Integrated Care Partnership Meeting Agenda

Friday 06 October 2023 14:00 – 16:30

The Council Chamber, County Hall, West Bridgford, Nottingham, NG2 7QP

"Every person enjoying their best possible health and wellbeing"

Our aims: to **improve outcomes** in population health and healthcare; **tackle inequalities** in outcomes, experiences and access; enhance **productivity and value for money**; and support broader **social and economic development**.

Our guiding principles: **prevention** is better than cure; **equity** in everything; and **integration** by default.

Our core values:

- We will be open and honest with each other.
- We will be respectful in working together.
- We will be accountable, doing what we say we will do and following through on agreed actions.
- We will challenge each other if we fall short of upholding our aims and guiding principles.
- We will work with our population and put their needs at the heart of the ICS.

	Item	Presenter	Type	Time
Introductory items				
1.	Welcome, introductions and apologies	Kathy McLean	Verbal	14:00
2.	Confirmation of quoracy	Kathy McLean	Verbal	-
3.	Declaration and management of interests	Kathy McLean	Paper	-
4.	Minutes from the meeting that took place on 17 March 2023	Kathy McLean	Paper	-
5.	Matters arising from the meeting that took place on 17 March 2023	Kathy McLean	Verbal	-
Items for discussion				
6.	ICS Partnership Agreement	Alex Ball	Paper	14:10
7.	Service user and citizen insights report	Alex Ball	Paper	14:30
8.	Integrated Care Strategy for Nottingham and Nottinghamshire 2023-2027: Review of impact	Mark Wightman/ Lucy Hubber/ Jonathan Gribbin	Paper	15:00
9.	Developing a Population Health Management (PHM) Outcomes Framework	Dr Dave Briggs/ Maria Principe	Paper	15:30
10.	Water Fluoridation	Cllr. John Doddy/ Cllr. Linda Woodings/ Jonathan Gribbin/ Lucy Hubber	Paper	16:00
Closing items				
11.	Questions from the public relating to items on the agenda	Kathy McLean	Verbal	16:20
12.	Any other business	Kathy McLean	Verbal	16:25

Date and time of next meeting held in public: 22 March 2024, 14:00-16:30, The Council Chamber, County Hall, West Bridgford, Nottingham, NG2 7QP

Meeting Title:	Integrated Care Partnership
Meeting Date:	06/10/2023
Paper Title:	**Declaration and management of interests**
Paper Reference:	ICP 23 003
Report Author:	Lucy Branson, Associate Director of Governance, NHS Nottingham and Nottinghamshire ICB
Report Sponsor:	Kathy McLean, Chair of the Integrated Care Partnership (and ICB Chair)
Presenter:	Kathy McLean, Chair of the Integrated Care Partnership (and ICB Chair)
Recommendation(s):	The Integrated Care Partnership is asked to **note** this item.

Summary:

The Integrated Care Partnership (ICP) is required to implement and demonstrate robust arrangements for the identification and management of conflicts of interest. These arrangements should support good judgement about how any interests should be approached and managed; safeguarding the ICP from any perception of inappropriateness in its decision-making and assuring the public that the use of taxpayers' money is free from undue influence.

ICP members must ensure that they always comply with their organisational/ professional codes of conduct and details of the declared interests for members of the ICP are attached at Appendix A. Members are reminded of their individual responsibility to highlight any interests not already declared should a conflict (or potential conflict) become apparent in discussions during the meeting.

A protocol for managing conflicts of interest at meetings of the ICP is attached at Appendix B.

An assessment of members' interests has been performed against the meeting agenda and the outcome is recorded in the section below on conflicts of interest management.

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

Appendices:
Appendix A: Register of Declared Interests for members of the ICP. Appendix B: Protocol for managing conflicts of interests at meetings of the ICP.

Report Previously Received By:
Not applicable to this report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Register of Declared Interests

• The ICP has made arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the ICP will be taken and seen to be taken without being unduly influenced by external or private interests.

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

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

Name	ICP Membership Role	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To:	Action taken to mitigate risk
ARMIGER, David	Chair, Bassetlaw Place Based Partnership	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
BRIGGS, David	Medical Director, NHS Nottingham and Nottinghamshire ICB	British Medical Associaton	Member		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration, NHS Nottingham and Nottinghamshire ICB	Mid Nottinghamshire and Greater Nottingham Lift Co (public sector)	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration, NHS Nottingham and Nottinghamshire ICB	Nottingham Schools Trust	Chair and Trustee			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration, NHS Nottingham and Nottinghamshire ICB	Care Workers Union	Director (not remunerated)			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration, NHS Nottingham and Nottinghamshire ICB	Cleaners Union	Director (not remunerated)			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DODDY, Cllr John	Chair of the Nottinghamshire Health and Wellbeing Board	Hickings Lane Medical Centre	General Medical Practitioner	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DODDY, Cllr John	Chair of the Nottinghamshire Health and Wellbeing Board	Nowenigma Ltd	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DODDY, Cllr John	Chair of the Nottinghamshire Health and Wellbeing Board	Clayfields House Secure Unit	Employed to provide medical care	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
GRIBBIN, Jonathan	Director of Public Health, Nottinghamshire County Council	Cornerstone Chuch	Director			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
GRIBBIN, Jonathan	Director of Public Health, Nottinghamshire County Council	Nottingham University Hospitals NHS Trust	Spouse is a Consultant in Obstetrics				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
HILL, Adam	Chair, Mid Nottinghamshire Place Based Partnership	Mansfield District Council	Chief Executive	✓				06/01/2023	Present	This interest will be kept under review and specific actions determined as required.
HOWARD, Emma	Head, Nottingham University Samworth Academy	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
HUBBER, Lucy	Director of Public Health, Nottingham City Council	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
KING, Daniel	VCSE Alliance Chair	Nottingham Trent University	Employee	✓				06/09/2023	Present	This interest will be kept under review and specific actions determined as required.
LANGRIDGE, Jill	Clinical Lead	Village Health Group (formerly Keyworth Medical Practice)	GP Partner	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements)
LANGRIDGE, Jill	Clinical Lead	Village Health Group as a subcontractor for Nottingham University Hospitals NHS Trust to deliver surgical	GP Partner	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements)

Name	ICP Membership Role	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To:	Action taken to mitigate risk
LANGRIDGE, Jill	Clinical Lead	Partners Health LLP (a membership organisation of general practices in Rushcliffe. Provider of extended access	GP member, entitled to receive profit shares (although profit shares are not currently paid out to members)	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LANGRIDGE, Jill	Clinical Lead	Keyworth Healthcare Services Limited (KMP Pharmacy)	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LANGRIDGE, Jill	Clinical Lead	Village Health Group (formerly East Leake Medical Group)	Spouse is GP Partner				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LANGRIDGE, Jill	Clinical Lead	Nottingham and Nottinghamshire CCG	Spouse is Deputy Medical Director				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LAUGHTON, Jane	Chief Exectuive Officer, Healthwatch Nottingham and Nottinghamshire	Active Partners Trust	Director/Trustee (not remunerated)		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LAUGHTON, Jane	Chief Exectuive Officer, Healthwatch Nottingham and Nottinghamshire	Nottingham University Hospitals NHS Trust	Spouse is employed as a Consultant				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MAWJI, Huseinali (Dr)	Clinical Director, Nottingham City Place Based Partnership	Victoria and Mapperley Practice	Senior GP Partner	✓				01/10/2023	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to General Medical Services.
MAWJI, Huseinali (Dr)	Clinical Director, Nottingham City Place Based Partnership	Nottingham City GP Alliance	Director, Company Secretary & Shareholder	✓				01/10/2023	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to General Medical Services.
MAWJI, Huseinali (Dr)	Clinical Director, Nottingham City Place Based Partnership	Nottingham City GP Alliance GP + Service	Sessional GP	✓				01/10/2023	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to General Medical Services.
MAWJI, Huseinali (Dr)	Clinical Director, Nottingham City Place Based Partnership	Nottingham City Changing Futures Programme Board	Vice Chair		✓			01/10/2023	Present	This interest will be kept under review and specific actions determined as required.
MAWJI, Huseinali (Dr)	Clinical Director, Nottingham City Place Based Partnership	NEMS Community Benefit Services Ltd	Sessional GP, Member of NEMS Clinical Audit Group and NEMS Medical Advisory Panel	✓				01/10/2023	Present	This interest will be kept under review and specific actions determined as required.
MAWJI, Huseinali (Dr)	Clinical Director, Nottingham City Place Based Partnership	HV Healthcare Ltd	Director, Chair and Shareholder	✓				01/10/2023	Present	This interest will be kept under review and specific actions determined as required.
MAWJI, Huseinali (Dr)	Clinical Director, Nottingham City Place Based Partnership	HV Healthcare Ltd	Spouse is Director and Shareholder				✓	01/10/2023	Present	This interest will be kept under review and specific actions determined as required.
MAY, Anthony	Chief Executive, Nottingham University Hospitals NHS Trust (Representative of the Nottingham and Nottinghamshire Provider Collaborative at Scale)	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
MCLEAN, Kathy	ICB Chair	University Hospitals of Derby and Burton NHS Foundation Trust	Trust Chair	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Kathy McLean Limited- Private limited company offering health related advice	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Barts Health NHS Trust (London)	Non-Executive Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.

Name	ICP Membership Role	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To:	Action taken to mitigate risk
MCLEAN, Kathy	ICB Chair	Barking, Havering and Redbridge University Hospitals NHS Trust	Non-Executive Director	✓				01/09/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS Employers	Member of the Workforce Policy Board		✓			TBC	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS Employers	Chair of the national negotiation committee for Staff and Associate Specialists on behalf of NHS Employers		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Care Quality Commission (CQC)	Occasional Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	The Public Service Consultants Ltd (Public Sector Consultancy)	Senior Clinical Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS England/Improvement	Lay Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS Providers Board	Trustee		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NEMS Healthcare Ltd	Partner is a shareholder				✓	01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangement)
MCLEAN, Kathy	ICB Chair	Oxehealth Ltd (vision-based patient monitoring and management)	Member of the advisory board	✓				Tbc	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangement)
REDFERN, Andrew	Chief Executive, Framework Housing Association	Derbyshire County Cricket League	Executive Committee Member			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
REDFERN, Andrew	Chief Executive, Framework Housing Association	Christian Projects Development Trust	Treasurer and Trustee			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
SACCO, Volt	Chief Executive Officer, Fosse Healthcare	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
SHERRATT,Donna	Race Health Inequalities Programme Lead, Nottingham City Place-Based Partnership	Nottingham CityCare Partnership	Employee	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
SULLIVAN, Amanda	Chief Executive	Hillview Surgery	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
UNDERWOOD, Catherine	Corporate Director for People Services, Nottingham City Council	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
WILLIAMS, Melanie	Corporate Director for Adult Social Care and Health, Nottinghamshire County Council	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
Cllr Linda Woodings	Chair Nottingham City Health and Wellbeing Board	*TBC*								

Appendix B: Protocol for managing conflicts of interest at meetings of the Nottingham and Nottinghamshire Integrated Care Partnership

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

    The above categories are not exhaustive, and each situation must be considered on a case-by-case basis.
4. In advance of any formal meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed.
5. At the beginning of each formal meeting, members and others attending the meeting will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting.

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

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

Integrated Care Partnership (Open Session)
Unratified minutes of the meeting held on:
Friday 17 March 2023 14:00 – 15:30
Council Chambers, County Hall

Members present:

Kathy McLean (Chair)	Chair of NHS Nottingham and Nottinghamshire ICB
Lucy Dadge	Director of Integration, NHS Nottingham and Nottinghamshire ICB
Cllr. John Doddy (Joint Vice-Chair)	Chair of the Nottinghamshire Health and Wellbeing Board
Jonathan Gribbin	Director of Public Health, Nottinghamshire County Council
Emma Howard	Head Teacher at Nottingham University Samworth Academy (partner member nominated by Nottingham City Council)
Lucy Hubber	Director of Public Health, Nottingham City Council
Jill Langridge	Clinical Director, South Nottinghamshire Place Based Partnership
Jane Laughton	Chief Executive Officer, Healthwatch Nottingham and Nottinghamshire
Anthony May	Chief Executive, Nottingham University Hospitals NHS Trust (Representative of the Nottingham and Nottinghamshire Provider Collaborative at Scale)
Dr Hugh Porter	Clinical Director, Nottingham City Place-Based Partnership
Andrew Redfern	Chief Executive, Framework Housing Association (partner member nominated by Nottinghamshire County Council)
Jules Sebelin	Chair of the Nottingham and Nottinghamshire Voluntary, Community and Social Enterprise Alliance
Donna Sherratt	Race Health Inequalities Programme Lead, Nottingham City Place-Based Partnership (partner member nominated by Nottingham City Council)
Amanda Sullivan	Chief Executive, NHS Nottingham and Nottinghamshire ICB
Cllr. Adele Williams (Joint Vice-Chair)	Chair of the Nottingham City Health and Wellbeing Board

In attendance:

Alex Ball	Director of Communications and Engagement, NHS Nottingham and Nottinghamshire ICB
Lucy Branson	Associate Director of Governance, NHS Nottingham and Nottinghamshire ICB
Mark Wightman	Director of Strategy and Reconfiguration, NHS Nottingham and Nottinghamshire ICB
Sue Wass	Corporate Governance Officer, NHS Nottingham and Nottinghamshire ICB (minutes)

Apologies:

David Armiger	Chair of Bassetlaw Place Based Partnership and Chief Executive of Bassetlaw District Council
Dr Dave Briggs	Medical Director, NHS Nottingham and Nottinghamshire ICB
Adam Hill	Chair of Mid Nottinghamshire Place Based Partnership and Chief Executive of Mansfield District Council
Volt Sacco	Chief Executive Officer, Fosse Healthcare (partner member nominated by Nottinghamshire County Council)
Catherine Underwood	Corporate Director for People Services, Nottingham City Council
Melanie Williams	Corporate Director for Adult Social Care and Health, Nottinghamshire County Council

Introductory items

ICP 22 017 Welcome, introductions and apologies

Kathy McLean welcomed members to the meeting of the Integrated Care Partnership. A round of introductions was undertaken and apologies were noted as above. A particular welcome was extended to new members Emma Howard and Dr Jill Langridge.

ICP 22 018 Confirmation of quoracy

The meeting was confirmed as quorate.

ICP 22 019 Declaration and management of interests

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

ICP 22 020 Minutes from the meeting that took place on the 16 December 2022

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

ICP 22 021 Action log and matters arising from the meeting that took place on the 16 December 2022

No actions from the last meeting were noted and no other business was raised.

Items for discussion

ICP 22 022 Integrated Care Strategy for Nottingham and Nottinghamshire

Kathy McLean introduced the item and highlighted that this was a landmark moment for the Partnership; the final Integrated Care Strategy was being presented for approval. Thanks were given to everyone who had contributed to its development. However, this was also the start of the journey to ensure that everyone within the Nottingham and Nottinghamshire health and care system were working towards the aims of the strategy, which needed to remain a 'live' document.

Mark Wightman, Jonathan Gribbin and Alex Ball went on to give a presentation, highlighting the following points:

a) Following the presentation of the initial strategy at the previous meeting, work had continued to incorporate the feedback from the Partnership, from wider partners and from the public.
b) Work had progressed to confirm the specific metrics that would be used to measure success.
c) A launch plan had also been developed to disseminate key messages.
d) A task and finish group had been convened to oversee the development of the metrics, which involved the agreement of strategic outcomes, quantifiable ambitions for each outcome measure and then the mapping of deliverables to each outcome measure.
e) A set of principles underpinned the work and the ambitions aimed to be stretching, yet realistic.
f) Due to the complexity of the work, the development of the metrics was still work in progress and there was still further work to do to on 'technical' considerations to ensure the integrity of the metrics.
g) There was an ambition to build an equity lens across all key indicators, using a population health management approach. However, it was noted that some metrics would not be meaningfully aggregated at ICS level and some metrics would be milestones, for example the completion of a specific piece of work, as in some areas it would not be possible to measure impact over the short to medium term.
h) It was proposed that the strategic system ambition metrics in the strategy became a subset of a broader population health management outcomes framework, consisting of a wider set of metrics based on local population data.
i) The success of the strategy would rest on its adoption by all staff working in the health and care sector. It was also important to raise awareness levels among the general population and wider stakeholders.
j) All partners in the system had a role to play in communicating and engaging with staff to describe our ambitions, what this means for our people and their role was in its success.
k) A range of communications activity over the coming year was described, including a partner 'toolkit', staff awards, and web-based and social media campaigns. A video was shown, which explained, in simpler terms, the strategy's aims, and which would be widely used in engagement activities. The use of case studies was highlighted as a tangible way to bring the strategy to life.

A wide-ranging discussion ensued, which included the following points:

l) Members noted that the success of the strategy involved a cultural change within the current workforce and queried whether, and how, this could be

tested. It was highlighted that system working as a default position would be achieved over the longer term; however, members agreed that it was important to find a way of measuring progress.

m) The concept of integrated listening to ensure that the measures proposed were meaningful and important to service users was discussed. The Partners Assembly was noted as an important conduit for this.

n) The importance of not being solely target-driven was noted and members emphasised the importance of having one set of outcome measures for the whole system with a clear link to the key aims of the strategy.

o) Members queried where progress would be routinely monitored. It was suggested that the NHS element would be monitored by the Integrated Care Board through the NHS Joint Forward Plan, with other elements monitored by the Health and Wellbeing Boards. It was noted that governance arrangements would need be confirmed to avoid duplication of effort and unnecessary work, as some measures would only show meaningful movement over a long timeframe.

p) The use of organisational development (OD) activities within individual organisations to promote cultural change was supported. The use of training modules and a funded consistent OD approach was suggested. It was noted that communication leads for all partner organisations were working together on consistent workforce messaging.

q) Regarding case studies, members noted the need to ensure that it was explicit within the case studies that learning was being taken into other areas. It was also proposed that case studies should be used to test whether this was the experience of service users.

r) Other avenues of communication were noted, including communication resources within education and other communication routes, such as faith groups. The need to ensure that the voluntary sector was fully brought in as an enabler was noted.

s) Branding was discussed, and the need to tailor messages to different audiences to describe what their particular role was in helping to promote the aims of the strategy was highlighted.

The Integrated Care Partnership:

- **Approved** the Integrated Care Strategy for Nottingham and Nottinghamshire.
- **Endorsed** the strategy launch plan.

ICP 22 023 Integrated Care Partnership 2023/24 Annual Work Programme

Lucy Branson introduced the item and highlighted the following points:

a) The report presented an indicative meeting schedule and work programme for the Integrated Care Partnership and its supporting Partners Assembly for 2023/24.

b) To date, the Partnership had concentrated on the development of the strategy, which had now been approved. Moving forward and in line with its terms of reference, it was proposed that the work programme for 2023/24 should cover four areas: a review of the impact of the strategy; progress on the development of the outcomes framework; receipt of insights from service users; and consideration of any proposed revisions to the strategy.

c) When reviewing the impact of the strategy, an early focus will be on the extent to which the conditions for success have been established and embedded.

d) It was proposed that the Partnership should meet twice a year following the meeting of the Partners Assembly, to enable feedback from the Assembly to be presented to the Partnership.

e) At the next meeting, updates on the work to develop healthy life expectancy and life expectancy targets, and the work to understand and identify health inequalities within each specific metric, would be presented. Progress in developing the Population Health Management (PHM) Outcomes Framework would also be considered.

The Integrated Care Partnership **endorsed** the proposed work programme for 2023/24, noting that this will be subject to ongoing review and refinement over the coming months as new ways of working evolve and embed.

Closing items

ICP 22 024 Questions from the public relating to items on the agenda

At this point, the Chair noted that no questions had been received in advance of the meeting from members of the public. Members of the public in attendance at the meeting were then given the opportunity to ask any questions they may have, having observed the meeting. No questions were raised.

ICP 22 025 Any other business

There was no other business.

Date and time of next meeting held in public: 6 October 2023, 14:00 to 16:30

Meeting Title:	Integrated Care Partnership
Meeting Date:	6/10/2023
Paper Title:	**Partnership Agreement for Nottingham and Nottinghamshire Integrated Care System**
Paper Reference:	ICP 23 006
Report Author:	Alex Ball, Director of Communications and Engagement, NHS Nottingham and Nottinghamshire Integrated Care Board
Report Sponsor(s):	Kathy McLean, Chair, Nottingham and Nottinghamshire Integrated Care Partnership
Presenter(s):	Alex Ball, Director of Communications and Engagement, Nottingham and Nottinghamshire Integrated Care Board
Recommendation(s):	The Integrated Care Partnership is asked to **approve** the revised Partnership Agreement for the Nottingham and Nottinghamshire Integrated Care System and to support partner organisations to embed the Agreement in their everyday work.

Summary:

In 2021, partners in the Nottingham and Nottinghamshire Integrated Care System (ICS) signed up to a Partnership Agreement, setting out the values and expected behaviours for our system. This Agreement has served partners well over the last two years but reflecting the ongoing maturation of the system and our ways of working, as well as the evolving external context in which the system is operating, it was felt timely to refresh the Agreement.

Using the ICS's established arrangements for partnership working, including the Reference Group and Voluntary, Community and Social Enterprise (VCSE) Alliance, as well as discussions within organisations and the Place Based Partnerships and Provider Collaborative, an updated version of the Agreement has been developed.

The updated version reflects the feedback received throughout this process, in summary:

- The existing Agreement was felt to be broadly fit-for-purpose.
- Now that the Integrated Care Strategy has been agreed, the three Principles and four Aims needed to be included in the Agreement.
- The language has been updated to reflect the role of the Voluntary, Community and Social Enterprise sector in our system.
- A move from using the word 'citizen' to a more inclusive 'person'.
- Specific mention of the wider determinants of health.
- A commitment to ongoing joint working and delivery and to challenge each other when behaviours are not as expected.

The updated Partnership Agreement can be found at Appendix A.

Once approved by the Integrated Care Partnership, organisations, partnerships and collaboratives across the system will be asked to formally sign up to the Agreement, with the opportunity to add a signature open to all partners working within the ICS.

How does this paper support the Integrated Care System's core aims to:	
Improve outcomes in population health and healthcare	Well established and recognised ways of working are critical to achieving delivery of the system's objectives.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help support broader social and economic development	As above.

Appendices:
Appendix A provides the updated Partnership Agreement for endorsement

Report Previously Received By:
The Partnership Agreement appended to this paper has been shared with ICS partner organisations for their thoughts and comments throughout its development, as set out in paragraphs 4-10 of the report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Partnership Agreement for Nottingham and Nottinghamshire Integrated Care System

Introduction and Context

1. In July 2021, the Partnership Board for the Nottingham and Nottingham Integrated Care system (ICS) adopted a Partnership Agreement setting out the values of our system and the behaviours expected to be espoused by partners when working together for our population.
2. This original Agreement was developed over several months in 2021 involving considerable input from system partners and other representative bodies. That work has served the Agreement well and it is still largely relevant and appropriate for our work.
3. However, a refresh of that Agreement is timely and appropriate for the following reasons:
    a) Our leadership cohort has changed, as around 40% of signatories of the original Partnership Agreement have now turned over in role meaning that leaders who play an important part in our system's delivery and strategy direction have not been able to influence the development and use of the Agreement.
    b) Our external context is changing, as we have a new operating model from NHS England and will have a new political leadership structure (East Midlands Mayor) in May 2024.
    c) The regulatory environment is evolving, as the Care Quality Commission has released its interim guidance on how it will assess ICSs, which includes examining, "shared direction and culture".
    d) Our own strategic direction is set, now that our Integrated Care Strategy has been agreed and for NHS partners the NHS Joint Forward Plan is also confirmed.

Refreshing the Partnership Agreement

4. Recognising the considerable effort that went into the development of the Partnership Agreement in 2021, an evolutionary approach was taken to developing the latest version of the Partnership Agreement, building on the existing Agreement and updating it for a new context, rather than starting from scratch.
5. The approach to refreshing the Agreement also used existing forums, meetings and groups and respected the system's agreed structures and partnerships rather than creating new ways to gather feedback.

6. The ICS's Reference Group met on 3 July 2023 with good attendance from across the system and wider partners. During that meeting, members of the Reference Group discussed how the Agreement needed to be updated, using the following questions as a guide:
    a) How does the Partnership Agreement need to change now that we have our Ambitions and Principles as agreed in the Integrated Care Strategy?
    b) How do the Values within the Agreement need to change based on where we are now?
    c) Who else should we involve in this refresh and ask to sign the Agreement?
7. Also during the 3 July meeting, leaders considered how best to embed and use the Agreement in their organisation or Partnership/Collaborative, using the following questions as a guide:
    a) How best should we use and foreground the Agreement in our work as a system once refreshed?
    b) What are the moments where you think the existence of the Agreement really helped to move things forward?
    c) Are there interactions or work that we do that does not seem aligned to the Agreement? What do we need to do differently?
8. After the Reference Group meeting, more detailed feedback was sought and received from:
    a) Individual ICS partner organisations.
    b) Place Based Partnerships.
    c) Provider Collaborative.
9. Further discussions were had with representatives of the Mid-Nottinghamshire Place Based Partnership and the Local Medical Committee on 11 and 13 September.
10. The proposed Partnership Agreement has been shared with the ICS's VCSE Alliance and with Healthwatch Nottingham and Nottinghamshire.

Summary of Feedback

11. The feedback received during discussion at the ICS Reference Group was as follows:
    a) The Agreement is broadly fit-for-purpose.
    b) A revised version needs to reflect the now agreed Integrated Care Strategy with specific reference to the three Principles and the four Aims.

c) There should be a reference to how we work with our population to help develop and transform services and an updating of the language away from ‘citizen’ to a more inclusive ‘people’.

d) It would be helpful to include content reflecting how partners will hold each other to account if expected behaviours are not met.

e) General Practice colleagues would want to be part of this Agreement with an opportunity to sign up via the Primary Care Networks.

f) Organisations and Partnerships/Collaboratives would want to discuss further and reflect other comments.

g) It was noted that the Agreement was not strongly embedded in organisations and Partnerships and so would need conscious effort to do so.

12. After the meeting of the Reference Group, a version of the Agreement reflecting this feedback was circulated for further comments and discussion, with the following additional feedback received in writing and through further dialogue:

a) It would be useful to include a reference to the Voluntary, Community and Social Enterprise (VCSE) sector’s role in the delivery of the Integrated Care Strategy.

b) Seeking of explicit commitment to subsidiarity and ongoing partnership working in the delivery and implementation of the system’s Integrated Care Strategy.

c) A need to refer to the wider determinants of health more explicitly.

d) Several members of the ICS’s VCSE Alliance indicated that they were content with the changes proposed, particularly the change of language from ‘citizen’ to ‘people’.

e) A requirement to reflect the change in the boundaries of the system since the original Agreement was drafted, i.e., to include Bassetlaw more clearly.

f) Some minor comments around specific wording and language.

g) A strong desire for the Agreement to be seen as something that is inclusive and open for all to sign up to including by leaders of Partnerships and Collaboratives, not just individual organisations.

