Integrated Care System Board
Meeting held in public

Thursday 15 October 2020, 09:00 – 10:30
Zoom
https://us02web.zoom.us/webinar/register/WN_noigpTVISO--hNaOiNQ9hg

AGENDA

	Time	Agenda Items	Paper	Lead	Action
1.	09:00	Welcome and Introductions	Verbal	Chair	To note
2.	09:05	Conflicts of Interest	Verbal	Chair	To note
3.	09:10	Minutes of 17 September 2020 ICS Board meeting and action log	Papers A1 A2	Chair	To agree
4.	09:15	Patient Story - Enhanced Care Response Team (ECRT) Supporting the Health and Care Sector in the Wake of Covid-19	Paper B	Alex Ball	To discuss
Strategy and System Planning					
5.	09:30	Draft Health Inequalities Strategy	Papers C1 C2	John Brewin / Andy Haynes	To agree
6.	09:45	New Ways of System Working: • Feedback from the ICS Chief Executive Officers Group • System Governance	Papers D1 D2 D3	Andy Haynes / Chair	To agree
7.	10:00	Primary Care Networks: One Year On	Paper E	Nicole Atkinson	To agree
Oversight of System Resources and Performance Issues					
8.	10:15	Integrated Performance and Finance reports	Papers F1 F2	Andy Haynes	To note
10:30 Close					

Next meeting date: 12 November 2020, 09:00-12:00

ICS Board 15 October 2020
Item 3. Enc A1.

Integrated Care System Board

Thursday 17 September 2020 09:00 – 10:30
Via MS Teams

Attendees

Name	Organisation
Adele Williams	Councillor, Nottingham City Council
Alex Ball	Director of Communications and Engagement, Nottingham and Nottinghamshire CCG and ICS
Amanda Sullivan	Accountable Officer, Nottingham and Nottinghamshire CCG
Andy Haynes	Executive Lead, Nottingham and Nottinghamshire ICS
Catherine Underwood	Corporate Director of People, Nottingham City Council
Claire Ward	Non-Executive Director, Sherwood Forest NHS Foundation Trust
David Pearson	ICS Independent Chair
Eric Morton	Chair, Nottingham University Hospitals NHS Trust
Eunice Campbell-Clark	Chair, Nottingham City Health and Wellbeing Board
Hugh Porter	GP, Clinical Director and Interim Lead for Nottingham City ICP (representing Nottingham City ICP)
Jon Towler	Non-Executive Director, Nottingham and Nottinghamshire CCG
Jonathan Harte	GP Partner and PCN Clinical Director (representing PCNs in Nottingham City ICP)
Julie Hankin	Executive Medical Director, Nottinghamshire Healthcare NHS Foundation Trust
Lyn Bacon	Chief Executive, Nottingham CityCare Partnership
Marcus Pratt	Programme Director – Finance and System Efficiency, Nottinghamshire ICS
Melanie Brooks	Corporate Director Adult Social Care and Health, Nottinghamshire County Council
Michael Williams	Chair, Nottingham CityCare Partnership
Nicole Atkinson	GP, Nottingham and Nottinghamshire ICS Clinical Lead and South Nottinghamshire ICP Clinical Lead
Paul Devlin	Chair, Nottinghamshire Healthcare NHS FT
Richard Henderson	Chief Executive, East Midlands Ambulance Service
Richard Mitchell	Chief Executive, Sherwood Forest Hospitals NHS FT
Rosa Waddingham	Chief Nurse, Nottingham and Nottinghamshire CCG and ICS
Thilan Bartholomeuz	GP and Clinical Lead for Mid Nottinghamshire ICP (representing Mid Nottinghamshire ICP)
Tim Heywood	GP and PCN Clinical Director (representing PCNs in South Nottinghamshire ICP)
Tony Harper	Councillor and Chair of Health and Wellbeing Board, Nottinghamshire County Council

Tracy Taylor	Chief Executive, Nottingham University Hospitals Trust

In attendance

Andrew Haw	Interim Data, Analytics and Digital Technology Lead, Nottingham and Nottinghamshire ICS, Data Protection Officer, Nottinghamshire Healthcare NHS Foundation Trust
Joanna Cooper	Assistant Director, Nottingham and Nottinghamshire ICS
Rebecca Larder	Programme Director, Nottingham and Nottinghamshire ICS

Apologies

John MacDonald	Chair, Sherwood Forest Hospitals NHS FT
Paul Robinson	ICS Finance Director and Chief Financial Officer, Sherwood Forest Hospitals FT
John Brewin	Chief Executive, Nottinghamshire Healthcare NHS FT
Gavin Lunn	GP (representing PCNs in Mid Nottinghamshire ICP)

1. Welcome and introductions

Apologies received as noted above.

On behalf of Board DP noted that Richard Stratton has now stood down from ICS Board. DP thanked Richard for his leadership and contribution to the ICS. DP welcomed Tim Heywood as the new representative for PCNs within South Nottinghamshire ICP, and to Rosa Waddingham as CCG and ICS Chief Nurse.

DP advised Board that he will not be seeking a new term as ICS Independent Chair when his current contract comes to an end. The ICS will now start a rigorous and robust recruitment process to appoint a new chair of the ICS from March 2021.

2. Conflicts of Interest

No conflicts were noted in relation to items on the agenda.

3. Minutes of 12 March 2020

The minutes of the meeting held on 12 March 2020 were agreed as an accurate record of the meeting by those present.

The action log and updates were noted.

ACTIONS:
DP and AH to review action log to ascertain which items are ongoing.

4. Recovery Insights Project

AB presented a summary of the interim findings of the Recovery Insights project. This project is a multimethod piece of work with citizens to support system recovery following the covid-19 pandemic.

Headlines have been shared with Recovery Cell to integrate into system recovery efforts. AB has been working with the Recovery Cell throughout to inform service changes.

Board thanked AB for this insightful work and reflected that the findings resonate within organisations. Board made the following comments:

- Important to build these insights into a longer term programme that connects recovery with citizens, perhaps through an ICS Citizens Panel.
- Important to link in 999 service user experience.
- Insights support a move to remote consultations and improved and more integrated discharge process.
- Board noted the disproportionate adverse impact on disadvantaged groups and highlighted that addressing these inequalities needs to underpin recovery plans. Disadvantaged groups and digital exclusion need to be considered as part of an ICS Health Inequality Strategy. AH advised that an application has been made to the Health Foundation to support this. JH advised that work is also underway on digital exclusion in the mental health system and NA that work is taking place in Connected Notts also. A coordinated approach to be agreed.
- Board noted that PCNs are also engaging with citizens to shape local services.

Board agreed that short term issues should be addressed through the Recovery Cell including, provision for an increased number of remote consultations and appropriately and safely discharging patients from hospital (Home First). Alongside this consideration to be given to an ICS approach to addressing inequalities for citizens who are hard to reach or find public services hard to reach.

ACTIONS:
AB to circulate the Recovery Insight slides to ICS Board members.
AB to bring the qualitative outputs of the research and engagement from the Recovery Insights project to a future ICS Board meeting.
RH to link with AB on providing insights from an EMAS perspective.

5. New Ways of System Working

AH provided ICS Board with an overview of the development of new ways of system working. Of note:

- ICS Chief Executive Officers Group (CEOG) established and meeting every two weeks to progress key areas of work.

- ICS Clinical Reference Group (CRG) discussing wider clinical leadership across the system.
- Progress is being made on rationalising system groups and draft Terms of Reference are being developed.
- AH and AS working to eliminate duplication between ICS and CCG teams.

ACTIONS:
AH to work with CEOG to bring back recommendations on new ways of system working to the 15 October meeting.

6. Approval of Data, Analytics and Information Technology (DAIT) Strategy

AH and Andrew Haw presented an overview of the work to date to develop an ICS DAIT Strategy and draft strategy for approval. All ICS partners have contributed to the development of the strategy and has been agreed by organisations and the CEOG. An implementation group is in place with key workstreams being discussed at CEOG on how to take forward implementation.

Board thanked AH and Andrew Haw for this work and made the following comments:

- Integration between health and social care key to this approach.
- Interoperability between software key to integrated approach. Mechanisms are in place for this.
- PD highlighted the importance of horizon scanning for new technology
- HP highlighted that ensuring a high quality of data and supporting staff key to implementation. Andrew assured that workforce IT literacy is a key strand to the DAIT strategy.
- TH advised that City and South ICPs have an F12 project to promote standardisation of coding in primary care.

AH advised that the proposed implementation timescales have been informed from IT leads and are already being aligned to priorities for 20/21 and being built into future implementation plan over next 3 year period. Some local resource allocation will need to be confirmed from within existing resources. ICS Chief Digital Officer to be discussed at CEOG in relation to the New Ways of System Working piece of work.

Board approved the ICS DAIT Strategy for Nottingham and Nottinghamshire.

ACTIONS:
AH to bring implementation plan for the DAIT strategy back to the 12 November meeting including resources and capacity requirements.

7. Any other business

DP highlighted that the work for reviewing and strengthening ICS governance has been completed. A further review of this work is needed, in particular for ICS Board membership and voting arrangements. DP to bring a paper to a future meeting.
Next meeting date: 15 October 2020, 09:00-12:00

ICS Board Meeting Log 2020	Active Actions

Completed
Ongoing
Outstanding

Reference Number	Discussion/Rationale	Date	Action	Update/Comment	Action Owner	Deadline	Status
B203	Item 7.ICS Outcomes Framework – operationalising the framework	12 September 2019	To provide an estimation of the timeline to develop and embed the outcomes framework based on the current levels of resourcing and what impact additional capacity and capability could have on this.	The key risks to developing and embedding the system outcome framework reported to the ICS Board are: • The requirements on the system in relation to responding to the Long Term Plan (LTP), COVID and associated returns e.g. Phase 3 pulling resource away from the System Outcomes Framework • Data availability and reporting frequency and boundaries • Analytical capacity to build a fully operational System Outcomes Framework report Work is progressing to take forward: - Development of ICS DAIT Strategy (analytical capacity) - Development of ICS Health Inequalities Strategy - System transformation evaluation approach (aligned to outcomes framework) - Discussion held at CCG Clinical Design Authority on how to continue to embed the outcomes framework - Joint development session to be arranged (ICS Team and CCG) on Outcome Framework and PHM	Tom Diamond	31 December 2020	Ongoing
B205	Item 13.The Development of Primary Care Networks for Nottingham and Nottinghamshire	12 September 2019	*Actions B257, B179, B205, B250 and B259 consolidated* To work with AS to develop an approach to devolving “tactical commissioning” to ICPs and PCNs.	Initial discussion held. The ICS Chief Executive Group will consider this progressing the development of the governance structure and ICP working principles through the review and strengthening of ICS governance in the first instance and will report recommendations to the ICS Board. *Deferred until later in 2020 - date TBC*	ICS Team	31 December 2020	Ongoing

ICS Board Meeting Log 2020	Completed Actions

Completed
Ongoing
Outstanding

Reference Number	Discussion/Rationale	Date and time	Action	Update/Comment	Action Owner	Deadline	Status
B240		16 January 2020	To review the title of the Mental Health and Social Care Partnership Board in the Terms of Reference for clarity of purpose.	Update requested 28 January 2020	Lucy Dadge	31 January 2020	Completed
B241		16 January 2020	To ensure that Nottingham City Council monthly finance figures are provided for the Integrated Performance Report on an ongoing basis.	This has been discussed with our key Finance lead (Ceri Walters). Assurance has been received that all City figures will be provided in a timely manner to allow them to be integrated in the Performance Report	Ian Curryer	31 January 2020	Completed
B242		16 January 2020	To provide Board with an overview of requirements for the ICS Evaluation and input needed from front line staff.	Completed	David Pearson	31 January 2020	Completed
B243		16 January 2020	To ensure that the requirements of the ICS Evaluation are recorded on the log of system support offers to share with Regional NHSEI colleagues.	Completed	Joanna Cooper	31 January 2020	Completed
B245		16 January 2020	To raise consistency of neonatal and maternity service provision across Nottingham and Nottinghamshire at the LMNS Board.	On behalf of the ICS the Nottingham & Nottinghamshire Local Maternity & Neonatal System (LMNS) is taking the lead on driving the associated transformation programme and the ambitions outlined within the LTP. Reducing variability and addressing inequalities are key priorities for the LMNS. In relation to the January Board discussion around bereavement the LMNS can confirm that a Postnatal & Neonatal Improvement Plan (as per national recommendations) is currently underdeveloped. Zephyrs & the MVP continue to be critical partners in addressing the improvements and consistency needed. Implementation of this plan will be led by a 'Better Postnatal & Better Newborn Care' work stream of the LMNS.	Elaine Moss	31 March 2020	Completed
B246		16 January 2020	To provide Board with a broader understanding of neonatal and maternity services and challenges at a future meeting.	A refreshed LMNS Strategy has been developed aligned to the ambitions outlined within the LTP. This strategy addresses the current challenges and describes the actions being taken locally to address. The LMNS will submit and present a report to the ICS Board meeting (March 2020) in order to update members on the progress of the maternity and neonatal transformation programme.	Elaine Moss	31 March 2020	Completed

ICS Board Meeting Log 2020	Completed Actions

Completed
Ongoing
Outstanding

Reference Number	Discussion/Rationale	Date and time	Action	Update/Comment	Action Owner	Deadline	Status
B248		16 January 2020	AS scheduled to present commissioning strategy in March and as part of this, to include draw out the specific responsibilities for prevention and wider determinants.	Item scheduled for the 12 March ICS Board meeting	Amanda Sullivan	12 March 2020	Completed
B249		16 January 2020	To send a thank you to front line staff for work during winter.	Completed	Chief Executives	31 March 2020	Completed
B250		16 January 2020	To provide a report to ICS Board at a future meeting on the resource requirements for the mental health work-stream.		John Brewin and Amanda Sullivan	31 March 2020	Completed
B252		16 January 2020	To provide ICS Board with an update on PCN development at a future meeting.	Item added to the workplan on a quarterly basis.	Nicole Atkinson	01 June 2020	Completed
B255		13 February 2020	To provide ICS Board with an update on finance at the 12 March meeting		Paul Robinson	12 March 2020	Completed
B254		13 February 2020	To liaise with Lynn Smart and Kate Wright regarding the Department of Health and Social Care visit		John Brewin	24 February 2020	Completed
B259		13 February 2020	To make the necessary amendments to the Finance Director Group Terms of Reference in line with the conversation at the ICS Board		Paul Robinson		Completed
B263		12 March 2020	To circulate the Mid Notts ICP presentation to Board members		Joanna Cooper		Completed
B254	Item 7.Winter Planning	16 January 2020	To incorporate the views of the ICS Board into planning for winter through A&E Delivery Boards and provide an update at the 12 March meeting.	Action being progressed through Phase 3 planning. Action for Board superceded.	Amanda Sullivan, Tracy Taylor and Richard Mitchell	31 December 2020	Completed
B256	Item 5.Operational Planning for 2020/21 PD asked for clarity on the assurance mechanism for Mental Health Investment Standard. AH advised that work is in place for year end aligned to levers for system response to the NHS Long Term Plan. Organisations will need to engage fully to support this work. Further guidance anticipated over the coming weeks.	13 February 2020	To provide an assurance on the Mental Health Investment Standard at the 16 April meeting	Delegated to the ICS Chief Executive Group.	Paul Robinson	31 December 2020	Completed
B253	Item 9.Mental Health Strategy Delivery Arrangements	16 January 2020	To provide ICS Board with report on the development of joint arrangements for intellectual and developmental disorders.	ICS Chief Executive Group agreed to delegate to Mental Health Board. Action closed for ICS Board.	John Brewin and Amanda Sullivan	31 December 2020	Completed
B258	Item 7.Integrated Performance and Finance Report	13 February 2020	To further develop the ICS Board agenda and forward workplan to meet the national direction of travel for ICSs	Arrangements in place for ICS Chief Executive Group to lead on the development of ICS Board workplan.	Andy Haynes	31 December 2020	Completed
B236	Item 7. ICS Integrated Performance report – Finance, Performance & Quality Following discussion on system finances, a focussed discussion on system finance was proposed for a future Chairs, NEDs and Elected Member event.	06 November 2019	To incorporate a discussion on system finance into the workplan for a future Chairs, NEDs and Elected Member event.	Action superseded by further ICS Board discussions. It is proposed to strengthen financial governance and oversight of ICS finances to include;1. Formal processes to assure the ICS Board of individual organisation consistency with ICS Planning. 2. Formal processes of escalation for individual organisation risk to be considered for ICS solutions/mitigation.	David Pearson and Andy Haynes	31 December 2020	Completed

ICS Board Meeting Log 2020	Completed Actions

Completed
Ongoing
Outstanding

Reference Number	Discussion/Rationale	Date and time	Action	Update/Comment	Action Owner	Deadline	Status
B261	Item 6.Integrated Performance and Finance Report	12 March 2020	To produce a detailed report on cancer performance for ICS Board and report in May 2020	Superceded by the Phase 3 plan, To be discussed at the ICS Chief Executive Group in the first instance to identify areas for additional focus on delivery for reporting to ICS Board.	Richard Mitchell	31 December 2020	Completed
B262	Item 6.Integrated Performance and Finance Report	12 March 2020	To produce a detailed report on workforce performance for ICS Board and report in May 2020	Superceded by the Phase 3 plan, To be discussed at the ICS Chief Executive Group in the first instance to identify areas for additional focus on delivery for reporting to ICS Board.	Lyn Bacon	31 December 2020	Completed
B265	Item 4. Recovery Insights Project	17 September 2020	AB to circulate the Recovery Insight slides to ICS Board members.	Circulated with the draft minutes	Alex Ball	24 September 2020	Completed
B251	Item 10. Update from ICPs	16 January 2020	To work with ICS Financial Sustainability Group to provide ICS Board with assurance on Transformation Funding allocations and the impact of schemes.	Date for item to be discussed to be agreed.	Amanda Sullivan	31 December 2020	Completed
B260	Item 5.Outcomes Framework	12 March 2020	To discuss ICS and CCG functions to ensure alignment and no duplications or gaps in their delivery.	Discussions taken place as part of the arrangements to review and strengthen ICS governance. Output to be considered at a future meeting. Superceded by CEOG discussions	Andy Haynes and Amanda Sullivan	31 December 2020	Completed
B264	Item 3. Minutes of 12 March 2020	17 September 2020	DP and AH to review action log to ascertain which items are ongoing.		David Pearson and Andy Haynes	15 October 2020	Completed
B257	Item 6.Update from ICPs JM asked for further work on the return on investment of schemes to ascertain value for money for the system, and highlighted that further discussion on the form of ICPs and operating frameworks is needed at ICS Board to better understand the implications for statutory organisations. AH advised that the ICS Executive Group are developing a paper on ICP development for a future ICS Board meeting.	13 February 2020	To lead a discussion with the ICS Executive Group on ICP Development and arranging a development workshop with ICS Board	Pace and clarity on interfaces is critical. AH highlighted this is linked to the governance review and one of the key outcomes. ICS Executive Group to consider feedback from the governance review. Commitment from partners required to support this being resolved at pace. Output from the work to review and strengthen ICS governance to be considered at a future meeting. Paper on ICP Development produced for discussion. To be taken forward as part of B205	Andy Haynes	31 December 2020	Completed
B247	Item 5. Prevention, Inequalities and the Wider Determinants of Health	16 January 2020	To work with Local Authority colleagues in City Council and County Council to bring items to ICS Board on wider determinants of health.	AH has discussed with CU and MB. Items to be put forward as required.	Adele Williams	31 December 2020	Completed
B267	Item 4. Recovery Insights Project	17 September 2020	RH to link with AB on providing insights from an EMAS perspective.		Richard Henderson	15 October 2020	Completed

ICS Board Meeting Log 2020	Decisions

Completed
Ongoing
Outstanding

Reference Number	Discussion/Rationale	Decision	Date	Update/Comment	Decision Owner	Deadline	Status
ICSB - D001	Item 3.Minutes of previous meeting/Action log	The minutes of the meeting held on 6 November 2019 were agreed as an accurate record of the meeting by those present. The action log and updates were noted.	16/01/2020		Joanna Cooper		Completed
ICSB - D002	Item 5. Prevention, Inequalities and the Wider Determinants of Health	Board support a short, medium and long term approach through the priorities identified in the ICS Prevention Plan and recognises that the joint approach across the system and in organisations delivers to the outcomes framework.	16/01/2020				Ongoing
ICSB - D003	Item 6.NHS Long Term Plan, ICS Strategy and Operational Planning for 2020/21	ICS Board approved the proposed system planning and approach and principles for 2020/21 Operational Plans. Further work to take place on the interface between CCG and ICS, and to ensure that system finances are central to the delivery of the plan.	16/01/2020		Andy Haynes		Ongoing
ICSB - D004	Item 9.Mental Health Strategy Delivery Arrangements	Board agreed the proposed Terms of Reference for the Mental Health and Social Care Partnership Board with the caveat that the title of the group be reviewed for clarity of purpose.	16/01/2020		Amanda Sullivan / John Brewin		Completed
ICSB - D005	Item 9.Mental Health Strategy Delivery Arrangements	Board agreed the ICS approach to the delivery of the multi-agency components of the Mental Health Strategy and supported further development of the joint arrangements for intellectual and developmental disorders.	16/01/2020		Amanda Sullivan / John Brewin		Completed
ICSB - D006	Item 3.Minutes of 16 January	The minutes of the meeting held on 16 January 2020 were agreed as an accurate record of the meeting by those present. The action log and updates were noted.	13/02/2020		Joanna Cooper		Completed
ICSB - D007	Item 7.Integrated Performance and Finance Report	Board agreed the recommendation to progress SRM actions through the ICS Performance Oversight Group.	13/02/2020		Andy Haynes		Ongoing
ICSB - D008	Item 3.Minutes of 13 February ICS Board meeting and action log	The minutes of the meeting held on 13 February 2020 were agreed as an accurate record of the meeting by those present. The action log and updates were noted.	12/03/2020		Joanna Cooper		Completed

