**Integrated Care System Board**
**Meeting in Public**

**Thursday 4 November 2021 15:30 – 17:30**
**Via Zoom**

| Name | Organisation |
|---|---|
| Adele Williams | Councillor, Nottingham City Council |
| Alex Ball | Director of Communications and Engagement, Nottingham and Nottinghamshire CCG and ICS |
| Amanda Sullivan | Interim Exec Lead, ICS and Accountable Officer, Nottingham and Nottinghamshire CCG |
| Boyd Elliott | Councillor, Nottinghamshire County Council |
| Claire Ward | Non-Executive Director, Sherwood Forest Hospitals NHS Foundation Trust |
| Eric Morton | Chair, Nottingham University Hospitals NHS Trust |
| Fran Steele | Director of Strategic Transformation, Midlands, NHSEI |
| Gavin Lunn | GP (representing PCNs in Mid Nottinghamshire ICP) |
| Hugh Porter | GP, Clinical Director and Interim Lead for Nottingham City ICP (representing Nottingham City ICP) |
| Idris Griffiths | Accountable Officer, Bassetlaw CCG |
| John Brewin | Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust |
| John Doddy | Chair of Health and Wellbeing Board, Nottinghamshire County Council |
| Jon Towler | Non-Executive Director, Nottingham and Nottinghamshire CCG |
| Kathy McLean | ICS Independent Chair |
| Louise Bainbridge | Chief Executive, Nottingham CityCare Partnership |
| Lucy Hubber | Director of Public Health, Nottingham City Council |
| Melanie Brooks | Corporate Director Adult Social Care and Health, Nottinghamshire County Council |
| Michael Williams | Chair, Nottingham CityCare Partnership |
| Mike Crowe | GP and PCN Clinical Director (representing PCNs in Nottingham City ICP) |
| Nicole Atkinson | GP, Nottingham and Nottinghamshire ICS Clinical Lead and South Nottinghamshire ICP Clinical Lead |
| Paul Devlin | Chair, Nottinghamshire Healthcare NHS Foundation Trust |
| Paul Robinson | Chief Finance Officer, Deputy Chief Executive and SIRO, Sherwood Forest Hospitals NHS Foundation Trust |
| Richard Henderson | Chief Executive, East Midlands Ambulance Service |
| Rosa Waddingham | Chief Nurse, Nottingham and Nottinghamshire CCG and ICS |
| Rupert Egginton | Director of Finance and Deputy Chief Executive, Nottingham University Hospitals NHS Foundation Trust |
| Stuart Poynor | ICS Finance Director, and Chief Finance Officer and Deputy Accountable Officer, Nottingham and Nottinghamshire CCG |

| | |
|---|---|
| Thilan Bartholomeuz | GP and Clinical Lead for Mid Nottinghamshire ICP (representing Mid Nottinghamshire ICP) |
| Tim Heywood | GP Lead (representing PCNs in South Nottinghamshire ICP) |

**In attendance**

| Name | Organisation |
|---|---|
| Andrew Haw (Item 9) | Interim Lead for Data, Analytics, Information and Digital Technology, Nottingham and Nottinghamshire ICS, Data Protection Officer, Nottinghamshire Healthcare NHS Foundation Trust |
| Chris Schofield (Item 4) | Lead Consultant Liaison Psychiatrist, Nottinghamshire Healthcare NHS Foundation Trust |
| Joanna Cooper | Assistant Director, Nottingham and Nottinghamshire ICS |
| Jonathan Lee (Item 9) | Head of Finance, Supporting the ICS Recovery Programme, Urgent and Emergency Care, Digital and Estates |
| Rebecca Larder | Programme Director, Nottingham and Nottinghamshire ICS |

**Apologies**

| Name | Organisation |
|---|---|
| Eric Kelly | Chair, Bassetlaw CCG |
| Hayley Barsby | CEO, Mansfield District Council |
| Mel Barrett | Chief Executive, Nottingham City Council |

## 1. Welcome and introductions

KM welcomed colleagues to the meeting, which is the final meeting of the ICS Board in public as the transition arrangements are put in place to establish the ICS on a statutory footing.

On behalf of the Board, KM thanked Tracy Taylor for her contributions to the wider system. Tracy stood down from the role of CEO of Nottingham University Hospitals early October due to ill health.

## 2. Conflicts of Interest

No conflicts were noted in relation to the items on the agenda. The register was circulated with the meeting papers for information.

## 3. Minutes of 2 September meeting and action log

The minutes of the meeting held on 2 September were agreed as an accurate record of the meeting by those present.

The action log and updates were noted.

## 4. Primary Care Psychological Medicine in South Nottinghamshire

JB introduced the citizen story on the primary care psychological medicine service in South Nottinghamshire and highlighted that the story demonstrates the interdependencies between physical and mental health. Thank you to Jane for her bravery in sharing her personal story with the Board.

Board discussed and noted the following key points:

- As the system develops it will be important to ensure that the ICS becomes a dynamic fleet of foot system.
- This story should be showcased as a good example of innovation and working beyond the medical model.
- Further roll out of the service to be considered in the system space with places and populations to understand demand, how to shape the service and make the best use of resources.
- Board members asked to hold the images from Jane's story throughout the meeting and as a Board think about getting the right ropes in place, and how to pull citizens up rather than expecting people to climb.

Board noted the need for further discussion and agreement on how as an ICS Places and Neighbourhoods will be supported to adopt innovative approaches.

**ACTIONS:**
JB to develop the citizen story as a case study for wider dissemination.

## 5. Report from the Independent Chair and Executive Lead

KM presented the circulated report from the Chair and Executive Lead. KM highlighted that an NHS Green Plan is under development for April 2022, which is important for future ways of working to support action against climate change.