Proposed Updated Partnership Agreement

13. A revised Partnership Agreement reflecting the above feedback is included at Appendix A.

14. Reflecting the overall sentiment that the Partnership Agreement is broadly fit-for-purpose but needed some updating, the changes can be summarised as:

a) Change of language from ‘citizen’ to ‘people’ throughout.

b) Including the three Principles and four Aims of the Integrated Care Strategy as a central part of the Agreement.

c) Addition of a fourth behaviour expected regarding how we challenge each other as we work together.

d) Inclusion of a reference to how we work with people and communities to develop plans.

e) A refresh of the language to make it as accessible and inclusive as possible.

f) An approach that enables all organisations to sign up to the Agreement should they wish on an open, inclusive and non-hierarchical basis.

g) A specific reference to the wider determinants of health.

h) A recognition of the role of the Voluntary, Community and Social Enterprise sector’s role in the ICS.

Embedding Our Partnership Agreement

15. A clear theme that emerged from the discussions at the Reference Group and subsequently, was that the Agreement needed to be embedded into everyday practice by all partner organisations within the ICS. Partners are well advanced in making this embedding a natural part of their work and some examples include:

    a) The terms of reference for the City Place Based Partnership Executive Team have been updated to reflect the content of the new Partnership Agreement.

    b) Nottinghamshire Healthcare NHS Foundation Trust has reconfirmed its commitment to the Partnership Agreement through its Trust strategic pillar of “Working Together” and continue to check progress on this through regular listening to stakeholders through its partnership survey.

    c) Nottingham CityCare has reflected on the Partnership Agreement and the alignment to the organisational values and mapped those against one another.

    d) The Nottingham and Nottinghamshire Provider Collaborative has similarly considered the Partnership Agreement against organisational values and behaviours and see the refreshed Agreement as a useful way of bringing the Integrated Care Strategy to life in their ways of working as a Collaborative.

Nottingham and Nottinghamshire Integrated Care System (ICS)

Partnership Agreement

We, the collective leaders of Nottingham and Nottinghamshire ICS, have agreed to establish a 'Partnership Agreement' to demonstrate our commitment to work effectively together for the benefit of all our communities and residents.

Our priority is to support, care for and be compassionate to local people. The role of our ICS is to enable health and care professionals, local authority colleagues, those that work in the voluntary, community and social enterprise (VCSE) sector and in social care to collaborate. This means working across organisational boundaries to maximise the use of our energies and resources. It also means taking decisions as close to our population as possible and working together to listen to each other and implement joint plans.

We do not underestimate the challenges ahead as our ICS looks to implement our shared Integrated Care Strategy but through our Partnership Agreement we commit to work together with the shared purpose of:

"Every person enjoying their best possible health and wellbeing"

This will require us to think as widely as possible – considering all the factors which make a difference to health such as housing, education, employment and much more.

We have agreed three main principles and confirmed four aims within our Integrated Care Strategy that will guide our ways of working together:

Principles

- **Prevention** is better than cure;
- **Equity** in everything;
- **Integration** by default.

Aims

- **Improve outcomes** in population health and healthcare;
- **Tackle inequalities** in outcomes, experiences and access;
- Enhance **productivity and value for money**;
- Support broader **social and economic development.**

These principles will be underpinned by the following core values:

- We will be open and honest with each other;
- We will be respectful in working together;
- We will be accountable, doing what we say we will do and following through on agreed actions;
- We will challenge each other if we fall short of upholding these principles and aims.

Finally, we will work with, and put the needs of, our population at the heart of the ICS: All system partners are committed to consistently listening to, and collectively acting on, the experience and aspirations of local people and communities.






#TogetherWeAreNotts

Nottingham and Nottinghamshire Integrated Care System (ICS)

Signatories

The following organisations and leaders are all equal peer signatories to the Partnership Agreement – they are listed here in alphabetical order to reflect that there is no hierarchy intended. All organisations that work within the ICS are welcome to sign the Agreement and can do so at www.healthandcarenotts.co.uk at any time. It should also be noted that many of the organisations below also deliver services for a wider population than Nottingham and Nottinghamshire.

Name and Organisation	Signature	Name and Organisation	Signature
Wil be listed alphabetically by organisational name			
Final list of signatories to be confirmed			
Will include all organisations represented at ICP, PBPs, VCSE organisations, PCNs – as inclusive as possible			
To also include organisational logos			

[Logos from all signatories]

Meeting Title:	Integrated Care Partnership
Meeting Date:	06/10/2023
Paper Title:	**Insight Report**
Paper Reference:	ICP 23 007
Report Author:	Prema Nirgude, Head of Insight and Engagement, NHS Nottingham and Nottinghamshire Integrated Care Board Katie Swinburn, Engagement Manager, NHS Nottingham and Nottinghamshire Integrated Care Board Alice Blount, Senior Insights and Engagement Officer, NHS Nottingham and Nottinghamshire Integrated Care Board
Report Sponsor:	Amanda Sullivan, Chief Executive, NHS Nottingham and Nottinghamshire Integrated Care Board
Presenter:	Alex Ball, Director of Communications and Engagement, NHS Nottingham and Nottinghamshire Integrated Care Board
Recommendation(s):	The Integrated Care Partnership is asked to **discuss** this report including how this can be used to support the delivery of the Integrated Care Strategy.

Summary:

In line with guidance from the Department of Health and Social Care (DHSC), in March 2023, the Integrated Care Partnership approved the Nottingham and Nottinghamshire Integrated Care Strategy. The strategy has been published and widely disseminated and can be found on the ICS website.

To support the implementation of the strategy and maximise its impact, work has continued across the system to continuously listen to our population to obtain key insight and intelligence from our communities. This report provides the Partnership with a summary of the activities and findings of work from across the Integrated Care System.

It includes a summary output from the ICS's Partners Assembly and a summary of the work from the ICS's VCSE Alliance. There is also a specific deep dive into the current cost of living crisis and the impact this is having on the health and wellbeing of our population.

The Integrated Care Partnership is asked to receive this report and discuss the contents with partners to support the delivery of our Integrated Care Strategy.

Appendices:

None.

How does this paper support the Integrated Care System's core aims to:	
Improve outcomes in population health and healthcare	This Report provide information and data from system partners to continue to support the delivery of the Integrated Care Strategy across Nottingham and Nottinghamshire
Tackle inequalities in outcomes, experience and access	As above.

How does this paper support the Integrated Care System's core aims to:	
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Report Previously Received By:
Not applicable.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Integrated Care Partnership: Insight Report

October 2023

Nottingham and Nottinghamshire Integrated Care System

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1 Executive Summary

1.1 Preface

In line with guidance from the Department of Health and Social Care[1] (DHSC), in March 2023, the Integrated Care Partnership approved the Nottingham and Nottinghamshire Integrated Care Strategy. The strategy has been published and widely disseminated and can be found on the ICS website[2].

To support the implementation of the Strategy and maximise its impact, work has continued across the system to continuously listen to our population to obtain key insight and intelligence from our communities. This report provides the Partnership with a summary of the activities and findings of work from across the Integrated Care System.

This is intended to support the ambition of the Integrated Care Partnership to act as the "guiding mind" of the system and enable it to consider how we continue to meet the needs of our communities.

1.2 Introduction

As part of the workplan of the Integrated Care Partnership (ICP), it was agreed that an Insight Report would be produced to provide evidence and insight to the Partnership. The purpose of the Integrated Care Partnership is to also support the development of the Integrated Care Strategy and will engage with a wider assembly of partners, at least once a year, comprising people who rely on care and support, unpaid carers, the full range of social care and NHS providers, the voluntary and community sector, local professional committees (e.g. optical and pharmaceutical committees), the Office of the Police and Crime Commissioner, etc. The insights from the Assembly will provide an opportunity for the Integrated Care Partnership to review the impact of the Integrated Care Strategy, focusing on improving outcomes in population health and healthcare, tackling inequalities in outcomes, experiences and access, enhancing productivity and value for money and supporting broader social and economic development.

Integrated Care Partnerships are a critical part of Integrated Care Systems (ICSs), and the journey towards better health and care outcomes for the people they serve. ICPs will provide a forum for NHS and Local Authority leaders to come together with key stakeholders from across the system and community. This report will provide details to the ICP on what we are hearing from our communities and citizens of Nottingham and Nottinghamshire.

Nottingham and Nottinghamshire Integrated Care Partnership (ICP) has developed an Integrated Care Strategy to improve health and care outcomes and experiences for local people (2023-2027). The Strategy has been developed for the whole population using the best available evidence and data, covering health and social care, and addressing the wider determinants of health and wellbeing. It builds on existing strategies including the Joint Health and Wellbeing Strategies for Nottingham[3] and Nottinghamshire[4].

As part of developing the Integrated Care Strategy, extensive work was undertaken to listen to citizens to understand their aspirations and ambitions for our area. Using a two-step approach, first a desktop research exercise was undertaken to understand the needs of our citizens and how these can be met. This stage also included identifying people and communities who are not regularly

[1] Guidance on the preparation of integrated care strategies - GOV.UK (www.gov.uk)
[2] Integrated-Care-Strategy-2023_27.pdf (healthandcarenotts.co.uk)
[3] www.nottinghamcity.gov.uk
[4] What is the Health and Wellbeing Board? | Nottinghamshire Joint Health and Wellbeing Strategy 2022-2026 (healthynottinghamshire.org.uk)

heard from in order to understand who we need to involve, and gaps in our knowledge that could form the basis of our involvement work. The second stage involved a number of listening activities to test the findings from the desk research, explore gaps in our knowledge, test the emerging content of the Integrated Care Strategy, and test the Vision and purpose for our ICS.

To support the delivery and implementation of the Strategy, and as part of their business-as-usual activities, all system partners have continued to listen to our population and this work is shared and coordinated through the ICS's Engagement Practitioners Forum. This report summarises that intelligence which has been gathered across the system and offers a synthesis of its combined findings.

More information about the Engagement Practitioners Forum and its members can be found in Section 5 and in particular, thanks is given to the following organisations for their contributions to this report.

- NHS Nottingham and Nottinghamshire Integrated Care Board
- Nottinghamshire Healthcare NHS Foundation Trust
- Voluntary Community and Social Enterprise Alliance
- Ashfield Voluntary Action
- Mansfield Community and Voluntary Sector
- Nottingham Community and Voluntary Sector
- Nottinghamshire County Council
- Nottingham City Council
- Nottingham Trent University
- University of Nottingham
- Healthwatch Nottingham and Nottinghamshire
- Small Steps Big Changes
- Nottingham University Hospitals NHS Trust
- Local Charities
- Citizens of Nottingham and Nottinghamshire.

1.3 Key Findings

- The population of Nottingham and Nottinghamshire in 2021 is larger, older, less likely to be in a legal relationship and less white than 10 years previously (*see below: 2 Nottingham and Nottinghamshire Census Data 2021)*
- The majority (80%) of the public continue to think the NHS needs an increase in funding, compared to 17% who think the NHS should operate within its current budget (*see below: 3.1 Perceptions of the NHS*).
- There is the most support for an additional tax earmarked specifically for the NHS (31%), as well as an increase in National Insurance (22%), and an increase in Income Tax (21%) (*see below: 3.1 Perceptions of the NHS*).
- When proposing the re-organisation of NHS services there will be differential responses according to the type of service being proposed to change including due to the frequency of use and the life stage impacted *(see below: 4.2 Tomorrow's NUH)*
- Our population generally support a shift to Prevention and an approach centred in Equity – but for both of these changes they are sceptical about how this can be achieved while protecting existing services and want to be involved in the choices involved *(see below: 4.3 Joint Forward Plan)*
- For Children Young People and Families, there needs to be more support provided around breastfeeding together with services being more co-ordinated and promoted to understand

what people can access and when. Additionally, there should be more support for children with Special Educational Needs and Disabilities *(see below 4.4 Family hubs*)

- Improving support for older individuals includes collaborating across agencies, enhancing access to various services, reducing isolation and addressing transportation issues, while improving digital literacy and innovation in dementia care (see below: 4.5 *Personalised Care & Support Planning*).
- Delivering access to Mental Health support digitally is a positive step forward for many but will not be suitable for all citizens - there needs to continue to be a blended approach *(see below: 4.7 Community Mental Health Co-production and Engagement)*
- There are gaps in services for those who abuse drugs aged 15-24, and also those who self-declare as 'Mixed' ethnicity. There is an unmet treatment need of 74% for alcohol dependent citizens aged 18 and over. This equates to up to 3,800 dependent drinkers who could benefit from specialist treatment *(see 4.12 Review and Commissioning of Alcohol and Drug Recovery and Treatment Services)*
- Collaborating with health, local authorities, Community Voluntary and Social Enterprises, and citizens will allow us to tackle health inequalities focussing on the wider determinants of health with our communities allowing success to be achieved by working with and assessing those experiencing health inequalities *(see 4.16 Community Transformation Programme).*
- The ICS Partners' Assembly revealed strong support for integration and collaborative efforts across organisations, as well as a clear emphasis on coproduction initiatives (see below: *5.2 Integration and Collaboration*).
- However, some did have reservations regarding the practicality and realism of the strategic ambitions of the ICS (see below: *5. ICS Partners Assembly*).
- Additionally, addressing concerns related to access to primary care services, staff retention, and involving individuals with lived experience, children, and young people in early years care and education emerged as top priorities for the Assembly (see below: *5.3 Community Engagement & Empowerment, and 5.8 Workforce Development as a system).*
- Addressing the challenges faced by older individuals requires a comprehensive, multi-agency approach with a strong focus on the VCSE sector, including awareness campaigns, support services, digital solutions, and community involvement *(see below: 6.1 VCSE Alliance – Frailty Deep Dive).*
- The experiences of racial minority groups, especially within Nottingham City, in accessing health and care services is multi-faceted and complex and requires dedicated attention to improve *(see below: 7 Race Health Inequalities Summit)*
- The Cost of Living Crisis means citizens are deprioritising climate change adaptation. This has implications for our carbon neutral ambitions across the system (*see below: 8.1 Climate Change and Ability To Act*)

1.4 Conclusions and Recommendations

Conclusion 1: Older population – We understand from our data that the population of Nottingham and Nottinghamshire are now older than 10 years ago and need to consider how our services will meet capacity and demand in the future.

> **Recommendation 1:** Health and social care providers should work together to create comprehensive programmes that address the various needs of older individuals, including collaborative services, improved transportation, and digital literacy programmes.

Recommendation 2: Allow a multi-agency approach with a strong focus on the VCSE sector, including awareness campaigns, support services, digital solutions, and community involvement

Conclusion 2: Collaborating with health, local authorities, Community Voluntary and Social Enterprises, and citizens will allow us to tackle health inequalities focussing on the wider determinants of health. Success will be achieved by working with and assessing those who are experiencing health inequalities.

Recommendation 3: Understand the needs of our ethnically diverse and underserved communities to understand what is important to them by building trust and working collaboratively with key networks.

Recommendation 4: Continue to work in partnership with systems and collaborate around engagement activity to understand the needs of our population.

Recommendation 5: Prioritise people and communities and allow them to be involved in codesigning and coproducing elements of services and strategic thinking.

Recommendation 6: To ensure we engage and involve children and young people and those with lived experience.

Recommendation 7: Continue to work with our System Analytic Intelligence Unit to understand the current demographics of our population and work with our underserved communities.

Conclusion 3: Collaborative Working of Systems - There is strong support for integration and collaborative working across organisations.

Recommendation 8: Ensure that the ICS builds on strengths, avoids duplication and identifies areas for growth to deliver the best possible health and wellbeing for our citizens.

Recommendation 9: Access to primary care services, staff retention, and involving individuals with lived experience, children, and young people in early years care and education emerged as top priorities for the ICS.

Conclusion 4: Workforce - Staff retention is a concern to system partners and citizens.

Recommendation 10: Support new technology to improve access for patients and increase efficiency and data sharing for staff.

Recommendation 11: To develop a robust workforce plan which will ensure that there is a sustainable workforce and encourage skills development to increase and retain talented staff.

Conclusion 5: Mental Health Services - Enhancing support for children and young people individuals should be a key priority.

Recommendation: 12 Delivering access to Mental Health support digitally is a positive step forward for many but will not be suitable for all citizens, there needs to continue to be a blended approach

Recommendation 13: A multi-agency approach is required, which includes collaborative efforts across organisations to enable improved access to services, reducing social isolation, addressing transportation issues, enhancing digital literacy, and fostering innovation in dementia care.

Recommendation 14: Ensure there is involvement of people with lived experience and children and young people and to start preventative initiatives in early years care and education.

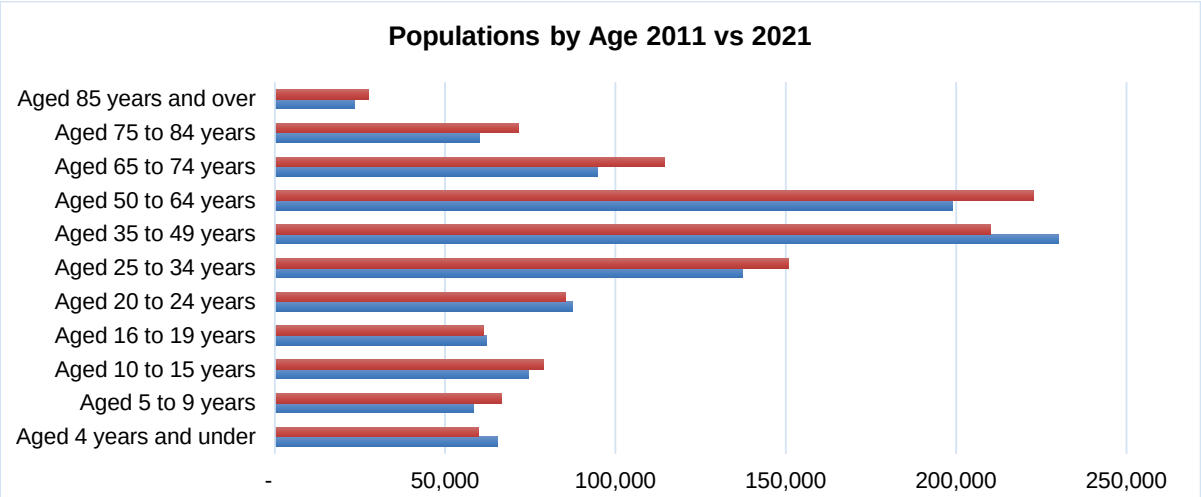
Conclusion 6: Cost of Living - The ongoing Cost of Living Crisis has led to a deprioritisation of climate change adaptation efforts. This shift in focus could have significant implications for achieving carbon-neutral ambitions.

Recommendation 15: Healthcare organisations should reassess and adapt their strategies to continue making progress toward carbon-neutral goals whilst considering the economic challenges faced by citizens. Initiatives that can save money and contribute to the carbon-neutral ambitions should be sought out and progressed.

Recommendation 16: Consideration should be taken into account of the impact of citizens travelling to appointments and the affordability of those, together with those who are digitally disadvantaged for appointments.

2 Nottingham and Nottinghamshire Census Data 2021

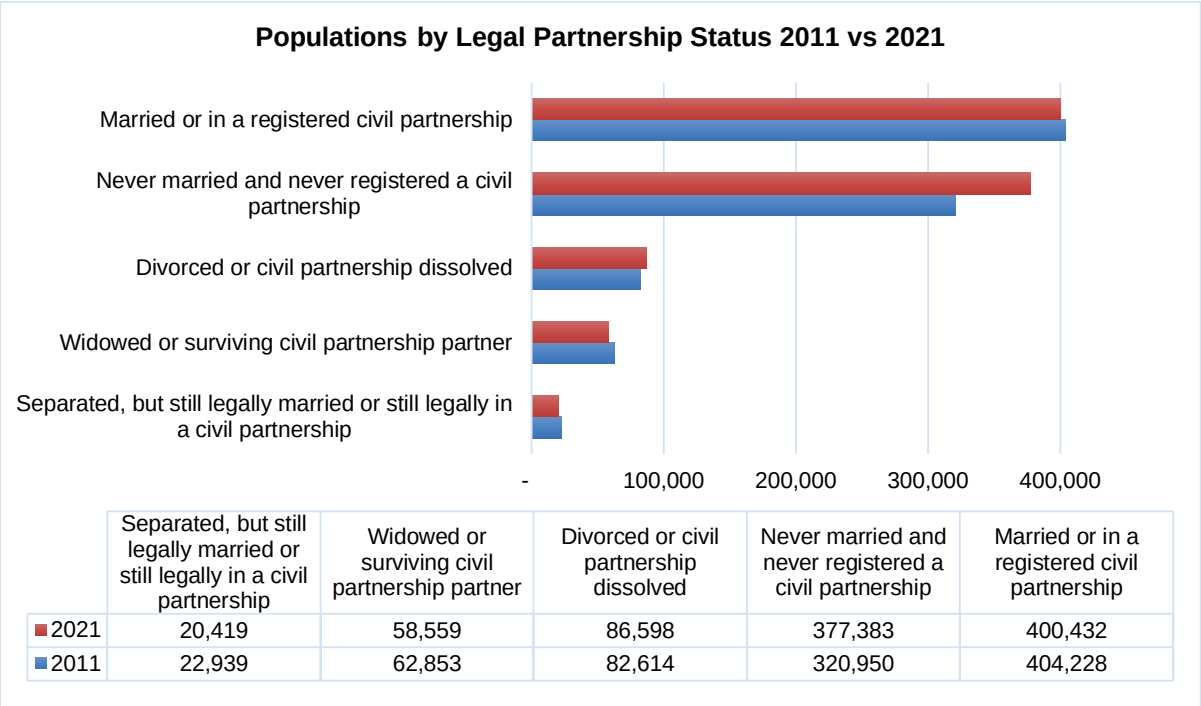
The 2021 Census data shows an increase of 5.5% in the population of Nottingham and Nottinghamshire since 2011, from 1,091,482 to 1,148,454. The Census data showed an increase across adult age groups, such as a 9.1% increase in the 25-34 age group and 16% increase in the number of people aged +65 which indicates a growing older population.



	Aged 4 years and under	Aged 5 to 9 years	Aged 10 to 15 years	Aged 16 to 19 years	Aged 20 to 24 years	Aged 25 to 34 years	Aged 35 to 49 years	Aged 50 to 64 years	Aged 65 to 74 years	Aged 75 to 84 years	Aged 85 years and over
2021	59,710	66,423	78,929	61,110	85,391	150,883	210,055	222,797	114,244	71,497	27,411
2011	65,218	58,176	74,504	62,019	87,328	137,165	230,084	198,989	94,741	59,950	23,308

Figure 1: This graph displays the population by age group. Key insights include an increase of 15.6% in the 50+ year old population, a 9.1% increase in the 25-35 age group, and a notable decrease in population size in the 35 to 49 age group of -9.5%.

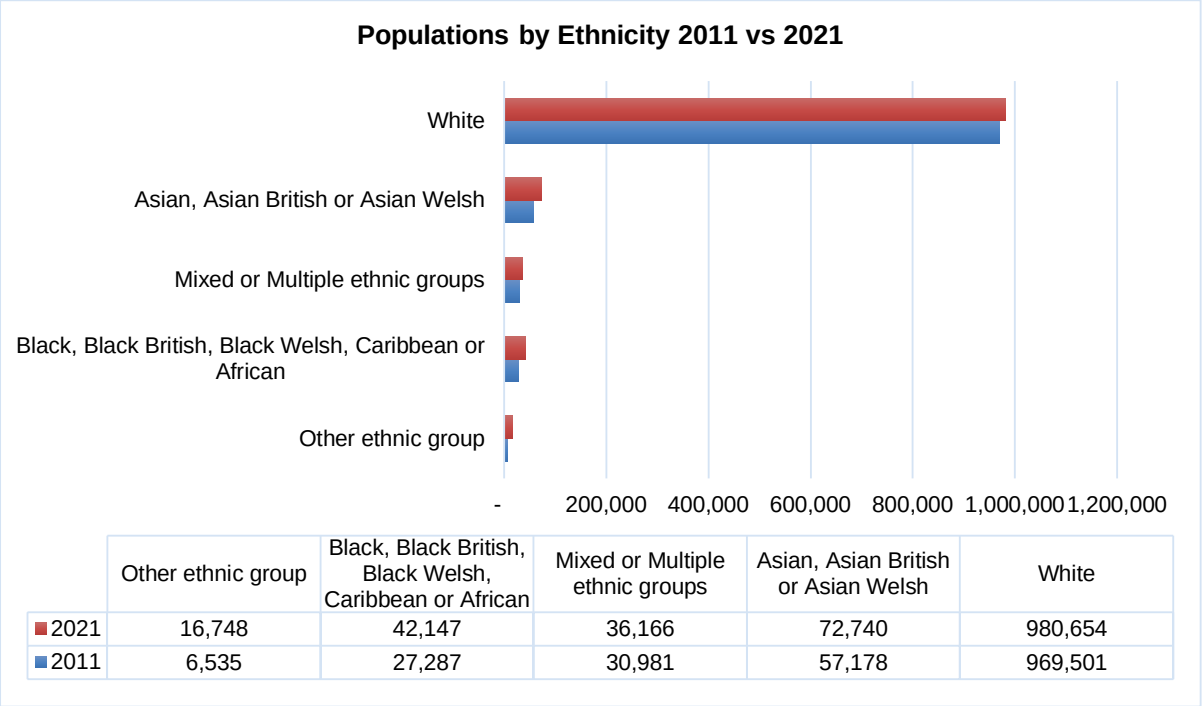
The legal partnership status of Nottingham and Nottinghamshire in 2021 is similar to 10 years previously apart from a 15% increase in the number of people who have never been married and never registered a civil partnership.



	Separated, but still legally married or still legally in a civil partnership	Widowed or surviving civil partnership partner	Divorced or civil partnership dissolved	Never married and never registered a civil partnership	Married or in a registered civil partnership
2021	20,419	58,559	86,598	377,383	400,432
2011	22,939	62,853	82,614	320,950	404,228

Figure 2: This graph displays the legal partnership status. Key insights include an increase of 15.0% for those who have never married and never registered a civil partnership. Other than that, these population sizes have remained largely the same.