ICS Board Meeting Log 2020	Decisions

Completed
Ongoing
Outstanding

Reference Number	Discussion/Rationale	Decision	Date	Update/Comment	Decision Owner	Deadline	Status
ICSB - D009	Item 5.Outcomes Framework	Board agreed the recommendations in the circulated report: •Approach to monitoring and evaluating system transformation in 2020/21 •System transformation priorities that form the basis of developing the approach to monitoring and evaluating system transformation at 'Level 1 – System Performance Measurement' •System transformation priorities that form the basis of developing the approach to monitoring and evaluating system transformation at 'Level 2 – System Evaluation'	12/03/2020		Andy Haynes		Ongoing
ICSB - D010	Item 3. Minutes of 12 March 2020	The minutes of the meeting held on 12 March 2020 were agreed as an accurate record of the meeting by those present. The action log and updates were noted.	17/09/2020		Joanna Cooper		Completed
ICSB - D011	Item 4. Recovery Insights Project	Board agreed that short term issues should be addressed through the Recovery Cell including, provision for an increased number of remote consultations and appropriately and safely discharging patients from hospital (Home First). Alongside this consideration to be given to an ICS approach to addressing inequalities for citizens who are hard to reach or find public services hard to reach.	17/09/2020		Amanda Sullivan		Ongoing
ICSB - D012	Item 6. Approval of Data, Analytics and Information Technology (DAIT) Strategy	Board approved the ICS DAIT Strategy for Nottingham and Nottinghamshire.	17/09/2020		Andy Haynes		Completed
ICSB - D013							
ICSB - D014							
ICSB - D015							
ICSB - D016							
ICSB - D017							
ICSB - D018							
ICSB - D019							
ICSB - D020							
ICSB - D021							
ICSB - D022							
ICSB - D023							
ICSB - D024							
ICSB - D025							
ICSB - D026							
ICSB - D027							
ICSB - D028							

ICS Board Meeting Log 2020 **Register**

Attendees/Loggist	Meeting Dates																			
	16/01/2020	13/02/2020	12/03/2020	17/09/2020																
NUH																				
Chair	A	A	A	A																
Chief Executive	A	A	A	A																
SFH																				
Chair	Apols	A	A	D																
Chief Executive	D	A	A	A																
NHCT																				
Chair	A	A	A	A																
Chief Executive	Apols	A	A	D																
CCGs																				
Accountable Officer	D	A	A	A																
Lay Chair	A	Apols	A	A																
City Council																				
Chair, Health and Wellbeing Board	A	Apols	A	A																
Chief Executive	A	Deputy	A	A																
Councillor	A	A	Apols	A																
County Council																				
Chief Executive's Representative	A	A	Apols	A																
Councillor	Apols	Apols	A	A																
Chair, Health and Wellbeing Board	A	Apols	Apols	Apols																
EMAS																				
Chief Executive	D	Apols	A	A																
MN ICP																				
Representative of Mid Notts ICP on behalf of PCNs	Apols	A	A																	
Representative of Mid Notts ICP	A		A	A																
City ICP																				
Representative of Nottingham City ICP	A	A	A	A																
Representative of Nottingham City ICP on behalf of PCNs	Apols	Apols	A	A																
South ICP																				
Representative of South ICP	A	A	A	A																
Representative of South ICP PCN on behalf of PCNs	A	A	A	A																
Nottingham CityCare Partnership																				
Chief Executive	A	A	A	A																
Chair	Apols	A	A	A																
Supporting roles																				
ICS Director of Communications and Engagement	A	A	A	A																
Clinical Director	A	A	A	A																
ICS Independent Chair	A	A	A	A																
Chief Nurse	A	A	Apols	A																
ICS Finance Director	A	A	A	D																
ICS Assistant Director	A	A	A	A																
ICS Executive Lead	A	A	A	A																

Item Number:	4	**Enclosure Number:**	B
Meeting:	ICS Board		
Date of meeting:	15 October 2020		
Report Title:	Enhanced Care Response Team (ECRT) Supporting the Health and Care Sector in the Wake of Covid-19		
Sponsor:			
ICP Lead:			
Clinical Sponsor:			
Report Author:	Donna Nussey, Head of Quality Improvement, Nottingham and Nottinghamshire CCG.		
Enclosure / Appendices:	None		

Summary:

Background:

At the height of the Covid-19 pandemic Nottingham and Nottinghamshire's care homes were supported by partners across the system to provide a pioneering response to the changing environment and the pressures faced to the health and care sector.

The successful system-wide approach in supporting Nottinghamshire's care homes has now been extended in order to support care homes throughout the pressured winter period including support for the possibility of a potential second surge.

When the Coronavirus pandemic took hold across the region care homes were bombarded with daily changes in information which staff had to deal with whilst also coping with increased deaths and the trauma caused by the virus.

In response to this, NHS Nottinghamshire and Nottingham Clinical Commissioning Group and a number of GPs from across the region provided leadership and clinical oversight to the care sector while being supported by a team from across the region.

The system-wide team of support included help from local authority experts such as public health and market management alongside Mid Nottinghamshire Integrated Care Provider which gave operational support, under mutual aid.

The response to the pandemic within care homes was initiated by a personal letter to all care homes, offering a range of support and asking what they required. This led to the launch of an Enhanced Care Response Team (ECRT) - a time limited support offer from the NHS.

What do ECRT offer?

The ECRT response included help and support in a number of different ways. The main purpose of the ECRT response was to provide support to care homes, provide clear information for best practice and help with training. The team did this by:

- Carrying out a daily central briefing collated and disseminated and a bi-weekly webinar on various subjects, often with key clinicians available to give advice and information.
- Compiling a toolkit of best practice which is regularly updated. Training from the toolkit has been delivered to 368 homes and has been downloaded more than 3,000 times.
- Offering and/or delivered PPE training within 14 days to 100% of care homes

As part of the ECRT response more than 40 nurses were redeployed to go out to care homes, support and offer training on the toolkit.

The ECRT will be in place until 31 December 2020 to provide a bridge whilst the system develops and commissions longer term building on the lessons learned during Covid-19 to co-design a proactive model of care, built in partnership with the care providers.

Actions requested of the ICS Board

To receive the report and discuss the issues raised.

Recommendations:

1.	To share with Board an example of innovative working to support the system during the covid-19 response.

Presented to:

Board	Partnership Forum	Clinical Reference Group	Chief Executive Group	Finance Directors Group
☒	☐	☐	☐	☐
Quality Group	Performance Oversight Group	Mid Nottingham-shire ICP	Nottingham City ICP	South Nottingham-shire ICP
☐	☐	☐	☐	☐

Contribution to delivering System Level Outcomes Framework ambitions

Our people and families are resilient and have good health and wellbeing	☒	Our people will have equitable access to the right care at the right time in the right place	☒	Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population	☒

Conflicts of Interest

☒ No conflict identified
☐ Conflict noted, conflicted party can participate in discussion and decision
☐ Conflict noted, conflicted party can participate in discussion, but not decision

☐ Conflict noted, conflicted party can remain, but not participate in discussion or decision

☐ Conflict noted, conflicted party to be excluded from meeting

Risks identified in the paper

Risk Ref	Risk Category	Risk Description	Residual Risk				Risk owner
			Likelihood	Consequence	Score	Classification	
Ref	e.g. quality, financial, performance	Cause, event and effect There is a risk that…	L1-5	L1-5	L x I	Grading	*Person responsible for managing the risk*

Is the paper confidential?

☐ Yes

☒ No

☐ Document is in draft form

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 Number:	5	**Enclosure Number:**	C1
Meeting:	ICS Board		
Date of meeting:	15 October 2020		
Report Title:	Nottingham & Nottinghamshire Health Inequalities Strategy		
Sponsor:	John Brewin, ICS lead for Health Inequalities		
ICP Lead:	N/A		
Clinical Sponsor:	Nicole Atkinson, ICS Clinical Director		
Report Author:	ICS Working Group - Health Inequalities Strategy		
Enclosure / Appendices:	Enc. C2. Nottingham & Nottinghamshire Health Inequalities Strategy		

Summary:

This paper provides the ICS Board with a summary of the work to date to develop the Nottingham and Nottinghamshire Health Inequalities Strategy.

The ICS established a small working group to develop the strategy and all ICS partners have contributed through the ICS Recovery Cell.

The draft Health Inequalities Strategy was shared with NHS England and Improvement as part of the Phase 3 planning submission in September. The system received positive feedback in particular:

- The strategy provides a great insight into the determinants of health and making links with wider cultural and societal factors;
- Excellent progress made on developing metrics and how this links with the system outcomes.

NHS England and Improvement also asked if they could share the strategy with other systems.

The strategy provides a framework for organisations, ICP and neighbourhoods to develop implementation plans which are targeted for local populations.

Actions requested of the ICS Board

To approve the Health Inequalities Strategy and to give consideration to implementation and next steps.

Recommendations:

1.	**APPROVE** the ICS Health Inequalities Strategy for Nottingham and Nottinghamshire
2.	**CONSIDER** how the ICS moves to implementation and **AGREE** a way forward.

Presented to:				
Board	Partnership Forum	Clinical Reference Group	Chief Executive Group	Finance Directors Group
☒	☐	☐	☐	☐
Quality Group	Performance Oversight Group	Mid Nottingham-shire ICP	Nottingham City ICP	South Nottingham-shire ICP
☐	☐	☐	☐	☐

Contribution to delivering System Level Outcomes Framework ambitions					
Our people and families are resilient and have good health and wellbeing	☒	Our people will have equitable access to the right care at the right time in the right place	☒	Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population	☒

Conflicts of Interest

☒ No conflict identified
☐ Conflict noted, conflicted party can participate in discussion and decision
☐ Conflict noted, conflicted party can participate in discussion, but not decision
☐ Conflict noted, conflicted party can remain, but not participate in discussion or decision
☐ Conflict noted, conflicted party to be excluded from meeting

Risks identified in the paper

Risk Ref	Risk Category	Risk Description	Residual Risk				Risk owner
			Likelihood	Consequence	Score	Classification	
Ref	e.g. quality, financial, performance	Cause, event and effect There is a risk that…	L1-5	L1-5	L x I	Grading	*Person responsible for managing the risk*

Is the paper confidential?

☐ Yes
☒ No
☐ Document is in draft form

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

Nottingham and Nottinghamshire Health Inequalities Strategy

ICS Board – 15 October 2020

Background

1. Health inequalities are the unjust differences in health experienced by different groups of people. In Nottingham & Nottinghamshire today there is a significant gap in healthy life expectancy between the most and least affluent areas of the country.

2. Closing this gap is one of the biggest challenges the system face, this about much more than access and quality of health and care services given wider determinants contribute 80% towards health outcomes. Health actions are necessary but not sufficient and this strategy covers a wide range of issues which affect our health and wellbeing including employment, education, our living situation and relationships.

3. To successfully address health inequalities ICS need to:

    - Increase our understanding around health inequalities and local population;
    - Promote ways of working across ICS partners, key stakeholders and communities most likely to reduce health inequalities;
    - Provide system outcomes which are key to reducing inequalities in health and wellbeing.

4. This strategy is designed to help establish a shared commitment and vision for addressing health inequalities across the health and care system.

5. The draft Health Inequalities Strategy was shared with NHS England and Improvement as part of the Phase 3 planning submission in September. The system received positive feedback in particular:

    - The strategy provides a great insight into the determinants of health and making links with wider cultural and societal factors;
    - Excellent progress made on developing metrics and how this links with the system outcomes.

    NHS England and Improvement also asked if they could share the strategy with other systems.

Approach

6. A small working group was established to develop the Nottingham and Nottinghamshire Health Inequalities Strategy. The working group members included public health, clinical, commissioner, provider and ICS team.

7. The strategy has been developed after considering the following:

    - ICS Five-year Strategic Plan;
    - Analysis (national and local) of the impact of Covid-19 on the health inequalities gap;
    - Guidance and other supporting information (Health and Local Government);
    - The importance of developing metrics and monitoring, to support the delivery of the strategy.

Engagement

8. The strategy was shared with members of the ICS Recovery Cell (partner organisations and ICPs) for review and contributions during August and September. All feedback has been included in the strategy.

Implementation of the Health Inequalities Strategy

9. Page 14 sets out the conditions for success, including system leadership to take forward the ICS Health Inequalities Strategy and move to implementation stage. The ICS Chief Executive Officers Group nominated John Brewin as the system lead for Health Inequalities.

10. The Health Inequalities Strategy provides a framework for organisations, ICP and neighbourhoods to develop implementation plans, which are targeted for local populations.

11. The schematic on page 15 outlines the relationship between system level health inequalities strategy and health inequalities action plan at a local level (organisation, ICP and neighbourhoods).

12. The system needs to consider the relationships, the importance of developing targeted actions at a local level and agree the approach and timeline to develop the implementation plans.

Recommendations

13. The ICS Board is asked to:

    - **APPROVE** the ICS Health Inequalities Strategy for Nottingham & Nottinghamshire
    - **CONSIDER** how the ICS moves to implementation and **AGREE** a way forward.

ICS Working Group – Health Inequalities Strategy
7 October 2020

ICS Board 15 October 2020:
Item 5. Enc C2.

Nottingham and Nottinghamshire Integrated Care System

Health Inequalities Strategy 2020-2024

7 October 2020 v1.8

Please cite 'this work has been informed by the Nottingham and Nottinghamshire ICS' when referencing this strategy or approaches used. This information has been placed in the public domain in order to benefit patients across the country as we believe the experience and approach may be useful for others, however we request that acknowledgement to the work in Nottinghamshire is made and referenced in all materials. This helps us to understand the wider impact benefits of our programme.

Foreword

Across Nottingham and Nottinghamshire there are more people living longer in ill health, unprecedented levels of demand for care and support, workforce shortages and considerable funding constraints. Combined these factors continue to place an ever-increasing strain on the local health and care system and looking to continue to do more and more of the same each year is not sustainable.

In response to this the leaders of our local health and care system have come together to develop a five-year strategic plan, underpinned by the ICS Clinical and Community Services Strategy, that sets out a shared vision 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'***. Delivery of this vision will be characterised by moving from a health and care system that is often siloed and reactive in nature to one where all partners are focused on the entire spectrum of interventions from prevention and promotion to health protection, diagnosis, treatment and care – and integrates and balances action between them.

Dr Andy Haynes
ICS Executive Lead

Addressing Health Inequalities

Health inequalities are the unjust differences in health experienced by different groups of people. In **Nottingham & Nottinghamshire today there is a significant gap in healthy life expectancy between the most and least affluent areas of the country**.

Closing this gap is one of the biggest challenges we face, **this about much more than access and quality of health and care services given wider determinants contribute 80% towards health outcomes**. Health actions are necessary but not sufficient and this strategy covers a wide range of issues which affect our health and wellbeing including employment, education, our living situation and relationships.

To successfully address health inequalities we need to:

- Increase our understanding around health inequalities and our local population
- Promote ways of working across ICS partners, key stakeholders and communities most likely to reduce health inequalities
- Provide system outcomes which are key to reducing inequalities in health and well being

Dr John Brewin
Chief Executive of Nottinghamshire Healthcare NHS Foundation Trust
&
ICS Lead for Health Inequalities

This strategy is designed to help establish a shared commitment and vision for addressing health inequalities across the health & care system. The strategy recognises the impact of COVID-19 (direct and indirect), and it supports the ICS Clinical and Community Services Strategy and the five year strategic plan. As recovery plans become clearer and have an impact on existing organisations' strategies, the strategy will iterate to reflect those changes.

If we get this right how will it feel for people

As **a citizen living** in Nottingham and Nottinghamshire this means:

- We will not worsen health inequalities; we will work to reduce them.
- We will support our population by providing them with the skills, training and tools to access digitally enabled health and care services in order to empower and enable them to manage their health and care and reduce health inequalities and social isolation (supported by digital inclusion programme)
- We will listen and engage with communities who need most support, deepening partnerships with community and voluntary sector.

As a **person receiving support** from our health and care system:

- Health and care services are accessible for all, particularly those at risk of exclusion because of personal, economic or social factors .
- We will improve how we proactively identify the health and care needs of our population in order to identify and put in place support and treatment that our population need in order to stay well.
- We will accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes.

As **a person working** in our health and care system:

- Health and care staff are valued and supported to maintain wellbeing and so deliver high quality care in all settings.
- We will strengthen leadership and accountability, with a named executive board member responsible for tackling inequalities in place in every ICS partner, alongside actions to increase the diversity of senior leaders.
- We will provide the people involved in providing health and care with the information and tools to understand and respond to health inequalities.

Our vision for health inequalities is that everyone has the same opportunity to lead a healthy life no matter where they live or who they are and that our front line professionals are valued and supported to deliver high quality care.

The context for this strategy

Overview

Our health and care partners across Nottingham and Nottinghamshire came together in 2016 in a Sustainability and Transformation Partnership (STP) with the collective goal of improving the quality and sustainability of health and care services.

This collaboration subsequently evolved into an Integrated Care System (ICS) in 2018 focussed on becoming a fully population health focused health and care system – a system where all partners are focused on the entire spectrum of interventions, from prevention and promotion to health protection, diagnosis, treatment and care; and integrates and balances action between them.

ICS members include:

- Nottingham City Council
- Nottinghamshire County Council
- City Care
- Nottingham and Nottinghamshire CCG
- Nottingham University Hospitals NHS Trust
- Sherwood Forest NHS Foundation Trust
- Nottingham Healthcare NHS Foundation Trust

The ICS covers a diverse population of over 1 million people living in the City of Nottingham (332,000) and Nottinghamshire County (764,700), however this does not include the residents of Bassetlaw as they are part of the South Yorkshire and Bassetlaw health care system

Challenges to be addressed

The key challenges faced and therefore to be addressed by the Nottingham and Nottinghamshire Integrated Care System can be grouped into three categories, that have a reinforcing effect on each other: the health and wellbeing of the population, the provision of services and the effective utilisation of health and care system resources.

Health and Wellbeing

- More people are living longer in ill health
- Deprived communities and certain groups of people have greatest exposure to factors that impact adversely on health
- COVID-19 has had a disproportionate impact which has widened the health inequalities gap

Service Provision

- Current health & care services have been set up to help sick people get well, often in a hospital setting
- Do not routinely and systematically identify and support people with ongoing needs
- Inequity of access to services (including digital and virtual services) has widened the health inequalities gap

Resource Utilisation

- Increasing vacancies in health and care workforce
- Ageing estate with high level of backlog maintenance
- Significant financial deficit forecast over next 5yrs, underpinned by recurrent deficit, non-delivery of savings plans and increasing activity/demand
- Resource allocation does not reflect population health need

Inequalities and the wider determinants of health

What are health inequalities?

To address the challenges we face as a health and care system and deliver our overall vision, through our 5-year ICS Strategic Plan we have identified five priorities, one of which is 'Prevention, Inequalities and the Wider Determinants of Health'

Health inequalities are ultimately about avoidable differences in the status of people's health. But the term is also commonly used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives, both of which can contribute to their health status. Health inequalities can therefore involve differences in:

- Health status, for example, life expectancy and prevalence of health conditions;
- Access to care, for example , availability of treatments;
- Quality and experience of care, for example, levels of patient satisfaction;
- Behavioural risks to health, for example, smoking rates; and
- Wider determinants of health, for example, quality of housing.

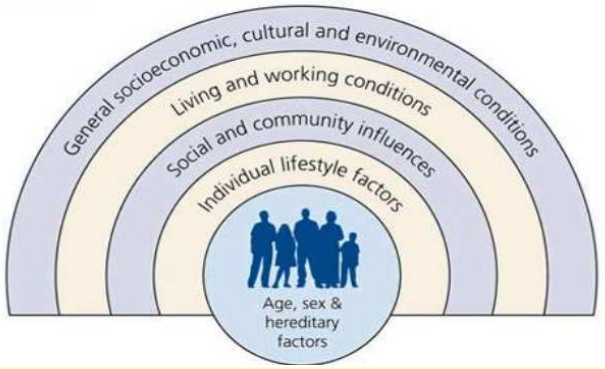
ICS Vision (Strategic Plan 2019-24)

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

What affects health and wellbeing

Access to and quality of health care services contribute to overall health outcomes and health inequalities. However, this is relatively small compared to what are known as the wider determinants of health. These include:

- Personal characteristics - age, gender, ethnicity
- Individual lifestyle factors - smoking, alcohol consumption, diet, physical activity
- Social and community influences – includes family and wider social circles
- Living and working conditions – access and opportunities in relation to jobs, housing, education and welfare services
- General socioeconomic, cultural and environmental conditions – factors such as disposable income, taxation and availability of work



The purpose of this strategy is to provide an over-arching framework for the ICS and its constituent members for addressing health inequalities and the wider determinants of health.

Where are we starting from?

We fully recognise that access to and quality of health care services is only a small contributor to overall health outcomes.

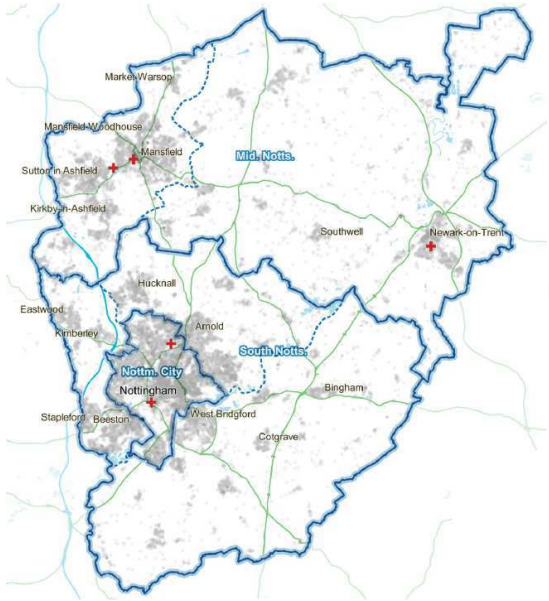
Health Behaviours 30%	Socioeconomic Factors 40%	Clinical Care 20%	Built Environment 10%
Smoking 10%	Education 10%	Access to Care 10%	Environmental Quality 5%
Diet / Exercise 10%	Employment 10%	Quality of Care 10%	Built Environment 5%
Alcohol Use 5%	Income 10%		
Poor Sexual Health 5%	Family / Social Support 5%		
	Community Safety 5%		

The wider determinants of health contribute 80% of health outcomes

Deprivation is a key driver of illness and ill health. It is our deprived communities that often have the greatest exposure to a range of factors that impact adversely on the health of individuals, families and communities, including fuel poverty, poor housing, higher unemployment and low paid jobs, lower educational attainment and poorer access to services. Lifestyle risk factors such as smoking, physical inactivity and poor diet, area also often most prevalent in these communities.

Ethnicity is also a key factor in health risks and behaviours, for example smoking is more common in mixed-ethnicity and white populations and some diseases are more prevalent in some ethnic groups.

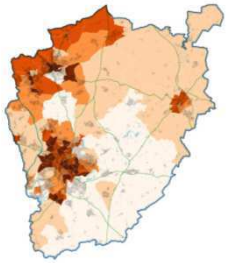
Mental health and learning disability inequalities are also often linked with wider cultural and societal systems of disadvantage which impact a person's wellbeing, including (but not limited to) adverse childhood experiences, stigma, discrimination and housing security.



The Nottingham and Nottinghamshire ICS covers a diverse mix of urban and rural, cities, towns and villages.