AS highlighted good progress against arrangements to support the transition. The vaccination programme is key to supporting the ICS through the winter period. There is a focus on winter to support system partners during this challenging period. The CCG are working with practices to support with access issues and making use of additional funding to support face to face access to primary care services.

## 6. Building the Integrated Care System

KM presented the circulated paper on building the Integrated Care System. KM highlighted the naming conventions in paragraphs 16-18 of the report, and that proposals are being developed for the ICP and thanked MB for leading their development.

KM advised that the outcome of recruitment to the Chief Executive role will be known in the coming weeks.

AS highlighted that transition plans are progressing well for April 2022 and that the system will continue to further evolve over time. Culture will be key to supporting the transition and a programme of work is being developed.

Board noted the report and following key points:

- The unique opportunity for system working that the transition brings.
- That there are some concerns from Local Authorities which have been escalated nationally through the LGA about membership of the Integrated Care Board.
- The importance of utilising Health and Wellbeing Strategies and the roles of Place to deliver and shape the Integrated Care Strategy.
- Clarification on the route for the development of the constitution for the Integrated Care Board. The constitution is being developed in two parts, including board membership, ICS Board members are asked to feedback by 10 November to support this process. The second stage of the constitution will be developed following this.

Board ratified the proposed naming conventions for the Integrated Care Board (ICB), Integrated Care System (ICS) and Integrated Care Partnership (ICP) that are subject to passage of the Health and Care Bill.

**7. Working with People and Communities**

AB presented the circulated paper on working with people and communities building on ICS Board development session time and guidance from NHSEI.

Board discussed the report and noted following key points:

- TH offered support from PCNs and cited the Fleetwood approach which avoids the use of the word “engagement” instead focussing on empowering people to lead the system and focus on citizen priorities.
- That patient programmes and PPGs will interface in this approach to capture patient experiences.
- Consideration be given to the role of governors to contribute to shaping services and engaging with communities.
- Recognition of the important role of Health and Wellbeing Boards on this agenda.
- Connectively into the System Analytics Unit key and more sophisticated approach to utilising qualitative data welcome.

ICS Board endorsed the overall approach described in the ‘Proposed Approach’ section with the caveats above, endorsed the approach to resolving the ‘Interdependencies’ section, and the ‘Next Steps’ listed including the writing of the

required Strategy being taken forward by the ICS's Director of Communications and Engagement in line with the proposed approach.

**ACTIONS:**
AS and AB to further develop the approach to paragraph 20 of the report – "The CCG's Internal Audit programme includes a final sense check of the proposed approach outlined above and the detailed delivery plan in February 2022, ensuring an increased level of assurance of compliance against the NHSE/I Guidance and wider expectations for this area of work."

### 8. Signature Schemes and embedding the ICS Outcomes Framework

AS and RW presented the circulated paper on the signature schemes and embedding the ICS Outcomes Framework. RW highlighted that citizen stories are being captured to inform the development of the approach.

Board noted the continued work to develop the system approach to embed the transformation and prevention areas, the routes being taken to embed an outcomes approach across all areas of planning, commissioning, service transformation and prevention, and the joint work being undertaken with the system analytics and intelligence unit to measure impacts of the signature schemes through the ICS outcomes framework.

### 9. East Midlands Once Care (EMOC) Partnership

JL and AH attended the meeting to present the circulated paper on the East Midlands Once Care (EMOC) Partnership.

Board supported the proposal to commit to a partnership agreement subject to the business case being supported by the ICS Finance Directors, and to delegate the final sign off to the System Executive Group.

AS and JL to ensure that Bassetlaw are incorporated into the programme from the outset.

### 10. Integrated Performance Report

AS presented the circulated Integrated Performance Report highlighting that demand of recovery, workforce challenges and constraints are being balanced. There are significant workforce challenges across the system and the level of support to staff wellbeing can't be underestimated.

Board noted the challenges and progress made during 2021/22, and the approach to NHS planning for 2021/22 and the year ahead. Board noted the following key points:

- Systems are being asked to look at ambulance handover performance to support ambulance teams. A system approach to discharge key to this.
- The lack of figures for Nottingham City is an alignment and timing issue, and information is being provided.
- As the Integrated Care Board (ICB) becomes a statutory body the level of detail and focus on performance in future may need to increase as the ICB will be carrying out a formal assurance role.
- A focus on primary and community care in future reports would be welcome.

**11. Experience from the front line: planning for winter, elective activity and the financial position**

AS presented the circulated report on planning for winter, elective activity and the financial position.

Board noted the winter preparedness plan and the associated high-level risks. Key points from the discussion include:

- The homecare market capacity is a key risk. Local Authority partners are focussing on the quality of care and supporting the workforce during this difficult period.
- The regional impact of ambulance delays within and across systems.
- Further assurance is needed that the system can safely get through the winter period. Information to be provided on issues, actions and progress, impact, and the consequences of not managing.

**ACTIONS:**
AS to provide further assurance that system winter plans are robust.

**12. Report from the Finance Committee**

SP presented the circulated report from the Finance Committee and highlighted that the deficit from H1 is to be addressed in H2. There are some unique challenges for the system in relation to electives, which it is hoped can be resolved with support from NHSEI.

Board noted that the ICS Finance Directors Group has been taking forward actions, including development of an ICS Financial Strategy, Financial Framework, H2 and longer term plans, 21/22 reporting including impact of ERF and supporting the statutory transition to an Integrated Care Board.

**13. Report from the Quality Group**

RW presented the circulated report from the Quality Group and highlighted challenges for the care workforce and the impact on ability to deliver due to these challenges.