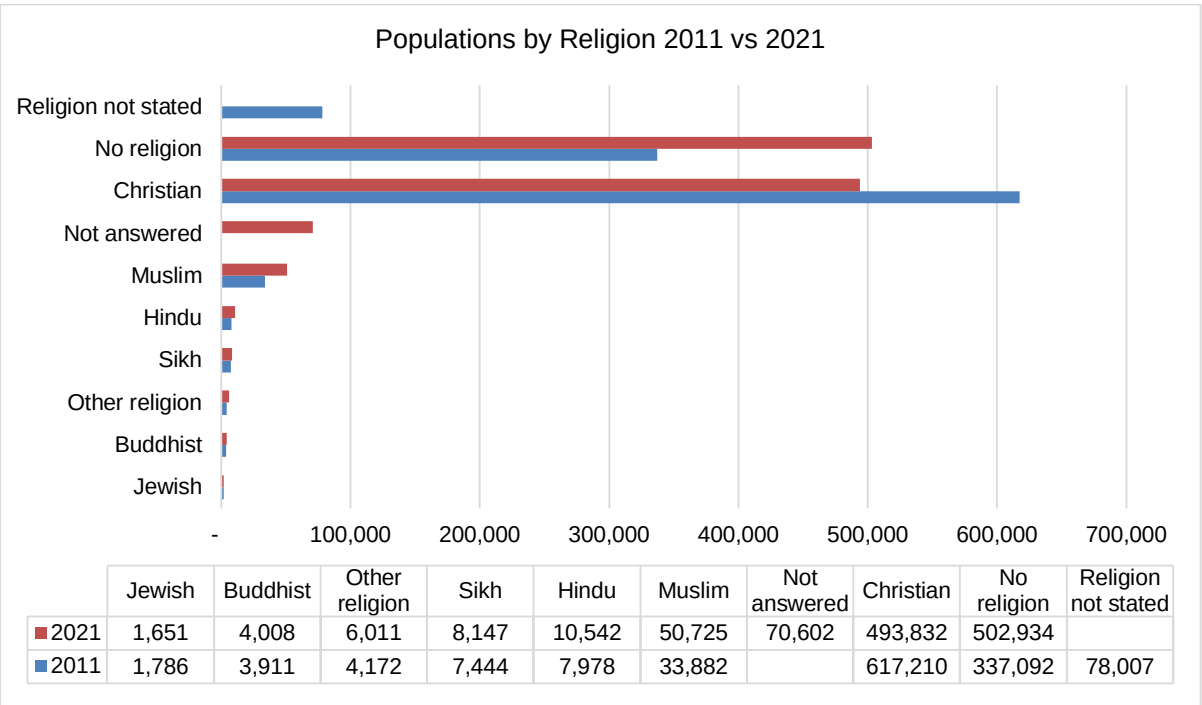
As shown in the graph below the majority of Nottingham and Nottinghamshire's population is white; accounting for 85.4% of the total population with a 1% increase between 2011 and 2021. However, there was a significant increase in the number of people who are from the BAME community. Between 2011 and 2021, the percentages have increased as follows: 21.4% for Asian, Asian British or Asian Welsh; 35.3% for Black, Black British, Black Welsh, Caribbean or African; and 61% for other ethnic groups.



	Other ethnic group	Black, Black British, Black Welsh, Caribbean or African	Mixed or Multiple ethnic groups	Asian, Asian British or Asian Welsh	White
2021	16,748	42,147	36,166	72,740	980,654
2011	6,535	27,287	30,981	57,178	969,501

Figure 3: This graph displays the ethnicity. The table notes drastic increases to the Asian, Asian British and Asian Welsh (21.4%), Mixed or Multiple ethnic groups (14.3%), Black, Black British, Black Welsh, Caribbean or African (35.3%), and Other ethnic groups (61.0%).

From a religious perspective, the majority of the population are either Christian (43%) or non-religious (44%). It was also noted the number of Christians has decreased by 25%, while the number of non-religious, Muslims or people who follow other religions has increased by almost 32%.



	Jewish	Buddhist	Other religion	Sikh	Hindu	Muslim	Not answered	Christian	No religion	Religion not stated
2021	1,651	4,008	6,011	8,147	10,542	50,725	70,602	493,832	502,934	
2011	1,786	3,911	4,172	7,444	7,978	33,882		617,210	337,092	78,007

Figure 4: This graph displays the population by religion. Key insights include a 33% increase in the non-religious population (33.0%), a 24% increase in the Hindu population, and a 25% decrease in the Christian population.

The population of Nottinghamshire is slightly older than the national average, with 21% aged 65+ in 2020 compared with 18% in England. The median age of the population in Nottinghamshire in 2019 was **43.8** years compared to 40 years in England.

We know many people living in Nottingham and Nottinghamshire could be living longer, healthier, happier lives than they currently do.

Additional data for Nottingham and Nottinghamshire shows that:

- More than 50,000 people of working age who are 'economically' inactive have long term health problems
- 65% of adults are overweight or obese
- One in six young people aged 6 – 19 has a probable mental health disorder
- Compared to national figures, more babies are born to mothers who were smoking at time of delivery (13% for Nottingham and 12.6% for Nottinghamshire).

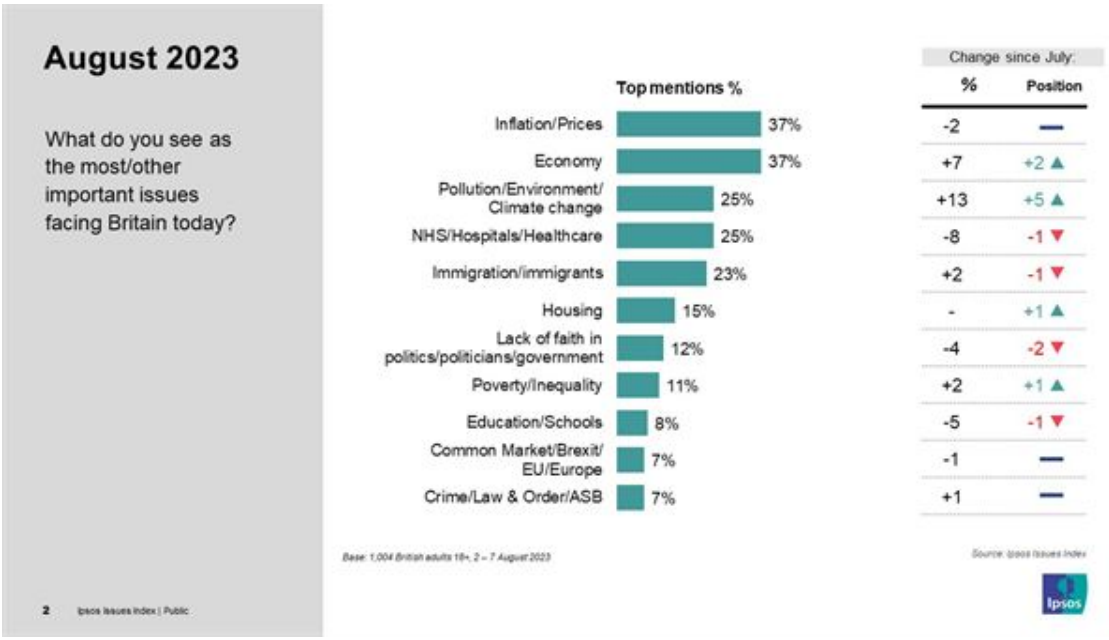
In conclusion, the Nottingham and Nottinghamshire 2021 population is larger, older, less likely to be in a legal relationship and less white than 10 years previously. As a system we need to ensure we track the demographics of our populations to ensure we deliver services which are tailored to people's needs and expectations for our residents of Nottingham and Nottinghamshire.

3 What's Important to Citizens?

This section provides an overview of what citizens think are the most important issues based on national data and research. We can generalise these insights to apply to Nottingham and Nottinghamshire (as seen above due to the similarity of our population to the rest of England) but should be cautious about assuming these national findings are directly applicable for our population.

Figure 4 sets these out, drawing on research by Ipsos Mori[5]. Inflation/prices and Economy are the joint most important. NHS/Hospitals/Healthcare are the fourth most important issues, dropping to 25% from 33% in July 2023.

[5] Latest UK Opinion Polls: Government approval recent changes | Ipsos



The Office of National Statistics (ONS) conducted research over the same time period[6] which found that when asked about the important issues facing the UK today, the most commonly reported issues continued to be the cost of living (91%), the NHS (86%), the economy (74%), climate change and the environment (67%) and housing (60%).

3.1 Perceptions of the NHS

The NHS has evolved over the years to meet the changing healthcare needs of the population, including the development of digital health solutions and expansion of services. However, it faces ongoing challenges, including increased demand, financial pressures, and workforce shortages, which have been exacerbated by the COVID-19 pandemic.

As part of the 75th Anniversary of the NHS (5 July 2023), the public were asked what they think about the NHS now and its future challenges[7]. The participants were representative sample of 2,450 UK adults aged 16 years and older. Key findings include:

- Among those in Great Britain who identify as British citizens, the NHS ranks highest with 54% of the public saying this is what makes them most proud to be British, higher than our history (32%), our culture (26%) or our system of democracy (25%).
- Among members of the public who say the NHS is something that makes them proud to be British, half (55%) are proud that it is free at the point of use, affordable and paid for via tax, and more than one-third (36%) are proud that it is available to all and treats everyone equally.
- However, 25% think healthcare will generally be free at the point of delivery in 10 years' time. In contrast, half (51%) think people will have to pay for some healthcare services that are currently free in 10 years' time.
- The public tend to think the NHS is unprepared to address most future health challenges, including meeting the increasing demands of an ageing population (77%), responding to the impacts of climate change (61%), and keeping up with new technologies (51%). They are the

[6] Public opinions and social trends, Great Britain - Office for National Statistics
[7] How the public views the NHS at 75 (health.org.uk)

most confident in the NHS's preparedness to respond to future pandemics (47% think it is well prepared).
- The public view lack of funding (40%), staff shortages (38%) and poor government policy (35%) as the main causes for the strain NHS services are under.
- Nearly three infour of the public (72%) think the NHS is crucial to British society and that everything should be done to maintain it (as opposed to thinking we probably can't maintain it in its current form – 26%). While still high, this is a significant drop from those who felt the same way in May 2022 (77%).
- The majority (80%) of the public continue to think the NHS needs an increase in funding, compared to 17% who think the NHS should operate within its current budget. There is the most support for an additional tax earmarked specifically for the NHS (31%), as well as an increase in National Insurance (22%) and an increase in Income Tax (21%).

A multi-country survey[8] (published in July 2023) found that:

- British citizens were the most likely to say that their health system is overstretched, with eight in 10 (83%) agreeing with this statement, while6% of people in Great Britain disagree[9].
- In addition to feeling the system is overstretched, half of Britons also feel pessimistic about the quality of the healthcare they receive, and 47% saying they expect the quality of their healthcare to get worse in the coming years. In contrast, only one in 10 say they think it will improve.
- The majority of British citizens (52%) disagree that it is easy to get an appointment with a doctor in their local area, but 29% agree it is easy. In total, 76% agreed that waiting times are too long. This was one of the highest rates of agreement among the 28 countries surveyed, with only Poland (79%) and Hungary (81%) more likely to agree that waiting times are an issue.
- A total of 46% of people saying they trust the healthcare service to provide them with the best treatment; a quarter of Britons (26%) say they disagree.

4 Summary of Engagement Activity Across Nottingham and Nottinghamshire ICS

4.1 Introduction

Since its inception in July 2022, the Engagement Practitioners Forum has more than 35 members from system partners across Nottingham and Nottinghamshire including NHS Trusts, Community and Voluntary Sector Organisations, Local Authorities and Place Based Partnerships. The aim of the forum is to bring together insight and intelligence from engagement activities to share learning, good practice and to share key findings and rich intelligence from our communities.

This section outlines the key programmes and engagement and involvement work undertaken together with insight obtained from those programmes together with links to the reports.

4.2 Tomorrow's NUH – NHS Nottingham and Nottinghamshire ICB

Nottingham University Hospitals (NUH) is one of the hospital trusts identified as part of the Government's New Hospitals Programme meaning there is an opportunity to secure considerable capital investment in its hospitals. This investment would also mean the potential relocation or reconfiguration of how services are provided to our population.

[8] Ipsos - Global Perceptions of Healthcare 2023
[9] In comparison, the global country average is 56%.

Three periods of engagement have taken place since November/December 2020 up to and including February and March 2023, hearing from more than 3,000 citizens, patient and stakeholders. We heard from people in the following ways:

1. Surveys
2. Telephone interviews
3. Focus groups
4. Attendance at community groups
5. Attendance at community events

The key findings from the engagement activities were:

- There was overall support for our proposals
- Access to buildings and services was important to people, in particular parking
- People wanted to know how services would work together, inside and outside the hospital
- People were concerned about the affordability of the model and whether we would have the right staff in the right places
- People supported our proposals to split emergency and elective care but were concerned about accessibility of centralised emergency care services
- People supported the co-location of maternity services on one site but were concerned about the accessibility of centralised services; reducing location choice for care and birthing services; and potentially longer travel times for some people
- The feedback from this engagement will be considered to develop a final set of options for changes to hospital facilities and services, which will be put forward to the citizens of Nottingham and Nottinghamshire in a formal public consultation.

A full copy of all our engagement reports can be found here.[10]

4.3 Integrated Care Strategy – NHS Nottingham and Nottinghamshire ICB

The Health and Care Act 2022 required each Integrated Care System (ICS) to produce an Integrated Care Strategy. This strategy should be “evidence based, system-wide priorities to improve health and reduce disparities… based on assessed need”.

This programme of work involved citizens in the development of the Integrated Care Strategy for Nottingham and Nottinghamshire. This was developed using a two-step approach. The first step was a desktop research exercise undertaken to understand the needs of our citizens and how these can be met, people and communities who are not to understand who we need to involve, and gaps in our knowledge that could form the basis of our involvement work. The second stage involved a number of listening activities to test the findings from the desk research, explore gaps in our knowledge, test the emerging content of the Integrated Care Strategy and trial the Vision and purpose for our ICS. In total, just under 750 individuals were involved in a range of activities which took place between October and November 2022 through:

[10] Tomorrows-NUH-Public-engagement-report-002.pdf (icb.nhs.uk)

https://notts.icb.nhs.uk/wp-content/uploads/sites/2/2022/04/Healthwatch-enagagement-report-January-2021-002.pdf

https://notts.icb.nhs.uk/wp-content/uploads/sites/2/2022/04/Tomorrows-NUH-Phase-2-engagement-report_May2022_final.pdf

https://notts.icb.nhs.uk/wp-content/uploads/sites/2/2022/04/TNUH_Targeted-Engagement-April-2023.pdf

- Targeted meetings with elected members, Healthwatch Nottingham and Nottinghamshire, the Nottingham and Nottinghamshire ICS Voluntary, Community and Social Enterprise (VCSE) Alliance and Engagement Practitioners Forum
- The ICS Partners' Assembly, which bought together 161 system stakeholders, carers, service users, patients and citizens
- The annual Nottinghamshire County Council Shadow event, which was attended by over 250 children and young people, including young adults with learning disabilities
- Two public events, which were attended by 48 individuals
- A survey, which gathered 206 responses.

Findings from the engagement included: -

- There were concerns about how the Integrated Care Strategy would actualise the ICS Purpose and Vision, with specific concerns around resourcing the right services for citizens, and more specifically around funding for acute services, social care and the VCSE sector
- "Improve outcomes in population health and healthcare" and "tackle inequalities in outcomes, experience and access" were considered to be the most important ICS aims
- There was support for the focus on prevention, but there were queries about how realistic it was to shift resources away from treatment of acute illnesses and into prevention
- It was agreed resources should be directed to populations with the greatest needs, who require the most immediate support and preventative activity. There were some concerns that equity may feel unfair to some, particularly if resources are reallocated and a perception that specific places, groups and communities are "worse off"
- There was support for services to become more integrated and working as a system, including the realignment and sharing of resources (including governance and some back-office functions), was the key to success. It was clear the ICS provided an opportunity to build on strengths and identify areas of development to deliver connected services which are accessible and easy for citizens to navigate.

A full copy of the engagement report can be found here[11].

4.4 Joint Forward Plan – NHS Nottingham and Nottinghamshire ICB

Each NHS organisation in the country was required to produce an NHS Joint Forward Plan following the creation of their system's Integrated Care Strategy. The Joint Forward Plan sets out the organisation's contribution to the delivery of the Integrated Care Strategy.

The overarching aim of this work was to involve citizens in the development of the NHS Joint Forward Plan for Nottingham and Nottinghamshire. In total, just over 300 individuals were involved in a range of activities which took place between May and June 2023 through:

- Targeted meetings with the Nottingham and Nottinghamshire ICS Voluntary, Community and Social Enterprise (VCSE) Alliance and Citizen's Intelligence Advisory Group
- The ICS Partners Assembly, which bought together 113 system stakeholders, carers, service users, patients and citizens
- A survey, which gathered 168 responses.

Nottingham and Nottinghamshire Integrated Care Board listened to the experiences and opinions of citizens, patient and stakeholders and gathered feedback and comments on the plan. In total, just over 300 individuals were involved in a range of activities which took place between May and June 2023 via our ICS Partners Assembly and an online survey.

The key findings from our engagement were:

[11] https://healthandcarenotts.co.uk/wp-content/uploads/2021/05/Integrated-care-strategy_engagement-report_final1.pdf

- There was support for prevention. However, there was scepticism around how realistic it was to shift resources away from acute and secondary care towards bold and innovative preventative approaches
- The importance of a connected and sustainable community, and the role of the VCSE sector and community leaders to enable this was highlighted. Inadequate investment was described as a risk
- There was agreement that resources should be directed to populations with the greatest needs to reduce health inequalities
- Great value was placed on collaboration, integration of services, and knowledge sharing to achieve the aims of the Integrated Care Strategy. There was also strong support for services to share expertise, resources and work collectively to enhance patient care across our ICS
- Future health and care services (specifically cancer and elective care) should be equitable, person-centred and coproduced with people with lived experience
- There was an ambition to streamline service pathways and ensure people receive the care required in the right place first time
- There was acknowledgement of the issues that the system is currently facing, specifically workforce challenges, access to and funding of GP and emergency services, dentistry and the VCSE sector.

All comments and feedback were provided in a report to feed into final version of the Joint Forward Plan[12].

4.5 Family Hubs – Nottinghamshire County Council

Nottinghamshire County Council is having ongoing discussions with young people, parents and families to support the development of Family Hubs which are for children, young people, parents and families.

Methods used included face to face discussions at existing groups, specific consultation events and surveys.

People said that:

- More support is needed around breastfeeding
- Services need to be promoted and coordinated more
- More support is needed for children with Special Educational Needs and Disabilities.

In response Nottinghamshire County Council has:

- Started a Breastfeeding Support Group, supported by the Specialist Infant Feeding Lead
- Improved service information on Notts Help Yourself to make sure that families and practitioners are aware of services available. This will form the 'Virtual Family Hub'
- Started a support group for parents of children with SEND.

The example provided is specific to Retford where the first of the Family Hubs in Nottinghamshire has commenced.[13] The engagement work has been built upon in 2022 and 2023, and is set out in detail by Nottinghamshire County Council.[14]

[12] Developing-the-JFP_final.pdf (healthandcarenotts.co.uk).
[13] Participation case example: Nottinghamshire - National Centre for Family Hubs
[14] Retford and the story so far | Nottinghamshire County Council

4.6 Personalised Care & Support Planning – NHS Nottingham and Nottinghamshire ICB

One of the six commitments in the NHS England Comprehensive Model of Personalised Care is that people have proactive, personalised conversations with clinicians. Focusing on what matters to them, delivered through a six-stage process, and paying attention to their clinical needs as well as their wider health and wellbeing. This is known as a Personalised Care and Support Plan (PCSP) and is one of our priorities to scaling up personalised care.

Through our work with My Life Choices[15] we have learned the importance of people having an About Me[16] conversation as it helps shift the conversation. This was reinforced and reported in a recent partnership co-production project, Removing the barriers to shared-decision making[17].

The aspiration in Nottingham and Nottinghamshire, is that over time, people with complex needs and long-term conditions will have an 'About Me' which can be accessed, read and talked about by all health and social care staff and their patients. The challenges we have experienced in scaling up the use of the 'About Me' are mainly digital barriers but finding several versions of an 'About Me' type document within different services, organisations and departments created duplication and confusion.

Alongside influencing Digital Notts[18] to follow the lead of NHS Wales and have 'About Me' accessed via the NHS App, we are working locally to overcome this challenge with a digital solution. By focussing our efforts on a digital option, we would be enabling people to complete an 'About Me' themselves, which then can be easily shared with various health and social care professionals.

This promotes a shift towards people being more proactive and self-directed, aiding a shift to conversations with healthcare professionals around 'what matters and is important to people'. This will mean Healthcare professionals can read and understand the person in more detail before meeting them. Evidence shows that this leads to a better-quality conversation around what is the best treatment option for the person, leading to a better shared decision. It also means people do not have to repeat the same information and their story at every stage of their care journey, something that people using our services repeatedly tell us they don't want to have to do.

Having a digitised 'About Me' will offer solutions to some challenges and will serve as a good starting point based on what matters most to individuals. This will, in turn, benefit the ICS as care outcomes of the population are better met based on the increase in shared decision making, leading to improved patient satisfaction, as well as a reduction in the frequency/length of clinical appointments.

The digitalisation of the 'About Me' is currently underway with our digital provider Digital Notts. A working group has been formed with multiple key stakeholders and My Life Choices members embedding co-production at the very beginning. They are working towards phase one, a text version via a patient facing system within the NHS app – currently Patient Knows Best[19]. The working group is keen to develop this work further to meet the needs of various groups of people who may want to use multimedia options such as photos, videos, easy read symbols and different language options. We are co-producing an easy read version of the 'About Me' with local learning disability groups Nottingham City Splat and Nottingham Mencap.

[15] My Life Choices - NHS Nottingham and Nottinghamshire ICB
[16] About Me
[17] PIFPA-Removing-barriers-to-shared-decision-making.pdf (icb.nhs.uk)
[18] Digital Notts - Connecting People and Data in Notts
[19] Home - Patients Know Best

4.7 Collaborative Practice – NHS Nottinghamshire Healthcare NHS Foundation Trust

The Lead Governors have been invited to participate and be involved within the Engagement Practitioners Forum to ensure the voice of the community and insights are gathered to feed into the Integrated Care System and Partners.

Nottinghamshire Healthcare NHS Foundation Trust's Council of Governors is collaborating to represent the "public at large" within the Integrated Care System area. Councils of Governors are keen to hear from communities and networks in Nottingham and Nottinghamshire. The Lead Governors from the three Foundation Trusts in the Integrated Care System area will ensure that they are represented and feed information from the wider public into the Integrated Care System.

Nottinghamshire Healthcare Foundation NHS Trust produce a report which provides the insight from communities to the Board which can be found here[20].

4.8 Community Mental Health Co-production and Engagement – Mansfield Community Voluntary Sector

Mansfield Community and Voluntary Service (CVS) was keen to understand the provision and access to Mental Health Services within Mid Nottinghamshire, to gain insight and feedback to support coproduction of local services.

This work is aimed at citizens in Mansfield experiencing mental health issues and community support colleagues, Social Prescribing Link Workers, Mansfield District Council looked after children and voluntary sector partners.

Central to the Community Mental Health (CMH) Transformation is a shift in the way services and pathways are designed with a focus on co-production and meaningful engagement of people with mental illness and poor mental health. Through adopting this approach, evidence suggests pathways are more likely to provide holistic, person-centred care and lead to improved access, experience, and outcomes for service users.

While recognising the strength of the local place based VCSE organisations, the ICB has decided to enhance its existing engagement contract that reaches into organisations and communities that are supporting people with poor mental health. This enhanced contract with the place based VCSE organisations will deliver a programme of Coproduction & Engagement to those living with poor mental health.

Feedback for the development of the NottAlone was mixed. Some cohorts of citizens will never access mental health support digitally and the support for residents who do not speak English is inconsistent. The next steps are to look at access to services, and prevention opportunities. A report can be found here to provide case studies and information[21]

4.9 Bellamy Estate – Mansfield Community Voluntary Service

Mansfield CVS has been working with citizens and partners to understand the health inequalities within the Bellamy Road Estate situated in Mansfield, Nottinghamshire. The aim of the work was to collaborate with partners to support health and wellbeing on the estate for the benefit of those who live there and those who provide services on the Bellamy Road estate.
From the engagement activities that took place people said they would like to see the following change to help them become healthier:

[20] https://www.nottinghamshirehealthcare.nhs.uk/download.cfm?doc=docm93jijm4n11794.pdf&ver=21697
[21] SMI Report - Mid Notts Q1.pdf

- Support with transport to get to activities and appointments
- Regular health and wellbeing support services provided on the estate
- More activities for different groups/communities
- Things lasting and people in the area trusting people
- Going to one place to get the help needed
- A community space for people to come together to social and access provision

A dedicated Health and Wellbeing Officer has recently been appointed to help people living on the Bellamy Road Estate focus on relationships with other residents. Is will help understand how to tailor and adapt services to meet communities needs and reduce health inequalities within the area.

A report has been produced detailing the insight monitoring from Quarter 1 2023[22]. The final report which will include Volunteer Impact findings is due for completion in October 2023.

4.10 NHS England/Improvement Prevent Programme – Ashfield Voluntary Action

Ashfield Voluntary Action (AVA) and Ashfield District Council (ADC) have been funded by the NHS (through NHS England) to support their work to reduce health inequalities in targeted areas of Ashfield. This partnership work aims to improve health outcomes on the Coxmoor Estate in Kirkby-in-Ashfield and in Butler's Hill and Broomhill in Hucknall.

The NHS acknowledges that people living in these communities have poorer health outcomes than in other parts of Ashfield. They also recognise the foundations for addressing these health inequalities are laid through effective communication. This can only happen when the community has confidence that their voice is being heard and their views valued. This is not an easy step, and it takes time to establish the trusted relationships necessary for this.

Ashfield Voluntary Action was keen to understand how it feels to live in their communities including the good and the not-so-good. Sometimes, small practical changes can have a massive impact.

A final report is being complied and will be available with the evidence and outcomes of this work[23].

4.11 Community Communications – Ashfield Local Design Team / Nottingham Trent University

The Ashfield Local Design Team in partnership with Nottingham Trent University, was keen to carry out mapping of community assets within the area to understand more around how to:

- Connect people to their community
- Increase people's involvement in activities, groups, clubs, courses etc and widen social interaction
- Encourage greater participation in the community.

Following on from the mapping work took place as follows:

- A printed version of the survey questionnaire was produced into the community to obtain a wider range of responses
- Have open conversations with people in the community: listen to their opinions, let people speak up and be heard, interact with them
- Make more use of printed media as it is accessible; establish places where it can be seen

[22] Bellamy NHSEI Insight Monitoring Q1 2023.pdf

[23] Reducing Health Inequalities - Information for Partners - Ashfield Voluntary Action

- Produce a booklet of information
- Email information to people as this is sustainable and environmentally friendly
- Enable more people to use social media – educate people in digital literacy
- People don't know where to go so have specific places for people to go to for information: designated noticeboards; use colour coding
- Use the Next-Door app to connect people with each other.

This piece of work allowed health inequalities to be addressed and meet the needs of local communities by providing activities and sessions to support health and wellbeing in the area[24].

4.12 Mansfield Local Design Team – NHS Nottingham and Nottinghamshire ICB

Work was undertaken by the Local Design Team in Mansfield who were keen to understand and identify local pharmacies that could provide blister packs for local people within the community who have issues and struggle to take their medication when dispensed in alternative packaging. This programme allowed the team to discuss and work with local pharmacies in the area to support the community in providing blister packs for those who need assistance when taking their medication. Work was also carried out with local pharmacies who could provide a delivery service to provide support and assistance to those who need this service within the community.

The work also identified alternative methods to support communities and people who need to receive and take regular medication including using digital devices to serve as a reminder.

4.13 Review and Commissioning of Alcohol and Drug Recovery and Treatment Services – Nottingham City Public Health

Substance misuse can have profound and negative effects on individuals and across communities. Alcohol and illicit drugs can cause a wide range of harm to physical and mental health, for example foetal alcohol syndrome affecting unborn babies, and the risk of contracting blood borne viruses and infection from injecting drugs.