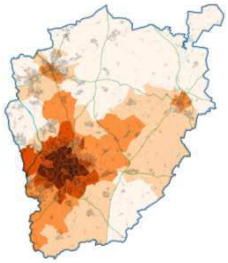
Darker shading – higher proportion

Deprivation



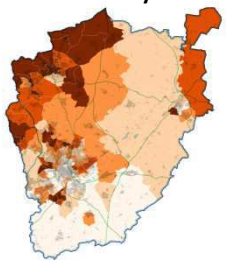
Most deprived communities are found in parts of the City and around Mansfield & Ashfield

Ethnicity



Percentage of population varies between 2% and 59% from BME ethnicity

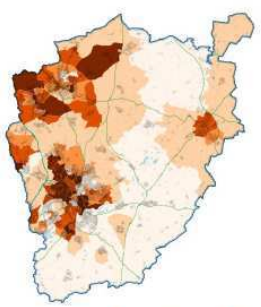
Long-term illness or disability



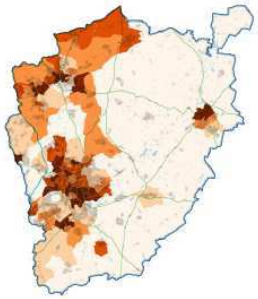
Up to a third of people report a long-term illness or disability that affects their daily activity

Where are we starting from?

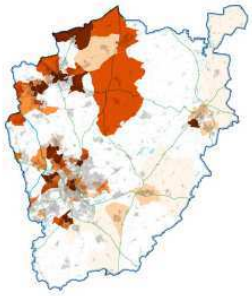
Lots of indicators show a similar pattern…



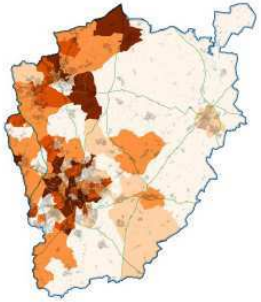
Obese or overweight
Age 10/11



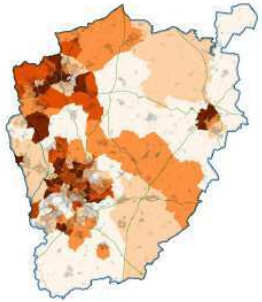
Hospital admissions
Alcohol harm



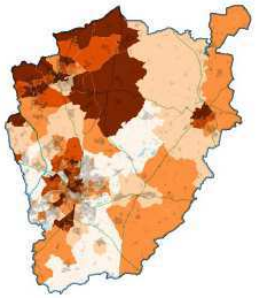
Proportion babies born
To women aged under 19



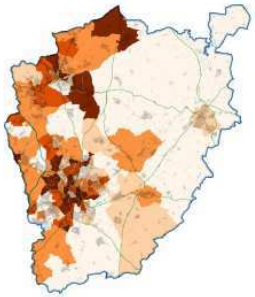
Emergency admissions
All age, all cause



Emergency admissions
All age, self harm

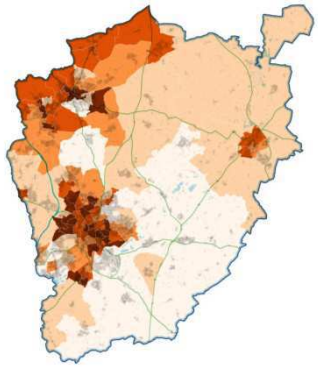


Admissions for injuries
Age under 15



Emergency admissions
Coronary heart disease

Many health and healthcare usage indicators are worse in areas with higher deprivation



Darker shading – higher proportion live in most deprived areas

This influences how long people live (life expectancy) and how much of their lives people spend in ill-health (healthy life expectancy)

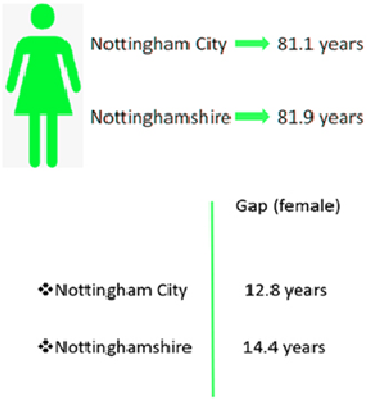
Where are we starting from?

Life Expectancy

Life expectancy is a measure of the average number of years somebody born in an area is expected to live. Life expectancy at birth for females in Nottingham City and Nottinghamshire is 81.1 and 81.9 years respectively, and for males 77.0 years and 78.5 years.

One way in which health inequalities can be measured is by comparing the gap in life expectancy between the most deprived and least deprived areas. In Nottingham City this is 12.8 years for females and 11.9 for males, in Nottinghamshire it is 14.4 for males and 14.9 for females.

Cancer, Circulatory and Respiratory disease are the greatest contributors to the overall life expectancy gap between the most and least deprived. For females these contribute to c.55% of the life expectancy gap between the most and least deprived areas, and for males c.65%.

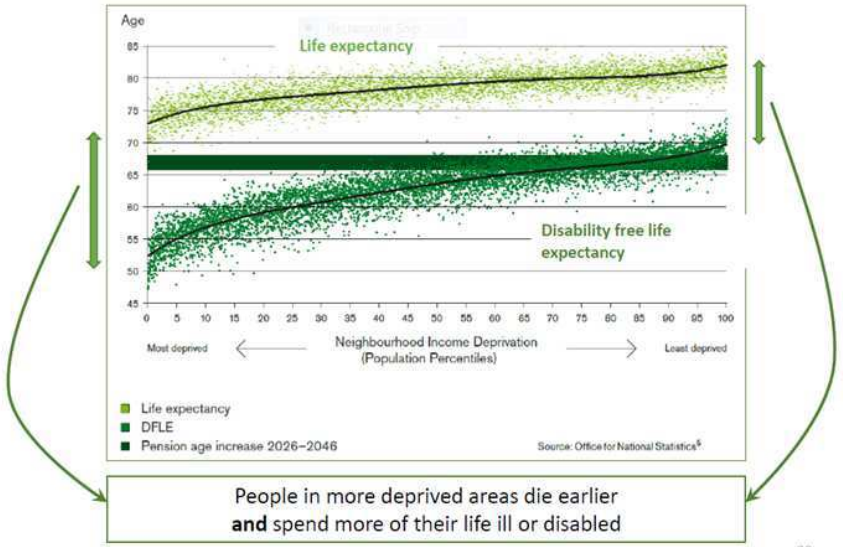


Healthy Life Expectancy

Healthy life expectancy is another important measure for understanding health inequalities. The gap between healthy life expectancy and life expectancy gives an indicator of morbidity, i.e. the amount of time somebody spends living in ill health and requires care support.

In Nottingham City on average the amount of time spent living in ill health is 26.0 years for females and 19.5 for males. For Nottinghamshire it is 20.5 years for females and 18 years for males.

However, we know this varies between geographies with people living in more deprived areas generally spending more of their life in ill health.



We must tackle the inequalities that exist across our ICS by focusing on those people and conditions that have the greatest impact

The impact of COVID-19 on health inequalities

The likely impact of COVID-19 on inequalities?

Prior to the COVID-19 pandemic there were stark inequalities in the social determinants of health, risk factors, health care provision and clinical outcomes across socio-economic, disadvantaged and inclusion health groups.

COVID-19 has exacerbated these inequalities and substantially increased them in both the short and long term. The likely higher COVID-19 mortality in deprived communities is likely to be compounded by subsequent worsening of ill health and pre-mature mortality due to economic and social impacts of the pandemic.

There are several different mechanisms by which COVID-19 may increase inequalities including:

1. Direct impact of COVID-19
   - *Disproportionally higher infection in more deprived areas*
   - *Disproportionate long-term impact in survivors*
2. Indirect: Health & Care Services
   - *Services reduced or stopped as a result of COVID-19 response*
   - *Access to services:*
     - *Change in access*
     - *Fear of accessing services*
     - *Ability to access e.g. digital, virtual*
3. Indirect: Wider Determinants
   - *Reduced agency (e.g. housing, social)*
   - *Unemployment / economic downturn*
   - *Education and school closures*
   - *Mental Health (impact of COVID-19, isolation and lockdown)*

Groups disproportionally impacted by COVID-19

Certain groups have been identified as being disproportionality impacted by the COVID-19 pandemic.

5. Mental health & Learning Disabilities

1. Black, Asian and minority ethnic (BAME) groups

People in black, Asian and minority ethnic groups are twice as likely to be living in poverty and are more likely to be employed in a key worker role or experiencing housing deprivation.

2. Disadvantaged communities

People facing greater socio-economic disadvantage risk greater exposure to the virus; for example, as key workers or through crowded housing conditions. These groups are also more likely to be in poorer health to begin with (such as respiratory conditions or heart disease) and therefore more severe symptoms and hospitalisation.

3. Vulnerable groups

People who belong to inclusion health groups face marginalisation or social exclusion, and subsequently poor health, directly because of a certain characteristic or experience: rough sleepers, people in temporary accommodation, Gypsy/Roma/Traveller communities, migrant worker, people recently released from prison, people with learning disabilities and autism, people with severe mental illness

4. Frailty and older people

People in this group are at far greater risk of worsening mental health: people living with mental health problems who access to services has been interrupted, people who live with both mental health problems and long term

We must address the widening health inequalities as a result of COVID-19 by focusing on these groups

What is the basis of our Health Inequalities Strategy?

Integrated Care System
Nottingham & Nottinghamshire

1

Metrics

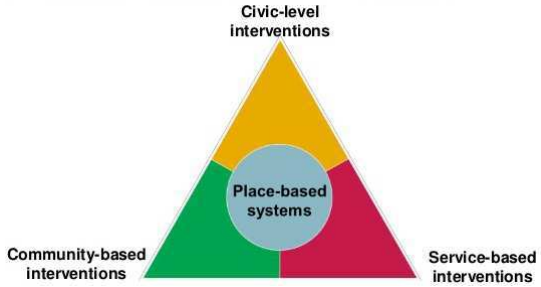
Define metrics (process, output & outcome) and data sets that will inform and identify where health inequalities exist across our prioritised groups for action ***and monitor***

- ***1. BAME Population***
- ***2. Disadvantaged Communities***
- ***3. Vulnerable Groups***
- ***4. Frailty & Older People***
- ***5. Mental Health & Learning Disabilities***

2

Population Intervention Triangle (PIT)

We have adopted the Population Intervention Triangle to guide and shape the specific actions to address the health inequalities identified and defined – ***these actions will be co-produced with our communities***.



This model brings together important elements of **effective place-based working *delivered through ICPs and neighbourhoods (PCNs)*:**

- Civic-level interventions – Policies, strategies, legislation and planning that act on the drivers of health inequalities, including the wider determinants – driven through the Health in All Policies approach and Health & Wellbeing Boards
- Service-based interventions – Where interventions have the potential to generate population-level change, a graduated and targeted support to the populations in greatest need, who are not using those services to the best effect.
- Community-based interventions – The main pillars are i) strengthening communities ii) volunteer and peer roles iii) collaborations and partnerships iv) access to community resource

3

Areas for action

We will build health inequalities action plans around areas for action across the prioritised groups recognising that the ***impact of actions will be short, medium and long term.***

Action Plans

Health & Care Services	• Protect the most vulnerable from COVID • Restore health & care services inclusively • Digitally enabled care which increase inclusion • Accelerate preventative programmes • Particularly support those who suffer mental health	**Short-term impact**
Lifestyle Factors	• Alcohol • Smoking • Diet and physical activity • Children and Young People	**Medium-term impact**
Living & Working Conditions	• Environment • Economy / Employment • Housing • Education/life learning	**Long-term impact**

These will not constituent a separate programme, they will cut across existing programmes

Health Inequality Strategy Objectives - Health & Care Services

Integrated Care System
Nottingham & Nottinghamshire

Area for action	Strategic objectives – Short-term Impact	PIT		
		CI	SBI	CBI
Protect the most vulnerable from COVID-19	• Ensure plans for protecting people at greatest risk during the COVID-19 pandemic are regularly updated, including:			
	• Ensure people who may be clinically extremely vulnerable to COVID-19 infection are identified and supported to follow specific measures (e.g. shielding) when advised and to access restored services when required.		✓	
	• Ensure plans set out how insight into different types of risk and wider vulnerability within communities will be improved, including through population health management and risk management approaches and deeper engagement, including carers.		✓	
	• Ensuring information on risks & prevention is accessible to all communities, including culturally competent campaigns.			
	• Using the benefits of ICPs to provide a place based approach allowing for proportionate universalism in supporting this group.		✓	
	• ICS constituent organisations/ICPs develop/deliver action plans following completion of COVID-19 risk assessments of staff.		✓	✓
	• Directly supporting the resilience of the community and voluntary sector through a system wide approach and framework.			✓
Restore health & care services inclusively	• Restore health & care services inclusively so they are used by those in greatest need:			
	• Guided by performance monitoring of service use & outcomes amongst those from the most deprived (20%) neighbourhoods and from BAME communities. Consideration will be given to how to expand the approach to those with a disability.		✓	
	• Monitoring will compare service use and outcomes across emergency, outpatient and elective care including cancer referrals and waiting time activity.		✓	
	• Ensure mandatory recording of ethnicity in clinical databases cited in specialised services specifications (by 31 March 2021)		✓	
Digitally enabled care which increase inclusion	• Ensure all ICS constituent organisations, no matter how people choose to interact with services, receive the same level of access, consistent advice and the same outcomes of care, by:			
	• Testing new care pathways are achieving a positive impact on health inequalities, starting with – 111 First; total triage in general practice; ;digitally enabled mental health; and virtual outpatients.		✓	
	• Assessing empirically how the blend of different 'channels' of engagement (face-to-face, telephone, digital) has affected different population groups.		✓	
	• Putting in place mitigations to address any issues.		✓	✓
Accelerate preventative programmes	• Improve uptake of flu vaccination in underrepresented 'at risk' groups.		✓	
	• Ensure care and support planning is continued - General Practice/PCNs/ICPs develop priority lists for preventative support and LTC management – priority groups for programmes such as obesity prevention, smoking cessation, alcohol misuse, cardiovascular, hypertension, diabetes and respiratory disease prevention should be engaged proactively.		✓	
	• Ensure everyone with LD and SMI is identified on their register and annual health checks/follow ups are completed.		✓	
	• Ensure the proportion of black and Asian women and those from the most deprived boroughs on continuity of carer pathways meets and preferably exceed the proportion of the population as a whole.		✓	
	• Implement place-based communications strategy targeting groups most at risk to reduce delays in seeking care.		✓	
Particularly support those who suffer mental ill-health	• Validate plans to deliver the system's mental health transformation and expansion programme, with a particular attention to advancing equalities in access, experience and outcomes for groups facing inequalities across different mental health pathways.		✓	
	• Improve the quality and flow of mental health data to allow more robust monitoring of disproportionalities in access and experience and tale action where problems are identified.		✓	

Health Inequality Strategy objectives – Lifestyle Factors

Area for action	Strategic objectives – Medium-term Impact	PIT		
		CI	SBI	CBI
Alcohol	• Targeted Population Health Management (PHM) approach by ICPs and neighbourhoods (PCNS):			
	• Increase population understanding of risk and harm through IBA (identification and brief advice) and targeted communications campaigns, working with partners outside health and care e.g. police and fire		✓	✓
	• Strengthen communication links between ED and primary care, developing a system wide approach		✓	✓
	• Case management approach to high volume service users		✓	✓
	• Using PHM, recognise and support service change and a system wide approach to dual diagnosis due to the increasing risk of suicide, self-harm, mental ill health, domestic violence and increasing dependency on drug and alcohol		✓	
	• Alcohol Care Teams to support entry into appropriate care and treatment to align with and integrate with community services to ensure whole systems approach.		✓	
	• Employee Health and Wellbeing – all ICS partners will Include alcohol as a priority for employee health and wellbeing, building opportunities through the ICS HR and OD Collaborative.	✓		
Smoking	• Targeted Population Health Management (PHM) approach by ICPs and neighbourhoods (PCNS):			
	• In the short term, to enhance the focus on prevention across the system recognising that those practicing unhealthy behaviours may have increased as a result of COVID19		✓	✓
	• Increase population understanding of risk and harm through VBA (very brief advice) and targeted communication campaigns		✓	✓
	• Place based approach to resources, investing in actions to reduce the prevalence of smoking, with a particular focus on low income groups, experiencing poor mental health and maternity	✓	✓	✓
	• Provide an integrated smoking cessation service, moving to a hub and spoke model		✓	
	• For the longer term, actively monitoring changes in habits impacted by a recession and taking a system wide approach to respond accordingly i.e. impact of price on product choice/policies on illicit tobacco	✓		
Diet and physical activity	• Targeted Population Health Management (PHM) approach by ICPs and neighbourhoods (PCNS):			
	• With Public Health expand on planning at place level to focus on provision of services in areas with high obesity rates, deprivation and BAME communities, with an immediate focus on the impact of COVID-19 e.g. reduced physical activity		✓	✓
	• Support wider roll out of successful Active Nottinghamshire programmes (targeted approach)		✓	✓
	• Taking the Government strategy on obesity implement targeted communication campaigns	✓		✓
	• Recognising the importance of tier 3 services for obesity, through the Clinical Services Strategy co-produce and redesign the delivery of targeted weight management services from tiers 1 to 4 from the basis of the impact on health inequalities		✓	✓
	• To continue to promote and support the Diabetes Prevention Programme		✓	✓
Children and young people	• Recognising the impact of COVID-19 for children and young people (school disruption and access to health & care services), take a system wide approach in recognising and prioritising return to school and remobilising	✓		
	• Accessibility to services as part of restoration (this includes recognising the increased pressure on certain services due to increased demand as a result of COVID19), taking a planned approach across ICPs.		✓	

Health Inequality Strategy objectives – Living and Working Conditions

Area for action	Strategic objectives – Long-term Impact	PIT		
		CI	SBI	CBI
Environment	• To support the strength of community assets through the system wide leadership and structures including ICPs and neighbourhoods (PCNs)		✓	✓
	• To ensure that as a system actions are taken to maintain accessibility to health and care services by those who lack digital literacy or do not have the means to use digital resources (supported by Patient Facing Digital Strategy and ICS Digital Inclusion Programme)		✓	✓
	• Explore opportunities of how the health and care system can manage it's lands and estates to support broader social, economic and environmental aims	✓		
	• System partners work together to support actions to improve air quality	✓		
Economy/ Employment	• Work across the civic-service interface to ensure as much of the health and care spend is retained, to have secondary economic effects locally e.g. through procurement supply chains	✓	✓	
	• Investment in the local labour market for service employment (e.g. work and skills provision - job fairs, recruitment and retention practices and apprenticeships)	✓		
	• Civic-service public health and NHS supported healthy workforce initiatives across the system	✓		
	• Target actions directly in response to a recession and the impact on health inequalities - take a PHM approach to a framework that allows to monitor risks in order to take action at an early stage (increased tobacco use increases tobacco-related poverty, further exacerbating the impact of the recession on low income families); job losses and economic instability may lead to overweight and obesity increases)	✓	✓	✓
Housing	• To identify and commit to actions that further provide for safe homes and are targeted to areas of highest need	✓	✓	✓
	• Supporting actions that help to keep people in their homes at a time of financial insecurity and increasing unemployment		✓	
	• As a system, provide support to community assets that are essential services for people in their own homes		✓	
	• Social housing embedded as part of integrated discharge approach		✓	
Education / Life Learning	• All partners to record data relevant to health inequalities i.e. ethnicity, such that as a system have a greater awareness of the monitoring and impact on health inequalities		✓	

	• The system (including ICPs and neighbourhoods) will work with partners outside of health and care to develop plans to work together to support:
	  • Giving every child the best start in life
	  • Enabling all children, young people and adults to maximize their capabilities and have control over their lives
		✓	✓	✓

	• Establishing partnerships with other key local "anchor institutions" including universities, schools and businesses	✓		

Ensuring delivery of our the strategy – conditions for success

Culture & Commitment

- All ICS partners are committed to addressing the health inequalities gap for Nottingham & Nottinghamshire.
- All ICS Partners recognise the significant impact of wider determinants on health inequalities (80% of health outcomes) and commit to work together to implement system-wide actions.
- All strategies should consider health inequalities, driven through the Health in All Policies approach and Health & Wellbeing Boards.

Commissioning Services of Health & Care Services

- The impact on health inequalities is set out prior to any changes in the commissioning or provision of services.
- Commissioning processes reviewed to ensure any unintended structural racism or bias is addressed.
- Strengthened engagement with communities who need most support, working with ICPs and neighbourhoods to deepen partnerships with community and voluntary sector.
- Services, and recovery actions are accessible for all, particularly those at risk of exclusion because of personal, economic or social factors.
- Where there is any flexibility, health and care services should always be allocated based on healthcare need, striving in particular for equity of access.
- Allocation of resources recognise targeted funding for health inequalities.

Governance

- All ICS partners have a named executive board member responsible for tackling inequalities in place
- ICS Prevention & Inequalities Board, supported by System Executive lead for Health Inequalities.

Implementation Plan

The strategy will be supported by an implementation plan. It is important that the plan:

- Captures the priorities and necessary actions as a result of COVID-19. This will require the system to fully assess and understand the impact at a local level. Work is underway across the system with targeted Population Health Management work, a wider impact assessment through the Local Resilience Forum and review of health & care data. Appendix 1 outlines a health inequalities framework to consistently review the local analysis and use this to inform commissioning and service priorities.
- Is appropriately resourced.
- Supported and aligned plans across ICS constituent organisations, ICPs and neighbourhoods (PCNs). See page 15.

Robust approach to monitoring and evaluation

- The system's monitoring and evaluation approach will support all system partners (commissioners , providers and ICPs) to consistently evaluate system change and transformation initiatives/interventions.
- This will be achieved through an agreed set of measures (service delivery, staff, patient/citizen, quality/patient safety etc) that align to the ICS System Outcomes Framework (see Appendix 2 & 3) and therefore delivery of the system's five-year strategic plan overall.
- Health and care data systems will collect information on risk factors and protected characteristics including ethnicity, to underpin our understanding and response to health inequalities.

