appropriate in each ICP footprint and whether this is to be multi-agency and how it aligns with the Integrated Urgent Care roll out
- Ensure systematic medication reviews for all people with multiple co-morbidities
- Complete the Better Births maternity review and implement the recommendations across our system
- Develop our community hub model for maternity and family health services
- Use assessment tools such as the Patient Activation Measure to build knowledge, skills and confidence with the person to self-manage and provide personalised solutions that meaningful to the individual
- Use person centred conversations to understand where adjustments to the individual's lifestyle could impact on their health, wellbeing and independence

Key Outcomes

- We will be systematically using readily accessible population level data to support segmentation and risk stratification.
- A narrowing in the life expectancy gap and the healthy life years gap across our populations
- Social Prescribers are in every Primary Care Network and are able to appropriately direct patients to a wide range of resources across their local community
- Local Community Pharmacies will be a key first point of contact with appropriate local and national payment mechanisms in place to support this
- Increased numbers of people have a single care co-ordinator to support them navigate and sign-post them to appropriate services

- Increased proportion of people are able to access Personal Health Budgets
- Those accessing services reporting:
    - Feeling more empowered to manage their condition and are able to access the right additional support when required
    - Receiving integrated, wrap around locally delivered care and support to meet their physical and mental health needs

- Ensure we have outcome measures in place that measure the whole system of care for people with complex needs
- A reduction in the number of people entering long term residential or nursing home care.

CARE IN A CRISIS

At different times in an individual's life they may require access to crisis care to manage a sudden onset of illness or a traumatic event. Our current models of managing these episodes are often predicated on patients themselves deciding whether their need is urgent or indeed an emergency or can be managed in a routine way through their GP.

As a system we are facing a number of operational challenges in terms of achieving the required levels of service delivery for A&E. This includes the 4 hour performance target. For example, NUH has consistently underperformed with an average of 64.4% achieved in March 2019, but Sherwood Forest has also seen deteriorating performance at 91.7% in Q4. Ambulance response times across our ICS are also longer than the required standards in all categories of response.

At least 8,500 (11.6%) of emergency admissions per year are for COPD, stroke, heart failure, asthma, diabetes, heart attacks, angina and hypertension – many of which we have already identified are preventable conditions. Over 75s make up less than 10% of the ICS population, but account for a 1/3rd of emergency admissions and a half of emergency bed days. Two thirds of emergency inpatient beds are occupied by the over 65s (c. 1,000 beds/day).

Spending time in hospital when it could be avoided can be detrimental to a persons' overall health - 35% of 70-year-old patients experience functional decline during hospital admission in comparison with their pre-illness baseline; for people over 90 this increases to 65% therefore we should do everything possible to ensure we avoid any un-necessary hospital admissions or delays in to a person's discharge.

It is estimated that there is a significant financial saving opportunity if we could radically redesign the urgent and emergency care system with an opportunity potential of circa £14m across the ICS in 2019/20.

The individual's perception of an emergency or urgent need may at times be somewhat different from the clinical opinion. This disconnect may be due to a lack of knowledge, fear and anxiety or simply a desire for the convenience of getting their need met in a convenient and immediate manner.

Therefore, a focus for the clinical strategy is in defining urgent, same day care in a way that is relevant to society and setting clear parameters for what a patient can consistently expect from different settings and how they will meet their individual needs.

This will clarify for citizens what they should expect from emergency and urgent care settings as well as the

different range of access to General Practice services both in and out of hours.

Emergency Care

Emergency care is defined as being required immediately or within 4 hours of the injury or symptom commencement.

Access to the emergency department will be triaged via the emergency ambulance or single front door to ensure people are directed to the appropriate level of service provision.

Ambulance services are at the heart of the urgent and emergency care system and we need to ensure that our paramedics and ambulance crews have the skills and resources to enable more care to be delivered at home or settings outside of hospital, whilst at the same time working to reduce delays in hospital handovers. We will increasingly support ambulance decision making with technology and appropriate algorithms to support the correct management and care for a patient.

Urgent Care

Urgent care is defined as being required within a 4 - 24 hour period after the commencement of symptoms or diagnosis.

The model of urgent care is still to be fully determined and will need to link into the developing Urgent Treatment Centres and to the Primary Care Networks. The latter will have a key role to play in meeting the urgent/same day demand elements of the clinical model for those who have primary health care needs.

The developing PCNs will ensure that 100% of practices are covered by extended hours access at evenings and weekends seven days a week and will support the delivery of a combined access offer including the *NHS App* and on-line booking options.

In addition, PCNs will continue to develop innovative solutions to increase 'streaming' of patients so that they are able to offer convenient same day urgent appointments whilst preserving continuity of care for patients with more complex long-term conditions.

Models to actively support people whose conditions are exacerbating to prevent a hospital admission are well developed in parts of the ICS. Our Clinical and Community Services Strategy assumes that models such as 'Call for Care' will be available routinely for all of our population. This will enable the emergency ambulance service and both in-hours and out-of-hours General Practice to access a dedicated team to provide urgent, home based assessment and intervention within 2-4 hours. This will enable people to safely stay in their own homes and prevent a hospital admission.

We will aim for a consistent model of Emergency and Urgent care access across all parts of the ICS that is clearly communicated and understood by the public. Our aim is that this will encourage appropriate usage of Emergency Department, Urgent Treatment Centres, General Practice and wider primary care services rather than the ongoing high levels of usage at hospital based emergency services.

We need to:

- Confirm our overall approach for accessing urgent levels of care to ensure appropriate signposting and consistency of offer to local alternatives such as Community Pharmacy
- Develop a clear and coherent long term communication campaign in conjunction with the public to support ongoing behaviour change and align the public and clinicians expectations over service offers
- Provide a web based, trustworthy source of localised information regarding self-help, advice and sign-posting
- Provide a single point of telephone access via NHS111 and the Clinical Assessment Service (CAS) that will intelligently triage all requests for care and signpost patients to the right point of care, including the capacity to make GP appointments in line with the requirements of the new GP Contract.
- Develop the offer from each of our PCNs to enable appropriate on the day access balanced with the ability to preserve continuity of care
- Develop a consistent model for a community hub and determine the locations for these across the ICS
- Ensure a model that meets the key components of 'Call for Care' is available in all areas of Nottingham and Nottinghamshire
- Ensure alignment of this model with the approach to support people who experience a mental health crisis

Key Outcomes

- Seamless integration across acute, community, primary and local authority crisis services. This could include co-location of a broad range of services within single sites or locality hubs to provide a 'one stop shop' approach. These should include physical, mental health, housing and social care and where appropriate wider community and voluntary sector services.
- A standardised, consistent emergency and urgent care offer across all the whole of the ICS
- Reduced demand on the hospital emergency department and the ambulance service
- The public reporting increased confidence in being able to access emergency department

alternatives in the wider community

- Delivery of the ED performance targets and an improved outcome and experience of care for those who need to use crisis services
- Parity of service offer whether the crisis is related to a mental health or physical health care need.

MANAGING ILLNESS

There is an expectation that most people at some point in their lives will require support to manage an episode of illness. Again, the aim here is to agree with the person what it is they want to achieve and provide specific support and intervention that meets those needs and enables them to return back to living a healthy and fulfilling life.

We recognise that our previous systems and processes have created services that are confusing and inequitable across our whole ICS. Nationally it's been estimated that up to 50% of patients attending General Practice have conditions that may not need a GP and could be treated by less qualified staff.

Previous work across the ICS has demonstrated that most of the elective or planned care activity currently takes place in hospitals resulting in people travelling to a main hospital site for care that could equally be delivered closer to home. Phase 2 of outpatient transformation work has the potential to release £5.6m of costs in 2019/20 if we develop different models of delivering planned care services.

We are not consistently delivering the required performance targets and some of these contacts are not always valuable e.g. Procedures of Limited Clinical Value (PLCV) and some outpatient appointments.

Our Clinical and Community Services Strategy and the ongoing service reviews will therefore focus on the fundamental principle to reduce variation and drive standardisation in outcomes for the whole population. This will require common pathways across primary, secondary and tertiary care and with social care to ensure there is consistency in entry and exit points when people find themselves needing care and support to manage episodes of illness.

Planned Care

Planned care is defined as care that is non-urgent, for which the patient receives a pre-arranged appointment and is either a self-referral or via a clinical referral.

A key principle in reviewing our planned care services is to ensure we reduce variation and drive standardisation where appropriate in order to reduce duplication and improve equity of service delivery and outcomes.

Considerable work has already been undertaken across the ICS to improve the pathways of planned care, from developing standard referral guidelines in a number of specialities to redesigning some clinical pathways such as Musculo-Skeletal services (MSK) and gynaecology.

The Clinical and Community Services Strategy development is therefore working alongside these ongoing programmes of work and assumes that

as we move forward all pathway reviews for planned care will take on a whole patient journey perspective and cover all aspects of care from referral to discharge with ongoing care in a person's place of residence where appropriate.

A key assumption of the clinical and community strategy is that increasingly a greater proportion of planned care will take place in a community setting. This will include the delivery of first and follow-up outpatient appointments on both a face-to-face basis and via the use of telephone or video technology.

It also assumes that the level of surgical intervention will decrease for an increasing proportion of patients who, through being full chose not to have an active surgical intervention but are managed through alternative means such as ongoing physiotherapy and support.

Perioperative care will increasingly take place out of hospital settings, in community locations, utilising a range of near patient diagnostics and outreach services supported by technology.

The utilisation of designated planned care facilities will support the system to enable consistent delivery of planned care, irrelevant of pressures on emergency services.

ACUTE AND SPECIALIST CARE

Although care at home is the preferable option wherever possible, the model accepts that home may not at times to be able to provide the level of support, expertise or environment required. Hospital beds will be provided where these are the appropriate option agreed by the patient and care team.

We will build on the national direction of travel towards the centralisation of specialised services being provided in larger centres where this is appropriate to do so and it is based on associated improved clinical outcomes and the development of network models of delivery.

Nottingham and Nottinghamshire has a significant range of specialised services provided in both physical and mental health care and we will concentrate our expertise on developing these services and being at the forefront of innovation.

Specialist care can also extend to our expertise in specialised diagnostic areas (e.g. PET CT, Medical Genetics) and we will continue to work with key partners locally and nationally to ensure that the citizens of Nottingham and Nottinghamshire have appropriate and timely access to the latest technologies.

Cancer Care

Prevention of cancer is equally as important as the diagnosis and treatment and we recognise the importance of national screening

programmes and maximising uptake into these via Primary Care Networks and communication campaigns at both a national and local level. To date our ICS screening rates for bowel, breast and cervical cancer across Nottinghamshire are all above the national average rates although they are below the national average in the Nottingham City population.

We have a good track record of achieving the targets for seeing people within 14 days if they are referred for a suspected cancer and 5,600 people were newly diagnosed with cancer in 2016/17 which is roughly in line with the national incidence rate. However, we have difficulties in meeting the 62 day wait standards and are failing to meet the surgical treatment of cancer within 31 days.

Diagnosing cancer will continue to take place in acute hospital settings for the foreseeable future, but it's anticipated over the life of this strategy that this will shift increasingly into community-based settings as technological advances support different diagnostic approaches. Referral processes will be a combination of GP direct access and patient self-referral if clear and obvious cancer symptoms are present.

We envisage that an increasing number of treatments will be undertaken closer to home through mobile chemotherapy and immunotherapy services. Treatment should be supported by an MDT, attached to a Primary Care Network and will be the key mechanism to link the patient with other support e.g. mental health outside of the defined cancer treatment.

Post-discharge care will increasingly shift to community or home settings, delivered either in primary care or by an expanded community cancer workforce who are able to undertake better assessment of need and reduce the requirement for crisis management.

We need to:

- Ensure we develop standard referral guidelines and planned care pathways that reduce variation and improve equity of outcomes for our population
- Ensure specialist care and cancer service developments deliver the appropriate models of centralisation and ensure outreach services are in place
- Continue to scope the required community infrastructure and capacity to support the shift to out of hospital models of community care

Key Outcomes

- Consistency of offer and delivery at all levels of care
- Timely access to care in the right location with reduced delays in transfers of care

- Care co-ordinated across defined pathways underpinned by integrated technology and health care record.
- Improved outcomes in early diagnosis and cancer survival rates

END OF LIFE

End of life care is the part of palliative care which follows from the diagnosis of a terminal illness where cure is no longer possible and the patient is entering the process of dying.

There is increasing acknowledgement of the growing palliative and end of life care needs for people with non-cancer diagnosis, and our emerging new care models around End of Life Care support the growing national policy direction.

End of life care national statistics indicate that currently;

- 1% of the population dies each year in the UK
- Only 25% of deaths are from cancer
- 46.9% die in hospital and 46% in their usual place of residence
  70% of people do not die where they choose

Increasingly people are using a Preferred Priorities for Care document to write down what their wishes and preferences are during the last year or months of their life. It includes their individual views on what is important to them and where they would like to die.

Across our ICS 48.8% of deaths occur in hospital compared to the national average. There is also a differential across our system with 53.1% in Nottingham City compared to 44.4% in Rushcliffe.

The term 'end of life care' is used by different people to mean different things, since this phase could vary between months, weeks, days or hours in the context of different disease trajectories. This Clinical and Community Services Strategy assumes that End of Life services will be based on the needs of the individual rather than a predetermined period of time. It is however anticipated that it will include people who are likely to die within the next 12 months who have;

- Advanced, progressive, incurable conditions
- General frailty and co-existing conditions that mean they are expected to die within12 months
- Existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- Life-threatening acute conditions caused by sudden catastrophic events

Palliative care is an approach that improves the quality of life of patients and their families through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other problems, physical, psychological and spiritual. It is based on the following palliative care principles:

- A focus on quality of life which includes good symptom control
- A whole person approach which takes into account the person and those that matter to them
- Respect for patient autonomy and choice
- Emphasis on open and sensitive communication

Our system has already undertaken considerable work in the Mid Nottinghamshire locality to develop an integrated service specification around a 'community hub' model of care to enable patients to be cared for as close to home as possible. These will be fully aligned with the ongoing clinical strategy work.

When end of life decisions are required, the lead clinical role should come from the Primary Care Network Multi-Disciplinary Team (MDT) regardless of clinical setting. This may be supported by living wills which can be shared with clinicians as required.

Specialist palliative care will be available to support the MDT team for those people with more complex palliative care needs. Specialist palliative care is provided by specially trained multi-professionals and can be accessed in any care setting. Advice regarding symptoms and medications, or a wider discussion of the patient's current situation including the appropriate provision of in-patient, community, day care or hospice and out-patient services is a key feature of the emerging model.

The specialist team is complemented by chaplaincy, therapists and psychology services working alongside a wider team of nursing staff to deliver the care required across the different aspects of the service.

We need to:

- Ensure conversations regarding end of life are based around the wishes of the person and those that matter to them and that these are clearly documented and shared across the MDT
- Ensure Primary Care is able to take a lead role in managing the end of life needs of their local population
- Develop partnership working across the system (PCNs and Specialist Palliative Care teams) to ensure the appropriate support is available to enable people to die at their preferred location
- Ensure end of life care is appropriately developed for all people who are dying, and extends beyond those dying from cancer
- Extend the use of enhanced summary care records and the use of a portal so that people's end of life wishes are readily available for all service providers irrelevant of care setting

Key Outcomes

- An increase in the number of people dying in their preferred location
- An increase in the number of families and carers reporting

feeling supported and aware of where to seek help and support in times of crisis

- An increase in the number of people with a living will that clearly outlines their wishes that has been shared with their clinical teams.

6. DELIVERING OUR NEW MODELS OF CARE

In order to ensure that our delivery models develop in a coherent and systematic approach our system is developing across 3 levels of collaboration;

- Primary Care Networks (PCNs) consisting of integrated health and care teams linking with wider local authority housing and community services across neighbourhood localities
- Integrated Care Providers (ICPs) facilitating the integrated provision and delivery of outcomes for the population. Three ICPs have been agreed - Mid Notts, South Notts and Nottingham City
- Integrated Care System (ICS) for the whole of Nottingham and Nottinghamshire

The Clinical and Community Services Strategy starts to define what needs to be delivered and to some extent, where and when that care needs to be delivered in our future vision.

This will continue to be developed further during the next stage of the strategy development. However, its success is to some extent entirely dependent on the 3 levels of the system continuing to collaborate, develop and mature into effective commissioning and integrated delivery structures.

Integrated Place Based Care

The notion of 'place' and 'neighbourhoods' have become increasingly important in health and care policy. Alongside the development of this clinical services strategy there has been a significant amount of work to develop the vision and model for delivery at a place level in our ICPs and at a neighbourhood level in our PCNs.

Primary Care Networks

General Practice accounts for nine out of ten patient contacts within the NHS and plays a crucial role in providing urgent care, coordinating and providing chronic disease management, health promotion and early intervention and in supporting people to manage their own care.

PCNs will work together with other local health and care providers around natural local communities to provided coordinated care through the development of integrated neighbourhood teams. 'Primary Care' is defined as first line services such as; general practice, community services, mental health, voluntary sector and social care etc.

The PCNs will utilise Population Health Management (PHM) intelligence and 100% population risk stratification to proactively identify and co-ordinate the care management of their neighbourhood population.

Our aim that PCNs will work collaboratively to focus on prevention and personalised care, supporting

patients to make informed decisions about their care and look after their own health by connecting them with the full range of statutory and voluntary services. To achieve this we aim to have a core consistent "community hub" offer across the ICS so that the range of services is understood by professionals and public alike. This will increase confidence in access of these services and over time enable ongoing reductions in hospital based provision.

The new models of care will incorporate the provision for local pharmacies to provide consistent low acuity urgent care services dealing with minor conditions and accurately signposting people with higher levels of need to the appropriate services.

The ability for pharmacies to support the self-care agenda should not be underestimated as part of both the management of long-term conditions and for those with an urgent care need.

Integrated Care Partnerships

Our three ICPs will undertake integrated provision and coordination of care, holding a clear contract value for what the providers are commissioned to deliver. This may result in ultimately moving towards capitated budgets in accordance with national policy intentions.

Our ICPs are an aggregation of the relevant Primary Care Networks (PCNs) and all other services that support health and wellbeing within their defined place. They will observe the overriding principle of equity of access to universal and targeted services to address health and wellbeing.

They will collaborate with other ICPs in the ICS to ensure consistency of entry and exit points for patients using the services of providers who are partners with more than one ICP.

Integrated Care System

The ICS is a collaboration of equal partners working to system wide objectives. The ICS is responsible for ensuring that appropriate strategies are in place to invest our resources in what we know works and to ensure culture change through removing blocks to integrated care.

The aim of the ICS is to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age.

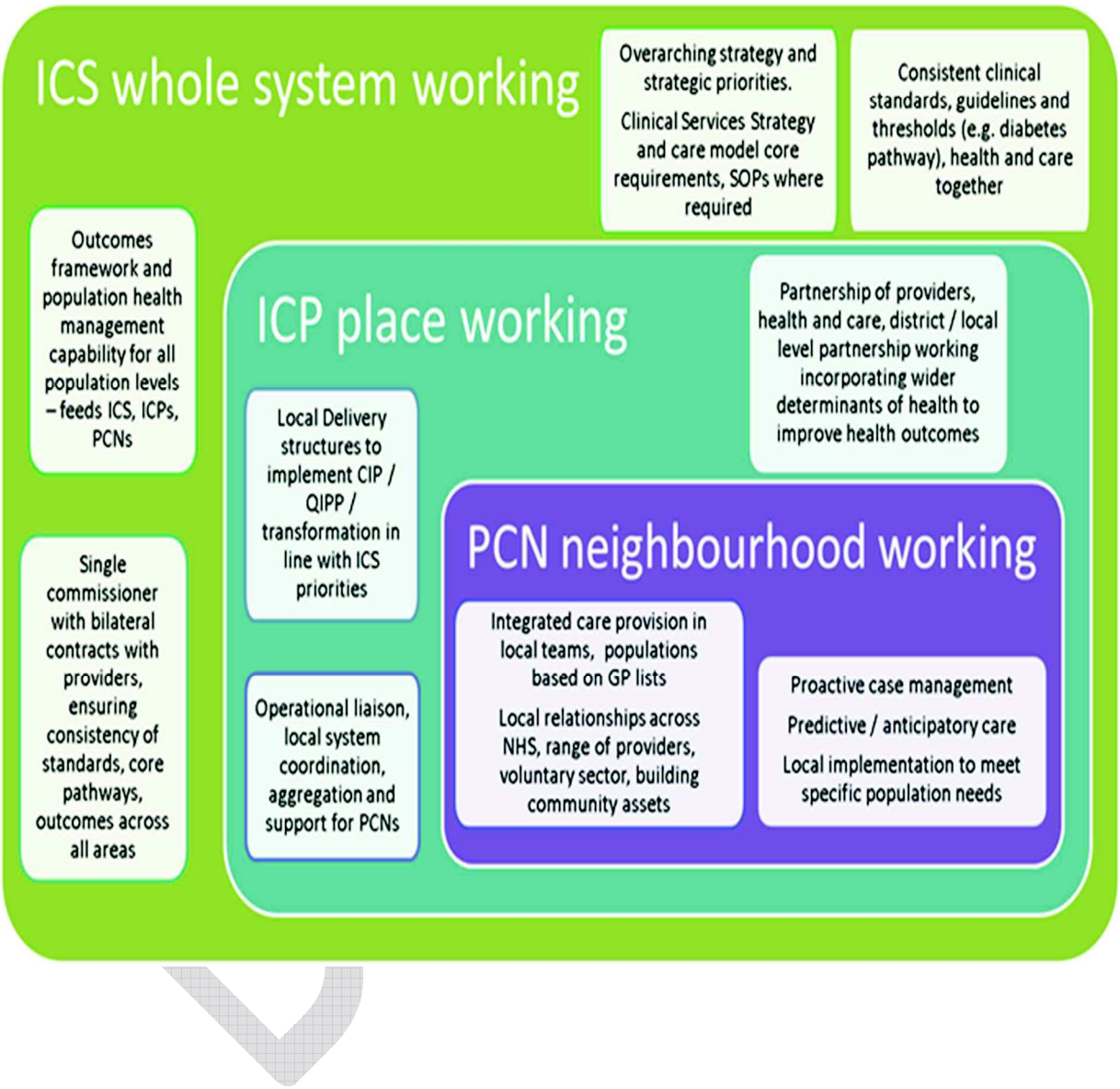
The ICS will work through the three ICPs and PCNs to ensure a comprehensive health and care offer is equitably available to all of our citizens. This strategy clearly articulates the need to blur the organisational boundaries between all sectors of health and care provision. This will inevitably require strong organisational leadership and a balance of the necessary trade-offs that will be required to support the

transition periods as we move from the old to the new models of care with associated activity, income and workforce consequences.

Page 17 outlines the agreed facilities that will be significant for service provision into the future and our ICS will be working collaboratively with the main service providers and through the ICPs to ensure that patients who require hospital based care can access this swiftly and safely. When a person's medical care requirements have been met then their discharge or transfer of care to the PCN teams needs to be smooth and seamless.

The following schematic demonstrates our vision of working at system, place and neighbourhood population levels detailing what should happen where in order to ensure the right activities for the right population levels.

Working at system, place and neighbourhood population levels: what should happen where (right task for the right population level)



This strategy provides a framework and agreed direction against which future service reviews will be undertaken. The aggregate impacts of the ongoing service reviews will provide key requirements for the future development of other supporting areas in the ICS including;-

Informatics and Technology Strategy

The delivery of an integrated shared care record cannot be under-emphasised if our strategic intent is to be met. We have made significant progress in system inter-operability and development of the Care Centric Portal but the aspirations around the development of a single health and care record need to be clarified and remain a system priority.

Estates Strategy

This strategy and the output of the ongoing service reviews will be essential in guiding decisions about where individual services are located and the consequential investment in estates and infrastructure that is required.

The system has already outlined a number of estate priorities in terms of acute services infrastructure and the outputs from the ongoing service reviews will clearly identify the associated community infrastructure necessary.

Workforce Strategy

The ICS has developed a People and Culture strategy. There is an urgent need to continue to review the range of skills needed and develop different types of roles that will enable us to have workforce that is agile and fit for the future.

Where necessary, consolidation of workforce and integration of provision will allow specialists to offer more effective support within a single setting and then provide a hub and spoke model to other locations to ensure economies of scale, maximise expertise and improve outcomes.

Hospital based activity will reduce in the new models of care and the specialist workforce necessary to support our acute hospitals will increasingly support outreach models of care to support generalist care in the community.

Demand & Capacity Modelling

Shifts in activity from acute hospital settings to a community facing delivery models are fully anticipated as a consequence of this clinical and community strategy. It is also anticipated that there may be some relocation of services as a consequence of the service reviews that will require closer consideration and potentially public consultation.

There is a clear need for a system wide demand and capacity modelling approach to enable us to better understand the size and volume of activities that will take place in each

sector as a consequence of the new pathways of care and service models. The current approach of each organisation modelling individual elements of impact is not sustainable and needs to be fully reviewed.

7. NEXT PHASE OF STRATEGY DEVELOPMENT

New models of care, workforce and commissioning must reflect whole patient journeys and providers within our ICS have already recognised that they will need to adapt, integrate and collaborate to accommodate this approach.

Our clinical models distinguish between the imperative of developing sustainable services designed around entire patient journeys which cross organisational boundaries and at this stage we have not assessed the impact on individual providers who will play a part in delivering care for part of those journeys.

The development of this Clinical and Community Services Strategy has not been undertaken in isolation. There are already a number of well-established groups exploring new service models for certain patient cohorts and taking forward evidence based care across the system. A number of these were explored as part of the first phase of workshops for the clinical strategy and these have not been duplicated, but we will complement and learn from each other as the systematic reviews move forward.

There is a need to ensure continual alignment with various other plans and system wide initiatives including the development of the ICS Five Year Strategic Plan, the mental health strategy delivery plan and the implementation of the Urgent Treatment Centre requirements.

ONGOING SERVICE REVIEWS

This Clinical and Community Services Strategy is only one component of the whole system review that is required. We are also taking forward a systematic review process of our 'end to end' pathways of care – from a patient first noticing they have a symptom or need through diagnosis, treatment and discharge to the management of ongoing care needs or end of life care.

This is an extensive system wide piece of work which will ultimately take place across a minimum of 20 services. The CSS Programme Board have reviewed these services against a range of quantitative and qualitative criteria and agreed the prioritisation of six services reviews which have all now commenced. These include;

- Cardio Vascular Disease – Stroke
- Respiratory – COPD and Asthma
- Frailty
- Children and Young People
- Colorectal Services
- Maternity and Neonates

These reviews will enable the long term ICS programme of change to be developed to deliver these New Care Models and to inform what the future requirements are for estate and

workforce in particular but also technology.

8. CONCLUSION

The Clinical and Community Services Strategy starts to define what needs to be delivered and to some extent, where and when that care needs to be delivered in our future vision.

This will continue to be developed further during the next stage of the strategy development. However, its success is to some extent entirely dependent on the three levels of our system continuing to collaborate, develop and mature into effective commissioning and integrated delivery structures.

Fundamental within our new service models is the principle that more care will be delivered closer to people's homes rather than in a central hospital based location. Prevention and population health management will drive a pro-active model of care that will target interventions and reduce the overall burden of ill-health.

In order for this to be achieved there needs to be a significant review of the infrastructure that is currently available to enable this shift in focus to take place.

Whilst providing convenient services close to home is important, patient choice and 'what matters to me' is equally as important as clinical expertise in terms of assessment of need. However, both the timeliness of the response and the level of care required will be the key determining factors in deciding upon the location that care is delivered.

We have a compelling need for change, driven by the changing needs of our local population, financial and workforce drivers and by the need to ensure we are consistently offering the best evidence based services for all of our citizens.

Taking forward the key recommendations in this clinical and community services strategy will offer the system a strategic framework within which it can aim to achieve its aspirations and vision for improving the health and well-being of the population of Nottingham and Nottinghamshire.

DOCUMENT CONTROL

Document Review

Date	Version	Reviewer	Role	Status
7/4/19	V1.0	Angela Potter	Programme Director	Initial drafting
10/4/19	v.1.3	AP/DH		Addition of comments from DH
23/4/19	V1.6	AP		Re-presentation following feedback from TT
26/4/19	V1.7	AP/DH		Ongoing review
21/5/19	V1.8	AP		Working Draft - updates following comments from members of CSS Board and Design Group
31/5/19	V1.9	AP		Working draft – updates from Alex Ball
04/06/19	V2.0	DH		Final Draft for ICS Board

Document Approval

Date	Version	Reviewer	Role	Status
26/4/19	V1.7	Clinical Strategy Board	Programme Board	Working Draft
21/5/19	V1.8	Sub-group	CSS	Working Draft

ENC. E1

Meeting:	ICS Board
Report Title:	Primary Care Strategy Briefing Paper
Date of meeting:	Thursday 13 June 2019
Agenda Item Number:	8
Work-stream SRO:	Nicole Atkinson
Report Author:	Jon Singfield, Deputy Director of Strategic Planning (CCGs)
Attachments/Appendices:	Enc. E2. Appendix A – Letter from NHSE requesting Primary Care Strategy Enc. E3. Appendix B – Working draft of Primary Care Strategy

Report Summary:

In a letter dated 26 April 2019, NHS England and NHS Improvement requested that each STP/ICS develop and submit a Primary Care Strategy. As well responding to the Long Term Plan, this also forms part of the process for the allocation of General Practice Forward View funding.

This paper introduces the working draft of the document, outlines the process and engagement undertaken to date and explains the next steps in the ongoing development until final submission on 28 June 2019.

The Board are asked to comment on the working draft, and to endorse the process for further development and submission of the plan, noting the timetable outlined in section 6.

Action:

☐ To receive
☒ To approve the recommendations

Recommendations:

1.	Comment on the working draft of the strategy (by 17 June 2019)
2.	Endorse the approach outlined above for further development of the Strategy
3.	Note the process for final approval and submission on 28 June 2019

Key implications considered in the report:

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

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

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

Is the paper confidential?

☐ Yes
☒ No

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

Integrated Care System
Nottingham & Nottinghamshire

Nottingham City Council | Nottinghamshire County Council | NHS

Primary Care Strategy – Briefing Paper

3 June 2019

Introduction

1. In a letter dated 26 April 2019, NHS England and NHS Improvement requested that each STP/ICS develop and submit a Primary Care Strategy. As well responding to the Long Term Plan, this also forms part of the process for the allocation of General Practice Forward View funding.

2. This paper introduces the working draft of the document, outlines the process and engagement undertaken to date and explains the next steps in the ongoing development until final submission on 28th June 2019.

3. The Board are asked to comment on the working draft, and to endorse the process for further development and submission of the plan, noting the timetable outlined in section 6.

Request from NHS England

4. A formal request for the ICS to produce a Primary Care Strategy was sent from the NHS England and NHS Improvement regional office on 26 April 2019. The letter (see Appendix A) set out the requirements and timescales and made clear the relationship between this Strategy in response to the Long Term Plan and the release of General Practice Forward View (GPFV) funding.

5. Accompanying the letter was a template which included recommended section headings as well as detailed guidance on the content and coverage the strategy should include.

6. In summary, the required sections include a vision, a case for change and an explanation of how we intend for primary care to fulfil the 5 key elements of the Long Term Plan, namely:

   i. We will boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services
   ii. The NHS will reduce pressure on emergency hospital services
   iii. People will get more control over their own health and more personalised care when the need it
   iv. Digitally-enables primary and outpatient care will go mainstream across the NHS
   v. Local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems everywhere

7. For each of these sections, the template requires:

- an understanding of the current situation
- the approach being developed
- an understanding of workforce implications and configuration
- how services will be delivered, including the role of technology
- how governance arrangements will support the delivery
- how changes will be resourced and managed

Approach to developing the Strategy

8. It was agreed that the CCGs would lead on the development of the strategy, with input and support from other colleagues within the ICS as appropriate.

9. A small working group was established led by the CCG staff with representation from GP clinical leads, the ICS executive team, programme leads and the authors of other related strategies.

10. The group initially contacted a wide range of relevant stakeholders across the system with targeted requests for content, either pre-existing documents with relevant information (to ensure consistency) or new content. These included relevant colleagues from across the system representing:

- Primary Care Network development
- Locality Teams
- GP Clinical Leads
- Clinical Services
- Workforce
- Urgent Care
- Estates
- Finance
- Information technology
- Communications and engagement
- Governance
- Performance
- Population Health Management

11. This was collated and edited into an initial rough draft which has since been circulated to contributors for review and comment.

12. The initial comments and additions received on the first draft have since been incorporated into this second draft. It should be noted that this document is still a work in progress and work continues to populate some sections and edit and improve others.

Alignment to other Strategies

13. With a range of strategies in response to the Long Term Plan currently in production, the importance of alignment and coherence between documents is recognised keenly.

14. The strategy builds on the system's existing General Practice Five Year Forward View Strategy.

15. To help ensure this alignment, the working group includes representation from the ICS Director of Strategy (responsible for producing the fuller ICS Strategy by Autumn 2019) and the programme lead and also the author of the recently produced Clinical Services Strategy.

16. The group have also communicated closely with those involved in the Urgent and Proactive Care Strategy, Personalisation Strategy, Prevention Strategy and Digital Strategy, Workforce Strategy and Estates Strategy.

17. In setting out the vision and the case for change, the Primary Care strategy draws heavily on the ICS Vision and priorities and demonstrates how these support the development of Primary Care within the Nottingham and Nottinghamshire system.

Next Steps

18. Work will continue to complete the Strategy and incorporate feedback from stakeholders.

19. Board members are asked to submit any comments or suggestions to the ICS team ICS@nottscc.gov.uk by no later than 5pm on **Monday 17 June 2019**.

20. Any responses would be incorporated within the third draft (to be finally approved by the ICS Managing Director) for initial submission to the NHS England regional office on 20th June. The officers at NHSE are then expected to review and respond to the ICS with any recommendations by 25th June 2019.

21. Any recommendations received from NHS England will then be incorporated within the final draft ahead of final submission on **28 June 2019.**

22. Given the tight turnaround between receiving recommendations from NHS England and the final submission date, there will be limited time for final approval. ICPs are asked to nominate an appropriate representative to review the final submission before the ICS Managing Director approves the final version before submission.

23. Whilst every endeavour will be made to maximise the time available for this, depending upon the scale of changes required, it is likely to be very limited. Nominees will therefore need to have some availability on 27 or 28 June to be able to review and comment on the final draft.

Timetable

03/05/2019	Letter and guidance received by CCG leads
08/05/2019	Plan and approach agreed by leads
09/05/2019	Requests for relevant, pre-existing information sent to colleagues
14/05/2019	Deadline for initial responses
17/05/2019	Initial rough draft compiled (composite of extracts received)
24/05/2019	**First draft (refined and developed) completed**
27/05/2019	First draft circulated for comment among key stakeholders
03/06/2019	Deadline for comments
06/06/2019	Second draft circulated to ICS Board members
13/06/2019	**Second draft discussed and approved at ICS Board**
17/06/19	Deadline for comments
20/06/2019	**Third draft submitted to region for review**
25/06/2019	Reviewed plan returned to ICS with recommendations
25/06 - 28/06	Final plan shared with nominated ICP leads for approval (availability dependent on scale of changes required)
28/06/2019	**Final plan submitted to regional NHSE**

RECOMMENDATIONS

24. The Board are asked to

i. Comment on the working draft of the strategy (by 17 June).
ii. Endorse the approach outlined above for further development of the Strategy.
iii. Note the process for final approval and submission on 28 June 2019.

NHS England and NHS Improvement
Anglesey House
Wheelhouse Road
Rugeley
Staffordshire
WS15 1UL

Tel: 0113 82 49629
Email: trishthompson@nhs.net

26 April 2019

By e-mail to Midlands Region STP leads

Dear colleague,

RE: Development and submission of 2019/20 STP Primary Care Strategy

Following publication of the NHS Long Term Plan and 2019/20 Operational and Contractual Planning Guidance, STPs/ICSs will need to have developed a Primary Care Strategy as they develop system level plans for the Autumn. The date for a Primary Care Strategy to be in place is **30 June 2019**.

This STP/ICS Primary Care Strategy is also required in advance of the new Network Contract DES for Primary Care Networks, which comes into effect on 1 July 2019. This will also ensure that each STP/ICS is able to meet the pre-requisites to receive their STP-level share of General Practice Forward View (GPFV) funding for four of the key GPFV programmes in 2019/20. Allocations for this funding will be released for the full financial year, in or around July 2019.

The STP/ICS Primary Care Strategy will need to clearly set out how the sustainability and transformation of primary care and general practice will be ensured, and should form part of the overarching local system strategy to improve population health. The strategy should set out how CCGs and primary care providers will be engaged in its implementation.

It is recognised that all STPs/ICSs have undertaken a considerable amount of work in developing workforce plans over the past year. These should form the basis of much of the resource planning for the overall Primary Care Strategy. Work undertaken on ETTF planning should also be a key feature.

To help with production of an STP/ICS Primary Care Strategy, a template guide has been developed which accompanies this letter. The template provides both a structure and guidance as to what should be included in the strategy. Ideally, we would like the template to be used by all STPs/ICSs so that we may receive consistent strategies that are easily comparable across the Midlands Region.

The Primary Care Strategy documentation must be approved by local STP/ICS governance structures/programme boards with final plans being submitted for regional assurance by 28 June 2019, in line with the timetable detailed below.

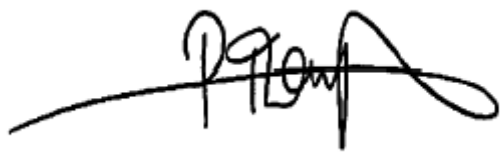
Step	Date of completion
1. Draft plans submitted to the Region for review	20 June 2019
2. Reviewed plans returned to STPs with recommendations	25 June 2019
3. Final plans submitted to the Region	28 June 2019

Finally, I want to thank you for your continued hard work during this extremely busy period. Please do access the support available to you from the GPFV team to support local Primary Care Strategy development.

If you have any specific questions regarding this request then these should be sent to the Regional Lead for the GPFV, Rachel Helmn, r.helmn@nhs.net.

Best wishes.

Yours sincerely,



Trish Thompson
Director of Primary Care and Public Health - Midlands
NHS England and NHS Improvement

ICS Board 13 June 2019

Item 8. Enc. E3.

Integrated Care System

Nottingham & Nottinghamshire

DRAFT: Nottingham and Nottinghamshire Integrated Care System (ICS)

2019/20-2023/24 Primary Care Strategy

PLEASE NOTE: Whilst this document is largely complete, this version remains a working draft which is still being developed and written. There are some gaps (identified with placeholders) and further editing to be undertaken. It is being shared at this stage to seek further comment and input.

Guidance from the provided template (shown in the blue boxes at the start of most sections) has been left in for information at this stage, but will be removed prior to final submission.

Version Control

Version Number	Date	Author	Details of Update
0.1	08/05/2019	Jon Singfield	Early draft collating pre-existing material
1.5	28/05/2019	Jon Singfield	First draft shared for comments with stakeholders
2.0	05/06/2019	Jon Singfield	Second working draft incorporating initial feedback, shared with ICS Board for further comment and input

Authorisation

Date	Name	Position

Table of Contents

List of Tables and Figures

1 Executive Summary

This section should summarise the overall approach that your STP is adopting to deliver the GP Forward View especially in light of the new GP Contract and the NHS Long Term Plan.

[To be written once rest of document completed]

2 Vision

This section should state what is the vision for Primary Care for the STP with endorsement from local stakeholders, for example the Local Authority, and takes The Long Term Plan into consideration.

2.1 Context

This Primary Care Strategy aligns to the overarching vision for the Nottingham and Nottinghamshire Integrated Care System (ICS). The ICS vision, which has full endorsement from key stakeholders, is as follows:

Figure 2-1 - ICS Vision Statement

Our Overall ICS Vision

Across Nottinghamshire, we seek to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age

The vision for the ICS includes three priority areas which are essential in order to improve outcomes for the population of Nottingham and Nottinghamshire. These include:

- effective resource utilisation
- independence, care and quality
- health and wellbeing.

2.2 Primary Care Vision

Our vision for primary care is aligned with the ICS Five Year Strategy which has been developed in order to deliver against the requirements of the NHS Long Term Plan. The vision is built on the foundations of Primary Care Networks which will enhance integrated care and which will deliver a person-centred (holistic) approach to continuous and proactive lifetime care, rather than the traditional disease focused approach.

Our vision for primary care delivers:

- **Effective Resource Utilisation** - fully integrated, primary and community based healthcare, successfully incorporating new models of care and multidisciplinary teams with wide ranging clinical and social care skills and capabilities
- **Independence, Care and Quality** - care organised around individuals and

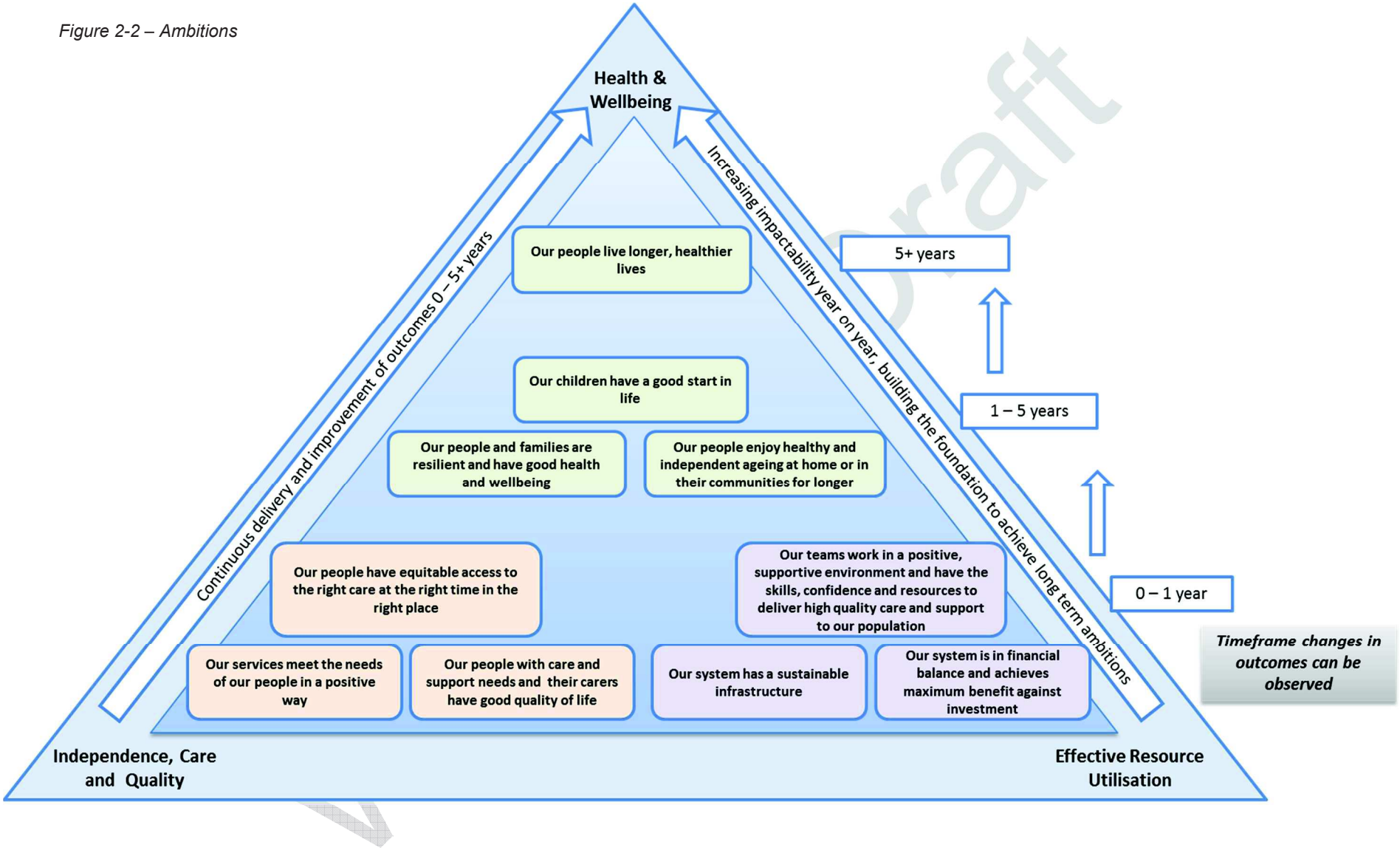
populations – as opposed to organisations - delivering the right type of care based on people's needs

- **Proactive and Community-Based Health & Wellbeing** - providing models of health and care that are more proactive and preventative, ensuring more people are looked after at home, and closer to home, thereby reducing the rising demand for hospital-based care.