The social impacts of substance use may include limiting the ability to work, to parent, and to function effectively in society, and can often be associated with criminal activity as a way of getting money to buy drugs.

There are significant costs associated with drug and alcohol use among health and social care and criminal justice systems.

An estimated 63% of people who use opiate and crack are aged 35-64, yet this cohort accounts for 81% of those accessing structured treatment for opiate and crack cocaine use. This suggests there is a potential unmet need in opiate and crack cocaine users aged under 35 years.

Of those aged 15-24 who use opiate and crack in Nottingham City, 93% are not accessing structured treatment. Reported drug use is highest among 16-19 and 20-24 year-olds but these age groups account for only 8% of people in structured treatment in Nottingham. There is a potential gap within service provision for this age group.

Data indicates that 'Mixed' ethnicity groups are underrepresented in treatment. There is a potential gap within service provision for this cohort. There is an unmet treatment need of 74% for alcohol dependent citizens aged 18 and over. This equates to up to 3,800 dependent drinkers who could benefit from specialist treatment.

[24] Inspiring Ashfield - Ashfield Voluntary Action

Nottingham City Council carried out a consultation and engagement activity, including stakeholders, public and an Expert Panel of citizens were utilised around the new 10 Government Drug Strategy, 'From Harm to Hope' necessitated a full review of service provision, extensive consultation, remodelling and procurement of new services.

New services have been procured and will launch October 2023. The Expert Panel will review services six months into the new contracts.

Full consultation report has been published[25]:

4.14 Gambling Related Harm Strategy – Nottingham City Public Health

Nottingham City Council Public Health Team carried out a health needs assessment and published a Strategy for Nottingham City citizens. This was informed by stakeholder engagement and structured interviews with gamblers and those affected by the gambling of others, and the Gambling Related Harm in Nottingham City: Health Needs Assessment[26].

Gambling related harm is recognised as a highly prevalent public health problem which damages physical and mental health, breaks down relationships, erodes finances, and drives up crime. We conducted a health needs assessment to estimate the local impact and inform a public health approach to prevent gambling related harm in Nottingham City.

National data suggests 0.4% of people aged 16 and over, and 2% aged 11-16 in school show signs of a gambling problem (some surveys report higher figures than this). When national data is applied to our population, we estimate approximately 4,500 people aged 16 and over and approximately 1,000 adolescents aged 11-16 in school show signs of an early or established gambling problem. Each person with a gambling problem has 6-10 affected others on average, who too experience harm.

The approach taken comprised of three parts:

1. Literature review – a search of published and grey literature to describe the:
    i. Predictors of gambling participation and gambling problems
    ii. Impacts to people with a gambling problem, their social groups, community and society
    iii. Current gambling harm prevention activities and services for people in Nottingham
2. Data analysis – estimating the local prevalence of:
    i. Gambling participation, gambling problems, and risk of gambling problems
    ii. Gambling related harm, based on demand for support services

3. Mapping – using routine data and geospatial information system software to:
    i. Map the location of licensed gambling facilities
    ii. Map the prevalence of risk factors for disordered gambling

This strategy was agreed and signed off by the Health and Wellbeing Board in August 2023 which will be published later this year.

[25] Substance Misuse (illicit drugs and alcohol) (2022) - Nottingham Insight
[26] https://www.nottinghaminsight.org.uk/d/acbrjYkl

4.15 My Support Network – NHS Nottingham and Nottinghamshire ICB

As part of the Community Transformation Programme, Newark Local Design Team has developed a document to allow patients to record who is providing care to them, in a bid to reduce the number of times a patient has to tell their story. This is for vulnerable patients in the Newark area and is collated within their own home to help and assist.

The aim of this programme was to improve the integration between care services, to better understand the experience and outcomes for people. The local design team worked with workforce and people to design a solution based on comments like:

"Wouldn't it be great if there was a way to share details about all the community contacts and friends and family supporting me in my care – everything in one place."

"As professionals we could save time searching for information and reducing pressure on the person to provide information" - so they are not having to repeat their story every time."

"Wouldn't it be great if multiple professionals throughout week all focussed on me as a person not a single intervention".

There was consideration that the document should be digital, so it could be accessed remotely by wider services. However, this was resisted as it was agreed that it should be easily accessible, and people commented that having a physical document they owned and could easily view provided reassurance.

The initiative is in its early stages, and formal evaluation is being completed, however early feedback from people and workforce has been:

- People felt more confident that services had the right information to support their needs for both physical health and emotional wellbeing.
- Contact details in one place saving time spent in an emergency searching for information, e.g. vital information for maintaining Andy's airway - crisis management reduced
- Reduces the amount of repetitive direction people give to teams from Health and Social Care.
- Reduces the time professionals spend in handover/chasing information giving more time to support people with their care needs and making a real connection.
- Gave professionals (and family) a snapshot of interventions that are in place and key points of contact.

Key learning point – Engagement and Co-production with people and workforce can develop simple and meaningful solutions that have a significant impact on care service experience and outcomes.

4.16 Community Care Transformation Programme – NHS Nottingham and Nottinghamshire ICB

The Community Care Transformation Programme (CCTP) engaged with system partners and citizens to develop ambitions for community care. Through that engagement, clear themes emerged around tackling health inequalities, focussing on wider determinants of health, working with our communities and collaboration between health, local authority, Community Voluntary and Social Enterprises and citizens.

This programme of work aligns to our Integrated Care Strategy:

- Through our work in developing and supporting community assets (and their usage) a focus of the programme is to ensure local organisations play a full role in increasing 'social value' and strengthening communities in supporting an individual's independence, health and wellbeing.
- Many of our organisations and teams are serving the same communities and the same individuals, but in many instances, they will be doing it independently of one another. This leads to situations for people with multiple health and care needs having different agencies visiting for support at different times during the day. This fragmented approach is not in the best interests of local people or our workforce and teams. Local Design Teams provide an opportunity to address this and support working in a more integrated way to ensure that local people have care that is joined up around them. Bulwell and Top Valley Local Design Team is an excellent example of this being effective[27]
- Within county localities, the plan for roll out is via the Health Inequalities Innovation Investment Fund. The collaborative bids with Bassetlaw, Mid Nottinghamshire and South Nottinghamshire are specifically requesting funding for additional Quality Improvement Lead capacity to enable roll out of community transformation at pace.

Success has been achieved through focus on priorities identified by health inequalities, and then within that work assessing how those experiencing health inequalities can be engaged with.

Case studies from the programme can be found here[28]

4.17 The Big Conversation – Nottinghamshire County Council

In Nottinghamshire lots of people need support to live their best life. Social care is personal, emotional, and practical support for people who need it. It works alongside health care.

From the 20 February to 22 March 2023, Nottinghamshire County Council held a 'Big Conversation' to ask people who use social care and their carers about the vision, the challenges, and what they want in the future. This was assisted by Community Catalysts[29] and the local Our Voice Coproduction Group[30].

542 people and carers with lived experience got involved and shared their experiences and ideas with us.

What people said:

- They like living in their own home. Some said they feel isolated. Some worry about the future and if they could stay in their home.
- Support services that do a good job and talked about services and staff who are not good.
- Some things stopped for the Covid pandemic and haven't started again.
- Some shared reasons they feel unsafe.
- Direct Payments - They help people live their life their way but can be hard to manage with lots of paperwork and responsibility.
- Public transport and buses are important.
- Having friends and connections in their community is important.
- Good information is important. Lots of information is not accessible and this is not good.

[27] https://www.youtube.com/watch?v=gV80B8v5Yv40
[28] Case studies - CCTP early adopters (002).pdf
[29] Contact us | Community Catalysts
[30] 2. Co-production group | Nottinghamshire County Council

- Money and finances – People talked about poverty (being very poor).
- More help and advice are needed with money and benefits.

What carers said:

- Understand what it is like to live with someone and care for them and how difficult things and very being a carer. Carers talked about carers' assessments and how these are not always good.
- Some care services and staff are good. Some are not as good. There are gaps in services.
- Some get good support from family and friends.
- Carers don't always have time to see friends and family. Some feel isolated and alone.
- The effect of caring on their health and wellbeing and sometimes they feel unsafe. There is also the worry about the person they care for.
- Hard to get the information they need. It is hard to speak to a person.
- Need more help to understand money and benefits, some things are unfair or not right.

The findings of this report[31], co-produced through the Big Conversation initiative, will serve as a guiding force as we develop Nottinghamshire County Council's new Adult Social Care Strategy. We will be developing the strategy over the next few months.

5 ICS Partners Assembly

5.1 Background

The Nottingham and Nottinghamshire ICS Partners Assembly
The Nottingham and Nottinghamshire ICS Partners Assembly is a bi-annual gathering of organisations and individuals who have an influence and interest in the health and care of the region's population. Those who attend the Assembly represent a diverse range of organisations from across the system, including the NHS, Local Authority, Voluntary, Community and Social Enterprise sector, as well as citizens, patient leaders and people with lived experience.

The second ICS Partners Assembly on 15th May 2023 brought together 113 system stakeholders, carers, service users, patients and citizens. The Assembly focused on involving citizens in the development of the NHS Joint Forward Plan for Nottingham and Nottinghamshire.

Delegates at the Assembly had the opportunity to share their views in a variety of ways including Mentimeter, tabletop discussions, pledges and comments cards. Captured below are the wordclouds generated from the two questions asked on Mentimeter.

[31] nottinghamshirebigconversationreport2023.pdf

“What NHS features, developments or services are the most important to celebrate in three words?”

Figure 5 Mentimeter: What NHS features, developments or services are the most important to celebrate? (ICS Partners Assembly, n = 95)

Figure 5 shows that the most popular words submitted for what delegates thought were the most important to celebrate in the NHS are free, equity, collaboration and care. The importance of the NHS continuing to be free chimes with national public opinion, where 19 out of 20 people in opinion polls say they want the NHS to remain free at the point of delivery.[32]

In the second Mentimeter exercise, near the end of the Assembly, delegates were asked to describe *“in one word what have you heard so far that has given you hope for the future?”.* 51 people submitted a word. Collaboration was again one of the most popular words. Prevention, coproduction and commitment were also submitted by many.

“We want to hear, in one word, what have you heard so far that has given you the most hope for the future?”

[32] Public satisfaction with the NHS and social care in 2022 | The King's Fund (kingsfund.org.uk)

Figure 6 Mentimeter: In one word, what have you heard so far that has given you the most hope for the future? (ICS Partners Assembly, n = 51)

The overarching themes from the insight at the ICS Assembly can be broken down into eight key areas:

1. Integration and collaboration
2. Community engagement and empowerment
3. Effective communication and information exchange
4. Prevention and focus on wider determinants of health
5. Resource allocation and funding coordination
6. Person-centred care
7. Workforce development as a system
8. Utilising existing knowledge and learning

5.2 Integration and Collaboration

There was strong support for integration and collaboration, in line with the Integration principle of the ICS. Many emphasised the need for alignment and coordination among various service providers; a more efficient system should include social care, housing, health, and food services working together. This chimes with the NHS@75 Assembly views[33] as the NHS has a crucial role in partnership with other sectors to improve the health of the population and wider determinants of health.

> ***"Help create 'one-stop' services."***

[33] The-NHS-in-England-at-75-priorities-for-the-future.pdf (longtermplan.nhs.uk)

We're shifting towards a more integrated, community-focused way of providing care. This means we're breaking down the barriers and silo working that used to separate different parts of the healthcare system, like primary care from hospitals. We want to make it easier for local healthcare teams and specialists to talk about individual cases and work together. There was a consensus on the importance of breaking down silo working and fostering collaboration across different sectors within healthcare to create a more efficient and seamless experience for patients. An example of good practice was in PCN development where improved access to mental health care has been achieved, however it was noted further improvements are needed.

"Encourage services to joint working. Each service provider has individual specifications, reduce duplication by creating joint service specifications."

One focus of the discussions drew upon the subject of current IT systems and the barriers they present. The use of different IT systems in partnership organisations is hindering integration, with examples of varying levels of technology, lack of system compatibility and data sharing challenges across organisations.

"Improve the communication between public and private sectors. Private can work with public and massively help. Look further to help achieve goals. Public and private can have a great working relationship."

Many wrote pledges towards the ICS principle of Integration, most of these pledged were to collaborate and link up with other system partners as well as joining up services and further partnership working. There was a distinct focus on collaboration and transparency when working with communities and system partners. Some pledges highlighted their commitment to coproduction with other system partners and others pledged to champion integration in specific areas such as data as well as participation in system forums such as the VCSE Alliance.

Solutions and suggestions for integration and collaboration included:

- Integration and alignment of IT Systems.
- Building and strengthening relationships between different organisations and sectors to work together more effectively and provide integrated services.
- Enhanced workforce support and collaboration

5.3 Community Engagement and Empowerment

Many at the Assembly emphasised the value of engaging with communities, involving community leaders and organisations, and investing in community hubs to drive change, build trust, and empower communities. The role of community champions was specifically highlighted.

Delegates noted several projects that are already progressing the ICS aim of supporting broader social and economic development. Examples included the positive impact of spending time in green spaces such as the allotment run by Cripps Health and Wellbeing Team and the Nature in Mind social prescribing project. Other good examples were the expanding community involvement in Beeston in conjunction with local GPs and the Broxtowe dementia pilot.

The risks discussed included the importance of transparent communication, inclusivity, long-term strategies, impact assessments, and building trust to achieve sustainable and meaningful outcomes in community work. Access issues were also highlighted as an important consideration; convenience and transportation, particularly in rural areas, are key to the success of a service.

"PLEASE do real coproduction at the earliest stages with partners AND carers/ those with lived experience as you save money and get the right service."

The value of engagement with communities in their own space as well as early engagement of community leaders and organisations was mentioned. The investment needed to support community hubs, understand communities' needs and facilitate community integration and interaction was highlighted. Further conversations centred on the role of communities to drive change, supporting infrastructure development by understanding what is already there and the worth of the VCSE sector in creating resilience and bridging connections. There was acknowledgement that some communities may be resistant to change and how crucial it is to address the social norms and behaviours that contribute to poor health outcomes. A specific example was put forward of New Zealand's ambition to create a smoke-free society and implement vaping regulations.

The engagement of communities and community influencers was highlighted as a key factor in ensuring populations have an ongoing voice and trust can be built. Tailoring communication and messaging to different communities and having community champions run events rather than system professionals to enable more in-depth communication and empower groups.

"Invest in initiatives that increase community capacity."

Aligning and defining the definitions and aims of the system as well as broad engagement and strong leadership to drive development forward, aligning with the aim of 'support broader social and economic development'. The aim could be further bolstered by adopting different ways of engaging different communities and creating a mechanism to share the good work that is happening to inspire others.

"To be guided by the voices of young people in our work."

Some expressed that it is important not to repeat what has been done before with communities and to concentrate on long term plans, investment and solutions. Many also pledged to engage with the younger generation and empower the voice of the young.

Solutions and suggestions for community engagement and empowerment included:

- Engage communities in coproducing solutions and involve them in decision-making processes to address healthcare challenges.
- Empower patients to be actively involved in their healthcare decisions, encouraging them to provide feedback, and improving their understanding of the healthcare system and available services.

5.4 Effective Communication and Information Exchange

Effective communication and information exchange are crucial for healthcare improvement. This theme stresses the importance of transparent communication, feedback mechanisms, and using multiple platforms to ensure accessibility and awareness of healthcare services.

Assembly discussions highlighted the impact communications and language, in particular using appropriate language and multiple platforms to ensure that information is accessible and to raise awareness of prevention services. Feedback and information exchange is vital for immediate improvements, particularly for patients who do not have online access or must travel for care.

> ***"No concentration on what will not be done or what will be stopped or reduced. What is not cost effective. Value for money is important BUT value perception for people is key."***

Linked to the need for further integration the importance of communication between organisations was emphasised at the Assembly. Improved communication between providers in the example of the Electronic Data Interchange (EDI) agenda for ethnic communities was highlighted as a good example of integration.

Comments were received on the significance of tailored communication and the use of terminology and definitions, highlighting that some words have different connotations and people's understanding of what they mean can differ. Clarification of what is meant will help people understand it and the work needed.

> ***"There needs to be a consideration given as to how we avoid post code lotteries. We must prevent PBP's and PCN's doing their own thing and ensuring best practice is shared."***

Some stressed the importance of how the work is communicated and evidenced. Information access and equity across Nottingham and Nottinghamshire was commented on.

Solutions and suggestions for communication and information exchange included:

- Improve communication and engagement with communities through careful messaging, use of interpreters, and providing information in alternative formats.
- Address digital exclusion by considering the diverse technological needs and preferences of different population groups.
- Enhanced communication and information sharing to provide continuity of care.

5.5 Prevention and Focus on Wider Determinants

At the Assembly there was a strong emphasis on the integration of prevention, addressing wider determinants of health, and prioritising resources for those most in need, specifically focusing on long-term strategies to achieve this.

> ***"How engaged are educators of young people involved in the setting up of principles and aims? Education is in the critical partner to provide health prevention and early intervention."***

There were pledges commenting that the ICS principle of Prevention was the most important principle in their opinion.

Many highlighted the importance of education and engagement of families, children and young people, the need to focus on long term planning and innovation. The importance of a flexible, empowering approach to education and early interventions was highlighted, in particular the role of public health education. Suggestions including integrating prevention efforts into schools and providing early access to information for children and parents were discussed. Conversations also highlighted a need to educate healthcare professionals to understand risks and develop necessary skills and empathy to help specific people overcome barriers, for example those in the deaf community.

A benefit of further work on prioritising prevention, promoting collaboration and adopting targeted and flexible approaches could enable more productivity.

> ***"Stand up for prevention, start with babies and children- need to redirect resources in reality not just in theory!"***

Many were supportive of a cultural and economic shift towards prevention, in particular the importance of prevention in reducing pressure on hospitals. Many pointed out a need for change and innovation, to explore bold long-term approaches. However, some delegates did note that issues with the current funding models mean that if funding is relocated to prevention, then there will be less spend elsewhere and initiatives could be difficult to implement with the needs of certain services, particularly in secondary care. Another barrier raised in the discussions was that a 1% allocation for prevention within the ICS Joint Forward Plan may not be adequate to address community needs.

> ***"Be forward thinking and improve innovation, not just focus on the short-term operational pressures."***

One of the NHS@75 recommendations was that the NHS gradually boosts its funding for evidence-backed preventive initiatives. The upcoming Major Conditions Strategy[34], currently under development by the Department of Health and Social Care, presents a significant opportunity to advance in this direction.

To work towards improving the wider determinants of health was a key theme. The delivery of the Core20PLUS5[35] community approach will enable further improvements on reducing the health disparities that exist, as well as ICSs fulfilling their wider legal duties to address health inequalities across services more broadly. Some focused on encouraging healthy choices, addressing inactivity, sustainable travel and ensuring people keep fit. Others flagged the importance of information sharing and awareness to enable free, fair and impartial access.

[34] Major conditions strategy: case for change and our strategic framework - GOV.UK (www.gov.uk)
[35] NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

Tailoring care to individuals from marginalised and disadvantaged backgrounds is crucial to combatting health disparities. In line with this theme, current preventative work within local government and the PBP "test and learn" approach has been used in areas of greatest need, such as Killisick, Bellamy Road, and Nottingham City, to gather insights and adapt strategies to different communities.

> ***"There is no such thing as hard to reach groups."***

Pledges were made towards the aim of supporting broader social and economic development. Most of the pledges were based on the importance of local interventions and community with a focus on those in disadvantaged groups. Others flagged the importance of the VCSE sector as well as ensuring that equity is threaded through the whole system.

> ***"Public debate on what the NHS will fund. A few highly expensive interventions for a few people or more for all. E.g., prevention for a greater number for people."***

Pledges were also made regarding how different organisations and forums could incorporate prevention and collaboration such as the VCSE sector, the VCSE Alliance and Community Champions.

Some pledges made against the ICS Equity principle highlighted the importance of access, whether environmental or technological and there was strong advocacy for underrepresented communities:

Solutions and suggestions for prevention included:

- Embrace technological innovation to support prevention efforts.
- Combine prevention and cure approaches, such as addressing musculoskeletal issues through physical activity.
- Consider incentives to encourage healthier lifestyles.
- Explore non-traditional settings for healthcare provision, such as roadshows.
- Learn from the flexibility and adaptability shown during the COVID-19 pandemic.
- Implement simple interventions and shift focus and resources towards living well rather than just curing illnesses.
- Promote understanding of risks and their impact on health outcomes.

5.6 Resource Allocation and Funding Coordination

The allocation of resources and funding coordination across different sectors, including the voluntary sector, was highlighted as critical for healthcare improvement. This involves ensuring that budgets are effectively managed and coordinated.

Many recognised the current resource challenge, particularly for local authorities and the VCSE sector. Many of the barriers mentioned in the discussions focused on the challenge of not having enough resource and access to funding, especially when considering the health system's reliance on the VCSE sector as a safety net when NHS provision falls short.

The challenge of securing government funding was mentioned, as well as tight deadlines often associated with funding schemes. It was suggested that there is a need to explore strategies to increase chances of successful funding bids.

Other pledges explored how organisations might come together to join up resources. Some highlighted the importance that services are provided by the VCSE sector rather than private companies.

Suggestions of ways in which the system could do more to further the ICS aim of 'Tackle Inequalities in outcomes experience and access' included streamlining complicated processes and embedding the VCSE sector. Learning from other systems was also mentioned as an opportunity to adopt successful schemes and improve our current approaches.

The majority thought it was vital to recognise the impact of wider determinants of health and stated that resources should be allocated to those most in need. Funding shortages should be managed and targeted for maximum impact.

There was also mention of how the system does not have complete control over its development as it is governed by politics and that unsuitable short-term policies contribute to lack of development.

The inequity of services, community assets and transport links were flagged as a concern for some delegates.

A need for efficient coordination, and reliable IT infrastructure to enhance productivity and value for money was highlighted.

The need to provide adequate funding for infrastructure investment and budget coordination across different sectors, especially the voluntary sector, was highlighted. Conversely, others pointed out that opportunities have been missed by historical resistance to private companies.

Some expressed that it is important not to repeat what has been done before and to concentrate on long term plans, investment and solutions.

"Sustainability, Inclusion, Diversity is a cross culture theme and leans on all of the work we do. We pledge to make this even more visible and to work with ICB colleagues at system level to align and share resource whenever feasible."

"Have discussions around how we might come together as anchor institutions to combine our resources in the most effective way"

"Much is spoken about the need for the VCSE sector to support work across the ICS. Without immediate, direct funding into the VCSE groups and organisations providing the services the ICS expects patients to be able to access, these services are not sustainable and will soon be lost."

Solutions and suggestions for resource allocation and funding included:

- Shift resources to target those most in need and ensure equitable distribution of resources across the healthcare system.
- Invest in technology to enhance healthcare delivery, improve patient outcomes, and optimise resource utilisation.
- Allocate funding specifically for primary care and services for marginalised communities.

5.7 Person-Centred Care

One of the main themes at the Assembly was the need for person-centred care, which includes reducing redundancy in patient story sharing, providing named individuals to lead healthcare journeys, and tailoring care to individual needs and resources.

Great emphasis was placed on the work that pharmacies and prescribers are doing to contribute to the ICS aim of 'Improve outcomes in population health and healthcare'. Other examples of this aim in action included work undertaken by TLAP (Think Local, Act Personal) with Nottinghamshire County Council, a pilot Mental Health treatment project, incorporating medicine consultations, follow-ups, and signposting, community champion work and the system change project related to Serious Multiple Disadvantage (SMD).

> ***"Making Every Contact Count. People citizen, system, comments. Tick off at least one Aim per contact."***

Providing quality, person-centred, joined-up care was identified as a key priority in discussions. There were many pledges that committed to working in a positive person-centred way. Recognising that one size does not fit all and personalising prevention initiatives for a person-centred approach is crucial. Examples of local initiatives include the use of social prescribers and care navigators.

Leaders should collaborate with patients and caregivers to streamline services. This becomes increasingly vital as the number of individuals with multiple health conditions rises, and patients seek guidance and assistance from various healthcare teams. A need for streamlined services and meaningful outcomes were highlighted. Others emphasised the need to think holistically and link various elements through system, place, locality, and individuals.

> ***"I pledge to work with others to ensure everyone receives great quality, personal care"***

Health and social care delivery should be customised to meet the mental, physical, and social requirements of diverse communities, guided by the insights and preferences individuals hold regarding their own care. The significance of personalised care is gaining recognition, such as through the utilisation of personal health budgets in both healthcare and social services, as well as providing choices regarding the location and manner of treatment when appropriate. Shared decision-making between patients and their healthcare teams is expanding rapidly. Transforming these opportunities into reality necessitates a shift in the culture and practices within the NHS.

A reduction in the need for patients to repeat their stories, providing a named person to lead their health and care journey, and ensuring care is tailored to individual needs and resources would be beneficial. Comments were also made on the importance of a "no wrong door approach", including the need for open referral processes and removing unnecessary eligibility criteria.

Solutions and suggestions for person-centred care included:

- Address digital exclusion by considering the diverse technological needs and preferences of different population groups.
- Optimise the use of time in engagement and appointments, follow-up visits, and communication with patients to ensure quality care and build trust.
- Implementing a person-centred approach to healthcare to ensure tailored and responsive care.
- Enable a streamlined referral process thereby removing barriers to accessing services.
- Explore additional roles to support patients, recognising that the patient knows best.

5.8 Workforce Development as a System

Workforce development and integration of services are essential for addressing recruitment challenges, supporting healthcare professionals, reducing workloads, and promoting collaboration between primary and secondary care. System leadership plays a crucial role in driving integration efforts.

Delegates acknowledged the potential challenges and the need for consistency, funding, and support for the workforce. It was highlighted how important it is to encourage work beyond organisational and geographical boundaries to foster collaboration, enhance service delivery and join up the workforce.

Many of the barriers mentioned in the Assembly discussions focused on the challenge of not having enough staff. A need for improved staff retention strategies was stressed. Others also highlighted the complexity of the system and how the hierarchical organisational structures in the health and social care sectors can result in obstacles to development.

"Listen to experience of communities and staff"

Suggestions to further develop the ICS aim of 'Support broader social and economic development' ensuring that wages are appropriate, maximising the NHS as an employer by promoting health and social care education as an attractive pathway into working in the sector, also via apprenticeship and NHS funded schemes and providing employment opportunities for refugee and asylum seekers. Another similar suggestion was around establishing staff schemes that support the local economy. Some flagged that a move into communities and away from acute care would help progress this aim.

The integration of services was flagged as a way that recruitment issues and workforce support could be addressed. It was suggested as a solution to the need to recruit and support healthcare professionals, reduce workload, and ensure collaboration between primary and secondary care. The support of system leaders would be vital in order to progress this.

"Be forward thinking and improve innovation, not just focus on the short-term operational pressures."