Schematic to show relationship between system level health inequalities strategy and health inequalities action plan

An over-arching framework for the ICS and its constituent members for addressing health inequalities and the wider determinants of health

ICS constituent organisations, ICPs and PCNs develop health inequality implementation plans for health & care services, lifestyle factors and living & working conditions - aligned to the ICS Health Inequalities Strategy

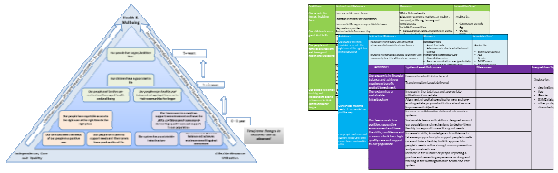
Implementation

	Health & Care Services	Lifestyle Factors	Living & Working Conditions
Nottinghamshire CC Nottingham CC N&N CCG NUH SFH NHC City Care			
Mid Notts ICP City ICP South Notts ICP			
Nottingham & Nottinghamshire ICS	***= System's Phase 3 response to COVID for addressing inequalities***		

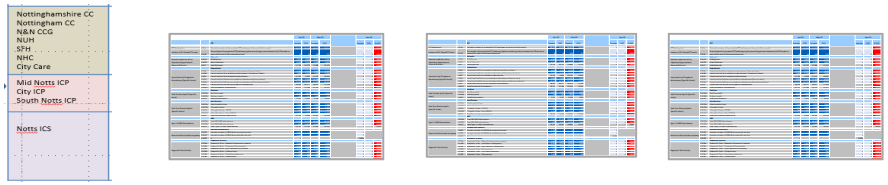
Plans iterated based on ongoing monitoring and evaluation

Monitoring & Evaluation

Set of Health Inequalities metrics aligned to System Outcomes Framework established to monitor progress of strategy



Systems and processes established for monitoring Health Inequalities metrics and evaluating health inequality implementation plan delivery



Appendix 1

A framework for assessing the impact on health inequalities as a result of COVID-19

This framework outlines a population health approach for assessing the impact of COVID-19 on health inequalities and prioritising where system and/or organisational actions are needed to address the worsening or developing health inequalities. The framework has been developed by the Provider Public Health Network.

Assess the impact on health inequalities

Nottingham & Nottinghamshire ICS Framework

Mechanisms for worsening or developing health inequalities:

Direct COVID
- Disproportionally higher infection in more deprived areas
- Disproportionate long-term impact in survivors

Indirect: Health & Care Services
- Services reduced or stopped as a result of COVID response
- Access:
  - Change in access
  - Fear of accessing health/care services
  - Ability to access e.g. digital, virtual

Indirect: Wider Determinants
- Reduced agency (e.g. housing, social) and voluntary sector in some communities
- Unemployment / economic downturn
- Education and school closures
- Mental Health (virus & lockdown)

At risk / target patient cohorts

Develop Metrics / Indicators

Model local situation

Matrix of Evidence
Assessment of risk factors/impacts across the at risk/target patient cohorts

Prioritise

Principles for prioritising where action is needed (organisation and/or system)

The **impact on health inequalities** among patients should be set out prior to any changes in the commissioning or provision of health or social care

Services, and recovery actions, should be made **accessible for all**, particularly those at risk of exclusion because of personal, economic or social factors

Where there is any flexibility, health and care services should always be allocated based on **healthcare need**, striving in particular for equity of access.

Wider determinants of health should be addressed at a place-based level and harness available community assets

Health and care staff should be valued and supported to maintain wellbeing and so deliver high quality patient care in all settings

Local impact assessment and principles inform key priority actions for system

Integrated Care System
Nottingham & Nottinghamshire

Appendix 2

Metrics for our health & care services action plans

Area for action		Metric	Measure type	ICS 5 Year Plan Metric		Inequalities 'lens'
				Headline	Programme	
1	**Protect the most vulnerable from COVID-19**	No. of people identified as clinically extremely vulnerable to COVID-19 infection - health and care workforce population and total population	Input			**Analyse by:** **•BAME Population** **•Disadvantaged Communities** **•Vulnerable Groups** **•Frailty and Older People** **•Mental Health & Learning Disabilities** **and** **•PCN** **•ICP** **•ICS**
		Sickness absence rate	Output	✓		
2	**Restore health and care services inclusively**	GP consultation rates	Output			
		GP referrals for first outpatient appointment	Output			
		Consultant-led first outpatient attendances (across acute and MH) and DNA rates	Output			
		Number of incomplete RTT pathways at the end of the month	Output	✓		
		Total elective spells (day case and ordinary)	Output			
		A&E activity	Output			
		Non-elective admissions - Same Day Emergency Care / LoS 7+ / LoS21+	Output	✓		
		Referral rates for 2ww cancer diagnosis	Output			
		Cancer staging at first diagnosis	Output	✓		
		Admission rates for heart attacks and strokes	Output			
3	**Digitally enabled care which increases inclusion**	111 access rates - online and telephone	Output			
		GP total triage rates - online and telephone	Output			
		GP consultation rates - video/telephone/face-2-face	Output			
		Digitally enabled mental health therapy rates incl. DNAs	Output			
		Consultant-led first outpatient rates - telephone/video/face-2-face incl. DNAs	Output	✓		
4	**Accelerate preventative programmes**	Flu vaccine coverage - health and care workforce population and total population	Output			
		Children and young people immunisation programme	Output			
		Number of people supported through the NHS Diabetes Prevention Programme	Output	✓		
		Proportion of people on with a learning disability on GP register receiving an annual health check	Output	✓		
		Percentage of women placed on a continuity of care pathway at booking appointment	Output		✓	
5	**Particularly support those who suffer mental ill-health**	Number of people accessing IAPT services	Output	✓		
		Number of children and young people accessing NHS funded mental health services	Output	✓		
		Mental health crisis activity	Output		✓	

Metrics for our lifestyle factors action plans

Area for action		Metric	Measure type	ICS 5 Year Plan Metric		Inequalities 'lens'
				Headline	Programme	
1	Alcohol	Admission episodes for alcohol-related conditions	Outcome	-	-	Analyse by: •BAME Population •Disadvantaged Communities •Vulnerable Groups •Frailty and Older People •Mental Health & Learning Disabilities and •PCN •ICP •ICS
		Attendance at A&E for alcohol-related conditions	Outcome	-	-	
		Average length of stay for alcohol-related conditions	Outcome	-	-	
		Number/proportion of (appropriate) people given intervention advice	Output	-	-	
		Number of comprehensive physical and mental assessments provided by Alcohol Care Team	Output	-	-	
		Number of brief advice interventions provided by Alcohol Care Team	Output	-	-	
		Number/proportion of affected people (appropriately) referred to specialist services / alcohol support programme	Output	-	-	
2	Smoking - general	Prevalence of current smokers	Outcome	-	-	
		Proportion of patients with smoking status recorded in secondary care	Output	-	-	
		Proportion of smokers offered support and treatment from GP within preceding 12 months	Output	-	-	
		Proportion of smokers who receive smoking cessation support in hospital/achieve temporary abstinence	Output	✓	-	
		Proportion of smokers who receive smoking cessation support from community service	Output	-	-	
	Smoking - during pregnancy	Proportion of pregnant women quit smoking at 4 weeks (of those engaged in programme)	Outcome	-	✓	
		Proportion of pregnant women smoking at delivery	Outcome	-	-	
		Proportion of pregnant women smoking at booking	Input	-	✓	
		Proportion attending 1st tobacco addiction appointment	Output	-	✓	
		Proportion taking up full intervention	Output	-	✓	
3	Diet and physical activity	Reception: Prevalence of overweight (including obesity)	Outcome	-	-	
		Year 6: Prevalence of overweight (including obesity)	Outcome	-	-	
		Percentage of physically active children and young people	Outcome	-	-	
		Proportion of population meeting the recommended '5-a-day' on a usual day (adults)	Outcome	-	-	
		Percentage of adults (aged 18+) classified as overweight or obese	Outcome	-	-	
		Percentage of physically active adults	Outcome	-	-	
4	Children and Young People	Percentage of children achieving the expected level in personal-social skills at 2-2.5 years	Outcome	-	-	
		Percentage of children achieving the expected level in communication skills at 2-2.5 years	Outcome	-	-	
		Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	Outcome	-	-	
		Hospital admissions caused by unintentional and deliberate injuries in children (aged 15-24 years)	Outcome	-	-	
		Percentage of looked after children whose emotional wellbeing is a cause for concern	Outcome	-	-	

Metrics for our living & working condition action plans

Area for action		Metric	Measure type	ICS 5 Year Plan Metric		Inequalities 'lens'
				Headline	Programme	
1	Environment	Violent crime - violence offences per 1,000 population	Outcome	-	-	Analyse by: •BAME Population •Disadvantaged Communities •Vulnerable Groups •Frailty and Older People •Mental Health & Learning Disabilities and •PCN •ICP •ICS
		The rate of compliants about noise	Outcome	-	-	
		The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	Outcome	-	-	
		The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the night-time	Outcome	-	-	
		Utilisation of outdoor space for exercise/health reasons	Outcome	-	-	
2	Economy / Employment	16-17 year olds not in education, emplyment or training (NEET) or whose activity is not known	Outcome	-	-	
		Gap in the employment rate between those with a long-term health condition and the overall employment rate	Outcome	-	-	
		Gap in the employment rate between those with a learning disability and the overall employment rate	Outcome	-	-	
		Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	Outcome			
		Percentage of people aged 16-64 in emplyment	Outcome	-	-	
3	Housing	Adults with a learning disability who live in stable and appropriate accomodation	Outcome	-	-	
		Fuel poverty	Outcome	-	-	
		Social isolation:percentage of adult social care users who have as much social contact as the would like (18+yrs)	Outcome	-	-	
4	Education / Life Learning	Percentage of children achieving a good level of development at the end of Reception	Outcome	-	-	
		Percentage of children achieving the expected level in the phonics screening check in Year 1	Outcome	-	-	
		Percentage of children achieving at least the expected level of development in communication, language and literacy skills at the end of Reception	Outcome	-	-	
		Percentage of children achieving at least the expected level of development in communication and literacy skills at the end of Reception	Outcome	-	-	
		Pupil absence	Outcome	-	-	

Appendix 3

The ICS Outcomes Framework

System Level Outcomes Framework

Our vision for the ICS is ambitious: Across Nottingham and 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.

To provide a clear view of our success as an Integrated Care System and to act as a foundation for population health and population health management, we have developed a system level outcomes framework.

Our System Level Outcomes Framework sets out the outcomes the whole ICS will work together to achieve and supports strategic planning by ensuring system improvement priorities and investment enable achievement of the outcomes.

Through this framework we will show:

- How outcomes for citizens are being achieved across the system **including how health inequalities are being reduced across the population**;
- Focus plans and inform priorities through clearly articulated measures; and
- Support organisations to work as one health and social care system to deliver impact and continually improve.

System Level Outcomes Framework Design

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

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

The tables on the following pages set out how our Health Inequalities measures described in Appendix 2 map across into out System Level Outcomes Framework Domains, Ambitions and Outcomes

The ICS Outcomes Framework: Health and Wellbeing

Ambitions	System Level Outcomes	Measures
Our people live longer, healthier lives	Increase in life expectancy	
	Increase in healthy life expectancy	• Violent crime – violence offences per 1,000 population • The rates of complaints about noise • The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime • The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the night-time • Utilisation of outdoor space for exercise/health reasons • 16-17 year olds not in education, employment or training (NEET) or whose activity is not known • Gap in the employment rate between those with a learning disability and the overall employment rate • Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate • Percentage of people aged 16-64 in employment • Adults with a learning disability who live in stale and appropriate accommodation • Fuel poverty • Social isolation: Percentage of adult social care users who have as much social contact as they would like (18+)
	Increase in life expectancy at birth in lower deprivation quintiles	
Our children have a good start in life	Reduction in infant mortality	• Children and young people immunisation programme
	Increase in school readiness	• Percentage of children achieving the expected level in personal-social skills at 2-2.5 years, Percentage of children achieving the expected level in communication skills at 2-2.5 years • Percentage of children achieving a good level of development at the end of Reception, Percentage of children achieving the expected level in the phonics screening check in Year 1, Percentage of children achieving at least the expected level of development in communication, language and literacy skills at the end of Reception, Percentage of children achieving at least the expected level development and communication and literacy skills at the end of Reception • Pupil absence
	Reduction in smoking prevalence at time of delivery	• Proportion of pregnant women quit smoking at 4 weeks (of those engaged in programme), proportion of pregnant women smoking at delivery, proportion of pregnant women smoking at booking, proportion attending 1st tobacco addiction appointment, Proportion taking up full intervention

The ICS Outcomes Framework: Health and Wellbeing

Ambitions	System Level Outcomes	Measures
Our people and families are resilient and have good health and wellbeing	Reduction in illness and disease prevalence	• Flu vaccine coverage – health and care workforce population and total population • Reception prevalence of overweight (including obesity), Year 6 prevalence of overweight (including obesity), percentage of physically active children and young people, proportion of population meeting the recommended '5-a-day' on a usual day (adults) • Percentage of adults (aged 18+) classified as overweight or obese
	Narrow the gap in the onset of multiple morbidities between the poorest and wealthiest sections of the population	• Smoking: prevalence of current smokers, proportion of smokers with smoking status recorded in secondary care, proportion of smokers offered support and treatment from GP within preceding 12 months, proportion who receive smoking cessation support in hospital/achieve temporary abstinence, proportion who receive support from community service • Alcohol: admission episodes for alcohol related conditions, attendance at A&E for alcohol-related conditions, av. Length of stay for alcohol-related conditions, no./proportion of people given intervention advice, no. of comprehensive physical and mental assessments provided y Alcohol Care Team, no./proportion of affected people referred to specialist services/alcohol support programme
	Increase the number of people who have the support to self-care and self-manage and improve their health and wellbeing	• Number of people supported through the NHS Diabetes Prevention Programme • Parentage of looked after children whose emotional wellbeing is a cause for concern
Our people will enjoy healthy and independent ageing at home or in their communities for longer	Reduction in premature mortality	• No. of people identified as clinically extremely vulnerable to COVID-19 infection in health and care workforce and total population
	Reduction in potential years of life lost	
	Increase in early identification and early diagnosis	

The ICS Outcomes Framework: Independence, Care and Quality

Ambitions	System Level Outcomes	Measures
Our people will have equitable access to the right care at the right time in the right place	Reduction in avoidable and unplanned admissions to hospital and care homes	• A&E activity • NEL admissions – SDEC / LoS 7+ / LoS 21+ • 111 access rates – online and telephone • Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years) • Hospital admissions caused by unintentional and deliberate injuries in children (aged 15-24 years)
	Increase in appropriate access to primary and community based health and care services	• GP consultation rates • Admission rates for heart attacks and strokes • Number of people accessing IAPT services • Number of children and young people accessing NHS funded mental health services • Mental health crisis activity
	Increase in the number of people being cared for in an appropriate care settings	• GP referrals for first outpatient appointments • Consultant-led first outpatient attendances (across acute and MH) and DNA rates • Number of incomplete RTT pathways at the end of the month • Total elective spells (day case and ordinary) • Referral rates for 2ww cancer diagnosis • GP total triage rates – online and telephone • GP consultation rates – video/telephone/face-2-face • Digitally enabled mental health therapy rates incl. DNAs • Consultant-led first outpatient rates – telephone/video/face-2-face incl. DNAs
Our services meet the needs of our people in a positive way	Increase in the proportion of people reporting high satisfaction with the services they receive	
	Increase in the proportion of people reporting their needs are met	• Proportion of people with a learning disability on GP register receiving an annual health check • Percentage of women placed on a continuity of carer pathway at booking appointment
	Increase in the number of people that report having choice, control and dignity over their care and support	
Our people with care and support needs and their carers have good quality of life	Increase in quality of life for people with care needs	
	Increase in appropriate and effective care for people who coming to an end of their lives	

The ICS Outcomes Framework: Resource Utilisation

Ambitions	System Level Outcomes	Measures
Our system is in financial balance and achieves maximum benefit against investment	Financial control total achieved	
	Transformation target delivered	
Our system has a sustainable infrastructure	Increase in the total use and appropriate utilisation of our estate	
	Alignment of capital spending for new and pre-existing estate proposal with clinical and service improvement objectives	
	Increase in collaborative data and information systems	
Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population	Sustainable teams with skill mix designed around our population and mechanisms to deploy them flexibly to respond to care & support needs	• Health and care staff sickness absence rates due to COVID-19
	Increase in skills, knowledge and confidence to take every opportunity to support people to self-care and take a flexible, holistic approach to people's needs with a strong focus on prevention and personalised care	
	Increase in the number of people reporting a positive and rewarding experience working and training in the Nottinghamshire health and care system	

Item Number:	6	**Enclosure Number:**	D1
Meeting:	ICS Board		
Date of meeting:	15 October 2020		
Report Title:	New Ways of System Working - Feedback from the System Executive Group		
Sponsor:	System Executive Group		
ICP Lead:	N/A		
Clinical Sponsor:	N/A		
Report Author:	Andy Haynes		
Enclosure / Appendices:	None		

Summary:

COVID-19 has brought about deep seated system-wide transformation with opportunity to embed new clinical, business and governance models (e.g. active decision making) into a 'new normal'. The System will need to determine what should be maintained and embedded from the COVID-19 response as well as which pre- COVID-19 arrangements need to be re-established and / or adapted for the new normal. It will be important to consider new ways of working in this context and particularly the recommendations on ICS Oversight Groups and Workstreams.

This report summarises the discussions and recommendations put forward by the System Executive Group on system workstreams, and a proposed Terms of Reference to formally establish this group as part of the system governance.

Actions requested of the ICS Board

To discuss and agree the recommendations proposed by the System Executive Group.

Recommendations:

1.	Agree the proposed TOR for the System Executive Group in Appendix 1;
2.	Agree the proposed system workstreams outlined in paragraph 5;
3.	Endorse the proposed principles for executive sponsorship of system workstreams outlined in paragraph 8;
4.	Agree the proposed workstream sponsors outlined in paragraph 9.

Presented to:

Board	Partnership Forum	Clinical Reference Group	System Executive Group	Finance Directors Group
☒	☐	☐	☒	☐
Quality Group	**Performance Oversight Group**	**Mid Nottingham-shire ICP**	**Nottingham City ICP**	**South Nottingham-shire ICP**
☒	☐	☐	☐	☐

Contribution to delivering System Level Outcomes Framework ambitions					
Our people and families are resilient and have good health and wellbeing	☒	Our people will have equitable access to the right care at the right time in the right place	☒	Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population	☒

Conflicts of Interest

☐ No conflict identified
☒ Conflict noted, conflicted party can participate in discussion and decision
☐ Conflict noted, conflicted party can participate in discussion, but not decision
☐ Conflict noted, conflicted party can remain, but not participate in discussion or decision
☐ Conflict noted, conflicted party to be excluded from meeting

Risks identified in the paper

Risk Ref	Risk Category	Risk Description	Residual Risk				Risk owner
			Likelihood	Consequence	Score	Classification	
Ref	e.g. quality, financial, performance	Cause, event and effect There is a risk that…	L1-5	L1-5	L x I	Grading	*Person responsible for managing the risk*

Is the paper confidential?

☐ Yes
☒ No
☐ Document is in draft form

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.

New Ways of System Working

15 October 2020

Background

1. COVID-19 has brought about deep seated system-wide transformation with opportunity to embed new clinical, business and governance models (e.g. active decision making) into a 'new normal'. The System will need to determine what should be maintained and embedded from the COVID-19 response as well as which pre-COVID arrangements need to be re-established and / or adapted for the new normal. It will be important to consider new ways of working in this context and particularly the recommendations on ICS Oversight Groups and Workstreams.

2. This report summarises the discussions and recommendations put forward by the System Executive Group on system workstreams, and a proposed Terms of Reference to formally establish this group as part of the system governance.

System Executive Group

3. Emerging from wave one, ICS Board agreed further development of ICS leadership arrangements and system governance and workstreams. The principle has been to build on the collaboration and distributed leadership that the COVID-19 response has fostered, and as such the ICS Chief Executive Officers Group has convened and met strategically every 2-3 weeks.

4. Board has already agreed to the formation of a System Executive Group at an extraordinary meeting on 13 August 2020. Board have agreed that this group should continue to take responsibility for managing the system on a week by week basis whilst retaining the benefits learned from COVID-19. This will free the ICS Board to take a more strategic overview of the system and create a balanced agenda across health and care. The proposed Terms of Reference (TOR) are included in Appendix 1 for approval.

System Workstreams

5. The ICS will need to demonstrate increasingly robust oversight mechanisms to satisfy NHSE/I that it is able to take on self-assurance and oversight, including in relation to financial governance and collaboration. The System Executive Group have discussed and propose the following configuration of workstreams at system level over the coming months:

	OCTOBER	DECEMBER	APRIL
HSCTCG/LRF Cells			

Capacity, Recovery (Phase 3), D20/Brexit, Service Change, Data Cell
Testing, PPE, Outbreak, Vaccination, Humanitarian Assistance Group/Shielding/Volunteers
Urgent Care, Discharge, Care Homes and Home Care, Primary Care

EXEC SPONSORED WORKSTREAMS

Estates, Mental Health, Health Inequalities and Workforce

OTHER WORKSTREAMS

Digital will continue with year 1 of the strategy which are all schemes largely implementing in partners
Clinical Services Strategy to complete wave 3 to January and then review
Back Office functions to progress amongst partners if planned and review in March
Cancer, Planned and Urgent Care to be managed via cells and review in March

BUSINESS AS USUAL

Maternity (LMNS), Transforming Care (TCP), System Finance, Clinical Reference Group and Communications

SYSTEM/CCG REVIEW

PCN and ICP Development, Quality and Safety, Performance Oversight, Population Health Management and Evaluation are under discussion within the Joint Senior Management Team and recommendations will be brought forward no later than the end of November

6. This proposal takes in to account the ongoing requirements for system governance being in place for COVID-19 response and recovery, and a review of system and CCG roles.

Principles for Executive Sponsorship Of System Workstreams

7. The proposed system workstreams include four executive sponsored workstreams: estates, mental health, health inequalities and workforce.

8. The System Executive Group propose the following principles for the executive sponsorship of system workstreams:
   a. Oversee workstream from a system perspective making recommendations which benefit and progress system objectives;
   b. Ensure engagement and communication with all system partners and elected members;
   c. Review and refresh system strategies relevant to the workstream with clear objectives for the period to April 2021 and a workplan for the period beyond;
   d. Review meetings and groups within the workstream to maximise efficiency and optimise delivery including support from system partners;
   e. Report on progress and make recommendations for System Executive Group to make decisions from;
   f. Annual review by System Executive Group and continuation in role by mutual consent.

9. The System Executive Group propose the following sponsors for these workstreams:
   a. Estates: Tracy Taylor
   b. Workforce: Lyn Bacon
   c. Health Inequalities: John Brewin and Nottingham City Council
   d. Mental Health: John Brewin and Nottinghamshire County Council

Recommendations

10. Board are asked to discuss and agree the following recommendations:
   i. Agree the proposed TOR for the System Executive Group in Appendix 1;
   ii. Agree the proposed system workstreams outlined in paragraph 5;
   iii. Endorse the proposed principles for executive sponsorship of system workstreams outlined in paragraph 8;
   iv. Agree the proposed workstream sponsors outlined in paragraph 9.