Delivery of the ICS vision is based on 10 ambitions and these have been used to frame the priorities for Primary Care.

The ambitions are illustrated in the diagram overleaf.

Figure 2-2 – Ambitions



In order to deliver our vision and ambitions, the priorities for Primary Care are as follows:

i. Delivering clinical and service consistency including access

- Localised and centralised clinical services which put care in communities where possible, but concentrate care where clinically necessary to improve patient outcomes and efficiency
- Excellent care plans and pathways developed by clinicians and supported by improvement science
- Integrated community–based mental health services, which recognise the personal, societal and economic importance of mental health
- A scaled-up primary-care system with access to speedy diagnostics and therapeutics provided in suitable facilities and supported through integrated community and pharmacy health teams

ii. Workforce resilience, capacity and happiness

- Workforce motivation and development that looks at the sensible delegation and demarcation of skills from the patient's perspective and not just the producer's

iii. PCN development and reorientation to population health

- Strong health promotion and illness prevention
- A health system that treats patients as active partners in their care (and communities as carers), and allows individuals and carers control over their life, and ultimately, their death
- Integrated health and social care provided seamlessly in the home

iv. Delivering digital transformation

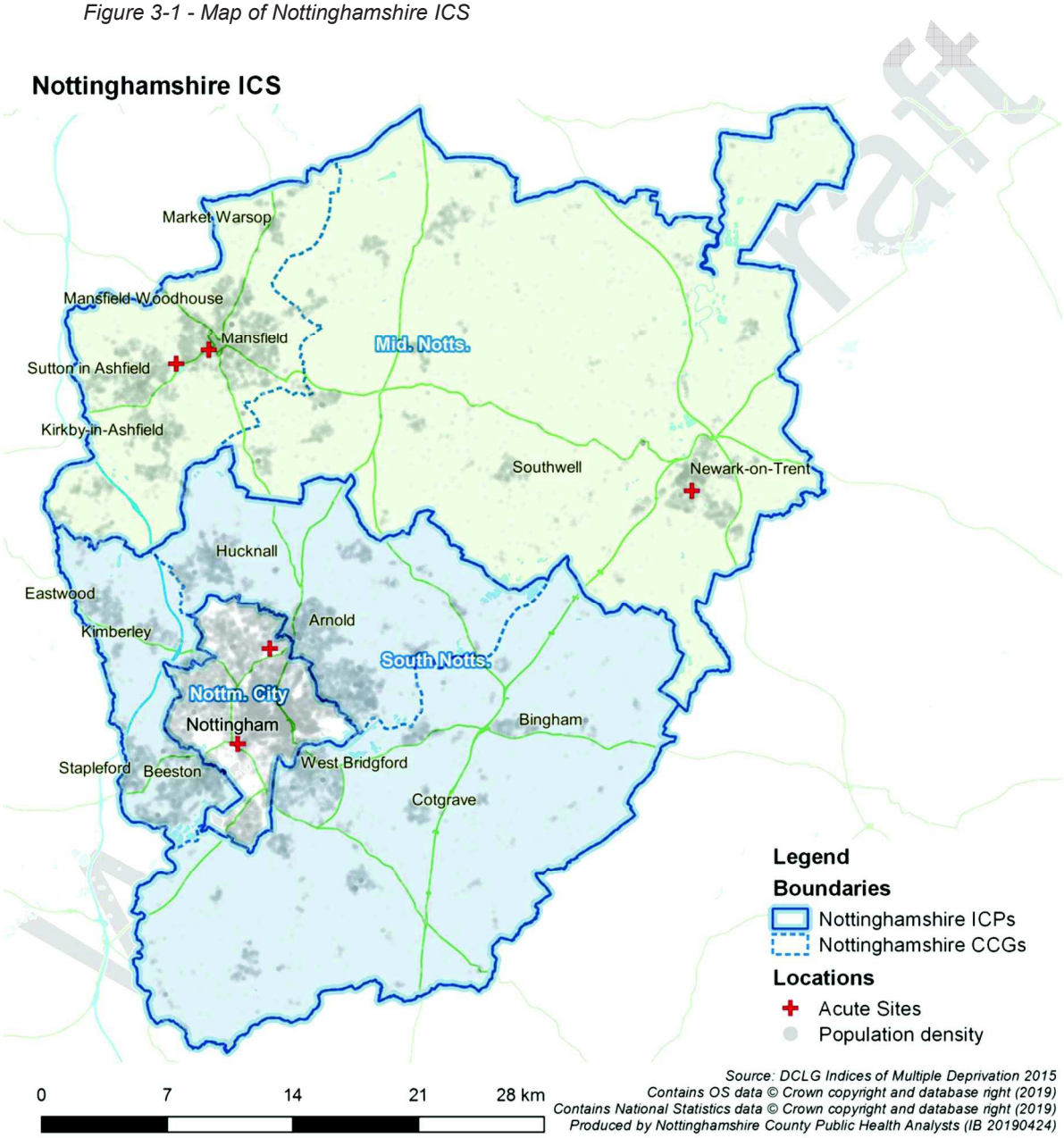
- Excellent population and patient segmentation and stratification techniques to encourage and support citizens and patients to live actively, all supported by the latest technology

3 Introduction

Nottingham and Nottinghamshire has a resident population of 1.1m people. The NHS annual budget is approximately £1.9bn and a budget of £525m for social care.

3.1 Map of Nottingham and Nottinghamshire ICS

Figure 3-1 - Map of Nottinghamshire ICS



3.2 Composition of System, Place & Neighbourhood

As part of the move to the new system architecture, Nottingham and Nottinghamshire have established three Integrated Care Partnerships (ICPs) and 20 Primary Care Networks (PCNs). The diagram below provides an illustration of responsibilities in relation to working as a system.

Figure 3-2 - Nottinghamshire ICS- What should happen where

3.3 PCN Configuration across Nottingham and Nottinghamshire

Primary Care Networks provide the local infrastructure that will deliver a person-centred (holistic) approach to continuous lifetime care, rather than the traditional disease focused approach. They comprise integrated, cross organisational and cross professional groups of staff who come together as an integrated community offer.

134 GP Practices have been aligned to 20 PCNs across the ICS. Each PCN has a designated Clinical Director who will provide strategic and clinical leadership for the ongoing development of each network.

Figure 3-3 - PCNs, Practices and Population by CCG area

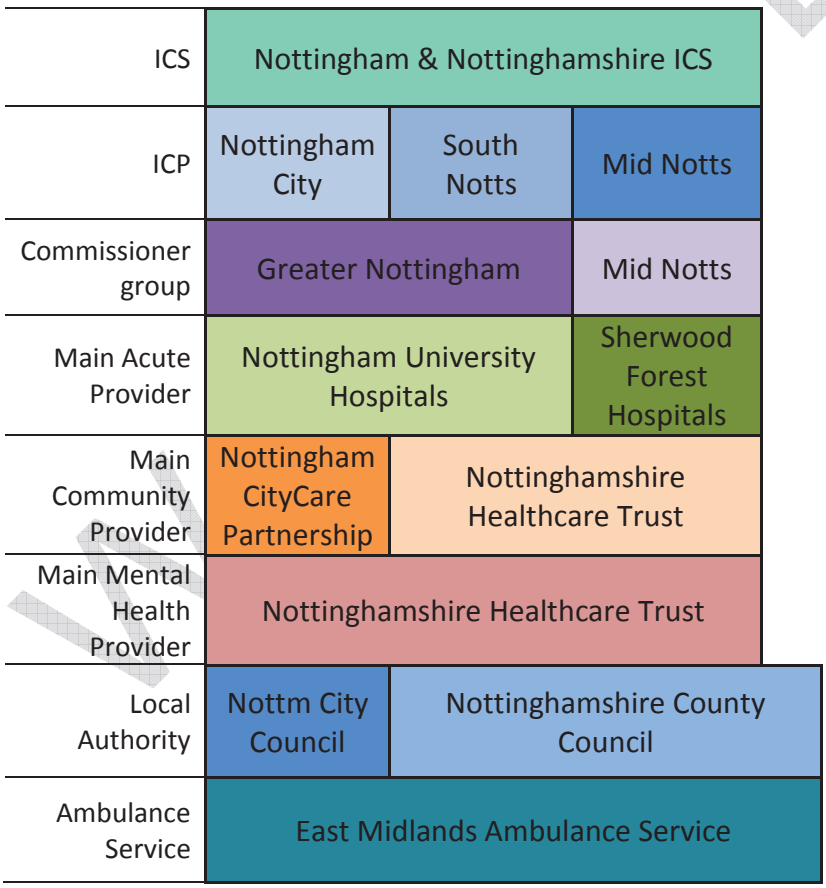
CCG	PCN	No of practices	Population
Mansfield & Ashfield	Ashfield South	8	38,794
	Ashfield North	5	51,705
	Mansfield South	5	46,587
	Mansfield North	8	58,425
	4	**26**	**195,551**
Newark & Sherwood	Sherwood	7	59,627
	Newark	7	76,147
	2	**14**	**135,004**
Nottingham City	1 – Bulwell & Top Valley	8	44,571
	3 – BACHS	12	59,168
	4 – Radford & Mary Potter	6	49,503
	5 – Bestwood & Sherwood	8	49,390
	6	8	66,474
	7	4	36,390
	8	5	31,662
	U	2	51,549
	8	**53**	**388,707**
Nottingham North & East	1 - Hucknall	4	36,715
	2 – Arnold & Calverton	3	33,778
	3 – Carlton & Villages	6	40,969
	4	4	29,647
	4	**17**	**141,109**
Nottingham West	Nottingham West	12	106,473
	1	**12**	**106,473**
Rushcliffe	Rushcliffe	12	128,389
	1	**12**	**128,389**
TOTAL	**20**	**134**	**1,095,233**

3.4 ICS Key Partners

Our partners are:

- Nottingham University Hospitals NHS Trust
- Sherwood Forest Hospital NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- Nottingham CityCare
- NHS Mansfield and Ashfield CCG
- NHS Newark and Sherwood CCG
- NHS Nottingham City CCG
- NHS Nottingham North and East CCG
- NHS Nottingham West CCG
- NHS Rushcliffe CCG
- East Midlands Ambulance Service
- Nottingham City Council
- Nottinghamshire County Council
- 6 District/Borough Councils
- Voluntary Sector Organisations

Figure 3-4 - Key system organisations by footprint



4 The case for change

This section should outline the case for change in your STP area typically this should include the following elements:

1. A summary of the current demographic profile and anticipated demographic changes, in your health economy that is determining the demand for primary care services. This should also address health inequalities and equality issues more generally in the local population.
2. The current profile of the primary care workforce in your health economy, the challenges that you face, any anticipated opportunities and/or threats that you consider material to the capacity and capability of the area's workforce.
3. The current and anticipated challenges to the delivery of primary care services. For example how the condition, location and capacity of the primary care estate is configured and whether it is capable of delivering the changing pattern of demand.
4. What are the key funding issues that the health economy faces and how it is capable of meeting the changing pattern of demand for services? Describe any funding gaps and how you intend to meet them.

4.1 Demographics and Health Inequalities

The populations of Nottingham and Nottinghamshire require health and care services that are of the highest quality and delivered as locally as possible. Our citizens have told us that they want to be supported to take more responsibility for their own health and that if they become ill they want to be cared for at home where-ever possible with a proactive support system wrapping services around them.

We have made great strides in improving the health and care that our population receive, but to continue to improve outcomes, meet the rising level of demand and stay within the funding available we recognise we need a transformation programme which will require all sectors – NHS, social care, local authority services, private and voluntary sectors to work collaboratively with our citizens to radically redesign the way we deliver our services.

There are a number of reasons why our services need to be re-focused to ensure we can maximise the health and well-being of our population within the available resources. These include;

Changing Demographics

There are currently 1.1m people in the Nottingham and Nottinghamshire ICS which is set to increase by 3% by 2024 and by 10% by 2039.

The age profile of our populations in Nottingham and Nottinghamshire are relatively similar to that of the England average, whilst our Nottingham City population has a smaller proportion of those aged 50+ and a higher proportion of younger people even when we discount for its large student population. People are living far longer with 13% of the ICS population currently aged 70+ which is set to rise to 18% by 2039.Deprivation is a strong driver of illness and poor levels of health. Our ICS has large variations in the levels of deprivation, for example Nottingham City and Mansfield and Ashfield are some of the most deprived districts in England compared to Rushcliffe which has significantly lower levels of deprivation.

Deprivation and socio-economic factors significantly affect a person's life expectancy. Nottingham City and Mansfield & Ashfield are affected by higher levels of unemployment, lower qualifications and less healthy lifestyle choices (healthy eating, smoking, overweight/obesity, low physical exercise) resulting in poorer health and wellbeing outcomes. Across the ICS we have a differential pattern in overall life expectancy with male life expectancy ranging between 77yrs – 80.7yrs and females ranging between 81.1yrs - 83.4yrs.

The healthy life expectancy, ie the number of years a person lives in 'good health', also shows a pattern of inequity – a male in Nottingham City lives 57 years in good health compared to a male in the rest of Nottinghamshire who lives 62.5 years. The pattern is similar for females with 53.3 years compared to 61.6 years.

The number of people living with multi-morbidity prevalence will also rise dramatically across our population significantly increasing the complexity of those people who do need health and care support. The number of people with 4+ diseases will more than double in the next 20 years and 2/3 of these will have mental ill-health as well as physical ill-health. By 2039 moderate frailty will increase by 96% and severe frailty by 117%.

Childhood obesity is a further key indicator of the impact our lifestyle choices have on the health of our population. It is associated with a higher chance of premature death and disability in adulthood. Overweight and obese children are more likely to stay obese into adulthood and to develop long term health (LTC) conditions such as diabetes and cardiovascular diseases at a younger age.

For most LTCs resulting from obesity, the risks depend partly on the age of onset and on the duration of obesity. Obese children and adolescents suffer from both short-term and long-term health consequences. The most significant health consequences of childhood overweight and obesity, that often do not become apparent until adulthood, include cardiovascular diseases (mainly heart

disease and stroke); diabetes; musculoskeletal disorders, especially osteoarthritis; and certain types of cancer (endometrial, breast and colon).

At the age of 4-5yrs Nottingham City children are already significantly less likely to be a healthy weight that those in Nottinghamshire and the rest of England. By age 10-11yrs the gap has grown further with only 57.8% of Nottingham City children being a healthy weight compared to 64.3% in England as a whole. By 10-11yrs 2in 5 children and 1in 15 children in Nottingham City are severely obese and this is increasing year on year for both age categories.

Changing Public Expectations

We therefore have a growing population with increasingly complex care needs that are placing different demands on the health and care services. However, they also want to be able to receive services in a very different way to that which their parents and grandparents did. Our citizens tell us they want easier access to services closer to home, increased use of technology and other ways that enable them to take greater control of their health and well-being.

Much of our estate was established over 50 years ago to meet a very different health need. Our health and care services need to adapt and change to provide high quality care for people at home or in the community (where appropriate) and to ensure everyone can benefit from modern day medicine, technological advances, and new models of care.

Clinical Sustainability

The current healthcare system is clinically unsustainable driven by demand pressures, insufficient levels of out of hospital services and staff shortages.

From an activity perspective we have seen:

- Increase in demand for primary care appointments
- **Outpatient appointments** have increased by 15% in the last 3 years (17/18 vs 14/15) with a 20% increase in age 70+ Outpatient appointments.
- **A&E attendances** have seen a 4% increase in the last 3 years (17/18 vs 14/15) with a 17% increase in age 70+ A&E attendances in last 3 years.
- **Inpatient episodes** have increased by 7% over the last 3 years but we have seen a corresponding decrease in bed days by 9% and an increase in day case activity of 10%. There has been a 17% increase in inpatient episodes in those age 75+.
- Currently 13% of the ICS population is aged 70+ and this population accounts for;
- 20% A&E attendances,

- 27% outpatient appointments,
- 31% of emergency inpatients,
- 33% of elective and 33% of day cases

Circulatory disease (including stroke, coronary heart disease), cancers and respiratory diseases currently account for 60% of the diseases that cause the gap in life expectancy between the most and least deprived areas in Nottingham and Nottinghamshire and these are set to rise. For example over the next 20 years stroke will increase to 84%, respiratory diseases to 101% and cancer to 179%.

Evidence has confirmed that these diseases can be prevented by improving lifestyle choices. For example;

- 9 out of 10 strokes are caused by risk factors that can be modified
- 40 - 45% of cancers are caused by risk factors that can be modified

Current data suggests that we still have significant areas of unhealthy lifestyle choices as demonstrated below;

Smoking	• Mansfield and Ashfield > 1 in 5 people • Rushcliffe 1 in 12 people
Exercised for 30 mins for 12 out of 28 days	• Nottingham City and Mansfield and Ashfield - 1 in 3 people • Rushcliffe - 1 in 2 people

With the population growing, ageing and spending a higher proportion of time in poor health, there will be an ever increasing need for carers. Informal carers need more support, they are 2.5 times more likely to experience psychological distress than non-carers; working carers are two to three times more likely to suffer poor health than those without caregiving responsibilities. Dementia carers particularly struggle and dementia is due to increase 86% in the next 10 years.

The pressures on our current services are unsustainable and require a radical re-think in not only how and where services are delivered to ensure efficient and effective delivery, but also how we shift to a more proactive model of care that focuses on preventing the population developing the disease burden in the first place.

Clinical sustainability also requires us to review and consider how and where we deliver services from. Treatments are becoming increasingly specialised offering the potential to improve quality of care further by enabling access to the latest treatments and techniques. This will enable specialist staff to build their skills

and capabilities, and to ensure all patients have access to specialist skills and equipment.

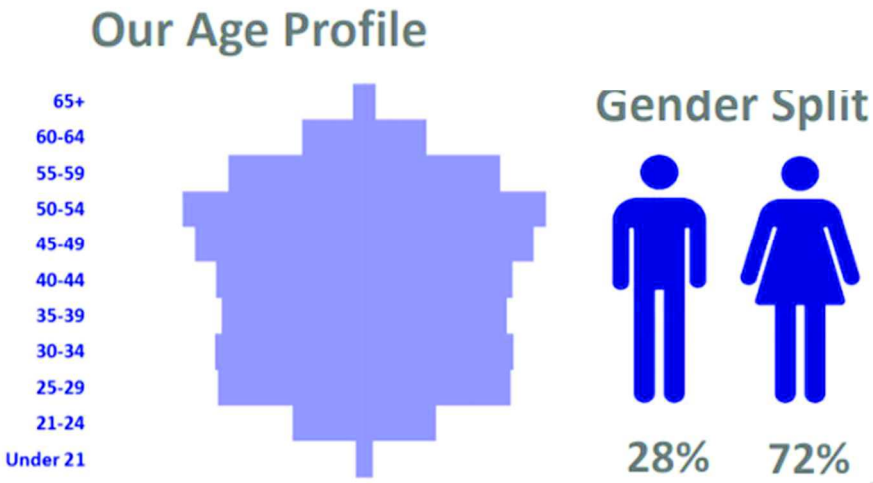
4.2 Workforce Challenges

Across the ICS

Workforce is a key driver for change within our system. Having staff with the right skills and expertise in the right locations is fundamental if we are to achieve our goals and ambitions as a system and we currently face a number of significant challenges in being able to achieve this.

The ICS has developed a 10 year People and Culture strategy which articulates the challenge and puts forward some of the mitigations in terms of recruiting and retaining high quality staff to deliver the care needs of our population. We employ a wide range of talented and dedicated staff across our system who provide excellent care and services to our populations. The profile of staff is as follows;

Figure 4-1 - Workforce key facts and figures



Our local analysis indicates that based on current demand trajectories our ICS will have a shortage of at least 1,500 clinical staff over the next five years. Our system is currently running with a high vacancy rate at 18.19% with turnover at 11.4%. This is exacerbated by a reduced supply of graduates and an ageing workforce with a significant number of staff reaching retirement age.

In terms of primary care, modelling has highlighted significant workforce challenges including a shortage of General Practitioners (77 FTE short by 2020) along with a general shortage of practice nurses and other primary care based staff.

Additionally, there are 2000 (9%) social care/ residential care staffing vacancies, with turnover in Nottingham and Nottinghamshire in line with the England average of 30.1%.

Our People and Culture strategy outlines a range of initiatives and actions that need to be taken for us to address this significant workforce challenge. These are aligned to four strategic workforce objectives:

- Recruitment & retention supporting our current workforce;
- Supporting and retaining our students;
- Developing and supporting emerging new roles;
- Preparing the workforce for new ways of working.

Staff engagement is a key enabler to delivery of both our People and Culture strategy and to this Primary Care Strategy. It is essential that we listen and respond to our workforce to shape the delivery of our priorities. Evidence tells us that an engagement and committed workforce leads to improved patient outcomes and increased staff satisfaction which will assist with recruitment and retention challenges.

Developing our Primary Care Strategy will also identify where we will deliver

services differently and how we can use enablers such as technological advances to mitigate some of the workforce challenges. We need to ensure that staff are empowered to work at the top of their licence and that we maximise their valuable contribution by developing new and innovative roles where appropriate to ensure we continue to focus on high quality patient outcomes.

Additionally, we recognise that the current roles and workforce structures are not fit for purpose. We need to develop a flexible workforce that is not constrained by organisational or professional boundaries. In order to achieve this we will need to link with education providers and review the approach to training our future workforce to focus on the skills we need rather than the roles themselves.

Primary Care and GP Practices

In engaging with our GP Practices across Nottingham and Nottinghamshire GP practices they have outlined that they:

- are struggling to recruit both salaried GPs and partners on a permanent basis, particularly GP partners. Given the number of GPs anticipated to retire over the next 5 years, practices are concerned that this will further exacerbate existing workforce challenges and pose risks to continuity of provision locally
- are concerned that a reduction in the number of general practice trainees will result in an increased risk to workforce capacity over than next 5-10 years
- are concerned that difficulties in recruiting doctors and nurses is reducing available capacity within the system, compounded by closing practices
- often have to manage vacancies through the use of temporary or locum GPs
- are finding it increasingly difficult to source locum medical cover for gaps in frontline general medical services provision
- are finding it challenging to maintain continuity of care and clinical quality with the need to use more temporary locum medical staff
- have concerns that financial austerity will introduce further financial challenges to sustaining frontline services
- recognise particular challenges in recruiting to practices that serve our most deprived populations, where workload is typically higher and more challenging whilst pay is often lower
- are aware of the need to develop and support primary care leadership and to encourage more inclusivity and greater diversity of leaders.

4.3 Estates & Infrastructure

The quality of the existing primary care estate provides both a challenge and an opportunity. Across the ICS area there is £168m of backlog maintenance required across the key provider organisations much of it critical for ongoing service delivery.

The healthcare estate infrastructure in the ICS costs circa £172 million per annum of which £78 million p/a is Private Finance (PFI) or LIFT payments.

Nottingham & Nottinghamshire Estate (Health) has:

- High number of NHS Property Services inherited from Nottingham City and Nottinghamshire County PCTs
- LIFT and PFI Estate across the system – high quality, commercial estate

Key challenges and issues:

- We do not have a single system long-term plan, historically estates plans produced at an organisational level for short/medium term
- There is underutilisation of high quality, commercial estate i.e. PFI and LIFT
- Clinical space is used for administrative purposes in many of these buildings.
- We have an aging primary care estate with growing levels of backlog maintenance and inadequate space to meet future requirements.
- There are 316 health buildings across the ICS including 115 GP owned buildings
- £171 million annual running costs
- £168 million backlog maintenance requirement (£110 million is high risk)

It is therefore essential that our strategy for primary care estates over the next five years supports and enables

- Better use of our primary care estate, especially PFI and LIFT building where there are long term contractual commitments, using the estate more effectively for the whole health and care system, looking beyond traditional organisational boundaries.
- The development of new primary care estate where required in order to deliver against the requirements of the NHS Long Term Plan.

4.4 Financial Sustainability

The Nottingham and Nottinghamshire ICS currently spends £3.2 billion on health and care services and for a number of years has been spending more money than it receives. Without change, the situation will get worse.

The system faces a gap of £159.6 million in 2019/20 representing 4.9% of the total system resources. This gap is expected to increase to in excess of £500 million by 2023/24 for NHS services alone if we do not change the way in which we design services and work with our populations to improve their health and well-being to prevent them entering ill-health in the first place.

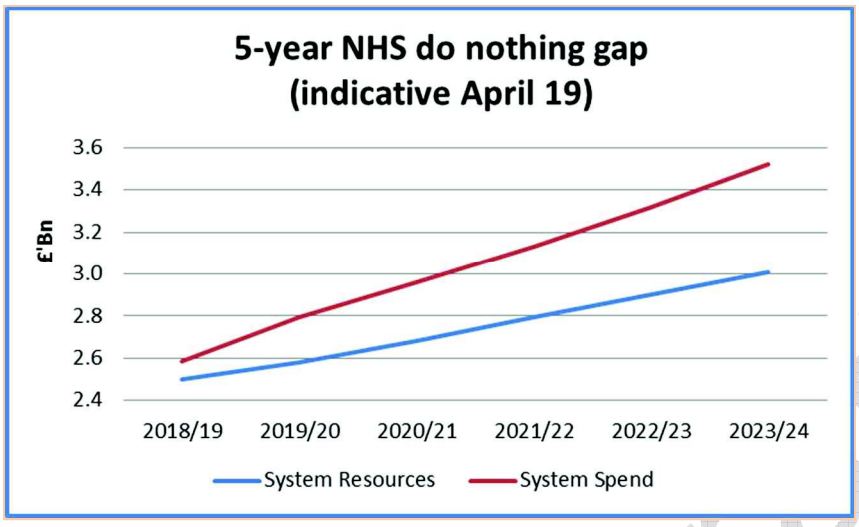
The improved NHS Long Term Plan funding settlement will result in system resources increasing by circa 20% over the next five years but this will not keep pace with cost increases which are projected at 35% for the same period if we don't do anything differently.

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).

Five-Year Plan: Finance & Efficiency Gap

- An initial indicative figure (more detailed analysis is ongoing) for the health system's do nothing five year gap has been identified as £510 million (increasing gap)
    - NHS system resources expected to increase by 20% over 5 years to £3 billion
    - NHS system costs expected to increase by over 35% over 5 years to £3.5 billion
- ICS has higher levels of fixed costs in comparison to other systems due to PFI costs
- NHS is implementing a new financial framework for providers and commissioners and it is expected that in future years we will move away from control totals and sustainability funding. However, for 2019/20 control totals remain in place, for individual organisations and ICSs.
- The five-year plan will need to deliver within available resources.

Figure 4-2 - Projected 5 year NHS do nothing gap



4.5 Case for change: Conclusion

We have a compelling need for change, driven by the changing needs of our local population and by the need to ensure we are consistently offering the best evidence based services for all of our citizens.

We are faced with a current health and care system that has a number of challenges, ranging from

- an inability to recruit and retain the key skills and workforce we require to deliver care,
- rising costs that mean our current services are costing more than the income we receive
- a primary care estate that is aging and does not have adequate space to support the delivery of new models of care.

These issues are very real and we need to address them in a way that will improve outcomes for individuals, our communities as well as all of our staff working across the system.

Experiences locally and nationally from testing alternatives through Vanguards and other developments tell us that primary care has a vital role to play in improving population health and helping to drive the system forward, including relieving pressure on A&E departments and offsetting winter spike demands. But our Primary Care provision also needs to find ways to address its own pressures and challenges in order to be able to fulfil its role effectively.

5 Fulfilling the NHS Long Term Plan

The following sections should outline, in summary how the strategy meets the five key elements as set out in Chapter 1 of the Long Term Plan (LTP):

1. We will boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services (section 5)
2. The NHS will reduce pressure on emergency hospital services (section 6)
3. People will get more control over their own health and more personalised care when the need it (section 7)
4. Digitally-enables primary and outpatient care will go mainstream across the NHS (section 8)
5. Local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems everywhere (section 9)

When addressing each element the strategy should note each of the following:

1. The role that PCNs will play in achieving each element of the LTP
2. How the workforce will be configured to achieve each of the elements
3. What changes will be required to the location and function of the estate in achieving each element.
4. How the increased use of new technology will support the delivery of primary care services.
5. What the pattern of funding will be to ensure this can be achieved within the limits of budgetary allocations. Particular reference to how you intend to manage the delegated funds for this year and the outcomes you intend to achieve with the delegated funding, should be included.

This section should provide your statement of intention to meet the key five elements of the NHS Long Term Plan (LTP) in primary care.

How we intend to fulfil the ambitions of the NHS Long Term Plan for primary Care

Our overarching aim for Primary Care Networks is that;-

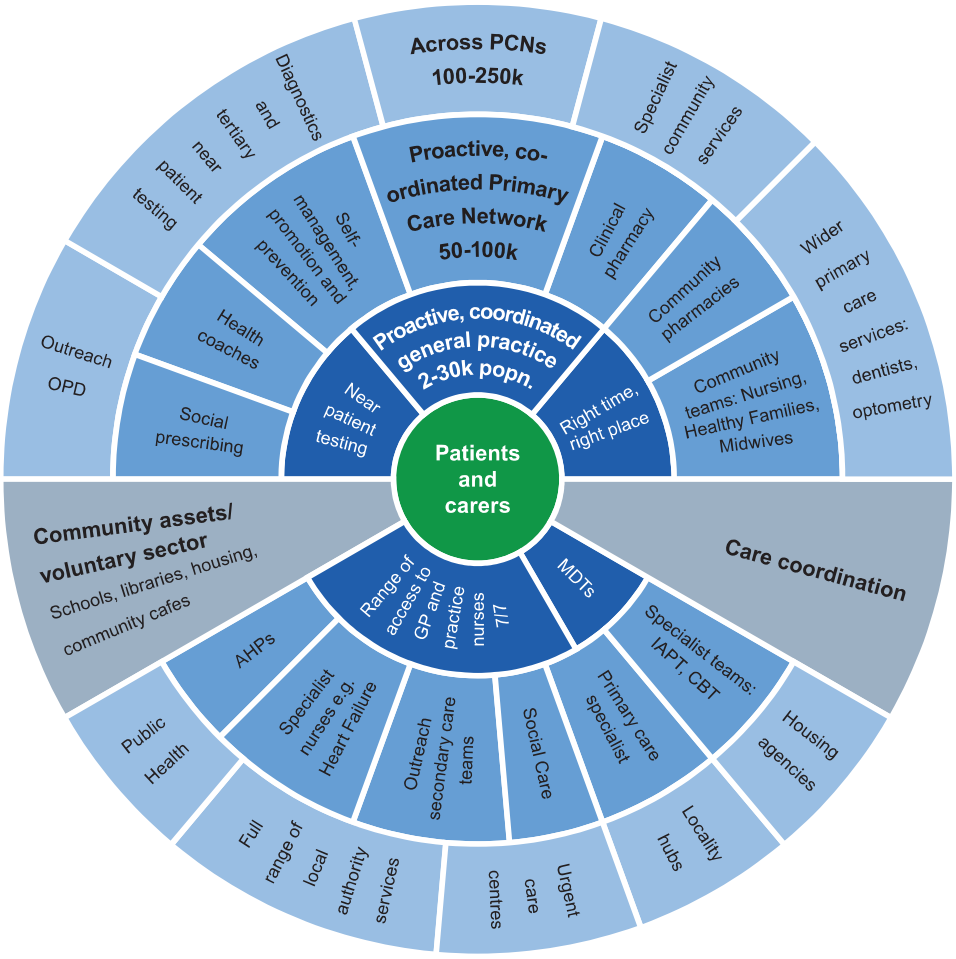
"PCNs will be at the heart of health and care provision; improving the wellbeing of our local populations through proactive, accessible, coordinated, and integrated health and care services."

Our vision therefore is an integrated, place-based care approach developed

around natural communities. Key characteristics of each PCN will be:

- An integrated and collaborative primary care workforce, with a strong focus on delivering quality services through partnership – 'primary care' is defined as first line services such as; general practice, community providers, secondary care, mental health, voluntary sector and social care;
- A supported and integrated workforce with a combined focus on prevention and personalisation of care with shared and improved qualitative health and care outcomes utilising population health management data;
- Citizens that are taking personal responsibility for their own well-being and are actively engaged in the development of their local Primary Care Network and in strengthening their local community;
- A proactive model of care, utilising risk stratification and targeted interventions to eliminate hospital admissions as a default for people who are not acutely unwell but do need some degree of help and support to prevent further deterioration.

Figure 5-1 - The model of Primary Care Networks across the ICS



In addition to core general practice and associated services, it is anticipated that all PCNs will incorporate the following services within their scope:

- Population health management for risk stratification of the population. Phase 1 will focus on 100% of patients with a long term condition but will ultimately cover 100% of the local population
- Proactive and self-care
- Enhanced care to care homes
- Planned care - secondary care consultations, procedures and outpatient appointments
- Urgent and unplanned care - access to GP-led urgent care through GP surgeries, OOH, integrated urgent care and urgent care centres, including access to diagnostics imaging and x-ray
- Step-up and step down care - to avoid hospital admissions and support early discharge, including mental health crisis teams

A great deal of progress has already been made within the system in implementing the ten 'High Impact' changes set out in the General Practice Forward View to improve efficiency and resilience, and work continues across these areas.

The Long Term Plan provides opportunity for our Primary Care to go further and build upon the foundations established to date, playing a critical role in the delivery of the new care models described in the following sections.

In addition to the priorities set out in the Long Term Plan, Nottingham and Nottinghamshire ICS has a set of priorities focussed on the particular needs of our population and the challenges in our system. As the table below demonstrates, these complement and support the Long Term Plan whilst helping to direct effort and resource where it is most needed.

Figure 5-2 - ICS Priorities mapped to Long Term Plan priorities

ICS Priorities		
ICS1	Redesign the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting	LTP1 LTP2 LTP5
ICS2	Improve support to people at risk of and living with single and multiple long term conditions and disabilities through greater proactive care, self-management and personalisation	LTP3 LTP4
ICS3	Re-shape and transform services and other interventions so they better respond to the mental health and care needs of the population	LTP1 LTP5
ICS4	Deliver increased value, resilience and sustainability across the system (including estates)	LTP4
ICS5	More action on and improvements in the upstream prevention of avoidable illness and its exacerbations	LTP3 LTP5

Long Term Plan Priorities		
LTP1	We will boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services (section 5)	ICS1 ICS3
LTP2	The NHS will reduce pressure on emergency hospital services (section 6)	ICS1 ICS3
LTP3	People will get more control over their own health and more personalised care when the need it (section 7)	ICS2 ICS5
LTP4	Digitally-enables primary and outpatient care will go mainstream across the NHS (section 8)	ICS2 ICS4
LTP5	Local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems everywhere (section 9)	ICS1 ICS3 ICS5

6 Key element 1 - We will boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services

This section should demonstrate the role primary care will play, in your health economy to develop the integration of primary and community health services. This should address the following areas:

1. A summary of the current situation regarding the integration of primary and community services, including any developments that have already been implemented or that are underway.
2. A description of how services will be integrated
3. How the workforce will be configured to deliver the proposed integration, the new and/or additional roles that will be needed and the implementation timeframe.
4. How services will be delivered, what role new technology might play and the timeframe for implementation any proposed solutions.
5. The section should also describe the governance and operational arrangements that will be required to deliver and implement the proposed changes.
6. The resourcing of the proposed changes should also be addressed, detailing both the set up and anticipated ongoing costs of delivering the proposed changes.

6.1 Current Situation

A great deal of work has already been undertaken across Nottinghamshire to integrate Primary and Community Services. There are strong examples of good practice already in place, including the award winning Vanguard in Rushcliffe, and a well-established Care Delivery Group model. Over the last twelve months work has been underway to build on the learning from the four Vanguard programmes: urgent care, care home, multi-specialty community provider, and integrated primary and acute care systems. The four New Models of Care work programmes have provided extensive learning and insights that support the continuation of work to progress and develop care close to home, supported by the integration of general practice, community provision, and social care.

More recently work has focussed on the development of Primary Care Networks across Nottingham, South Nottinghamshire and Mid Nottinghamshire. This work has been supported by all key health and care partners across the

ICS. The publication of the NHS Long Term Plan and Investment and Evolution: a five-year framework for GP contract reform to implement The NHS Long Term Plan have provided added impetus to progress the work to formally establish Primary Care Networks across the ICS area.

6.2 How services will be integrated

PCNs need to embrace a much wider approach than the traditional model of general practice. The approach will focus on the prevention agenda with the aim of reducing the need for complex care in future years. This will be achieved through;

- Robust risk profiling and targeted, outcome based interventions
- 100% coverage of population health management data that links into the wider community to enable people to proactively take control of their health and well-being
- General Practice stratifying and proactively targeting at risk people in their locality
- Patient choice and self-care, supporting patients to make choices about their care and look after their own health by connecting them with the full range of statutory and voluntary services.

Prevention needs to be seen to have an equal level of importance as treatment modalities and be implemented at scale. It should be accessed at all levels, from an individual GP consultation, right through to accessing the wider community assets. This will be achieved through:

- An expansion of social prescribing and health coaching aligned and navigated through dedicated care co-ordinators.
- Promotion and access to screening programmes will continue to have their profile raised with the aim that national priorities and targets are surpassed.
- A focus on ‘what is important to you’ rather than ‘what is wrong with you’.
- A focus on personalisation and personal health budgets which will also enable a more proactive approach to maintaining well-being.

Care co-ordination needs to take place across all levels of the health and care system from the individual consultation within the GP practice, through to coordinating with wider services across a number of PCN’s. This will be achieved through;

- Shifting the response of care co-ordination to a more proactive focus so that

care co-ordinators are able to actively contact patients and work alongside social prescribers and health coaches to proactively signpost and motivate people to promote their well-being.

- A well-developed JSNA at an ICS level and clear implementation plans developed through the ICPs. Local authority and voluntary sector organisations – housing, education, fire and police services, leisure, and environmental health services, along with engagement with local businesses and voluntary organisations will be key to

Addressing the wider determinants of health through engagement with the wider social network is vital. Issues such as debt, poor housing and social isolation can have a negative impact on a person's health and wellbeing. This will be addressed through:

- Giving children and young people a good start in life by engaging with education providers in local communities and focusing on healthy families
- Development of local strategies that will provide training and job opportunities, good quality housing and keep people connected to their local community by enabling people to create and engage with local community assets
- Ensuring that parity of esteem is delivered between physical and mental health problems, and that a holistic approach is delivered to support patients and their families.

6.3 Workforce configuration to deliver integration

The workforce will move away from service specific care to a more generalist role and will be trained to treat the patient, not the disease, recognising that most patients may have one or more health or social care need.

6.4 Service delivery and technology

The use of technology and effective information sharing will be critical. Utilising technology and information patients will have the ability to book their appointments online, re-order prescriptions, access their GP medical records and access online consultation services. Patients will be empowered by giving them the tools to support their own self-care as well as offering more telephone advice/video consultation appointments.

6.5 Governance and Operational Arrangements

[To follow]

6.6 Resourcing and costs

[To follow]

7 Key element 2 - The NHS will reduce pressure on emergency hospital services

This section should demonstrate the role primary care will play, in your health economy to reduce pressure on emergency hospital services. This should address the following areas:

1. A summary of the current situation regarding the integration of primary and community services, including any developments that have already been implemented or that are underway.
2. A description of the role primary care will play in reducing pressure on emergency services, providing an estimate of the potential impact and how this might develop over time.
3. How the workforce will be configured to reduce pressure on emergency services, the new and/or additional roles that will be needed and the implementation timeframe.
4. How services will be delivered, what role new technology might play and the timeframe for implementation any proposed solutions.
5. The section should also describe the governance and operational arrangements that will be required to deliver and implement the proposed changes.
6. The resourcing of the proposed changes should also be addressed, detailing both the set up and anticipated ongoing costs of delivering the proposed changes.

7.1 Current Situation

Our emergency care services are under huge pressure and it is recognised that any sustainable solutions require whole system transformation, including leveraging the role of Primary and Community services to a greater extent. PCNs are seen as a key enabler in helping with this transformation.

General practice is already meeting the core national requirements in respect of GP extended access which includes:

- 100% population coverage
- Monday to Friday 8am to 8pm
- Saturday and Sunday/Bank Holiday pre bookable appointments

There are also a number of other initiatives being delivered which are targeted at reducing pressure on emergency services. These include:

- Acute Home Visiting Service – proactively completes ‘on the day’ requests

for a home visit. Leading to reductions in hospital attendance; increase utilisation of single point of access and earlier arrival times at hospital, allowing secondary care to turn patients around on the same day.

- Enhanced Care Home Service which manages patients in a community setting
- Community monthly Multi-Disciplinary Team (MDT) risk stratification meetings by PCN identifying those at risk of admission or deterioration.
- High intensity user MDT meeting focussing on proactive care planning for people deemed high volume service users
- Non clinical navigators using E-healthscope to identify patients who have triggered demand on secondary care services such as ED.
- Practice level information used to performance manage individual practice secondary care utilisation
- Local public engagement through Patient Participation Groups, including education

7.2 Role of primary care in reducing pressure on emergency services

A key priority for the ICS is to transform the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting.