Board noted the recommendations:

- that Nottingham University Hospitals NHS Trust, Nottinghamshire Healthcare Foundation Trust, and Mediscan remain under enhanced surveillance with improvement and action plans in place.
- that three new areas of concern have been recommended for enhanced surveillance, with all areas having recognised partnership boards in place: Care Sector, Local Maternity and Neonatal System, and Learning Disabilities and Autism Partnership.
- that a system-wide standard operating procedure (SOP) has been developed by the Infection Prevention and Control system group in collaboration with providers to provide and approach to safe discharges during periods of excessive demand.
- that work continues on the development of an ICS co-production strategy and toolkit.

**14. Report from the Transition and Risk Committee**

JT presented the report from the Transition and Risk Committee. The transition plan remains on track, however, Committee wanted to highlight that this is complicated resource intensive work with challenging timescales over the coming period.

At its 1 July meeting ICS Board agreed to delegate assurance to Committee to ensure that system enabling functions were developing in line with the overall ICS Board development, in addition to the transition work-streams. This was for a time limited period whilst further consideration was given to ICS assurance arrangements (i.e. three months). Board agreed with the proposal from Committee to extend this period of assurance to April 2022 whilst the Integrated Care Board committees are established in shadow form.

**15. Questions from members of the public relating to items on the agenda**

Members of the public are welcome to submit questions related to items on the agenda. No questions were received for this meeting.

**16. Review of Meeting against Partnership Agreement**

KM thanked colleagues for support to the ICS Board. KM highlighted the opportunity to think about how this group is engaged in the future and that KM will be seeking views from colleagues over the coming weeks.

TH highlighted that many of these relationships will continue at place and neighbourhood.

**ICS Board 3 March 2022: Item 3. Enc A2**

| ICS Board Meeting Log 2020/21 | Active Actions |
|---|---|

| |
|---|
| Completed |
| Ongoing |
| Outstanding |

| Reference Number | Discussion/Rationale | Date | Action | Update/Comment | Action Owner | Deadline | Status |
|---|---|---|---|---|---|---|---|

| ICS Board Meeting Log 2020/21 | Completed Actions |
|---|---|

Completed
Ongoing
Outstanding

| Reference Number | Discussion/Rationale | Date and time | Action | Update/Comment | Action Owner | Deadline | Status |
|---|---|---|---|---|---|---|---|
| B291 | Item 4. Primary Care Psychological Medicine in South Nottinghamshire | 04 November 2021 | JB to develop the citizen story as a case study for wider dissemination. | Citzen Story developed and available online. | John Brewin | 03 March 2022 | Completed |
| B292 | Item 7. Working with People and Communities | 04 November 2021 | AS and AB to further develop the approach to paragraph 20 of the repot - "The CCG's Internal Audit programme includes a final sense check of the proposed approach outlined above and the detailed delivery plan in February 2022, ensuring an increased level of assurance of compliance against the NHSE/I Guidance and wider expectations for this area of work." | | Amanda Sullivan and Alex Ball | 03 March 2022 | Completed |
| B293 | Item 11. Experience from the front line: planning for winter, elective activity and the financial position | 04 November 2021 | AS to provider further assurance that system winter plans are robust. | Detailed discussions have taken place in the A&E Delivery Board and discussed at an ICS Board Development Session on 3rd February 2022. | Amanda Sullivan | 03 March 2022 | Completed |

| ICS Board Meeting Log 2020/21 | Decisions |
|---|---|

Completed
Ongoing
Outstanding

| Reference Number | Discussion/Rationale | Decision | Date | Update/Comment | Decision Owner | Deadline | Status |
|---|---|---|---|---|---|---|---|
| ICSB - D034 | Item 6. Building the Integrated Care System | Board ratified the proposed naming conventions for the Integrated Care Board (ICB), Integrated Care System (ICS) and Integrated Care Partnerhsip (ICP) that are subject to the passage of the Health and Care Bill. | 04/11/2021 | | Amanda Sullivan and Kathy McLean | | Completed |
| ICSB - D035 | Item 7. Working with People and Communities | ICS Board endorsed the overall approach described in the ' Proposed Approach' section with the caveats above, endorsed the approach to resolving the 'Interdependencies' section, and the 'Next Steps' listed including the writing of the required Strategy being taken forward by the ICS's Director of Communications and Engagement in line with the proposed approach. | 04/11/2021 | | Amanda Sullivan and Kathy McLean | | Completed |
| ICSB - D036 | Item 9. East Midlands Once Care (EMOC) Partnership | Board supported the proposal to commit to a partnership agreement subject to the business case being supported by the iCS Finance Directors, and to delegate the final sign off to the System Executive Group. | 04/11/2021 | | Stuart Poynor | | Completed |
| ICSB - D037 | Item 14. Report from the Transition and Risk Committee | At its 1 July meeting ICS Board agreed to delegate assurance to Committee to ensure that system enabling functions were developing in line with the overall ICS Board development, in addition to the transition work-streams. This was for a time limited period whilst further consideration was given to ICS assurance arrangements (i.e. three months). Board agreed with the proposal from Committee to extend this period of assurance to April 2022 whilst the Integrated Care Board committees are established in shadow form. | 04/11/2021 | | Amanda Sullivan / Jon Towler | | Completed |