Solutions and suggestions for workforce development included:

- Promote workforce integration across different services. System leaders should champion and support this integration.
- Promote health and care jobs as an attractive career path with competitive wages, investment in leadership training and development opportunities.
- Provide opportunities for refugees and asylum seekers in healthcare.
- Boost Staff Retention: Develop strategies to retain healthcare professionals by enhancing job satisfaction, reducing burnout, and offering career growth opportunities.
- Simplify hierarchical structures.

5.9 Utilising Existing Knowledge and Learning:

Leveraging existing knowledge, data sources, and best practices is essential for healthcare improvement. Learning from other healthcare systems and adopting successful approaches are vital.

The NHS can gain valuable insights by learning from other sectors that are leading in their interactions with clients and more importance should be placed on patient experience and results, rather than solely focusing on the quantity and timeliness of treatment provided.

"To actively listen to connect common themes - to showcase progress and highlight challenges persistently"

Many Assembly discussions were on the topic of utilising existing knowledge to avoid duplication, identify and target priority areas as well as focus on outcomes and understand the impact of interventions. For example, using NHS and JSNA (Joint Strategic Needs Assessment) data to identify trends and plan interventions. Suggestions included learning from areas of best practice and working with research colleagues to understand the impact of the voluntary sector. Pledges were made around awareness of current progress and what is working well. Community-based organisations were flagged as a helpful resource as they can capture what is happening on the ground.

"Playing a bigger role in challenging existing funding structures where it might not be working"

Solutions and suggestions for utilising existing knowledge and learning included:

- Utilise existing research, data, and evidence to fill knowledge gaps, inform decision-making, and identify areas for improvement.
- Address digital exclusion by considering the diverse technological needs and preferences of different population groups.

6 VCSE Alliance

6.1 VCSE Alliance – Frailty Deep Dive

The Nottingham and Nottinghamshire Voluntary, Community and Social Enterprise (VCSE) Alliance
The Nottingham and Nottinghamshire VCSE Alliance is a group of VCSE organisations across Nottingham and Nottinghamshire that can act as a single point of contact to enable the generation of citizen intelligence from the groups and communities that they work with. Nottingham and Nottinghamshire VCSE Alliance is made up of: • Local representatives of national and regional VCSE organisations working countywide to provide services to citizens. • A collective of the Community and Voluntary Services (CVSs) and other infrastructure organisations. A full list of member organisations is available here.

The VCSE Alliance has led on a co-designed framework for gathering citizen intelligence and insight. The framework will help us understand and theme the information that VCSE organisations hold, allowing us to explore the trends in our population and help highlight the gaps in service and how to resolve them. A Framework Subgroup came together to focus on a clinical priority and understand the intelligence held by VCSE Alliance members. Frailty was chosen as the first focus.

Frailty
NHS England[36] defines frailty as a loss of resilience that means people don't recover quickly after a physical or mental illness, an accident or other stressful event. Frailty often occurs in older people who are at highest risk of falls, disability, admission to hospital, or the need for long term care.

The NHS report, The NHS in England at 75: priorities for the future[37] highlights the importance of a substantial change in how we approach and respond to the ongoing increase in chronic illnesses and frailty. According to The Health Foundation's analysis[38], if we continue with the current care models, it is projected that by 2030/31, there will likely be a need for an additional 20,000 to 40,000 hospital beds to accommodate the rising cases of frailty and chronic illnesses.

We know that having timely, relevant, transparent, and high-quality data is vital for enhancing, innovating, and ensuring accountability in healthcare. The Hewitt Review[39] highlighted the significant role of NHS England in cooperation with the DHSC, local government and other relevant stakeholders in local government, in establishing data standards to coordinate data sharing across the healthcare system, paving the way for more extensive improvements in healthcare delivery. The Hewitt Review also says how crucial it is to acknowledge that a significant proportion of people accessing health and social care face substantial barriers to utilising digital solutions.

[36] NHS England » Frailty – what it means and how to keep well over the winter months
[37] The-NHS-in-England-at-75-priorities-for-the-future.pdf (longtermplan.nhs.uk)
[38] How many hospital beds will the NHS need over the coming decade? - The Health Foundation
[39] The Hewitt Review: an independent review of integrated care systems (publishing.service.gov.uk)

It has been evidenced that long term conditions tend to cluster in those aged over 65, for example in a study on multimorbidity[40] only 5.3% of people older than 65 years with dementia have only dementia, therefore almost everybody with dementia has multiple other conditions and it makes sense to care for the person as a whole rather than a series of standalone conditions.

Figure 7 highlights the key points described in the System Analytics Intelligence Unit's (SAIU) Population Health Management Deep Dive Report Into Ageing Well[41]. The electronic frailty index (eFI) is a calculation to identify the population aged 65 and over who may be living with varying degrees of frailty. It considers clinical signs, symptoms, diseases, disabilities and abnormal test values. eFI is used to stratify the population aged 65 and over into four groups: Fit - Mild frailty - Moderate frailty - Severe frailty.

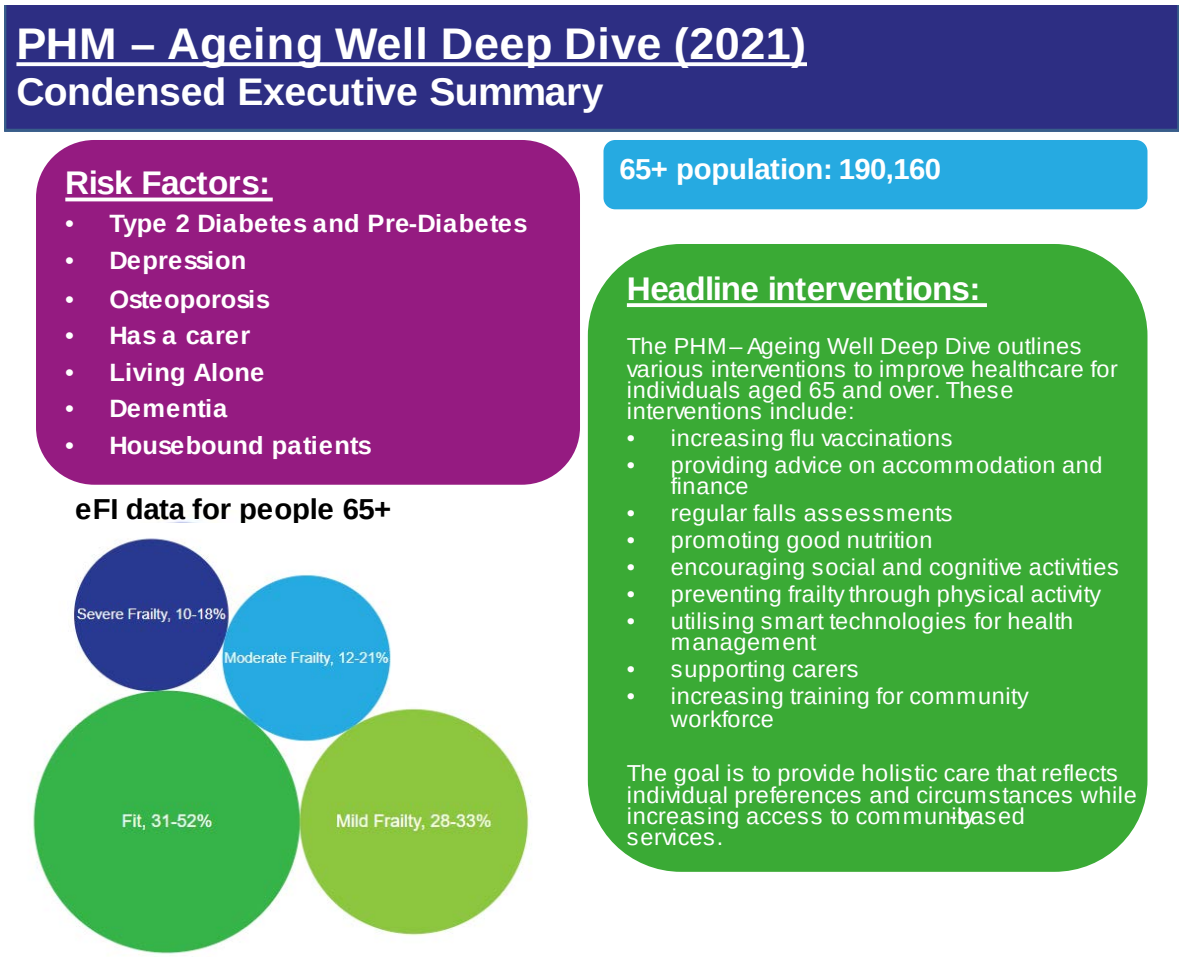


Figure 7 Population Health Management – Ageing Well Deep Dive, condensed executive summary.

The Subgroup used this report to develop ten questions to ask VCSE Alliance members. Some of the key themes and recommendations included:

[40] Bruce Guthrie et al, *BMJ* 2012;345:e6341

[41] Nottingham & Nottinghamshire ICS - System Analytics Intelligence Portal - PHM Ageing Well Deep Dive- April 2021.pdf (sharepoint.com)

- Increasing support for older people involves applying multi-agency working, providing referrals to social prescribers, promoting support groups and improving access to financial advice and mental health support.
- Addressing transportation issues in rural areas is crucial, including support for community transport schemes and improving access to emergency medical services.
- Increasing awareness and access to services through information campaigns and community outreach.
- Implementing strategies to prevent falls and injuries among the elderly including promoting mobility programmes and facilitating multi-agency referrals.
- Utilising technology can greatly improve access to healthcare and social care, requiring support and education for digital literacy is key.
- Adapting local healthcare systems, supporting carers, addressing social isolation, and innovative dementia care are all flagged.

6.2 VCSE Alliance – Frailty Survey Responses

Alliance members highlight restricted access to essential services, worsened by COVID-19. They call for awareness campaigns and community outreach to help isolated individuals, especially the elderly, with multiple conditions. Community groups, volunteering and supported living complexes are seen as a solution for isolated older individuals.

A multi-agency approach involving charities, voluntary groups, and statutory agencies is crucial to reduce isolation and hospitalisation. Economic challenges and limited access to healthy food require support and promotion of affordable alternatives. Long-term conditions often coexist in older individuals, necessitating holistic care.

Community-based support services can alleviate strain on healthcare services. Carers need respite and support, particularly for mental health. Transportation issues persist, requiring better access to emergency services.

Supportive services like health walks, technology, and education are essential for maintaining mobility and digital literacy. Normalising mental health support is crucial for older individuals, especially in rural areas.

High-quality data sharing is vital for healthcare improvement. Digital solutions should consider the needs of vulnerable individuals.

The VCSE sector can support older individuals through transportation, befriending services, and technology. Education for healthcare professionals is necessary for dementia care. Addressing various aspects of dementia care and involving the community in health checks are important.

In summary, addressing the challenges faced by older individuals requires a comprehensive, multi-agency approach with a strong focus on the VCSE sector, including awareness campaigns, support services, digital solutions, and community involvement.

6.3 VCSE Alliance – Recommendations

The recommendations from the VCSE Alliance survey are set out below:

Combatting loneliness and Isolation	Falls Prevention and Mobility	Technology and Healthcare Integration	Supporting Carers

• Raise awareness of available support services. • Improve digital skills for online access. • Promote services for different communities. • Establish social interaction initiatives.	• Conduct home assessments for falls risk. • Establish clear referral pathways. • Promote falls prevention education. • Encourage use of available assistive technology.	• Offer technology education for older individuals. • Implement online appointments and records. • Streamline welfare benefits processes. • Improve connections with mental health providers.	• Recognise and support caregivers' needs. • Provide respite opportunities. • Support young carers with flexibility. • Reduce caregiving costs.
Preventative Healthcare	**Enhancing Transportation and Accessibility**	**Post-Discharge Support**	**Dementia Awareness and Safety**
• Increase resources for preventive measures. • Invest in early detection and diagnosis. • Promote healthy lifestyles and nutrition.	• Support community transport services. • Explore alternative transportation solutions. • Improve access and referral routes.	• Conduct home checks post-hospital discharge. • Support patients and families with reablement	• Ensure dementia support groups. • Provide safety equipment and education.

Whilst this work has been initiated and led by the VCSE Alliance, to support the triangulation of intelligence the ICB Engagement Team reached out to others within our ICS with an interest in Frailty and Proactive Care to gain their insight and strengthen the recommendations. This included the ICB Population Health Management Team, the ICS Ageing Well Team, Nottinghamshire County Council Falls and Reablement team, East Midlands Academic Health Science Network and ICB Research and Evidence Team.

The frailty insight will help to inform the Mid Nottinghamshire place plan and future work will be undertaken with the Ageing Well and Community Transformation teams in upcoming frailty projects.

7 Race Health Inequalities Summit

7.1 Background

On Thursday 11 May 2023, the first Nottingham City Place-Based Partnership (PBP) Race Health Inequalities Summit was held. The event was developed as part of the PBP Race Health Inequalities Group and a sub-steering group who, led by Nottingham Community and Voluntary Service (NCVS), brought together leaders from across Nottingham to discuss how race affects people's health outcomes, the healthcare they receive, and what steps we can take as a partnership to address these inequalities.

As well as hearing from a range of expert speakers, it was an opportunity for partners representing different organisations from the public and voluntary sectors to come together and make valuable new connections[42].

7.2 Aims

Race health inequality is a particular issue in Nottingham, with local data shining a light on how race can affect a patient's health outcomes.

The aim of the Summit provided an opportunity for partners to address some of these issues. The day had a particular focus on mental health and maternity care, where health inequalities are known to disproportionately impact people from minority communities.

7.3 Methods

The event was structured around presentations, a marketplace and round table discussions. The event would only be effective with a broad range of diverse voices in terms of ethnicity, experience, across the generations, community representation statutory services, commissioners and providers. This was achieved across the 200 people in attendance. The event was delivered across four key areas;

- Nottingham context
- Mental Health Deep Dive
- Launch of PBP Culturally Competent Organisation Maturity Matrix
- Maternity Deep Dive

7.4 Findings

This section summarises emerging themes from the discussions at The Race Health Inequalities Summit. The themes have been identified via thematic analysis of workshop discussion notes and even presentations. Analysis and desk research is continuing, so these initial findings may subsequently be amended.

The themes reflect the views of those attending the summit in relation to health inequalities; they have not been compared at this stage to previous findings, or data and findings from other areas of England.

7.5 Mental Health Deep Dive

Causes or drivers of race inequalities in mental health

Theme 1: System-level drivers

Mental health services are stretched, with reduced investment and closures of mental health services in the community. The wait times for children and young people is a significant issue. There is **rationing** in the form of waiting lists, penalising policies 'three strikes and you're out', and eligibility criteria. Whilst this affects everyone, there is a **disproportionate impact on minority ethnic communities**.

Fragmentation of services. Inconsistent referral pathways and a lack of coordination. Different wards in Nottingham have different services. Pathways into services are not clear. Whilst there is a need for other services to support the NHS and facilitate access, there are few community groups

[42] Nottingham makes history with the first Race Health Inequality Summit | SSBC (smallstepsbigchanges.org.uk)

involved in this. Moreover, attendees fed back that statutory sector professionals may not respect the expertise of community organisations. This has resulted in referrals coming from better off areas, rather than being driven by need.

Lack of data. Data is old, and if data is based on people who are using services, it won't help us understand those not accessing services. There is limited resource for the in-depth engagement needed to understand minority communities. At the same time, these communities experience consultation fatigue.

Theme 2: Service-level drivers of health inequalities

Organisational cultures are discriminatory. Staff within services lack cultural competence, and there is an underrepresentation of minority ethnic communities. Lack of knowledge and discriminatory attitudes amongst staff can result in people being judged or stereotyped, or mental health needs not being recognised because of their different presentation. Sometimes social circumstances can become the focus of an assessment, with the need for mental health support being overlooked.

Services can be culturally inappropriate or insensitive, deterring people from accessing them: for example, rules for residents (e.g. clothing) or food offered in hospitals may not be appropriate, and mental health service users may be unable to speak to someone of the same culture, or unable to access an interpreter.

Service design may be based on the needs and circumstances of dominant groups. Talking therapies (IAPT Improving Access to Psychological Therapies) focus on a white middle class.

Mental health workforces lack diversity. Mental health professions are white dominated and talent from minority communities is underused, which can affect access to services. There is a need for therapists from different backgrounds, yet the qualifications of migrants may not be recognised.

Theme 3: Community-level drivers of health inequalities

Language. There is a need for more interpreters. Interpreters can be involved too late in the process, can be from the same community, compromising privacy, or may be male, which can be inappropriate. Sometimes interpretation is poor quality or the family is interpreting. 'Form-based' processes are particularly hard for communities where English is a second language.

Isolation, economic disadvantage. Particularly if English is not their first language, people may not be aware of what help/services are available or have the know-how to access and navigate services. People may feel intimidated, anxious, or lack confidence when thinking about involving services; it was commented that the lower referral rates to post-natal services may be due to fear of social services involvement. Digital exclusion can also create barriers to accessing services. Economic disadvantage prevents people from taking part in activities that would support mental wellbeing.

Community attitudes and beliefs. Different communities' beliefs about mental health and how to address mental health problems, alongside other beliefs, such as those around gender, can contribute to people not accessing mental health services. Mental health may not be talked about by older generations and/or mental health needs may be stigmatised. For instance, there may be differences in the cultural acceptability of new mothers accessing mental health support. There may also be an expectation that mental health problems should be dealt with inside the community in the first instance, e.g. by a faith leader.

Household composition. Lifestyles can affect access to mental health support. For example, in an extended household, particularly if family dynamics are part of the issue for a person, accessing support online may be a barrier.

Theme 4: Enablers of change/actions

Using lived experience to support services to develop and change and to raise awareness amongst decision-makers and commissioners. Involving more members of minority communities in services.

Helping communities think differently about mental health. Using different language with communities, to support discussions about mental health. Adopting a listening approach. Be available and be visible e.g. wellbeing hubs. Leaflets in languages to help awareness, increasing outreach into communities.

Making information accessible: access to interpreters, access to the Internet at libraries, targeted literature.

Co-production with communities. There is a good example of how a domestic abuse programme for Muslim women was designed by Muslim women. Train people from communities to work in the local health system. Community champions to pair up with ICB coproduction and engagement teams.

Developing the mental health workforce. Training professionals and enabling them to learn from communities and people with lived experience. Changing attitudes towards community organisations. Recruiting people from minority communities.

Identifying how to make early help accessible and investing in prevention for communities. Could people in communities such as teachers be trained to be able to link people to help? Some schools already have mental health programmes. Relationships are key: Community Champions started out encountering mistrust, but then recruited volunteers and built stronger connections with diverse communities and were proactive in looking for gaps.

Be accountable and be realistic, managing expectations.

7.6 Maternity Deep Dive

Maternal mortality rates are higher among BME women than white women in the UK, with black women nearly 4x more likely to die during pregnancy or childbirth than white women. Moreover, families who are at higher risk of poor outcomes or who had a poor outcome at NUH are underrepresented in inquiry referrals (the Independent Maternity Review Inquiry).

Causes or drivers of race inequalities in maternity health

Theme 1: The service system/organisational factors

Underfunded and reduced services. The reduction in funding is having an impact on pregnant women, families, and the workforce. The NHS is in survival mode, leading to lack of care. As with mental health, whilst this impacts everyone, it means that marginalised groups get even less care.

Lack of data and insight. It was commented that BME women do not complain in situations where more white women do. There is a lack of awareness of the inequalities; a summit attendee had commented that the statistics were ‘astonishing’.

Organisational cultures. There is a problem with the attitudes of some clinical staff. There is a lack of training and awareness, with some not believing that racism is a problem/that there is a need for change. One summit attendee commented that attitudes change when English is not the spoken language.

Unrepresentative workforce. The backgrounds of GPs and other doctors do not reflect the population There is a lack of diversity in the maternity workforce, including amongst midwives. There is a problem with the recruitment and retention of midwives, and hence there are not enough ethnic community representative midwives to influence the cultural competence of their peers.

Theme 2: Communities and structural inequality

Wider determinants of health (social, economic and environmental inequalities) experienced by minority communities in Nottingham. Summit attendees discussed the fact that unequal maternity health outcomes are driven by wider issues than maternity care, and involves issues of class and social inequality, with poor public health and deprivation. This puts women from minority communities at risk both prior to giving birth and post birth. 'Maternity care is not going to fix this in a nine-month period.'

For example, women may have pre-existing factors such as unmet mental health needs. Air pollution is the largest environmental threat to public health with the most deprived communities in the UK experiencing the worst air quality. There is evidence for racial inequalities in exposure to air pollution in the UK.

Theme 3: Communities: socio-cultural factors

Language and knowledge of services. Eight per cent of households in Nottingham speak no English. There is a lack of understanding of health services and a mistrust; for example, there may not be understanding of healthcare practices e.g. Weighing babies.

Lack of health information and lack of appropriate health information. There is a need for maternity education for girls and women, as some cultures do not talk about this topic. Some language and attitudes on health information is not appropriate and discriminatory. One person commented that language on a flyer said, 'when things go wrong', noting that her child had not 'gone wrong', he had a disability.

Theme 4: Enablers of change/actions

Linking communities to services and helping people navigate services. Make services easier to navigate by bringing services together and coordinating them, providing an updated directory of services, and using the VCS to educate clients on services and signpost people both to services and to where they can get support when they have had poor experiences. There need to be more community spaces for parents and families to access support services. Use community volunteers and VCS organisations to act as a conduit between maternity services and families.

Supporting advocacy. Charities and groups who advocate for women, e.g. attending appointments, need to be resourced.

Provide a service environment that enables co-production, including commissioning that reduces barriers. This will require services to be accessible to communities including facilities. Reach out to communities; don't expect them to come to you. Learn from small organisations and VCS organisations. Engage communities and involve them in decision-making. Recognise the contributions of volunteers and incentivise/compensate participation.

Make maternal health inequalities a strategic priority across the local system. It was commented that there are no government targets on this issue, that grassroots organisations are trying to make change but there is no leadership from the top. Consider having Nottinghamshire-wide priorities that all organisations contribute to. Promote opportunities for organisations to work together on initiatives.

Workforce development: improve recruitment and retention, training, and career development.

- Recruitment needs to reflect the population, so there is a need to connect with local people. Access to nursing and midwifery training needs to be made truly accessible e.g. making bursaries available and carrying out a recruitment drive.

- There is a need for diversity at all levels of organisations to ensure that there is diversity amongst decision-makers. There should be leadership development opportunities to help people from ethnic communities into these positions.
- Cultural competency should be at the heart of midwife training. There is a need for cultural awareness training.

Data and insight. As with mental health inequalities, there is a need for more qualitative data and research on the needs and priorities of communities. This includes forums enabling people's voices to be heard directly, in order to avoid 'middlemen translating stories'.

Action needs to be wider than addressing this as an issue within services. 'Maternity care cannot be improved just by maternity improving things for BME populations.'

8 Cost of living crisis

As the expenses associated with essential goods and services continue to rise, many households are encountering severe financial strain. This carries profound implications, not only for individual families but also for the broader socioeconomic landscape of the UK. In August 2023, over half (53%) of adults reported that their cost of living had increased compared with a month ago[43].

This section describes what we know about the impact of the cost of living crisis for citizens living in Nottingham and Nottinghamshire.

8.1 Climate Change and Ability to Act

The cost of living continues to impact on feelings about taking action to reduce climate change[44]. Two in five (41%) believe the economic costs of climate change will be greater than the measures to reduce it. However, over half say they are too worried about the cost of living to think about the impact of climate change (52%) or would like to do more to reduce climate change but cannot afford to (51%). Only 3 in 10 (29%) say they often find sustainable lifestyle choices cheaper.

8.2 Housing

Half of renters/mortgage holders have seen their rent/mortgage payments increase in the last three months[45]. This is up from a third (33%) in January. Just under half (45%) say their payments have stayed the same, while just 2% say they have decreased. The Office for National Statistics (ONS) analysis[46] found that around a third (35%) of adults reported it was difficult (very or somewhat) to afford their rent or mortgage payments, compared to 29% in August 2022. This proportion appeared higher among groups including; those receiving support from charities (57%), living in a household with one adult and at least one child (47%), receiving some form of benefits or financial support (45%), Asian or Asian British adults (53%), Black, African, Caribbean or Black British adults (47%), renters (43%) and disabled adults (41%). 43% of renters reported that it was difficult to afford their rent payments, and 28% of mortgage holders reported it was difficult to afford their mortgage payments.

[43] Public opinions and social trends, Great Britain - Office for National Statistics
[44] Britons concerned about climate change, but cost of living is a barrier to action | Ipsos
[45] Half of renters/mortgage holders have seen their housing payments increase in the last 3 months | Ipsos
[46] Impact of increased cost of living on adults across Great Britain - Office for National Statistics (ons.gov.uk)

8.3 Food Insecurity

According to Trussell Trust[47], 4% of all UK adults (or their households) have experienced food insecurity in the 12 months to mid-2022. The research highlights the main driver as a lack of money. There are specific communities that are more likely to be experiencing food poverty:

- More than half of households experiencing food insecurity, and three quarters of people referred to food banks in the Trussell Trust network say that they or a member of their household are disabled.
- Working-age adults are much more likely to need to turn to a food bank than pensioners. This is particularly the case for single adults living alone and those not currently in paid work.
- Families with children are at a high risk of food insecurity. Nearly half (47%) of all households experiencing food insecurity include children under the age of 16.
- People from ethnic minority groups, women, people who are LGBTQ+, people who have sought or ever applied for asylum, and people who were in care as a child, are all overrepresented in the proportion of the population experiencing food insecurity and receiving food aid. While around 7% of the UK population were supported by charitable food support, including food banks, most people facing hunger (71%) had not yet accessed any form of charitable food support.

Furthermore, paid work does not always protect people from having to use food banks. One in five people using food banks in the Trussell Trust network are in a working household. Just under a third (30%) of people in work who have had to use a food bank, are in insecure work such as zero hours contracts or agency work.

In July 2023, ONS reported that around 1 in 20 (5%) of adults reported that in the past two weeks they had ran out of food and had been unable to afford more, this proportion appeared higher among groups including; those receiving support from charities (45%), living in a household with one adult and at least one child (28%), receiving some form of benefits or financial support (21%), Mixed or Multiple ethnicity adults (14%), Black, African, Caribbean or Black British adults (13%), renters (14%) and disabled adults (9%)[48]. These findings are consistent with the research conducted by the Trussell Trust.

8.4 Fuel Poverty

When asked about what people are doing because of the increases in the cost of living, 44% were using less fuel such as gas or electricity in their homes[49]. Using less gas and electricity in a home during the winter periods will increase the risk of damp and mould within accommodations which there pose a risk of respiratory illness and other diseases for the occupants.

At a system level, we used our data capability through a public health lens and looked at the measures we could use to map fuel poverty. They matched the fuel poverty areas, usually deprived areas, with people with long-term conditions. And then, the GPs, the voluntary sector, and the PCNs could target people at very high risk.

[47] 2023-The-Trussell-Trust-Hunger-in-the-UK-report-web-updated-10Aug23.pdf (trusselltrust.org)
[48] Impact of increased cost of living on adults across Great Britain - Office for National Statistics (ons.gov.uk)
[49] Impact of increased cost of living on adults across Great Britain - Office for National Statistics (ons.gov.uk)

This data was then supplied each place-based partnership with the data for their areas. And then they worked with their council colleagues. The schemes did vary slightly in different districts, depending on whether it was a district council[50].