This is being addressed through four strategic areas, each supported by a series of initiatives, with Primary Care playing a key role in many of these:

i. Out of hospital urgent care
ii. Pre hospital urgent care
iii. Hospital care - Flow and right place
iv. Home First Integrated Discharge

i) Out of hospital urgent care

Primary care is core in the delivery of this strategic area and all four initiatives:

Initiative	Description
Same Day Access to Primary Care	Each PCN will provide same day access to an appropriate health or social care professional via a GP led multi-disciplinary service model which includes therapists, pharmacists, community physical and mental health nurses and social workers. Delivery will be through a network of practices and/or hubs within PCNs with services available from early morning into the evening, 7 days a week. Out of Hours services will be

	either aligned or integrated with the daytime same day access service.
Single Point of Access (Call for Care)	In circumstances where patients do deteriorate community based urgent response and recovery support will be readily available with the aim of preventing unnecessary admission to hospital. Access to these services will be via a single point of access, known locally as Call for Care. Health and social care referrers will hand over the patient, and often complex family, care needs to Call for Care who will assess the patients' needs and mobilise appropriate services and equipment, including a two hour response and support (both social and health care support). Call for Care will be accessible to all health professionals and provide other services, like EMAS, with support so patients can remain at home where clinically appropriate. Call for Care will also be able to access step up bedded capacity should a patient require a period of rehabilitation. The Strategic Commissioner will agree with each of the ICPs the optimal hours the service will operate , the pathways, and how it will integrate with its PCNs.
Community Crisis Response	Out of hospital crises response will centre around an integrated rapid response service that will: ▪ Respond within two hours (accessed by the single point of access) of referral in line with NICE guidelines, where clinically judged to be appropriate, thereby preventing A&E attendances and unnecessary admissions to hospitals and residential care; ▪ Provide a 'pull approach' by supporting the active management of patients at the front door to prevent A&E attendance and admissions by ensuring urgent response pathways are utilised appropriately to prevent decision to admit; and ▪ Support and accelerate complex discharges into the community from hospital. This urgent response and recovery support will be delivered by flexible joint health and social care teams that include GPs, allied health professionals, district nurses, mental health nurses, therapists and reablement, and will be fully integrated

	with Primary Care Networks and local hospitals. The integrated rapid response service will deliver holistic assessments and short term interventions based on an acute medical health condition within the patient's usual place of residence wherever possible, or refer into a 'step-up' bed. The integrated rapid response service will make appropriate referrals and have direct access to other community providers and closely align with the Acute Home Visiting Service (AHVS), which are staffed by experienced Advanced Nurse Practitioners who visit patients that GPs would normally visit at home. The Strategic Commissioner will agree with each of the ICPs the optimal hours the community crisis response service will operate, based on needs, the duration of care packages provided, how the service supports the active management of patients at the hospital front door and how it integrates with step-up beds, specialist teams (e.g. falls), AHVS and the voluntary sector.
Community 'step-up' beds	Even when primary and community care professionals identify the need for an in- patient stay it is still be possible to avoid an acute admission by using 'step-up' beds. Step-up beds will be used when it is not safe to support people in their usual place of residence, an assessment is needed and patients are likely to benefit from a short term bed based in patient stay. They will be accessed through Call for Care. The Strategic Commissioner will determine with the three ICPs the location and number of step-up beds on an ongoing basis including in community hospitals, a ward on an acute site and / or in the independent sector to ensure they meet local need. Local PCNs will be looked to for medical cover to the beds

ii) Pre Hospital Urgent Care

Primary care has a key role in the delivery of two of the four initiatives within this area.

Initiative	Description
Integrated Urgent Care Service	The Strategic Commissioner will commission an Integrated Urgent Care Service that operates across all three ICPs and is comprised of two elements; an integrated Clinical Assessment Service (CAS) and Urgent Primary Care Treatment Services. The CAS will move from a 'hear and refer' to a 'consult and complete' model, with the aim to close the majority of calls within its services or make a direct booking into another service for example a GP surgery within a PCN or Urgent Treatment Centre. This consult and complete model would move towards reducing reliance on A&E referral and ambulance conveyance unless clinical presentation indicates this is the only appropriate course of action. A single entry point via NHS 111 either by phone or internet based NHS 111 online applications. These calls (or online referrals) will be received and triaged by 111 call handling staff with appropriate calls be passed to a Clinical Assessment Service for further clinical assessment. Patients who then require treatment face to face (rather than telephone) will be directed to an appropriate service which may be accessed via a booked appointment. One of these options for patients with a minor injury or illnesses will be an Urgent Treatment Centre. The Strategic Commissioner will agree the pathways and conditions that are managed by the CAS and how it integrates with PCNs with the three ICPs to ensure they meet the needs of the population. In addition the Strategic Commissioner will procure an out of hours service across Nottingham and Nottinghamshire to a single specification that provides face to face treatment and home visits.

Ambulance Conveyance and Arrivals	This initiative is predominantly aimed at the Ambulance Service, although it does draw upon services such as Call for Care and Community Pathfinder.
Front Door Triage and Divert	When patients present at an A&E there are still opportunities to provide alternative care rather than assessment within A&E and potential onward admission. Triage and divert will be supported by Primary Care Streaming that is integrated with the CAS and a multi-disciplinary front door team who are experts in signposting and finding alternative care, where needed, in the community. The team will include nurses, therapists, mental health specialists, social care professionals and social prescribers. Professionals will work to the same thresholds, providing an appropriate response across the spectrum of urgent care. This team and service will be part of or integrated with the Community Crisis Service depending on the model agreed between the Strategic Commissioner and the ICPs. Senior decision makers are key to the success of the A&E. When patients enter the A&E a decision making clinician will see new patients on or as close to arrival as possible. The A&E team will not admit a patient likely to be able to go home just to avoid a breach of the emergency care four hour standard.
Mental Health Liaison Service	All age mental health liaison services will be available in all acute trusts 24/7 providing direct support into A&E as well as wards to support admission avoidance and early discharge

iii) Hospital Care – Flow and Right Place

The initiatives within this strategic area are predominantly around practices within the acute hospitals, although improved management and utilisation of community bed capacity is needed to support this.

iv) Integrated Discharge

Initiative	Description
Discharge to Assess and Manage	The vast majority of patients (approximately 85%) will leave the hospital with no ongoing care needs. These patients will be discharged in a timely manner with appropriate transport planned in advance. The remaining 15% of patients will need to leave the hospital with ongoing support. The provision of high quality reablement care will reduce the dependence of patients upon on going care and in many cases eliminate the need for support after the first few weeks of discharge. When a patient is declared to be medically optimised a full Discharge to Assess process will be implemented. When an intensive level of care (daily and/or 24 hour care) is agreed the patient will be admitted to either: ▪ Urgent response/intensive rehabilitation at home for home based daily rehabilitation; or ▪ Intensive rehabilitation within a bedded facility When a less intensive level of care is agreed, the patient will be supported either: ▪ Within their usual place of residence with health and/or social care support; or ▪ Within a bedded facility to receive rehabilitation, if they are non-weight bearing and their needs can not be met in an alternative setting or if they are requiring a DST CHC assessment. The Strategic Commissioner will determine with the three ICPs the location type (intensive vs. less intensive) , duration of care package and number of step-down rehabilitation beds on an ongoing basis, supported by bed utilisation reviews, including in community hospitals, a ward on an acute site and / or in the independent sector to ensure they meet local need. Similarly the Strategic Commissioner will determine with the three ICPs the required capacity for intensive rehabilitation and less intensive rehabilitation, and the duration of care packages to be provided within patients homes on an ongoing basis. Local

PCNs will be looked to for medical cover to the beds.

7.3 Workforce configuration

One Clinical Pharmacist per PCN - in line with the national GP contract

Social Prescriber – one per PCN – in line with the new National DES

7.4 How services will be delivered

Each ICP will undertake work to understand demand and capacity in secondary care.

GPs will continue to offer extended access and will focus on improving the utilisation of pre bookable appointments.

PCNs will continue to work with community provider partners in identifying those most at risk of hospital admission and will proactively put in place plans to manage the particular issues identified; this will be far and wide reaching to include ill health, social care needs and determinants wider than health such as housing and debt.

The CCG expects that a common set of outcomes is adopted across PCNs within the ICPs in Nottingham and Nottinghamshire. Where appropriate, a consistent model for delivery will be adopted by all geographies. Primary care, community services and local authorities will be key partners in providing proactive case management.

Each practice population will be reviewed using a common risk stratification tool that will identify the patients who are most at risk of attendance at or admission to hospital. Once identified some patients may only require a simple intervention that reduces their risk and will not require a full care plan and regular review. For practical reasons only those most complex patients who remain high risk will have regular reviews of their care plans. Other patients will be reviewed as the data iteratively escalates them back into the risk thresholds.

Interventions and care plans agreed should concentrate on managing the patient's needs in the community. If patients do attend A&E or require admission to hospital the care plan will be available to hospital staff and will detail jointly agreed "ceilings" of treatment (as well as care), including a

comprehensive social history to allow for effective discharge planning at the point of admission.

The NHSE new care model - Enhanced Health in Care homes framework is being rolled out and the framework aims to enhance 7 core elements and 18 sub elements to maximise benefits of existing works to improve the quality and safety of care for residents living in care homes. Many of these elements will support hospital avoidance.

7.5 Governance and Operational Arrangements

The assurance and monitoring of this will be carried out through the ICS Primary care steering group and the ICP A&E Delivery Board

The Joint Primary Care Commissioning Committee (JPCCC) will provide oversight

7.6 Resourcing and Costs

[To follow]

8 Key element 3 - People will get more control over their own health and more personalised care when they need it

This section should demonstrate the role primary care will play, in your health economy to personalise care and should address the following areas:

1. A summary of the current situation regarding the personalisation of healthcare services, including any developments that have already been implemented or that are underway.
2. A description of the role primary care will play in personalising healthcare services.
3. How the workforce will be configured to deliver personalised care, the new and/or additional roles that will be needed and the implementation timeframe.
4. How services will be delivered, what role new technology might play and the timeframe for implementation any proposed solutions.
5. The section should also describe the governance and operational arrangements that will be required to deliver and implement the proposed changes.
6. The resourcing of the proposed changes should also be addressed, detailing both the set up and anticipated ongoing costs of delivering the proposed changes.

8.1 Current Situation

NHS England named the Nottingham and Nottinghamshire ICS as a demonstrator site for the comprehensive model of personalised care. The vision of personalised care in the Nottingham and Nottinghamshire ICS is to maximise independence, good health, and wellbeing throughout people's lives, shifting the focus from 'what is the matter to you' to 'what matters to you'.

The ICS is working to give people access to a range of services that enables them to make choices that will focus on self-care without unnecessary intervention, developing access to an array of appropriate choices to support this. For those who need more assistance, people are offered personal budgets, personal health budgets or integrated budgets in order to ensure meaningful choice and control, resulting in both health and social care that meets the person's needs. A person-centred approach is used to empower all people using health and social care services in order for them to build their own knowledge, skills and confidence to self-care.

In 2018/19, after signing a memorandum of understanding in 2018/19 with NHS England, the ICS and partner organisations have delivered:

- A clear vision for implementing personalised care in line with the NHS Long Term Plan and Universal Personalised Care: Implementing the Comprehensive Model
- System ownership, especially at senior level within ICS organisations, with many starting to see personalised care as a solution
- Shared leadership across health and social care, working as a team
- 2,321 PHBs/integrated budgets, 18,519 personalised care and support plans, and 14,662 self-management and community support plans in 2018/19
- 199 looked-after children and young people with a PHB, with 100% reporting that they feel better about their quality of life
- Patient Activation Measures implemented within pulmonary rehab (resulting in learning to guide further roll-out in 19/20)
- Programmes of workshops including personalised care and support planning, health coaching, and expansion of social prescribing
- A common quality framework and guidance for personalised care and support planning
- Strategic co-production involved in all stages of project planning, delivery, and service development via the My Life Choices group of people with lived experience

Primary care has been a key part of delivering these achievements in 2018/19 and will continue to play a strong role as we move forward in 2019/20 and beyond toward the ambitions of personalised care.

8.2 Role of Primary Care in Personalising Healthcare Services

The focus will be on ‘what is important to you’ rather than ‘what is wrong with you’ and will be achieved through patient engagement and activation being fully embedded within each PCN. There will be a focus on personalisation and personal health budgets which will also enable a more proactive approach to maintaining well-being.

8.3 Workforce Configuration

To successfully deliver personalised care, the ICS is working to train and equip staff involved in the delivery of all people's care to identify self-care needs and take a flexible, holistic approach to people's needs with a strong prevention focus, encompassing person-centred approaches. This will develop a workforce which is trained, equipped, and supported to deliver preventative and person-centred approaches and includes:

- Production of a toolkit to provide the ICS workforce with the knowledge and skills to understand and deliver personalised care
- Embedding personalised care in induction, training, supervision and appraisals
- Developing professional skills and behaviours to deliver PCSP as fundamental ways of working across health and social care staff
- Establishing support networks for link workers, navigators, health coaches or community connectors
- Carrying out a train-the-trainer programme to empower members of the workforce to help spread the personalised care approach with their teams and colleagues

In 2018/19, 53 colleagues across the ICS, including those from primary care, received training in health coaching conversations. By 2020, the ICS personalised care team will increase this to 250.

The ICS will embed at least one link worker in every primary care network (PCM) in 2019/20; these link workers will support primary care by signposting people and connecting them with groups and organisations within their community alongside work toward developing local organisations and groups within the community

8.4 Service delivery and implementation

A multi-disciplinary approach to care coordination, reflecting the outputs of segmentation/stratification, will be embedded that breaks down the traditional silos between primary and community services and supports greater integration between health and social care. Each ICP and its PCNs will agree a standard operating model (including capacity requirements) and shared accountability structure for care coordination with the commissioner, with clearly defined responsibilities for each person involved, including the individual receiving the care, the GP and other members of the integrated health and care teams. This will include the frequency and focus of care coordination reviews, the presence of coordinators in practices outside of review meetings, the use of real time

information outside of coordination reviews and referrals to disease/condition management programmes. This responsibility and accountability structure will be transparent across organisations and the performance and results (KPIs) of the approach within each PCN defined, monitored and shared. .

Building on the successes of 2018/19, the ICS is discussing a subsequent MOU with NHS England for 2019/20 with further targets toward the embedding of personalised care:

- 1,615 people completing the Patient Activation Measure (PAM)
- 15,000 people referred for self-management support, health coaching and similar interventions
- 15,000 people referred for social prescribing community groups, peer support and similar activities
- 19,580 personalised care and support plans or reviews
- 2,900 personal health budgets or integrated budgets across a range of cohorts

Primary care plays an important role in working toward these targets and developing a culture where a different, person-centred conversation is the norm and people are recognised as equal partners.

i. Personalised Care and Support Planning and Personal Health Budgets

The ICS will build on the successes in 2018/19 to continue the expansion of personalised care and support planning and budgets. This includes expanding both within existing cohorts (such as continuing healthcare, looked-after children, NHS and direct payment carers' breaks, joint-funded budgets, Section 117 aftercare, and personal wheelchair budgets) and expanding to additional cohorts, such as neuro-rehabilitation in Mid-Nottinghamshire, further areas of mental health (including the personality disorder cohort), fast track, and cancer (in partnership with Macmillan).

In 2019/20, the personalised care team will continue working toward a digital solution for sharing the information in the personalised care and support plans between teams across the ICS, building on current work to increase interoperability between primary care systems (such as SystmOne) and other systems across the other health and social care organisations in the ICS.

Alongside this, the All About Me one page profile document is an important element in the shift to personalised care. It forms the first page of a personalised care and support plan and is the starting point to summarise what matters to a person and how they would like to be supported. In 2019/20, the

personalised care team will continue to expand the use of the All About Me, including with primary care colleagues.

ii. Health Coaching

The ICS will train 250 staff in health coaching by 2020, including those from primary care. This will be evidence-based and include primary and secondary prevention approaches which have an initial focus on delivering outcomes over a short-term timescale. This training will support staff in all interactions with people to have brief conversations on how they might make positive improvements to their health or wellbeing, seeking to have a significant impact on population health through supporting people and their families to live healthier lifestyles.

iii. Patient Activation Measure (PAM)

The ICS personalised care team will continue to drive rollout of the Patient Activation Measure (PAM) tool across the ICS through an action plan identifying specific cohorts to roll out to each quarter, building on learning from the initial cohort of pulmonary rehabilitation in 2018/19 and working with Sheffield, who have implemented PAM on a wide scale, as a mentor site. The ICS aims to complete 1,615 PAM assessments in primary care in 2019/20.

Through PAM, primary care staff can support people to manage their health in a way that empowers them and suits them best, tailored to their activation level (a person's knowledge, skills, and confidence). This includes those with long-term conditions. Using the results of PAM, primary care colleagues can then support people to build their knowledge, skills, and confidence, leading to improved self-management.

iv. Shared Decision Making (SDM)

Shared decision making (SDM) involves working with clinicians and practitioners to ensure they involve people more fully in designing support around individual needs, meaning equipping people with the knowledge that they need to then be an equal partner in care and treatment decisions. The ICS personalised care team aims to extend SDM to at least two further clinical situations in primary and secondary care and at the primary/secondary care interface, targeting areas where it will have the greatest impact.

v. Community Connectivity and Community Development

Community connectivity programmes are already in place in some areas of

Nottingham and Nottinghamshire; in 2019/20, the ICS will extend this capability ICS-wide through establishing at least one link worker per PCN while creating and embedding a social prescribing and community connecting model within ICP and PCN areas. This approach will aim for people to be easily referred to these link workers from a wide range of local agencies, including primary care, local authorities, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community and social enterprise (VCSE) organisations.

Alongside the advent of these link workers, the ICS will work to strengthen and increase capacity to support this community connecting, encouraging a vibrant and active community and self-care sector. This will allow primary care professionals to have confidence when connecting people to neighbourhood and community groups and local organisations.

The ICS will work in partnership with Community and Voluntary Service (CVS) organisations to establish clear KPIs for community development in the VCSE sector to work to ensure a safe referral system is in place, meaning that primary care colleagues can feel assured when referring people to link workers for community connectivity.

This work will support community groups with all relevant aspects to ensure both people and link workers are safe. This includes, but is not limited to, insurance, safeguarding, lone working, first aid, data protection, DBS checks, food safety, and working with vulnerable citizens. Through this work, referral agencies and statutory bodies have an honest and transparent relationship with VCSE organisations, allowing innovative community initiatives to establish themselves without being prevented by barriers around risk aversion in statutory agencies. The ICS personalised care team will work with VCSE organisations to create reasonable and safe referrals, based on what matters to people while minimising bureaucratic controls and working to overcome an overly risk-averse approach to local community development.

The ICS will also work to further develop digital resources that primary care colleagues can point people toward such as Nottinghamshire Help Yourself and Ask LION for signposting and community support.

8.5 Governance and Operational arrangements

The ICS personalised care team is working toward ensuring personalised care is a golden thread throughout all work at the ICS, ICP, and PCN level and is included as a strategic priority throughout ICS key system and planning processes, working to embed system-wide leadership through a shared understanding of the relationships between the social determinants of health, lifestyles, and health behaviours.

Wording around key elements of personalised care will be included for all new or revised service specifications. The ICS will work in 2019/20 to build a personalised care approach into all commissioning, contracting, and payments, joining up commissioning across primary care and other organisations and providers to maximise funding and reduce duplication. This will maximise funding, reduce duplication, and provide greater flexibility within contracts to provide choice and control.

8.6 Resourcing and costs

The majority of resourcing and cost in 18/19 and 19/20 have been managed through the use of NHSE MOU monies. Moving into 2019/20 CCGs and provider organisations will need to look at more sustainable plans for releasing resource to manage personalise care.

9 Key element 4 - Digitally-enabled primary and outpatient care will go mainstream across the NHS

This section should demonstrate the role primary care will play, in your health economy to enable the introduction of digitally enabled primary care.

1. A summary of the current situation regarding the introduction and adoption of digitally enable primary healthcare services, including any developments that have already been implemented or that are underway.
2. A description of the role primary care will play in delivering digitally enabled healthcare.
3. How the workforce will be configured to deliver digitally enabled services, the new and/or additional roles that will be needed and the implementation timeframe.
4. How services will be delivered and the timeframe for implementation any proposed solutions.
5. The section should also describe the governance and operational arrangements that will be required to deliver and implement the proposed changes.
6. The resourcing of the proposed changes should also be addressed, detailing both the set up and anticipated ongoing costs of delivering the proposed changes.

9.1 Current Situation

Primary Care in Nottinghamshire has made significant progress in the delivery of overall the strategic digital plans to support the 19/20 contract requirements and foundations for the Long Term Plan.

The deployment of numerous technological solutions supports improved information sharing, infrastructure and digital maturity. These key enablers deliver the ambitions set out in Nottinghamshire's Local Digital Roadmap and the emerging Integrated Care System digital strategies.

Clinical Information Sharing

The CCGs, in agreement with other organisations has successfully rolled out the Medical Interoperability Gateway (MIG) which is used to deliver information to the Nottinghamshire Health and Care Portal. This allows data from GP practices operating to be viewed in other agencies such as emergency departments, community and social care enabling them to make better, informed decisions about care.

The Medical Interoperability Gateway (MIG) also supports information sharing across Out of Hours, Community Services, GP Federation(s) and Mental Health Services. In addition, an End of Life care dataset bought on line through the Electronic Palliative Care Co-ordination System (EPaCCS) is available to all primary and community care providers as well a number of third party care providers across Nottinghamshire.

Use of Information to support care

The GP Repository for Clinical Care (GPRCC) has been developed to support clinical workflows across the community. Data is received nightly from GP, community, mental health, acute provider and social care systems. Over 100 workflows aimed at clinical coordinators, pharmacists, GPs, community teams and mental health are derived in keeping without our clinically led strategy. Risk stratification and the Electronic Frailty Index are used to prioritise our response to acute workflows. A dashboard informs practices, PCNs and CCGs about how it is performing over hundreds of indicators monitoring key outcomes.

Data standardisation and digital library

F12 is a locally built solution for standardising the collection of data across Long Term Conditions and referrals. All local guidelines and forms are accessible from a central library that is referenced by our other projects along with references to key National guidelines. Information from standard templates is extracted into a database, hosted by eHealthScope. These can be used to populate other data collection templates used elsewhere in the community.

Information governance

The CCGs have achieved an acceptable level of IG toolkit compliance (including partners) and several pieces of additional assurance work have taken place, relating to shared information tools, in the last 12 months. Nottinghamshire is also engaged with accredited independent third party suppliers to conduct exercises such as PEN/Vulnerability testing when delivering or changing technical infrastructure and Privacy and Security Impact Assessments are undertaken on new technology implementations. Cyber security remains an important consideration in all technology enabled projects. Nottinghamshire adopt robust processes in data security and IT security.

NHS App

Nottinghamshire is a pilot area for the national NHS App which has now been deployed across the whole GP estate in Nottinghamshire and Nottingham. This is a significant step in modernising GP services, and should make life easier for patients and for practices, with the ability to book and manage appointments online, order repeat prescriptions, view your medical history and access 111 Online, among other services.

UEC

As part of the UEC services redesign Nottinghamshire Practices have already completed the technical enablement to allow appointment booking into GP appointments. Following this work is underway to release appointment slots in line with the redesign planning and capacity requirements.

GP IT Futures

The end of the GPSoC contract represents both a challenge and an opportunity to General Practice and the PCNs. The move to a GP IT Futures compliant system will enable new models of digital exploitation and ensure data sharing can be achieved in line with the aspirations of the wider health and care system for the Nottinghamshire ICS. In order to achieve this Nottinghamshire Health Informatics Service will be a key partner and will be commissioned to support practices.

Assistive Technology

Several pieces of work are underway that use technology to support care delivered outside of traditional care settings and that support self-care by patient/citizens. Nottinghamshire has a number of projects underway utilising TeleCare devices in patients' homes in the Greater Nottingham area which include self-care applications and a Tele-dermatology service. Alongside this another initiative using 'Flo' (which is a text messaging 'Telehealth' service to patients) is used widely in the Mid Nottinghamshire area is supporting key cohorts of patient such as those with early heart failure and COPD diagnosis.

9.2 Role of Primary Care in delivering digitally enabled healthcare

The vision is to transform the way people experience access General Practice and Primary Care services across Nottinghamshire. By providing digital health tools and services that connect them to the information and services they need, when they need them it enable people to access care in a convenient and coordinated way, promoting independence through the digital tools they are familiar with in other aspects of daily life.

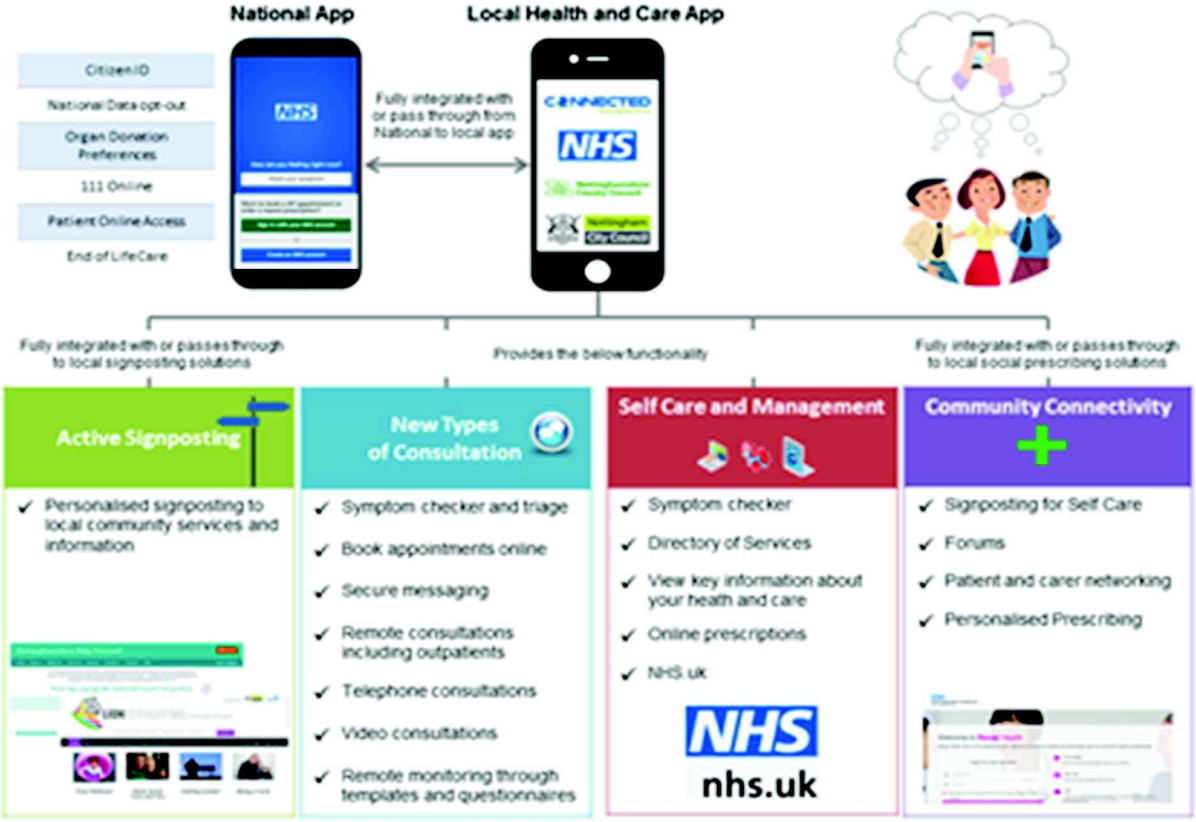
General Practice across Nottinghamshire will support the NHS England commitment to become much better at involving patients and their carers by:

- empowering people to manage their long term conditions and make informed decisions about their care and treatment
- supporting people to improve their health, giving the best opportunity to lead the life that they want

Public Facing Digital Services

In order to support this transformation in the way GP services are delivered practices will need to give people the tools they need to assist them in managing their own health condition, improve their wellbeing and provide information to enable them to live healthier lifestyles and prevent the development of ill health. This includes the deployment of digital tools to support Self Care and Management, Active Signposting, Community Connectivity and New Types of Consultations (including online and video consultation).

Figure 9-1 - Integration of local capabilities with NHS App



We shall procure a local Application to deliver this functionality. This App will be linked to the NHS App, to provide identity management via a single sign on, and in time it will enable patients to manage their interaction with some secondary care services as well as general practice. This will be rolled out across Nottinghamshire by April 2020, with further development beyond that.

This will enable patients to:

- adopt preventative approaches within their lifestyles
- have easier and more convenient access to key information to enable them

to better support themselves at home
- manage and control long term conditions better
- access more convenient methods of consultation (and thereby reduce the number of missed or avoidable appointments)

The intention is that by promoting self-care and signposting to appropriate services this initiative will reduce reduce demand on general practice as well as supporting more flexible working patterns. This in turn will link to GP retention plans and attracting clinicians back to general practice.

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Population Health Management (PHM)

The development of Primary Care Networks (PCN) will require service transformation based on this neighbourhood unit of delivery. This work is interwoven with other plans to support the PCN digital requirements and will require clinical and managerial input at all practices.

Building on the leading PHM work across GP Practices in Nottinghamshire identification of proactive care interventions has already surpassed 7,700 per month in 2019. Linking into the ICS led work to segment and identify cohorts of patients in the priority multi-morbidity groups primary care teams will further develop and refine the technology that is used in the GPRCC and eHealthscope tools described above. In plain terms, this analytical approach will enable care to be delivered to those patients that need it most.

9.3 Workforce configuration

Implementing the Public Facing Digital Services described above will require significant change management. An implementation plan has been produced with a timeframe from mid-2019 for 18 months. The plan identifies the requirement for GP Fellows, GP digital leads, practice nurse digital champions and practice managers to work with general practices. Funding has been identified from the GP Forward View programme.

It is anticipated that this will lead to some changes in clinical work patterns within each general practice as they adapt to digital working but this will be within existing resources. It is hoped that, as described above, this may help alleviate some of the current level of demand in primary care.

Effective organisations are underpinned by successful, resilient and well-

supported IT systems. For Nottinghamshire CCGs to continue their success they must be supported by high quality, resilient, responsive and cost-effective IT services. The increased reliance on IT and the probable extension to the hours within which primary care services are accessible to patients means that the CCGs' IT service providers must respond to cover the broader scope and time required and meet the rising customer expectations. The CCGs will review the arrangements for IT support and ensure fit for purpose, appropriate and cost effective user support is in place to underpin the ambitions of this strategy.

CCGs recognise the importance of training and its vital contribution towards best and efficient use of clinical systems and IT. Through the revised GP IT Futures contracts, the Primary Care Development Centre and local provider arrangements, the CCGs will ensure appropriate training is provided to all Nottinghamshire practices.

In addition, PCNs will require additional capabilities to support their new functions and allow greater sharing between individual GP practices. Much of the technology to deliver this is already in place. A review of the analytic support function is currently underway to determine the resources, including workforce, required for this.

9.4 Service delivery

The CCGs hold a Service Level Agreement (SLA) between their informatics service provider and the GP practices. This SLA identifies and details all the elements necessary to maintain IT services. It provides a framework for the provision of specified services including operational support, desktop support, network support, application support, programme management and business change, training and telecommunications, where locally agreed and funded. The CCGs will continue to review this service against national guidance within the GP IT operating model to ensure value for money in GP IT investment.

Arrangements for GP IT funding are changing as the current GPSoC arrangements are due to end in December 2019. Funding for GP systems will be allocated directly to CCGs on a per capita basis. Guidance is still awaited on future procurement arrangements.

The other elements of the primary care digital landscape are at varying stages of development and implementation. Data sharing via the Medical Interoperability Gateway (MIG) is already live. GPRCC is already working, and the functionality is constantly reviewed and upgraded - Phase 4 implementation will occur during 2019/20. The Public Facing Digital Services (PFDS) App will be procured in 2019, with implementation across Notts phased through 2019/20 with the aim of every practice being able to offer online consultation by April

2020. Additional functionality, including video consultation, intelligent management of long term conditions, and links to secondary care and mental health services should be in place by October 2020.

9.5 Governance and operational arrangements

Delivery of the strategic aims will be overseen by the IT Management Board, which reports to the ICS Board. A number of working subgroups report to the IT Management Board, covering records and information governance, technical issues, and project delivery, such as PFDS and GPRCC.

Operational oversight will be provided by the Primary Care IT team, within the Finance directorate of the CGG, who will manage the SLA with the informatics service provider. Currently, work across the health community is facilitated by a team called Connected Nottinghamshire, but his will be succeeded by different substantive arrangements in 2020.

Across Nottinghamshire we have a diverse population including individuals with specific language or communication requirements. Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA) are undertaken for all projects and are a key consideration at every stage of the project lifecycle.

9.6 Resource requirements

Future funding for primary care IT clinical systems will be allocated on a per capita basis, currently projected to be £1.26 per patient per annum. However, this funding stream alone is insufficient to deliver our vision for digital transformation in primary care.

To support delivery of this strategy and drive efficiencies there is a requirement for new funding and innovative use of existing funding for both capital and revenue investment. Where possible joint procurements will be utilised through the use of the Midlands Accord, procuring systems and solutions exploiting scales of economy in order to reduce the financial burden on individual organisations and maximise cost savings.

It is anticipated that applications for funding will be submitted against a number of national, regional and local finance schemes. These include but are not limited to; GP Forward View funding, Health Service Led Investment fund, Local Digital Roadmap/National Technology fund, Developing Digital Maturity Fund, Academic Health Science Network funding and other opportunities as they arise.

As part of the controls for each project, identification of finance and controls on expenditure will be managed by the project lead and reported to the appropriate programme board or IGM&T meeting. In addition to this each project will have a benefits evaluation, including return on investment and value for money calculation (where appropriate). These controls will provide assurance to each project board attributed to the individual CCG area.

With national policy changing to move more responsibility for IGM&T to the CCGs it is recognised that additional financial pressure will need to be considered. The Health and Social Care Network (HSCN) and GP Public Wifi projects are examples of projects that have to be implemented but that only have limited financial support (two years). This approach must be balanced against limited revenue locally. In order to ensure IM&T projects are affordable and linked to transformation and improvement locally projects will be prioritised annually with CCGs.

10 Key element 5 - Local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems everywhere

This section should demonstrate the role primary care will play, in moving your health economy to becoming an Integrated Care System.

1. A summary of the current situation regarding the development of your health economy becoming, or already having become and Integrated Care System.
2. A description of the role primary care plays or will play in the Integrated Care System and how you intend to ensure that it supports key facets of patients' mental health.
3. How the workforce will be configured to deliver services as Integrated Care System, the new and/or additional roles that will be needed and the implementation timeframe.
4. How services will be delivered, what role new technology might play and the timeframe for implementation any proposed solutions.
5. The section should also describe the governance and operational arrangements that will be required to deliver and implement the proposed changes.
6. The resourcing of the proposed changes should also be addressed, detailing both the set up and anticipated ongoing costs of delivering the proposed changes.

10.1 Current Situation

Nottingham and Nottinghamshire have a fully operational Integrated Care System that includes all statutory NHS organisations, Local Authorities in Nottingham and Nottinghamshire and includes: Clinical Commissioning Groups (CCGs) and a unitary and two-tier local government structure with a City Council, and a County Council with seven District Councils as well as the two major hospital trusts, a large mental health, learning disabilities provider and number of community providers that serve the Nottingham and Nottinghamshire population.

The ICS Board meets monthly and is chaired by a Non Exec Director and provides system leadership, oversight and assurance of successful delivery of the whole systems objectives and outcomes. It brings together all Chief Executives and Non-Executive Chairs along with Clinical Leads from statutory health and social care organisations across Nottingham/Nottinghamshire. The Board is committed to strengthening its approach to providing greater transparency to key stakeholders and will continue to embed a unified

leadership and governance approach with partners, clinicians, Public Health expert's patients and citizens that affiliates and meets national targets within each organisations strategic objectives.

As an ICS we are currently working with a wider group of representatives from other organisations that deliver local services such as the voluntary (third) and community sector, giving them a forum to contribute to the development of an integrated health and care system where local people will receive better, more joined-up care, closer to home. Local organisations will be better able to keep pace with the growing and ageing population and address some of the current problems in the NHS, while making it sustainable for the future. Benefits will include:

- Those who are largely well today will be helped to stay well.
- Those with complex or advanced long-term conditions will be supported to manage their own care, with a system to escalate care quickly in the event of exacerbations.
- People will remain independent thanks to prevention programmes and proactive rather than reactive care.
- People will receive care at home and in the community as much as possible.
- Multi-disciplinary teams will work across organisational boundaries to deliver integrated care as simply and effectively as possible.
- The social value that health and social care can add to communities will be maximised.

10.2 Primary Care's role in the ICS and Mental Health agenda

Nottingham and Nottinghamshire ICS has recently published an integrated Mental Health and Social Care Strategy, aiming to transform mental health and wellbeing across the footprint. This strategy is to be factored into all relevant aspects of other ICS work if true integration is to be enabled. This includes the parallel clinical services strategy work around acute, community and primary care services. This strategy represents our system's commitment to the re-shaping of services and other interventions so that they better respond to the needs of our population. We now need to plan together how to achieve this, including where to focus our combined efforts in the short, medium and longer term. We are seeking a seamless service and a step change in people's mental health and wellbeing. Our strategy seeks to recognise that everyone is different and care and support needs to

be personalised accordingly, yet everyone deserves equality (with parity of esteem in all situations and scenarios).

In order to meet the strategic vision of the ICS, The Population Health Management programme will be at the heart of driving this transformational approach forward. The programme will bring key partners together in primary, secondary, social care and third sector providers to fully integrate not just a medical model but an all-encompassing integrated whole system, all-age, person-centred approach, driven by access to physical and mental health and social care in the same place at the same time, with no wrong door, where prevention is at the heart of all we do.

The Nottingham and Nottinghamshire ICS has identified a significant level of unwarranted variation across our region due to a lack of joined-up services, and a lack of real insight and actionable intelligence about both the needs of our population and standardised interventions to address these. This has led to gaps in health and care outcomes for our population and is a key driver for our system's £230m financial deficit.

We have already undertaken significant work to identify, articulate and quantify the specific gaps and unwarranted variation in health and wellbeing; care and quality; and our baseline financial position. Our aim is to help people to be, stay or regain good health and wellbeing. To do this we must take a preventative approach and build strong and joined-up community services. Working together in this way will allow us to look across the system at how services are provided and identify opportunities to add value, improve outcomes and eliminate duplication and reduce costs.

Our current approach is underpinned by a rigorous PHM programme structure, utilising a wide range of experts, internal and external, both clinical and non-clinical, to understand our population's current needs, activity, cost and outcomes. Our initial focus will be on the population segment of people with Long Term Conditions. Through further sub-segmentation and risk stratification of this segment, the programme will lead the delivery of standardised, evidence-based pathway/journey redesign approach, with appropriate interventions to achieve the aims of the ICS outcomes framework, and in turn to meet the needs of our population at a Primary Care Network level.

There will be a clear process for monitoring and evaluating change within the programme framework. We will quantify the financial impact of the interventions proposed by the programme as part of the evaluation criteria for agreeing these. The approach taken will identify opportunities to address gaps in care, reduce acute emergency activity which is avoidable and which does represents the optimal value-for-money, and shift resource into proactive, targeted out-of-hospital interventions to keep our population well. Ultimately this will underpin our system strategy to achieve financial sustainability and reduce pressure within the hospitals acute sector.

10.3 Workforce Configuration

Redesigning health and care delivery around the needs of our population will require our teams to work in new ways and have new skills as well as offering exciting career and development opportunities to people working in Nottinghamshire. Our People and Culture Strategy sets out our vision for future capacity, capability and behaviours and how we will work with our colleagues to embed our planning into wider system plans to ensure care is delivered in the appropriate setting by people with the right skills. We have set a 10 year strategic horizon to align with the national Long Term Plan and the Nottinghamshire Clinical Services Strategy. However, we will focus on the development of a five year delivery plan (in line with national planning guidance) with the opportunity to review and refresh at regular intervals.

Through the PHM programme we will be able to develop a population health-led approach to shape the skills and future skills that we will need to deliver future models of care using system dynamics modelling. This approach engages clinicians and managers across the system in developing a range of scenarios to bridge the gap between supply and future demand for skills and provides the opportunity to test the impact of new ways of working and new and innovative roles.

Our approach will continue to take a system wide and population health based view of role and team design and cultural aspects of change and includes improvements to our workforce information and intelligence, integrated workforce planning, recruitment and retention, role redesign, attracting the right people with the right skills, career development, training, development and leadership at all levels.

By working together as a system and with our population we will strengthen current teams by supporting them to develop new skills and work in new ways, enable smooth introduction of new roles, developing solutions to support areas where there are shortages, improving integration across sectors and organisations, embedding approaches to prevention, promoting independence, self-care, community resilience and personalisation and enabling change through system wide organisational development and sharing of resources.

Delivering good health and care outcomes will require citizens and communities to understand and take responsibility for their own health and wellbeing. As an ICS we have a role in supporting people, families, carers, communities and voluntary organisations to have the skills and capacity to build that resilience in our communities. The ICS People and Culture Strategy will support development of both our paid workers, volunteers, families and carers.

10.4 Service delivery and implementation

A multi-disciplinary approach to care coordination, reflecting the outputs of segmentation/stratification, will be embedded that breaks down the traditional silos between primary and community services and supports greater integration between health and social care. Each ICP and its PCNs will agree a standard operating model (including capacity requirements) and shared accountability structure for care coordination with the commissioner, with clearly defined responsibilities for each person involved, including the individual receiving the care, the GP and other members of the integrated health and care teams. This will include the frequency and focus of care coordination reviews, the presence of coordinators in practices outside of review meetings, the use of real time information outside of coordination reviews and referrals to disease/condition management programmes. This responsibility and accountability structure will be transparent across organisations and the performance and results (KPIs) of the approach within each PCN defined, monitored and shared.

10.5 Governance and Operational arrangements

The ICS Board meets monthly and provides system leadership and oversight to assure successful delivery of the objectives and outcomes agreed in the STP through the two transformation programmes and supporting workstreams. It brings together all Chief Executives and Non-Executive Chairs along with Clinical Leads from statutory health and social care organisations across Nottingham/Nottinghamshire. The ICS Board is committed to strengthening its approach to providing greater transparency to key stakeholders.

10.6 Resourcing and costs

[to be added]

11 Workforce

Workforce and workload are key issues facing general practice and the pressures experienced both nationally and locally have been detailed earlier in this strategy. These pressures are acknowledged in both the GPFV and '*Investment and Evolution: a five-year framework for GP contract reform to implement The NHS Long Term Plan'*.

The NHS Long Term Plan sets out the objective to develop and deliver a national workforce implementation plan in which there are requirements to:

- ensure we have enough people, with the right skills and experience, so that staff have the time they need to care for patients well
- ensure our people have rewarding jobs, work in a positive culture, with opportunities to develop their skills and use state of the art equipment, and have support to manage the complex and often stressful nature of delivering healthcare
- strengthen and support good, compassionate and diverse leadership at all levels – managerial and clinical – to meet the complex practical, financial and cultural challenges a successful workforce plan and Long Term Plan will demand.

A Nottinghamshire clinical services strategy is currently in development across the ICS, based on a place based model of care. The aim of the overarching strategy is to shift the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention, delivered in people's homes or in community locations where this is appropriate. The final primary care workforce strategy will therefore need to respond to the workforce implications of this strategy.

The six design principles for the clinical services strategy include the following:

- Care will provided as close to home as is both clinically effective and most appropriate for the patient, promoting equality of access
- Prevention and early intervention will be supported through a system commitment to 'make every contact count'
- Mental health and wellbeing will be considered alongside physical health and wellbeing
- The model will require a high level of engagement and collaboration both across the ICS and neighbouring ICSs
- The models of care to be developed will be based on evidence and best practice, will ensure that pathways are aligned and will avoid un-necessary duplication
- They will be designed in partnership with patients and the public and will

operate across the whole healthcare system to deliver consistent outcomes for patients through standardised models of care except where the variation is clinically justified

The primary care workforce strategy will reflect the primary care ICS priority objectives which include:

- a systematic approach to primary care delivery across the ICS to develop local primary care networks
- a more integrated and collaborative primary care workforce
- a supported and integrated workforce with a combined focus on prevention and personalisation of care with shared and improved qualitative health and care outcomes utilising population health management data
- implementation of the new GP contract
- to build on the network of clinical pharmacists and the value they bring
- to implement social prescribing
- the key workforce aim to ensure there are 5,000 more doctors alongside 5,000 other clinical professionals working in primary care
- 2 year post-CCT GP and graduate nurse fellowships in primary care to support entry to practice and retention
- extended access to GP appointments
- increased access to talking therapies in general practice

Across Nottinghamshire, great progress has been made in developing and implementing a range of initiatives to support the recruitment and retention of GPs and the wider general practice team. It is expected that the full benefits of these will be realised as the various schemes become more firmly embedded. However, as a system, we recognise that there is much more to be done.