**ICS Board Meeting Log 2020-22** **Register**

| Attendees/Loggist | Meeting Dates | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 16/01/2020 | 13/02/2020 | 12/03/2020 | 17/09/2020 | 15/10/2020 | 12/11/2020 | 10/12/2020 | 21/01/2021 | 18/02/2021 | 06/05/2021 | 01/07/2021 | 02/09/2021 | 04/11/2021 |
| **NUH** | | | | | | | | | | | | | |
| Chair | A | A | A | A | A | A | A | A | A | A | A | A | A |
| Chief Executive | A | A | A | A | A | A | A | A | A | A | D | D | A |
| **SFH** | | | | | | | | | | | | | |
| Chair | Apols | A | A | D | D | A | A | D | D | A | A | A | A |
| Chief Executive | D | A | A | A | A | A | A | A | A | A | A | D | A |
| **NHCT** | | | | | | | | | | | | | |
| Chair | A | A | A | A | A | A | A | A | A | A | Apols | A | A |
| Chief Executive | Apols | A | A | D | A | A | A | A | A | A | A | A | A |
| **CCGs** | | | | | | | | | | | | | |
| Accountable Officer | D | A | A | A | A | A | A | A | A | A | A | A | A |
| Non-Executive Director | A | Apols | A | A | A | A | A | A | A | A | A | A | A |
| **Bassetlaw CCG** | | | | | | | | | | | | | |
| Accountable Officer | | | | | | | | | | | | | A |
| Chair | | | | | | | | | | | | | Apols |
| **City Council** | | | | | | | | | | | | | |
| Chair, Health and Wellbeing Board | A | Apols | A | A | A | A | A | A | A | A | A | A | A |
| Chief Executive's Representative | A | Deputy | A | A | Apols | A | Apols | A | A | A | D | A | D |
| Councillor | A | A | Apols | A | A | A | A | A | A | N/A | N/A | N/A | N/A |
| **County Council** | | | | | | | | | | | | | |
| Chief Executive's Representative | A | A | Apols | A | Apols | A | A | Apols | Apols | Apols | A | A | A |
| Councillor | Apols | Apols | A | A | Apols | A | A | A | Apols | Apols | A | Apols | A |
| Chair, Health and Wellbeing Board | A | Apols | Apols | Apols | Apols | A | A | A | A | Apols | A | Apols | A |
| **EMAS** | | | | | | | | | | | | | |
| Chief Executive | D | Apols | A | A | A | A | A | A | A | A | A | A | A |
| **NHSEI** | | | | | | | | | | | | | |
| Director of Strategic Transformation, North Midlands | | | | | A | A | Apols | A | A | A | A | A | A |
| **Nottingham CityCare Partnership** | | | | | | | | | | | | | |
| Chief Executive | A | A | A | A | A | A | A | A | A | A | A | A | A |
| Chair | Apols | A | A | A | A | A | A | A | A | A | A | A | A |
| **MN ICP** | | | | | | | | | | | | | |
| Representative of Mid Notts ICP | A | | A | A | Apols | A | A | A | Apols | A | A | A | A |
| Representative of Mid Notts ICP on behalf of PCNs | Apols | A | A | | | A | A | Apols | A | A | Apols | A | A |
| **City ICP** | | | | | | | | | | | | | |
| Representative of Nottingham City ICP | A | A | A | A | Apols | A | A | A | A | A | Apols | A | A |
| Representative of Nottingham City ICP on behalf of PCNs | Apols | Apols | A | A | A | Apols | A | Apols | A | A | A | Apols | A |
| **South ICP** | | | | | | | | | | | | | |
| Representative of South ICP | A | A | A | A | A | A | A | A | A | A | A | A | A |
| Representative of South ICP PCN on behalf of PCNs | A | A | A | A | A | A | A | A | Apols | A | Apols | A | A |
| **Supporting roles** | | | | | | | | | | | | | |
| ICS Director of Communications and Engagement | A | A | A | A | A | A | A | A | A | A | A | A | A |
| Clinical Director | A | A | A | A | A | A | A | A | A | A | A | N/A | N/A |
| ICS Independent Chair | A | A | A | A | A | Apols | Apols | A | A | A | A | A | A |
| Chief Nurse | A | A | Apols | A | A | A | A | A | A | A | A | A | A |
| ICS Finance Director | A | A | A | D | A | A | A | A | A | A | A | A | A |
| ICS Assistant Director | A | A | A | A | A | A | Apols | A | A | A | A | A | A |
| ICS Executive Lead | A | A | A | A | A | A | A | A | A | A | A | A | A |

| | | | |
|---|---|---|---|
| **Item Number:** | 4 | **Enclosure Number:** | B1 |
| **Meeting:** | ICS Partnership Board | | |
| **Date of meeting:** | 3 March 2022 | | |
| **Report Title:** | Working With People and Communities: Citizen Intelligence Strategy | | |
| **Sponsor:** | Amanda Sullivan, Interim Executive Lead, Nottingham and Nottinghamshire ICS | | |
| **Place Lead:** | N/A | | |
| **Clinical Sponsor:** | N/A | | |
| **Report Author:** | Alex Ball, Director of Communications and Engagement, Nottingham and Nottinghamshire ICS | | |
| **Enclosure / Appendices:** | Enc B2: Working With People and Communities: Citizen Intelligence Strategy | | |

**Summary:**

This paper proposes the strategy for working with people and communities in the new ICS from July 2022. It responds to:

- NHSE/I guidance issued in September 2021.
- The feedback received from ICS Board in November 2021, where our approach to working with people and communities was discussed.
- NHSE/I Strategy content guide for Integrated Care Boards – working with people and communities, issued in November 2021.
- Subsequent conversations discussions with partners (e.g. Nottingham City Council and Healthwatch Nottingham and Nottinghamshire) in December 2021.