8.5 Affording Medications

One significant impact of the increased cost of living crisis is people's ability to afford essential medications and prescriptions. An example was reported by Asthma + Lung UK[51] charity which found that many asthma patients are cutting back on using their inhalers to make them last longer, and this was to save on prescription charges.

8.6 Accessing Dental Services

On a national level, accessing NHS dental services is becoming very challenging, with about 90% of dental practice across the UK are not accepting new adult patients. In June 2022, Healthwatch Nottingham and Nottinghamshire published its report[52] about accessing NHS dentistry which showed the association between affordability and lack of accessibility. Of the 303 respondents, over half of them were unable to book an appointment, of them, 20% were offered private appointments by the practices but couldn't afford it. It is anticipated that the cost of living crisis will make accessing dental services more challenging, and feed into dental health inequalities between high and low income household.

8.7 Domestic Violence Against Women

Several resources have shown how the cost of living crisis is forcing survivors of domestic violence to stay in unsafe environment as they can't afford being alone. As found by Women's Aid[53], about 73% of domestic abuse survivors who are living with and having financial link with the abusers said that the cost of living crisis had either prevented them from leaving or made it harder to leave.

8.8 Cost of Transport to Access Healthcare

In an engagement activity conducted by Healthwatch Nottingham and Nottinghamshire, the patients of Wellspring Surgery in Nottingham have raised their concern around stopping the phlebotomy services in their GP practice and move the services to another location which requires the use of transportation. One of the main concerns was the inability to afford the cost of using transportation. As a result of this engagement, the recommendation[54] was accepted by the Integrated Care Board and patients now are being reimbursed for the cost to commute to phlebotomy services. This example shows how financial hardship, which has been worsen by the current cost of living crisis, could prevent people from attending different heath appointments and lead to significant health outcomes.

It is well evident that commuting to the healthcare services, like GP appointments, is already a struggle faced by many people for wide range of reasons like anxiety, suitability of the transport, accessibility and timing. In addition to that, cost and affordability have always been a struggle faced by people on low income which got worsen by the cost of living crisis. People reported how they are struggling financially and unable to pay for transportation to attend GP appointments and other services. They also reported that financial struggle is not being taken into consideration and

[50] Fuel Poverty Project - NHS Nottingham and Nottinghamshire ICS - NHS Nottingham and Nottinghamshire ICS (healthandcarenotts.co.uk)
[51] https://www.bmj.com/content/378/bmj.o2363
[52] https://hwnn.co.uk/wp-content/uploads/2022/07/Hot-Topic-Access-to-Dentists-Report-FINAL.pdf
[53] https://www.womensaid.org.uk/the-cost-of-living/
[54] https://hwnn.co.uk/wp-content/uploads/2023/08/HWNN-ANNUAL-REPORT-2023-FINAL-COPY.pdf

overlooked by the support providers, like social prescribers. Like other challenges to access the healthcare system, inability to afford transportation to health services will deteriorate individual's health and reduce the chances of preventing preventable diseases[55].

8.9 Impact on Students

Students are among different communities who are affected by the cost of living crisis. In June 2023, the University of Nottingham Student Union talked to 265 students about the impact of cost of living crisis on their academic and personal lives. The report found the cost of living crisis is impacting students areas of students' mental health and wellbeing, their physical health, their academic progress and their social life and relationships[56].

8.10 Employment Impacts

The UK job market is experiencing significant shifts and UK employees are adversely affected due to the cost of living crisis. A report from PricewaterhouseCoopers (PwC)[1] revealed that 47% of UK employees have little to no savings left at the end of each month, and a further 15% say they struggle to pay their bills every month.

In the UK, over one in ten workers (12%) hold multiple jobs, and a significant majority (70%) attribute this choice as a means to increase earnings. The cost of living crisis is also impacting wage expectations, with 34% of UK employees intending to request a salary increase in the coming year—an increase of 7% compared to 2022.

23% of workers planning to change jobs in the next year, marking a 5% increase from the previous year. Dissatisfaction with current jobs is also prevalent, with 21% expressing discontent, particularly regarding pay, workload, and overall job satisfaction. It is noted within the report that with economic uncertainty, employers are recommended to seek innovative ways to engage employees, as traditional pay increases may be limited. Organisations that prioritise employee well-being, flexible work arrangements, career advancement, and personalised benefits will foster loyalty and retain more staff[57].

8.11 Impact on VCSE Sector

Pro Bono Economics (PBE) is collaborating with the National VCSE Data and Insights Observatory, managed by Nottingham Business School within Nottingham Trent University, to examine the influence of the cost of living crisis on charitable organisations and community groups. Professor Daniel King, director of the National VCSE Data and Insights Observatory at Nottingham Business School and Chair of the Nottingham and Nottinghamshire VCSE Alliance has said "The cost-of-living crisis creates pressing challenges for many charities, as rising costs meet falling income and escalating demand."[58]

The cost of living crisis is putting strain on many individuals, making charitable support essential however, the study[59] emphasised the presence of a significant and expanding salary disparity among employees in the VCSE sector.

[55] 1741008_Stevenson.pdf (ntu.ac.uk)
[56] How the cost of living crisis is jeopardising the student experience for those most affected
[57] https://www.pwc.co.uk/press-room/press-releases/quarter-of-the-uk-workforce-expect-to-quit-in-the-next-12-months.html
[58] Major whole-sector survey set to capture impact of cost-of-living crisis on charities | Nottingham Trent University
[59] https://www.probonoeconomics.com/news/signs-of-increasing-optimism-among-charities-but-volunteer-concerns-grow

There are some positive economic signs, like falling energy prices and reduced economic inactivity, benefiting employers. In the charity sector, optimism is rising as more organisations expect to meet increasing demand, partly due to improved finances and easier staff recruitment. However, volunteer recruitment and retention are major concerns, impacting charities' ability to meet rising demand. Efforts to promote volunteering are crucial, as demonstrated by recent initiatives like the Big Help Out and the willingness of millions to volunteer. Converting these intentions into action is vital for the charity sector and the communities it serves.

9 Conclusions

The data and insights gathered from our Integrated Care System provide valuable information on the needs of our local citizens in Nottingham and Nottinghamshire, including our minority population. These insights indicate the alignment of our work and further embedding of the Integrated Care Strategy has the potential to meet the current capacity and demand effectively.

The gathered insights will provide key intelligence needed as we work towards refreshing our Strategy. They serve as an important resource that will guide us in making informed decisions to ensure the continued effectiveness and responsiveness of our ICS. We are committed to using this information to refine our approach and ensure that our healthcare services remain adaptable and inclusive, ultimately benefiting our community.

10 Next Steps

The Integrated Care Partnership are asked to consider the insight contained within this report and to support the findings in the further development of our Integrated Care Strategy. As part of Working with People and Communities Strategy we will work to develop an Insight Hub from all of our system partners across Nottingham and Nottinghamshire.

A further report will be provided to the Board within the next year collaboratively to provide further insight from our communities.

Prepared: September 2023

Meeting Title:	Integrated Care Partnership Board
Meeting Date:	06/10/2023
Paper Title:	**Integrated Care Strategy for Nottingham and Nottinghamshire 2023-2027: Review of Impact**
Paper Reference:	ICP 23 008
Report Author(s):	Joanna Cooper, Assistant Director of Strategy, NHS Nottingham and Nottinghamshire Integrated Care Board Vivienne Robbins, Deputy Director of Public Health, Nottinghamshire County Council Liz Pierce, Public Health Consultant, Nottingham City Council
Report Sponsor(s):	Lucy Dadge, Director of Integration, NHS Nottingham and Nottinghamshire Integrated Care Board Melanie Williams, Corporate Director for Adult Social Care and Health, Nottinghamshire County Council Catherine Underwood, Corporate Director for People Services, Nottingham City Council
Presenter(s):	Mark Wightman, Director of Strategy and Reconfiguration, NHS Nottingham and Nottinghamshire Integrated Care Board Lucy Hubber, Director of Public Health, Nottingham City Council Jonathan Gribbin, Director of Public Health, Nottinghamshire County Council
Recommendation(s):	The Integrated Care Partnership is asked to **note**: • The impact of the Integrated Care Strategy and the conditions for success that have been established and embedded. • How the Integrated Care Strategy will be delivered through the NHS Joint Forward Plan and the Joint Local Health and Wellbeing Strategies. • The updates on the work to develop healthy life expectancy targets and the work to understand and identify health inequalities within each specific metric. The Integrated Care Partnership is also asked to **discuss** and agree the proposed approach for a light touch review of the Integrated Care Strategy at the end of this first year.

Summary:

In line with guidance from the Department of Health and Social Care (DHSC), at its meeting on 13 March 2023, the Partnership approved Nottingham and Nottinghamshire's Integrated Care Strategy. Subsequent work has focussed on implementation and refining measures to monitor the impact of the strategy to assure the Partnership that the right conditions for success have been established and embedded.

This paper provides the Partnership with progress since the last meeting as well as outlining an approach to reviewing and refreshing the strategy by March 2024.

Appendices:

Appendix A provides a high-level timeline for further development of the Integrated Care Strategy.

How does this paper support the Integrated Care System's core aims to:	
Improve outcomes in population health and healthcare	The Integrated Care Strategy is fundamental to meeting the four core aims.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Report Previously Received By:
Integrated Care Strategy Steering Group.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Integrated Care Strategy for Nottingham and Nottinghamshire 2023-2027: Review of Impact

Introduction and context

1. In line with guidance from the Department of Health and Social Care (DHSC), at its meeting on 13 March 2023, the Integrated Care Partnership (ICP) approved the Nottingham and Nottinghamshire's Integrated Care Strategy. The strategy has been launched and can be found on the ICS website: https://healthandcarenotts.co.uk/wp-content/uploads/2021/05/Integrated-Care-Strategy-2023_27.pdf

2. Subsequent work has focussed on implementation and refining measures to monitor the impact of the strategy to assure the Partnership that the right conditions for success have been established and embedded. This paper provides the Partnership with a summary of progress since the last meeting; a more detailed update will be available in March 2024.

Delivering the Integrated Care Strategy

3. The Integrated Care Strategy is being delivered by the Nottingham City and Nottinghamshire County Health and Wellbeing Boards through the implementation of their joint local health and wellbeing strategies, and by NHS partners coalescing around the development and delivery of the NHS Joint Forward Plan.

4. For Nottingham City, the Health and Wellbeing Board has established arrangements for the delivery of its Health and Wellbeing Strategy (https://www.nottinghamcity.gov.uk/media/gd0fxokf/nottingham-city-joint-health-and-wellbeing-strategy-2022-25.pdf) to be coordinated through the Nottingham City Place Based Partnership, with the Health and Wellbeing Board retaining its oversight role. The Place Based Partnership has well developed programme plans for smoking and tobacco control; eating and moving for good health; and addressing severe multiple disadvantage[1] priorities, which are all on track in terms of delivery. A programme plan for delivery of the financial wellbeing priority is expected to be published ahead of the November meeting of the Health and Wellbeing Board. In July 2023, the Nottingham City Health and Wellbeing Board also endorsed a five year strategy on gambling related harm, with themes of regulation, knowledge and awareness, and support pathways.

[1] Severe Multiple Disadvantage (SMD) refers to people with two or more of the following issues: mental health issues, homelessness, offending and substance misuse. SMD can include other sources of disadvantage, for instance poor physical health, domestic/sexual abuse, community isolation, undiagnosed brain injuries, autism and learning disabilities.

5. For Nottinghamshire County, the Health and Wellbeing Board continues to deliver a range of workshops, Covid Impact Assessments, Joint Strategic Needs Assessments (JSNAs), and papers to support the evidence base and implementation of the Nottinghamshire Joint Health and Wellbeing Strategy (https://www.nottinghamshire.gov.uk/media/4350014/nottinghamshirejointhealthwellbeingstrategy2022-2026.pdf). A monthly Joint Health and Wellbeing Strategy Steering Group has been set up as an 'engine room' to support joined up delivery across the three Place Based Partnerships (Bassetlaw, Mid-Nottinghamshire and South Nottinghamshire), and other partner organisations. The Health and Wellbeing Board also now utilises a Joint Health and Wellbeing Strategy outcomes dashboard to inform its work and this approach will continue to evolve over the next year. During this financial year, Nottinghamshire County Council has allocated an additional circa. £1 million of in-year funding from public health grant reserves to strengthen impact within a range of programmes that will contribute to delivery of the Joint Health and Wellbeing Strategy. These include increasing support for those with the greatest need (e.g. those experiencing SMD and those who are homeless), weight management, community support through Community Friendly Nottinghamshire, alcohol use, and tobacco. The Health and Wellbeing Board will commence a review in the Autumn/Winter to consider how it can increase its effectiveness in improving health and wellbeing and reducing health inequalities.

6. The Nottingham and Nottinghamshire Smoking and Tobacco Control Alliance has launched a smoking and tobacco control vision document and delivery plan, which can be found here: https://www.mynottinghamnews.co.uk/wp-content/uploads/2023/05/43.114-Smoking-and-Tobacco-Control-Vision.pdf. Tobacco control is a priority for both the Nottingham City and Nottinghamshire County Health and Wellbeing Boards and the vision document sets out a collective ambition to see smoking among adults in Nottingham and Nottinghamshire reduced to 5% or lower by 2035 and support progress to a smoke free generation. A number of task and finish groups will develop and deliver priority actions in the areas of smoking cessation; illicit tobacco; smokefree environments; and prevention for children and young people.

7. On 13 July, the Integrated Care Board approved the initial NHS Joint Forward Plan, which can be found here: https://healthandcarenotts.co.uk/wp-content/uploads/2021/05/J15562-Joint-Forward-Plan_v6-090823.pdf. The Joint Forward Plan for the local NHS sets out the five-year response to the Integrated Care Strategy as well as how the NHS Mandate will be delivered. As part of its development, the Joint Forward Plan was considered by the Nottingham City and Nottinghamshire County Health and Wellbeing Boards and both confirmed that the plan will contribute to the delivery of their Health and Wellbeing Strategies. Currently, work is underway with NHS partners to confirm the delivery and oversight mechanisms for the lifetime of the plan, and from March 2024, the plan will be reviewed and refreshed on an annual basis.

8. During 2023/24, the Integrated Care Board agreed a £4.5 million Health Inequalities and Innovation Fund (HIIF) to invest further in prevention and inequalities. This investment will grow year on year during the five-year period of the Joint Forward Plan. An initial nine schemes have been approved which are aligned to the priority areas of SMD and alcohol dependency, children and young people and best start in life, and integrated community working.

Impact of the Integrated Care Strategy

9. The Integrated Care Strategy Steering Group continues to meet monthly to oversee delivery of the strategy. Key areas of progress made in the first six months since the Integrated Care Strategy was approved include:

    a) Supporting children and young people to have the best start in life with their health, development, education and preparation for adulthood. A recent OFSTED inspection of children's services found that Nottingham City Council continues to make good progress against an action plan to improve its Children's Services department.

    b) Supporting frail and/or older people with underlying conditions to stay well, remain independent and avoid unnecessary admissions to hospital in the short term. Partners are working together to jointly develop the same day emergency care pathway to prevent hospital admissions and keep people at home.

    c) Ensuring that all health and care staff understand the building blocks of health and health inequalities, work is underway in Adult Social Care in Nottingham City Council and Nottinghamshire County Council to embed strengths based conversations and championing preventive approaches for citizens. This will help staff to find out what is important to people accessing services and identify what support they feel they need to make positive changes in their life. Initial discussions are taking place to consider how Making Every Contact Count (MECC), personalisation and strength based approaches can be coordinated across the Partnership to improve outcomes for adult social care service users.

    d) Establishing clinical priorities for the next 24 months to support children, young people and adults with the greatest needs. The clinical priorities include COPD; Stroke; Heart Failure; Cancer; Dementia; Delirium and Confusion; Pneumonia; Cellulitis; Sepsis; Falls and injuries; MSK; Maternity; CYP; Mental Health. Each will be supported by a Population Health Management approach that includes detailed analysis and an in depth review with recommendations approved through different levels of clinical leadership. Improvements in care quality, effectiveness and clinical outcomes for local people will be tracked as this work progresses.

e) Focusing and investing in prevention priorities such as a new Integrated Wellbeing Service. The service has been developed to support Nottingham's citizens to receive personalised help to live healthier lives and support people living with SMD.

f) The Partnership being selected as a Scaling People Services Vanguard for the Midlands, attracting external funding to the system. This will support the partnership to test and develop a single health and care recruitment hub to better support our staff and teams.

g) The review of the Better Care Fund (BCF) being completed. The output will inform commissioning decisions and has identified potential areas to scale up collaborative commissioning including prevention, urgent care, mental health and Children and Young People.

h) Adding social value as major institutions in our area. The Partnership has been chosen as one of ten NHS England Pathfinders for Care Leavers. A project is underway to support 250 young people into work by January 2024.

10. A more detailed update, mapped to the Integrated Care Strategy's 14 priorities, will be presented to the Partnership at its March 2024 meeting.

Healthy Life Expectancy Targets

11. At the time of approving the Nottingham and Nottinghamshire Integrated Care Strategy, the Partnership agreed that the system Healthy Life Expectancy and Life Expectancy targets should be revisited and refreshed. The Partnership remain committed to progressing this work.

12. Work has been undertaken to consider what measures could be used. Reliable measures of healthy life expectancy are currently only available for upper-tier local authorities, regional or national geographies. Local Authority Public Health colleagues and ICB System Analytics and Intelligence Unit (SAIU) colleagues are working together to develop and test alternative measures, derived from data held by the SAIU. One possible version is based on the Cambridge Multimorbidity Score, as used in recent work by the Health Foundation (Health in 2040: projected patterns of illness in England - The Health Foundation) but several possible options will be tested. All of these will be available for small populations (at Primary Care Network level or smaller) and will be disaggregated by ethnicity, deprivation, sex and other characteristics where possible.

13. Early results are anticipated by December 2023 to support Partnership discussions on setting the level of ambition for healthy life expectancy.

Refresh of the Strategy for March 2024

14. DHSC guidance requires that whenever the Partnership receives a new JSNA from a Health and Wellbeing Board, the Partnership must consider whether the Integrated Care Strategy needs to be revised. Due to the number and rolling timing of JSNAs completed across the system it is advised instead to align the review to the timescales for the annual refresh of the NHS Joint Forward Plan.

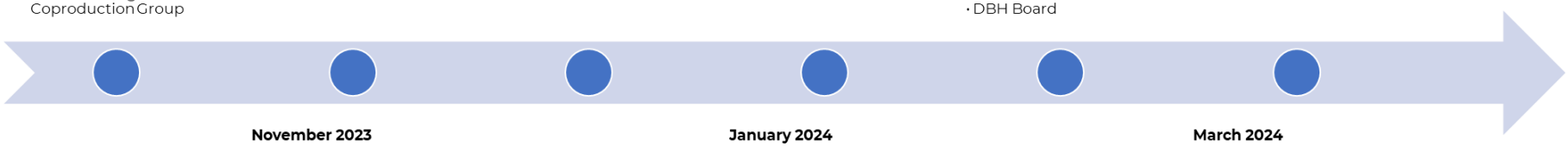
15. The Partnership also needs to consider any changes in their wider context including new or changed policies or guidance and be transparent and inclusive about the timing of the refresh and the opportunities to be involved.

16. It is proposed therefore that at the end of this first year of the strategy, the Partnership review and reconfirm the strategy at their March 2024 meeting. To guide this review, the Partnership are asked to consider a period of engaging with statutory partners and key system groups, a high-level timeline is proposed in Appendix A.

Appendix A High-level timeline for the review of the Integrated Care Strategy for March 2024

Integrated Care Strategy Review March 2024 - High Level Timeline

Integrated Care System
Nottingham & Nottinghamshire



October 2023
- 6 Oct ICP meeting
- 19 Oct Integrated Care Strategy Steering Group
- 24 Oct ICS Partners Assembly
- 25 Oct Strategic Coproduction Group

November 2023
- **Annual review of the Integrated Care Strategy and Equality Impact Assessment (EQIA) to commence**
- 9 Nov System Planning Group
- 16 Nov Integrated Care Strategy Steering Group
- 23 Nov System Planning Group
- 23 Nov Citizen Intelligence Advisory Group
- Strategic Coproduction Group

December 2023
- 5 Dec VCSE Alliance
- 7 Dec ICB Strategic Planning and Integration (SPI) Committee
- 7 Dec System Planning Group
- 21 Dec System Planning Group
- 21 Dec Integrated Care Strategy Steering Group
- Strategic Coproduction Group

January 2024
- **Strategy review being considered by statutory partners**
- 4 Jan System Planning Group
- EQIA Consultation panel
- 18 Jan System Planning Group
- 24 Jan City HWB
- 25 Jan Integrated Care Strategy Steering Group
- 25 Jan NHT Board
- 26 Jan NUH Board

February 2024
- EQIA sign off panel
- 1 Feb ICB SPI Committee
- 1 Feb System Planning Group
- 6 Feb EMAS Board
- 7 Feb County HWB
- 15 Feb System Planning Group
- 22 Feb Integrated Care Strategy Steering Group
- 29 Feb System Planning Group
- SFH Board
- DBH Board

March 2024
- **1 March deadline for final input into strategy review**
- 14 March ICB Board
- **22 March ICP meeting to review and reconfirm the system strategy**

Meeting Title:	Integrated Care Partnership
Meeting Date:	06/10/2023
Paper Title:	**Developing a Population Health Management (PHM) Outcomes Framework**
Paper Reference:	ICP 23 009
Report Author:	Maria Principe, SAIU Director, NHS Nottingham and Nottinghamshire ICB
Report Sponsor:	Dr Dave Briggs, Medical Director, NHS Nottingham and Nottinghamshire ICB
Presenter:	Maria Principe, SAIU Director, NHS Nottingham and Nottinghamshire ICB
Recommendation(s):	The Integrated Care Partnership is asked to **note** the progress in developing a Population Health Management (PHM) Outcomes Framework.

Summary:

This report details the progress of the integrated approach to Population Health Management (PHM) Outcomes Monitoring.

In stage one, which focused on metrics definition and dashboard integration, we successfully defined key metrics for phase one in collaboration with public health experts, which include reduction in avoidable mortality, increase in life expectancy, emergency admissions, and prevalence of long-term conditions. A strategic outcomes dashboard has been integrated and made available on SharePoint.

Challenges include the need for defined outcome targets. Stakeholder engagement remains strong with an outcomes technical group established. Our achievements in stage one emphasises our dedication to an integrated PHM monitoring approach, aiming for services that are safe, effective, and equitable.

To maintain this momentum, our proposals include continuous framework evaluation, further expert group consultations, and transparent collaboration. Upcoming steps encompass finalising metrics, data source integration, and launching the final dashboard by March 2024.

How does this paper support the Integrated Care System's core aims to:	
Improve outcomes in population health and healthcare	The integrated approach to Population Health Management (PHM) emphasises key health metrics like reducing avoidable mortality and increasing life expectancy. With the strategic dashboard on SharePoint, stakeholders can make data-driven decisions swiftly. This initiative, supported by strong stakeholder engagement and continuous evaluation, aims to enhance both population health outcomes and the overall quality of healthcare services, ensuring a comprehensive and fair health system
Tackle inequalities in outcomes, experience, and access	The paper highlights the need to address health inequalities in outcomes, experiences, and access. Using an integrated Population Health Management approach, it

How does this paper support the Integrated Care System's core aims to:	
	advocates for tracking critical metrics via a SharePoint dashboard. With robust stakeholder engagement and data-driven strategies, the goal is to ensure consistent, high-quality care and equitable health outcomes for all.
Enhance productivity and value for money	The paper presents an integrated Population Health Management approach as a means to optimize healthcare outcomes. By utilising a data-driven SharePoint dashboard and fostering stakeholder engagement, it suggests that healthcare systems can achieve greater productivity and ensure better value for investment, ultimately delivering more effective and cost-efficient care.
Help the NHS support broader social and economic development	As above.

Appendices:
A: Screen shots of the developing PHM Outcomes Dashboard

Report Previously Received By:
This work was agreed by the integrated Care Partnership at its March 2023 meeting. Subsequent reports have been considered by NHS Nottingham and Nottinghamshire's Integrated Care Board in May and September 2023.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Developing a Population Health Management (PHM) Outcomes Framework

Introduction

1. At the time of approving the Integrated Care Strategy, the Integrated Care Partnership endorsed a proposal to establish a collaborative virtual intelligence system across the Integrated Care system (ICS) to enable a Population Health Management (PHM) Outcomes Framework to be developed.

2. This report provides an update on the progress of the integrated approach to Population Health Management (PHM) Outcomes Monitoring. Outcomes monitoring within our local system is vital in order to provide an objective measure of the quality of health and care provided to patients and citizens. Outcomes can range from patient satisfaction to clinical outcomes such as mortality rates, readmission rates, and complication rates. By measuring outcomes, we can identify areas for improvement, make evidence-based decisions, and ensure that resources are being used effectively, meeting the needs of our diverse population. In the pursuit of delivering services that are not only safe and effective but also equitable, our system remains committed to continually assessing and improving its performance.

3. In collaboration with key partners, NHS Nottingham and Nottinghamshire Integrated Care Board's (ICB) System Analytics and Intelligence Unit (SAIU) is championing a robust programme aimed at delivering a population health outcomes monitoring dashboard that is meticulously crafted around an exhaustive array of metrics. These metrics harness local, patient-specific population data.

4. This programme of work is expected to span three years, with an interim dashboard set to be launched by March 2024. The methodology incorporates segmentation[1] and stratification[2] tools to decode the intricacies of the local population. This, in turn, facilitates the deployment of effective primary, secondary, and tertiary prevention interventions, ultimately improving outcomes.

The current ICS Outcomes Framework

5. The current Nottingham and Nottinghamshire Outcomes Framework is a set of indicators that were developed to measure the effectiveness of local public services and help improve the quality of life for people living in Nottingham and

[1] Segmentation involves grouping the population into cohorts of people with similar relevant characteristics, e.g. age, the presence of long-term medical conditions, social factors.
[2] Stratification groups the population, based on complexity of different risk factors and/or increased risk of poor outcomes and/or the amount of resource required to achieve the best outcomes, e.g. older people with mild, moderate or severe frailty.

Nottinghamshire. It was co-produced in 2019 and was designed to provide a comprehensive view of the health and wellbeing of local communities and includes a range of indicators covering areas such as physical health, mental health, education, employment, crime, and the environment.

6. Some of the key points of the framework include:

   a) Improving health and wellbeing: The framework aims to improve health and wellbeing outcomes for local people by focusing on key areas such as reducing health inequalities, promoting healthy lifestyles, and improving access to healthcare services.

   b) Tackling poverty and deprivation: The framework recognises the link between poverty and poor health outcomes and seeks to reduce poverty and deprivation in the local area by improving education and employment opportunities, increasing access to affordable housing, and providing support for vulnerable groups.

   c) Improving education and skills: The framework aims to improve educational attainment and skills levels among local people, particularly in areas of social deprivation.

   d) Reducing crime and antisocial behaviour: The framework includes indicators related to crime and antisocial behaviour and seeks to reduce these issues by working with local partners to improve community safety and reduce the fear of crime.