Our draft primary care workforce strategy for the next five years will therefore respond to the challenges identified, and addresses five key areas:

- Planning, attracting and recruiting our future workforce
- Retaining staff and trainees, promoting career paths and talent management
- Role redesign and development of new roles
- Preparing and supporting people to work in new ways, including digital skills development
- Enabling cultural change and leadership development to maximise system effectiveness

The strategy includes:

- a range of GP retention schemes targeting each stage of career (via the

Phoenix Programme) including GP Trainee Transition, Preceptorship and Fellowship
- general practice nurse 10 point plan delivery
- implementation of the nursing associate role
- embedding clinical pharmacists in general practice (national schemes transition to PCN)
- development of advanced practice skills in the wider team
- roll-out of the medical team administrator/GP assistant role and extended skills for other administrative/support staff
- development of other new roles such as physician associate, paramedics, mental health professionals and physiotherapy in PCNs
- a greater role for the Training Hub working alongside primary care networks to support the expansion of clinical placements, improve quality of education and training, establish shared learning opportunities, roll out bespoke education programmes
- robust training needs analysis across primary care
- joint training across health and social care to understand different conditions and the impact on wellbeing and promote better outcomes
- the use general practice simulation tools to consider the workforce transformation possibilities
- working with the Training Hub

Our work programme will be based on the following principles:

- Securing supply
- Enabling flexibility
- Providing broad pathways for careers
- Widening participation
- Inclusive, modern, attractive employers
- Integration of financial, service and workforce planning around population need
- Active focus on diversity and inclusion and teams that represent our local population

A number of primary care workforce initiatives currently being developed and/or implemented across Nottingham and Nottinghamshire are briefly described below.

i. General Practice Phoenix Programme

The Nottingham and Nottinghamshire ICS is in the privileged position of having an excellent relationship with the Local Medical Committee who have taken a key role in the development and implementation of the primary care workforce strategy. The Nottinghamshire General Practice Phoenix Programme was created in January 2019 to provide a single point of access for workforce schemes in Nottinghamshire. This is hosted by the Nottinghamshire LMC and includes seven workforce schemes:

- The GP Trainee Transition Scheme
- Preceptorship
- Fellowship Lite
- Special Interests
- Clinical Network Leaders
- GP Portfolio Plus
- Practice manager development

ii. International GP recruitment

This is a national programme to recruit international GPs, currently from six European Union countries. Initially mid-Notts submitted a bid for 26 international GP recruits. Greater Nottingham submitted a bid to a later tranche for a similar number. However the scheme was heavily oversubscribed and therefore the total Nottinghamshire bid has been limited to 36. Progress has been slow and to date there is only one GP working in Nottinghamshire as a result of the international recruitment scheme. However it is hoped that numbers will increase over the coming months/years as the initiative gains momentum.

iii. Targeted Education Recruitment Scheme (TERS)

TERS is a joint venture between NHS England, Health Education England (HEE), the British Medical Association (BMA) and the Royal College of General Practitioners (RCGP) to support recruitment in areas to which it has traditionally been hard to recruit. NHS England is funding a £20,000 salary supplement to attract GP trainees to work in areas of the country where GP training places have been unfilled. TERS funding of £240k has been utilised in Mansfield and Ashfield CCG to support full take up of GP trainee placements in 2017/18 and 2018/19.

iv. GP Trainee Transition Scheme

This scheme will provide third year GP trainees with support based on individual needs. This might include coaching, mentoring, portfolio careers advice, brokering of discussions with potential employers (mainly GP practices).

v. Nottinghamshire post-CCT fellowships

This involves the development of a Nottinghamshire-specific post-CCT Fellowship scheme, building on the successes of the scheme currently managed by Health Education England (HEE) which has been scaled back in 2018/19. As per the established approach newly/recently qualified GPs would spend approximately 40% of their time in clinical practice and the remainder on project work, supported by the Nottinghamshire Training Hub Alliance. This scheme enables participants to develop portfolio careers which may be of more interest than working as a GP on a full-time basis. A Fellowship helps trainees to access a more flexible career, improve networks, and increase project management skills. Under the existing HEE Post CCT Fellowship Scheme six Fellows were funded and appointed in September 2018. All chose practices in Greater Nottingham for their clinical sessions.

vi. Nottinghamshire Portfolio Plus Scheme

This established initiative, led by Nottinghamshire Local Medical Committee (LMC) is available to support GPs at any stage of their career. It aims to help GPs to enjoy a better working life thereby improving GP recruitment and retention. Expert facilitators and clinical champions work with GPs to explore the development of flexible working and extended career options. GP Portfolio Plus also has a specially created peer support network. It is supported by the GP-S Mentoring Service and has links to the GP Training Transition Scheme.

This scheme originated from a survey of GPs approaching retirement. 30 GPs responded to the LMC stating an intent to leave the profession within two years, in the main because of workload, workforce problems and finance. The average age of those known was 52 with the youngest at 35 and oldest at 67. The Scheme launched in May 2018 and has supported 18 GPs to date (as of 1 November).

vii. GP-S Mentoring Service

This service provides GPs with a free and confidential structured mentoring and coaching programme of up to four sessions of two hours each. GPs are seen by a trained peer on a one-to-one basis and supported to work on areas of their

choice. The service was launched in 2015 and is hosted by Nottinghamshire Local Medical Committee working with Derby and Derbyshire Local Medical Committee. It has seen approximately 240 GPs access support across Nottinghamshire, Derbyshire, Lincolnshire and Telford & Wrekin.

viii. GP Retention (Retainers) Scheme

This long-standing scheme is aimed at doctors who are seriously considering leaving or have left general practice due to personal reasons, approaching retirement, or requiring greater flexibility. The scheme supports both the retained GP and the practice employing them by offering financial support in recognition of the fact that this role is different to a 'regular' part-time, salaried GP post, offering greater flexibility and educational support.

Retained GPs may be on the scheme for a maximum of five years with an annual review each year to ensure that the doctor remains in need of the scheme and that the practice is meeting its obligations.

ix. Tier 2 Scheme

This scheme supports the retention of overseas doctors or international medical graduates (IMG) that have completed their GP training in the UK and are looking for a practice to sponsor them for the remaining two years (after five years doctors get indefinite approval to remain in the UK).

There has been some interest in this scheme from practices across Nottingham and Nottinghamshire and practices that express an interest in applying are receiving visits from NHS England staff to support them with the process including accessing funding. There are xx practices across Nottinghamshire who are signed up as Tier 2 sponsors, with additional practices who have expressed interest in becoming sponsors.

x. Medical assistants

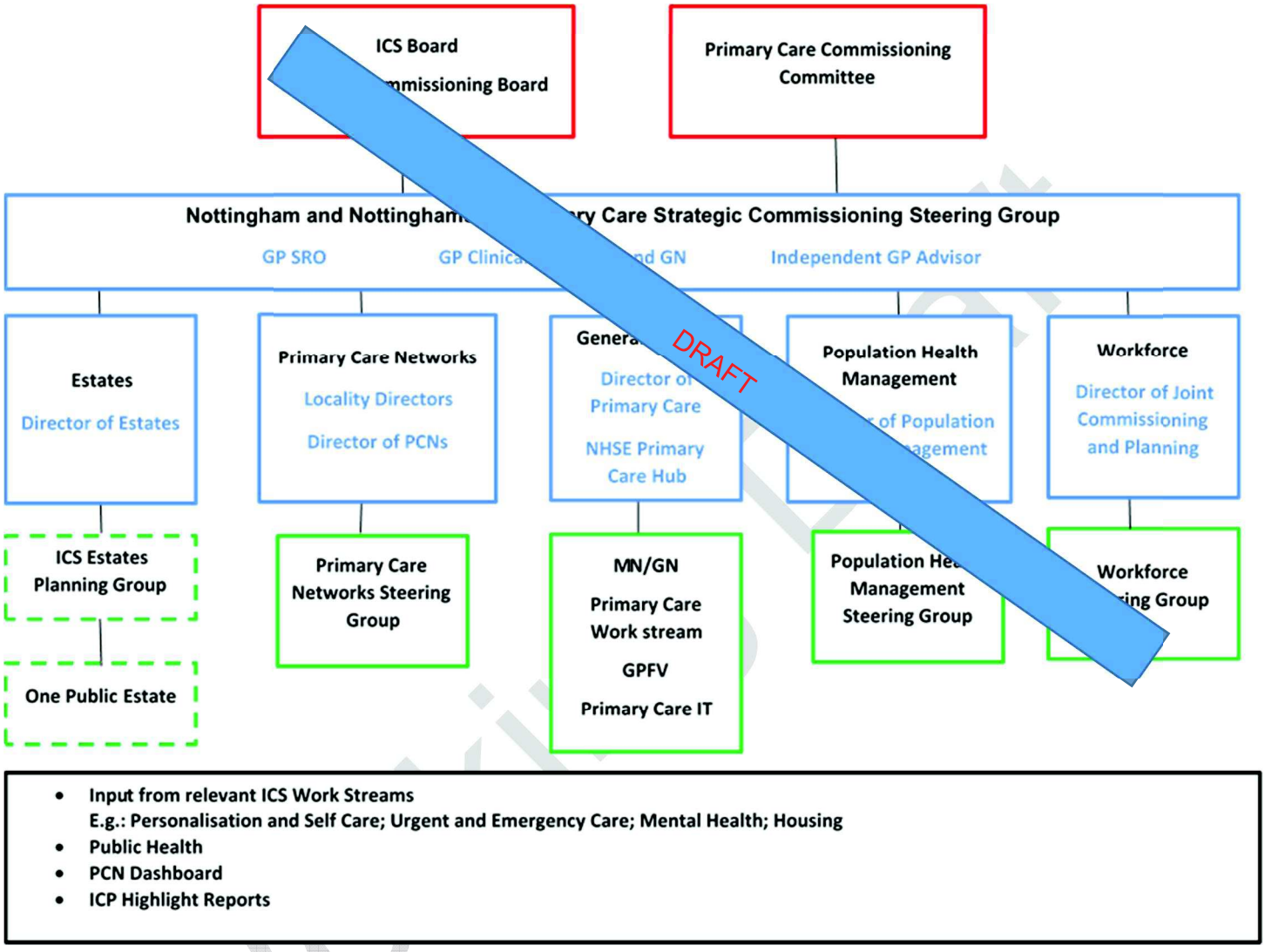
Medical assistants/doctors' assistants/medical team administrators are all similar job titles for staff trained especially to support their GPs with administrative and in some cases, basic clinical work. Nottinghamshire Local Medical Committee is working with the training hubs to financially support a practice from each of the CCG areas to form a working group and start a pilot scheme based on experiences of early working with this new role in the north-west of England, West Midlands, and London. The first meeting of the pilot steering group took place in early December 2018 with the aim to start the roles early in 2019/20.

In addition there are a number of schemes being progressed locally that relate to recruitment and retention of other primary care professionals e.g. the General Practice Nurse 10 Point Plan, the development and local implementation of the nurse associate role, and recruitment of additional pharmacists into general practice via the Clinical Pharmacist Programme.

Early engagement with service redesign leads across the ICS will be essential to ensure we take a proactive and long term approach to understanding and reshaping the capacity and skills we will need in the future.

12 Governance

Fig 12.1 – Proposed Governance for Strategic Primary Group



[Further content to follow]

13 Estates

13.1 Background

With the development of integrated care systems, a significant change to the way planning and resourcing estates is required. Rather than the organisation based approach to planning and managing assets there has to be a collective direction of travel across a wider area involving several partner organisations, including local authorities.

The Nottinghamshire ICS Estates Strategy represents a combined system-wide approach to estates including key priorities and a pipeline of emerging developments. For primary care it incorporates all of the outstanding priorities identified from the previous individual CCG estates strategies approved by Governing Bodies in 2016.

13.2 ICS Estates Strategy

The first Nottinghamshire ICS estates strategy has been assessed as **Improving**. Detailed feedback has been received to improve the assessment to **Good or Strong** which is currently being reviewed by system partners ahead of re-submission in June 2019.

An estates group with key individuals from the ICS team and partner organisations has been established reporting into the ICS Planning Group and ultimately the ICS Board. This group will work on the recommendations and refine the estates strategy accordingly.

In relation to primary care, two key areas were identified:

- the link between capital and estates plans and the system's overarching clinical and service strategies was not always clear. This needs to become clearer as the plans evolve and in particular they need to facilitate the system plans for moderating demand and preventing avoidable hospitalisation
- although all strategies set out their approach to primary care estate in general this was less well developed and this will be a key priority for future development.

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

13.3 Clinical Services and Estates Strategy Alignment

The ICS Clinical Services Strategy is progressing well and will effectively influence the Estates Strategy development, and in particular primary care estate, against a background where there is:

- a system- wide need to have a smaller acute estate footprint but also address very high levels of infrastructure risk
- a requirement to have a more developed community service offer, particularly in relation to providing services closer to home; and the requirements of the emerging PCNs for local network hubs.
- a need to utilise PFI estate capacity which is tied to long term commitments in the ICS; recognising fixed points – some service locations will not change in the future clinical model and recognising these allows them to be determined as fixed points around which future care models can be built. It is also important to recognise the need to effectively use PFI and LIFT estate. Fixed points have been agreed by the ICS Clinical Services Strategy Programme Board to reflect these issues and support planning.

Clinical pathway reviews are being considered against the twenty service areas of highest activity volume in the system. Six initial areas of priority have been identified:

1. Cardiovascular Disease – Stroke
2. Maternity and Neonatal
3. Respiratory (COPD and Asthma)
4. Frailty
5. Children and Young People
6. Colorectal

The Clinical Service Strategy service review work aims to develop improved models of care with strong emphasis on prevention and education and system sustainability. Service reviews will also be evidence based. Evidence shows that many of the services can have an increased offer of care closer to home, if not in the home setting itself through advances in assistive technology, self-care and monitoring.

Collectively this work should deliver the opportunity to consolidate the care needed in the acute hospital setting by transforming pathways to provide many of these services locally within primary and community hubs.

The Clinical Services Strategy work has a clear connection to the estate requirements in the ICS and as the service models develop will look to the Estate work to help inform the available options that will enable these new care models.

13.4 Approach to Primary Care Estates and Emerging Plans

An estates strategy that focuses entirely on the technical aspects of the location, size and funding of buildings, which seeks to fit an off-the-shelf solution to a complex local problem, is doomed to failure. A strategy with a much greater chance of success will be one developed by system leaders who truly connect with the needs and potential of the population they serve and the staff they employ, who have a deep understanding of the benefits that can be realised through partnerships with local authorities and industry, and who are able to work with advisors that bring creative solutions to well understood challenges.

Strategic estates plans should be developed in an integrated and inclusive way at a more local level with a bottom up approach. It is at local community levels where there is the right level of detailed understanding of population needs, and the most productive opportunities to align the political, civic, institutional, professional and personal interests involved.

To this end the immediate priorities are:

i. To understand the emerging requirements of Primary Care Network hubs:

- For each PCN configuration, map out the current primary and community facilities and provide a reference document for each PCN; meeting with Locality Directors and Clinical Directors to identify key risks and vulnerabilities
- Recognising and identifying requirements for population health management and working with a range of stakeholders in a place based manner
- Linking the development of digitally enabled initiatives with the future requirements for face to face contacts and the impact on estates assets.
- Obtain funding for and commission 6 facet surveys in Greater Nottingham and re-visit surveys done more recently in Mid-Notts
- Identify gaps and further priorities for ICS capital, ETTF and business as usual capital with particular emphasis on:
    - Quality of estate
    - Housing growth
    - Opportunities for consolidating and disposing of estate including co-locating with partner organisations
    - Opportunities for integrating health and social care staff

ii. To link in with the Clinical Services Strategy service reviews at a

service level to quantify the impact on primary and community facilities of shifting activity from acute hospital facilities:

- Immediate connection with the existing Outline Business Cases being developed in anticipation of Wave 5 ICS capital bids in 19/20:
  - Eastwood
  - Hucknall
  - Strelley
  - East Leake
  - Newark
- Scope the **fixed points** and identify 'true' vacant space and options for better utilisation
- Continue to support the feasibility of revenue funded schemes through 3PD or GP led funding.

iii. To maximise the potential of working with partners:

- Develop a joint strategy with Nottinghamshire Healthcare Trust for primary and community hubs
- Continue to actively engage with the N2D2 One Public Estate work, including multi-agency locality reviews and linking this work with PCNs; explore opportunities for local government borrowing as a potential funding option.
- Develop a consistent operating model with council planners to be actively consulted/informed of major housing developments, building on successful work with Rushcliffe, Ashfield, Gedling and Newark and Sherwood Borough Councils; maximising the potential for Section 106 contributions

iv. To 'get our house in order':

- Ensure that data is accurate and up to date across the 200+ primary care properties and tenancy agreements
- Simplify or remove complex historical arrangements which are often costly and incur unnecessary management fees
- Explore the opportunities highlighted through the ICS Estates Rationalisation work, including where there are opportunities to dispose of properties whilst not making short term decisions where there may be a longer term need.
- Rationalise the CCGs' Headquarters requirements following the merger and restructure, being mindful of the need to preserve a locality presence for PCN facing teams.

14 Measurement

This section should demonstrate how the system will use existing methods to monitor the delivery of local priorities through published reports and provide enablers for PCNs to deliver to their local populations.

1. A confirmed baseline to measure from and how the STP will measure change in the GP patient survey
2. Monitoring the workforce plan through the general practice workforce publications from NHS Digital
3. Monthly assessment when completing the GPFV monitoring survey
4. How the Primary Care annual assurance statements (https://www.england.nhs.uk/wp-content/uploads/2019/02/Annex-B-guidance-for-operational-and-activity-plans-assurance-statements-v2.pdf) and technical definitions (https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/) will hold the system to account.
5. Describing how any learning from the GPFV MoU mid and end of year reviews will influence future plans.
6. How will the system be making sure that Patient participation groups are engaged throughout the process so that the patients voice is heard.
7. A description of the role a primary care commissioning committee, or similar, plays or will play in the Integrated Care System and how you intend to ensure that it supports PCNs in their development.
8. It must also include information on how the STP/ICS plans to provide data for a PCNs local population to allow them to understand, in depth, their populations' health and care needs for symptomatic and prevention programmes such as screening and immunisation.

14.1 GP Patient Survey

The baseline data will be taken from the GPPS 2018 Practice results data file. This gives a practice level breakdown for each question at response level as well as the calculated % question result.

It is proposed that the CCG will use the baseline data from the 2018 GP Practice Survey to provide the Primary Care Networks with the ability to monitor their performance against agreed priorities. This will provide the CCG with a robust tool for measuring patient satisfaction to be reported to the Primary Care Commissioning Committee.

The CCG will undertake an analysis of the baseline results to identify areas for

improvement or focus. This will include benchmarking results against organisations with a similar demographic profile, against the National results; and presenting results over an historical timeline.

As well as the GP Patient Survey, we have access to a rich mine of information from areas such as Patient Participation Groups; Friends and Family test results; CQC inspections. Additionally, we have the capacity to overlay the GP Patient survey results with the GP Workforce plan. This will indicate whether there is a correlation between staffing levels and rates of patient satisfaction. The aim will be to build a comprehensive picture of overall satisfaction levels at GP practice level which can be aggregated up to PCN level.

The intention is that the CCG will commission GP practices to undertake a patient survey that focusses on the priorities that have been agreed. This will be carried out on a quarterly basis. The results will then be made available to PCNs.

The CCG will deliver the GP Practice survey results aggregated to a PCN level via interactive dashboards and infographics, which will allow users to drill through to row level data. The dashboard tools will allow PCNs to benchmark performance against local and national results; provide a timeline series that can help identify changes in performance.

Wider PCN Reporting

Each PCN will be provided with a “point of contact” so that ongoing needs for analytics and performance data are addressed. We will establish routine reporting of all the relevant, identified metrics. There will be a range of aggregations including drill-down to PCN level. We are currently planning how these dashboards will be developed and they will include in-depth demographic, epidemiological and other data sets that will enable population and health care needs to be proactively identified at PCN level. The data sets will be comprehensive and will draw on data expertise across the full range including local authority and public health analytics expertise.

14.2 GP Workforce plan

The baseline data at CCG level will be taken from the December 2018 GP Workforce files:

GP Workforce GP CCG level data

GP Workforce Nurses CCG level data

GP Workforce Admin NonClinical CCG level data

GP Workforce Direct Patient Care CCG level data

In addition we have access to anonymised row level data covering the demographics of the workforce. This allows analysis at NHS England and HEE Region, STP, and CCG level.

GP Workforce Practice level data

This file gives anonymised demographic and qualification data at practice level. This will allow analysis at PCN level.

All of the data sources listed above will be available on a quarterly basis. The baseline data allows analysis at NHS England Region, HEE Region, STP and CCG level. Data is published as both a headcount and FTE. In addition we have access to quarter on quarter changes at GP Practice level.

It is proposed that the CCG will use the baseline data from the December 2018 GP Workforce datasets to provide the Primary Care Networks with the ability to monitor their staffing levels on a quarterly basis. All this helps to provide, alongside organisational Strategic Business and Workforce Plans, indicators on what the workforce will look like in the future. The better the information and its quality the more sound the judgements will be on commissioning the workforce for the future

The CCG will undertake an analysis of the baseline results to identify areas for improvement or focus, such as clinical staff / patient ratio.

The data will help PCNs by building and understanding the:

- Age profile of the workforce which can then be related to understanding turnover, retention (stability) and retirement data;
- Effect of gender on working patterns – for example the increasing numbers of GP's who are female and the impact that this may have on training numbers.
- Staff movements - understanding the workforce data within this area provides essential information on how the shape of the historical and current workforce has ebbed and flowed.

14.3 GPFV monitoring survey

[to follow]

14.4 Primary Care annual assurance statements

[to follow]

14.5 Learning from GPFV MoU Reviews

The Nottingham and Nottinghamshire ICS has completed a process to determine how to utilise GPFV funding in order to achieve maximum impact and benefit. A number of schemes have been prioritised which focus on the four key programme areas – GP retention, practice resilience, reception and clerical staff training and online consultation.

Although GPFV funding allocations have been confirmed for 2019/20 and 2020/21 a decision has been made locally that the initial focus will be on 2019/20 only. This is in the context of the emerging PCNs and recognises that the workforce, training and organisational development needs of PCNs are likely to become clearer during 2019/20.

The schemes for 2019/20 will be supported by clear measurable outcomes/outputs. Achievement against these will be assessed via mid and end of year reviews. These reviews will be used to inform investment priorities for 2020/21 and future years. Progress and delivery will be monitored via the Nottingham and Nottinghamshire Primary Care Strategic Commissioning Steering Group.

14.6 Patient Participation Groups

A new communications and engagement strategy is under development with the objective of demonstrating that the newly merged CCG will have effective engagement of its population in place.

The strategy is being developed as part of the merger process. Its content will be informed by the following:

- Patient and public participation in commissioning health and care: Statutory guidance for clinical commissioning groups and NHS England (https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf)
- The Patient and Community Engagement Indicator in NHS England's Improvement and Assessment Framework (https://www.england.nhs.uk/wp-content/uploads/2019/01/ccg-iaf-patient-community-engagement-indicator-guidance-v1.pdf).

To provide assurance around PPI the strategy will set out how the merged CCG will manage engagement in relation to the following:

- Governance
    - Involving the public in the CCG's decision making bodies
    - Providing a patient committee structure that assures the CCG that the voice of its population is informing its commissioning decisions on a continuous basis
    - How providers will be held to account for their own public

involvement activities

- Engagement in commissioning
  - How engagement will be embedded in commissioning activity
  - How the CCG will determine the appropriate level and approach for engagement e.g. formal consultation
- Equalities and health inequalities
  - Ensuring engagement takes account of equalities and health inequalities
  - Providing assurance that the CCG has mechanisms in place to engage across its populations, including those that are seldom heard and those protected by a characteristic under the Equalities Act 2010.

The above focus is aligned to the guidance for CCGs on meeting their statutory duties for PPI.

A single patient group for Greater Nottingham will be established by the end of June 2019. This group will replace the Greater Nottingham CCGs' existing patient committees. It will sit alongside the Mid Notts Patient and Public Engagement Committee (PPEC) as one of two patient groups providing assurance around PPI for the Nottinghamshire-wide Governing Bodies.

14.7 Governance

Going forward the Nottingham and Nottinghamshire Primary Care Strategic Commissioning Steering Group will be the overarching forum that will monitor and ensure delivery of the ICS Primary Care Strategy. This will be supported by a number of workstreams leading on core areas including general practice, primary care networks, estates, workforce and population health. The steering group will also provide the governance around GPFV funding.

14.8 Public information

15 Finance

This section should set out how much the STP estimates implementing the strategy is likely to cost, and identify how the STP might be able fund the increased expenditure on workforce, estates and other enablers.

It is important to include:

- The current levels of expenditure using the current model of care
- Forecast levels of expenditure using new models of care across all workstreams (workforce, PCNs, estates, digital technology and other enablers)
- The overall STPs financial position with a breakdown by CCG available
- The risks associated with the strategy and how they will be mitigated

Please ensure this section also accounts for all funding available.

15.1 Current expenditure

The CCGs in Nottingham and Nottinghamshire ICS are facing significant financial pressures. The financial challenge for 2019/20 is £53 million in Greater Nottingham and £25 million in mid Nottinghamshire. CCG programme budgets are therefore under significant pressure and the level of investment in to Primary Care should be seen in this context. Discretionary areas, funded from core/programme allocations will need to be reviewed to ensure that they are aligned with the PC investment strategy.

Table 15-1 – Primary Care developments funded via Delegated Budgets £000's

	City	NNE	NW	Rush-cliffe	M&A	N&S	Total
£1.761/head to practices for engagement	£672	£270	£166	£225	£370	£257	**£1,960**
New workforce re-imbursement scheme	£721	£270	£185	£194	£488	£339	**£2,197**
DES changes: ▪ extended hours DES finishes	-£544	-£219	-£135	-£182	-£167	-£98	**-£1,345**
▪ network contract DES access	£415	£167	£103	£139	£216	£150	**£1,190**

Table 15-2 - £1.50 per head (from Core allocation) £000's

£1.50 per head (from Core allocation) £000's	City	NNE	NW	Rush-cliffe	M&A	N&S	Total
£1.50/head network	£572	£230	£142	£192	£293	£204	£1,633

Table 15-3 - GPFV (Anticipated NR Allocation 2019/20) (£000's)

Anticipated Allocation (NB. Covers all 6 CCGs)	**£854**
Current Plan	
Practice Resilience	£254
GP Retention Programme	£200
Reception & Clerical Staff Training	£125
On Line Consultation	£297
Req'd Reduction to match Allocation	-£22
Total Plan	£854

Table 15-4 - Extended Access £000's

Extended Access £000's	City	NNE	NW	Rush-cliffe	M&A	N&S	Total
from Programme Allocation	£2,250	£0	£0	£676	£1,169	£767	£4,862
anticipated Allocation 19/20 (*estimate £6/head)	£0	£920	£568	£0	£0	£0	£1,488

Table 15-5 - Practice Engagement £000's

Practice Engagement £000's	City	NNE	NW	Rush-cliffe	M&A	N&S	Total
opening PC budgets / BCF	£2,133	£1,124	£793	£826	£0	£0	£4,876

15.2 Forecast expenditure

[to follow]

15.3 Overall ICS Position, broken down by CCG

[to follow]

15.4 Risks and mitigations

[to follow]

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Meeting:	ICS Board
Report Title:	Confirmation of the Primary Care Network Configurations for Nottingham and Nottinghamshire
Date of meeting:	Thursday 13 June 2019
Agenda Item Number:	9
Work-stream SRO:	Nicole Atkinson
Report Author:	Helen Griffiths/Lucy Dadge
Attachments/Appendices:	Appendix 1 – Primary Care Configurations Appendix 2 - Clinical Directors for the Primary care Networks Appendix 3 – Comparison of CCG Activity

Report Summary:

At the 9 May 2019 ICS Board meeting, members considered a paper on the development of Primary Care Networks (PCN) across Nottingham and Nottinghamshire, which included a position statement (April 2019) on the proposed configurations of the developing formations of the PCNs for Nottingham and Nottinghamshire.

At the ICS Board meeting, the members approved and agreed the vision and aspirations of the Primary Care Networks, as well as noting and endorsing the progress to date on the PCN configurations.

The final approval of the PCN configurations was delegated to the Managing Director of the ICS in time for the submission to NHSE&I, by the deadline of 31 May 2019.

This paper will:

- Outline the Clinical Commissioning Group's and NHSE's governance process for approval of the PCN registrations
- Confirm the final PCN configurations for Nottingham and Nottinghamshire, as signed off by the Managing Director of the ICS
- Detail the rationale for the PCN configurations
- Confirm the Clinical Directors for each PCN
- Outline the next steps for the development of the PCNs

Action:

☒ To receive
☐ To approve the recommendations

Recommendations:

1.	To note the report
2.	To confirm support for the PCN configurations and newly appointed Clinical Directors for each PCN for Nottingham and Nottinghamshire
3.	To note the next steps for the development of the PCNs

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

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

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

Is the paper confidential?

☐ Yes
☒ No

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

Integrated Care System
Nottingham & Nottinghamshire

Nottingham City Council | Nottinghamshire County Council | NHS

Confirmation of the Primary Care Network Configurations for Nottingham and Nottinghamshire

13 June 2019

Introduction

1. The purpose of this report is to provide the ICS Board with an overview of the confirmed Primary Care Networks (PCNs) for Nottingham and Nottinghamshire, including the approval requirements, governance process and rationale. The paper will also detail the newly appointed Clinical Directors for the PCNs, as well as outline the next steps for the development of the PCNs across the ICS.

Background

2. In the NHS Long Term Plan, Primary Care Networks (PCNs) are described as an essential building block of every Integrated Care System, with general practice taking the leading role in each PCN.

3. The PCN model is intended to dissolve the historic divide between primary care, community health services and social care. PCNs are centred on provision not commissioning. It is acknowledged that there are many benefits of this model including:

    - **Better health and care:** a PCN is a natural unit for integrating most NHS care and aligning with other local services. Collectivised general practice can become the footprint on which other NHS and local authority community-based services can then align. By serving a defined population, PCNs bring a clear geographical locus for improving health and wellbeing.

    - **Stability:** many individual practices face increased daily operational pressure and being part of a PCN may be able to help avoid a practice closure, removing the need to consider alternative provision. It is intended that the PCN model is a way of helping GP partnerships survive and evolve over the coming decade and provide a means of mutual support for better workload management.

    - **Different roles:** it is easier to sustain advanced GP, nurse and allied health professional roles for patients at a larger scale rather than at an individual practice level. The PCN will operate at a size where clinicians able to build effective working relationships being sufficiently large enough to run an extensive multi-disciplinary team.

    - **Investment:** by creating the PCN as a dedicated joint investment and delivery vehicle, GP practices can offer services that the NHS could not reasonably ask of every individual practice to deliver.

- **Community leadership:** PCN clinical directors will provide strategic and clinical leadership to help support change across primary and community health services.

4. The contract mechanism for PCNs is a Directed Enhanced Service (DES). A DES is an extension of the core GP contract (February 2019) and is established in accordance with Directions given to NHS England.

5. All Clinical Commissioning Groups (CCGs) (through delegated functions from NHS England) are required to offer participation in the Network Contract DES to all practices. Eligibility applies to all existing and future holders of in-hours (essential) primary medical services contracts.

NHSE Guidance for Primary care Networks

6. NHS England (NHSE) guidance on the establishment of PCNs started to be published from January 2019 with NHSE policy guidance on emerging models being issued up to and including May 2019.

7. The NHSE guidance on PCNs provides the following key directions for consideration during the approval process:

- **A PCN will typically serve a population of at least 30,000 people**. Low population density across a large rural and remote area could be a permissible exception for a slightly smaller network list size.

- **Although the population size of a PCN will not tend to exceed 50,000 people, this is no longer a strict requirement** and commissioners may agree to larger PCNs. In such circumstances, the PCN may organise itself operationally into smaller neighbourhood teams that cover population sizes between 30,000 to 50,000 (Revised NHSE guidance, May 2019).

- **Each PCN must have a boundary that makes sense to its constituent practices and to other community-based providers**, who configure their teams accordingly and to its local community.

- While it is possible that a single geography could be served by more than one PCN (building on current multi-practice arrangements) most areas are likely to have a single PCN.

- **Normally a practice will only join one network**.

- **It is likely that most network areas will not overlap**, but this is not an absolute rule: for example, a large town of 100,000 population could have two different 50,000 networks operating on exactly the same footprint. They would have to collaborate on wider place-based goals. And a practice's catchment area may continue to span more than one network, just as it can currently span across more than one CCG.

Approval Process

8. Nationally, delegated co-commissioning CCGs were responsible for confirming that the PCN registration requirements had been met by Friday 31st May 2019. The CCGs Primary Care Commissioning Committees (PCCCs) were required to approve that the registration requirement had been met by all PCNs.

9. CCGs were specifically asked to consider and approve all PCN contracts within its CCG at the same time. This was to ensure that every constituent practice was included, and 100% of the CCG's own boundary was covered.

10. As part of confirming its support, the CCG was required to secure an explicit pledge of support from the leadership of the local Integrated Care System / Sustainability and Transformation Partnership. A paper was presented to the ICS Board on 9th May. The Board approved the vision and an aspiration for PCNs. Initial progress to date on the configurations was noted and endorsed, and final approval of the submission to NHSE&I was delegated to the ICS Managing Director on behalf of the Board.

11. It is noted that any subsequent changes to network areas require CCG approval. Boundaries will require active support from both the local CCG and NHS England.

PCN Registrations

12. A total of twenty applications were submitted to the relevant CCGs to meet the NHSE deadline of 15 May 2019. The submissions and approvals can be summarised as follows:

ICP/CCGs	Number of applications received	Approvals Process
Mid Nottinghamshire CCGs: **Mansfield and Ashfield CCG** **Newark and Sherwood CCG**	 **3** **3**	 **MN PCCC meeting 23 May 2019**
Mid Nottinghamshire Total	***6***	
Nottingham City CCG	**8**	**GN PCCC (virtual approval) 30 May 2019**
Nottingham City Total	***8***	

South Nottinghamshire: **Nottingham West CCG** **Rushcliffe CCG** **Nottingham North and East CCG**	 **1** **1** **4**	**GN PCCC meeting 31 May 2019**
South Nottinghamshire Total	***6***	
Grand Total	***20***	

13. Each PCN submission was assessed against the NHSE criteria. 100% of the Nottingham and Nottinghamshire population is covered by a PCN, and every constituent practice across the CCGs has applied to register in a PCN

14. A summary of the PCN registrations is included in Appendix 1.

15. A list of the Clinical Directors for each PCN is included in Appendix 2.

16. The agreed and confirmed PCN applications were submitted to NHS England to meet the 31 May 2019 following consideration by the relevant PCCCs.

Rationale for PCN Configurations - South Nottinghamshire

17. The three CCG locality teams worked closely with all GP practices, GP partnerships, and the LMC to propose the final configurations of the PCNs.

Areas to note on the submissions received by Nottingham West CCG and Rushcliffe CCG

18. Both CCGs each received an application which described an overarching PCN for both Nottingham West and Rushcliffe, these proposed an operational model of delivery whereby each overarching PCN worked across three defined and well established PCN neighbourhoods.

19. For both PCN submissions, further to the revised NHSE regulatory parameters (May 2019) consensus emerged that the practices were able to apply as an overarching Network. Practices had concluded that this enabled the best contribution to the Integrated Care System (ICS) and future South Nottinghamshire Integrated Care Partnership (ICP).

20. It was determined that clinical practice would continue to be arranged with a focus on neighbourhoods, with the overarching PCNs providing the benefits of working across populations, which have historically be constituted as Care Delivery Groups (CDGs), to deliver the economies of scale in the supporting infrastructure.

21. Further detail and consideration were sought in relation to both submissions to understand further how operationally working at a neighbourhood level would be delivered in both localities.

22. Detail and rationale include:

Relationships with other providers

23. Service delivery has been well established and successfully delivered at a neighbourhood level in both Rushcliffe and Nottingham West since 2010 when CDGs were first established. CDGs bring together groups of GP practices and community teams, interfaced with social care, and aligned to the borough/district council boundaries (Rushcliffe BC, Gedling BC, Ashfield BC, Newark and Sherwood DC, Broxtowe BC). Of note, both Nottinghamshire Healthcare Trust and Nottinghamshire County Council also configure their service delivery teams in these delivery units.

24. Excellent working relationships across community services and social care have enabled significant service transformation. Over the last four years, practices in Rushcliffe have worked collectively to deliver an exemplar vanguard programme of New Models of Care – the Principia MCP, in partnership with community services, social care and the voluntary sector.

25. Nottingham West continues to be one of the top performing CCGs nationally in terms of quality and safety of primary care services, with eight out of 12 GP practices achieving a CQC rating of 'outstanding'. Practices are within a boundary that will support the development of expanded MDTs.

26. See Appendix 3 which outlines a comparison of Nottingham and Nottinghamshire CCG's activity for out-patient activity, emergency admissions, and elective admission for March 2018 to February 2019.

Operating effectively at a Neighbourhood Level

Integrated service delivery

27. The neighbourhoods will provide the 'docking' points of community provision for all providers across health, social care and the voluntary and community services. This will be the building block around which integrated care systems are built.

Population Health Management

28. An overarching network for Rushcliffe and Nottingham West enables the practices to maximise population health management whilst making the best contribution to the ICS and future South Nottinghamshire ICP. The proposed Networks will balance the need for working at scale with a focus on neighbourhoods where appropriate. The proposed PCNs are natural communities

and contiguous with the population boundaries of health and social care, local authority services, with natural flows of populations who live, work and use community assets across these areas. To support patient flow and choice consideration of transport links has been reviewed when proposing the PCNs as it is recognised patient behaviour is a key determinant in how healthcare is accessed.

29. There will be a coordinated shared view and understanding of the system's priorities and what they mean for the PCN and a neighbourhood sensitive population health management delivery model.

30. Clear understanding of patient demographics, patient flow, transport links, public sector infrastructure and planned future housing developments characterise how the PCNs will ensure appropriate neighbourhood working.

Performance Management

31. A local PCN dashboard is currently being developed, which will be followed by the national PCN dashboard in April 2020. This will provide information at a neighbourhood level to ensure focus is placed on the right priorities, management of clinical variation, highlight opportunities and drive performance at a neighbourhood level. Review of performance via the dashboard will ensure the PCN configurations are appropriate and optimise outcomes.

Emerging system architecture

32. The configuration of Rushcliffe and Nottingham West PCNs is considered within the overall principles of the ICS recognising the accelerator status of the ICS and using this as a framework for the transformational development of the proposed PCNs. This approach recognises the level of maturity of collaboration and integration at a neighbourhood level across the ICS footprint.

33. The proposed Networks would balance the need for working at scale with a focus on neighbourhood where appropriate. This consensus is based on a number of factors:

- The long-established common ground between all practices and partners on fair and reasonable partnership terms and collective outcomes
- The nature of provider networks operating in the configuration of PCNs is able to balance general practice at scale with neighbourhood sensitivities where appropriate
- The existing shared business and clinical operations via both Partners Health and the Principia new model of care for Rushcliffe, and Primary Integrated Community Services Nottingham West
- An already established and shared expertise in network management which provides an efficient infrastructure to manage the administration of the network
- A track record of good financial stewardship

- The opportunities this presents to form the basis of the ICP structure and governance, to be established between providers and between providers and commissioners

34. Both applications sought to build on the relationships and improvements made over years through Partners Health and Principia in Rushcliffe, and, in Nottingham West, Primary Integrated Community Services, and a continuously evolving business model which includes infrastructure, finance, and healthcare delivery.

35. Operating on a small-enough scale to make relationships work is an essential facet of the 'Primary Care Home' sites, whose experiences have informed these plans. Some individual practices are already bigger. If a large 'super-practice' (e.g. 200,000 patients) meets all the other registration requirements, it can serve as a single very large Primary Care Network. In reality, it will be organising itself into four separate neighbourhood teams, each covering a mean of 50,000 people. (Kings Fund 2019)

36. There is administrative efficiency to be found by not registering each as a PCN, and this was highlighted by The Kings Fund (2019)

Accountable clinical leadership model

37. Primary care representation is stronger through accountable clinical directors and neighbourhood clinical leadership teams from each network being the link between general practice and the wider system.

38. South Nottinghamshire CCGs have worked closely with Nottinghamshire LMC on the appointment process of the clinical director for each of the six PCNs. For Rushcliffe and Nottingham West, a total of eight applications were submitted to a panel for review. The panel consisted of colleagues from the wider partners including Nottinghamshire Healthcare Foundation Trust, the chair of the LMC, and patient representatives.

39. From the eight applications two named clinical directors, with accountability for the purposes of NHSE registration, were agreed by the PCNs for the registration purposes. For Rushcliffe this was noted on the PCN registration form as an interim arrangement until 30 June 2019. Each clinical director will work alongside a clinical leadership executive team made up of the remaining six applicants who will engage and lead each PCN neighbourhood. There is representation of GP clinical leads from each of the PCNs neighbourhoods. The clinical leadership team will work with practices, patients, the leaders of local providers and community assets in an inclusive executive operating at a neighbourhood level. This approach will also enable newly appointed Clinical Directors to be supported and mentored and ensure succession planning.

Collectivised General Practice

40. Collectivised general practice is well established and mature in South Nottinghamshire. In Rushcliffe collectivisation is coordinated by Partners Health, a limited liability partnership solely owned by the Rushcliffe practices. In Nottingham West and Nottingham North and East, GP practices are supported by two federations set up through Primary Integrated Care Services. There is established and shared expertise in network management, shared business and clinical operations successfully delivered via both Partners Health and Primary Integrated Community Services (PICS).

41. GP Partnerships and federations have played a key part in supporting GP resilience. A key task for PCNs will be to improve overall performance, by leading service transformation and reducing clinical variation. The experience in Rushcliffe and Nottingham West is that this can best be achieved by working collectively working at scale.

42. Evidence shows that collaboration in general practice is most successful when it has been generated organically by general practices over a number of years, underpinned by trust, relationships and support, and where there was a clear focus and agreement on the role of the collaboration (for example, whether it was to share back-office functions, provide community services or for quality improvement) (Kings Fund 2019).

43. All practices have a PCN perspective and commit to the principles of collectivism, participation, mutual accountability, commitment, and collaboration. There is a track record of good financial management with financial vehicles already established without the need for unnecessary bureaucracy.

44. The GP partnerships, on behalf of its member practices, will act as the lead point of contact with the commissioning CCG, receive and distribute PCN funding, and recruit and manage additional PCN workforce, reducing the administrative burden if several PCNs are established to do this

Areas to note on the submissions received by Nottingham North and East CCG

45. **When assessed against the NHSE criteria two key concerns were identified which required for further consideration**:
    - the ability of other service providers to align themselves with PCN 3 and PCN 4 given the overlaps between their practice populations;
    - the ability of PCN 3 to offer services in a way that makes geographical sense to their patients, in particular the patients registered with Daybook Medical Practice.

46. The CCG locality team facilitated a meeting of the practices in PCN 2, 3 and 4 on 29 May 2019; 11 out of the 12 practices were represented. As well as the LMC, NHS England and Local Partnerships were also represented at the meeting.

47. Following discussions, it was agreed that PCN 3 and PCN 4 would adopt a consistent approach to the commissioning of community services delivered in

both PCNs and that this agreement would be written into the relevant network agreement Schedules.