**Actions requested of the ICS Board**

To endorse the Working with People and Communities: Citizen Intelligence Strategy

**Recommendations:**

| | |
|---|---|
| 1. | ICS Partnership Board is asked to endorse the Working with People and Communities: Citizen Intelligence Strategy |
| 2. | ICS Partnership Board is asked to note work currently underway to develop the Working with People and Communities: Co-Production Strategy |
| 3. | ICS Partnership Board is asked to note the milestones and progress made to implement the Working with People and Communities: Citizen Intelligence Strategy. |

**Presented to:**

| Board | Transition and Risk Committee | Clinical Executive Group | System Executive Group | Finance Directors Group |
|---|---|---|---|---|
| ☒ | ☐ | ☐ | ☐ | ☐ |
| Quality Group | Bassetlaw Place | Mid Nottingham-shire Place | Nottingham City Place | South Nottingham-shire Place |

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|

**Contribution to delivering System Level Outcomes Framework ambitions**

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

**Conflicts of Interest**

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

**Risks identified in the paper**

| Risk Ref | Risk Category | Risk Description | Residual Risk | | | | Risk owner |
|---|---|---|---|---|---|---|---|
| | | | Likelihood | Consequence | Score | Classification | |
| N/A | | | | | | | |

**Is the paper confidential?**

☐ Yes
☒ No
☐ Document is in draft form

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

**Working With People and Communities: Citizen Intelligence Strategy**

**3 March 2022**

## Context and Background

1. The move to statutory ICSs and the establishment of a new Integrated Care Board and a wider Integrated Care Partnership as heralded in the Government's White Paper *Integration and innovation: working together to improve health and social care for all*[1] (February 2021) means there needs to be a different approach for working with people and communities.

2. ICS implementation guidance on working with people and communities (September 2021)[2] sets out the following key points:

   - A strong and effective ICS will have a deep understanding of all the people and communities it serves.
   - The insights and diverse thinking of people and communities are essential to enabling ICSs to tackle health inequalities and the other challenges faced by health and care systems.
   - The creation of statutory ICS arrangements brings fresh opportunities to strengthen work with people and communities, building on existing relationships, networks and activities.

3. The same guidance highlighted key actions for ICBs:

   - ICBs are expected to develop a system-wide strategy for engaging with people and communities by April 2022, using the 10 principles in the guidance as a starting point.
   - ICB constitutions are expected to include principles and arrangements for how the ICB will work with people and communities.
   - ICBs should work with partners across the ICS to develop arrangements for ensuring that integrated care partnerships (ICPs) and place-based partnerships have representation from local people and communities in priority-setting and decision-making forums.
   - ICBs are expected to gather intelligence about the experience and aspirations of people who use care and support and have clear approaches to using these insights to inform decision-making and quality governance.

4. In November 2021, NHS England and Improvement shared a public engagement strategy "content guide" to support current ICSs when developing strategies for how future ICBs will work with people and communities. The enclosed Working

[1] https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version
[2] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0661-ics-working-with-people-and-communities.pdf

with People and Communities: Citizen Intelligence Strategy reflects the suggested approach set out in that "content guide".

**Overview of the Citizen Intelligence Strategy**

5. The ICS is committed to working with people and communities and this is evidenced by the work on engagement and coproduction already taking place across the system. The two system-wide strategies for citizen intelligence (as described in this document) and coproduction (involving people as equal partners to shape services and approach) will form our collective system approach to working with people and communities.

6. Our framework for generating qualitative and quantitative citizen intelligence involves a number of mechanisms of equal value, ensuring we are fully inclusive and have a strong focus on health inequalities, enabling the involvement of people and communities.

7. We need to ensure that all of our Places and neighbourhoods are supported to develop skills and expertise in generating high quality citizen intelligence and understanding how this can influence health and care services. To enable this, we will develop a training package for individuals working with people and communities to ensure the necessarily skills, confidence and tools they need to generate and utilise high quality citizen intelligence and insight.

8. As we diversify and strengthen the ways that we generate citizen intelligence, there is a clear need for strategic oversight of the public involvement work and wider system intelligence and insight. The strategy sets out the governance for citizen intelligence aligned to the system's governance to enable the ICB to listen and respond to needs and aspirations of people and communities in Nottingham and Nottinghamshire.

**Feedback from ICS Board**

9. In November 2021 the Director of Communications and Engagement for the ICS presented to the Board the proposed approach to working with people and communities. The presentation and paper set out a comprehensive approach for working with people and communities in the new ICS from April 2022.

10. The Board endorsed the overall approach, although noting a number of areas that still needed to be worked through. The Board indicated it would want to see the next iteration of the plan before March 2022.

11. Since the last ICS Board meeting, consideration has been given to the feedback shared at that time, specifically:

    - Confirming the role of Foundation Trust Governors, Foundation Trust members, Trust patient groups and expert patient groups.
    - Sharing examples of citizen intelligence work happening at Place

- Promoting an asset based approach to generating citizen intelligence.
- How we will ensure meaningful and ongoing dialogues with citizens.
- Consider the language used when describing citizen intelligence, making it relevant and appropriate to all system partners.
- The role of Health and Wellbeing Boards.
- How citizen intelligence fits with the ICS System Analytics and Intelligence Unit.
- How citizen intelligence fits with existing resources within Local Authorities.
- The sources of existing data that could inform how we work with people and communities.

12. A number of follow up conversations with partners, including Nottingham City Council and Healthwatch Nottingham and Nottinghamshire also took place following the November Board meeting.

13. These elements are reflected in the enclosed strategy.

**Milestones and progress**

14. ICSs were expected to be fully operational by April 2022 but the move to put ICSs on a statutory footing has been delayed by three months to July 2022. Despite this delay, work has continued to develop the Citizen Intelligence Strategy and its enablers.