7. Despite the national recognition of the Outcomes Framework as a beacon of good practice, the ICS has encountered internal hurdles that has hampered its ability to effectively monitor and track progress. These multifaceted challenges are:

   a) Relevance of the current framework: Delivering successful outcomes requires a multi-faceted approach that involves all stakeholders within the health and care system. The Outcomes Framework developed in 2019 is still meaningful, relevant, and reflective of the needs of the population being served. That said, it is considered that a review and refresh of some elements would be beneficial, with particular a focus on patient experience, as outcomes in this area could be more robust and aligned.

   b) Data recording: As a system, the recording of referral activity is robust. However, the approach to recording and reporting data relating to interventions is more variable. This makes it difficult to draw meaningful conclusions that feeds into the reporting of outcomes. There are three separate challenges:

      - Some data is not captured at all.
      - Some data is captured by providers but is not visible to system partners.

- Some data is captured in an inconsistent way, with no clear standards and terminology.

c) Targets/Ambitions: As a system we have a clearly defined outcomes framework, which will be refreshed. However, we also need to set targets to these outcomes. Currently there is inconsistency in the approach to target setting.

d) Ownership and Delivery: Since the creation of the outcomes framework in 2019, the system has changed significantly and this has diluted the ownership of this agenda. Clear lines of accountability are required for delivery of outcomes and interventions.

Approach to developing a PHM Outcomes Framework

8. Since March 2023, the ICB's SAIU has been working with subject matter experts and programme leads across the ICS to define the interventions and metrics required for creating and monitoring PHM outcomes and to assist the monitoring and evaluation of the ambitions set within the Integrated Care Strategy. The following phased approach was agreed:

a) Phase 1 (August 2023): Scope and semi produce a dashboard, covering high level outcomes.

b) Phase 2 (November 2023): Continue working with programme leads to finalise metrics for interventions and specific outcomes.

c) Phase 3 (January 2024): Identify and integrate data sources into the GP Repository for Clinical Care (GPRCC), working closely with providers and digital teams.

d) Phase 4 (March 2024): Finalise and launch the PHM Outcomes Dashboard on SharePoint, accessible to all partners.

<u>Current position of Phase 1</u>

9. Good progress has been made in relation to the first phase of this work and the SAIU has produced a dashboard with high level outcomes covering:

a) Reduction in Avoidable/Premature Mortality.

b) Increase in life expectancy.

c) Emergency admissions.

d) Prevalence of long-term conditions.

10. More work is required to agree how healthy life expectancy will be monitored; however, this will work will continue in parallel to the phases listed at paragraph 8 above.

11. Significant work has been undertaken with system partners, at pace, to gain support and buy-in, particularly around data recording, capture and sharing. Appendix A provides examples of work completed to date, which has involved:

    a) Identification and alignment of key metrics for phase 1: Collaborative working with public health colleagues and subject matter experts identifying and listing the metrics required to measure high-level and cohort-specific outcomes. Work is ongoing with healthy life expectancy.

    b) Creation and development of a Microsoft PowerBI dashboard that provides the necessary intelligence at system, local area, and place levels.

    c) Data integration and baseline establishment: Ongoing work with public health colleagues to agree outcome targets to support the system to identify whether plans are sufficiently ambitious and delivering.

Next steps

12. By maintaining a balanced perspective between preserving the current outcomes framework and selectively integrating new ideas, we are on track to create and deliver a fully integrated outcomes dashboard by March 2024.

13. In delivering the second phase of our trajectory we will tackle the following challenges:

    a) Clear communication and collaboration: Foster clear communication with all stakeholders, explaining the rationale behind the chosen approach and ensuring collaborative decision-making.

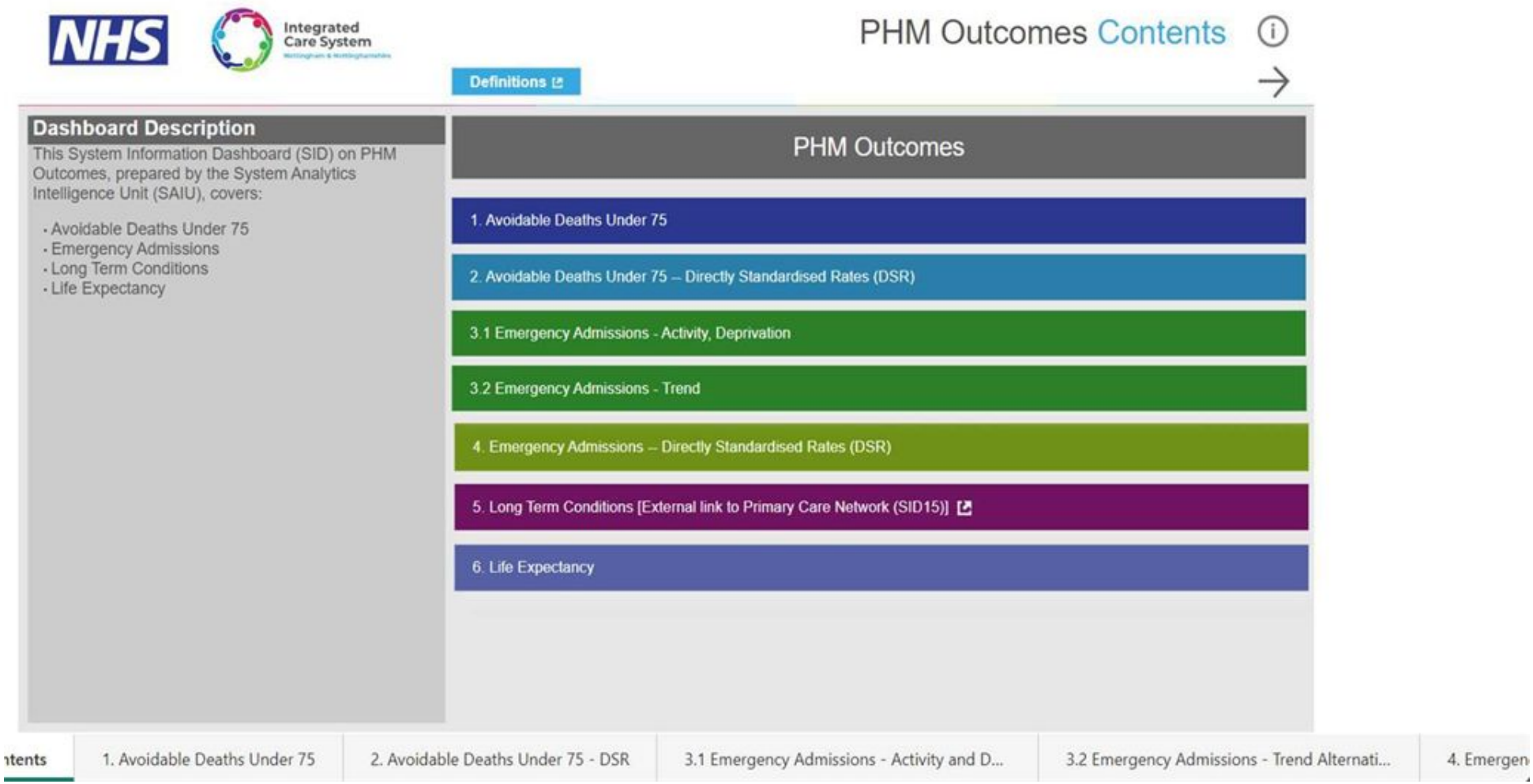
    b) Work with system leaders to agree the necessary governance and oversight of the outcomes dashboard.

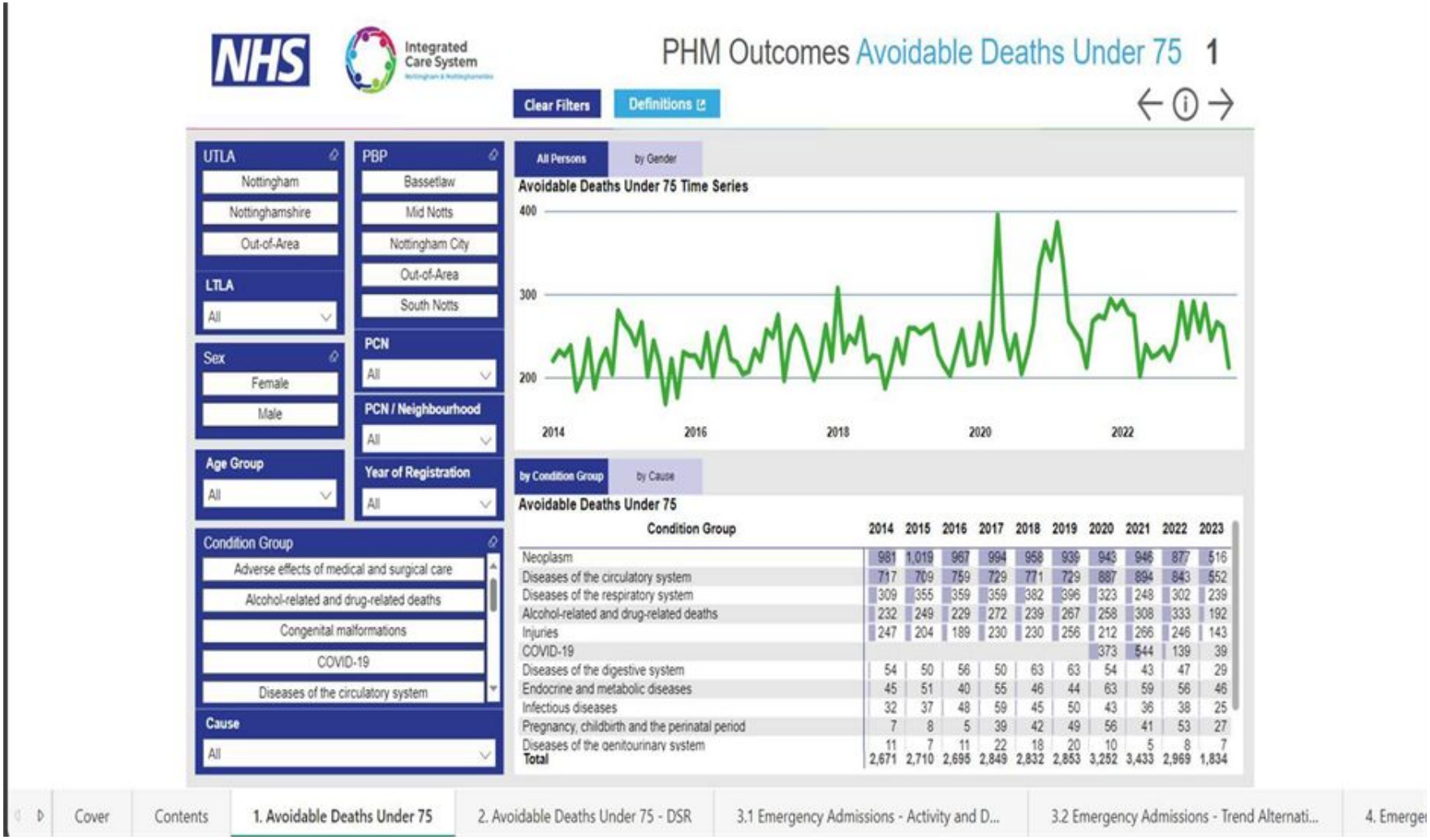
    c) Ongoing evaluation of existing framework: Continue with the ‘running refresh’ approach, maintaining constant evaluation and updates to ensure that the existing framework remains aligned and relevant to the Integrated Care Strategy and Joint Forward Plan.

    d) Subject matter expert groups: Input from relevant groups within the system to identify and contribute the most impactful interventions and cohort specific outcomes so that these can be integrated into the outcomes dashboard.

    e) Work with public health colleagues to identify appropriate ambitions to map onto phase 1 of the dashboard.

Appendix A


NHS
Integrated Care System
PHM Outcomes Contents
Definitions
Dashboard Description
This System Information Dashboard (SID) on PHM Outcomes, prepared by the System Analytics Intelligence Unit (SAIU), covers:
· Avoidable Deaths Under 75
· Emergency Admissions
· Long Term Conditions
· Life Expectancy
PHM Outcomes
1. Avoidable Deaths Under 75
2. Avoidable Deaths Under 75 – Directly Standardised Rates (DSR)
3.1 Emergency Admissions - Activity, Deprivation
3.2 Emergency Admissions - Trend
4. Emergency Admissions – Directly Standardised Rates (DSR)
5. Long Term Conditions [External link to Primary Care Network (SID15)]
6. Life Expectancy
ntents
1. Avoidable Deaths Under 75
2. Avoidable Deaths Under 75 - DSR
3.1 Emergency Admissions - Activity and D...
3.2 Emergency Admissions - Trend Alternati...
4. Emergen


NHS
Integrated Care System
PHM Outcomes Avoidable Deaths Under 75 1
Clear Filters
Definitions
UTLA
Nottingham
Nottinghamshire
Out-of-Area
LTLA
All
Sex
Female
Male
Age Group
All
PBP
Bassetlaw
Mid Notts
Nottingham City
Out-of-Area
South Notts
PCN
All
PCN / Neighbourhood
All
Year of Registration
All
Condition Group
Adverse effects of medical and surgical care
Alcohol-related and drug-related deaths
Congenital malformations
COVID-19
Diseases of the circulatory system
Cause
All
All Persons
by Gender
Avoidable Deaths Under 75 Time Series
400
300
200
2014
2016
2018
2020
2022
by Condition Group
by Cause
Avoidable Deaths Under 75
Condition Group 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023
Neoplasm 981 1,019 967 994 958 939 943 946 877 516
Diseases of the circulatory system 717 709 759 729 771 729 887 894 843 552
Diseases of the respiratory system 309 355 359 359 382 396 323 248 302 239
Alcohol-related and drug-related deaths 232 249 229 272 239 267 258 308 333 192
Injuries 247 204 189 230 230 256 212 266 246 143
COVID-19 373 544 139 39
Diseases of the digestive system 54 50 56 50 63 63 54 43 47 29
Endocrine and metabolic diseases 45 51 40 55 46 44 63 59 56 46
Infectious diseases 32 37 48 59 45 50 43 36 38 25
Pregnancy, childbirth and the perinatal period 7 8 5 39 42 49 56 41 53 27
Diseases of the genitourinary system 11 7 11 22 18 20 10 5 8 7
Total 2,671 2,710 2,695 2,849 2,832 2,853 3,252 3,433 2,969 1,834
Cover
Contents
1. Avoidable Deaths Under 75
2. Avoidable Deaths Under 75 - DSR
3.1 Emergency Admissions - Activity and D...
3.2 Emergency Admissions - Trend Alternati...
4. Emerge


NHS
Integrated Care System
PHM Outcomes Avoidable Deaths Under 75
Directly Standardised Rates (DSR)
2
Clear Filters
Definitions
PBP
Bassetlaw
Mid Notts
Nottingham City
South Notts
PCN / Neighbourhood
Arnold & Calverton
Arrow Health
Ashfield North
Ashfield South
BACHS
Beeston
Bestwood & Sherwood
Bulwell & Top Valley
Byron
City South
Clifton & Meadows
Eastwood/Kimberley
Time Period
All
Cause
All
Avoidable Deaths: Mortality Rate
Persons | 3-Year Period: 2020-2022 | Age Standardised Rates Per 100,000 Population (Aged Under 75 Years)
Nottingham City 332.0
Mid Notts 278.7
Bassetlaw 258.1
South Notts 215.0
ICB: 265.0
0
100
200
300
DSR - Age Standardised Rate Per 100,000 Population
Avoidable Deaths: Mortality Rate
Persons | 3-Year Period: 2020-2022 | Age Standardised Rates Per 100,000 Population (Aged Under 75 Years)
Radford & Mary Potter 419.3
Nottingham City East 386.1
BACHS 358.8
Bulwell & Top Valley 352.4
Mansfield North 334.6
Clifton & Meadows 333.4
Ashfield North 321.4
Newgate Medical Group 304.0
Bestwood & Sherwood 301.4
Rosewood 301.4
Ashfield South 292.5
Byron 279.5
Synergy Health 273.3
Larwood & Bawtry 258.5
Eastwood/Kimberley 244.8
Stapleford 243.8
Beeston 241.6
Newark 238.1
Retford And Villages 234.6
City South 229.3
Sherwood 222.8
Arrow Health 213.8
ICB: 265.0
0
200
400
DSR-Age Standardised Rate Per 100,000 Population
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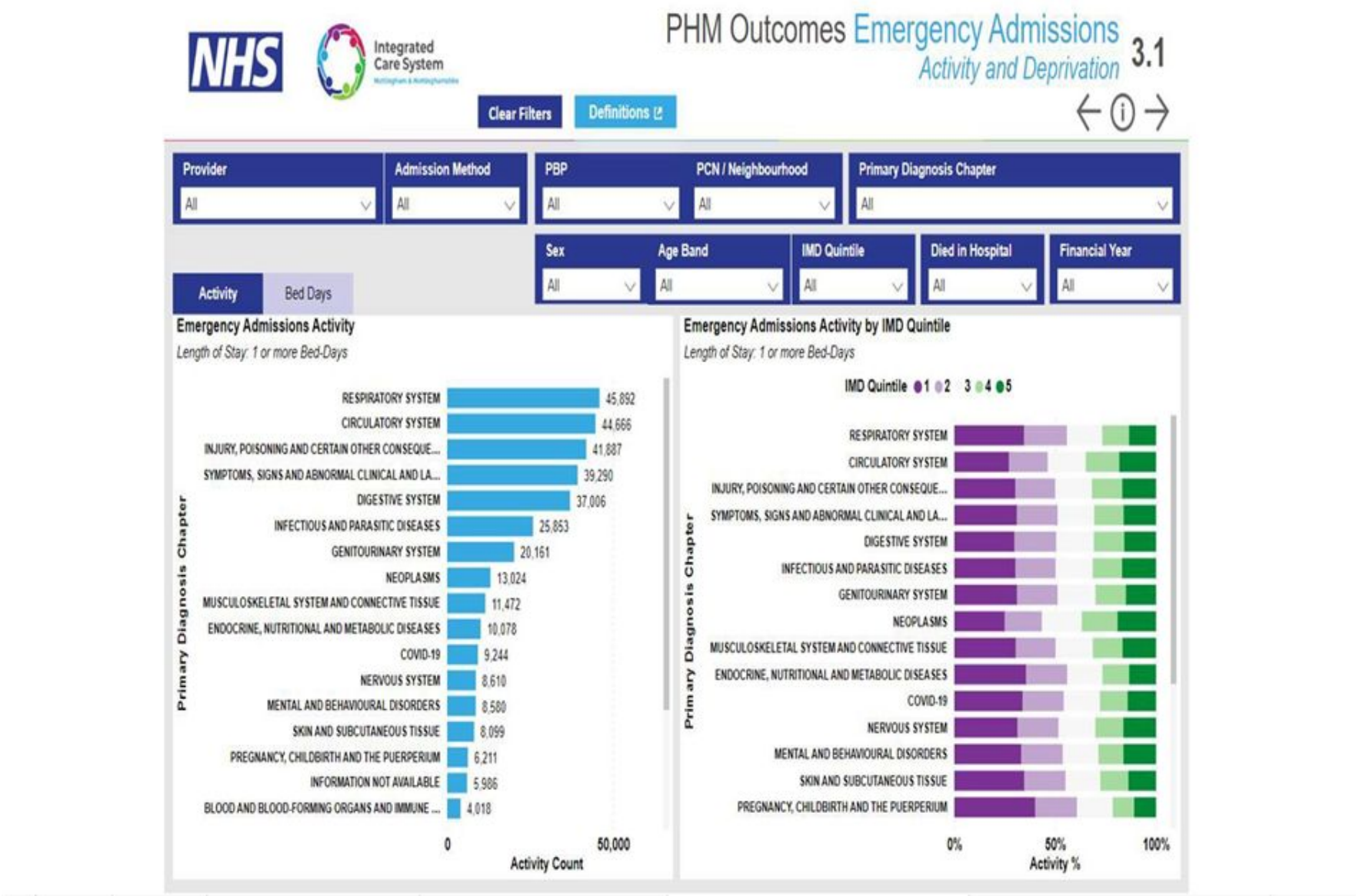
NHS
Integrated Care System
PHM Outcomes Emergency Admissions
Activity and Deprivation
3.1
Clear Filters
Definitions
Provider
All
Admission Method
All
PBP
All
PCN / Neighbourhood
All
Primary Diagnosis Chapter
All
Sex
All
Age Band
All
IMD Quintile
All
Died in Hospital
All
Financial Year
All
Activity
Bed Days
Emergency Admissions Activity
Length of Stay: 1 or more Bed-Days
RESPIRATORY SYSTEM 45,892
CIRCULATORY SYSTEM 44,666
INJURY, POISONING AND CERTAIN OTHER CONSEQUE... 41,887
SYMPTOMS, SIGNS AND ABNORMAL CLINICAL AND LA... 39,290
DIGESTIVE SYSTEM 37,006
INFECTIOUS AND PARASITIC DISEASES 25,853
GENITOURINARY SYSTEM 20,161
NEOPLASMS 13,024
MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE 11,472
ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES 10,078
COVID-19 9,244
NERVOUS SYSTEM 8,610
MENTAL AND BEHAVIOURAL DISORDERS 8,580
SKIN AND SUBCUTANEOUS TISSUE 8,099
PREGNANCY, CHILDBIRTH AND THE PUERPERIUM 6,211
INFORMATION NOT AVAILABLE 5,986
BLOOD AND BLOOD-FORMING ORGANS AND IMMUNE ... 4,018
Primary Diagnosis Chapter
0
50,000
Activity Count
Emergency Admissions Activity by IMD Quintile
Length of Stay: 1 or more Bed-Days
IMD Quintile 1 2 3 4 5
RESPIRATORY SYSTEM
CIRCULATORY SYSTEM
INJURY, POISONING AND CERTAIN OTHER CONSEQUE...
SYMPTOMS, SIGNS AND ABNORMAL CLINICAL AND LA...
DIGESTIVE SYSTEM
INFECTIOUS AND PARASITIC DISEASES
GENITOURINARY SYSTEM
NEOPLASMS
MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE
ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES
COVID-19
NERVOUS SYSTEM
MENTAL AND BEHAVIOURAL DISORDERS
SKIN AND SUBCUTANEOUS TISSUE
PREGNANCY, CHILDBIRTH AND THE PUERPERIUM
Primary Diagnosis Chapter
0%
50%
100%
Activity %
Cover
Contents
1. Avoidable Deaths Under 75
2. Avoidable Deaths Under 75 - DSR
3.1 Emergency Admissions - Activity and ...
3.2 Emergency Admissions - Trend Alternati...
4. Emergen


NHS
Integrated Care System
PHM Outcomes Life Expectancy 6
Clear Filters
Definitions
PBP
Bassetlaw
Mid Notts
Nottingham City
South Notts
PCN / Neighbourhood
Arnold & Calverton
Arrow Health
Ashfield North
Ashfield South
BACHS
Beeston
Bestwood & Sherwood
Bulwell & Top Valley
Byron
Sex
All
Financial Year
2022 - 2023
Life Expectancy at Birth
South Notts 82.2
Bassetlaw 80.8
Nottingham City 80.4
Mid Notts 80.3
ICB: 81.1
PBP
0 20 40 60 80
Life Expectancy at Birth (Years)
Life Expectancy at Birth
Unity (Nottm) 88.9
Rushcliffe South 84.3
Rushcliffe Central 83.7
City South 83.6
Stapleford 83.5
Arnold & Calverton 82.5
Rushcliffe North 82.5
Eastwood/Kimberley 81.7
Arrow Health 81.7
Newark 81.6
Newgate Medical Group 81.4
Beeston 81.3
Synergy Health 81.3
Retford And Villages 81.0
Sherwood 80.8
Bestwood & Sherwood 80.4
BACHS 80.4
Larwood & Bawtry 80.0
Clifton & Meadows 79.9
Rosewood 79.9
Mansfield North 79.6
Ashfield North 79.5
Nottingham City East 79.4
Ashfield South 79.4
ICB: 81.1
PCN / Neighbourhood
0 50 100
Life Expectancy at Birth (Years)
Cover
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2. Avoidable Deaths Under 75 - DSR
3.1 Emergency Admissions - Activity and D...
3.2 Emergency Admissions - Trend Alternati...
4. Emerge

Meeting Title:	Integrated Care Partnership
Meeting Date:	06/10/2023
Paper Title:	**Water Fluoridation**
Paper Reference:	ICP 23 010
Report Author(s):	Vivienne Robbins, Deputy Director of Public Health, Nottinghamshire County Council David Johns, Deputy Director of Public Health, Nottingham City Council Paul Miles, Senior Public Health and Commissioning Manager, Nottinghamshire County Council
Report Sponsor(s):	Cllr John Doddy, Chair of Nottinghamshire Health and Wellbeing Board (Joint Vice-Chair) Cllr Linda Woodings, Chair of Nottingham City Health and Wellbeing Board (Joint Vice-Chair) Jonathan Gribbin, Director of Public Health, Nottinghamshire County Council Lucy Hubber, Director of Public Health, Nottingham City Council Amanda Sullivan, Chief Executive, NHS Nottingham and Nottinghamshire ICB Dr Dave Briggs, Medical Director, NHS Nottingham and Nottinghamshire ICB
Presenter(s):	Cllr John Doddy, Chair of Nottinghamshire Health and Wellbeing Board (Joint Vice-Chair) Cllr Linda Woodings, Chair of Nottingham City Health and Wellbeing Board (Joint Vice-Chair) Jonathan Gribbin, Director of Public Health, Nottinghamshire County Council Lucy Hubber, Director of Public Health, Nottingham City Council
Recommendation(s):	The Integrated Care Partnership is asked to **endorse**: • A letter from the Chairs of the two Health and Wellbeing Boards, the Chair of the Integrated Care Partnership and integrated Care Board and the Chief Executive of the Integrated Care Board, to the Secretary of State for Health and Social Care that requests him to expedite the extension of water fluoridation for every community in Nottingham and Nottinghamshire.

Summary:

A healthy mouth and smile have such an important role to play in our lives. They ensure people can eat, speak and socialise. Poor oral health can result in significant pain and eventual tooth loss, with an adverse impact on school or work, family and social life.

Water fluoridation is a population-level public health intervention which has been shown to reduce the likelihood and scale of tooth decay in children and adults. Reviews of studies[1] conducted around the world confirm that water fluoridation is an effective and safe public health measure, providing the greatest value for money of all oral health interventions for 0–5-year-olds.[2]

Summary:
There is a significant unmet oral health need leading to preventable illness across the Nottingham and Nottinghamshire Integrated Care System (ICS), with many children experiencing worse dental health than many other parts of England. Locally water fluoridation schemes currently operate in North Nottinghamshire, serving around 247,000 (22%) of residents within the ICS. Areas covered include parts of Ashfield, Mansfield and Bassetlaw, plus a small area in Newark and Sherwood. There are no water fluoridation schemes operating in Nottingham City. The Health and Care Act 2022[3] put new provisions in place, which empower the Secretary of State for Health and Social Care, to establish new, vary or terminate existing water fluoridation schemes in England. Over the summer, Full Council support has been confirmed by resolution by a motion in Nottinghamshire County Council (July 2023) and a paper in Nottingham City Council (September 2023) to explore expanding the current fluoridation schemes to the rest of the population that would deliver oral health benefits today and for future generations. The purpose of this report is to seek agreement from the Integrated Care Partnership to formally endorse a letter to the Secretary of State for Health and Social Care that requests him to expedite the extension of water fluoridation for every community in Nottingham and Nottinghamshire.