48. Further consideration as to the proposal from PCN 3 concluded that Daybrook Medical Practice should be included as a core member of the network, due to good working relationships similar practice populations; and remedial actions being taken to ensure patients can access services from the nearest 'hub'

49. The population of PCN 4 is currently below the 30,000 threshold by 353 patients. Housing developments in the area mean that the PCN will reach the 30,000 threshold during 2019/20. The practices within PCN 4 have stated that if they are not supported to establish a PCN of their own at this point in time because of their population size, as soon as they reach a population of 30,000 they will apply to leave PCN 3 and resubmit an application to form their own PCN.

50. After much discussion, and consideration, on order to ensure good working relationships and to avoid the disruption of practices leaving a PCN soon after it has formed it was agreed to not reject the PCN 4 proposal on the grounds of population size.

Rationale for PCN Configurations - Mid Nottinghamshire CCGs

51. Mid Nottinghamshire CCG worked closely with the LMC throughout the process to allow PCNs to own, engage and drive their own nomination of key leaders and agree their terms of business.

Areas to note on the submissions received by the Mid Nottinghamshire CCGs

52. **Four of the PCNs in Mid Nottinghamshire have a total list size over 50,000**: The practices within these PCNs have established collaborative working over recent years and are based on appropriate geography.

Rationale for PCN Configurations - Nottingham City CCG

53. Nottingham City CCG Locality Team and Nottinghamshire LMC worked closely with all the GP practices across Nottingham City to propose the final configurations of the PCNs.

Areas to note on the submissions received by Nottingham City CCG:

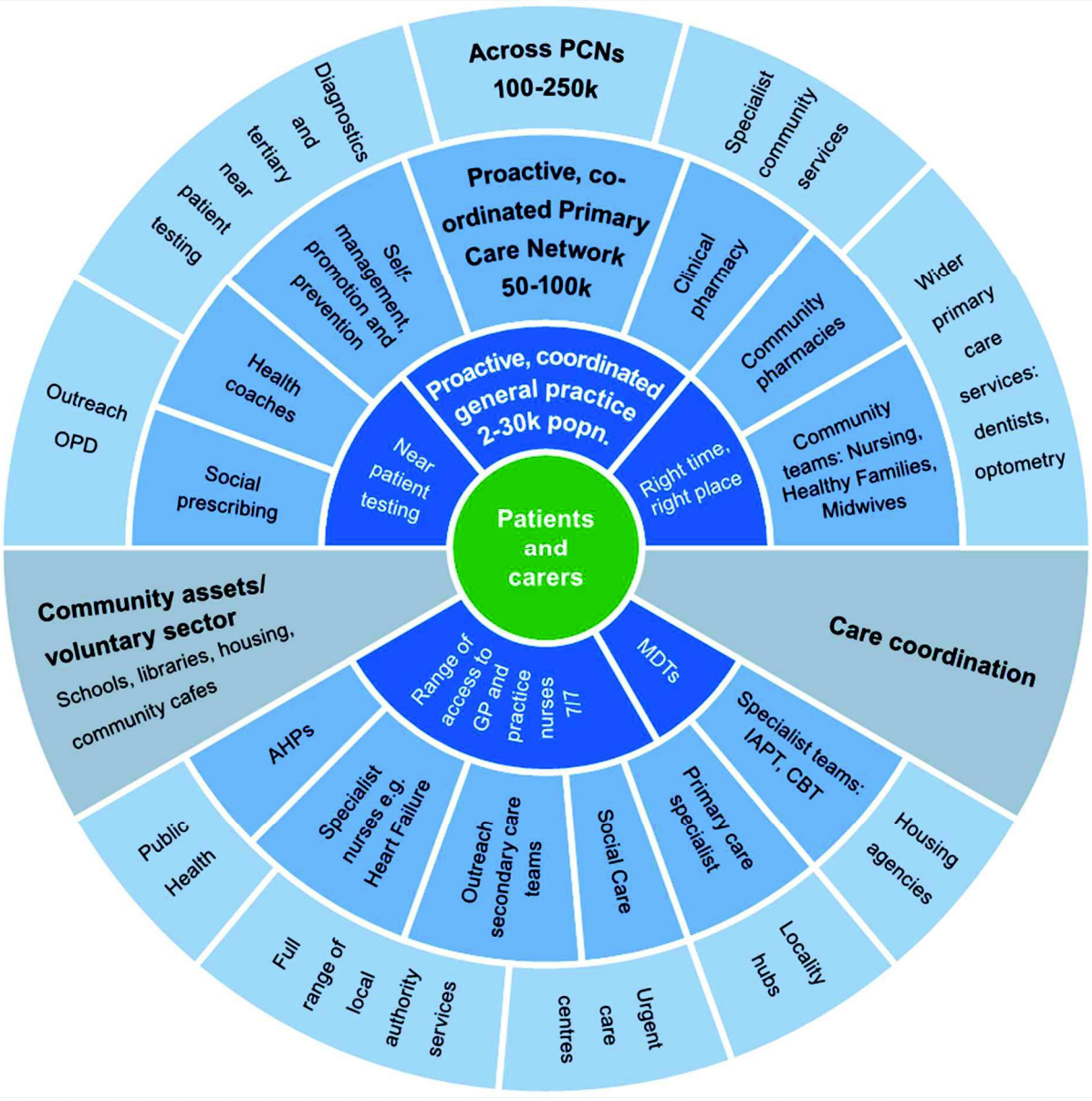
54. **The creation of a University Practice PCN (currently known as PCN U)**: PCN U was developed with the two University practices. Both practices in the PCN have list sizes comprised primarily of the student population. Despite the practices being in different geographical locations they are still contiguous, overlapping with PCN 4, PCN 7, and PCN 8. Joining together in a PCN for this defined population makes sense for commissioned services and the needs of the student community.

55. **Three of the PCNs in Nottingham City have a total list size over 50,000**: in each of the three cases the population demographics and needs are similar. PCN 3 and PCN 6 are largely unchanged from their original established Care Delivery Group configurations; these groups of practices have a well-established and proven track record of successful working relationships

Rationale for PCN Configurations

56. The model in Figure 1 was presented in the 9 May paper to demonstrate the range of core services that have been locally identified to be delivered through the PCN configurations further to the PCN workshops

Figure 1



57. This table has been developed to further demonstrate how the PCNs will deliver services at Practice level, across a PCN neighbourhood, and across PCNs:

Practice level 2 – 30k	**PCN Neighbourhoods 50 – 100k**	**Overarching PCN/PCNs 100 – 250k**
Access to GP and practice nurses	Social prescribing; self-management and prevention	Specialist community services
Proactive care/MDTS	Clinical and community pharmacy	Other NHS services e.g. dentistry; optometry
MDT meetings	Community health teams	Housing
Near patient testing	Specialist health teams	Locality hubs
	Social care	Urgent Care Centres
	Outreach secondary care teams	Local Authority services
		Public Health Services
		Outreach outpatient departments
		Diagnostic and tertiary near patient testing

Next Steps

58. All Schedules which support the PCN Network Agreement DES to be developed and enacted by 30 June 2019.

59. From 1 July 2019 PCNs across the country will go live.

60. Organisational development and leadership to support the newly formed PCNs is being determined at a national, regional and local level.

61. Half day workshops are scheduled across the three PCN ICP footprints for July 2019.

62. Consistent approach to workforce development to support the emerging roles for Social Prescribers, Community Pharmacists, First Contact Physiotherapists; Physician Associates and Community Paramedics.

63. Continue to build upon existing and develop new relationships with community teams, social care, voluntary sector, acute providers, district councils and community assets.

64. Determine how PCNs will be represented at both the ICS and ICPs.

65. Ensure a systematic communication and cascade of information through PCNs.

66. Engagement activities to the wider workforce.

67. Engage with patients and the public and members to build the emerging narrative and service offer to local communities

Recommendations

68. The Board are asked to:

- Consider this report
- Confirm support for the PCN configurations and newly appointed Clinical Directors for each PCN for Nottingham and Nottinghamshire
- Note the next steps for the development of the PCNs

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

Appendix 1: Nottingham City and Nottinghamshire PCN application summary, May 2019

Nottingham City

PCN	Practice		Criteria							
	ODS	Name	Network Contract DES Registration Form completed in line with guidance	Size – between 30,000 and 50,000 patients	Geographical contiguity – practice boundaries must overlap or be adjacent	Formation of PCNs cannot result in a practice(s) being left out or not contiguous with other patients	PCNs can only cross upper tier local authority areas in exceptional circumstances	No practice can be excluded from a PCN	PCN structures must make geographical sense to patients and for commissioned services	Accountable clinical director
Nottingham City CCG										
PCN 1 Bulwell & Top Valley	C84043	Leen View Surgery	Yes	44,571	Bulwell, Highbury Vale, Rise Park, Top Valley	Complete	Complete – all practices within Nottingham City Council	Complete	Yes	Dr Andrew Foster, Parkside Medical Practice
	C84064	Parkside Medical Practice								
	C84135	Queens Bower Surgery								
	C84129	Rise Park Surgery								
	C84717	Riverlyn Medical Centre								
	Y05622	Southglade Medical Practice								
	C84138	Springfield Medical Centre								
	C84004	St Albans Medical Centre/Nirmala								
PCN 3 BACHS	C84091	Aspley Medical Centre	Yes	59,168	Aspley, Beechdale, Bilborough, Broxtowe, Cinderhill, Old Basford, Strelley	Complete	Complete – all practices within Nottingham City Council	Complete	Yes	Dr Jonathan Harte, Aspley Medical Centre
	C84704	Beechdale Surgery								
	C84647	Bilborough Surgery								
	Y06356	Bilborough Medical Centre								
	C84650	Boulevard Medical Centre								
	C84034	Churchfields Medical Practice								
	C84104	Greenfields Medical Centre								
	C84694	Limetree Surgery								
	C84676	Mayfield Medical Practice								
	C84116	Melbourne Park Medical Centre								
	C84680	RHR Medical Centre								
	C84698	Strelley Health Centre								

	Practice		Criteria							
PCN	ODS	Name	Network Contract DES Registration Form completed in line with guidance	Size – between 30,000 and 50,000 patients	Geographical contiguity – practice boundaries must overlap or be adjacent	Formation of PCNs cannot result in a practice(s) being left out or not contiguous with other patients	PCNs can only cross upper tier local authority areas in exceptional circumstances	No practice can be excluded from a PCN	PCN structures must make geographical sense to patients and for commissioned services	Accountable clinical director
PCN 4 Radford & Mary Potter	C84105	The Fairfields Practice	Yes	49,503	Hyson Green, Radford, Forest Fields, Bobbers Mill, The Park	Complete	Complete – all practices within Nottingham City Council	Complete	Yes	Dr Josephine Guha, The Forest Practice
	C84103	The Forest Practice								
	C84691	High Green Medical Practice								
	C84117	Radford Medical Practice/NTU								
	C84096	Radford Health Centre - Phillips								
	C84136	St Luke's Surgery								
PCN 5 Bestwood & Sherwood	C84695	The Alice Medical Centre	Yes	49,390	Bestwood, Carrington, New Basford, Sherwood, Sherwood Rise	Complete	Complete – all practices within Nottingham City Council	Complete	Yes	Dr Michael Crowe, Hucknall Road Medical Centre
	C84011	Elmswood Surgery								
	C84078	Hucknall Road Medical Centre								
	C84682	Sherrington Park Medical Practice								
	C84628	Sherwood Rise Medical Centre								
	C84151	The Medical Centre - Irfan								
	C84619	Tudor House Medical Practice								
	C84664	Welbeck Surgery								
PCN 6	C84693	Bakersfield Medical Centre	Yes	66,474	Lace Market, Mapperley, Mapperley Park, St Ann's, Sneinton	Complete	Complete – all practices within Nottingham City Council	Complete	Yes	Dr Hussain Gandhi, Wellspring Surgery; Dr Margaret Abbott, Windmill Practice
	C84018	Family Medical Centre								
	C84063	GreenDale Primary Care Centre								
	C84602	Mapperley Park Medical Centre								
	Y02847	NEMS - Platform One Practice								
	C84085	Victoria and Mapperley Practice								
	C84072	Wellspring Surgery								
	C84683	Windmill Practice								

	Practice		Criteria							
PCN	ODS	Name	Network Contract DES Registration Form completed in line with guidance	Size – between 30,000 and 50,000 patients	Geographical contiguity – practice boundaries must overlap or be adjacent	Formation of PCNs cannot result in a practice(s) being left out or not contiguous with other patients	PCNs can only cross upper tier local authority areas in exceptional circumstances	No practice can be excluded from a PCN	PCN structures must make geographical sense to patients and for commissioned services	Accountable clinical director
PCN 7	C84044	Deer Park Family Medical Practice	Yes	36,390	Old Lenton, Wollaton	Complete	Complete – all practices within Nottingham City Council	Complete	Yes	Dr Katherine O'Connor, Wollaton Park Medical Centre
	C84039	Derby Road Health Centre								
	Y03124	Grange Farm Medical Centre								
	C84122	Wollaton Park Medical Centre								
PCN 8	C84092	Bridgeway Practice	Yes	31,662	Clifton, The Meadows, Wilford	Complete	Complete – all practices within Nottingham City Council	Complete	Yes	Dr Heetan Patel, Clifton Medical Practice
	C84046	Clifton Medical Practice								
	C84081	John Ryle Medical Centre								
	C84144	Meadows Health Centre - Larner								
	C84060	Rivergreen Medical Centre								
PCN U	C84023	Cripps Health Centre	Yes	51,548	Clifton, Dunkirk, Lenton Abbey, New Lenton	Complete	Complete – all practices within Nottingham City Council	Complete	Yes	Dr Matthew Litchfield, The University of Nottingham Health Service
	C84714	Sunrise Medical Practice								

Mid-Nottinghamshire

	Practice		Criteria							
PCN	ODS	Name	Network Contract DES Registration Form completed in line with guidance	Size – between 30,000 and 50,000 patients	Geographical contiguity – practice boundaries must overlap or be adjacent	Formation of PCNs cannot result in a practice(s) being left out or not contiguous with other patients	PCNs can only cross upper tier local authority areas in exceptional circumstances	No practice can be excluded from a PCN	PCN structures must make geographical sense to patients and for commiss-ioned services	Accountable clinical director
Mansfield & Ashfield CCG										
Ashfield North	C84077	Brierley Park Medical Centre	Yes	51,705	Sutton in Ashfield, Harlow Wood, Huthwaite, Fackley, Teversal, Skegby	Complete	Complete – all practices within Nottinghamshire County Council	Complete	Yes	Dr Andrew Pountney, Woodlands Medical Practice
	C84061	Kings Medical Centre								
	C84114	Skegby Family Medical Centre								
	C84012	Willowbrook Medical Practice								
	C84014	Woodlands Medical Practice								
Ashfield South	C84067	Ashfield House (Annesley)	Yes	38,794	Kirkby-In-Ashfield, Annesley, Underwood, Jacksdale, Barrows Green, Selston Green, Hall Green	Complete	Complete – all practices within Nottinghamshire County Council	Complete	Yes	Dr Junaid Dar, Family Medical Centre (Kirkby)
	C84074	Family Medical Centre (Kirkby)								
	C84629	Health Care Complex								
	C84654	Jacksdale Medical Centre								
	C84076	Kirkby Health Centre								
	Y05690	Kirkby Community Primary Care Centre								
	C84140	Lowmoor Road Surgery								
	C84142	Selston Surgery								
Mansfield North	C84710	Bull Farm Primary Care Resource Centre	Yes	58,425	Meden Vale, Church Warsop, Warsop Vale, Spion Kop, Mansfield Woodhouse, Ravendale, Mansfield, Pleaseley	Complete	Complete – all practices within Nottinghamshire County Council	Complete	Yes	Dr Khalid Butt, Oakwood Surgery
	C84658	Meden Medical Services								
	C84016	Oakwood Surgery								
	C84051	Orchard Medical Practice								
	C84057	Pleasley Surgery								
	C84127	Riverbank Medical Services								
	C84637	Sandy Lane Surgery								
	C84031	St Peters Medical Practice (Dr Sharma)								

PCN	Practice		Criteria							
	ODS	Name	Network Contract DES Registration Form completed in line with guidance	Size – between 30,000 and 50,000 patients	Geographical contiguity – practice boundaries must overlap or be adjacent	Formation of PCNs cannot result in a practice(s) being left out or not contiguous with other patients	PCNs can only cross upper tier local authority areas in exceptional circumstances	No practice can be excluded from a PCN	PCN structures must make geographical sense to patients and for commiss-ioned services	Accountable clinical director
Mansfield South	C84679	Acorn Medical Practice	Yes	46,587	Mansfield, Newton Town, Ladybrook, Bleak Hills, Berry Hill, Forest Town	Complete	Complete – all practices within Nottinghamshire County Council	Complete	Yes	Dr Milind Tadpatrikar, Roundwood Surgery
	C84020	Churchside Medical Practice								
	C84036	Forest Medical								
	C84106	Mill View Surgery								
	C84069	Roundwood Surgery								

PCN	Practice		Criteria							
	ODS	Name	Network Contract DES Registration Form completed in line with guidance	Size – between 30,000 and 50,000 patients	Geographical contiguity – practice boundaries must overlap or be adjacent	Formation of PCNs cannot result in a practice(s) being left out or not contiguous with other patients	PCNs can only cross upper tier local authority areas in exceptional circumstances	No practice can be excluded from a PCN	PCN structures must make geographical sense to patients and for commiss-ioned services	Accountable clinical director
Newark & Sherwood CCG										
Newark PCN	Y05369	Balderton PCC (C84648)	Yes	76,147	Newark-on-Trent, Southwell, Balderton, Collingham, Sutton-on-Trent, Norwell, Caunton, Oxton, Fernwood	Complete	Complete – all practices within Nottinghamshire County Council	Complete	Yes	Dr James Cusack, Lombard Medical Centre
	C84009	Barnby Gate Surgery								
	C84045	Collingham Medical Centre								
	C84019	Fountain Medical Centre								
	C84660	Hounsfield Surgery								
	C84029	Lombard Medical Centre								
	C84049	Southwell Medical Centre								
Sherwood PCN	C84037	Abbey Medical Group	Yes	59,627	Ravenshead, Oxton, Farnsfield, Bilsthorpe, Ollerton, New Ollerton, Edwinstowe, Kirton, Boughton, Walesby, Perlethorpe, Kings Clipstone, Clipstone, Newlands, Rainworth, Blidworth	Complete	Complete – all practices within Nottinghamshire County Council	Complete	Yes	Dr Kevin Corfe, Abbey Medical Group
	C84123	Bilsthorpe Surgery								
	C84656	Hill View Surgery								
	C84113	Major Oak Medical Practice								
	C84021	Middleton Lodge Practice								
	C84087	Rainworth HC								
	C84059	Sherwood Medical Partnership								

South Nottinghamshire

	Practice		Criteria							
PCN	ODS	Name	Network Contract DES Registration Form completed in line with guidance	Size – between 30,000 and 50,000 patients	Geographical contiguity – practice boundaries must overlap or be adjacent	Formation of PCNs cannot result in a practice(s) being left out or not contiguous with other patients	PCNs can only cross upper tier local authority areas in exceptional circumstances	No practice can be excluded from a PCN	PCN structures must make geographical sense to patients and for commiss-ioned services	Accountable clinical director
Nottingham North and East CCG										
PCN 1 Hucknall	C84095	Oakenhall Medical Practice	Yes	36,715	Hucknall, Bestwood Village, Linby, Papplewick	Complete	Complete – all practices within Nottinghamshire County Council	Complete	Yes	Dr Adam Connor, Whyburn Medical Practice
	Y00026	Om Surgery								
	C84053	Torkard Hill Medical Centre								
	Y06443	Whyburn Medical Practice								
PCN 2 Arnold & Calverton	C84047	Calverton Practice	Yes	33,778	Arnold, Calverton	Complete	Complete – all practices within Nottinghamshire County Council	Complete	Yes	Dr Kate Evans, Stenhouse Medical Centre
	C84055	Highcroft Surgery								
	C84026	Stenhouse Medical Centre								
PCN 3 Carlton & Villages	C84066	Daybrook Medical Practice	Yes	40,969	Carlton, Daybrook, Mapperley, Burton Joyce, Lowdham	Complete	Complete – all practices within Nottinghamshire County Council	Complete	No	Dr Umar Ahmad, Plains View Surgery
	C84646	Ivy Medical Group								
	C84133	Peacock Healthcare								
	C84115	Plains View Surgery								
	C84150	Unity Surgery								
	C84033	Westdale Lane Surgery								
PCN 4	C84613	Jubilee Practice	Yes	29,647	Carlton, Netherfield, Bakersfield, Colwick, Gedling, Woodthorpe, Lambley, Burton Joyce, Lowdham, Woodborough, Epperstone, Gunthorpe, Gonalston, Bleasby, Thurgarton, Oxton, Hoveringham, Caythorpe, Mapperley	Not contiguous	Complete – all practices within Nottinghamshire County Council	Complete	No	Ian Campbell, Park House Medical Centre
	C84709	Park House Medical Centre								
	C84010	Trentside Medical Group								
	C84696	West Oak Surgery								

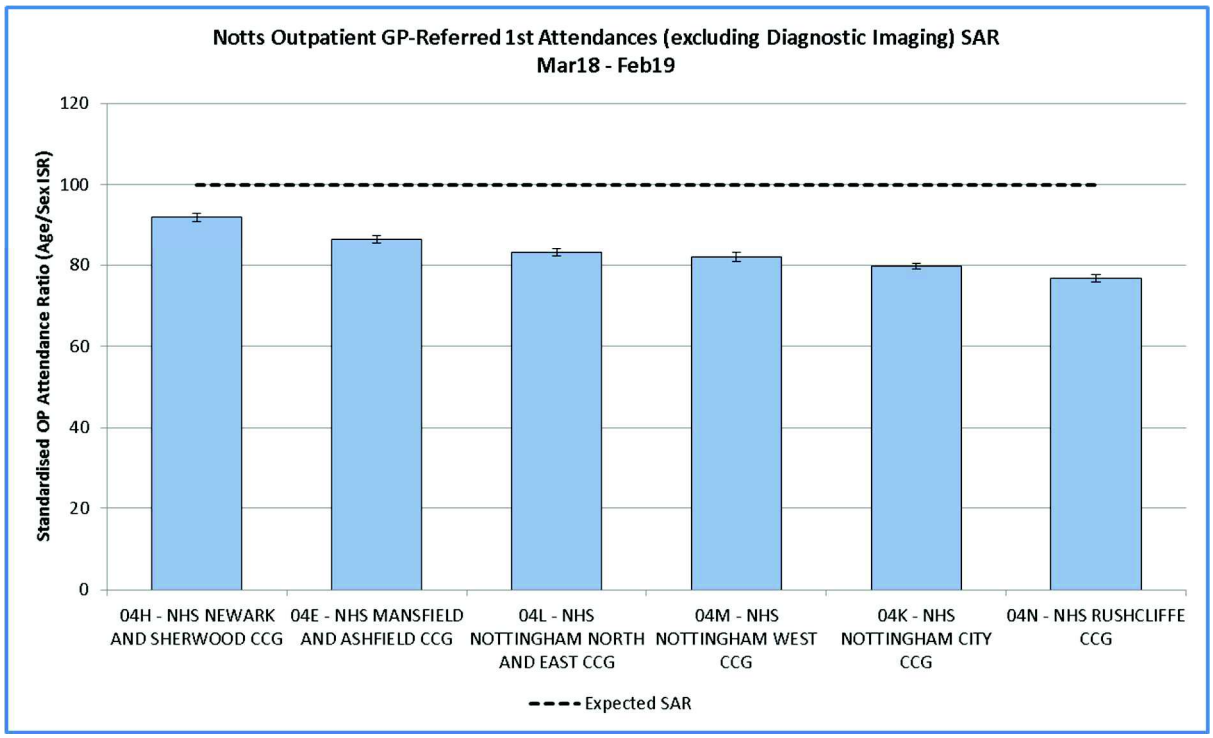
PCN	Practice		Criteria							
	ODS	Name	Network Contract DES Registration Form completed in line with guidance	Size – between 30,000 and 50,000 patients	Geographical contiguity – practice boundaries must overlap or be adjacent	Formation of PCNs cannot result in a practice(s) being left out or not contiguous with other patients	PCNs can only cross upper tier local authority areas in exceptional circumstances	No practice can be excluded from a PCN	PCN structures must make geographical sense to patients and for commiss-ioned services	Accountable clinical director
Nottingham West CCG										
Nottingham West PCN			Yes	106,473		Complete	Complete – all practices within Nottinghamshire County Council	Complete	Yes	Dr Nicole Atkinson, Eastwood Primary Care Centre
	PCN Neighbourhood - Beeston:			47,476	Beeston, Bramcote, Chilwell					
	C84065	Abbey Medical Centre								
	C84112	Bramcote Surgery								
	C84120	Chilwell Valley and Meadows Practice								
	C84080	Manor Surgery								
	C84030	Oaks Medical Centre								
	PCN Neighbourhood – Eastwood/Kimberley:			37,159	Eastwood, Newthorpe, Giltbrook, Kimberley					
	C84032	Eastwood PCC								
	C84667	Giltbrook Surgery								
	C84624	Hama Medical Centre								
	C84131	Newthorpe Medical Centre								
	PCN Neighbourhood – Stapleford:			21,337	Stapleford					
	C84705	Hickings Lane Medical Centre								
	C84107	Linden Medical Group								
	C84042	Saxon Cross Surgery								
				501	Not re-registered from practice closure					

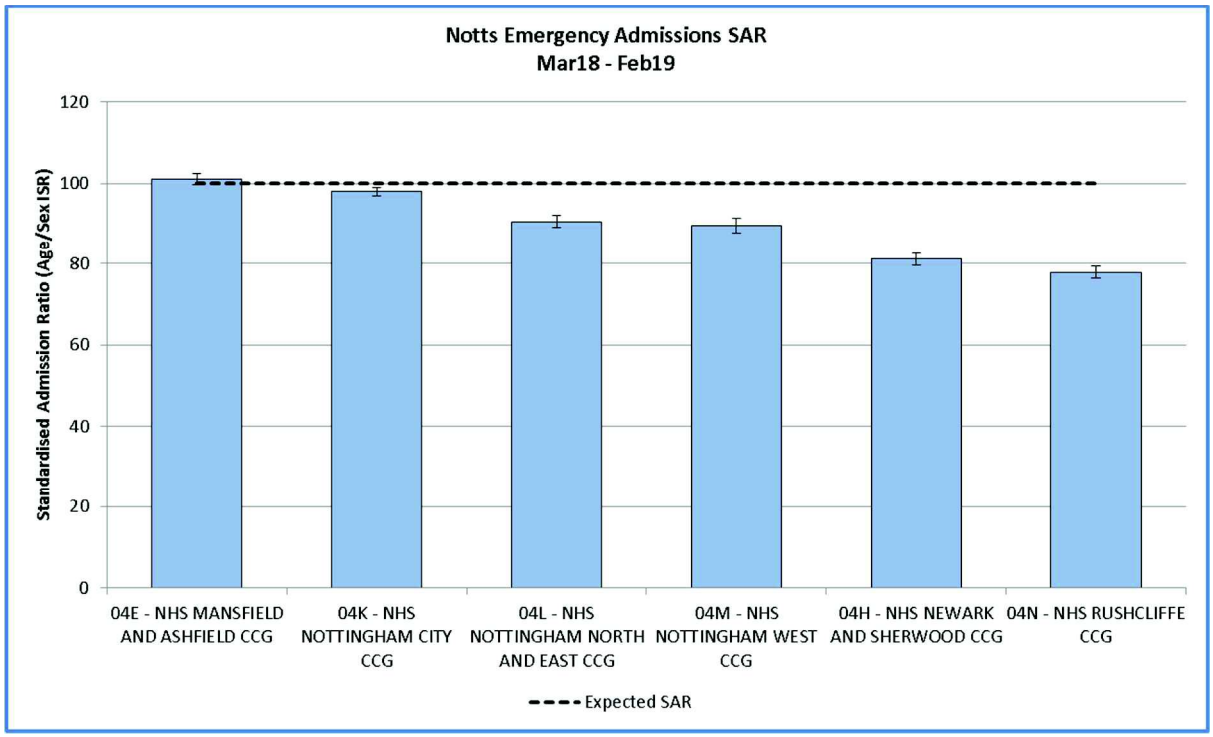
PCN	Practice		Criteria							
	ODS	Name	Network Contract DES Registration Form completed in line with guidance	Size – between 30,000 and 50,000 patients	Geographical contiguity – practice boundaries must overlap or be adjacent	Formation of PCNs cannot result in a practice(s) being left out or not contiguous with other patients	PCNs can only cross upper tier local authority areas in exceptional circumstances	No practice can be excluded from a PCN	PCN structures must make geographical sense to patients and for commiss-ioned services	Accountable clinical director
Rushcliffe CCG										
Rushcliffe PCN			Yes	128,389		Complete	Complete – all practices within Nottinghamshire County Council	Complete	Yes	Dr Stephen Shortt, East Leake Medical Group
	PCN Neighbourhood – North:			39,770	East Bridgford, Bingham, Radcliffe-on Trent					
	C84017	Belvoir Health Group								
	C84025	East Bridgford Medical Centre								
	C84084	Radcliffe On Trent Health Centre								
	PCN Neighbourhood – Central:			48,129	West Bridgford, Wilford, Gamston					
	C84605	Castle Healthcare Practice								
	C84703	Gamston Medical Centre								
	C84090	Musters Medical Practice								
	C84086	St George's Medical Practice								
	C84621	West Bridgford Medical Centre								
	PCN Neighbourhood – South:			40,490	Keyworth, East Leake, Kegworth, Ruddington					
	C84005	East Leake Medical Group								
	C84048	Keyworth Medical Practice								
	C82040	Orchard Surgery								
	C84028	Ruddington Medical Centre								

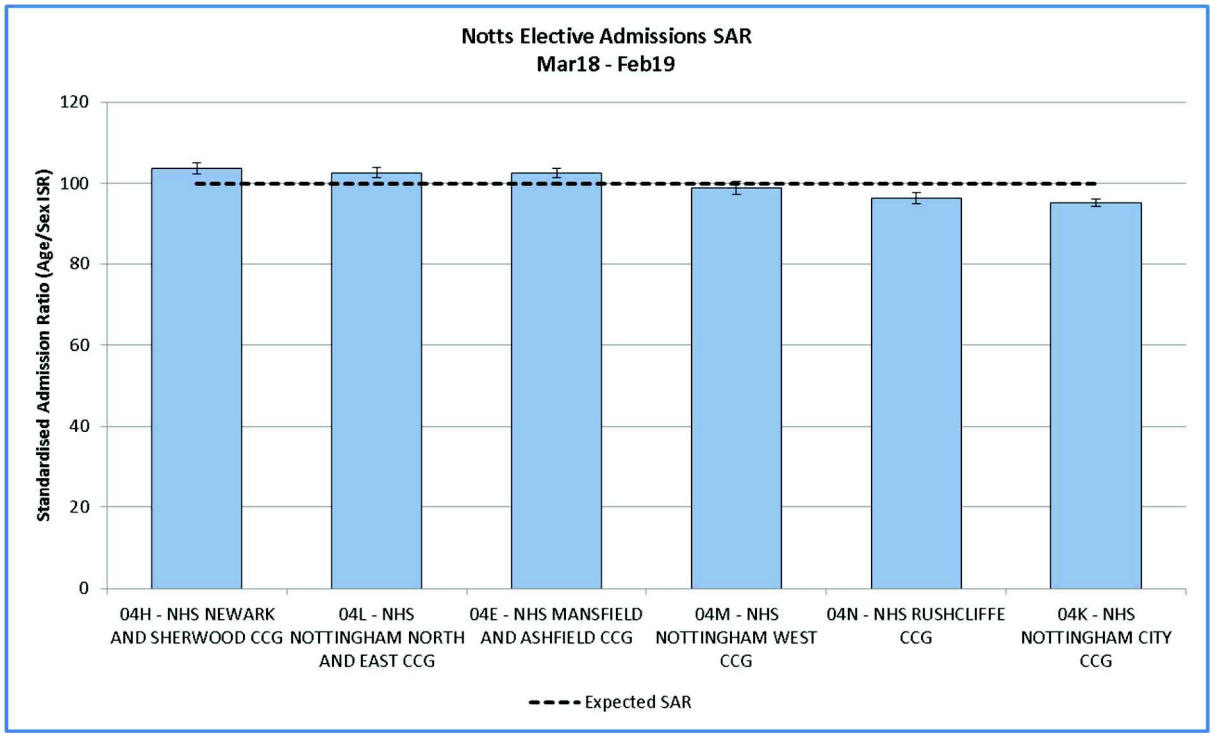
Appendix 2: Clinical Directors for the Primary care Networks

ICP	PCN	Clinical Director Deputy Clinical Director
Mid Notts	**Ashfield South**	Dr Junaid Dar Dr Deepa Balakrishnan
	Ashfield North	Dr Andrew Poutney Dr Gavin Lunn
	Mansfield South	Dr Milind Tadpatrikar
	Mansfield North	Dr Khalid Butt Dr James Mills
	Sherwood	Dr Kevin Korfe
	Newark	Dr James Cusack
City	**PCN 1**	Dr Andrew Foster
	PCN 3	Dr Jonathan Harte
	PCN 4	Dr Jo Guha
	PCN 5	Dr Mike Crowe
	PCN 6	Dr Hussain Gandhi Dr Margaret Abbott
	PCN 7	Dr Katherine O'Connor
	PCN 8	Dr Heetan Patel
	PCN U	Dr Matthew Litchfield
South Notts	**Eastwood and Stapleford** **Bramcote and Beeston**	Dr Nicole Atkinson Neighbourhood deputies TBC
	Rushcliffe North **Rushcliffe Central** **Rushcliffe South**	Clinical Executive to support neighbourhoods: Dr Stephen Shortt (Chair until 30.6.19) Dr Matt Jelpke Dr Richard Stratton Dr Lynn Ovenden Dr Nigel Cartwright Dr Gurvinder Sahota
	NNE PCN 1	Dr Adam Connor
	NNE PCN 2	Dr Kate Evans
	NNE PCN 3	Dr Umar Ahmad
	NNE PCN 4	Dr Ian Campbell

Appendix 3: Comparison of CCG Activity - March 2018 – February 2019






Notts Elective Admissions SAR
Mar18 - Feb19
Standardised Admission Ratio (Age/Sex ISR)
120
100
80
60
40
20
0
04H - NHS NEWARK AND SHERWOOD CCG
04L - NHS NOTTINGHAM NORTH AND EAST CCG
04E - NHS MANSFIELD AND ASHFIELD CCG
04M - NHS NOTTINGHAM WEST CCG
04N - NHS RUSHCLIFFE CCG
04K - NHS NOTTINGHAM CITY CCG
Expected SAR

ENC. G

Meeting:	ICS Board
Report Title:	Local priorities for inclusion in the 19/20 MOU with NHS England & Improvement
Date of meeting:	Thursday 13 June 2019
Agenda Item Number:	10
Work-stream SRO:	Wendy Saviour
Report Author:	Tom Diamond
Attachments/Appendices:	None

Report Summary:

This report concerns the progress made since the discussion at the 9 May ICS Board meeting. The purpose of this paper is to provide a further iteration of local priorities for inclusion in the 2019/20 MOU.

As well as the expectations set in line with national policy and guidance, in particular the NHS Long Term Plan, nine local priorities are proposed for the 2019/20 MOU.

It is expected that the MOU for 2019/20 will be agreed locally with the regional NHS England and Improvement team. The ICS MOU will be devolved to the Nottinghamshire ICPs for delivery.

Action:

☐ To receive
☒ To approve the recommendations

Recommendations:

1.	The Board are asked to consider the suggested local priorities for inclusion in the 2019/20 ICS MOU.

Key implications considered in the report:

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

Engagement to date:

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

Contribution to delivering the ICS high level ambitions of:

Health and Wellbeing	☒

Care and Quality	☒
Finance and Efficiency	☒
Culture	☒

Is the paper confidential?

☐ Yes
☒ No

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

Local priorities for inclusion in the 19/20 MoU with NHS England & Improvement

13 June 2019

Introduction

1. A Memorandum of Understanding (MOU) between the Nottingham and Nottinghamshire ICS and NHS England and NHS Improvement (NHSE&I) was agreed for 2018/19. The agreement outlines key objectives and deliverables for the Integrated Care System (ICS).

2. These objectives and deliverables were largely set centrally in line with national policy and guidance. However there was an opportunity for a small number of local deliverables to be set that were specific to the Nottingham and Nottinghamshire ICS. For 2018/19 a total of eight local objectives were agreed.

3. It is anticipated there will be an MOU for 2019/20, once again with the majority of objectives and deliverables being set centrally in line with national policy and guidance (the NHS Long Term Plan in particular) with the opportunity to agree a small number of local priorities.

Current position

4. An overview of progress made in 2018/19 against the key deliverables was considered by the ICS Board at the 11 April meeting. The Board considered the following key areas to accelerate progress:

    a. Whilst the resilience of the system was improved, challenges remain with the overall system priority of achieving the 4 hour target in Greater Nottingham.

    b. 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.

    c. 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.

5. ICS Board considered early proposals for the priorities to be included in the 2019/20 MOU at the 9 May ICS Board meeting. Board members asked that the following points be addressed:

    a. More emphasis be given to priorities which will demonstrate tangible changes rather than an emphasis on structure and governance. Suggested that structure and governance priorities could form one overarching priority to reflect this.

b. Red rated performance issues such as urgent care should be stated as local priorities for the system.

c. Further work is needed to cross reference with the ICP priorities.

d. Emphasis on system architecture should be to conclude rather than to develop further.

e. Implementation of the mental health strategy and its impact should be incorporated.

f. Priorities should be ordered as “big ticket” items, how the system is organised, and local priorities.

g. Priorities should be reflected in the ICS Board workplan.

6. The process to develop an MOU for 2019/20 is yet to be initiated by NHSE&I, however, early discussions have been held.

7. Board are asked to note that the ICS MOU will be devolved to the Nottinghamshire ICPs for delivery.

Issues

8. Issues raised at the 9 May Board have been reflected in this report for discussion.

9. Board is asked to consider the proposals overleaf for local priorities to be incorporated into the 2019/20 MOU.

Nottingham and Nottinghamshire ICS 19/20 MOU local priorities

'Big Ticket'

1. **Urgent and Emergency Care**
   Continue to redesign the emergency and urgent care system, including integrated primary care models, to ensure timely care in the most appropriate setting and delivery of key performance indicators (4 hour A&E Standard, ambulance response times, length of stay and delayed transfers of care). Ensure that the hospital discharge processes are designed to deliver to benefits of a fully functioning discharge and reablement process
2. **Proactive and Personalised Care**
   Improve support to people at risk of and living with single and multiple long term conditions and disabilities through greater proactive and personalised care - thereby reducing exacerbations and crises and the demand on emergency and emergency care services
3. **Mental health**
   Reshape and transform services and other interventions so they better respond to the mental health and care needs of the population by implementing the ICS's all age mental health and social care strategy – this will support the delivery of key performance indicators (CYP service access, IAPT access, EIP concordant compliance and inappropriate out of area placements)
4. **Cancer**
   Ensure performance against the cancer access standards is improved and consistently delivered including the new 28 day referral to diagnosis target being introduced in 2019

Local

5. **Clinical services strategy**
   Commence implementation of agreed service changes identified in the outputs of the initial phases of the clinical services strategy
6. **Alcohol**
   Reduce alcohol related harm across the ICS through continued delivery of the agreed eight point plan developed by the Nottinghamshire Alcohol Pathways Group

ICS development

7. **System Level Outcomes Framework**
   Embed the ICS System Level Outcomes Framework by developing a coherent approach to measuring and reporting the outcomes within the framework at an ICS Board, ICP and PCN level
8. **System architecture**
   Deliver key actions which conclude the development of the ICS organisational and governance architecture, including: integrated oversight, integrated provider structures, integrated planning and delivery by ICPs and PCNs, integrated capacity planning, a final form for the strategic commissioner and strengthening the role of non-NHS organisations within

Recommendations

10. The Board are asked to consider the suggested local deliverables and objectives set out above for inclusion in the 2019/20 ICS MOU.

ENC. H1

Meeting:	ICS Board
Report Title:	Proposed merger of the Nottingham and Nottinghamshire CCGs
Date of meeting:	Thursday 13 June 2019
Agenda Item Number:	11
Work-stream SRO:	Amanda Sullivan, Accountable Officer, Nottingham and Nottinghamshire CCGs
Report Author:	Alex Ball, Director of Communications and Engagement, Nottingham and Nottinghamshire ICS and CCGs
Attachments/Appendices:	Enc. H2. Future arrangements for NHS commissioning across Nottingham and Nottinghamshire

Report Summary:

The NHS Long Term Plan as published on 7 January 2019 contains a confirmation of the direction of travel for CCG configurations into a single Strategic Commissioner CCG for each ICS area.

The six CCGs in the Nottingham and Nottinghamshire ICS have commenced the process to apply to merge by April 2020 and are currently consulting with stakeholders on this proposal.

In order to support the formal application to merge, the leadership of the ICS are invited to write a letter of support for the merger.

This paper outlines the work undertaken to date and the further work due to come over the subsequent weeks and invites that ICS Board to offer its support to this proposed merger.

Action:

☐ To receive
☒ To approve the recommendations

Recommendations:

1.	To note the application in May 2019 from the Nottingham and Nottinghamshire CCGs to NHS England to commence the process to merge by April 2020
2.	To note the commencement of the stakeholder consultation on this proposed merger on 21 May 2019
3.	To agree to write collectively as ICS leaders to the Accountable Officer of the CCGs confirming the ICS's support for this proposed merger.

Key implications considered in the report:

Financial	☐	
Value for Money	☒	
Risk	☐	
Legal	☒	

Workforce	☒	
Citizen engagement	☐	
Clinical engagement	☐	
Equality impact assessment	☐	

Engagement to date:

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

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

Is the paper confidential?

☐ Yes
☒ No

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

PROPOSED MERGER OF THE NOTTINGHAM AND NOTTINGHAMSHIRE CCGS

13 JUNE 2019

Introduction

1. The NHS Long Term Plan as published on 7 January 2019 contains a confirmation of the direction of travel for CCG configurations: "Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area. CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long Term Plan implementation".

2. The Nottingham and Nottinghamshire CCGs (Mansfield and Ashfield; Newark and Sherwood; Nottingham North and East; Nottingham West; Rushcliffe; Nottingham City) have been working closely together for a considerable period of time: Over the past five years, the CCGs have worked more collaboratively, culminating in two geographical areas: Mid Nottinghamshire – two CCGs (worked jointly from March 2016) and Greater Nottingham Clinical Commissioning Partnership (formed April 2018) – four CCGs.

3. Over the past year, and well before the publication of the NHS Long Term Plan in January 2019, CCGs across Nottingham and Nottinghamshire had already started to consider the potential for a more formal joining up of commissioning arrangements.

4. In recent months, the CCGs have introduced a number of joint arrangements to serve all six CCGs. The CCGs now have a single Accountable Officer supported by a single leadership team. Joint committees will soon meet 'in common' and the first joint Governing Body meeting will take place in July 2019. Transitional work is underway both to align wider CCG governance and to bring together staffing structures.

Current Status

5. The CCGs have discussed the possibilities for future commissioning arrangements openly with many organisations, groups and individuals over the past year, including member GPs, local authorities, voluntary services, hospitals and other healthcare partners.