15. Nottingham and Nottinghamshire is one of eight ICSs across the country to be awarded funding of £20k from NHSE/I to strengthen public engagement through the development of a Citizens' Panel. The funding will be used to pilot a Citizens' Panel in Nottingham, with a view to refining this model for expansion to Nottinghamshire.

16. The ICS and VCSE have been awarded funding of £25k from NHS/I and 2.5 days of independent facilitation from the National Association for Voluntary and Community Action (NAVCA) to strengthen system level VCSE alliances that will:

    - Encourage and enable the sector to work in a coordinated way.
    - Provide the ICS with a single route of contact and engagement with the sector and links to communities.
    - Better position the VCSE sector in the ICS and enable it to contribute to the design and delivery of integrated care and have a positive impact on heath priorities, support population groups or reduce health inequalities.

17. An external consultant has been appointed to lead this work and Task and Finish Group has been established. By April 2022 the ICB and ICP are expected to have developed a formal agreement for engaging and embedding the VCSE sector in system-level governance and decision-making arrangements.

## Next steps

18. The Citizen Intelligence Strategy will be submitted to NHSE/I in due course for their assurance, and will be presented to the ICB Board for final signoff on 1 July 2022. Until then, there may be minor amendments made to the strategy. The final strategy will be typeset and designed to reflect the branding of Nottingham and Nottinghamshire ICS.

# Working with people and communities: Citizen Intelligence Strategy 2022 - 2025

## 1. Context

### 1.1. ICS overview

1 July 2022 will see the introduction of the Nottingham and Nottinghamshire Integrated Care Board (ICB) and a wider Integrated Care Partnership (ICP), bringing together partners across health and social care including;

- NHS Nottingham and Nottinghamshire Integrated Care Board
- East Midlands Ambulance Service NHS Trust
- Nottingham CityCare
- Nottingham City Council
- Nottinghamshire County Council
- Nottinghamshire Healthcare NHS Foundation Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- Nottingham University Hospitals NHS Trust
- Voluntary, Community and Social Enterprise organisations
- Healthwatch Nottingham and Nottinghamshire

All system partners are committed to consistently listening to, and collectively acting on, the experience and aspirations of local people and communities through the ICB and ICP and will work to:

1. Have a deep understanding of all the people and communities it serves.
2. Capture the insights and diverse thinking of people and communities to enable the ICB and ICP to tackle health inequalities and the other challenges faced by health and care systems.
3. Bring fresh opportunities to strengthen work with people and communities, building on existing relationships, networks and activities.

### 1.2. Key population demographics and issues

The Nottingham and Nottinghamshire footprint has a population size of just over 1.1 million people living in the City of Nottingham (332,900) and Nottinghamshire County (828,200)[1], covering a mixed urban and rural area, spanning communities with some of the highest and lowest levels of deprivation in the country.

Nottingham City[2]

- 30% of the population are aged 18 to 29 – full-time university students comprise about 1 in 8 of the population.
- The 2011 Census shows 35% of the population as being from BAME groups.
- Despite its young age-structure, Nottingham has a higher than average rate of people with a limiting long-term illness or disability.

[1] Population estimates | Nottinghamshire County Council
[2] Demography chapter: the people of Nottingham (2021) - Nottingham Insight

- White ethnic groups have higher rates of long term health problems or disability overall, although this varies with age, with some BME groups having higher rates in the older age-groups.
- Nottingham is ranked 11th most deprived district in England in the 2019 Index of Multiple Deprivation (IMD), a relative improvement on 8th in the 2015 IMD.
- 34% of children and 25% of people aged 60 and over live in areas affected by income deprivation.
- Rates of car ownership are low, particularly amongst pensioners living alone and lone parents.

Nottinghamshire[3]

- 21% of the population are aged 65+.
- 20% of the population are aged 0 – 27.
- BAME populations are relatively low in Nottinghamshire, 4% compared with 15% nationally and generally have a younger age profile than the general population (Census 2011).
- For those aged 18-24 years, unemployment rates have been higher than national levels for 8 of the past 9 years and (1.3% in May 2018, compared with 1.0% nationally)
- People living within the more deprived areas of Nottinghamshire have higher levels of unemployment, lower levels of qualifications, less healthy lifestyle choices and poorer health and wellbeing outcomes compared with those in less deprived areas
- Deprivation levels for Nottinghamshire as a whole are comparable with England. However, within Nottinghamshire there are communities with both some of the highest levels of deprivation in the country and some of the lowest levels of deprivation.

### 1.3. Our statutory duties

Statutory functions currently exercised by CCGs are expected to transfer to ICBs from 1 July 2022. Most relevant to this strategy is our statutory duty to involve people, whether directly or through representatives, in:

- Planning the provision of services;
- The development and consideration of proposals for changes to the way services are provided, and;
- Decisions to be made affecting the operation of services.

NHS organisations also have a duty under section 244 of the Health and Social Care Act to consult the local Health Scrutiny Committee on any proposal for 'substantial development or variation of health services' (see Appendix 1).

The 'Design Framework' for establishment of Integrated Care Systems published by NHS England / Improvement also includes a clear direction of travel for our work in this space[4].

### 1.4. Where we are now

In Nottingham and Nottinghamshire we can build on our experience of engaging with our communities as an ICS over the last two years and for many years prior to this. This includes working collaboratively with our partners to engage communities on system-wide

[3] Key population facts - Nottinghamshire Insight
[4] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0661-ics-working-with-people-and-communities.pdf

programmes such as the vaccine roll out and moving toward more strategic, insight-based forms of engagement. For example, to learn about the impact of service changes introduced during the first wave of the Covid-19 pandemic, a mixed-method approach to data collection was adopted, triangulating multiple sources of insight (qualitative data from focus groups and community conversations, quantitative data from surveys and desktop research). The quality and breadth of the outputs of this work informed the model of how we generate and utilise citizen intelligence and insights.