Appendices:
Appendix 1: Map of fluoridated areas Appendix 2: Benefits of water fluoridation Appendix 3: Flow chart of fluoridation process (Phase 2) Appendix 4: Concerns or risks associated with water fluoridation

Report Previously Received By:
Upper tier local councils have approved a resolution to support the expansion of fluoridation schemes locally. This was expressed as a motion in Nottinghamshire County Full Council on the 13 July 2023 and approval to the portfolio holder's paper by Nottingham City Full Council on 11 September 2023.

How does this paper support the Integrated Care System's core aims to:	
Improve outcomes in population health and healthcare	Water fluoridation is a safe and effective population-level health intervention that has been shown to improve oral and wider health outcomes for the local population.
Tackle inequalities in outcomes, experience and access	Dental decay is a preventable disease that is strongly associated with deprivation. Although fluoridation is a universal intervention evidence shows it has the greatest impact in areas of deprivation.
Enhance productivity and value for money	Public Health England (PHE, 2016) confirmed that water fluoridation is the most cost-effective oral health intervention indicating that in a cohort of five-year-old children, for every £1 spent a £12.71 return on investment will be generated after five years and £21.98 after ten years. This includes 204 fewer hospital admissions for tooth extractions and reducing demands on oral health services caused by tooth decay across the ICS.

How does this paper support the Integrated Care System's core aims to:	
Help the NHS support broader social and economic development	General wellbeing for individuals would also be enhanced, as oral health affects people's ability to speak, eat, smile and socialise. Wider benefits for the ICS would be seen, including improved productivity in the workplace, healthier ageing and reduced time away from school or work due to poor oral health or attending appointments.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Water Fluoridation

Introduction

1. A healthy mouth and smile have such an important role to play in our lives. They ensure people can eat, speak and socialise. Poor oral health can result in significant pain and eventual tooth loss, with an adverse impact on school or work, family and social life.

2. There is a significant unmet oral health need leading to preventable illness across the Nottingham and Nottinghamshire Integrated Care System (ICS), with many children experiencing worse dental health than many other parts of England.

3. Water fluoridation is a population-level public health intervention which has been shown to reduce the likelihood and scale of tooth decay in children and adults. Reviews of studies[1] conducted around the world confirm that water fluoridation is an effective and safe public health measure, providing the greatest value for money of all oral health interventions for 0–5-year-olds.[2]

4. Improving the oral health of our local population involves a package of interventions. Water fluoridation compliments work already underway in Nottinghamshire County Council and Nottingham City Council to promote good oral health including oral health promotion and training, targeted supervised toothbrushing in Early Years and schools. Joint working arrangements are well established through the Nottingham and Nottinghamshire Oral Health Steering Group.

5. In line with the Health and Care Act 2022[3], the responsibility for Primary Dental Services and Prescribed Dental Services was delegated by NHS England to Integrated Care Boards (ICBs) from 1 April 2023. This will allow the ICB to have greater influence on the current dental access and performance issues that have been highlighted to Nottinghamshire Health Scrutiny Committee in March 2023 (online report).

6. The purpose of this report is to seek agreement from the Integrated Care Partnership to endorse a letter to the Secretary of State for Health and Social Care that requests him to expedite the extension of water fluoridation for every community in Nottingham and Nottinghamshire.

Background

7. All water contains the mineral fluoride naturally in varying amounts; it is also present in some food. Nottingham and Nottinghamshire has a low natural level of fluoride in its water. Water fluoridation involves adjusting the fluoride level in drinking water supplies to an amount that is optimal for dental health (1mg/l).

8. About six million people, or 10% of the UK population, live in areas with fluoridated water supplies.[4] In Nottinghamshire, about 247,000 people (22% of

residents within the ICS area), predominantly in Ashfield, Bassetlaw and Mansfield, benefit from artificially fluoridated water supplies under arrangements dating back to the 1970s. Appendix 1 gives more information about the current local water fluoridation schemes.

9. Adjustment of fluoride levels in drinking water supplies in England is permitted in legislation. The Health and Care Act 2022 put new provisions in place, which empowers the Secretary of State for Health and Social Care, instead of upper tier local authorities, to establish new, vary or terminate existing water fluoridation schemes in England.[5] Before any fluoridation scheme could be varied, feasibility studies, consultations and the capital and revenue costs would need to be assessed by the Secretary of State. Councils may still lobby central government to consider new or varied schemes in their areas.

Benefits of fluoridation

10. Fluoridation works in two ways. For children younger than eight years, fluoride helps strengthen the adult (permanent) teeth that are developing under the gums. For adults, exposure to fluoridated water supports tooth enamel, keeping teeth strong and healthy.

11. Estimates of the potential benefits of extending fluoridation to other areas of the Nottingham and Nottinghamshire ICS from the 2022/23 baseline include:

    a) A 35% reduction in decayed, missing and filled teeth (dmft) in five-year-old children from an average of 1.3 to 0.85 teeth in Nottingham City and from 0.62 to 0.4 dmft in Nottinghamshire County.[6]

    b) A 15% increase in five-year-old children with no tooth decay at all (approximately 1,215 per year).[7]

    c) Around a 56% reduction in hospital admissions for tooth extractions in children from the most deprived 20% of areas of Nottingham City (approximately 89 fewer extractions a year). Plus, an approximate 30% reduction in hospital admissions for tooth extractions in Nottinghamshire children living in areas not already fluoridated (approximately 115 fewer extractions a year in children aged 0-19 years old).[8]

    d) There would also be reductions in tooth decay in adults[9], with cost savings to individuals from avoided dental treatment and to the wider NHS.

    e) Oral health would improve for up to 130,000 more people aged over 65 who are particularly at risk of some oral health conditions that can be prevented / reduced in severity through fluoridation.[10]

    f) Wider benefits for adults would be seen, including improved productivity in the workplace and healthier ageing. General wellbeing for individuals

would be enhanced, as oral health affects people's ability to speak, eat, smile and socialise.

g) There would be an estimated return of £12.71 after five years and £21.98 after ten years for every £1 invested in fluoridation.[2]

12. A summary evaluating the effects of fluoridation is provided in Appendix 2.

13. Although children from both affluent and deprived areas benefit from fluoridation, the most significant impacts of water fluoridation on improving oral health are seen in areas of deprivation, because of the well-established correlation between deprivation and sub-optimal dental outcomes. Currently in the ICS area there are just over 13,500 (29%) children under five years of age benefiting from fluoridation and just over 47,300 (71%) living in non-fluoridated areas. Currently, the areas in Nottinghamshire that are fluoridated are those of greatest deprivation. However, there are pockets of deprivation within the remaining districts and all residents are likely to have some benefit from water fluoridation. All children in Nottingham City do not currently benefit from water fluoridation.

Level of need

Nationally

14. In the UK, tooth decay is the most common reason for hospital admission in children aged between six and ten years. The consequences of tooth decay are lifelong and poor oral health can lead to:

    1. Significant but avoidable suffering and pain.
    2. Days off school, with potential impacts on learning and school performance.
    3. Time off work, with economic and productivity consequences.
    4. Low self-esteem and confidence.
    5. Hospital admissions and treatment under general anaesthetic for children.
    6. Costly dental treatment.

15. The UK Chief Medical Officers' statement on water fluoridation in 2021 concluded that:

    'On balance, there is strong scientific evidence that water fluoridation is an effective public health intervention for reducing the prevalence of tooth decay and improving dental health equality across the UK. It should be seen as a complementary strategy, not a substitute for other effective methods of increasing fluoride use.'

16. Enhancing fluoridation schemes locally will contribute towards improving the overall oral health of our population and reducing oral health inequalities and

future demand on dentistry. It also supports the delivery of the NHS England's Core20PLUS5[11] clinical priority to reduce tooth extractions due to decay for children (aged ten years and under) admitted as inpatients in hospital.

Local need

17. Many children in Nottingham and Nottingham experience worse dental health than many other parts of England.

    a) In 2022, the average number of teeth affected by dental decay amongst five-year-olds in Nottingham was 1.3 teeth. This is significantly higher than the England average 0.8 teeth. Similarly, over a third of five-year-olds had visually obvious signs of dental decay (34.2%); significantly worse compared to the England average (23.7%).[12]

    b) Overall levels of tooth decay in children in Nottinghamshire are better than the England average. In 2022, the average number of teeth affected by dental decay amongst five-year-olds in Nottinghamshire was 0.62 teeth, slightly lower than the England average. The most recent data also indicates that 18.1% of local five-year olds had experience of decay in 2021/22.[12]

18. National evidence confirms the association between sub-optimal oral health and deprivation. Within the County, in 2021/22, the highest prevalence of tooth decay experienced in five-year-olds was identified in Newark and Sherwood (23.5%), an area where the majority of water is not fluoridated. Conversely in Mansfield 16.9% and Ashfield 16.1% of five-year-olds experienced tooth decay; both are fluoridated and without the water fluoridation, the oral health of these children would likely be worse. Comparing the oral health of these children with those in non-fluoridated areas with similar socio-economic characteristics demonstrates that the oral health of children from similar areas without water fluoridation is worse than the national average. For example, in Boston in Lincolnshire (non-fluoridated area which is a Mansfield CIPFA statistical neighbour), 32.0% of five-year old children had visible decay experience compared to Mansfield where it is 16% of five-year old children.[12]

Working together to secure understanding and support

19. In July 2023, Nottinghamshire County Council Full Council approved a resolution to work with other local councils, the Integrated Care Partnership and water companies to champion the oral health agenda including the expansion of water fluoridation to all parts of Nottinghamshire. In September 2023, Nottingham City Council Full Council re-affirmed its commitment to improving dental health including advocating for a local water fluoridation scheme for Nottingham.

20. Both local authorities are working jointly to engage with key stakeholders (including regional Office for Health Improvement and Disparities (OHID) and

NHS England colleagues) and developing a formal request letter to ask the Secretary of State for Health and Social Care to expedite a more detailed exploration of water fluoridation schemes that benefits all Nottingham and Nottinghamshire residents.

21. The process for extending water fluoridation can be split into two distinct phases:

    a) Phase One (September 2023 to March 2024): Stakeholder engagement and developing a request letter to the Secretary of State. This will be led by local authorities and a fluoridation working group with the aim that the Secretary of State agrees to explore expanding the existing fluoridation schemes. Executive sponsorship/leadership for Phase One is provided by Cllr. John Doddy (Nottinghamshire) and Cllr. Linda Woodings (Nottingham City).

    b) Phase Two (if phase one is successful, 2024 onwards may take three to ten years to fully implement): Exploring and expanding water fluoridation schemes locally, led by the Department for Health and Social Care. This will involve feasibility studies, public consultation, and if successful, building infrastructure. The local system will be asked to support rather than lead this phase. The steps within Phase Two are detailed in Appendix 3.

Risks and considerations

22. Although there have been no recent complaints in relation to water fluoridation in Nottinghamshire, nationally concerns are sometimes voiced about water fluoridation. Routine monitoring of health in fluoridated areas for over 50 years and scientific reviews has not revealed any health problems associated with optimal levels of water fluoridation.[13] There is a low risk of dental fluorosis, about which further information is given in Appendix 4.

Conclusion

23. Water fluoridation is a population-level public health intervention which has been shown to reduce the likelihood and scale of tooth decay in children and adults. Reviews of studies conducted around the world confirm that water fluoridation is an effective and safe public health measure, providing the greatest value for money of all oral health interventions in particular for 0–5-year-olds and those living in the most deprived areas of the ICS. Local political support has confirmed a timely opportunity to progress the Nottingham and Nottinghamshire's aspiration to expand the current fluoridation scheme to all our people to improve oral health benefits today and into the next generation.

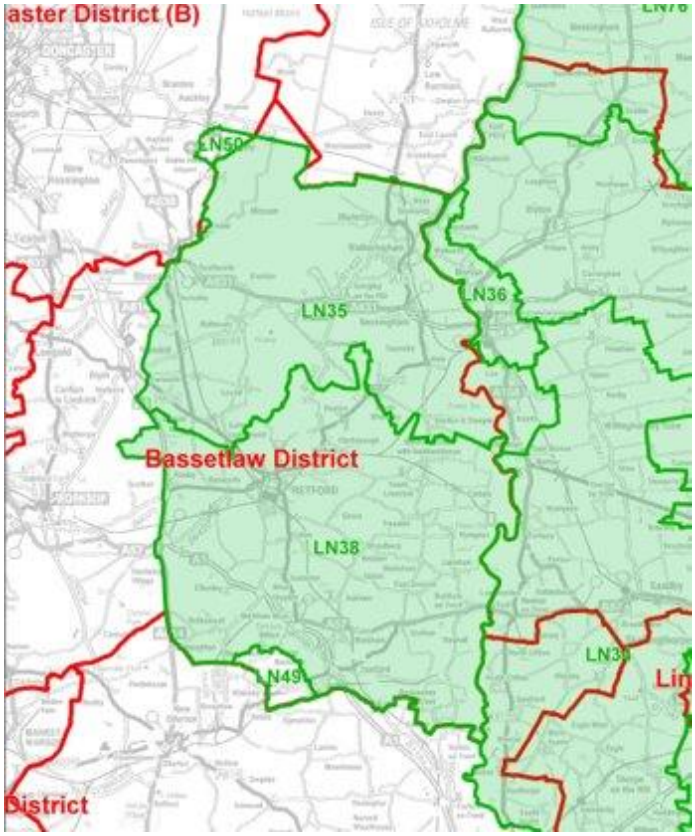
References

[1] Public Health England (PHE), 2020, Improving oral health: a community water fluoridation toolkit for local authorities
[2] York Health Economics Consortium for PHE, 2016, A rapid review of the evidence on the cost effectiveness of interventions to improve the oral health of children aged 0-5 years
[3] Health and Care Act 2022
[4] PHE, 2018, Water Fluoridation: Health monitoring report for England
[5] Health and Care Act 2022: Regulation 3 brought into force on 1st November 2022 sections 175 (fluoridation of water supplies) and 176 (fluoridation of water supplies: transitional provision) of the Act in so far as they relate to water supplied to areas in England.
[6] Modelling based on:
a) Office for Health Improvement and Disparities (OHID), 2023, National Dental Epidemiology Survey of five-year olds, 2021/22
b) Cochrane Review, 2015, Water Fluoridation to prevent tooth decay
[7] Ibid
[8] Modelling based on:
a) OHID, 2022, Water Fluoridation: Health Monitoring Report for England 2022
b) Hospital tooth extractions in 0 to 19 year olds: 2022 - GOV.UK (www.gov.uk)
c) Community Dental Services-CiC tooth extraction data 2021/22
d) Nyakutsikwa, Blessing (2021): Water fluoride concentrations (mgF/L) per Lower Super Output Area (LSOA) in England (2009 - 2020). University of Manchester.
[9] There is an estimated 27%-35% reduction in tooth decay among those who have spent their whole life in fluoridated areas (Griffin et al. 2007). It is not possible to quantify the local scale of this estimated reduction, as recent robust local prevalence estimates for tooth decay among adults are not available.
[10] Modelling based on:
a) Nyakutsikwa, Blessing (2021): Water fluoride concentrations (mgF/L) per Lower Super Output Area (LSOA) in England (2009 - 2020). University of Manchester.
b) Nottinghamshire County Council, 2019, Adult Social Care and Public Health Strategy
c) Office for National Statistics, 2021, Census 2021
[11] NHS England, 2021, Core20PLUS5 an Approach to Reducing Health Inequalities
[12] OHID, 2023, National Dental Epidemiology Survey of five-year olds, 2021/2
[13] Bardsley et al., 2014, Health Effects of Water Fluoridation: A review of the scientific evidence
[14] Committee on Toxicity (COT), 2003, COT Statement on Fluorine in the 1997 Total Diet Stud
[15] Ibid

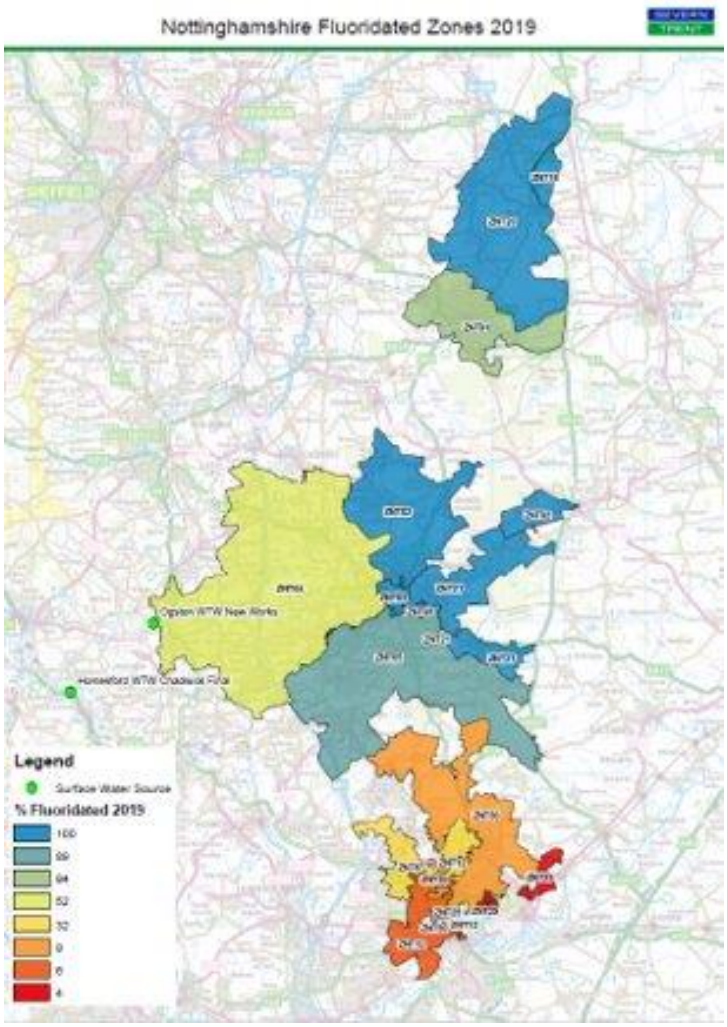
Appendix 1: Nottinghamshire's current fluoridation arrangements

1. In Nottinghamshire, water fluoridation arrangements date back to the 1970s and serve around 247,000 people in parts of Ashfield, Bassetlaw and Mansfield, plus a small area in Newark and Sherwood, including the towns of Harworth, Kirkby, Mansfield, Rainworth, Sutton, Worksop and Retford. There are no water fluoridation schemes operating in Nottingham City. Due to water distribution arrangements, some of these areas receive blended water from both fluoridated and non-fluoridated supplies.
2. Fluoridation in the County is operated by two water companies. Four water treatment works run by Severn Trent Water (STW) fluoridate eight different Water Quality Zones (WQZ) across mid and north Nottinghamshire, and some small areas of Derbyshire. Three water treatment works in two WQZs in eastern parts of Bassetlaw (where supplies also cover a small area within Newark and Sherwood) are operated by Anglian Water. The maps below show the fluoridation coverage.
3. Water fluoridation schemes are overseen by OHID, which has an ongoing programme of capital investment to ensure that any operational issues are addressed. These might include maintenance, repair and replacement of equipment to ensure that current schemes receive the intended level of fluoridation.

Map 1 – Anglian Water fluoridated zones in Nottinghamshire



Map 2 – Severn Trent Water fluoridated zones in Nottinghamshire



Note: Low levels of fluoride are noted in other parts of the County, in the water zones ZNT07, ZNT12, ZNT29 and ZNT30 (areas in Nottingham City, parts of Gedling and Ashfield). These areas do not receive any artificially fluoridated water. There are some very low natural levels from the supplying borehole.

Appendix 2: Potential benefits of expanding fluoridation in Nottingham City and Nottinghamshire

Estimates of quantifiable benefits:

Impact	Scale	Local Analysis
Children have fewer decayed, missing or filled teeth	35% fewer decayed, missing and filled baby teeth and 26% fewer decayed, missing and filled permanent teeth.	At the last survey, five-year-olds in Nottingham City had an average of 1.3 and Nottinghamshire had an average of 0.62 decayed (d), missing due to dental decay (m) and filled (f) teeth (t) (dmft). If all areas were fluoridated, this could result in 35% fewer dmft in 5-year-olds, equating to an average of 0.85 (Nottingham City) and 0.4 (Nottinghamshire) dmft.[6]
Children experience less tooth decay	15% increase in children with no decay in their baby teeth at five years of age.	In Nottingham City, a 15% increase represents 410 extra children per year who could have no decay in their baby teeth at age five. In non-fluoridated areas of Nottinghamshire, a 15% increase represents 805 extra children per year, a combined total of 1215 children across the ICS.[7]
Reduction in hospital admissions for caries-related dental extractions in children in the most deprived 20% areas	Incidence of admissions is 56% lower in the most deprived fluoridated areas and 37% lower in children from indices of multiple deprivation (IMD) quintile 3 (average deprivation quintile).	Around a 56% reduction in hospital admissions for tooth extractions in children from the most deprived 20% of areas of Nottingham City would result in approximately 89 fewer extractions a year in children aged 0-19 years old. In 2021/22 a total of 375 Nottinghamshire residents aged under 19 years old had teeth extracted under general anaesthetic. Of these 237 (63.2%) lived in non-fluoridated areas (less than 0.7 mg/l)40. Following methodology used in [Water Fluoridation, Health monitoring report for England 2022], and applying

Impact	Scale	Local Analysis
		preventive fractions by national IMD quintile, an estimated 115 or 30.8% of these procedures could have been avoided if water fluoridation had been in place in all areas.[8] This equates to 204 avoided hospital admissions across the ICS in total.
Reduced tooth decay in adults	27-35% reduction among those who have spent their whole life in fluoridated areas.	There is no local data available on prevalence of decay amongst Nottinghamshire adults and/or those born in fluoridated parts of North Nottinghamshire.
Reduced root surface decay in older people	This condition can arise following gum recession in older people. Increased cohort of older people potentially vulnerable to this condition, owing to anticipated demographic changes, alongside more people keeping their natural teeth for longer. This growing group of adults aged over 65 could potentially benefit from fluoridation to help reduce their risk of root surface decay – both in terms of prevalence and severity.	There are currently around 40,000 people aged over 65 living in Nottingham City and around 90,000 non-fluoridated areas of Nottinghamshire (of whom 15,535 are over 85). Projected increases in older demographic groups would increase this by 36,308 people (based on a 30% increase in 65 to 84-year-olds and a 90% increase in 85+ year olds), to a total of 126,262 over 65-year-olds by 2030.[10]

Additional benefits of having improved oral health:

- Reduction in days lost from school
- Improvement in school performance
- Reduction in days lost from work
- Reduction in avoidable costs for dental treatment in adults – both in terms of dental charges falling on individuals and in terms of costs to the wider health system.

Appendix 3: Process for expanding a water fluoridation scheme following formal request (Phase 2)

Appendix 4: Concerns or risks associated with water fluoridation

Fluorosis	Dental fluorosis (mottling of teeth) is one of a number of different conditions that can affect the appearance of teeth. There is a well-established adverse association between levels of fluoride in water and the prevalence of dental fluorosis. Dental fluorosis is cosmetic and does not indicate or result in any harm to general health. It is usually seen as paper-white flecks or fine white lines, but it can vary in appearance from barely visible white lines to patches which may be of aesthetic concern. The risk period for the development of dental fluorosis in permanent (adult) teeth is when the teeth are growing in the jaws; dental fluorosis cannot develop after teeth are formed. A small minority of children in both non-fluoridated and fluoridated areas of the UK have noticeable dental fluorosis, though severe dental fluorosis is rare. In a PHE study, dental fluorosis was observed in 10.3% of children examined in two fluoridated cities compared to 2.2% in two non-fluoridated cities. However, there was no significant difference between children surveyed in fluoridated and non-fluoridated areas when asked their opinion about the appearance of their teeth, taking into account concerns that have resulted from any cause (e.g. poor alignment, decay, trauma etc.).[4] Skeletal fluorosis is a health condition characterised by skeletal abnormalities and joint pain, common in regions of the world which have extremely high naturally occurring fluoride levels in the water and hot, dry climates.[14] For example, fluoride occurs naturally at up to 18 parts per million (ppm) in 15 states of India, where skeletal fluorosis can be found. For comparison, both the World Health Organisation (WHO) guideline limit for fluoridation and the maximum permitted value in English fluoridation schemes is 1.5 ppm. In temperate climates, no cases of clinical skeletal fluorosis have been seen with natural fluoride levels up to 4 ppm in drinking water. There is no evidence of clinical skeletal fluorosis arising from exposures in the UK or from levels of fluoride found in water fluoridation schemes worldwide.[15]
Alleged harmful effects of fluoridation on other aspects of health	Studies have investigated hip fracture, Down's syndrome, kidney stones, bladder cancer, osteosarcoma (a cancer of the bone) and found either no evidence of any difference in rates between fluoridated and non-fluoridated areas. For a few conditions, some evidence suggested that rates were lower in fluoridated than in non-fluoridated areas (kidney stones, bladder cancer).[4]

Safety of fluoridation operations	The independent Drinking Water Inspectorate regulates and monitors the quality of public water supplies in England. Water quality is monitored by water companies in line with regulations and standards, which include maximum concentrations for chemicals that may be found in water. Water companies comply with a Technical Code of Practice for water fluoridation. Only specified chemicals are allowed to be used which comply with British Standards. Water companies must establish any variation in natural fluoride concentration in the raw water and take this into account when designing control mechanisms. Continuous fluoride monitoring, linked to alarm monitoring and automatic shut-down, is a requirement for all dosing installations, to eliminate the possibility that concentrations could be above the permitted level.
Toxicity of fluoride	At high concentrations, fluoride can be toxic. This is why the health warning on fluoride toothpastes says not to swallow, but these toothpastes contain fluoride at over 1000 ppm, a thousand times the level in fluoridated water. The WHO guideline limit of 1.5 ppm is intended to protect against potential harmful effects over a lifetime of exposure to fluoride from all sources. Water fluoridation schemes in the UK seek to achieve a level of 1.0 ppm, with the maximum permitted level stipulated by the Drinking Water Inspectorate at 1.5 ppm.
Ethics	The topic of fluoridation can prompt debates about ethics. Dental and health professionals argue that combating tooth decay using a safe and effective public health measure is a necessary and highly ethical course of action to take. However, ethical concerns can focus on issues around the population being unable to choose whether or not to drink fluoridated water. Nevertheless, fluoride already occurs naturally in water supplies. Water fluoridation schemes adjust fluoride levels to replicate a naturally occurring benefit that would occur where fluoride is already present at the optimal level of 1.0 ppm.