6. These conversations have directly helped to shape the thinking, including the preferred proposal to merge. The CCGs understand from these conversations that stakeholders are supportive of a solution which paves the way for closer integration and better partnership working, enables more strategic commissioning, reduces administration costs, and releases valuable resources to focus on services and initiatives closer to the front-line.

7. All six CCG Governing Bodies agreed in April 2019 that the preferred way forward would be to fully merge and an application to NHS England to commence this process to merger has been submitted.

8. To support this application, a stakeholder consultation launched on 21 May 2019 and will run through to 17 June 2019.

Future Activities

9. A formal CCG membership vote in each of the 6 CCGs considering the merger proposal will follow from 24 June 2019 to 28 June 2019.

10. Following the conclusion of this consultation and the membership vote, the joint Governing Body of the six CCGs will meet on 4 July 2019 to review the results of the consultation and vote and make a decision to make a final formal application to merge.

11. A final formal application to NHS England will be due by 26 July 2019.

Reasons to Merge

12. There are many advantages to merging the six CCGs. These will benefit – either directly or indirectly – patients and local people, GPs and other clinicians, health and care partners and many others. These are the top five reasons why the CCGs believe that a merger into one single, statutory commissioning organisation is the right way forward.

    a. Better healthcare and health outcomes: Align with health and care partners across the system in order to address health inequalities and ensure consistency of services where appropriate
    b. Better use of clinical and other resource: Save precious clinical time and resources that can be invested into tackling community health priorities via the new Primary Care Networks.
    c. Stronger, consistent commissioning voice and leadership: Provide a stronger clinical voice in strategic decisions about health and care services, as well as at neighbourhood level via Primary Care Networks.
    d. Greater support for transformation and local innovation: Scale-up the most successful local clinical innovations to rapidly share best practice across a wider area.
    e. Significant administrative savings: Reduce duplication in back office functions in order to redirect clinical and other essential resources closer to the front-line where they are needed most.

13. Further details on the reasons to merge can be found in the appended copy of the stakeholder consultation document.

14. Details of the NHS England process for CCG mergers can be found online here - https://www.england.nhs.uk/publication/procedures-for-clinical-commissioning-groups-to-apply-for-constitution-change-merger-or-dissolution/

Recommendations

15. The Board are asked to:
    i. Note the application in May 2019 from the Nottingham and Nottinghamshire CCGs to NHS England to commence the process to merge by April 2020.
    ii. Note the commencement of the stakeholder consultation on this proposed merger on 21 May 2019.
    iii. Agree to write collectively as ICS leaders to the Accountable Officer of the CCGs confirming the ICS's support for this proposed merger.

Consultation Document

Future arrangements for NHS commissioning across Nottingham and Nottinghamshire

Ensuring everyone in Nottingham and Nottinghamshire has the best possible health and wellbeing

We can provide this document in other languages and formats, such as Braille and large print, on request. Please telephone 0800 028 3693 or email Ncccg.patientexperience@nhs.net for more information.

About this Consultation

This consultation is jointly led by the six NHS Clinical Commissioning Groups (CCGs) across Nottingham and Nottinghamshire. We are collectively considering the future of commissioning arrangements for the area we serve and would like to invite views from key stakeholders on the options available.

This consultation is aimed at stakeholders who work closely with commissioners and would be impacted by the proposed new structure and governance arrangements. However, the consultation paper is a public document and we would welcome feedback from anyone with an interest in the proposals. For the purposes of this consultation, our key stakeholders include:

- Member GP Practices
- Local clinicians
- Healthwatch and other patient representative bodies
- Voluntary and community services
- Local authorities
- Other healthcare partners
- CCG Staff
- Local decision makers

What is not included

This consultation is about commissioning arrangements only. It does not relate to any other NHS organisation or NHS-funded services, such as hospitals, mental health organisations, or primary and community care, and will not affect the funding they receive from us.

This proposal is specifically about the future of the six Nottinghamshire NHS CCGs described on page 4. It does not consider Bassetlaw in the north of Nottinghamshire and so does not include Bassetlaw CCG. This is because this particular area will remain part of the South Yorkshire and Bassetlaw healthcare system.

Contents

Introduction

Dear Colleague,

We are consulting on a proposal to change the future of commissioning for Nottingham and Nottinghamshire.

You will be aware that we have been working in closer alignment since the area became one of the first-wave of Integrated Care Systems (ICSs) nationally in 2017.

Over the past year, we have engaged with member GPs, local clinicians, healthcare partners, patient representative groups and others in exploring how our six CCGs can work more efficiently and effectively across the healthcare system.

We are forming a single joint leadership team and will begin a wider internal reorganisation during the summer this year.

We believe that our natural next step should be to establish one single organisation. We also need to make sure our valuable resources are used in the best way to support people in living longer, happier, healthier and more independently into their old age. We would like to seek your views and opinions about our proposal to merge, before making a formal application.

Whatever our future form, our main focus will remain on ensuring that everyone living in Nottingham and Nottinghamshire has the best health and wellbeing they can. To achieve this we will work together, alongside our health and care partners, to provide people with access to quality healthcare and reduce the health inequalities that exist today.

This decision will have an impact on how we operate as commissioners and how we work together. We ask that you please take the time to consider our proposal and respond to us with your views by 9am Monday 17th June.

We look forward to hearing from you.

Ever-closer collaboration and integration has been a natural progression for our six CCGs since they were established in 2013

Nicole Atkinson
Clinical Chair
NHS Nottingham West CCG

Thilan Bartholomeuz
Clinical Chair
NHS Newark and Sherwood CCG

James Hopkinson
Clinical Chair
NHS Nottingham North and East CCG

Gavin Lunn
Clinical Chair
NHS Mansfield and Ashfield CCG

Hugh Porter
Clinical Chair
NHS Nottingham City CCG

Stephen Shortt
Clinical Chair
NHS Rushcliffe CCG

Amanda Sullivan
Single Accountable Officer for all six CCGs

Existing commissioning arrangements

Our six CCGs are:

NHS Mansfield and Ashfield Clinical Commissioning Group

NHS Nottingham North and East Clinical Commissioning Group

NHS Rushcliffe Clinical Commissioning Group

NHS Newark and Sherwood Clinical Commissioning Group

NHS Nottingham West Clinical Commissioning Group

NHS Nottingham City Clinical Commissioning Group

How we are structured now

All six CCGs are separate statutory organisations with the same healthcare responsibilities and the need to meet legal and NHS duties.

Over the past five years, CCGs have worked more collaboratively, culminating in two geographical areas:

- Mid Nottinghamshire - 2 CCGs (worked jointly from March 2016)
- Greater Nottingham Clinical Commissioning Partnership (formed April 2018) - 4 CCGs

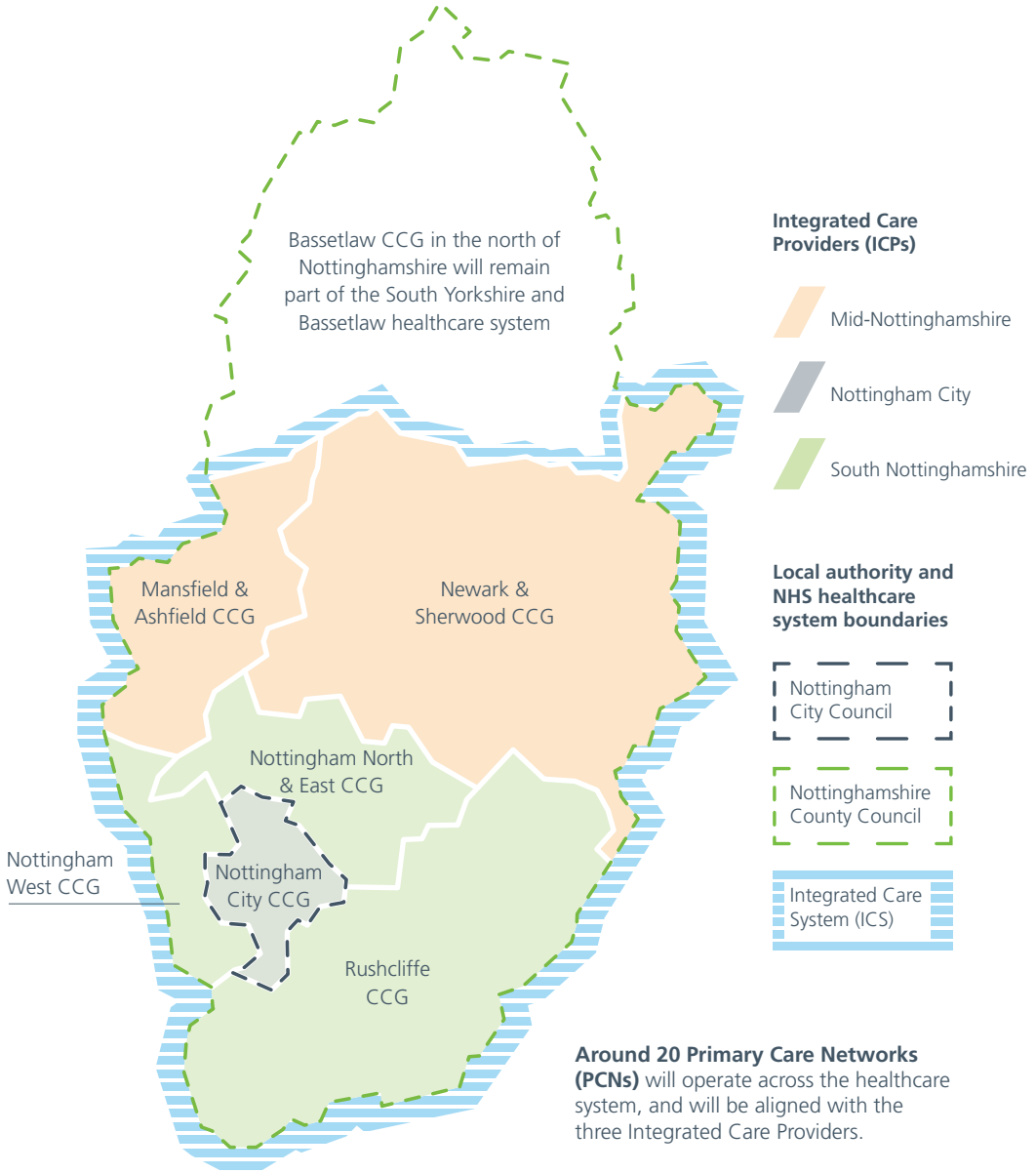
Over the past year, and well before the publication of the NHS Long Term Plan in January 2019, CCGs across Nottingham and Nottinghamshire had already started to consider the potential for a more formal joining up of commissioning arrangements.

In recent months, CCGs have introduced a number of joint arrangements to serve all six CCGs. We now have a single Accountable Officer supported by a single leadership team. Joint committees will soon meet 'in common' and the first joint Governing Body meeting will take place in July 2019. Transitional work is underway both to align wider CCG governance and to bring together staffing structures.

Our boundaries and the areas we serve

The map shows the areas covered by each CCG. It also demonstrates how our boundaries align with those of local authorities and the new Integrated Care System (www.healthandcarenotts.co.uk), which will coordinate healthcare across Nottingham and Nottinghamshire.

Nottingham and Nottinghamshire Integrated Care System (ICS)



Around 20 Primary Care Networks (PCNs) will operate across the healthcare system, and will be aligned with the three Integrated Care Providers.

Introducing our proposal

Each of the Nottingham and Nottinghamshire CCGs has a Governing Body responsible for leading decisions about commissioning with the involvement of member GP practices, local people, partners and other stakeholders. Chaired by a GP, Governing Body members include GPs, lay members, a nurse and a secondary care doctor, as well as non-clinical leaders.

We have discussed the possibilities for future commissioning arrangements openly with many organisations, groups and individuals over the past year, including member GPs, local authorities, voluntary services, hospitals and other healthcare partners.

These conversations have directly helped to shape our thinking, including the preferred proposal to merge. We understand that our stakeholders are supportive of a solution which paves the way for closer integration and better partnership working, enables more strategic commissioning, reduces administration costs, and releases valuable resources to focus on services and initiatives closer to the front-line.

All six CCG Governing Bodies agreed in April 2019 that our preferred way forward would be to fully merge, but no decisions have yet been taken and we remain open to the views of our key stakeholders. This document describes the merger proposal and explains why we have identified this as being the appropriate next step.

Our Proposal: Apply to merge the CCGs

A clear vision

Our overall commissioning aim is to enable people living across Nottingham and Nottinghamshire to have the best health and wellbeing they can.

To achieve this, we must work effectively with all our partners across the entire area to provide people with consistent access to quality healthcare. At the same time, we must also respond to the needs of specific populations and neighbourhoods so that we can reduce the health inequalities that exist today.

We therefore need to be able to operate at a 'system' level across the entire geographical area, as well as maintain our focus on more specific, local healthcare requirements.

The arrangements we put in place for commissioning should be fit for the future and be affordable and sustainable in the longer-term.

Merging to create opportunity

All six CCG Governing Bodies agreed in April 2019 that a merger represents the best opportunity for us to improve health and wellbeing across the areas we serve, as well as redirect clinical and other essential resources closer to the front-line where they are most needed. Delivering better health outcomes, reducing health inequalities, and improving the quality and consistency of local healthcare services are at the heart of our proposal. Whilst changes underway to the NHS around us are important and complement what we are proposing, they are not the primary reason why we feel a merger is the right thing to do.

Duplication ties up valuable resources

At present, the six CCGs do things multiple times – and often differently – across Nottingham and Nottinghamshire. We have the opportunity to reduce duplication, increase our consistency of approach (but not when differences are appropriate) and free up valuable resources, inlcuding clinical time, expertise and development support.

The NHS is changing around us

More widely, the NHS across England is developing to respond to the changing needs of the population. Like elsewhere, across Nottingham and Nottinghamshire we will soon see the creation of new organisations and partnerships. These aim to support health and care organisations in working more effectively together to deliver and improve services, from neighbourhood level all the way up to county-wide.

New Primary Care Networks and Integrated Care Providers will take on some of the existing responsibilities of our six CCGs, for example, leading the transformation of care pathways and creating a more comprehensive, personalised offer for local healthcare. Click here for more information.

Regardless of whether we merge or stay as we are, we believe we must give these new arrangements the best opportunity to succeed in delivering the best health and care services for our local population.

Top 5 benefits of merging

There are many advantages to merging our six CCGs. These will benefit - either directly or indirectly - patients and local people, GPs and other clinicians, health and care partners and many others. Here are the top five reasons why we believe we should combine our CCGs into one single, statutory commissioning organisation.

A full merger would allow us to provide:

1. Better healthcare and health outcomes	Align with health and care partners across the system in order to address health inequalities and ensure consistency of services where appropriate.
2. Better use of clinical and other resource	Save precious clinical time and resources that can be invested into tackling community health priorities via the new Primary Care Networks.
3. Stronger, consistent commissioning voice and leadership	Provide a stronger clinical voice in strategic decisions about health and care services, as well as at neighbourhood level via Primary Care Networks.
4. Greater support for transformation and local innovation	Scale-up the most successful local clinical innovations to rapidly share best practice across a wider area.
5. Significant administrative savings	Reduce duplication in back office functions in order to redirect clinical and other essential resources closer to the front-line where they are needed most.

These benefits are explained in more detail on pages 14-15 in the supporting information section

Other benefits include:

- More control over defining and creating the health system we need and want for the population
- Greater buying power with the ability to deliver better value for money
- Better opportunity to attract, afford and retain staff with the right talent and skills
- Would help achieve a better balance between standardisation and personalisation of care across the area
- Taking forward the best practice from individual CCGs and agreeing common approaches to increase consistency and quality of care
- Making it easier for health and care partners to engage and work with us
- Meets the NHS Long Term Plan requirements
- More affordable so more likely to be sustainable in the longer-term

Why we don't think we can stay as we are

NHS Long Term Plan

The system continues to change around us and we need to adapt. The NHS Long Term Plan sets clear expectations for the next generation of commissioning organisations. These include typically having a single commissioner within each healthcare system and one set of commissioning decisions. Staying as we are would not directly align with the national direction for the NHS.

Duplication and sustainability

We have made some savings by implementing joint arrangements across our CCGs. However, each CCG is a separate legal entity and it costs significantly more to service all six organisations than it would a single body.

Harder to focus on healthcare needs at a local level

The new Primary Care Networks and Integrated Care Providers will take on our existing responsibility to develop personalised care services which meet healthcare needs at neighbourhood level. Their work will directly inform our commissioning plans and activities.

In fact the new arrangements of one single CCG taking strategic decisions across the whole area and smaller PCNs at local level would directly lend themselves to having an even closer local focus, whilst at the same time enabling more effective commissioning of services across the entire geography.

We believe that by supporting, and working with these networks and alliances, we have an opportunity to strengthen our existing approach to commissioning for specific populations and communities.

We already have in place arrangements to engage and involve local people, clinicians, partners and others in the development of our commissioning plans. Over the coming weeks we are creating a new communications and engagement strategy with the aim of building on the good practice of today.

Running costs of six CCGs versus one

If we continue to run multiple CCGs the costs incurred will be much higher than having one streamlined organisation. The time and money spent on governance arrangements and essential statutory duties e.g. annual reports that could be invested in delivering care for patients.

Furthermore, with the shared arrangements we already have for leadership and governance, many of the collaborative arrangements we would need are already in place. Not proceeding to the next logical step of merging would mean that the momentum and progress on delivering better health for the people of Nottingham and Nottinghamshire would be lost.

The new Primary Care Networks and Integrated Care Providers will take on our existing responsibility to develop personalised care services which meet healthcare needs at neighbourhood level.

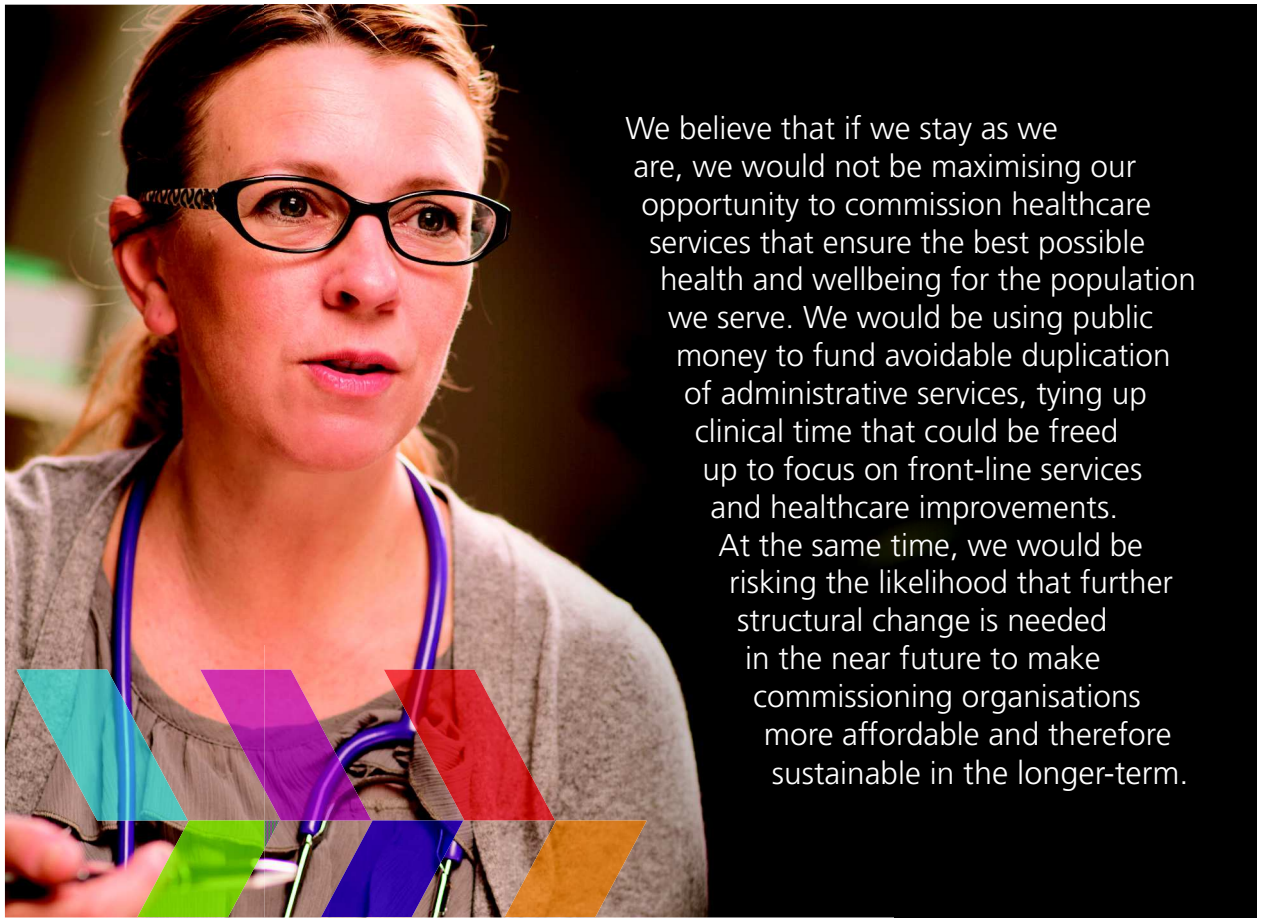
Why we don’t think we can stay as we are

Improving clinical leadership, involvement and engagement

At present, the six CCGs employ clinical leaders and clinical staff, and involve and engage many more GPs and other local clinicians. A single organisation would not require as much clinical resource and would encourage the streamlining of related programmes and activities.

A significant proportion of these clinical resources are tied up in duplicate activity as well as in the administration of the CCG itself.

If the decision to proceed to merger is not taken then this valuable clinical resource will continue to be invested in CCG administrative responsibilities rather than seeing patients on the front line, where they are most needed.



We believe that if we stay as we are, we would not be maximising our opportunity to commission healthcare services that ensure the best possible health and wellbeing for the population we serve. We would be using public money to fund avoidable duplication of administrative services, tying up clinical time that could be freed up to focus on front-line services and healthcare improvements. At the same time, we would be risking the likelihood that further structural change is needed in the near future to make commissioning organisations more affordable and therefore sustainable in the longer-term.

How to share your views

This consultation ends at 9.00am on Monday 17 June 2019. So that we can fully consider your views when we finalise our proposals, your feedback must be received by this time.

Over the next few weeks, senior representatives from the CCG will be meeting with GP member practices and other stakeholders, and we will be involved in a number of other events and activities. For more information, please visit our website:

www.nottinghamnortheastccg.nhs.uk/nhs/ccgs-merger/

Please share your views by:

- Completing our online survey ***www.surveymonkey.com/r/ProposedCCGMerger***
- Responding to the questions on page 11 and sending your answers to us
- Downloading the question and answer sheet from our website and sending the completed document to us by:

  Email: ncccg.patientexperience@nhs.net

  Post (no stamp required):
  Freepost RTGE-CRAT-BABH
  NHS Mansfield & Ashfield CCG
  Birch House
  Mansfield
  NG21 0HJ

If you need help or have any questions about this consultation, you can email us (see left) or call on 0800 028 3693. This includes if you would like to attend an event, require translation services, need us to post information to you or require help with the online questionnaire.

We would encourage you to complete the consultation questions online if you can.

This approach makes it easier to process feedback and compare the views of different groups. The online consultation questionnaire can be accessed from anywhere provided that you have a suitable device with an internet connection.

You will have the opportunity to share your views openly as well as being asked a number of specific questions. You don't need to answer all the questions if you don't want to.

www.surveymonkey.com/r/ProposedCCGMerger

Consultation questions

The questions we are asking in relation to this consultation are:

Q1

To what extent do you support our proposal to merge the six CCGs and create a single commissioning organisation?

Please explain your answer

Q2

To what extent do you support keeping the CCGs as they are now?

Please explain your answer

Q3

Is there anything else you think the CCGs should consider when discussing future arrangements for commissioning?

What happens next

Finalise proposals

We will formally consider the feedback we receive from you during our joint Governing Board meeting on 4 July 2019. Stakeholder views will directly inform our decision as to whether to make a formal application to merge.

NHS England review

If the agreed option is to merge, an application would be made to NHS England for approval. This is the organisation that leads the National Health Service (NHS) in England and is responsible for overseeing our commissioning activities.

NHS England will be particularly interested in the feedback we receive from you. They will want to make sure that our proposed plans are appropriately supported by our key stakeholders, in particular, GP member practices, Healthwatch and healthcare partners. They will also want to make sure that we have effective plans in place to ensure effective clinical leadership as well as ongoing engagement with local people, clinicians and other stakeholders in any new arrangements.

Responding to stakeholder feedback

We have appointed independent parties to evaluate the responses we receive. Their report will summarise what key stakeholders have told us and we will share this on our website. We will discuss feedback in Governing Body meetings and other forums, and will respond formally to the feedback we receive.

Latest news and information

Please visit our website where you will find the latest news and information about this programme of work.

www.nottinghamnortheastccg.nhs.uk/nhs/ccgs-merger/

You can also contact us if you have any queries about the consultation – please see details on page 10.

Timescales

Should we agree to merge and NHS England accepts our proposal, the single CCG organisation would be in place from 1 April 2020. In the meantime, we will make the various organisational changes that need to be made in readiness and will engage with key stakeholders to inform this work.

If we decide not to make an application for merger, we will continue to implement existing plans for closer collaboration between CCGs and will discuss how we can work in the most effective way with the emerging arrangements across the new Integrated Care System.

Supporting Information

The following pages provide further detail about:

- Top 5 merger benefits explained
- The new NHS arrangements and where commissioning will sit
- Plans underway to deliver essential CCG requirements or 'must-haves' in the future

Top 5 benefits of merger explained

There are many advantages to merging our six CCGs. These will benefit - either directly or indirectly - patients and local people, GPs and other clinicians, health and care partners and many others. Here are the top five reasons why we believe we should combine our CCGs into one single, statutory commissioning organisation.

A full merger would enable:

1. Better healthcare and health outcomes

Being a single commissioner would complement emerging developments within the NHS arrangements around us, in particular the Integrated Care System (ICS), Integrated Care Providers and Primary Care Networks (find out more here). Our boundaries would mirror the ICS footprint and align with local authority boundaries (view here).

By structuring ourselves in the best way to enable health and care partners across the system to work more effectively and efficiently together, we would provide the best opportunity to improve healthcare, tackle health inequalities and ensure consistency of services in terms of quality and availability across Nottingham and Nottinghamshire.

2. Better use of clinical and other resource

Through the new Primary Care Networks and Integrated Care Providers, GPs and other healthcare providers will focus on developing and delivering services to meet healthcare needs in their neighbourhoods, whilst still being involved in strategic commissioning through their membership of the CCG.

Duplicating commissioning activities, particularly where clinicians are involved, uses valuable time and resources, which could be freed up to deliver and support front-line services where they are most needed.

3. Stronger, consistent commissioning voice and leadership

As a single body we would provide a stronger, single and more consistent commissioning vision, leadership, voice and approach for the Nottingham and Nottinghamshire health and care system. Clinical leadership would have a greater impact, with consistent decision-making and more clinical efficiency at a system-level, as well as within neighbourhoods through Primary Care Networks.

"A single CCG would remain a clinically-led, GP membership organisation. Strong clinical leadership, together with the involvement of local people, clinicians and partners, remains an absolute priority."

Top 5 benefits of merger explained

4. Greater support for transformation and local innovation

Working across the system to implement a single, cohesive strategy, accompanied by speedier decision-making, would enhance the pace at which transformation can be achieved. We could therefore deliver better patient health outcomes more quickly and effectively, and improve the consistency of services as well as our approach to commissioning.

Front-line clinicians would be able to innovate locally to deliver our strategy consistently within and across neighbourhoods, with best practice properly supported, identified and applied more rapidly across a wider area.

5. Significant administrative savings

Having a single organisation would eliminate duplication of administrative support functions like finance, payroll and procurement. The significant savings made would be better channelled into addressing priority activities which deliver real benefits for local healthcare, rather than serving the CCG organisations themselves.

CCGs have to make a 20% saving in running costs by 2020/21*. At present, this would need to be applied to each of the six CCG budgets. Reducing duplication through merger would make a significant contribution towards this saving. Furthermore, by pooling together, we could collectively address the target in a more innovative and effective way, ensuring ongoing funding for the commissioning activities we need the most.

* The 20% cost savings are to be applied only to CCG administration costs. Patient services, such as hospitals, GPs and community services, are not part of CCG running costs and will NOT be affected.

Other benefits include:

- More control over defining and creating the health system we need and want for the population
- Greater buying power with the ability to deliver better value for money
- Better opportunity to attract, afford and retain staff with the right talent and skills
- Would help achieve a better balance between standardisation and personalisation of care across the area
- Taking forward the best practice from individual CCGs and agreeing common approaches to increase consistency and quality of care
- Making it easier for health and care partners to engage and work with us
- Meets the NHS Long-Term Plan requirements
- More affordable so more likely to be sustainable in the longer-term

‘Must-Haves’

Our ‘Must-Haves’

Regardless of the future arrangements for commissioning, there are a number of ‘must-haves’ that we are committed to delivering. Although they do not form part of this consultation because we need to do them anyway, we recognise that they are likely to be of particular relevance to our GP members.

We must have:

- ✓ The ability to deliver our commissioning ambitions and responsibilities effectively and as quickly as possible, both at neighbourhood level and across the entire geography we serve
- ✓ Strong clinical leadership and involvement in the new arrangements (find out more here)
- ✓ Effective engagement with local people, clinicians, healthcare partners and others to inform commissioning decision making and activities from neighbourhood lto system-wide levels (find out more here)
- ✓ An ongoing focus on the health and care needs of neighbourhoods or specific populations, as well as a strategic focus across Nottingham and Nottinghamshire (find out more here)
- ✓ A single commissioning vision with strategic priorities and health outcome goals at system, place and neighbourhood levels
- ✓ The best opportunity to work effectively with our partners and pave the way for better integration of health and care services
- ✓ The ability to deliver both the 20% savings in CCG running costs* by 2020/21, and restore financial balance across the system in the foreseeable future

* Running costs relate to the administration of the CCG organisation itself, e.g. payroll, finance and procurement. They do not include patient services, which are covered by a separate budget and which will not be affected by this consultation.

‘Must-Haves’

Regardless of the future arrangements for commissioning, there are a number of ‘must-haves’ that we are committed to delivering. As well as asking for your response to this consultation, we welcome views on how we can enable these ‘must-haves’ to happen.

Must-Have 1: Clinical leadership and involvement

Strong clinical leadership and involving clinicians in making healthcare decisions are essential aspects of commissioning. All GP practices are members of a CCG and have a say in what, and how, local NHS services are provided. None of this will change, even if we become a single commissioning organisation.

As well as GPs, we also involve clinicians from hospitals, mental health and community services, and other care settings in our decision-making. Listening to, and learning from, the experiences of front-line clinicians helps us to commission better services for local people in the long-term.

We believe that the good work taking place within CCGs to involve clinicians must not only continue, but be strengthened in any new arrangements. Our GP clinical chairs are developing plans to make sure this happens, and which include:

- CCGs will continue to be clinically-led. Depending on the outcome of this consultation, several GP leaders, a nurse and a secondary care doctor would sit on either an overarching Governing Body, or on a joint committee representing each CCG (as they do now). Our supporting CCG committees will maintain strong clinical involvement, with members including GPs, pharmacists and Allied Health Professionals
- We are working with partners to ensure leadership by, and the involvement of, GPs and other clinicians within the new ICS, ICP and PCN arrangements. Each PCN will be led by a designated Clinical Director
- We will create a specialist clinical group or ‘cabinet’ across Nottingham and Nottinghamshire to provide clinical advice and scrutiny of developments within care pathways and other significant programmes of work
- We will combine similar programmes of clinical work underway across CCGs, e.g. urgent care, cancer or end of life, with each programme led by a senior clinician

If you would like to help shape our thinking around clinical leadership and engagement, including how we can nurture diverse, compassionate and inclusive leadership, please share your views and these will be forwarded to the senior clinical team overseeing this work.

Key question:

How can we ensure ongoing clinical leadership in any future commissioning arrangements, and how can we strengthen what we do already?

Must-Have 2: Effective engagement

Regardless of what our future organisational arrangements look like, we remain committed to engaging and involving our key stakeholders in our commissioning activities.

As happens now, the Governing Body of a single CCG would include patient representatives (lay members) and clinical leads including a GP Clinical Chair, other GPs, a nurse and a secondary care doctor. We would also continue to strengthen and build upon our arrangements for involving and engaging local people, clinicians, CCG staff, partners and others in our everyday activity, which include patient participation groups, patient and public engagement committees, lay member representation and other events and activities.

‘Must-Haves’ (continued)

Effective engagement (continued)

By introducing an Integrated Care System and three Integrated Care Providers which mirror local authority boundaries overall, our partners should find the NHS across Nottingham and Nottinghamshire much more accessible and easier to work with. Furthermore, services delivered by partners at a neighbourhood level, e.g. voluntary services and social care, will be able to work more closely with NHS providers through the Primary Care Networks.

Over the next few weeks we will be refreshing our communications and engagement strategy and will be involving our various stakeholders in doing so. The strategy will include plans for strengthening our approach to engaging with patients, GPs, partners and others, whether as six separate organisations or as a single commissioner. Although not part of this particular consultation, we would welcome your views on how we might achieve this.

Key question:

How can we strengthen our arrangements to involve local people, GPs, other clinicians and healthcare partners in future commissioning activities?

Key Must-Have 3: Ensuring a focus on the health and care needs of neighbourhoods or specific populations, as well a strategic focus across Nottingham and Nottinghamshire

The Primary Care Networks and the three Integrated Care Providers have an essential role to play in understanding, recommending and delivering the services needed at a local level. Based on clinical evidence and experience at a local level, their recommendations will directly inform our commissioning strategy across Nottingham and Nottinghamshire. In turn, PCNs and ICPs will deliver our commissioning aims at a local level, personalising services as required both within and across their neighbourhoods.

Because more clinicians and other healthcare providers will work together to inform services in a specific area, we believe that there will be a far better opportunity to get services right locally.

As a single commissioner with oversight of all these needs, we would also be able to identify where needs are the same across different areas. This means that we can plan and buy unique services for specific neighbourhoods or populations. We can also ensure that consistent services are available across all areas where needed.

As part of our communications and engagement arrangements, we ensure that we listen to, engage and communicate with neighbourhoods and communities across the area we serve. Through patient participation groups, patient and public engagement committees and groups, lay member representation and various events and activities throughout the year, we ensure that patients have a strong voice and are able to help shape our strategies, plans and activities both within neighbourhoods, and across the area we serve.

Regardless of our future organisational form, we remain committed to this type of engagement and will continue to build upon what we do already.

Key question:

What else should a strategic commissioner do to ensure a continuing focus on health and care needs at a local level?

New and emerging NHS arrangements

The NHS is changing around us to meet the developing needs of people living across England, whilst making better use of public funds. These changes are aimed at achieving greater consistency in the quality and availability of healthcare services, and to address health inequalities. They will also streamline healthcare activities, enabling commissioners to do what they do best, e.g. assessing needs and setting meaningful outcomes, whilst supporting providers in doing what *they* do best, e.g. innovating and delivering personalised care solutions to the people they serve.

The new nationwide arrangements will help NHS organisations to take a more strategic view of healthcare across a wider population, to identify common areas of health need and to address them collectively instead of doing things many times and differently. People will find it easier to gain access to healthcare services that both meet their needs and are consistent across the wider area. In turn, this will help address the 'postcode lottery' where some people do not have access to the same services because of where they live.

Our new Integrated Care System (ICS) will bring together NHS organisations, local authorities, voluntary services and other key partners within Nottingham and Nottinghamshire. With a strategic view across the entire geography, the ICS will focus on achieving the best possible health and care services for the entire population, as well as for specific populations and neighbourhoods.

At the same time as enabling a more strategic approach, the changes support a greater clinical focus on healthcare within specific neighbourhoods through the creation of Primary Care Networks (PCNs). The PCNs across Nottingham and Nottinghamshire will in turn be aligned to one of three Integrated Care Providers to collaborate across a wider area in delivering and improving healthcare services.

The changes also aim to make the NHS more efficient and effective by reducing unnecessary duplication and by placing clinical and other valuable resources closer to the front-line.

More about the new arrangements being set up across Nottingham and Nottinghamshire can be found overleaf.

You can find out more about nationwide NHS developments, why they are being made and what they aim to achieve in the *NHS Long Term Plan*, available on the following website: **www.longtermplan.nhs.uk**

Locally, our commissioning priority is to ensure that everyone living in Nottingham and Nottinghamshire has the best possible health and wellbeing they can. We believe the new NHS arrangements being introduced across our area will help us to achieve this. We want to give them every opportunity to succeed and recognise that we will need to adapt the way in which we work if we are to make this happen.

Having explored the various options, we believe that the new arrangements would benefit most from having a single commissioning organisation.

An overview of new NHS arrangements for Nottingham and Nottinghamshire

Primary Care Networks (PCNs) - NEIGHBOURHOODS

As well as having a view of healthcare across the overall area, it is equally essential that we maintain our focus on local needs within a specific neighbourhood or population. Primary Care Networks (PCNs) are being set up to do exactly that. Around 20 new PCNs will be set up across our area so that organisations providing healthcare services at a local level can work even better together.

PCNs will consist of groups of general practices working together with a range of local providers, including primary care and community services, mental health, social care and the voluntary sector. Through these networks, local health and care providers will focus on delivering more personalised, coordinated health and social care to meet the needs of their particular neighbourhood.

PCNs will be led by clinicians and will be appropriately funded, resourced and supported. They will be aligned to one of three Integrated Care Providers (ICPs) according to their geographical location.

Integrated Care Providers (ICPs) - PLACE

All PCNs will belong to one of three Integrated Care Providers (ICPs). These will serve wider populations living within the geographical areas of Nottingham City, Mid-Nottinghamshire* and South Nottinghamshire**. These areas reflect local authority boundaries overall, and build on existing collaborations and alliances which have proven to work well.

ICPs are alliances of health and care providers, including PCNs, that will work together to deliver care by agreeing to collaborate rather than compete. They will be responsible for the cost, quality and consistency of services for the population they oversee. They will develop better pathways of care for patients and more effective ways of working together. Like PCNs at a neighbourhood level, ICPs will inform commissioning decisions relating to the area they serve.

* Mid-Nottinghamshire: Ashfield, Mansfield, Newark and Sherwood
** South Nottinghamshire: Broxtowe, Gedling and Rushcliffe

Our Integrated Care System (ICS) - SYSTEM

The NHS is not the only body that plays a key role in influencing and responding to people's health and wellbeing. For example, local authorities are a major partner because they provide social care, public health and other services which influence the health and wellbeing of the population. Other important partners include voluntary services and the independent sector.

Under the new changes, NHS, local authorities and other key organisations will form a partnership across a designated geography, called an 'Integrated Care System' or 'ICS'. Locally, our ICS covers the geography of Nottingham and Nottinghamshire excluding Bassetlaw, which is historically aligned to services within South Yorkshire. Together, partners within the ICS will focus on ensuring the best possible health and care services both across the entire area, as well as for specific populations and neighbourhoods.

An ICS organisation will provide clinical and administrative expertise to support health and care partners in working together effectively across the area. It will also take the lead on workforce planning and play a regulatory role.

Responsibilities of new organisations and alliances

SYSTEM:
Nottingham and Nottinghamshire Integrated Care System (ICS)

Population: 1 million+

Partner organisations work together to oversee health and care across Nottingham and Nottinghamshire

Key responsibilities:

- Respond to ICP and PCN feedback and recommendations, and set the healthcare strategy for the system to include expected health outcomes
- Improve local health and wellbeing across the entire area and at neighbourhood level
- ***Strategic Commissioning (clinically-led)****
- Manage resources and workforce planning
- Coordinate health and care partnerships
- Regulation

This is where future commissioning arrangments will fit

PLACE:
Three Integrated Care Providers (ICPs)

Population: 330,000 - 700,000

Health and care providers collaborate across the geography (place) they serve

Key responsibilities:

- Oversee the cost, quality and consistency of services
- Develop better pathways of care and more effective ways of working together
- Inform commissioning decisions
- Deliver commissioning strategies and plans
- Tailor healthcare where appropriate to meet needs within their place

All PCNs will be aligned to one of the three ICPs

NEIGHBOURHOOD:
Primary Care Networks (PCNs*)

Population: 30,000 - 50,000

GPs work with social care, pharmacists, mental health and other local health and care providers to focus on services within their neighbourhoods

Key responsibilities:

- Deliver coordinated health and care services within their neighbourhood
- Personalise services on their doorstep to meet specific local needs
- Innovate locally to deliver and inform commissioning decisions and plans
- Encourage, represent and respond to the local patient voice

Each PCN will be led by a clinical director

*The number of patients in each PCN is flexible depending on the locality. There will be around 20 PCNs across the area. This is subject to discussion and agreement in May 2019.

How does commissioning fit within new NHS arrangements?

Whether as a single organisation or through joint arrangements, CCGs must both meet the national criteria, and deliver the system requirements as effectively as possible.

We believe that a single, strategic commissioning organisation would have the best opportunity to make this happen. Furthermore, we would be supporting the delivery of care closer to home by reducing duplication and moving valuable resources closer to the front-line, as well as by supporting the collaboration of primary, secondary and community care providers.

The Long Term Plan clearly sets out the expectations for local commissioning, and signals significant changes to the role that commissioners will play within their health and care system.

Key aspects can be summarised as follows:

- Typically, there will be a **single commissioner** within each ICS area
- Every ICS is expected to enable a **single set of commissioning decisions** at system level
- CCGs must become **leaner, more strategic organisations** that support providers in partnering with local government and other community organisations
- Working through the ICS, commissioners will make **shared decisions with providers** about using resources, designing services and improving population health
- Commissioners will be exclusively **responsible for certain decisions,** e.g. procurement and the awarding of contracts
- **Streamlined commissioning** arrangements across the ICS footprint are essential

Although arrangements for the Nottingham and Nottinghamshire ICS are still emerging, a number of requirements have already been agreed for the role of a future strategic commissioner.

These are:

- **Commissioning for outcomes** within and across neighbourhoods through the development of ICP contracts and PCNs
- Commissioning the **transformation of services,** designing and delivering large-scale change in conjunction with partners
- Overseeing and mitigating any **quality and equality impacts** of service change
- Providing **professional leadership** across the system (nursing, therapies, pharmacy, linking general practice with secondary care)
- Driving the **personalisation agenda** whereby services are tailored to specific needs
- Agreeing a long-term system **financial strategy for the system,** including achieving financial balance
- Delivering a 20% **reduction in commissioning running costs** by 2020/21

Glossary

CCG	Clinical Commissioning Group
ICS	Integrated Care System
ICP	Integrated Care Provider (Three within Nottingham and Nottinghamshire healthcare system)
NHS England	The organisation that leads the National Health Service (NHS) in England and is responsible for overseeing our commissioning activities.
PCN	Primary Care Network (there will be around 20 across Nottingham and Nottinghamshire)

Integrated Care System
Nottingham & Nottinghamshire

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ENC. I

Meeting:	ICS Board
Report Title:	Mid Nottinghamshire Integrated Care Provider Update – June 2019
Date of meeting:	Thursday 13 June 2019
Agenda Item Number:	12
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 receive
☐ To approve the recommendations

Recommendations:

Key implications considered in the report:

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

Engagement to date:

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

Contribution to delivering the ICS high level ambitions of:

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

Is the paper confidential?