**Case Study – Promoting Covid-19 vaccination uptake**

It is acknowledged that different approaches to generating citizen intelligence are of equal value, and will be essential to ensure we are fully inclusive and have a strong focus on health inequalities. To promote uptake of Covid-19 vaccinations across Nottingham and Nottinghamshire, opportunities were promoted to talk to community groups about the vaccine and address any concerns. Through reaching out to diverse groups and where possible, gaining support from bilingual clinicians to lead these sessions accurate messages have been conveyed around the Covid-19 vaccinations.

As part of this, the Nottingham Muslim Women's Network expressed an interest in hosting a Covid-19 vaccination information session in Arabic for community members. The session was led by Dr Ban Alazzawi, who speaks Arabic, who addressed concerns around the vaccine. During this session, Dr Ban built a rapport with the group and addressed concerns around the vaccine. As a result, community members felt confident and comfortable in communicating their health concerns with a female clinician in Arabic.

Following this session, Dr Ban was added to the network for Arab women, Heya, and has supported in sharing further information with the group via WhatsApp. The group have worked with Dr Ban to share concerns their members have on receiving information on other health issues, particularly diabetes. As a result of this further information sessions continue to be arranged.

Our Local Authorities, particularly through their elected members, are champions for their populations and communities and we greatly benefit as a system from clearly hearing from elected members in our key governance forums and in the development of our activity plans. The role of Non-Executive Directors from NHS organisations is also a key aspect of how we ensure that we are hearing from a diverse range of viewpoints when formulating policy and responding to challenges and opportunities.

We also know that there is much work already taking place at neighbourhood and Place. For example, the voluntary, community and social enterprise (VCSE) sector have strong links with groups and communities, including those who are underserved and experiencing the greatest health inequalities. From the Covid-19 pandemic, Community Champions have emerged and Community Development Forums have been established. However there is a need for better co-ordination, collaboration and reporting of citizen insight.

**Case Study – Mid-Nottinghamshire virtual PPG event**

Patient Participation Group (PPG) members from across the Mid-Nottinghamshire area were invited to participate in a virtual PPG event on Thursday 10th December 2020. The event was aimed at listening and learning from PPG experiences during the pandemic whilst providing important updates for PPG members on system structures, the local COVID-19 position and work taking place across the system.

This virtual event took place on the online platform, Zoom and was attended by 20 PPG members from across the six Mid-Nottinghamshire Primary Care Networks (PCNs).

PPG members were also provided an opportunity to voice their successes or concerns over the pandemic. A key area for development related to strengthening communication and engagement between PPGs, PCNs, ICP and the wider health system.

Further work is also required ensure that citizen engagement is understood, valued and sought out across the ICS and seen as a key part of our work. We will also need to ensure that all of our Places are supported to develop skills and expertise in this area of work, in line with their relative maturity.

## 2. Aims and principles

### 2.1. ICS Vision

This Citizen Intelligence Strategy aligns to the overarching vision for the Nottingham and Nottinghamshire Integrated Care System (ICS). The ICS vision, informed by what our population communicates to us and which has full endorsement from key stakeholders, is as follows:

**Our overall ICS Vision**

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

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

- Health and wellbeing
- Independence, care and quality
- Effective resource utilisation

### 2.2. Our principles for working with people and communities

The principles that will guide the work of the system from July 2022 are based on the guidance (*ICS implementation guidance on working with people and communities*[5]) but adjusted to reflect the Nottingham and Nottinghamshire context:

1. We will work with, and put the needs of, our citizens at the heart of the ICS.

[5] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0661-ics-working-with-people-and-communities.pdf

2. We will prioritise reaching out to those communities affected by inequalities who are less likely to be heard.
3. We will use community development approaches that empower people and communities, making connections to social action.
4. We will work with Healthwatch and the voluntary, community and social enterprise sector as key transformation partners.
5. We will redesign models of care and progress system priorities in partnership with staff, people who use health, care and support services and unpaid carers
6. We will understand our community's experience and aspirations for health and care.
7. We will systematically capture and report community intelligence that includes findings drawn from a citizen's panel, VCS partners, statutory sector partners and networks at Place and neighbourhood level.
8. We will use insight gathered through a range of engagement approaches to inform decision-making.
9. We will develop a culture that enables good quality community engagement to be embedded
10. We will systematically provide clear and accessible public information about vision, plans, progress and outcomes to build understanding and trust amongst our citizens.

These principles are included in the draft ICB constitution pending ratification for the establishment of the ICB.

### 2.3. Our vision for working with people and communities

Our vision for working with people and communities contains two key elements – that of Citizen Intelligence and for Co-Production. These are closely aligned and complementary activities but are different disciplines with different techniques and arrangements.

**Citizen Intelligence**

*A process of actively listening to citizens to understand their experiences of health and care services to enable a focus on areas that need improvement or changes. An on-going cycle of activities that generate genuine citizen insights to guide the work of transformation and commissioning.*

**Co-Production**

A way of working that includes people who use health and care services, carers and communities in equal partnership; and which does this at the earliest (and all) stages of service design, development and evaluation.

The ICS is committed to working with people and communities and this is evidenced by the work on engagement and coproduction already taking place across the system. The two system-wide strategies for citizen intelligence (described in this document) and coproduction (involving people as equal partners to shape services and approach – shared in outline form at Appendix 2) will form our collective system approach to working with people and communities. Our system-wide 'Working with people and communities: Co-Production Strategy 2022-2025' will be published in July 2022. The combined overall Strategy for Working with People and Communities will be agreed and endorsed by the ICB Board at its first meeting in July 2022.