Andy Haynes on behalf of the System Executive Group
12 October 2020

Appendix 1

DRAFT TERMS OF REFERENCE

NAME OF GROUP:	**System Executive Group**
PURPOSE	The purpose of the Executive Group is as follows: a) Oversee system transformation and the delivery of the Long Term Plan; b) Providing robust oversight at strategic level across the system, including in terms of strategic risk management and escalations to the ICS Board; c) Enabling the development of the system to achieve greater integration and maturity; d) Enabling the ICS Board to have a more strategic remit and supporting a stream-lined and simplified decision-making structure.
EXECUTIVE GROUP RESPONSIBILITIES	a) Develop, refine and revise the ICS's strategic plan and monitor achievement against key milestones and priorities; b) Apportion transformation funding to ICS work streams; c) To oversee the performance of each work stream, with the Executive Group responsible for day to day management of the work being undertaken in each work stream; d) Oversee a streamlined, consolidated and integrated System Oversight structure, supporting the Board to discharge its collective management of system performance function; e) Review the ICS risk register on agreed intervals and ensure robust plans are in place to mitigate or eliminate risk within the ICS; f) Act as a leadership cohort, demonstrating what can be achieved with strong system leadership and increased freedoms and flexibilities;

	g) Develop a mechanism for collaborative action and collaborative decision-making for those issues which are best tackled on a wider scale; h) Working closely with those parts of the System focussing on system oversight, promote open dialogue with NHSE/I and other national bodies; i) Adopt and model an approach to making collaborative decisions and resolving disagreements in a way that promotes integration, subsidiarity and the shared values and principles of the ICS.
REPORTING AND ACCOUNTABILITY	The Executive Group will be accountable to the ICS Board. The Executive Group has no formal powers delegated by Partner organisations. The Executive Group has a key role within the wider governance and accountability arrangements for Nottingham and Nottinghamshire. These will be confirmed following work to review and strengthen ICS governance arrangements. System Oversight Groups and the System Transformation Workstreams report into the Executive Group, enabling robust oversight and delivery monitoring of transformation within the ICS and ensuring that the ICS Board is able to operate more efficiently, and with a clear, focussed remit on its two core functions. The minutes will be submitted to each meeting of the ICS Board. The minutes, and a summary of key messages will also be submitted to all Partner organisations after each meeting.
MEMBERSHIP	Membership of the Executive Group: • ICS Executive Lead or Managing Director • Nottingham and Nottinghamshire Clinical Commissioning Group Accountable Officer • Nottinghamshire University Hospitals NHS Trust Chief Executive • Sherwood Forest NHS Foundation Trust Chief Executive / Chief Executive Lead of the Mid Nottinghamshire ICP • Nottinghamshire Healthcare NHS Foundation Trust Chief Executive

	• Nottingham City Council Chief Executive or representative • Nottinghamshire County Council Director of Adult Social Care • Nottingham CityCare Partnership Chief Executive • Chief Executive Officer East Midlands Ambulance Service If a member is unable to attend a meeting of the Executive Group, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered, to represent their organisation, place or group effectively. Where appropriate, the following will be in attendance: • The ICS Programme Director • The system Directors of Finance • The Chair of the Clinical Reference Group Additional attendees for specific agenda items are expected to include: • Senior Responsible Officers and Programme Leads for system-wide groups and work-streams • Representatives of wider partner organisations, who are not part of the core membership. • Members of the Nottingham and Nottinghamshire core team and external advisers. The Chair and Deputy Chair will be nominated at the inaugural meeting .
PRINCIPLES	• 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.
MEETINGS	To be held in accordance with the Meetings Protocol.
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 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 AND DECISION MAKING:	The Executive Group will be quorate when 5 or more of Partner organisations are present. The Executive Group will generally operate on the basis of forming a consensus on issues considered, taking account of the views expressed by members. The Chair will seek to ensure that any lack of consensus is resolved amongst members. Where this cannot be achieved, the matter will be referred for discussion at the ICS Board.
CONFLICTS OF INTEREST	Members of the ICS Executive Group will: • Operate in line with their organisational governance framework for probity and decision making.

	• Work in line with the ICS System Objectives, Principles and Behaviours approved at the 9 May 2019 ICS Board meeting. Where any Executive Group member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate in meetings (or parts of meetings) in which the relevant matter is discussed.
FREQUENCY OF MEETINGS	The Executive Group will normally meet fortnightly. An annual schedule of meetings will be published by the ICS team. Extraordinary meetings may be called for a specific purpose at the discretion of the Chair. A minimum of seven working days' notice will be given when calling an extraordinary meeting.
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 5 working days before each meeting; • The Chair agreeing the final agenda; • Papers will be circulated 3 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 presented to the ICS Board and available for each Partner organisation.
REVIEW DATE:	Terms of Reference and membership of the Group will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the Partnership.
DATE APPROVED:	

Item Number:	6	**Enclosure Number:**	D2
Meeting:	ICS Board		
Date of meeting:	15 October 2020		
Report Title:	New Ways of System Working – System Governance		
Sponsor:	ICS Chief Executive Group		
ICP Lead:	N/A		
Clinical Sponsor:	N/A		
Report Author:	Andy Haynes		
Enclosure / Appendices:	Item 6. Enc. D3. Governance Guidance: Mechanisms to support the work of Integrated Care Systems		

Summary:

At the 17 September ICS Board meeting, the ICS Independent Chair reminded Board of work initiated before the Covid-19 pandemic to review and strengthen ICS governance arrangements. This paper aims to provide Board with an overview of the work commissioned and sets out a potential approach to reconsidering and refreshing this work in line with emerging requirements.

In July 2020 NHSEI issued further guidance for ICSs. This paper also provides an overview of this guidance which needs to be taken into consideration in refreshing system governance. There are potential opportunities in this to address current gaps.

Actions requested of the ICS Board

To review the paper and approve the recommendations.

Recommendations:

1.	Agree to establish a task and finish group to review the draft governance manual as per paragraph 14 and convene a Board development session;
2.	Agree to adopt an ICS Conflict of Interest policy in line with national guidance and receive a register of interests every six months;
3.	Consider whether NHSEI be represented at ICS Board at meetings both in public and confidential sessions.

Presented to:

Board	Partnership Forum	Clinical Reference Group	Chief Executive Group	Finance Directors Group
☒	☐	☐	☐	☐
Quality Group	Performance Oversight Group	Mid Nottingham-shire ICP	Nottingham City ICP	South Nottingham-shire ICP
☐	☐	☐	☐	☐

Contribution to delivering System Level Outcomes Framework ambitions

Our people and families are resilient	☐	Our people will have equitable	☐	Our teams work in a positive, supportive	☐

and have good health and wellbeing		access to the right care at the right time in the right place		environment and have the skills, confidence and resources to deliver high quality care and support to our population	

Conflicts of Interest

☒ No conflict identified
☐ Conflict noted, conflicted party can participate in discussion and decision
☐ Conflict noted, conflicted party can participate in discussion, but not decision
☐ Conflict noted, conflicted party can remain, but not participate in discussion or decision
☐ Conflict noted, conflicted party to be excluded from meeting

Risks identified in the paper

Risk Ref	Risk Category	Risk Description	Residual Risk				Risk owner
			Likelihood	Consequence	Score	Classification	
Ref	e.g. quality, financial, performance	Cause, event and effect There is a risk that…	L1-5	L1-5	L x I	Grading	*Person responsible for managing the risk*

Is the paper confidential?

☐ Yes
☒ No
☐ Document is in draft form

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.

New Ways of System Working: System Governance

15 October 2020

Introduction

1. At the 17 September ICS Board meeting, the ICS Independent Chair reminded Board of work initiated before the Covid-19 pandemic to review and strengthen ICS governance arrangements. This paper aims to provide Board with an overview of the work commissioned and sets out a potential approach to reconsidering and refreshing this work in line with emerging requirements.

2. In July 2020 NHSEI issued further guidance for ICSs. This paper also provides an overview of this guidance which needs to be taken into consideration in refreshing system governance. There are potential opportunities in this to address current gaps.

Background

3. Pre-Covid-19, ICS Board began a journey of further developing system working. This focus was initially on the next iteration of system leadership and governance arrangements. ICS Board engaged independent legal advisors to appraise and make recommendations for the strengthening of ICS governance arrangements for the coming period. The agreed output of the commission was an ICS governance manual which would:
    - Clarify where decisions and assurance processes lie for specific functions;
    - Support corporate memory and provide a point of reference;
    - Support preparedness with the expected national policy direction.

4. There was an understanding that any ICS governance manual developed as part of this work would need to be locally owned and maintained.

5. Whilst ICS work was in abeyance during the Covid-19 response, the legal advisors were still able to pull information together into a draft manual and set out some proposed areas for development taking into account stakeholder views and expertise gained from discussions earlier in the year together with knowledge of best practice. The draft ICS governance manual is now with the ICS support team to review and maintain.

6. Board now need to determine how best to take this work forward. This includes incorporating work on developing new ways of system working, which are reflective of progress made over recent months, and new NHSEI guidance.

NHSEI Guidance

7. NHSEI published further guidance in July 2020 (*Governance Guidance: Mechanisms to support the work of Integrated Care Systems,* appended to this report). Guidance reiterates NHS Long Term Plan guidance and highlights the following governance considerations:
   - ICSs are not statutory bodies, and there are currently no formal mechanisms for organisations to make legally binding decisions jointly;
   - A governance strategy should be developed to clearly align organisational and system arrangements to the overarching system vision, removing any forums which duplicate work;
   - Guidance outlines the purpose and proposed membership of the Partnership Board and role of this Board in developing a "Thriving ICS";
   - A system approach to managing conflicts of interest should be developed in support of meeting the highest standards for openness and transparency in conducting system business. This includes holding meetings in public, publishing Board papers and minutes, and producing an annual report;
   - A clear and appropriate system-wide decision making framework needs to be agreed, including utilising existing forums to support decision making and oversight, and decisions at place and neighbourhood level;
   - Continued expectation that ICS partner organisations actively participate at system level through their existing governance structures, e.g. reporting to Boards on their work as part of the system as part of business as usual reporting;
   - A clear governance structure outlining the relationships between each governance group or board;
   - Establishing Health and Wellbeing Boards as a key part of ICS and place governance utilising Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) to support planning and delivery;
   - Democratic oversight to be provided through Overview and Scrutiny Committees;
   - Establishing system subgroups including, assurance or oversight, clinical forums and finance group.

8. The work that was commenced pre-Covid-19 and resulted in a draft governance manual provides a strong foundation for these guidelines to be implemented. In determining how to take forward this work forward, proper consideration needs to be given to making early progress in relation to conflicts of interest and one aspect of board membership.

Conflicts of Interests

9. Board agreed at its 8 August 2019 meeting following legal advice not to continue with a separate ICS policy relating to Conflict of Interest (COI) on the basis that a partnership should not have its own policy (members of the ICS Board are bound by their employing organisations COI policy and another layer may be contradictory). Board agreed the following approach:

a. To operate in line with their organisational governance framework for probity and decision making;
b. To work in line with the ICS System Objectives, Principles and Behaviours;
c. For the Chair of each group to take overall responsibility for managing conflicts of interest within meetings as they arise (recorded in the minutes of meetings).

10. NHSEI guidance published in July 2020 updates this position and best practice is now to have an ICS approach in place:
    a. Following NHS guidance on managing COIs recommended;
    b. Partnership Board to maintain a register, drawn from existing registers and actively updated by members of the Board;

11. Board are asked to agree to adopt an ICS Conflict of Interest policy in line with national guidance and receive a register of interests every six months.

Board Membership

12. Board have highlighted the need to review and consider membership and voting rights, which needs to be reflected as part of determining the next steps.

13. In the short term there is opportunity to consider membership of the ICS Board in relation to the NHSEI guidance. Guidance outlines that membership of the Board should reflect the breadth of the ICS including representation from NHS regulators. In Midlands, Nottingham and Nottinghamshire is an outlier in that NHSEI are represented on all other STP Boards at meetings in public and private.

Proposed Way Forward

14. It is proposed that a small group review the current draft governance manual, and recommendations within, alongside the NHSEI guidance and latest work on new ways of working. Following this an ICS Board development session will be convened to discuss the recommendations of this group.

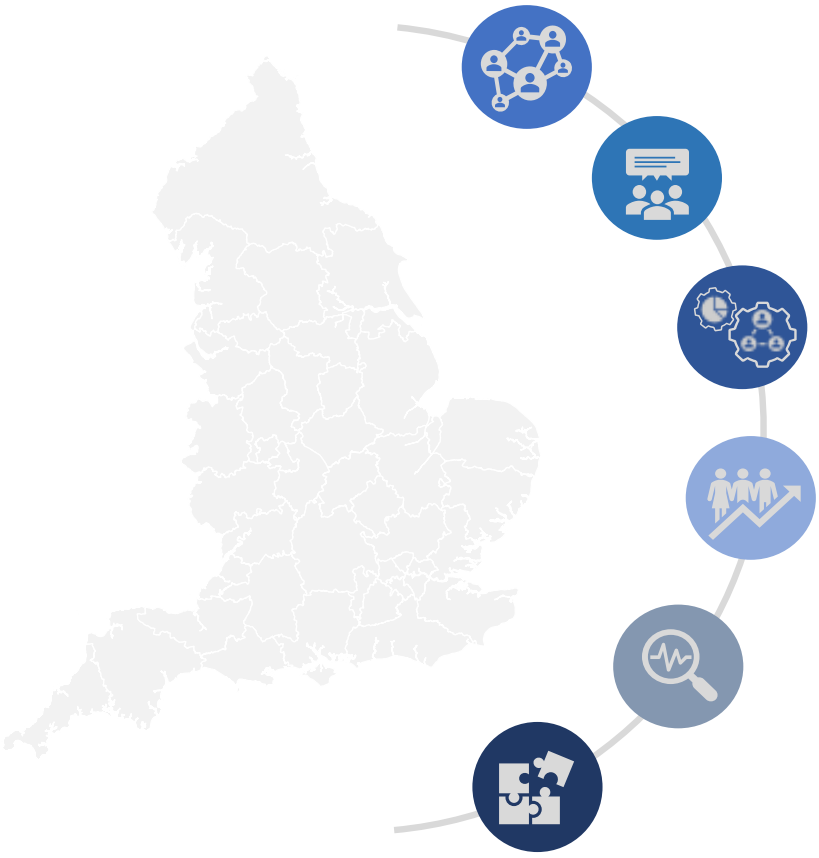
15. Board are asked to determine the membership of this task and finish group. There is an option for ICS team to do this work on behalf of the Board if that would be acceptable to the Board.

Recommendations

16. Over the coming months as work takes place to move through the next stage of development and emerging policy the governance manual will be relevant and pertinent. Board are asked to discuss and agree the following recommendations:
    i. Agree to establish a task and finish group to review the draft governance manual as per paragraph 14 and convene a Board development session;

ii. Agree to adopt an ICS Conflict of Interest policy in line with national guidance and receive a register of interests every six months;
iii. Consider whether NHSEI be represented at ICS Board at meetings both in public and confidential sessions.

Andy Haynes on behalf of the ICS Chief Executive Officers Group
6 October 2020



Governance Guidance: Mechanisms to support the work of Integrated Care Systems

Guidance to help systems think through what type of governance arrangements they might need to consider for their system

V1.0 July 2020

Author: System Strategy and Policy Team, NHSEI
Contact: england.SSP-PMO@nhs.net

Contents

Introduction

This resource pack is designed to help systems think through what type of governance arrangements they might need to consider for their system. It draws on work carried out by a number of systems in England on this topic.

Integrated Care System (ICS) partners will perform two fundamental roles: (i) coordination of system transformation and (ii) collective management of system performance. System partners should agree what activities and functions will be required to be carried out at the system-tier to fulfil these two roles. ICSs will then put in place governance arrangements to support partnership working and to embed a collective model of decision-making and accountability.

Relationships are critical to an ICS's success – and governance can facilitate some of those relationships. When ICS governance is done well, it:

- ensures conversations happen across institutional and professional silos – this is particularly important for bridging the divide between NHS organisations and non-NHS organisations;
- brings a range of perspectives to bear, leading to better decision-making and ensuring that patients' and staff's needs are properly accounted for; and
- builds trust because it allows everyone (professionals, patients, and communities) to see how decisions get taken, and by whom.

However, governance cannot replace effective cross-organisational relationships; it can only facilitate them. Governance should enable cross-organisational working to improve the health of the population and deliver improved outcomes. It should also link to organisational governance that is already established.

Good Governance enables:

1. **System Vision**: Develop a system-wide vision focused on improving the health of it's population and reducing health inequalities through wide engagement which is meaningful to the citizens who live in the ICS

2. **Delivery:** Delivery of the vision and plan is overseen by the Partnership Board , which is made up of a wide range of stakeholders selected for their ability to represent the population and best achieve these outcomes

3. **Collaborative working**: There is collaborative working across the system at all levels which allows a flexible approach to wider membership to involve active parties in the system who might influence the wider determinants of health

4. **Planning:** The system has effective planning across all partners enabling a focus on achievement of outcomes rather than a retrospective review of targets

What is system governance?

Governance supports organisations in the system to achieve their shared goals.

Organisations come together in an ICS to achieve the common ambition of improving people's experience of services, their health outcomes and the overall health and wellbeing of the local population. This requires organisations to establish ways of working through which they will develop and agree their shared objectives, and align their resources to them. This should also support them to effectively manage, transform and oversee the system in delivering its plans.

The NHS Long Term Plan stated that all ICSs should develop their system level governance arrangements, stating the importance of multi-professional leadership within it.

It stated that every ICS will:

- Establish a Partnership Board , drawn from constituent organisations
- Have a non-executive chair (locally appointed, but subject to approval by NHS England and NHS Improvement) and arrangements for involving organisational non-executive members of boards/ governing bodies;
- Have sufficient clinical and management capacity drawn from across their constituent organisations to enable them to implement agreed system-wide changes;
- Fully engage with primary care, including through a named accountable Clinical Director of each primary care network;
- Clearly articulate the links between the neighbourhood – place – system, including robust reporting and escalation processes which link all tiers of the system; and
- Build a culture of improvement and development across the governance groups.

When developing system governance, it is important to differentiate and ensure balance between individual accountability and strong collective leadership across NHS partners within an ICS.

Currently there is no formal mechanism by which organisations – commissioners and providers, statutory and non-statutory – can make legally binding decisions together. Therefore, their agreements are reached in collaborative forums.

Representatives of organisations should have ongoing engagement with their own board members, including non-executives, lay members, governors and councillors.
As ICSs are not statutory bodies, all constituent organisations must continue to meet their statutory obligations/ duties.

The ICS Non-Executive Chair and Leader have specific responsibilities too.
Each system will have a Non-Executive Chair and a Leader who are responsible for successfully bringing system partners together to achieve their agreed objectives.
The appointments process and examples of role descriptions for Non-Executive Chairs and System Leaders can be found here.

Governance strategy

Systems may find it beneficial to develop a governance strategy, which will enable them to clearly align their organisational and system arrangements to the overarching system vision; removing any forums which duplicate work. Example strategies can be accessed here.

Partnership Boards (1/2)

The purpose of Partnership Boards is to:

- provide a vehicle for engaging partners; ensuring strategic alignment of the health and care organisations within the system
- have shared ownership of the vision and strategy for the system, and support mutual accountability for delivery of system plans and management of collective resources
- create a forum for collective decision making where the Partnership Board is considered the most appropriate place for agreement; acknowledging that some decisions may need to be taken elsewhere, and that decisions taken at the Partnership Board may also need to be ratified by each organisation
- bring together representatives of separate organisations concerned with improving the health of the local population, providing a forum for them to agree what they want to achieve together and to oversee their progress in achieving it

The Partnership Board should strive to support the development of the system to a 'thriving ICS'. Information on what this entails can be found in the System Maturity Matrix within the Designing ICSs in England document.

The **membership** of the Board should reflect the breadth of the ICS (e.g. multi-professional leadership and reflective of the diversity of the population). As this will result in a large membership, consideration should be given as to the use of sub-groups, networks and committees to structure discussion and decision making.

In addition to the Non-Executive Chair and Leader, membership will typically include representatives from:

- **NHS commissioners** – clinical commissioning groups (CCGS) and specialised commissioning
- **NHS provider trusts** – acute, mental health and community
- **Local government** – county councils, district, borough and parish councils,
- **NHS regulators and other bodies** – NHS England, NHS Improvement, Health Education England
- **Primary care** – primary care networks, as well as potentially Local Medical Committees (LMC), General Practice (GP) federations, Local Professional Networks (LPC – including community pharmacists, optometrists and dentists)
- **Independent sector providers** – private sector
- **Health and wellbeing boards**
- **Community and voluntary sector** – Voluntary, community and social enterprise sector – including infrastructure organisations and funders, hospices and other providers, charities supporting various groups of interest/identity, grass-roots community organisations
- **Public representatives** – Healthwatch, patient and carer groups
- And may include or be aligned with:
- **Education and research** – universities and academic health sciences networks
- **Other sectors** – industry, police and crime, education, fire service, etc to ensure the system can effectively tackle the wider determinants of health

Partnership Boards (2/2)

Terms of Reference

- It is good practice for Partnership Board to develop Terms of Reference (TOR) including:
    - Established system values and behaviours
    - Purpose of the Board and mission statement
    - Responsibilities of the Board
    - Membership
    - Quoracy
    - How to address conflicts of interest (COI)
    - How it engages and relates to other boards and groups within the system e.g. Health and Wellbeing boards, 'place level' boards and organisation (such as trust) boards

- Examples can be found here:

- Systems may also develop a partnership memorandum of understanding (MOU), establishing how they will work as partners across their whole system. An example MOU can be found here.

Conflicts of interest

- In discharging their duties transparently, ICSs and Partnership Boards will need to consider, record and manage conflicts of interest.

- The NHS guidance on managing conflicts of interest provides principles and rules for how to do this. Any partners from CCGs, NHS Trusts and Foundation Trusts should already be complying with this guidance, and it is also recommended to organisations which are subject to different legislative and governance requirements. Further information can be found by following this link: FAQs for provider managers.

- ICSs may maintain a Board COI register, drawn from existing registers. If ICSs choose to develop a register the Partnership Board members should declare both to their employing organisation and to the ICS, to enable visibility and scrutiny of COI in the ICS's decision-making. Certain members of the Partnership Board may have further COI requirements, depending on the organisation they work for.

- All systems should meet the highest standards of openness and transparency in the conduct of their affairs by holding meetings in public and publishing Board papers and minutes and producing an annual report. The Partnership Board will also act as the primary link to the regional team.

System governance considerations (1/2)

- The work of the Partnership Board needs to be supported by a **clear and appropriate system-wide decision-making framework** that spans the architecture of system – place – neighbourhood; describing how the constituent organisations of the system operate.