☐ Yes
☒ No

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

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Mid Nottinghamshire Integrated Care Provider Update

13 June 2019

1. The Mid Nottinghamshire (Mid Notts) ICP Board met formally for the first time on May 14 2019. This was also the first meeting for the newly appointed independent Chair Rachel Munton. The key items discussed were:

2. **Health inequalities across the ICP**
   Jonathan Gribbin, Director of Public Health at Nottinghamshire County Council presented information on the health and wellbeing of residents across the ICP geography followed by discussions about how the ICP might effectively address these as a system. Data broken down to a PCN level will be presented at the next meeting in order to have fuller place-based conversations and agree next steps and actions.

3. **ICP Transformation Monies**
   Paul Robinson, ICP Finance Lead, gave an update on the £1.5m allocated to the Mid-Nottinghamshire ICP from the ICS and a discussion took place on how this money could be used to support transformation across the ICP. ICP partners will work on this outside of the Board meeting so that a full ICP plan on effective use of the sum can be taken to the June ICS Board.

4. **Transition from Better Together Board to Mid-Nottinghamshire ICP Board**
   It was agreed to formally transition from the Better Together Board to the Mid-Nottinghamshire ICP Board. The necessary adjustments to membership and updated Terms of Reference will be worked through, including the location for business and governance aspects of the Better Together Board that will no longer be considered at this meeting. Thanks were given to those who had given their support to the Better Together Board as a strong foundation on which to build.

5. **Developing an ICP strategy and identity**
   It was agreed to work with partners in the ICP to use existing organisational strategies and plans to identify areas of commonality to form a set of strategic ICP intentions. This will also reflect upcoming results from the engagement on the Long Term Plan and the anticipated ICS five year plan in Autumn 2019. The formation of a consistent 'identity' for the ICP - a narrative about what the ICP is, and what it will achieve is critical.

6. Feedback from attendees suggested this was an excellent start to the ICP, where the enthusiasm must now be capitalised upon in order to improve the lives of those who live and work in Ashfield, Mansfield, Newark and Sherwood.

7. The next ICP Board is due to meet on Tuesday, 11 June.

Richard Mitchell
Chief Executive, Sherwood Forest Hospitals NHS Foundation Trust
richard.mitchell2@nhs.net
13 June 2019

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ENC. J1

Meeting:	ICS Board
Report Title:	2019/20 System Operational Plan (NHS)
Date of meeting:	Thursday 13 June 2019
Agenda Item Number:	13
Work-stream SRO:	Wendy Saviour
Report Author:	Helen Pledger/Tom Diamond
Attachments/Appendices:	Enc. J2 Elective Care Transformational Plans

Report Summary:

2019/20 Operational Plan Submission (NHS)

The ICS Board received the draft 2019/20 Operational Plan and Overview on 1 April. The April submissions have been reviewed by NHS England and NHS Improvement and organisations were asked to submit a final 2019/20 Operational Plan on 15 May 2019.

In addition, the ICS submitted a 2019/20 planning and contract alignment return on the 23 May 2019.

This paper updates the ICS Board on the changes included in the May submissions for finance, activity and operational performance.

2019/20 Transformational Plan – Elective Care

The ICS is required to submit an Elective Care Transformational Plan for 2019/20 to NHS England and NHS Improvement (Appendix 1). A draft plan is required for 28th June and final plan for 28th July.

This paper proposes an approach which will allow the ICS to complete the plan in line with the national timetable. If the approach is agreed, the ICS Board will receive an update on the final plan submission and agreed governance approach in August.

Action:

☒ To receive
☒ To approve the recommendations

Recommendations:

1.	The ICS Board is asked to NOTE the changes to the System Operational Plan (NHS) following the re-submission of organisational plans in May 2019.
2.	The ICS Board is asked to NOTE that further work is underway to develop Transformational Plans to meet the 2019/20 savings and efficiency requirement, with oversight at the ICS Planning Group and ICS Financial Sustainability Group.

3.	The ICS Board is asked to NOTE that the NHS Operational Plan will be consolidated with Local Authority Plans to present an overall system position for 2019/20 (ICS and ICP level).
4.	The ICS Board is asked to AGREE that the ICS Planning Group will oversee the development of and approve the 2019/20 Elective care Transformation Plan.

Key implications considered in the report:		
Financial	☒	Report identifies changes in the final submissions of 2019/20 Operational Plans
Value for Money	☒	
Risk	☒	
Legal	☐	
Workforce	☒	
Citizen engagement	☐	
Clinical engagement	☐	
Equality impact assessment	☐	

Engagement to date:

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

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

Is the paper confidential?

☐ Yes
☒ No

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

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2019/20 System Operational Plan (NHS)

3 June 2019

Introduction

1. The ICS Board received the draft 2019/20 Operational Plan and Overview on 1 April. The April submissions have been reviewed by NHS England and NHS Improvement and organisations were asked to submit a final 2019/20 Operational Plan on 15 May 2019. In addition, the ICS submitted a 2019/20 planning and contract alignment return on the 23 May 2019.

2. This paper updates the ICS Board on the changes included in the May submissions for finance, activity and operational performance.

3. The ICS is required to submit an Elective Care Transformational Plan for 2019/20 to NHS England and NHS Improvement (Appendix 1). A draft plan is required for 28th June and final plan for 28th July. This paper outlines a proposed approach.

2019/20 Operational Plan – May Submission

2019/20 Financial Plan

4. The system has submitted an operational plan to deliver a £65.7 million in-year deficit for 2019/20 (System Control Total £67.7 million in-year deficit).

5. The health savings and efficiency requirement for 2019/20 is £145 million (5.2%). Transformational Plans have identified schemes totalling £129 million and work is underway to address the remaining requirement, with oversight at the ICS Planning Group and ICS Financial Sustainability Group.

6. The system has agreed to participate in the 2019/20 incentive scheme, this requires the three NHS providers to re-allocate £4.9 million of provider sustainability funding from organisational (paid on delivery or organisation control total) to system (paid on delivery of system control total). By participating in the incentive scheme the ICS will receive £5 million of flexible transformational funding, ICPs are currently developing plans for the use of this funding. Plans will be presented to the 12 July ICS Board.

7. Funding of capital plans have been updated to reflect cash impact of 2018/19 bonus provider sustainability funding where applicable.

2019/20 Activity Plan

8. Mid Nottinghamshire CCGs have corrected outpatient activity and this now aligns with the Sherwood Forest Hospitals plan.

9. Minor amendments to referral activity levels to ensure alignment across providers and commissioners.

2019/20 Operational Performance

10. RTT waiting list performance has been amended to maintain the March 2019 position.

11. Performance against all other key performance indicators remains as per the April submission.

12. Nottingham University Hospitals are included in a national pilot to review A&E performance metrics.

2019/20 Planning and Contract Triangulation

13. The triangulation return identified two differences between ICS NHS partners following the submission of the latest planning and contract data:

    a. £12.5 million planning difference between Sherwood Forest Hospitals and Mid Nottinghamshire CCGs. This relates to QIPP schemes expected to contracted in year, schemes are currently being developed and taken through ICP structures/processes.

    b. EMAS contract not yet signed; this has now been resolved.

2019/20 Transformational Plan – Elective Care

14. The ICS is required to submit a 2019/20 Elective Care Transformational Plan to NHS England and NHS Improvement (Appendix 1). A draft plan is required for 28th June and final plan for 28th July.

15. It is proposed that the ICS Planning Group oversees the development of and approves the 2019/20 Elective Care Transformational Plan for submission. The ICS Planning Group will:

    a. Ensure that the Elective Care Transformational Plan aligns with the overall 2019/20 System Operational Plan (many elements required in the Elective Care Transformational Plan already form part of the 2019/20 System Operational Plan).
    b. Will review the workstream and governance approach and agree the appropriate approach to complete the plan and take forward the Elective Care work programme (with ICPs).
    c. Ensure that Mid Nottinghamshire and Greater Nottingham Transformation Boards are driving the development of implementation plans and are fully embedded in the agreed approach.

16. This approach will allow the ICS to complete the plan in line with the national timetable. If the approach is agreed, the ICS Board will receive an update on the final plan submission and agreed governance approach in August.

Recommendations

15. The ICS Board is asked to:

A. **NOTE** the changes to the System Operational Plan (NHS) following the re-submission of organisational plans in May 2019.

B. **NOTE** that further work is underway to develop Transformational Plans to meet the 2019/20 savings and efficiency requirement, with oversight at the ICS Planning Group and ICS Financial Sustainability Group.

C. **NOTE** that the NHS Operational Plan will be consolidated with Local Authority Plans to present an overall system position for 2019/20 (ICS and ICP level).

D. **AGREE** that the ICS Planning Group will oversee the development of and approve the 2019/20 Elective care Transformation Plan.

Helen Pledger
ICS Finance Director
3 June 2019
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Tom Diamond
ICS Director of Strategy
3 June 2019
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17.05.2019

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David Pearson
Nottingham and Nottinghamshire STP Lead

Sent via email

Dear David Pearson

STP Elective Care Transformation Plans

I am writing to you to set out the agreed national and regional transformation priorities for elective care in 2019/20 and to request that each STP develops an Elective Care Transformation Plan that draws together all the key elective care transformation initiatives being undertaken within the STP. The plans should include the following workstreams:

- Performance Management
- Reducing Long Waiters
- Theatre Productivity
- First Contact Practitioner
- Ophthalmology (EyesWise)
- Outpatient Transformation
- Capacity Alerts
- Advice and Guidance

Appendix 1 below outlines in more detail the requirements for each priority. It would be helpful to set your initiatives within the context of the broader management of referrals and the delivery of Right Care and GIRFT priorities, and the productivity opportunities identified in the Model Hospital. The Region intends to allocate monies to STPs to aid planning and management of the elective priorities (to be confirmed in due course).

There is no pre-defined format for the plans, but STPs should look to develop short strategic documents with a focused set of actions that can be presented to the relevant STP board or oversight group.

STPs should submit a draft version of their plan by 28 June 2019 to your Elective Care Transformation Lead for review. Final versions should be submitted by 26 July 2019.

The new NHS Midlands Improvement team is keen to support the above priorities through a range of initiatives and will also be targeting support to a number of additional areas including Data Quality & Access, Endoscopy, Outpatient Transformation and Theatres. More detail will be shared in due course.

If you have any queries on this letter, please speak to your Elective Care Transformation Lead.

Yours sincerely

Jeffrey Worrall

Regional Director of Performance and Improvement

Appendix 1 – Regional Elective Priorities for STPs

Performance Management

- Set out the approach to the management of STP RTT waiting lists along with the anticipated impact and benefits.

Reducing Long Waiters

- Actions to ensure that there should be no reportable 52 week waits from Q3 onwards.
- Delivery of a targeted reduction in 40+ week waits by end of Q2 (scale to be agreed with each system)
- Implementation of 6-month choice (as per national guidance due to be published in due course).

Theatre Productivity

- Develop a system theatre productivity improvements plan, including identifying opportunities to share capacity and activity across systems.

First Contact Practitioner for MSK

- Expand current STP pilots to cover a population of circa 150,000.
- Take part in national evaluation processes.
- Develop plans for full five-year rollout across STP.

Ophthalmology (EyesWise)

- Complete actions from the Ophthalmology High Impact Intervention on failsafe prioritisation and clinical audit.
- Ensure that no patients are “Lost to follow up” and that patients are seen within at least 25% of the timeframe for their intended date for follow up.
- Develop implementation plans to follow through on conclusions from Eye Health Capacity Reviews.

Outpatient Transformation

- Implement learning from Elective Care Specialty Handbooks to transform outpatient provision where appropriate and take part in Targeted Transformation work where opportunities arise.
- Develop detailed and phased plans from to deliver on long term plan commitment to reduce face to face OP attendances by 30% by 2023.

Capacity Alerts

- Develop local monthly processes to identify services across the STP that would benefit from Capacity Alerts.
- Ensure that Capacity Alerts are in place in the STP during quarter two.

Advice and Guidance

- Identify areas where Advice and Guidance functionality can be exploited to improve outcomes for patients and reduce demand on secondary care.

ENC. K1

Meeting:	ICS Board
Report Title:	June 2019 Integrated Performance Report
Date of meeting:	Thursday 13 June 2019
Agenda Item Number:	14
Work-stream SRO:	Wendy Saviour
Report Author:	Sarah Bray
Attachments/Appendices:	Enc. K2 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, with further deteriorations in March 2019 and Q1 2019/20.
- Quality, due to performance across Transforming Care and Maternity.

Service Delivery Area	2018/19 ICS Performance		
	No. KPIs	% Not Achieved	% Achieved
Mental Health	10	50%	50%
Urgent & Emergency Care	5	80%	20%
Planned Care	6	33%	67%
Cancer	8	50%	50%
Nursing & Quality	9	22%	78%
Finance	N/A	N/A	N/A
Workforce	N/A	N/A	N/A
Overall Performance Delivery	38	45%	55%

Nottingham and Nottinghamshire ICS - Performance Overview - as at 4th June 2019

Significant improvements have been made across Children's Wheelchairs, which has moved from 61.2% Q4 2017/18 to achievement of 100% Q4 2018/19.

Assurance Framework Overview

Q3 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) - Choices in Maternity Service (3/42) - RTT (3/42) - Dementia Diagnosis (4/42)	**Worst Performing** areas out of the 42 ICSs are: - A&E 4 hour wait (40/42) - Maternal Smoking at time of delivery (38/42) - Cancers diagnosed at an early stage (35/42) - High quality adult social care (34/42)

Action:

☒ To receive
☐ To approve the recommendations

Recommendations:

1.	That the Board note the contents of the report

Key implications considered in the report:

Financial	☒	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	Finance Directors Group	Planning Group	Programme Delivery Group
☐	☐	☒	☐	☐
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.

Integrated Care System
Nottingham & Nottinghamshire

Nottingham City Council | Nottinghamshire County Council | NHS

Integrated Performance Overview

4 June 2019

Red Risks to System Delivery		
RAG	***Performance Issues***	***Actions to Address***
A: Mental Health	***Performance*** concerns relating to: IAPT Access M&A CCG, reductions across Greater Notts CCGs. CYP Access & data capture issues EIP Concordant 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 – remain national outlier on volumes of placements. 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 Service Improvement 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. Executive Mental Health monthly oversight is in place across the ICS, to progress the actions required through the service improvement plans. Mental Health Strategy Implementation Plans are being developed, which will align all actions across Mental Health, and build on learning from areas of good practice. Discussions are ongoing with Health Education England to progress potential barriers to success, including CBT training programmes.
B: Urgent Care	ICS A&E performance remains below target and has marginally increased to 80.43% April 2019 (NUH 66.72%/ SFHT 90.96%) Re-admission rates have increased at both Trusts since February, 11.6% increase SFHT, 6.5% at NUH. EMAS performance has made small improvements over the last 3 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 seen small improvements March and April. Actions to address capacity gaps and front door service redesign continue to be implemented. Weekly executive calls continue to be in place to respond to the pressures across the system. 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 system has submitted plans to deliver the NHS system control total £67.7 million deficit for 2019/20.** **The NHS do-nothing financial gap is £144.9 million (5.2%).**	**The system is able to receive £57.4 million of Provider Sustainability Fund (PSF), FRF and MRET funding as all organisations have accepted their control totals.** Additional deep dive sessions have been held with the planning footprints to further progress the efficiency plans across the system.

Amber Risks To System Delivery		
C: Planned Care	RTT failed to achieve for the ICS 91.7%. Waiting lists remained are over March 2018 levels, however have continued to decrease, to 3.5% (March 19). (NUH -0.3%, SFHT 5.5%). SFHT +52 weeks expected nil at March 19, however NUH had 5 long waiters at the end of March due to patient choice factors. Children's wheelchair waits have significantly improved over the year to 100% delivery Q4.	SFHFT failed to achieve the standard at March 2019 – 89.96%. SFHFT and the CCG are monitoring recovery plans at speciality levels, which include staffing and additional capacity, for recovery 2019/20. SHFT Waiting lists recovery back to March 18 levels was not expected to be achieved by March 2019, due to coding changes within Paeds. The end of year position was as expected. 52+ waits recovery to nil at NUH is expected by Q2 2019/20 due to patient choice factors.
D:Cancer	Cancer 62 performance has reduced further to 79.39% March 2019. (SFHT 88.36% / NUH 73.2%). Backlogs have increased during the month.	The trusts expected performance for April 19 to June 19 is 69-77%, which is a reduction from expected levels. The trusts continue to work through the increased demand, and capacity constraints during the winter period. Recovery is not expected to be achieved before Q2 2019/20.
E. Nursing & Quality	Transforming Care did not achieve 2018/19 trajectory +16 over planned levels. CHC: ICS achieved both QP standards for Q4. LeDeR – There has been an increase in the number of completed reviews to 18% (21). Maternity did not achieve the continuity of carer 20% requirement, for 2018/19. Q4 performance was 2.2%, which is the lowest in the Region. The ICS is assessed by NHSE as 'Requiring Some Support' because of delayed implementation.	TCP remains in regional escalation. Recovery plans are in place, focus on admission avoidance, with refreshed targets having been agreed for 2019/20. 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, with proposals for dedicated resource within each provider to lead the implementation.
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 are asked to note the:

a. Integrated Performance Report and
b. Key risk areas:
   - Urgent Care System delivery
   - Mental Health service and service transformation delivery
   - Financial Sustainability

Sarah Bray
Head of Assurance & Delivery
4 June 2019
sarah.bray6@nhs.net

ENC. K1

Meeting:	ICS Board
Report Title:	June 2019 Integrated Performance Report
Date of meeting:	Thursday 13 June 2019
Agenda Item Number:	14
Work-stream SRO:	Wendy Saviour
Report Author:	Sarah Bray
Attachments/Appendices:	Enc. K2 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, with further deteriorations in March 2019 and Q1 2019/20.
- Quality, due to performance across Transforming Care and Maternity.

Service Delivery Area	2018/19 ICS Performance		
	No. KPIs	% Not Achieved	% Achieved
Mental Health	10	50%	50%
Urgent & Emergency Care	5	80%	20%
Planned Care	6	33%	67%
Cancer	8	50%	50%
Nursing & Quality	9	22%	78%
Finance	N/A	N/A	N/A
Workforce	N/A	N/A	N/A
Overall Performance Delivery	38	45%	55%

Nottingham and Nottinghamshire ICS - Performance Overview - as at 4th June 2019

Significant improvements have been made across Children's Wheelchairs, which has moved from 61.2% Q4 2017/18 to achievement of 100% Q4 2018/19.

Assurance Framework Overview

Q3 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) - Choices in Maternity Service (3/42) - RTT (3/42) - Dementia Diagnosis (4/42)	**Worst Performing** areas out of the 42 ICSs are: - A&E 4 hour wait (40/42) - Maternal Smoking at time of delivery (38/42) - Cancers diagnosed at an early stage (35/42) - High quality adult social care (34/42)

Action:

☒ To receive
☐ To approve the recommendations

Recommendations:

1.	That the Board note the contents of the report

Key implications considered in the report:

Financial	☒	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	Finance Directors Group	Planning Group	Programme Delivery Group
☐	☐	☒	☐	☐
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
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1. Recommendations

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a. Integrated Performance Report and
b. Key risk areas:
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   - Mental Health service and service transformation delivery
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Sarah Bray
Head of Assurance & Delivery
4 June 2019
sarah.bray6@nhs.net

ENC. L1

Meeting:	ICS Board
Report Title:	Mental Health Performance Deep Dive
Date of meeting:	Thursday 13 June 2019
Agenda Item Number:	15
Work-stream SRO:	Dr Julie Hankin/Dr Amanda Sullivan
Report Author:	Maxine Bunn/Lucy Anderson
Attachments/Appendices:	Enc. L2. Mental Health Performance Report

Report Summary:

The Mental Health Deep Dive provides an overview of performance in 2018/19, demonstrating improvements against all National mental health standards, which covers children and young people's access standards, Early Intervention in Psychosis (EIP), Improving Access to Psychological Therapies (IAPT), Increasing Physical Health checks for people with Severe Mental Illness and Reducing Out of Area Placements, (urgent and emergency mental health pathway including crisis resolution and home treatment teams) and Liaison Psychiatry.

A performance report is attached as Enclosure A, which provides comprehensive overview of performance against each indicator during 2018/19. Recovery Action Plans have been developed which outline key actions to improve performance and delivery against the action plans is monitored by the system.

The report highlights difficulties the system has addressed during 2018/19 which includes data, transformation plans, availability of training and system working. The report concludes with a summary of next steps and priorities for 2019/20.

Action:

☒ To receive
☒ To approve the recommendations

Recommendations:

1.	Note the contents of the report
2.	Support discussions taking place with HEE/NHSE to determine if the in-house CBTp training course can be accredited
3.	Approve the next steps that have been outlined in sections 18-34

Key implications considered in the report:

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

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

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

Is the paper confidential?

☐ Yes
☒ No

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Mental Health Performance Deep Dive

28 May 2019

Introduction

1. Prior to the publication of the Five Year Forward View for Mental Health in February 2016 there were limited performance standards for mental health services. The purpose of this briefing is to provide an overview of performance in Nottinghamshire against the national mental health standards and to highlight action being taken across the ICS to improve delivery against the standards. A summary of the main issues that have been addressed across the system and have contributed to improvements in performance will also be provided.

Current Position

2. From July 2018 Recovery Action Plans were developed for children and young people's access standards, Early Intervention in Psychosis (EIP), Improving Access to Psychological Therapies (IAPT), Increasing Physical Health checks for people with Severe Mental Illness and Reducing Out of Area Placements, which incorporates the urgent and emergency mental health pathway including crisis resolution and home treatment teams and Liaison Psychiatry.

3. As demonstrated in the Mental Health Performance Report (Enc. M2) performance has improved from April 2018 and is summarised below in sections 4-9:

4. Children and young peoples' access standards:
Performance in quarter 1 was 9.6% and the projection for quarter 4 is 25.3% based on local data and 17.3% based on national reporting against a target of 32%.

5. Children and young peoples' eating disorder access standards:
Performance against the started treatment in 1 week (urgent) standard has increased from 66.7% in quarter 1 to 100% in quarter 4. Performance against the routine standard has increased from 77.8% in quarter 1 to 91.7% in quarter 4 against a target of 95%

6. Early Intervention in Psychosis:
There are two standards for EIP – starting treatment in 2 weeks and delivering NICE compliant services. The standard for starting treatment was 53% in 2018/19 has been consistently exceeded in Nottinghamshire; performance in March 2019 was 69.9%. in 2018 Greater Nottingham was graded level 2 against NICE compliant standards and Mid Notts was graded level 1, an audit undertaken in April 2019 has graded the ICS as achieving level 2 against the NICE standards, which indicates an improvement in performance.

7. Improving Access to Psychological Therapies:

Performance against the access standard has increased from 4.07% in April 2018 to 4.65% in February 2019; the access standard in February 2019 is 4.75%. The 6 week and 18 week waiting time standards have been achieved by the ICS and recovery rates are consistently above the 50% standard.

8. Increasing Physical Health checks for people with Severe Mental Illness: Performance against the standard has increased from 31.1% in quarter 1 2018/19 to 36.2% in quarter 4 2018/19 against a standard of 60%.

9. Reducing Out of Area Placements:
The number of inappropriate out of area bed days has reduced from 5549 in quarter 1 2018/19 to 3319 in quarter 4 2018/19 which is a significant reduction of 40.2%. The target is to achieve zero inappropriate out of area bed days by quarter 4 2020/21.

Issues

10. **Data** - There have been a number of data quality and data flow issues which have impacted on performance in 2018/19, predominately these have impacted on children and young people's access standards, EIP and reducing out of area placements, which has impacted on performance reporting and agreeing remedial actions.

11. Nationally performance information is reported via the Mental Health Service Data Set (MHSDS) for the children and young people's access standard. Initially only Nottinghamshire Healthcare NHS Foundation Trust (NHT) was able to flow data and report performance. There are a number of providers in Nottinghamshire who contribute to the access standard and nationally reported performance has not been reflecting local data. Actions have taken place during 2018/19 and it is expected to be rectified in quarter 1 2019/20, with all providers' performance data being reflected in national reporting, which will improve the reported performance for Nottinghamshire.

12. Data quality was identified as an issue for EIP, which was impacting on delivery of the standard across all CCGs. It was also identified that not all cases of EIP had been reported for Newark and Sherwood CCG. The provider has been providing exception reports which highlighted data quality issues and enabled agreed actions to be taken and monitored. Exception reports continue to be provided and monitored through the contracting process. There were also differences in performance data that was reported through the Strategic Data Collection Service (SDCS) and the MHSDS, performance reported via SDCS was better than what had been reported through MHSDS. The national objective is that all information is reported via MHSDS. Focused action was taken to review data quality and there are now minimal differences in performance reported via SDCS and MHSDS in readiness for full migration to reporting through MHSDS.

13. Due to a number of issues with the quality of data provided to monitor out of area placements, an Information Breach Notice was issued in March 2019 from the CCG to the provider through the formal contract process. In response to the

Information Breach Notice a plan has been developed which outlines actions being taken to improve data quality and reporting. All actions are on track and the plan is monitored through the monthly contract review meeting.

14. **Transformation Plans** - Prior to the development of Recovery Action Plans from July 2018, there were limited plans outlining action required to ensure achievement of the standards in Nottinghamshire. National and regional feedback highlighted that systems where performance has improved had developed delivery and transformation plans. Although some plans were available in Nottinghamshire they were not specifically detailed, coordinated or monitored. From July 2018 system wide plans have been developed which articulate and demonstrate the impact of the actions required to improve performance. Steering groups have been established and performance management frameworks to monitor delivery of the agreed system wide actions have been implemented.

15. **Availability of Training** – A risk has been identified which may prevent the system progressing to comply with NICE standards for EIP services. If a service area scores 1 in any domain the system is unable to progress above level 2 compliance. The system is projected to reach at least level 3 in all domains except one. In order to achieve level 3 or 4 compliance CBTp therapy must be available; however there are limited national courses and the training programme is two years. This will impact on the ability of the ICS to achieve level 3 or 4 compliance. The provider has developed an in-house CBTp course and discussions are taking place with HEE/NHSE to determine if this course can be accredited, the Board is asked to note and support progress of this action.

16. **System Working** - Improving performance against the standards and service delivery cannot be addressed by one organisation in isolation. There is evidence of partnership working, for example the development of street triage in Nottinghamshire, however the ICS infrastructure has enabled this to be strengthened. The Nottinghamshire Crisis Care Concordat enabled strong working relationships to be built between system partners working together on the Crisis pathway. The ICS has built upon the partnership working developed to deliver the Crisis Care Concordat and has created a task force made up of system partners which monitors improvements across the urgent care pathway which are taking place at pace. A number of workshops have been held which have been facilitated by the task force.

17. The workshops have focussed on the role of community and voluntary sector partners within the Crisis pathway and issues affecting discharges from inpatient care. The workshops have identified specific actions such as the implementation of a partnership bed management process which have contributed to a reduction in Out of Area placements.

Next Steps

18. 2018/19 has enabled the system to plan for future service delivery and performance has improved across all standards. There will continue to be focus

on all the key areas, underpinned by improved data quality, robust and detailed delivery plans, which incorporate standards, outlined in the NHS plan (2019) and strengthened system working. Specific actions that will be taken include:

19. **Children and Young People's access standards** – a joint review of demand and capacity is being undertaken to agree areas for improvement, which will be monitored during quarter 1.

20. A Communication plan is now live, with the objective of increasing referral rates, events are planned and taking place throughout the county.

21. **EIP-** A referral template for Local Mental Health Teams has been developed to include suspected EIP. This will ensure access to the service is streamlined. The template was uploaded to SystmOne for Greater Nottingham in early May 2019 with GP Communications planned to support this. It will be implemented in Mid Nottinghamshire by the end of May 2019.

22. The Individual Placement Support service implementation steering group has started and recruitment will commence, to ensure the service is available across the ICS.

23. Currently 80% of EIP staff are trained in Behavioural Family Therapy with the remainder to be trained by the end of quarter 1 2019/20.

24. EIP staff are being trained to undertake physical health checks and a support worker in each local mental health team will support with ensuring the physical health checks are undertaken.

25. **IAPT** - Focused work is being undertaken with the CCGs with low referral rates, this will be prioritised in Nottingham North and East initially.

26. Regular review meetings with providers will continue to ensure the interim pathway will resolve waiting times issues within the projected timeline.

27. In Mid Nottinghamshire, the provider continues to recruit to vacant posts, with increased capacity from the national team to support those patients being transferred from exiting providers, plus the development of Step 2 introduction groups to help support clients into service.

28. **Out of Area Placements** - the Crisis Resolution and Home Treatment Team (CRHT) service model has been re-specified, a plan for a revised delivery model was submitted in May 2019 and an implementation plan will be agreed in quarter 1 2019/20. This will ensure CRHTs are developed to deliver a robust service offering an alternative to a hospital admission. To support delivery of the service transformation the provider has commenced recruitment of CRHT staff.

29. Five additional female psychiatric intensive care beds have been subcontracted which are able to be categorised as appropriate out of area following completion and agreement of the continuity of care principles.

30. Sixteen inpatient beds have been subcontracted from the Priory Group and admissions started on 1 May 2019. Continuity of Care has already been agreed by the system for the Priory Group and the beds are located at the same unit.

31. The Framework 'Moving Forward' service has been expanded. The service aims to facilitate timely discharge, in addition to providing in reach to NHT wards, the service will also be provided to patients admitted to Priory wards.

32. **Physical health checks for people with severe mental illness** - Analysis of practice level data is complete and shows the highest and lowest performing practices, the number of patients receiving 0,1,2,3,4,5,6 checks, and the size of the SMI register for each practice. Analysis has also identified by CCG which components are less well delivered (BMI, cholesterol and glucose). Action plans are being developed with locality teams.

33. EIP staff are being trained to undertake physical health checks and a support worker in each local mental health team will support with ensuring the physical health checks are undertaken.

34. Detailed analysis of the additional 5 components will be undertaken now the technical guidance has been finalised. The additional components will be communicated to localities and practices.

Recommendations

35. The Board is asked to:
    - note the contents of the report
    - support discussions taking place with HEE/NHSE to determine if the in-house CBTp training course can be accredited, and
    - approve the next steps that have been outlined in sections 18-34.

Lucy Anderson
Deputy Director of Out of Hospital and Mental Health Contracting

Maxine Bunn
Associate Director of Commissioning – Mental Health and Community

28 May 2019

Children and Young Peoples (CYP) Mental Health Services

CYP Eating Disorder started treatment in 1 week (Urgent) performance has improved from 66.7% in Quarter 1 to 100% in Quarter 4 2018/19. The patient numbers involved are very small which can have a big impact on percentages. The ambition is to achieve 95% by April 2020.

CYP Eating Disorder started treatment in 4 weeks (Routine) performance has also improved consistently in 2018/19 rising from 77.8% in Quarter 1 to 91.7% in Quarter 4. Again small numbers will impact the percentages. The target is to achieve 95% by April 2020.

CYP increasing access - Overall performance based on national data is predicted to be 17.3% against the 32% target for 2018/19. Based on local provider data the projection is approx. 25% for the full year 2018/19. Significant work has been undertaken by providers to improve data quality and data flows to MHSDS which should be reflected in quarter 1 performance.

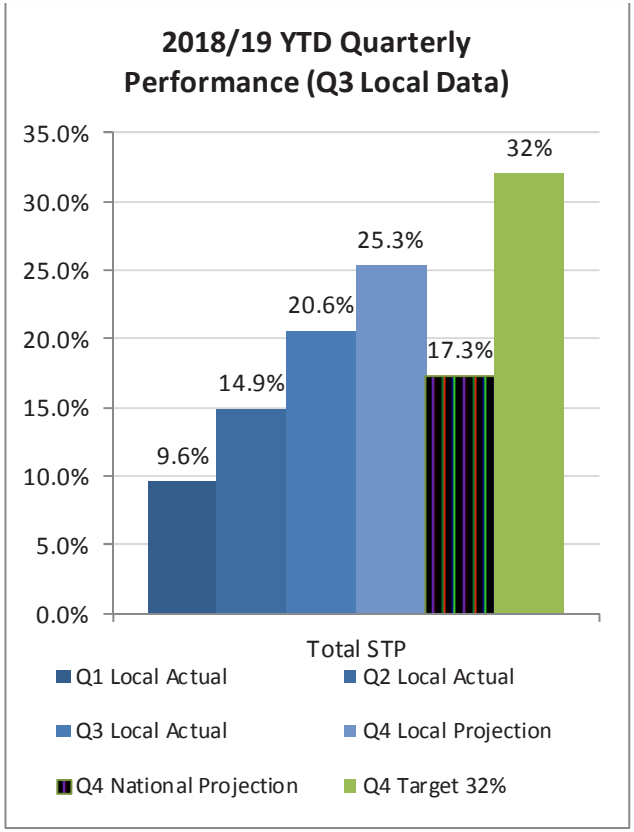
The CYP increasing access target rises from 32% to 34% from April 2019.

CYP ED - Ambition = 95% by April 2020	CYP ED started treatment in 1 week (Urgent) - Ambition = 95% by Apr-20				CYP ED started treatment in 4 weeks (Routine) - Ambition = 95% by Apr-20			
	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Nottinghamshire	**66.7%**	**0.0%**	**50.0%**	**100.0%**	**77.8%**	**66.7%**	**81.3%**	**91.7%**
Mansfield and Ashfield CCG					100.0%	**50.0%**	**50.0%**	100.0%
Newark and Sherwood CCG			**0.0%**		**50.0%**		**50.0%**	100.0%
Nottingham City CCG	100.0%	**0.0%**		100.0%	100.0%		100.0%	100.0%
Nottingham North and East CCG	100.0%		100.0%			**66.7%**	100.0%	**66.7%**
Nottingham West CCG				100.0%	100.0%	**50.0%**		100.0%
Rushcliffe CCG	**0.0%**				**66.7%**	100.0%	100.0%	100.0%

Nottinghamshire patients	**<5**	**<5**	**<5**	**<5**	**9**	**9**	**16**	**12**

Figures above reflect performance at the end of each individual quarter. Source: NHS England data.

CYP Increasing Access (18/19 Full Year Target 32%)	Local Data					
	Q1 Local Actual	Q2 Local Actual	Q3 Local Actual	Q4 Local Projection	Q4 National Projection	**Q4 Target 32%**
Nottingham North and East	8.5%	12.9%	17.9%	21.8%	18.7%	32%
Nottingham West	7.7%	11.8%	16.1%	20.2%	16.6%	32%
Rushcliffe	11.2%	16.6%	21.6%	24.6%	24.5%	32%
Mansfield and Ashfield	8.6%	12.1%	16.4%	20.2%	19.0%	32%
Newark and Sherwood	11.1%	16.4%	21.4%	26.3%	25.0%	32%
Nottingham City	10.4%	17.4%	25.0%	30.9%	11.6%	32%
Total STP	**9.6%**	**14.9%**	**20.6%**	**25.3%**	**17.3%**	**32%**



Source: Local provider data has been used as work continues between Commissioners & Providers to increase both the number of Providers able to submit data to MHSDS and also the quality of data submitted.

Local providers included are NHFT, Nottingham City Council, Base 51, CityCare BEH. Kooth Q3 only.

National projection taken from NHSE data, based on MHSDS Data to February 2019.

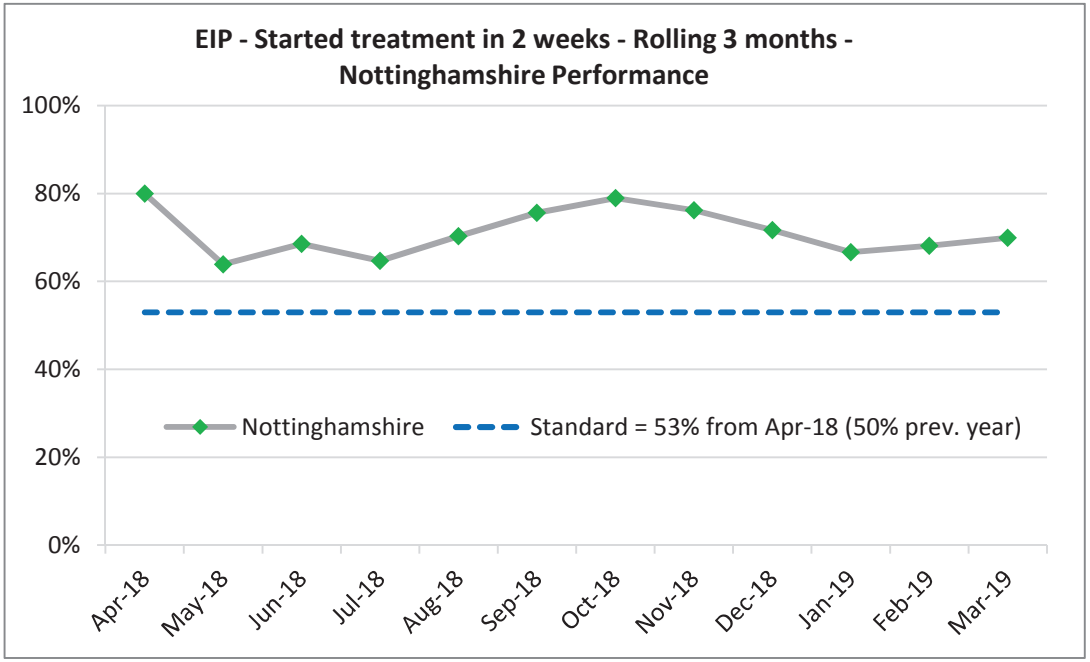
EIP	EIP - Started treatment in 2 weeks Rolling three months - Target = 53%											
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Nottinghamshire	80.0%	63.9%	68.6%	64.7%	70.3%	75.6%	78.9%	76.2%	71.6%	66.7%	68.1%	69.9%
Mansfield and Ashfield CCG	100.0%	100.0%	100.0%	100.0%	80.0%	80.0%	80.0%	88.2%	78.9%	71.4%	62.5%	79.3%
Newark and Sherwood CCG	100.0%	100.0%	100.0%							100.0%	100.0%	100.0%
Nottingham City CCG	92.3%	82.4%	83.3%	71.4%	68.4%	71.4%	71.0%	65.5%	61.3%	64.0%	73.0%	76.9%
Nottingham North & East CCG	80.0%	50.0%	0.0%	0.0%	66.7%	100.0%	100.0%	83.3%	85.7%	80.0%	100.0%	25.0%
Nottingham West CCG	40.0%	57.1%	100.0%	75.0%	75.0%	60.0%	80.0%	60.0%	71.4%	50.0%	50.0%	50.0%
Rushcliffe CCG	0.0%	16.7%	28.6%	50.0%	66.7%	85.7%	100.0%	100.0%	100.0%	100.0%	50.0%	38.5%

Overall Nottinghamshire the percentage of patients starting treatment within 2 weeks has been consistently well above the 53% target for every month in 2018/19 YTD (63.9%-80% range).

Nottingham City, Mansfield & Ashfield have all achieved the target each month. There was an issue with cases of EIP in Newark and Sherwood CCG not having been reported, however for the months that performance has been reported the target has been achieved.

Nottingham North & East and Nottingham West performance is lower in recent months - these percentages appear low in part due to the small numbers of patients involved, however the provider is providing exception reports which outlines information on all breaches and enables actions to be agreed

The percentage to start treatment within 2 weeks rises to 56% from April 2019.



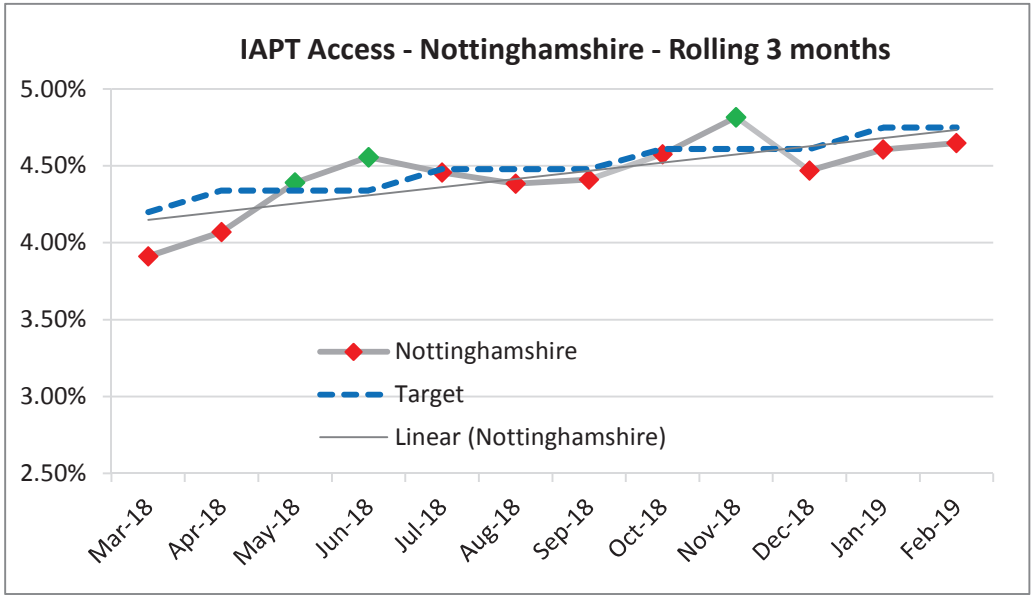
Improving Access to Psychological Therapies

	IAPT Access - Rolling 3 Months										
	NHS Digital Data*										
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Nottinghamshire	**4.07%**	**4.39%**	**4.56%**	**4.46%**	**4.38%**	**4.41%**	**4.57%**	**4.82%**	**4.47%**	**4.61%**	**4.65%**
Mansfield & Ashfield CCG	3.44%	3.65%	3.77%	3.77%	3.79%	3.82%	3.91%	3.94%	3.56%	3.94%	4.22%
Newark & Sherwood CCG	4.16%	4.46%	4.54%	4.46%	4.63%	4.84%	5.10%	5.02%	4.46%	4.97%	5.32%
Nottingham City CCG	4.44%	4.67%	4.58%	4.36%	4.14%	4.13%	4.39%	4.89%	4.63%	4.70%	4.53%
Nottingham North & East CCG	3.53%	4.08%	4.50%	4.53%	4.44%	4.37%	4.57%	4.66%	4.34%	4.21%	4.34%
Nottingham West CCG	4.81%	4.91%	5.23%	4.88%	5.03%	5.13%	5.13%	5.13%	4.73%	4.63%	4.63%
Rushcliffe CCG	3.96%	4.63%	5.51%	5.71%	5.56%	5.61%	5.56%	6.05%	5.66%	5.76%	5.71%
Target	**4.34%**	**4.34%**	**4.34%**	**4.48%**	**4.48%**	**4.48%**	**4.61%**	**4.61%**	**4.61%**	**4.75%**	**4.75%**

Nottinghamshire access performance overall has improved in 2018/19 from 4.07% in April 2018 to 4.65% in February 2019 (latest available data, March data expected 13 June).

Although the access standard has only been achieved in 3 months the general trend has been upward with rates improving in year for all CCGs except Nottingham West which has seen a small drop.

Access targets rise again in April 2019 and will differ by CCG in Quarter 1 ranging from 4.9% for Nottingham City CCG to 5.3% for Rushcliffe CCG. All CCGs have a target of 5.5% by Q4 19/20.

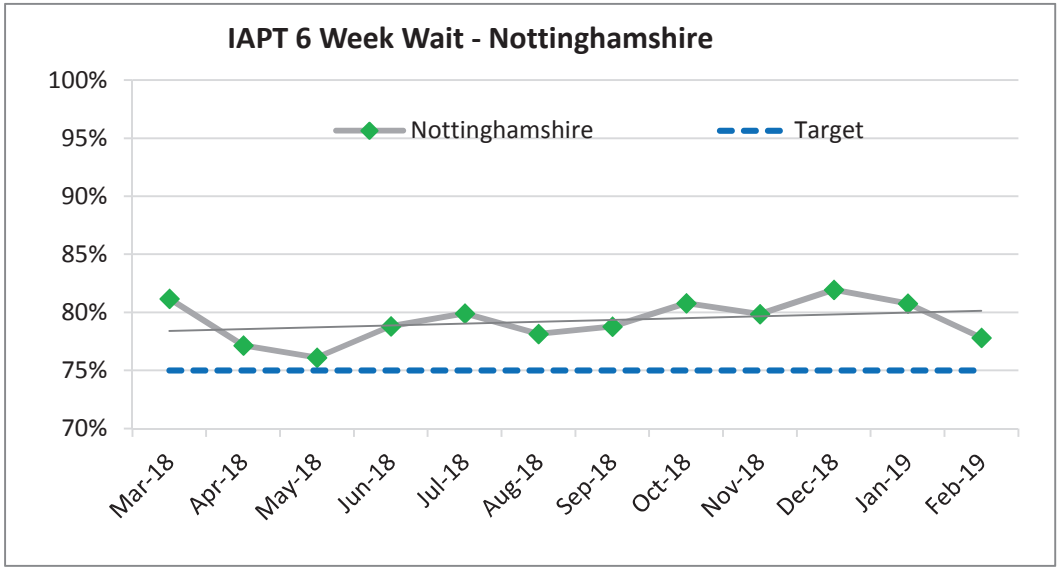


	IAPT 6 Week Wait - Monthly										
	NHS Digital Data*										
	Apr-18	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**
Nottinghamshire	**77.14%**	**76.10%**	**78.81%**	**79.92%**	**78.14%**	**78.79%**	**80.80%**	**79.85%**	**81.94%**	**80.77%**	**77.83%**
Mansfield & Ashfield CCG	81.08%	79.07%	84.21%	77.27%	78.72%	77.78%	86.05%	81.82%	84.85%	86.84%	84.21%
Newark & Sherwood CCG	85.19%	88.00%	80.00%	88.00%	75.00%	76.00%	80.65%	80.56%	84.00%	77.42%	69.57%
Nottingham City CCG	70.13%	69.32%	75.00%	74.16%	79.52%	76.54%	73.49%	77.42%	77.92%	77.65%	76.92%
Nottingham North & East CCG	77.78%	84.38%	78.57%	84.85%	77.78%	84.62%	83.78%	81.82%	84.00%	82.14%	80.00%
Nottingham West CCG	82.61%	74.19%	80.00%	82.14%	76.00%	80.77%	85.19%	85.19%	77.27%	84.00%	80.00%
Rushcliffe CCG	78.46%	75.00%	83.33%	86.67%	78.13%	82.14%	86.21%	77.50%	88.24%	81.48%	75.00%
Target	**75.00%**	**75.00%**	**75.00%**	**75.00%**	**75.00%**	**75.00%**	**75.00%**	**75.00%**	**75.00%**	**75.00%**	**75.00%**

Overall Nottinghamshire 6 week wait performance has been above the 75% target every month in 2018/19 YTD (77-82% range).

In the past 6 months data (September 2018 – February 2019) only on 2 occasions has the 75% target not been achieved by individual CCGs (Nottingham City-October 2018 and Newark & Sherwood- February 2019).

6 week wait target remains the same in 2019/20 at 75%.

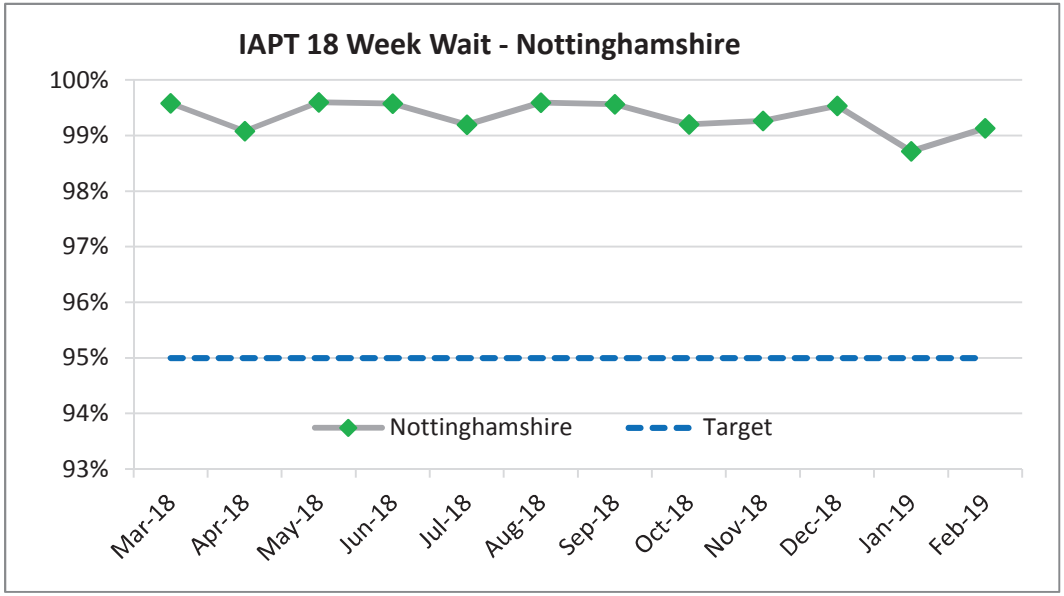


	IAPT 18 Week Wait - Monthly										
	NHS Digital Data*										
	Apr-18	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**
Nottinghamshire	**99.08%**	**99.60%**	**99.58%**	**99.20%**	**99.60%**	**99.57%**	**99.20%**	**99.27%**	**99.54%**	**98.72%**	**99.13%**
Mansfield & Ashfield CCG	97.30%	100.00%	100.00%	100.00%	100.00%	97.78%	100.00%	100.00%	100.00%	100.00%	100.00%
Newark & Sherwood CCG	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.77%	95.65%
Nottingham City CCG	98.70%	98.86%	100.00%	98.88%	100.00%	100.00%	98.80%	97.85%	98.70%	98.82%	98.90%
Nottingham North & East CCG	100.00%	100.00%	96.43%	100.00%	97.22%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Nottingham West CCG	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.00%	100.00%
Rushcliffe CCG	100.00%	100.00%	100.00%	96.67%	100.00%	100.00%	96.55%	100.00%	100.00%	100.00%	100.00%
Target	**95.00%**	**95.00%**	**95.00%**	**95.00%**	**95.00%**	**95.00%**	**95.00%**	**95.00%**	**95.00%**	**95.00%**	**95.00%**

Overall Nottinghamshire 18 week wait performance has been above the 95% target every month in 2018/19 YTD (98-99% range).

Individual CCGs also exceeded the target in all months.

18 week wait target remains the same in 2019/20 at 95%.

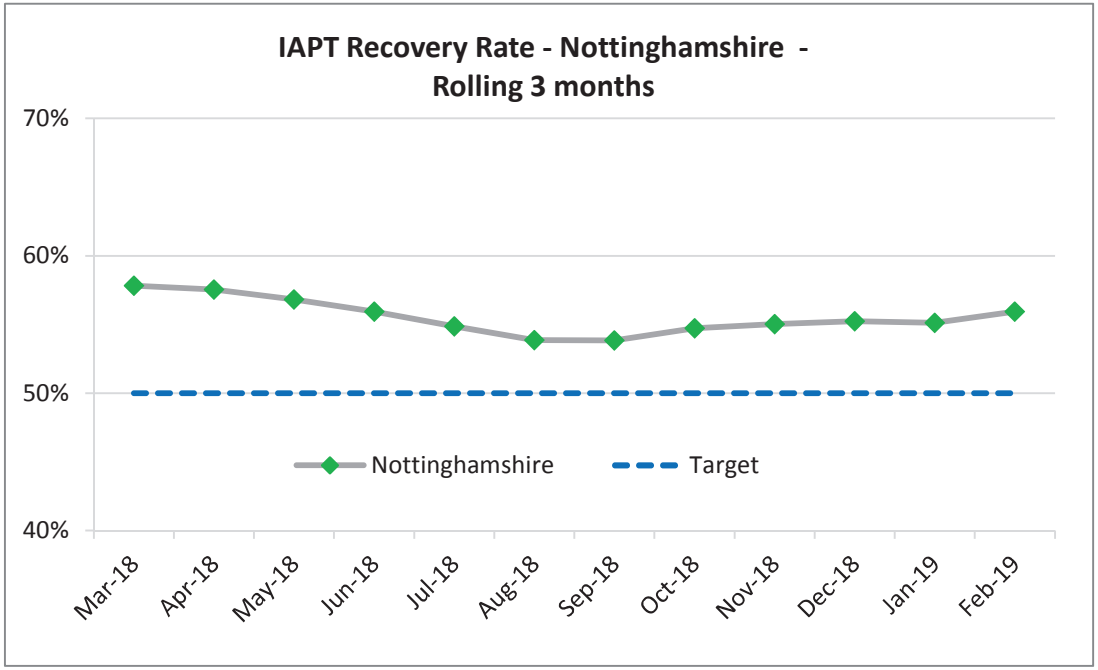


	IAPT Recovery Rate - Rolling 3 Months										
	NHS Digital Data*										
	Apr-18	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**
Nottinghamshire	**57.53%**	**56.81%**	**55.93%**	**54.86%**	**53.86%**	**53.85%**	**54.71%**	**55.02%**	**55.23%**	**55.11%**	**55.94%**
Mansfield & Ashfield CCG	56.60%	53.45%	53.85%	52.42%	52.76%	52.27%	51.54%	52.71%	53.39%	56.14%	56.48%
Newark & Sherwood CCG	57.50%	59.49%	59.21%	59.46%	56.94%	53.52%	55.84%	56.67%	59.78%	60.00%	61.84%
Nottingham City CCG	51.83%	52.48%	51.98%	51.69%	50.19%	50.81%	51.87%	52.02%	51.44%	50.41%	52.44%
Nottingham North & East CCG	61.73%	59.55%	55.81%	55.43%	53.68%	54.95%	54.74%	54.95%	54.35%	55.95%	59.04%
Nottingham West CCG	61.11%	61.54%	61.84%	59.26%	58.11%	56.76%	60.27%	58.44%	58.11%	52.70%	50.75%
Rushcliffe CCG	68.66%	64.56%	63.16%	59.76%	60.98%	61.63%	61.90%	61.96%	61.22%	62.50%	61.18%
Target	**50.00%**	**50.00%**	**50.00%**	**50.00%**	**50.00%**	**50.00%**	**50.00%**	**50.00%**	**50.00%**	**50.00%**	**50.00%**

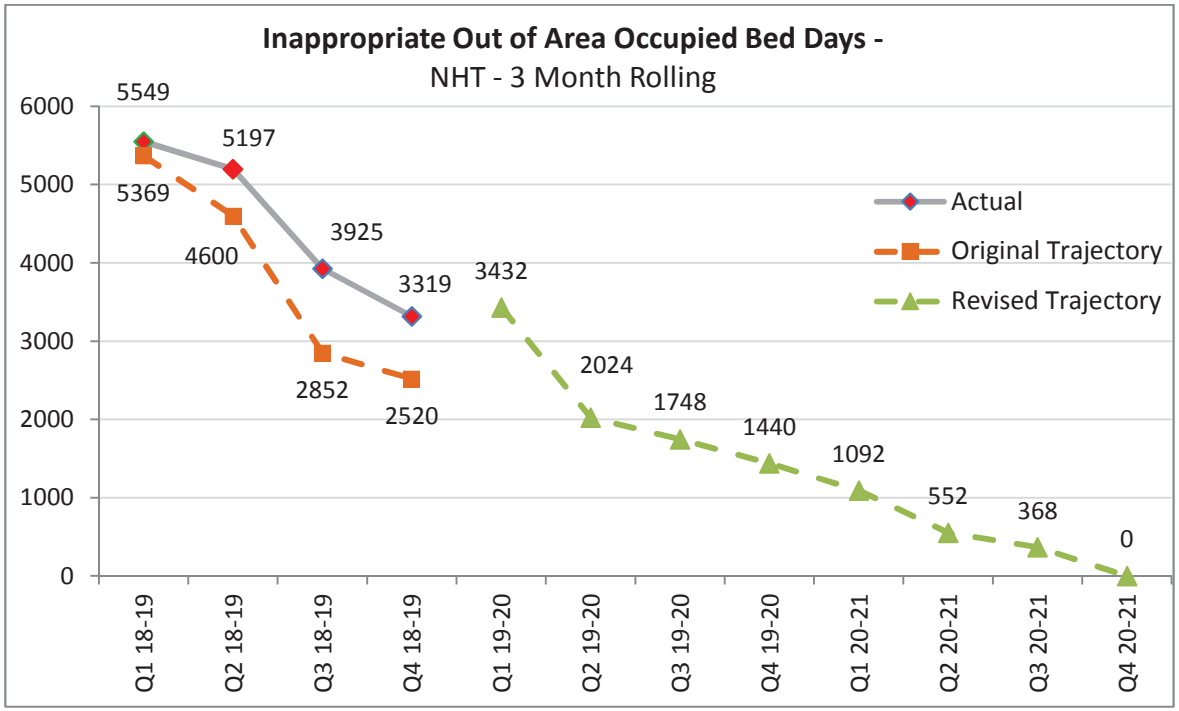
Overall Nottinghamshire recovery has been consistently above the 50% target every month in 2018/19 YTD (53.8% - 56.8% range).

Individual CCGs also exceeded the target in all months.

Recovery rate target remains the same in 2019/20 at 50%.



Out of Area Placements



The number of inappropriate out of area occupied bed days has reduced significantly from Quarter 1 2018/19 (5549) to 3319 by Quarter 4.

This is a reduction of 2230 bed days which equates to a 40.2% drop in year.

The Target is to achieve zero out of area occupied bed days by Q4 2020/21.

OoAP Occupied Bed Day Performance	Period	Actual	Trajectory
Nottinghamshire Healthcare FT	Q4 2018/19	3319	2520

Source: Actual data provided by Nottinghamshire Healthcare Foundation Trust.

Physical health checks for people with a serious mental illness

Total Nottinghamshire - Number of Patients		Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19	Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19
The number of people on the General Practice SMI registers (on the last day of the reporting period) excluding patients recorded as 'in remission' (Denominator):	at period end	6834	6876	6840	6778				N/A
Of the above, patients who have had (Numerators):									
1. measurement of weight (BMI or BMI + Waist circumference)	in 12 months to period end	3713	3704	3753	3912	54.3%	53.9%	54.9%	57.7%
2. blood pressure and pulse check (diastolic and systolic blood pressure recording + pulse rate)		5156	5128	5188	5345	75.4%	74.6%	75.8%	78.9%
3. blood lipid including cholesterol test (cholesterol		3475	3568	3774	4116	50.8%	51.9%	55.2%	60.7%
4. blood glucose test (blood glucose or HbA1c		3894	3888	3920	4064	57.0%	56.5%	57.3%	60.0%
5. assessment of alcohol consumption		4788	4614	4564	5165	70.1%	67.1%	66.7%	76.2%
6. assessment of smoking status		4868	4826	4914	5246	71.2%	70.2%	71.8%	77.4%
All six physical health checks - note this cannot be greater than the minimum figure reported in 1 to 6		**2122**	**2105**	**2175**	**2457**	**31.1%**	**30.6%**	**31.8%**	**36.2%**

Local data collated by Data Management (EHS) Team.

The number of completed Physical Health Checks for people with a Serious Mental Illness remained relatively flat for Quarters 1 to 3 2018/19. Quarter 4 saw an increase to 36.2% for Nottinghamshire overall.

The target for 2019/20 remains at 60% although additional health checks have now been added, which will be recorded and reported, however performance will be based on the original 6 indicators.

ENC. M1

Meeting:	ICS Board
Report Title:	ICS Board - Revised Governance Arrangements
Date of meeting:	13 June 2019
Agenda Item Number:	16
Work-stream SRO:	David Pearson, ICS Independent Chair
Report Author:	Deborah Jaines, Deputy Managing Director
Attachments/Appendices:	Annex A - Extract of ICS 'Partnership' Board requirements from Long Term Plan Enc. M2. Annex B - Revised Terms of Reference

Report Summary:

Following the discussion at the ICS Board on 11 April, it was agreed that the review of effectiveness of the Board (originally proposed for July 2019) should be deferred until April 2020.

Nevertheless, the Board agreed that a number of issues needed to be discussed and resolved in the near term.

Those issues mentioned at the April Board meeting were listed as:

- Indemnity
- Voting arrangements for clinical members of the group
- Membership and representation on the Board, which could be fulfilled by existing Board members, including public health, workforce and Information/digital.

The Chair asked that these issues and any other pressing matters be collated and brought to a future meeting. This short paper provides a list of the issues that have been identified through this process and offers some potential solutions to address the governance matters that need to be resolved in advance of the fuller review of the Board's effectiveness in 2020.

Action:

☐ To receive
☒ To approve the recommendations

Recommendations:

1.	Review and agree the proposed changes (shown as tracked changes) to the Terms of Reference shown in Annex B.
2.	Agree that non-executive directors or elected members could take a role as sponsors for key issues listed in section 5.

Key implications considered in the report:		
Financial	☐	
Value for Money	☐	
Risk	☐	

Legal	☒	Preliminary legal advice from Browne Jacobson was sought, as advised by the Board previously
Workforce	☐	
Citizen engagement	☐	
Clinical engagement	☐	
Equality impact assessment	☐	

Engagement to date:

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

Contribution to delivering the ICS high level ambitions of:

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

Is the paper confidential?

☐ Yes
☒ No

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

Integrated Care System
Nottingham & Nottinghamshire

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ICS BOARD - REVISED GOVERNANCE ARRANGEMENTS

13 June 2019

Introduction

1. Following the decision to defer a full review of the effectiveness of the ICS Board until 2020, this paper brings together a number of issues that need resolution in the near term. These issues have been gathered in the following ways:
   - Identified in the Board meeting of 11 April.
   - 1-1 discussions between the Chair and other Board members.
   - A check against the requirements of ICS Boards as indicated in the Long Term Plan (Annex A).
   - Identified by the ICS Governance Task and Finish Group.
   - Highlighted by Browne Jacobson as needing resolution earlier than 2020.

Issues arising

2. The issues requiring specific earlier remedy have been addressed in the revised Terms of Reference (TOR), attached at Annex B.

3. In summary, the revised TOR seek to:

   - Make a clearer distinction that the ICS Board is not a statutory organisation but that it performs an important partnership role.
   - Alters the voting arrangements to take account of the establishment of three ICPs and considers these as 'organisations' for the purpose of voting. In this way, providing a 'vote' for clinical representatives of the ICPs.
   - Includes the Independent Chair in the voting arrangements, as per the legal advice received and to address concerns raised at the Governance Task and Finish Group.
   - Incorporates the working principles agreed at the meeting of the ICS Board 9 May 2019.
   - Includes the City Council as members following the period of their suspended membership.

4. Board members are asked to review Annex B, which show the revisions as tracked changes and agree which of the changes to the Terms of Reference can be adopted.

Issues for further consideration

5. The Board will wish to balance the effective undertaking of Board functions alongside proportionate membership and attendance. Current Board

members had previously asked that consideration be given to how the following issues could be adequately represented at the Board:

- Prevention and population health management (a previous proposal for the creation of a new ICS role having been rejected, 15 March 2019)
- Workforce and Organisation Development (a previous proposal for the creation of a joint role with the CCG having been rejected, 15 March 2019)
- Digital and information (to mirror the CIO/CCIO responsibilities of statutory organisations and to sponsor the exploitation of digital opportunities).

6. Prevention issues regularly feature on the ICS Board agenda although no single person ensures that prevention and population health management are considered as part of other papers that might be presented. Workforce and OD and 'Digital' are issues that are raised on an ad hoc basis but there is no consistent 'championing' of these issues.

7. One way of overcoming this would be for a non-executive director or elected member to take a role in actively championing these issues and sponsoring discussions in the Board meetings. If there is enough interest in this as a potential solution, the Independent Chair would be happy to convene a meeting of interested members to flesh out what this might mean in practice and what benefits this could bring to the Board.

8. Board members are asked to give a view on whether non-executive directors or elected members could take a role as sponsors for key issues listed in section 5.

9. Browne Jacobson have been commissioned to provide a decision-making 'tree' to provide absolute clarity on which decisions can be taken at the ICS Board so that this Board does not inadvertently fetter the decisions or actions of a statutory board. This should be available by the end of July 2019.

Issues remaining for the longer-term review in March 2020.

10. Following legal advice, it was proposed that in the longer term work is undertaken to create a governance manual providing a clear framework in which the Board would operate. This would incorporate a clear demonstration of where decisions are made. One of the issues raised by Board members pertained to the need for indemnity which should be dealt with through the creation of such a manual.

11. There is no current dispute resolutions process but this would be an explicit part of the governance manual.

Recommendations

12. The ICS Board is recommended to:

- Review and agree the proposed changes (shown as tracked changes) to the Terms of Reference shown at Annex B.

- Agree that non-executive directors or elected members could take a role as sponsors for key issues listed in section 5.

Deborah Jaines
Deputy Managing Director
May 2019

Annex A

Section 1.52 of the Long-Term Plan outlines requirements for ICS Boards as follows:

- A 'partnership board', drawn from and representing commissioners, trusts, primary care networks, and – with the clear expectation that they will wish to participate - local authorities, the voluntary and community sector and other partners;
- A non-executive chair (locally appointed, but subject to approval by NHS England and NHS Improvement) and arrangements for involving non-executive members of boards/ governing bodies;
- Sufficient clinical and management capacity drawn from across their constituent organisations to enable them to implement agreed system-wide changes;
- Full engagement with primary care, including through a named accountable Clinical Director of each primary care network;
- A greater emphasis by the Care Quality Commission (CQC) on partnership working and system-wide quality in its regulatory activity, so that providers are held to account for what they are doing to improve quality across their local area;
- All providers within an ICS will be required to contribute to ICS goals and performance, backed up by a) potential new licence conditions (subject to consultation) supporting NHS providers to take responsibility, with system partners, for wider objectives in relation to use of NHS resources and population health; and b) longer-term NHS contracts with all providers, that include clear requirements to collaborate in support of system objectives;
- Clinical leadership aligned around ICSs to create clear accountability to the ICS. Cancer Alliances will be made coterminous with one or more ICS, as will Clinical Senates and other clinical advisory bodies. ICSs and Health and Wellbeing Boards will also work closely together.

Integrated Care System
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DRAFT TERMS OF REFERENCE

ICS Board 13 June 2019
Item 16, Enc. M2

NAME OF GROUP:	ICS Board ~~– Shadow December 2018-July 2019~~
~~PURPOSE~~ INTRODUCTION	The role of the Integrated Care System Board (ICSB) is to deliver on the expectations of citizens, patients and members of the public for their health and care services, as described in the Memorandum of Understanding with NHSE/I dated September 2018. The role of the Integrated Care System Board ~~(ICSB)~~ is to provide leadership for, and delivery of, the overarching strategy and outcomes framework for the Nottinghamshire Integrated Care System. The ICS Board will also provide oversight and facilitation of the transformation and design of the future state of health and care in Nottinghamshire, in particular overseeing the establishment of the Integrated Care Providers (ICPs) and the Primary Care Networks (PCNs) The ICS Board is a strong partnership of the system, with representation from the system from providers and commissioners as well as representatives of the local authorities who will continue to have responsibility for the statutory responsibility for the Joint Strategic Needs Assessments. The ICS Board will seek to act in the best interest of citizens, patients and the system as a whole rather than representing individual interests of one constituent organisation.
BOARD RESPONSIBILITIES	The ICS Board will: • Produce and champion a coherent vision and strategy for health and care in Nottingham and Nottinghamshire • Develop and describe the high level strategic objectives for the system that are related to health and wellbeing • Produce an outcomes framework for the whole geography to deliver increasing healthy life expectancy, address local variation and seeking to reduce health inequalities • Work with the Integrated Care Providers (ICPs) to determine the service offer to be expected of each. • Undertake stakeholder engagement which will include engaging with staff, patients and citizens

	• Develop a coherent approach to measuring outcomes and strategic objectives within the framework • Ensure the delivery of high quality outcomes, putting patient safety and quality first. • Oversight of the system financial resources including system financial control total. • Have responsibility for the collective delivery of the ICS MOU.
~~**STATUS**~~	~~The ICSB has ultimate responsibility and accountability for achievement of the objectives contained within the ICS MOU and setting the strategic direction for the system.~~ ~~The Integrated Care Provider Boards will be accountable to the ICSB for the delivery of relevant elements of the ICS MOU and its contribution to the achievement of the overarching strategy and outcomes framework.~~ ~~The ICSB is authorised to create sub-groups in order to take forward specific programmes of work as considered necessary by the ICSB membership.~~ ~~Meetings will take place in public from April 2019. Any reserved matters will be explicitly stated ahead of the meeting.~~ ~~Until such time as a change in legislation may affect the statutory powers of this group, the ICS Board exists as a partnership whose 'decisions' are required to be ratified by statutory organisations. Statutory partners are expected to respect the decisions reached by the ICS Board in line with the commitments to the ICS as set out in the MOU.~~
~~**LIMITS OF AUTHORITY AND RELATIONSHIP WITH STATUTORY ORGANISATIONS AND PARTNERSHIPS**~~ **REPORTING AND ACCOUNTABILITY**	~~Statutory organisations will retain their statutory duties. A list of organisational prohibited and reserved matters can be found in Annex 2.~~ See Annex 1 for the governance structure. The ICP Boards will report directly to the ICS Board on the delivery of relevant elements of the ICS MOU and delivery of the ICS outcomes framework. Existing arrangements for health scrutiny will be utilised. The ICS Board will receive reports from the Health and Wellbeing Boards and make recommendations to them on

<table>
<tr><td></td><td>matters concerning delivering ICS MOU priorities and delivery of the ICS outcomes framework.</td></tr>
<tr><td>MEMBERSHIP</td><td>Board members are selected so as to be representative of the constituent organisations, but attend to promote the greater collective endeavour.

ICS Board members are expected to make good two-way connections between the ICS Board and their constituent organisations, modelling a partnership approach to working as well as listening to the voices of citizens, patients and the general public.

Chair: ICS Independent Chair

Vice Chair: CCG ~~Chair~~Lay Member Representative

Members:
<table>
<tr><th>~~Voting~~ Membership (one vote per organisation / ICP)</th><th>Member</th><th>Nominated Deputy</th></tr>
<tr><td>Chief Executive Nottinghamshire Healthcare NHS FT</td><td>Chief Executive</td><td>To be confirmed</td></tr>
<tr><td>Chair or nominee Nottinghamshire Healthcare NHS FT</td><td>Chair</td><td>Non-Executive Director</td></tr>
<tr><td>Chief Executive Sherwood Forest NHS FT</td><td>Chief Executive</td><td>Director of Strategic Planning and Commercial Development</td></tr>
<tr><td>Chair or nominee Sherwood Forest NHS FT</td><td>Chair</td><td>To be confirmed</td></tr>
<tr><td>Chief executive Nottingham University Hospitals NHS Trust</td><td>Chief Executive</td><td>Executive Medical Director</td></tr>
<tr><td>Chair or nominee Nottingham University Hospitals NHS Trust</td><td>Chair</td><td>Non-Executive Director</td></tr>
<tr><td>Chief/Accountable Officer, CCGs</td><td>Accountable Officer</td><td>To be confirmed</td></tr>
<tr><td>CCG Chair</td><td>CCG Lay Member</td><td>To be nominated</td></tr>
<tr><td>Nottinghamshire County Council CEO or nominee</td><td>Corporate Director of Adult Social</td><td>~~Corporate Director of Adult Social Care~~</td></tr>
</table></td></tr>
</table>

	CareChief Executive	Director of Public Health
Nottinghamshire County Council elected member	Two elected members	To be nominated
Nottingham City Council CEO or nominee	Chief Executive	To be nominated
Nottingham City Council elected member	One elected member	To be nominated
NHSE/I representative	NHS England DCO*	To be confirmed
*awaiting confirmation following NHSE&I reorganisation		
In attendance		
ICS Independent Chair	ICS Chair	Vice Chair
ICS Managing Director	ICS Managing Director	
EMAS Chief Executive	Chief Executive	To be confirmed
The ICP lead from Greater Nottingham City ICP	ICP Lead	
The ICP lead from South Nottinghamshire ICP	ICP Lead	
The ICP lead from Mid Nottinghamshire ICP	ICP Lead	
Two clinical leads from Greater Nottingham City ICP with one to represent pPrimary eCare providersNetworks	To be confirmed If not already part of membership	
Two clinical leads from South Nottinghamshire ICP with one to represent Primary Care Networks	To be confirmed	
Two clinical leads from Mid Nottinghamshire -ICP with one to represent pPrimary eCare providersNetworks	To be confirmed If not already part of membership	

	ICS Officer - finance director lead	ICS Finance Director	
	ICS Officer - -Clinical director	ICS Clinical Director	
	ICS Officer - Nursing/Quality director	~~To be confirmed~~CCG and ICS Chief Nurse	
	~~ICS Officer – Public Health Director~~	~~To be confirmed~~	
	ICS Officer - -Director of Communications and Engagement	ICS Director of Communication and Engagement	
	~~ICS officer – Workforce and OD~~	~~To be confirmed~~	
	Secretariat		
	ICS Administrator	ICS Assistant Director	

Board members will recognise the importance and contribution for key ICS issues relating to prevention and population health management, digital and information, and workforce and OD. Non-Executive Directors will be invited to sponsor and champion these area specifically.

GOVERNANCE ~~STRUCTURE~~

The ICS Board has ultimate responsibility and accountability for achievement of the objectives contained within the ICS MOU and setting the strategic direction for the system.

The Integrated Care Provider Boards will be accountable to the ICS Board for the delivery of relevant elements of the ICS MOU and its contribution to the achievement of the overarching strategy and outcomes framework.

The ICS Board is authorised to create sub-groups in order to take forward specific programmes of work as considered necessary by the ICS Board membership.

Meetings will take place in public from April 2019. Any reserved matters will be explicitly stated ahead of the meeting.

The ICS Board is a non-statutory body. It operates on a partnership and collaborative basis. Each of the constituent statutory organisations represented on the ICS Board

	remains responsible for discharging their statutory duties. However, the ICS Board is able to make decisions on matters that are within its remit and are non-statutory (for instance agreeing system priorities, using place-based planning) and the intention is that it will enable partnership discussion, which can then inform statutory decisions that are taken by one or more of the member organisations. The members of the ICS Board commit to working collaboratively; openly and supporting the development and role of the ICS Board and delivery of the ICS MOU. Subject to the limitations on the ICS Board's role, each partner organisation is expected to support any decisions made by the ICS Board, in line with the commitments to the ICS as set out in the MOU. ~~See Annex 1.~~
~~**BOARD RESPONSIBILITIES**~~	~~The ICS Board will:~~ • ~~Produce and champion a coherent vision and strategy for health and care in Nottingham and Nottinghamshire~~ • ~~Develop and describe the high level strategic objectives for the system that are related to health and wellbeing~~ • ~~Produce an outcomes framework for the whole geography to deliver increasing healthy life expectancy, address local variation and seeking to reduce health inequalities~~ • ~~Work with the Integrated Care Providers (ICPs) to determine the service offer to be expected of each.~~ • ~~Undertake stakeholder engagement which will include engaging with staff, patients and citizens~~ • ~~Develop a coherent approach to measuring outcomes and strategic objectives within the framework~~ • ~~Ensure the delivery of high quality outcomes, putting patient safety and quality first.~~ • ~~Oversight of the system financial resources including system financial control total.~~ • ~~Have responsibility for the achievement of the ICS MOU.~~ ~~Prohibited and Reserved Matters are limited to those outlined in Annex 2. The ICS Board may not make a final decision on any of the matters set out in Annex 2, which are reserved for determination by the Commissioners.~~ ~~Where exercising a reserved matter under Annex 2, and subject to any need for urgency because to act otherwise would result in the Commissioner breaching their statutory obligations, the Commissioner will first consult with and advise the ICS Board in relation to its proposed exercise of a reserved matter.~~

	~~If a decision in respect of a reserved matter (under Annex 2) if notified to the ICS Board, the Board shall implement that decision as if it were a decision of the ICS Board.~~
PRINCIPLES	~~[In development]~~ • We shall encourage cooperative behaviour between ourselves and engender a culture of "Best for Service" including no fault, no blame and no disputes where practically possible • We shall seek to ensure that sufficient resources are available, including appropriately qualified staff who are authorised to fulfil the responsibilities as allocated • We shall assume joint responsibility for the achievement of the Outcomes • We commit to the principle of collective responsibility and to share the risks and rewards (in the manner to be determined as part of the agreed "transition arrangements) associated with the performance of the ICS Objectives • Our activities shall adhere to statutory requirements and best practice by complying with applicable laws and standards including EU procurement rules, EU and UK competition rules, data protection and freedom of information legislation; and • We agree to work together on a transparent basis (for example, open book accounting where possible) subject to compliance with all applicable laws, particularly competition law, and agreed information sharing protocols and ethical walls.
REQUIRED ATTENDANCE:	Members are expected to attend 75% of meetings held each calendar year. It is expected that members will prioritise these meeting and make themselves available. Where this is not possible a Nominated Deputy of sufficient seniority (as named above) may attend to support delivery in a timely manner and to have delegated authority to make decisions on behalf of their organisation or role on the ICS Board in accordance with the objectives set out in the Terms of Reference. For Local Authority representatives this will be in accordance with the due political process.
QUORUM:	Quorum will be reached with at least the Chair or Vice Chair, and one Member (as named above) from each Nottinghamshire based statutory organisation present. These organisations being as follows:

	Nottingham University Hospitals NHS Trust Nottinghamshire CCGs Nottinghamshire County Council Nottingham City Council Nottinghamshire Healthcare NHS FT Sherwood Forest -NHS FT If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions for agreement by statutory bodies may be taken. If any member of the Group has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.
DECISION MAKING	The ICS Board will meet in public. The ICS Board will make decisions on system matters (e.g. relating to the ICS MOU, transformation funding allocated to the ICS, strategic priorities and performance monitoring of the ICS). ~~recommendations for agreement by the statutory organisations in line with their statutory duties.~~ These ~~governance~~ decision making arrangements provide a fair approach to representation from ~~individual~~ partner organisations. The ICS Board Chair will actively seek to reach decisions by consensus ~~where possible~~. Should this not be possible then a vote of the Group's Members will be required. No single member (or the organisation / ICP they represent) will have a right of veto over system-wide decisions. There will be one vote per statutory organisation or ICP, by nominated Members or Deputies present at the meeting, with decisions made by a simple majority. ~~These organisations~~ Members being as follows: Nottingham University Hospitals NHS Trust Nottinghamshire CCGs Nottinghamshire County Council Nottingham City Council Nottinghamshire Healthcare NHS FT Sherwood Forest NHS FT

	NHS England / Improvement Nottingham City ICP South Nottinghamshire ICP Mid Nottinghamshire ICP ~~'In attendance' members and t~~Those not present at the meeting shall not vote. In the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a casting vote to prevent a deadlock. The ICS Board may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between the meetings of the Group and in relation to which a decision must be made prior to the next scheduled meeting. Where an urgent decision is required a supporting paper will be circulated to all members and a decision sought from voting members. The ICS Board members may meet either in person, via telephone conference or communicate by email to take an urgent decision. The quorum, as described above, must be adhered to for urgent decisions. In such circumstances, a minute of the discussion and decision will be taken by the secretary and will be reported to the next meeting of the ICS Board for formal ratification.
CONFLICTS OF INTEREST	The ICS Board will maintain a standing register, as per any other corporate decision-making body. In advance of any meeting of the ICS Board, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each meeting of the ICS Board, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting. Members must ensure that they

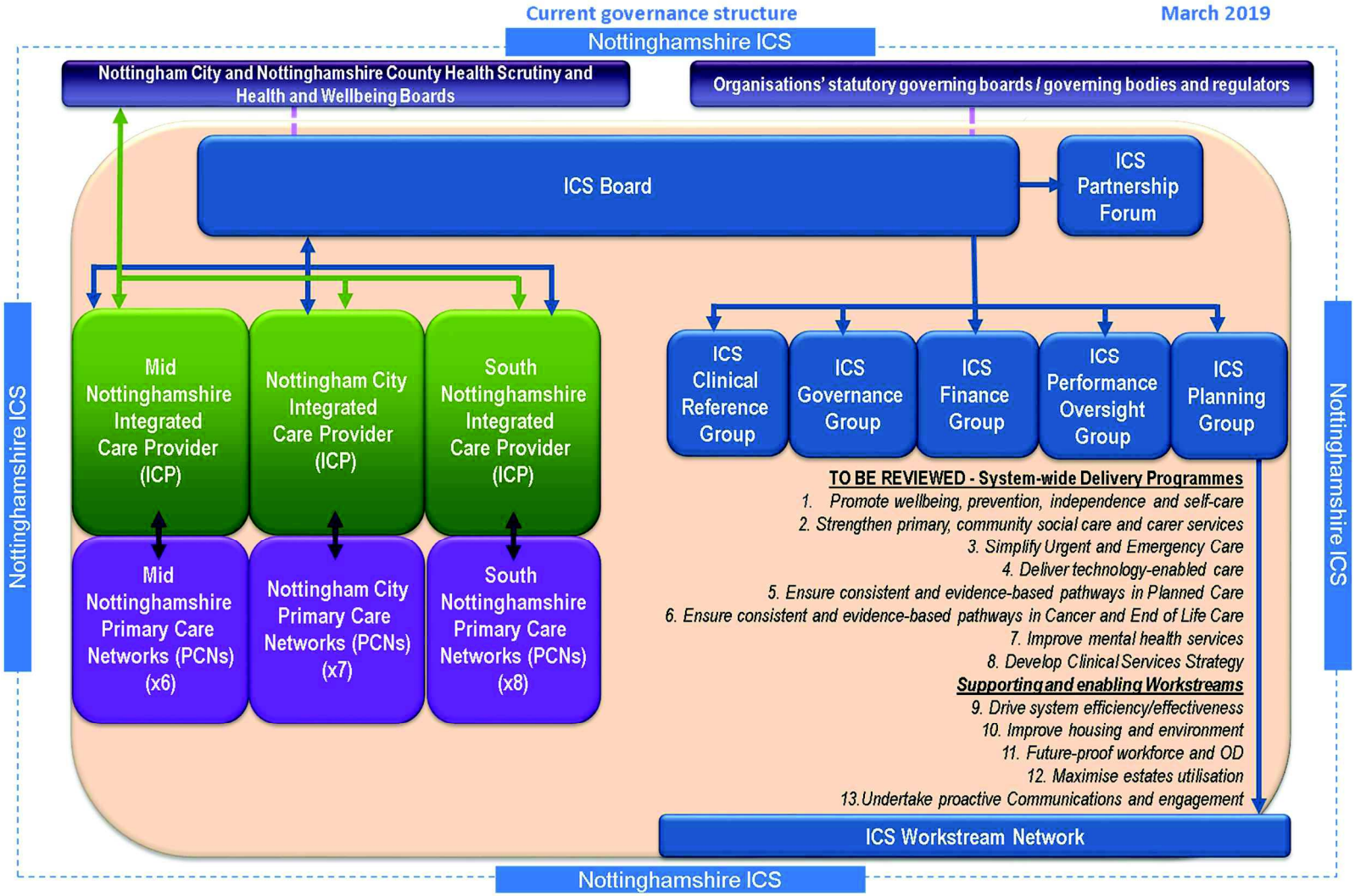
	continue to comply with relevant organisational policies / guidance. The Chair of the ICS Board will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the ICS Board decision-making arrangements. b) Allowing the individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the ICS Board decision-making arrangements.
FREQUENCY OF MEETINGS	The ICS Board will meet in shadow form on a monthly basis ~~to at least July 2019~~. The Board will consider relevant issues by correspondence between meetings if required and will be flexible in convening extraordinary meetings outside of the monthly cycle.
~~SERVICING~~ SECRETARIAT:	The Group will be serviced by the ICS Team. • Draft agendas will be agreed with the Chair. • Agreed items for the agenda, to be sent to the ICS Team, with the relevant paperwork, up to 9 working days before each meeting; • The Chair agreeing the final agenda; • Papers will be circulated 5 working days before each meeting; • Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing; • The draft minutes of each meeting will be circulated within 5 working days of the meeting being held and will be ratified at the following meeting. Ratified minutes of the meeting will be published.
REVIEW DATE~~.~~:	These Terms of Reference will be reviewed in ~~July 2019~~ March 2020 to ensure continued fitness for purpose in the light of potential changes to the expectations of national requirements or local issue. The ICS Board will re-consider progress and risks in the implementation of the ICSs aims and objectives and approve

	any mitigation measures and other action required to ensure success, in line with the approved ICS MOU.
DATE APPROVED-:	

The Nottingham and Nottinghamshire
Integrated Care System

Nottingham City Council | Nottinghamshire County Council | NHS

Annex 1 – Governance Structure



Annex 2 – Prohibited and Reserved Matters

DRAFT – based on the 2018/19 Alliance Agreement, legal advice to be sought

Partners are required to comply with certain statutory and regulatory duties which prohibit certain matters from discussion. The ICS Board shall not decide to do or omit to do anything which would:

1. Cause any Partner to breach
    a. Legalisation or applicable case law; or
    b. Any regulatory requirement including requirements of the Care Quality Commission; or
    c. Any specific Department of Health or NHS England policies; or
    d. In the case of the Council, the Council's Constitution and any applicable Council policies or social care guidance; or
    e. In the case of the Nottinghamshire CCGs, the CCGs Constitution;
2. Cause a Provider to breach any terms of its provider license from NHS Improvement; and/or
3. Require any Commissioner to invest further monies which are additional to or beyond those already committed to by the Commissioner at the time of the relevant decision, act or omission.

In addition, there are a number of reserved matters for Commissioners. Commissioners have specific statutory responsibilities for ensuring the provision of safe, efficient and integrated health and care services and that their role as commissioners of these services means that they shall be entitled to exercise the following decisions without seeking approval from the ICS Board:

1. any decision to undertake public consultation or to respond to or liaise with a Local Healthwatch organisation, the Nottinghamshire Health and Wellbeing Board, the Nottinghamshire Safeguarding Adults Board and/or other bodies with whom the Commissioners are required to consult

In the case of Nottinghamshire CCGs, unless and until there are statutory instruments to provide for a change in statutory responsibilities, the following functions will remain the responsibility of the CCGs:

- Population needs assessment
- Commissioning and commissioning decisions
- Allocating CCG level resources
- Mandated expenses
- Publishing the annual commissioning plan
- Strategic planning of services
- Managing and developing the supply chain of services
- Procurement of services
- Demand management
- Engagement and consultation on service change proposals
- Integrating the provision of services

- ~~Addressing health inequalities~~
- ~~Planning and implementation of cost improvement schemes~~
- ~~Decision making related to funding routes~~
- ~~Pathway planning, signposting to services and care navigation~~
- ~~Patient choice~~
- ~~Personalisation, person centred care (including self-care and realising the value) and personal health budgets~~
- ~~Development of outputs, outcomes measures and monitoring~~
- ~~Contract management for services within and outside of the ICS / ICP scope~~
- ~~Quality monitoring / contract management of sub-contracted Services~~
- ~~Oversight and management of system performance~~
- ~~Oversight of risk and reward mechanisms~~
- ~~Management of FOI requests and provision of data for responses~~
- ~~Complaint handling~~

~~This list is not a comprehensive statement of CCG functions and activities.~~