- In addition, **we expect that system partners will rely on other governance forums to support decision-making and oversight**. This will likely include regular meetings of Executives across NHS providers and commissioners to monitor and oversee NHS transformation, as well as operational and financial performance. ICSs may also put in place a system oversight group representing all system partners, where Non-Executive Chairs/ Directors and other Lay Members can play a role in holding the System Executive/ Leadership Group to account for delivery of system-wide objectives, some systems have used the existing Health Oversight and Scrutiny Committee (HOSC) for this purpose.

- **It is important that the ICS establishes mechanisms for working together and making decisions together at place**. ICSs may elect to have a place-based committee or partnership meeting. In some systems we expect, in line with the legislative proposals, that these may mature into joint committees.

- **We also expect that ICS partner organisations will continue their participation and role as part of the wider system through their existing governance structures**. For example, we would expect that Foundation Trusts provide updates to their Board on their work as part of the system, as part of their normal reporting and lines of accountability to their members and governors.

- **Developed systems are able to set out a clear governance structure** that explains the relationship between each governance group or board. Example diagrams of governance structures from systems can be found in Annex A, further examples can be found here.

- Systems have found that **Health and Wellbeing Boards are essential components of ICS governance** and indeed can be the forum in which the parties reach agreement. A range of best practice examples from systems on how this can be achieved and the benefit of this can be found here.

- **Health and Wellbeing Boards should have a clear role as part of the architecture of the place** using the joint strategic needs assessment (JSNA) and joint health and wellbeing strategy (JHWS) to support planning and delivery. The Overview and Scrutiny Committee's role should be leveraged in providing democratic oversight.

System governance considerations (2/2)

There is no set structure of sub-groups for systems to follow in establishing governance, however, some common sub-groups are emerging across systems. Further examples from systems can be found here.

These examples are not exhaustive and systems may choose different structures. We would recommend each system tests and develops what works for their local priorities with all partner organisations. Forums to consider are:

- Managing assurance could be achieved through **an assurance or oversight group** that follows delivery of work programmes, namely cross-organisational transformational activity, across the system. As systems are at varying stages of maturity, the level of oversight this group provides depends on what degree of collective responsibility they have agreed to take on with the Regional team.
- Many systems are implementing **clinical forums** which bring together clinical leaders to advise on priorities for quality improvement and transformation.
- Systems may develop a **finance group**, as these can be crucial to the effective operation of the system. A full suite of resources for developing system level financial governance can be found here: https://future.nhs.uk/connect.ti/Finance/view?objectId=12024048#12024048

Statutory groups

- A key element of effective system level governance is collaboration through joint committees. For example West Yorkshire and Harrogate Health & Care Partnership has developed a joint committee of its CCGs. Further information can be found here.

- Equally, successful systems are benefitting by working together through Health and Wellbeing Boards and Health and Overview Scrutiny Committees.

Further guidance

- Further information for developing robust governance arrangements from the Healthcare Financial Management Association (HFMA) can be found by following this link: https://www.hfma.org.uk/publications/details/sustainability-and-transformation-partnerships

- Detailed guidance on the legal options available to systems to collaborate including joint committees, joint appointments, forum arrangements, committees in common, joint ventures, etc can be found in the Mechanisms for Collaboration Guidance document here.

System accountability and transparency

Accountability

- Integrated Care System (ICS) partners will perform two fundamental roles: (i) coordination of system transformation and (ii) collective management of system performance. System partners should agree what activities and functions will be required to be carried out at the system-tier to fulfil these two roles.
- All STP/ICSs require an Non-Executive Chair who will have a key leadership role in the system working across all partners and sectors. They should ensure that the system's vision is fully realised and continues to evolve.
- As part of the new operating model, the NHSEI Regional team will hold the collective leadership of the system to account for NHS performance in the system, as well as the health outcomes of the population. NHS organisations will collectively hold each other to account for their roles in contributing towards this. Non-NHS bodies, such as local government, social care providers and the Voluntary Community Sector (VCSE) will have a role to play in the delivery of services and transformation but will not have formal accountability for NHS performance to NHSEI. This ability to work together is crucial to success
- The collective accountability model will not replace the responsibility of individual NHS organisations to manage their own performance and the primary accountability for organisational performance will continue to rest with the individual organisations. However, we do expect that in mature systems performance risks can increasingly be managed within and between organisations. The Regional team will continue to maintain its statutory responsibilities, including overseeing the performance of individual organisations and deciding upon regulatory intervention, when necessary.
- Systems should also utilise existing Health and Overview Scrutiny Committees to oversee and provide scrutiny to the work of the system.

Transparency

It is important that systems operate in an open and transparent way in everything they do and the governance mechanisms they develop must support them to do this. We recommend that they follow the following 10 principles for building trust (Annex B provides detailed examples from systems):

1. Transparency in decision making
2. Availability of public information about vision, plan, progress, performance
3. Regular flow of updates to a range of audiences
4. Proactive and systematic dialogue with public representatives
5. Involvement of voluntary sector, Healthwatch and key partners and enablers
6. Redesign of services in partnership with citizens and communities
7. Understanding of existing information on public and patient experience and aspirations
8. Reaching out to the unengaged to properly understand communities
9. Focus on patient and community empowerment
10. Strong communications and engagement leadership

The role of non-executives

Non-Executive Directors play a significant role within both commissioning and provider organisations in terms of assurance, accountability and Board level challenge by:

- Providing a lay perspective on the work of the organisation.
- Ensuring that statutory duties and functions are upheld.
- Maintaining strategic oversight of the organisation from an independent perspective, often bringing a different perspective from communities and people rather than organisation or sector
- Playing a key role in formal audit and governance structures as well as determining senior officer remuneration.
- Being appointed to Board roles within CCGs that carry a statutory responsibility such as audit and the duty to involve patients and members of the public in their work.

ICSs should consider how non-executives from constituent organisations form part of, and engage with, wider system governance.

To ensure organisations are supporting the whole system, non-executives should have a seat on the Partnership Board or a role in supporting it.

Points for consideration

Partnership Boards will need to consider:

- The number of Non-Executive representatives they require
- Where Non-Executive representatives are best placed in the wider governance system.
- How reflective Non-Executive representatives are of the communities the ICS covers
- How Non-Executives will be supported to manage the duality of their role to both the organisation and the system, including any conflict of interest arising
- Levels of remuneration and realistic time commitment
- Role descriptions, training, support and appraisals
- Developing a strategy to meet the equality and diversity targets for the NHS
- How they will be recruited

On a transitional basis there may be mechanisms in place to retain existing skills, knowledge and experience of current Lay Members/ Non- Executive Directors and to consider whether there are other opportunities for involvement in an associate or advisory capacity.

The role of voluntary, community and social enterprise

The NHS Long Term Plan highlights that the voluntary, community and social enterprise sector (VCSE) has a key role as a transformation, integration and innovation partner to support better health and care outcomes. The VCSE is a significant delivery partner, including an employer of a significant proportion of the health and care workforce. It advocates for different communities across the system and can help the NHS to reach diverse groups and bring innovative approaches to tackling inequality and joining up care. It also brings assets into the health and care economy, such as additional funding streams, mobilising volunteers, and relationships with marginalised communities.

Points for Consideration

Systems should ensure there is an inclusive, recognised and empowered voice for the VCSE at system level.

Developing Relationships: Systems should work with VCSE partners to agree an approach that connects VCSE Partnership Board members to the wider VCSE sector across the system. This can be through an established system-wide VCSE leadership group, steering group or Alliance/Assembly. If there is none in place the ICS should work with the sector to develop one for the system. The NHS England/Improvement Voluntary Partnerships Team can provide support with this.

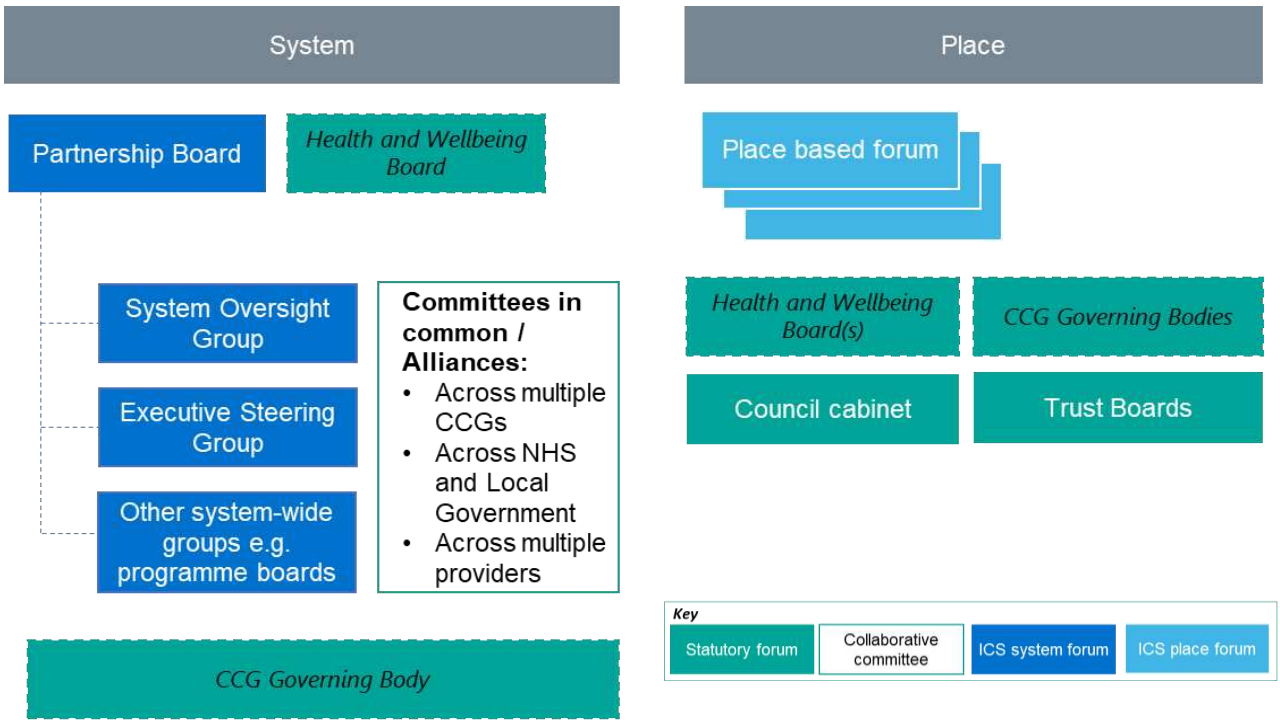
Establish effective communications: There need to be defined and recognised communication channels such as system stakeholder meetings, VCSE-led strategic alliances or assemblies, which connect the Partnership Board to the wider sector and support the process of two-way feedback.

Involving the VCSE in governance beyond the Partnership Board

Systems should identify how best to systematically involve the VCSE in system-wide workstreams, including the possibility of members of the VCSE leading certain workstreams.

The role of the VCSE in governance at place and neighbourhood level needs to be developed. Systems should consider how the VCSE is represented within Integrated Care Partnerships/Integrated or Local Care Organisations, as well as neighbourhood level integration hubs or networks. There will be existing relationships at both these levels and it is important to build on these and consider the connections to system-level governance.

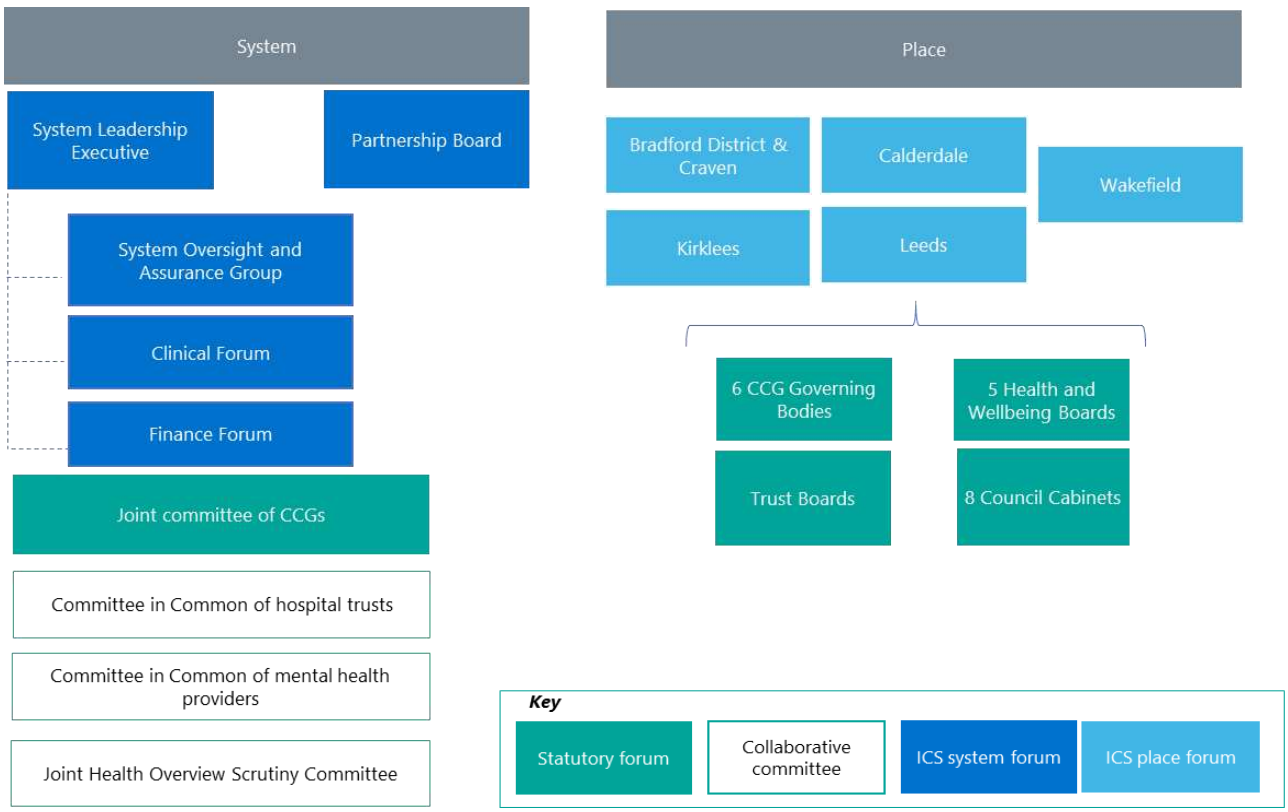
Annex A: Generic approach to system governance



Key considerations:

- As part of setting out ICS governance, system partners should give due consideration to how the existing forums can be best utilised and how arrangements may change in future to streamline decision-making.
- Organisational governance will continue to apply and these forums can be a useful way of organisations keeping their lay members informed of system-wide issues and progress e.g. Foundation Trust Council of Governors.
- Depending on the size and complexity of the system, certain forums may operate at system or place level e.g. Health and Wellbeing Boards, Governing Bodies.
- In smaller systems, there are opportunities to streamline governance e.g. by joining up the Health and Wellbeing Board and the Partnership Board, but this is dependent on existing ways of working, agreement of system partners and alignment of footprints.
- Members of a system Partnership Board may create sub-committees to drive key priorities or advisory groups including engagement forums. In cases where these are set up, it is important to describe how they relate to the Partnership Board and other governance forums.
- Place-based forums in some systems are referred to as Integrated Health and Care Partnerships. Usually these forums bring together all the key organisations involved in integrating care and addressing population needs across the 'place' footprint.
- These do not always align to local authority footprints and therefore consideration will need to be given to how HWB, HOSCs etc can feed in at place.

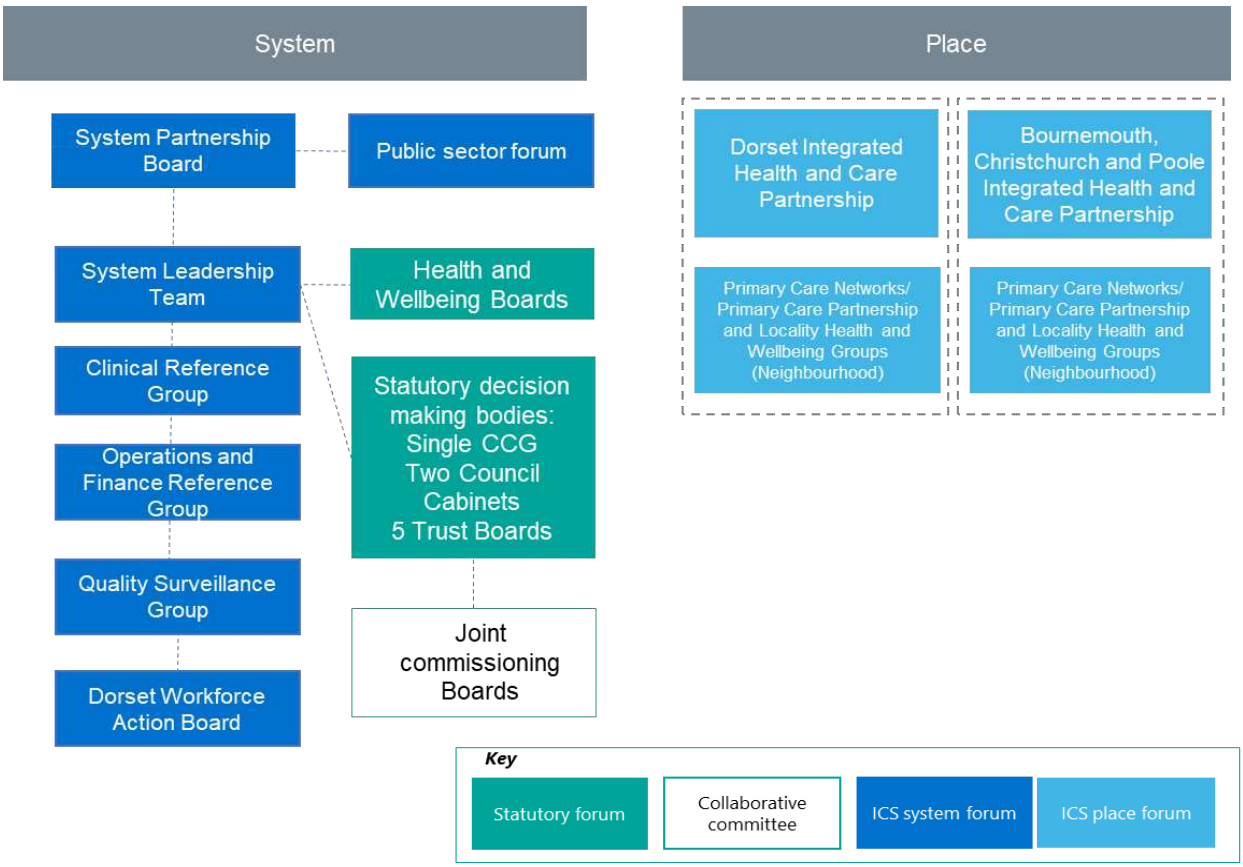
Annex A: West Yorkshire & Harrogate ICS system governance



Summary:

- West Yorkshire & Harrogate (WY&H) has a population of 2.7 million, five places with six CCGs and eight council cabinets (5 unitaries, 1 county,1 district,1 borough).
- At system level WY&H have a Partnership Board which brings together executives, non-executives, elected members of the NHS, Councils and local communities. The Board is chaired by an existing council leader from WY&H. The System Leadership Executive Group, includes the CEOs / AOs of partners organisations, clinical leaders and other stakeholders and is responsible for setting and overseeing the strategic direction of the partnership, building collective responsibility for delivery and assurance
- The System leadership executive is supported by three advisory groups: system oversight and assurance, a finance forum and a clinical forum.
- In addition, at system level WY&H have a number of collaborative forums to support decision making, including a statutory joint committee of all CCGs, a committee in common of the hospital trusts, and a West Yorkshire Councils consultative forum, further there is a Joint HOSC providing system level scrutiny.
- WY&H's model is focussed on delivery at place, delivered by the relevant individual organisations working together as part of a Health and Care Partnership, aligned with their five HWBs
- External scrutiny is provided by the HOSC in each place. Three of the places are covered by a single CCG, with the final two places (Kirklees and Bradford District & Craven) having multiple CCGs working together within the place footprint.

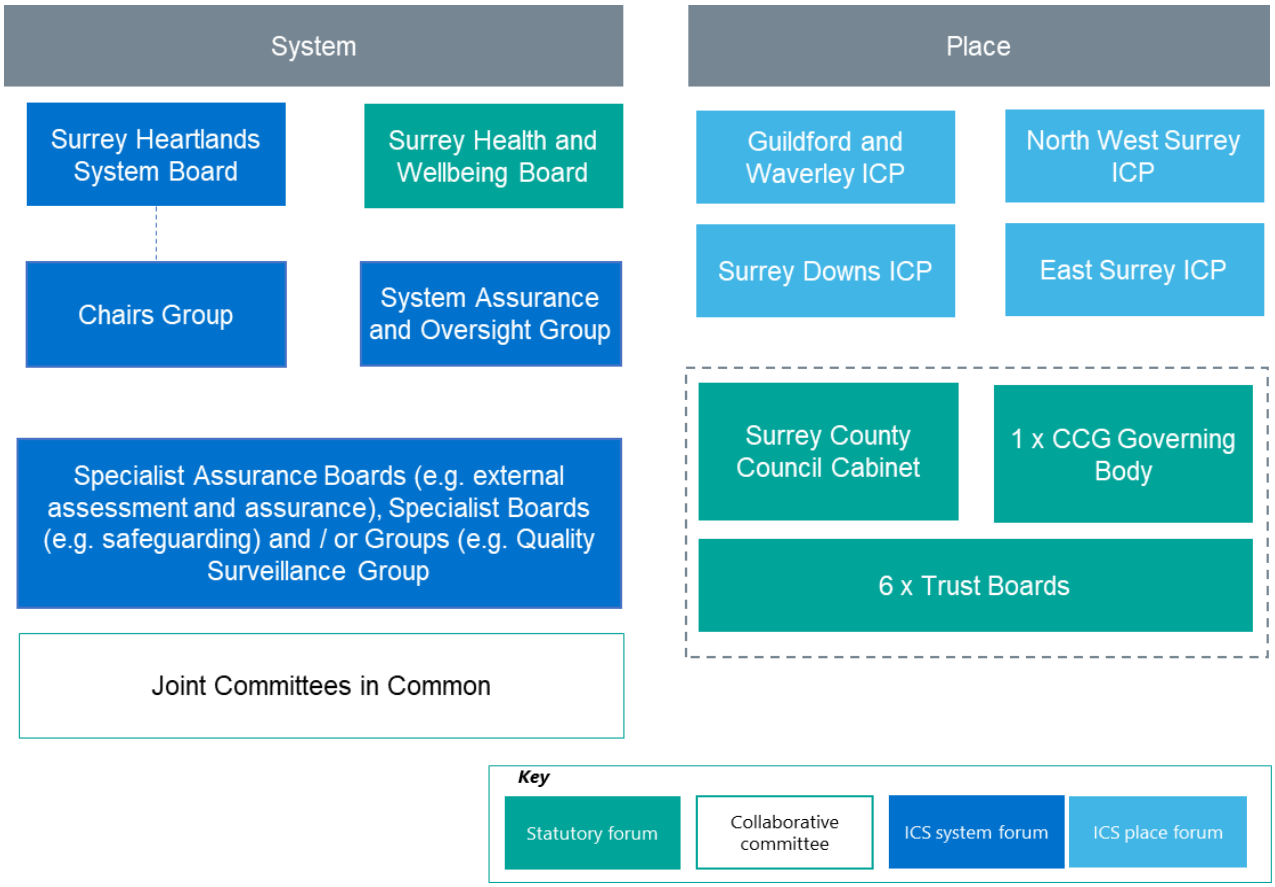
Annex A: Dorset ICS system governance



Summary:

- Dorset has a population of 0.8m, one CCG and two place footprints, based around their local councils.
- Due to Dorset's size the majority of ICS governance is conducted at the system level through the System Partnership Board which includes leaders from all partner organisations who have joint accountability for the delivery of the population outcomes.
- Underneath this is the System Leadership Team, where senior responsible officers and the two specialist functions of finance and clinical operations meet. These groups are supported by a number of groups and boards, including a public sector forum.
- Dorset has two Integrated Health and Care Partnerships (one for each place) aligned with their council footprints and underpinned by the constituent Primary Care Networks, Primary Care Partnerships and Locality Health and Wellbeing groups.
- Dorset has two HWBs, which are linked directly with both the Partnership Board and System Leadership team at the system level. The HWBs also engage directly with each statutory organisation within the system.

Annex A: Surrey Heartlands ICS system governance



Summary:

- Surrey Heartlands has a population of 0.9million and has four places
- At system level, the HWB acts as the overall strategy setting board for Surrey. It sets the long term vision and strategy looking across all public services and considers the wider determinants of health and wellbeing.
- Alongside the HWB, the System Board oversees the implementation and delivery of the Surrey Heartlands strategy in the context of the overall Surrey Health and Wellbeing Strategy.
- Surrey Committees-in-Common facilitate and streamline strategic decision-making for jointly commissioned services.
- The system has several collaborative groups, including a system assurance and oversight group and quality surveillance group.
- The four places, locally termed Integrated Care Partnerships (ICPS), each have an ICP board, which oversee and provide assurance of local transformation, finance, performance and quality. The ICPs have primacy for decision making with issues escalated to system level as required.
- Surrey also has a joint committee in common across its council cabinet and CCGs, to drive integration of commissioning through aligned decision-making, and streamline decision-making.
- Surrey has enabled Non-Executive and Lay Member engagement at all levels of their governance arrangements.

Annex B: Transparency principles (1/3)

Transparency in decision making

- Greater Manchester has a Health and Care Board which meets bi-monthly in public. These meetings are livecast, all agendas and papers are published in advance, and there are external representatives on the board, with a transparent recruitment process. When the ICS develops major plans, it engages in dialogue with local people through a process of co-production that involves the VCSE and 'experts by experience.' As well as outward-facing transparency, the system has invested in internal development to support transparency and trust between partners.
- https://www.gmhsc.org.uk/meetings-and-events/

Availability of public information about vision, plan, progress, performance

- Nottingham and Nottinghamshire ICS makes a range of information publicly available on its website and social media including its vision for health and care in the area, strategies for its priority areas with data on gaps and challenges, and details of the board and its meetings. Information covers formal elements such as published strategies and board minutes to more informal communication like blogs and videos from partnership leaders representing all organisations. There is information available for members of the public wanting to know about the system as a whole along with more localised information about the areas within the ICS. The ICS also welcomes members of the public to its Board meetings to observe the discussions.
- https://healthandcarenotts.co.uk/about-us/

Regular flow of updates to a range of audiences

- West Yorkshire and Harrogate Health and Care Partnership regularly communicates about the positive difference the partnership is making including a series of public-facing case studies. Governance of the ICS is transparent, with Partnership Board meetings held in public and live streamed, but the ICS recognises that many local people want to know the impact the partnership is having locally rather than the detail of how it works. It uses a range of communication approaches, with a focus on plain English and use of inclusive and accessible formats such as easy read and vlogs (short videos from a range of leaders.) Working through networks is an important element of the approach, with trusted partners such as the Engagement Champions Group who can make information relevant and accessible to their communities.
- https://www.wyhpartnership.co.uk/our-priorities/difference-our-partnership-making

Annex B: Transparency principles (2/3)

Proactive and systematic dialogue with public representatives

- An NHS Reference Group in Gloucestershire ICS provides a forum for all partners in the area – the council, the CCG, NHS providers, Healthwatch and the Health Overview and Scrutiny Committee – to meet regularly to review health and care challenges and planned changes. The group has informal and confidential discussions, enabling trust and relationships to develop and bringing different perspectives to bear. This contributes to plans that are better tested and gives NHS partners a much better understanding of potential concerns and impacts.
- https://www.onegloucestershire.net/who-we-are/

Involvement of voluntary sector and Healthwatch and key partners and enablers

- Suffolk and North East Essex ICS has representatives from the voluntary sector and Healthwatch on its board, and reports that 'conversations, tone, decision-making is all visibly changed due to the make-up of the Board.' The ICS recognised that it could not deliver on its ambitions for agreed priorities such as child poverty, obesity and loneliness without engaging the voluntary sector and local people. It has worked with two Community Foundations to channel funding to the VCSE to support work in priority areas, drawing on their experience in grant-making and in identifying need. Healthwatch partners supported the involvement of members of the public in the recruitment of the ICS chair, including review of the draft job description.
- https://www.candohealthandcare.co.uk/news/edition-7/uniting-essex-with-kindness/

Redesign of services in partnership with citizens and communities

- ICSs can draw on established links between Healthwatch, the voluntary sector and communities, when seeking to redesign services in partnership with local people. For example, in Dorset, as part of a review to improve children's community health services, voluntary sector organisations enabled access to children and young people, including specific groups such as those with disabilities and individuals who were part of the LGBT+ community.
- https://www.dorsetsvision.nhs.uk/wp-content/uploads/2018/08/Report-Children-Services-2018.pdf

Understanding of existing information on public and patient experience and aspirations

- Surrey ICS uses an engagement toolkit to draw on a number of involvement methodologies for its workstreams. One of the tools is desk research which involves looking at existing insights (local and national) into the issue or service area in question. The NHS has one of the most comprehensive survey programmes in the world, which yields rich feedback. Members of the public frequently seek assurance that their previous feedback has been considered when they are invited to get involved in health services.
- https://www.surreyheartlands.uk/get-involved/citizen-engagement-programme/

Annex B: Transparency principles (3/3)

Reaching out to the unengaged to properly understand communities

- Many ICSs are developing citizens panels to support them to understand the views and priorities of a representative sample of their population. By setting criteria for recruitment, surveys and panels can reach a wider cross-section of the public, including groups typically not reached. Working with local partners is also essential for community outreach. South Yorkshire and Bassetlaw ICS worked with its local Community Foundation and the South Yorkshire Housing Association to help it reach target communities that were likely to be under-represented in engagement – for example BAME groups, LGBT groups, young carers, prisoners.
- https://www.healthandcaretogethersyb.co.uk/application/files/2515/2579/1881/1._HSR_Stage_2_Report.pdf

Focus on patient and community empowerment

- Lancashire and South Cumbria ICS seeks to share and spread grass roots community empowerment work across its system, while recognising that such initiatives need to be locally driven and reflect the assets and concerns of people at a 'micro' level. One such initiative in Morecambe Bay supported a diverse range of local people, including members of the public and health professionals, to build their skills together in areas like dialogue, facilitation and co-creation. Projects that have developed out of this training include an award-winning mental health café offering peer support, and work to tackle child poverty and loneliness among older people.
- https://www.facebook.com/morecambecollective/

Strong communications and engagement leadership

- ICSs highlight the importance of an agreed vision for engagement that is shared by all partners. Dorset ICS researched existing perceptions of its communication and engagement and all partners drew on the findings to develop a shared improvement and action plan. One of the outcomes of its plan is a training programme for over 80 engagement champions covering multiple workstreams and organisations in the system who are now working with local people to redesign and improve local services and tackle complex health and care challenges. The ICS highlights the importance of visible leadership support for engagement.
- https://www.dorsetccg.nhs.uk/dorsets-we-are-the-champions/

More information on all examples: 'Engaging people, communities and the voluntary sector in integrated care systems'. Ipsos Mori, 2019 can be found here

Item Number:	7	**Enclosure Number:**	E
Meeting:	ICS Board		
Date of meeting:	15 October 2020		
Report Title:	Primary Care Networks: One Year On		
Sponsor:	Nicole Atkinson		
ICP Lead:	N/A		
Clinical Sponsor:	Nicole Atkinson		
Report Author:	Nicole Atkinson and Helen Griffiths		
Enclosure / Appendices:	None		

Summary:

This paper provides an overview of the development of the Primary Care Networks (PCN) within Nottingham and Nottinghamshire over the past 12 months, providing an outline of the priorities for 2020/21.

Actions requested of the ICS Board

To note the progress to date.

Recommendations:

1.	NOTE the progress and development of the newly formed PCNs.
2.	NOTE the on-going priorities and considerations for 20/2021.
3.	NOTE the governance arrangements for the ICS Primary care Transformation Funds.
4.	NOTE the risk to delivering 2020-21 transformation initiatives due to uncertainty regarding funding allocations.

Presented to:

Board	Partnership Forum	Clinical Reference Group	Chief Executive Group	Finance Directors Group
☒	☐	☐	☒	☐
Quality Group	**Performance Oversight Group**	**Mid Nottingham-shire ICP**	**Nottingham City ICP**	**South Nottingham-shire ICP**
☐	☐	☐	☐	☐

Contribution to delivering System Level Outcomes Framework ambitions

Our people and families are resilient and have good health and wellbeing	☒	Our people will have equitable access to the right care at the right time in the right place	☐	Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population	☒

Conflicts of Interest

☒ No conflict identified
☐ Conflict noted, conflicted party can participate in discussion and decision
☐ Conflict noted, conflicted party can participate in discussion, but not decision
☐ Conflict noted, conflicted party can remain, but not participate in discussion or decision
☐ Conflict noted, conflicted party to be excluded from meeting

Risks identified in the paper

Risk Ref	Risk Category	Risk Description	Residual Risk				Risk owner
			Likelihood	Consequence	Score	Classification	
Ref	e.g. quality, financial, performance	Cause, event and effect There is a risk that…	L1-5	L1-5	L x I	Grading	*Person responsible for managing the risk*
	Quality and Transform-ation	There is a risk that the PCNs will not be able to deliver the 2020/21 transformation initiatives due to uncertainty regarding funding allocations.	2	3	6	G	Associate Director of Primary Care Network Development Nottingham and Nottingham-shire CCGs

Is the paper confidential?

☐ Yes
☒ No
☐ Document is in draft form

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 Networks: One Year On

15 October 2020

Introduction

1. This paper provides an overview of the development of the Primary Care Networks (PCN) within Nottingham and Nottinghamshire over the past 12 months. PCNs were established in July 2019, their stated aims included the stabilisation of general practice, the dissolution of the historic divide between primary and community health services and above all, to help reduce health inequalities.

2. Meeting these expectations has been impacted by COVID-19, however, the work that the 20 PCNs across Nottingham and Nottinghamshire have achieved, and continue to work towards, has been significant.

3. Further details on the PCNs are available on the ICS website.[1]

Achievements

Relationships with partner Practices and associated partners

4. The PCNs have quickly established themselves both as individual entities, but also as a network of PCNs across Nottingham and Nottinghamshire. Relationships with key partner organisations have also started to emerge with the inclusion of Community Service Teams, Community Pharmacy, Mental Health care teams, and District Councils becoming involved in the PCN meetings with regular attendance fostering trust and establishing ways of working. Early discussions have also taken place with Local Authority colleagues to support their involvement in the development of the PCN and consider health inequalities within their areas.

Workforce and Additional Roles

5. In the initial year each PCN received additional funds to support two roles; Clinical Pharmacists and Social Prescribing Link Workers. These roles have been enhanced from 1 April 2020 with the introduction of further roles as summarised below:

[1] https://healthandcarenotts.co.uk/care-in-my-area/mid-nottinghamshire-icp/primary-care-networks/

Role	Number	WTE	Role	Number	WTE
Clinical Pharmacist	47	40.52	Physician Associates	0	0
Pharmacy Technician	1	1.00	First Contact Physiotherapists	9	8.36
Social Prescribing Link Workers	42	35.88	Dieticians	0	0
Health & Wellbeing Coaches	0	0	Podiatrists	0	0
Care Co-ordinators	0	0	Occupational Therapists	0	0

*Recruitment details as of July 2020

6. As part of the Directed Enhanced Service (DES) for 2020/21, PCNs were required to complete a workforce return using the agreed national workforce planning template. Each PCN provided details of recruitment plans for 2020/21 for submission required on 31 August 2020. A further submission outlining indicative intentions through to 2023/24 is required by 31 October 2020.

7. Discussions are underway with CCG Finance colleagues to agree and determine an Unclaimed Funds process as outlined in the Network DES Contract Specification.

Clinical Pharmacists

8. The role of the Clinical Pharmacists has been embraced in all the PCNs. Examples of the work currently being undertaken by the Clinical Pharmacists include medication reviews, in particular to care home residents, and developing specialism areas, for example Atrial Fibrillation, and Pain Management.

9. The CCG Medicines Management Team provides a support package for the Clinical Pharmacists and is supported through the Clinical Pharmacy Support and Advisory Group:
   - Production of templates, processes and resources, made available through F12 and Ardens e.g. SMR template
   - Supported links with the Community Pharmacy Leads
   - Development of a comprehensive prescriber induction pack one to one sessions
   - Invitations to lCS wide medicines training and webinars

Social Prescribing Link Workers

10. The Link Workers have been instrumental in supporting patients and their carers to navigate the voluntary and community services environment. This has largely occurred through signposting, but also referring patients to appropriate voluntary, community and social enterprise (VCS) services.

11. The Link Workers are all supported by the individual PCNs, and GP Federations are providing supervision and mentorship. A Nottingham and Nottinghamshire wide forum is in place to ensure that all involved are kept updated on the national picture, able to share experiences and learning which is supported at a Regional level. Link Workers have an active role within their PCN meetings and also the Multidisciplinary team meetings supporting wider and non-clinical care.

Delivery of Extended Hours Access

12. One of the key deliverables for the PCNs has been to deliver Extended Hours Access across the PCN. Providing additional clinical sessions (routine appointments including emergency or same day appointments) to all registered patients within the PCN. The delivery of the additional access has been provided both face to face, telephone, video and online consultations with a range of healthcare professionals providing access for all patients across Nottingham and Nottinghamshire.

Leadership & Development

13. A local comprehensive Leadership Programme has been provided for the Clinical Directors. The PCN Development Funds allowed for an increase of clinical time for the Clinical Directors across all PCNs to support the development of the PCN and their own leadership needs. This increase of capacity has continued for 2020/21.

14. A variety of leadership development sessions were made available to support:

- Dedicated coaching and mentoring to support leadership positions.
- Three day leadership programme that focused on various leadership principals, raising awareness and creating ownership, defining purpose, beginning the visioning process etc. Feedback from the programme was well received by those in attendance.
- A monthly ICS Clinical Directors Network has been established to support PCN development, discuss specification requirements and share learning. This protected time allows the clinicians to enhance relationships, provide a supportive environment and share best practice.
- A system wide conference was held on 6 December 2019 led by The Kings Fund. The event had a number of key speakers to share areas of best practice locally and nationally. The event was very well received with attendance from all partners across the ICS.
- TeamNet was rolled out to all general practice across Nottingham and Nottinghamshire CCG in January 2020. Utilisation of the platform, by both practices and the CCG, was accelerated in response to COVID-19 and has been the single portal for the CCG to communicate with general practice during this time and will remain as such to support recovery and restoration.

COVID and Clinical Management Centres

15. The PCNs response to COVID-19 has been positive despite the workload for PCNs increasing significantly due to shielding workforce, change of working practices, and their proactive response and commitment in establishing Clinical Management Centres. The PCNs reported that their relationships, trust and commitment was enhanced, which allowed them to make informed and rapid decisions to support patient care and ensure workforce safety during the height of the pandemic. The PCNs have played an active part in the restoration and recovery phase and have been very proactive in supporting the recovery of Primary Care Services.

16. The PCNs are on standby to support any surge in COVID and preparing to support an enhanced delivery of the flu programme that will meet the requirements of the revised infection control and Standard Operating Procedures for Primary Care. Understandably there is concern around further pressures and resilience on the Primary Care workforce; this is proactively being discussed within PCN meetings and across the system.

Challenges

Transformation

17. PCNs are proactively implementing the required service specifications with the DES for 2020/21 commencing 1 October 2020: Enhanced Health in Care Homes; Early Cancer Diagnosis; and Structured Medication Reviews and Medicine Optimisation.

18. All specifications have required a level of service transformation within Primary Care and collaboration with key partners. Delivery of the Enhanced Health in Care Home specification has been exceptionally challenging due to the number of Care Homes across Nottingham and Nottinghamshire. New working relationships and models of delivery have been established to ensure the specification is met, which has required a high level of consultation across all partners.

Finance

19. The Primary Care Transformation Funds are allocated to the ICS, underpinned by a funding agreement between the ICS and NHSE/I. The funding agreement sets out the requirements and deliverables to be achieved through use of this ring-fence budget.

20. The Primary Care Programme Board has been established to oversee the planned use of these funds and implementation progress. NHSE/I will hold the Board to account for use of this and may request formal progress reporting alongside a formal in-year review and end of year impact report.

21. To support the prioritisation and allocation of this funding, a clinically led planning group - the Primary Care Transformation Group - has been set up with representatives from the ICS, CCG and Primary Care. This group is advisory to help plan and gain a consensus agreement on the use of funds and to make a recommendation to the Primary Care Programme Board on how funds are to be distributed.

22. To support the development of a system plan within an ICS primary care resource envelope, there is a need to understand what is expected to be delivered from within the ICS envelope and what is expected to come from other national programme funds or bidding process, if further resource is available. An ICS Primary Care Transformation Fund Framework has therefore been developed.

23. In year monitoring will be key to the effective use of this fund. Due to internal and external factors, plans will change throughout the year. The Primary Care Programme Board will need to be agile in reassigning primary care resources. The CCG finance team will maintain the primary care financial picture throughout the year, updated on a monthly basis, including year to date expenditure and forecasts. ICS Finance will link with CCG Finance colleagues to ensure that regular reports can be shared with the Primary Care Programme Board on a monthly basis in a robust and timely manner.

24. Prior to COVID indicative funding allocations for system Primary Care Transformation Funding had been shared. Plans were being put in place through an inclusive process and methodology for prioritising funding. With the advent of COVID this work has been paused until confirmation from NHSEI of the PCN Development Funds for 2020/21 has been received. PCNs are therefore not in a position to take forward any local transformation initiatives, this also applies to GPFV and primary care workforce funding.

Workforce

25. Planning and recruitment to the additional roles is a high priority and time consuming focus for the PCNs. PCNs welcome the additional capacity and broader skill set, however there is a recognised risk of the availability of the staff, as well as ensuring these emerging roles work well and interface with CCG contracted services. On-going support is provided by the Locality Teams and GP Federations to recruit and embed the new roles, as well as facilitating discussions with the CCG community contracts team and community providers to ensure a collaborative interface of the posts.

IT Infrastructure

26. The IT infrastructure for the emerging roles is a challenge. There has not been any allocated funding nationally to the networks to support the provision of IT equipment. This has been further exacerbated by the requirement of many primary care staff to undertake agile working due to COVID. The CCG successfully bid for additional funds through the Estates & Technology Transformation Fund (ETTF) but this funding will not be sufficient in the longer term. Currently funding has been utilised to support the issue of additional laptops in the short term to primary care. There is a risk with increasing numbers of PCN staff employed in the coming year that ETTF funds will not be sufficient to support the equipment required. This is being monitored on a monthly basis and further discussions around Primary Care IT are taking place.

PCN Estates Needs

27. As the transformation of primary and community care takes place and additional roles are developed within the PCNs, primary care estate will increasingly become a focus of attention across the system. Early discussions with the PCNs are taking place to identify future estate needs based on emerging priorities. This will be incorporated into the system estates strategy. It is important that PCNs fully engage in this process and are able to inform future estates requirements.

Next Steps / Priorities

28. Key PCN priorities for the remaining six months of 2020/21 include:
    - Confirmation from NHSEI on the requirements of the PCN Dashboard; PCN Prospectus and Investment and Impact Fund.
    - Further development of the multidisciplinary models of working in primary care; building on current community services, the introduction of new roles and skill sets, and wider community assets.
    - Establish a broader workforce as identified in the PCN workforce plans. Consider the additional two roles that will become reimbursable for PCNs to recruit from 2021 including; Mental Health Practitioners and Emergency Care Paramedics.
    - Improved access, including provision of extended access hours, as well as support total triage and remote consultation.
    - Implement and develop the three new service specifications as detailed above, and prepare for new specifications due to commence April 2021: Cardio vascular disease; Tackling inequalities; Anticipatory care; Personalised care.
    - Progress the implementation of Population Health Management.
    - PCNs will need to make the best use of people and technology to improve efficiency, maximise income and strengthen the workforce.

29. The ICS Board are asked to:

- **NOTE** the progress and development of the newly formed PCNs
- **NOTE** the on-going priorities and considerations for 20/2021
- **NOTE** the governance arrangements for the ICS Primary care Transformation Funds
- **NOTE** the risk to delivering 2020-21 transformation initiatives due to uncertainty regarding funding allocations

Nicole Atkinson
29 September 2020

Item Number:	8	**Enclosure Number:**	F1
Meeting:	ICS Board		
Date of meeting:	15 October 2020		
Report Title:	ICS Executive Lead Report – Integrated Performance		
Sponsor:	Dr Andy Haynes		
ICP Lead:	n/a		
Clinical Sponsor:	n/a		
Report Author:	Sarah Bray – Associate Director for System Assurance		
Enclosure / Appendices:	Enc F2 – ICS Delivery Dashboard		

Summary:

To provide an update on key events and information from the last month from the ICS Leadership Team.

This report supports the ICS Board in discharging its three core responsibilities:

1. Delivery of System Transformation;
2. Delivery of System Performance;
3. Progress of ICS along maturity assessments, and integration across health and social care system.

Updates are provided for:

- Covid-19 19 response and approach to recovery
- Phase 3 Planning
- Integrated Performance (quality, service delivery, finance, people)
- Quarter 1 2020/21 review of ICS Maturity

Actions requested of the ICS Board

To note the report

Recommendations:

Presented to:

Board	Partnership Forum	Clinical Reference Group	Chief Executive Group	Finance Directors Group
☒	☐	☐	☒	☐
Quality Group	Performance Oversight Group	Mid Nottinghamshire ICP	Nottingham City ICP	South Nottinghamshire ICP
☐	☐	☐	☐	☐

Contribution to delivering System Level Outcomes Framework ambitions

Our people and families are resilient and have good health and wellbeing	☐	Our people will have equitable access to the right care at the right time in the right place	☐	Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population	☐

Conflicts of Interest

☒ No conflict identified
☐ Conflict noted, conflicted party can participate in discussion and decision
☐ Conflict noted, conflicted party can participate in discussion, but not decision
☐ Conflict noted, conflicted party can remain, but not participate in discussion or decision
☐ Conflict noted, conflicted party to be excluded from meeting

Risks identified in the paper

Risk Ref	Risk Category	Risk Description	Residual Risk				Risk owner
			Likelihood	Consequence	Score	Classification	
Ref	e.g. quality, financial, performance	Cause, event and effect There is a risk that…	L1-5	L1-5	L x I	Grading	*Person responsible for managing the risk*

Is the paper confidential?

☐ Yes
☒ No
☐ Document is in draft form

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

ICS Executive Overview
6 October 2020

1. The system has drawn together during Covid-19 which has led to some service and patient behaviour changes which will benefit and transform the system if these positive changes can be collectively harnessed and embedded. The next few months are critical in resetting the aim and ambition for health and care services across Nottingham and Nottinghamshire.

2. The system has continued to have monthly reviews with the NHS England / Improvement Regional team which have tended to focus upon the response by the system to Covid-19 and on progress and preparations being made by the system for recovery and restoration of services for the citizens of Nottingham and Nottinghamshire. NHSE/I consider good progress is being made, with further significant work required collectively to address the demands of recovery of services, winter and EU exit for the remainder of the year.

3. In addition, the system has had a second ICS Development review meeting with NHSE/I Regional team at the beginning of October 2020 at which early confirmation was received of available support for the next stage of local system development.

Covid-19

4. There are five key interrelated challenges this Winter for systems; Covid-19 “second spike”, Winter Pressures including Flu, End of the EU Exit Transition Period (31/12/20), Restoration and Recovery and delivery of a vaccination programme on a scale previously unchartered during this period. They are interrelated because they all have the potential to or will; impact on operational capacity (demand for services and incident management / operational capacity), to contribute to potential risk to supplies chain (PPE / Pharmaceuticals / Medical Consumables), and to move the system to a National Declaration of “Level 4 Incident” for Covid-19 and EU Exit National coordination which will require additional capacity within the system to deliver.

5. As such the system have agreed to build on the incident management work already undertaken within the system in response to Covid-19 to ensure full system oversight through a single lens in this next phase, through a central Incident Control Centre and Incident Management Team, reporting into the Health and Social Care Economy Tactical Coordination Group (HSCETCG), and the System Chief Executives operational call. This is aligned to LRF and EPRR approaches. A system wide EU Exit group is also in place which will report into the Incident Management Team.

6. Given the current infection rates in the City and County, and in preparation for the next phase of incident management as a system the following priority areas are being supported;

    - The delivery of a comprehensive and whole system approach to Covid-19 vaccination planning with a view to receiving the first vaccinations into the system in December. This level of vaccination delivery will be unprecedented in the system, and the delivery programme is likely to run between 4 and 9 months dependent upon confirmed scale and vaccination availability.
    - Refresh of the system triggers and escalations to incorporate outbreaks, Covid-19 second wave, EU Exit, the Covid-19 vaccination programme and the delivery of the Phase 3 recovery plan. Ongoing close monitoring of the data, triggers and escalations.
    - Effective utilisation of the system capacity through the ongoing work of the capacity, urgent care and right care, first time cells.
    - Testing response and support to outbreak situations and the development of innovative approaches to testing across the system including hyper local testing sites to assist with engaging communities, ongoing MTU mobilisation, and support to care homes in surveillance testing and in outbreak situations, and the development of a prototype approach to swabbing in reach in response to hyper local escalations.

System Transformation

Phase 3 NHS Plan – 2020-21 Recovery

7. On 31 July 2020 the ICS received a request to develop plans for Phase 3 NHS Response, which covers the period October 2020 to March 2021, as part of recovery of services and plans for winter. The Recovery Cell has co-ordinated development of the plan for the ICS, and included representation from all partner organisations. Following approval by the ICS Board and individual ICS organisations the final Phase 3 plan was submitted to NHSEI on 21 September 2020. The plan comprised of an executive summary, main narrative, activity and performance trajectories and the Local People Plan. Initial feedback from the regulator has been positive, however further work was required in relation to the financial position.

8. The plan aims to recover pre-Covid-19 levels of services in line with the specific requirements set out in the national and regional Phase 3 recovery guidance. The majority of requirements will be met including primary and community care, mental health, learning disability and autism. A small number of elective and diagnostic requirements remain out of reach due to the workforce and physical space constraints being faced during Phase 3.

9. Following submission on the 21 September, the NHS system funding envelope and Phase 3 financial framework was received. Intense work has been undertaken to understand the implications of this for the submission of the Phase Three financial plan to NHSEI on 5 October. This has been led by the Finance Directors Group.

Re-set of the Long Term Plan

10. The HSCETCG Recovery Cell has commenced a piece of work across the system whereby all organisations are undertaking a stocktake against the 2020-21 Operational plan and assess performance against the key constitutional areas. This will inform the plan reset expected to be undertaken during Q3 / Q4.

11. In addition, the HSCETCG Recovery Cell will use the 25 System Transformation Priorities as a framework to understand the impact of Covid-19 response across all aspects of delivery, including service delivery, quality, use of resources, to inform the refresh of the 5 Year System Plan. An initial review has been undertaken on the implementation status of the transformation areas, which is included within the report, and has determined two additional areas which require including on the priorities list, which are Primary Care New Care Models and Homelessness/ severe multiple disadvantages group. The Recovery Cell has since identified five initial areas for transformation system efforts to be focused, which are Discharges and admissions, mental health crisis and liaison, Primary care new models, homeless/ disadvantaged group and Outpatients redesign.

12. From these areas, two have been identified to rapidly test an evaluation approach, which are discharges and outpatients. This work is progressing.

System Performance

Quality

13. The ICS Quality Group continues to focus on both developing a system oversight of quality and associated risks, but also supporting the development and conversations around quality assurance and oversight in all of the system spaces in PCNs, ICPs and provider footprints.

14. As the restoration of transformation work streams has commenced there has been an initial focus on those programmes, understanding the impact of Covid-19 on both performance and outcomes, as well as the revision and agreement of priorities and trajectories. There is a system agreement to support a conversation around hidden harms and impacts on quality as a result of Covid-19. Given the rise of nosocomial outbreaks across the system

and the impact that Covid outbreaks have across our system, the next immediate area of focus for the ICS Quality Group will be seeking assurance of robust infection prevention and control (IPC) systems, support and partnerships in place. Whilst at a local level IPC frameworks have provided some significant assurance this work will focus on the assurance and development of proactive engagement and collaboration across partners as part of outbreak management and wider health protection oversight.

15. The delivery of the National Flu Programme for 2020/21 continues and population health management tools have been used to shape and deliver this in a way which targets the most vulnerable communities and people in our system. Collaboration, sharing of resource and vaccines and an every contact counts approach to the programme have supported positive delivery to dates. This supported by targeted and localised messaging across place based partners has ensured that by the end of September 81,420 vaccinations have been administered and recorded (18% of the eligible population).

Service Delivery

16. Performance into quarter 2 2020-21 continues to highlight the impact of the Covid-19 response across service delivery and activity levels, and the effect this has had on volumes of patients waiting for diagnostics, cancer and planned treatments. There is a system wide Clinical Prioritisation approach for patients waiting, ensuring the highest clinical priority patients are utilising all available capacity across the system. This may mean that patients with lower clinical priority needs may have increased waits, however there are safety netting procedures in place for longer waiters.

17. Service recovery is progressing well across the system. Population referrals are still 36% lower than Pre-Covid-19 levels, however urgent cancer referrals have returned to pre-Covid-19 levels. Capacity constraints do remain due to Covid-19 requirements, including reduced theatre productivity, reduced bedstock for social distancing and reductions in diagnostic capacity. Despite these difficulties the system is performing better than the regional average for restoration of the following services:
    - Cancer 2ww 93% of Pre-Covid-19 levels.
    - Cancer patients waiting 62+ days or 104+ days have significantly reduced and are below prior year levels
    - Outpatient activity 120% on last year's activity
    - Elective activity 110% last year's activity
    - Diagnostic Activity 80% on last year's activity.

18. GP Appointments fell during August to 80% of last year's level, due to annual leave following Covid-19 immediate response.

19. Urgent care volumes continue to rise to pre-Covid-19 levels with 111 calls increasing as a consequence of increased Covid-19 concerns, however services continue to perform well. All parts of the system are striving to identify and embed the best practice service changes which have been implemented during the Covid-19 response across health and care to enable sustainable service improvements across the urgent care system.

20. Remote access by the public continues to increase, with telephone consultations in primary care increasing by 129% from August 2019 and NHS App downloads increasing to 5.15% July 2020 of the total applicable population. Additional engagement is needed to further increase the population use of the NHSApp and to register on-line with practices.

21. During 2019/20 improvements were made across many areas of mental health, including OAPs, IAPT access and CYP Access, with additional focus still required to increase CYP Access further and undertake more SMI Physical Health Checks. However Covid-19 had a significant impact on patients accessing and referring into mental health services. IAPT referrals have now returned to pre-Covid-19 levels. Alternative delivery options for Physical Health checks are being explored due to the constraints of Covid-19. OAPs have increased due to bed capacity affected by Covid-19 requirements, however the CCG volumes are overstated currently due to a mis-allocation of responsible CCG, for some patients, to Nottinghamshire.

Finance

ICS Month 5 Integrated Performance Report

NHS Partners

22. For months 1-6 of 2020/21 NHS partners in the ICS are operating under a different financial framework following the Covid-19 outbreak. Organisations have been provided prospective funding based on 2019/20 plus inflation with an additional retrospective payment to cover Covid-19 costs and any other reasonable costs above resources provided. On this basis all NHS partners are reporting a break-even position.

23. Costs incurred in months 1-5 total £1,523 million including £62.5 million of Covid-19 related costs. Non Covid-19 spend is £11.1m greater than inflation adjusted spend to the same period in 2019/20 – a real term's increase of 0.7%.

24. The month five report shows unconfirmed claims for non-Covid-19 expenditure of £10.3 million; an improvement on the previous month due to approved CCG claims. NHS partners have spent a total of £72.6m on Covid-19 related revenue expenditure and £11.3m of capital between the period February to July 2020. Of this, £10.0m of revenue relating to Covid-19 has

been spent in August 2020. The main areas of Covid-19 spend relate to the hospital discharge programme, increasing ITU capacity and sickness/isolation cover.

NHS Capital

25. £1.5m of Covid-19 capital claims have been rejected (£0.8m SFH, £0.7m NUH) as they were not deemed to meet the criteria specified by NHSE/I. The capital has been committed and now must be met from within the ICS capital envelope. NHS Provider Trusts have developed capital plans within the ICS capital envelope of £79.3 million for the year. In addition the ICS have been allocated a critical infrastructure risk capital fund of £18.6 million in 2020/21. This is to be used to address high and significant backlog maintenance within the ICS. Plans have been developed, mainly targeting risks at Nottingham City Hospital and Queen's Medical Centre.

26. Capital Plans within the envelope above have been approved but NHSE/I have only made available £10.0m of cash support to take forward these plans. The ICS requires cash to support its capital programme, due to the lack of internally generated cash at NUH and SFH – the amount applied for in 2020/21 is £21.5m (shortfall of £11.5m). This means the ICS is unable to take forward a number of high priority capital schemes, notably at NUH where the infrastructure risk is greatest. The Finance Director Group have highlighted this to the NHSEI Regional Director of Finance and asked for a meeting to discuss.

Local Authority Partners

27. The local authorities continue to operate under the previous financial regime although additional income has been provided to support a proportion of increasing costs and lost income due to the pandemic. However, the additional income is insufficient to meet the costs incurred leading to a forecast overspend for adult and child social care services in 2020/21 of £24.8m at Nottinghamshire County Council and £13.5m at Nottingham City Council.

NHS Phase 3 Recovery Plan - Finance

28. Initial financial plans for months 7-12 have been submitted by the ICS in relation to the NHS organisations. There is a further submission during October and it is expected this will form the basis of performance reporting in the latter half of the year.

People and Culture

29. Vacancy and sickness absence rates remain static this month. Recruitment programmes are underway in organisations with a focus on nursing

recruitment. System bids for support on IR and training of existing overseas trained staff working in unregistered roles are being developed.

30. Workforce plans have been submitted informing on the recruitment to additional roles in primary care for 2020/21 with budgets confirmed around the funding allocations for PCNs.

31. The system talent academy CARE4Notts has begun its implementation with two work programmes. The first is the coordination of a bid with Nottingham City Council and system partners to design and deliver a number digital apprenticeships, and the second is creating placements to support the government initiative Kickstart Scheme for getting 16-24 years old into employment. The scheme supports 6 months fully funded placements with a minimum of 30 placements.

32. A focus on wellbeing remains a key priority and support programmes continue to be in place to support all staff with a continuous approach to risk assessments in place.

33. The local People Plan submitted 21 September 2020 has received good feedback with work underway to finalise the delivery plan and dashboard. The People and Culture Board will establish monitoring of the system People Plan actions and reports from organisations on delivery of employer actions.

34. The vaccination workforce group, combining both flu and Covid-19, has developed a delivery framework

System Maturity

Regional review – increased maturity rating for delivery

35. As reported last month, an internal review against the ICS Maturity Matrix was undertaken for Quarter 1 2020/21 and reported to NHSEI Midlands. The system has now assessed as 'maturing' against all domains of the Matrix (as detailed below) and confirmed by the ICS CEO Group. The system is also in discussion with NHSEI on progress achieved against the nationally defined 'consistent operating standards' for an ICS as outlined in the annual NHS operating guidance and NHSEI Phase 3 letter. The latter is forming part of the discussion on ICS development needs.

System Leadership, Partnerships and Change Capability

36. Work is on-going in reviewing and strengthening ICS governance arrangements with the introduction of the ICS CEO Group and the ICS Quality Group. The ICS Board has reflected on lessons learnt from Covid-19-19 experience, and which should be retained and embedded going forward.

System Architecture and Strong Financial Management and Planning

37. Key components and leadership in place at system, place and neighbourhood level, with plans underway to recruit to senior ICS leadership roles. Consideration being given to streamlining roles and responsibilities of the ICS and Strategic Commissioner during the next phase of system development.

Integrated Care Models

38. Proactively progressing with development opportunities and support from a range of partners to test new approaches for delivery of local priorities, e.g. 3V and Pfizer for MSK value improvement and Imperial for PHM. In addition the system is focusing on embedding and learning from the Covid-19 response over service delivery areas, such as development of a whole system DAIT Strategy, Inequalities Strategy and focused care homes service delivery.

Track Record of Delivery

39. Work continues to develop the system oversight and assurance approach in conjunction with NHS England and Improvement. Additionally work is underway on the development of a system evaluation framework to evidence the impact of delivery of LTP priorities.

SYSTEM DELIVERY DASHBOARD

ICS Board 15 Oct: Item 8. Enc F2

RAG	KPIs Achieved
	>80%
	50%-79%
	<50%

October 2020

Management of System Performance

Urgent Care -
August 2020,
111 increased activity, EMAS and ED back to pre-COVID levels
21 day stay 48% Yr on Yr reduction

Mental Health -
Q3 & 4 to focus on access (CYP/IAPT). IAPT referrals have returned to pre-COVID levels. Physical health checks options during COVID are being

Planned Care -
July 2020, elective and outpatients activity in month was over prior year levels. 18 week provider backlog grown 450% since July 2019, 486 people >52

Cancer -
End September, 62 & 104 day waits have significantly decreased to below prior year levels.
Referrals are at 93% prior year.
Pressures on surgery and radiotherapy.

Finance -
NHS Run rate is higher than prior year + inflation levels.
2020/21 funding regime does not cover expected spend
Underlying deficit is increasing.

Workforce -
Sustantive staff +7.3% year on year increase.
Bank & Agency staff 18% over planned levels.
Static position on staff turnover and sickness Q2.

Constitutional & LTP Metrics Delivery

Service Area	No. KPIs	% Achieved	Delivery RAG	Assurance Level	Assurance Group
Planned Care & Diagnostics	7	14.3%			Performance Group
Cancer	8	25.0%			
Urgent & Emergency Care	11	63.6%			
Mental Health	13	53.8%			
Primary Care	5	60.0%			
Personalisation*	4	paused			Quality Group
LD & Autism*	3	paused			
Maternity*	1	paused			
Quality	3	100.0%			
Workforce	6	66.7%			People
Finance	5	20.0%			Finance

Assessment Ratings	CQC - NHS Trusts	CQC - Nursing Homes	CQC - Residential Homes	CQC - GPs	CCG Annual Rating
	01-Sep-20	01-Sep-20	01-Sep-20	01-Jul-20	2018-19
Outstanding	0	6	16	19	0
Good	3	56	165	105	2
Requires Improvement	2	28	39	3	4
Inadequate	0	1	2	2	0
Not Rated	0	2	8	1	0

ICS System Outcomes Framework (SOF) Ratings - Q3 2019/20*

4 Best Performimg	4 Worst Performing
3/42 Dementia Diagnosis 76.6% (2019 11)	40/42 Maternal Smoking 15.8% (19-20 Q2)
4/42 IAPT Access 5.45% (19-20 Q1)	38/42 Cancer Early Diagnosis 48.12% (2017)
5/42 Personal Health Budgets 183 (19-20 Q2)	35/42 Diabetes patients achieve NICE targets 36.3% (2018-19)
5/42 6 Weeks Diagnostics 0.95% (2019 11)	32/42 Mental Health Out of Area Placements 220 (2019 09)

*during COVID non-essential reporting was paused including SOF

System Transformation

August: 10604 Online Completed 111 Sessions.
Calls risen above pre-COVID levels

399056 GP Appointments in August 2020, -21% August 2019.
47% Virtual,

2020 Flu Programme -
Utilised Population Health Management to target most vulnerable citizens. All contacts maximised.
81,420 vaccines administered and recorded by end of September.

25+2 New System Transformation Priorities

	Transformation Area	No. KPIs	Implementation Stocktake Review 19 June 2020	Transf'n Funding £m
Prevention	Tobacco - Smoking Cessation		Delayed	
	Alcohol - Reduce Alchol Related Harm		Delayed	
	Diabetes Prevention Programme		Delayed	
	CYP - Obesity / Healthy Weight		Delayed	
Proactive Care	Segmentation & Risk Stratification		Delayed	
	Care Co-ordination - MDTs		Delayed	
	Condition Management - Frailty		Delayed	
	Condition Management - Respiratory		Delayed	
	Condition Management - CVD		tbd	
	Condition Management - Diabetes		Delayed	
	Condition Management - EOL		Accelerated	
	Enhanced Health in Care Homes		Accelerated	
Urgent Care	OoH - SPA Community Crisis Response		Delayed	
	OoH - Community Crisis Response		Delayed	
	Pre Hospital - Integrated Urgent Care	Eval	Delayed	
	Effective Integrated Discharge Function	Eval	Accelerated	
	Effective Integrated D2A	Eval	Accelerated	
	Stroke Services		tbd	
Mental Health	Improving Access - Perinatal MH		Delayed	
	Improving Access - CYP		In Progress	
	Improving Access - Crisis & Liaison		Accelerated	£2.8m
PC	**Planned Care - Outpatient Pathways**	Eval	Accelerated	
LD&A	LD&A - Timely Diagnosis & Support		Delayed	
CYP	Whole Child Health - Transitions		In Progress	
Tech	DAIT & Virtual Working		Accelerated	
New	**Primary Care - New Models**		New	
	Homelessness		New	

Initial areas to focus system efforts on
-KPIs to be determined
-Funding to be confirmed as part of revised financial regime

Progress against System Plan

Finance Group	YTD Plan £m	YTD Actual £m	YTD Variance %	YTD RAG
Finance *(NHS Based)*				
-Run Rate Vs 19/20 +inflation	1511.6	1522.7	0.7%	
-ICS Capital Spend (in envelope)	16.8	10.9	-34.9%	
True-up Funding *(NHS Based)*	Claimed	Confirmed	Unconfirmed	Rejected
-COVID - Revenue confirmed	62.5	52.3	10.3	0.0
-COVID - Capital confirmed	11.3	7.5	2.3	1.5
-Retrospective True-up confirmed	32.4	19.3	13.1	0.0

As at 31st August 2020

People & Culture Group	YTD Plan	YTD Actual	YTD Variance	YTD RAG	Forecast RAG
Workforce *(NHS Provider Based)*					
-No. Substantive Staff	27199	27344	145		
-No. Bank Staff	1204	1431	226		
-Agency Staff	406	481	75		
-Staff Sickness Absence %	4.2%	4.4%	0.2%		
-Staff Vacancy %	11.4%	7.5%	-3.9%		

As at 30th August 2020

Finance / POG	YTD Plan	YTD Actual	YTD Variance	YTD Var %	1 Month YoY %
Activity *(Population Based)*					
- Referrals	70,036	51,197	-18,839	-26.9%	-36.5%
- Elective	36,779	22,370	-14,409	-39.2%	-1.5%
- Outpatients	227,255	179,535	-47,720	-21.0%	16.8%
- Non-Elective	29,867	26,071	-3,796	-12.7%	-9.3%
- A&E	104,981	63,756	-41,225	-39.3%	-28.6%

As at 31st July 2020

Performance Oversight Group	Period	Plan	Actual
Capacity *(Provider Based)*			
-Primary Care Appointments	Aug-20	-	399,056
-Acute Beds Available per day	Aug-20	2151	1539
-Home Care Packages			tbd
-Community Contacts			tbd
-Mental Health Contacts			tbd

System Maturity Ratings

Internal Review - Q1 2020/21

System Leadership, Partnerships & Change Capability	System Architecture, financial management & Planning	Integrated Care Models	Record of Delivery	Coherent & Defined Population	Overall
Maturing	Maturing	Maturing	Maturing	Maturing	Maturing