Overall Strategy for Working with People and Communities

Strategy for Citizen Intelligence (this document)

Strategy for Co-Production (due July 2022)

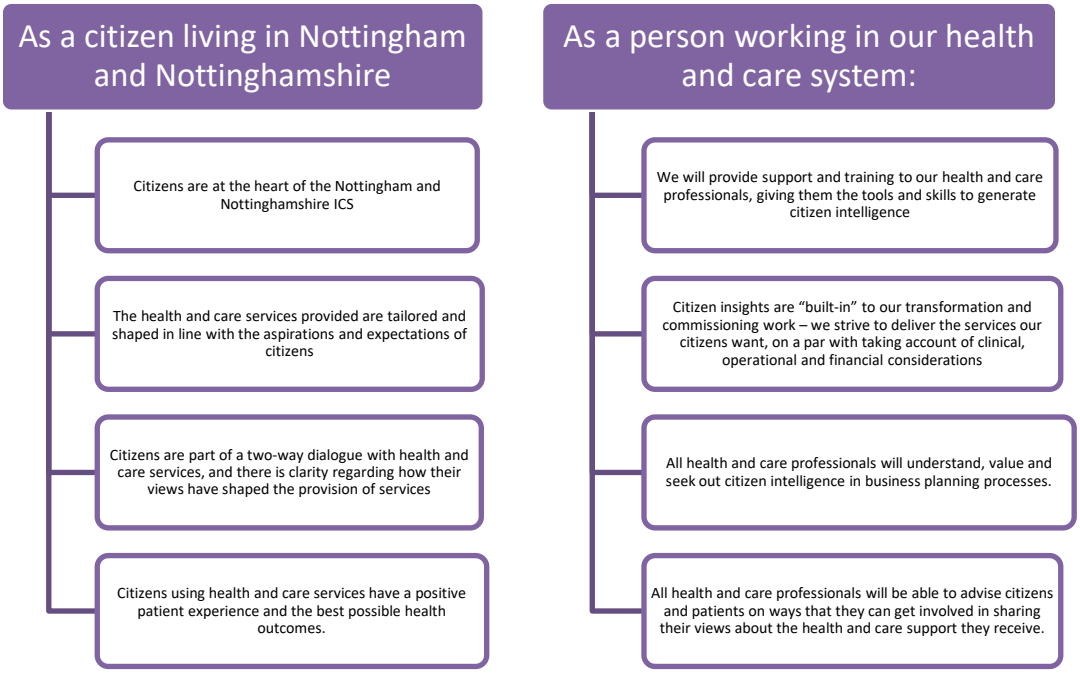
The overall Working with People and Communities strategy is the golden thread through each of our enabling strategies, to ensure that we put citizens and patients at the centre of all we do:

- Primary care strategy 2019/20 – 2023/34[6]
- Data, Analytics, Information and Technology (DAIT) Strategy 2020 - 2024[7]
- Health Inequalities Strategy 2020 - 2024[8]
- Public-Facing Digital Services 2021 – 2024[9]

To deliver on our ambitions to be a beacon of good practice in the way we work with people and communities in Nottingham and Nottinghamshire we need to work differently to understand the needs of our communities and how to meet them. This means going beyond asking our communities what they think of our existing services and changes we may want to make to them and doing more work to generate insights from local people that we can use to make lasting changes to people's health. Through generating and utilising citizen intelligence, we will be powerful drivers of patient centred approaches that provide greater choice and control to patients by transforming services around the specific needs of the populations.

If we get this right, the outcomes will be:

[6] primary-care-strategy.pdf (healthandcarenotts.co.uk)
[7] Item_6._Enc_C2._Notts_ICS_DAIT_strategy_August_2020_v3.1.pptx (live.com)
[8] Notts ICS HI strategy 06 October v1.8 (healthandcarenotts.co.uk)
[9] PowerPoint Presentation (healthandcarenotts.co.uk)




## 2.4. Our approach for involving people and communities

We will work differently with the people and communities of Nottingham and Nottinghamshire to understand and respond to the issues that impact on their health outcomes and reduce health inequalities. We recognise the need for diverse but complementary ways of reaching, hearing from and involving our people and communities. We will work with identified groups of people, whether they are connected by geographic location, special interest, or affiliation to identify and address issues affecting their well-being using a range of approaches across a spectrum of different involvement methods and approaches as shown in Table 1.

**Table 1. Spectrum of Participation**

| Method of involvement | Objective |
|---|---|
| Inform | To provide information to assist citizens in understanding the problem, alternatives, opportunities and/or solutions. |
| Consult | To obtain feedback, listening to and acknowledging concerns and aspirations. |
| Involve | To involve citizens throughout the process, ensuring their specific concerns and aspirations are understood and considered. Provide feedback on how their input influenced the decision |
| Collaborate | To work in partnership with citizens, seeking their perspectives and encouraging their ideas and solutions to inform priorities and planning. |
| Empower | To involve stakeholders in shared decision making about strategic priorities and service delivery. |

Our approach to engagement has been informed by the International Association for Public Participation's IAP2 Spectrum for Public Participation[10] outlines incremental levels of

[10] International Association for Public Participation (iap2.org)

involvement, with the lowest being “inform” while “empower” involves the greatest level of participation in decision making processes.

### 2.5. Our framework for working with people and communities

The framework (see Figure 1) for working with people and communities was developed through defining the core functions required to support the ICB for Nottingham and Nottinghamshire to deliver on its legal duties to make arrangements to involve patients, unpaid carers and the public in planning and commissioning arrangements.

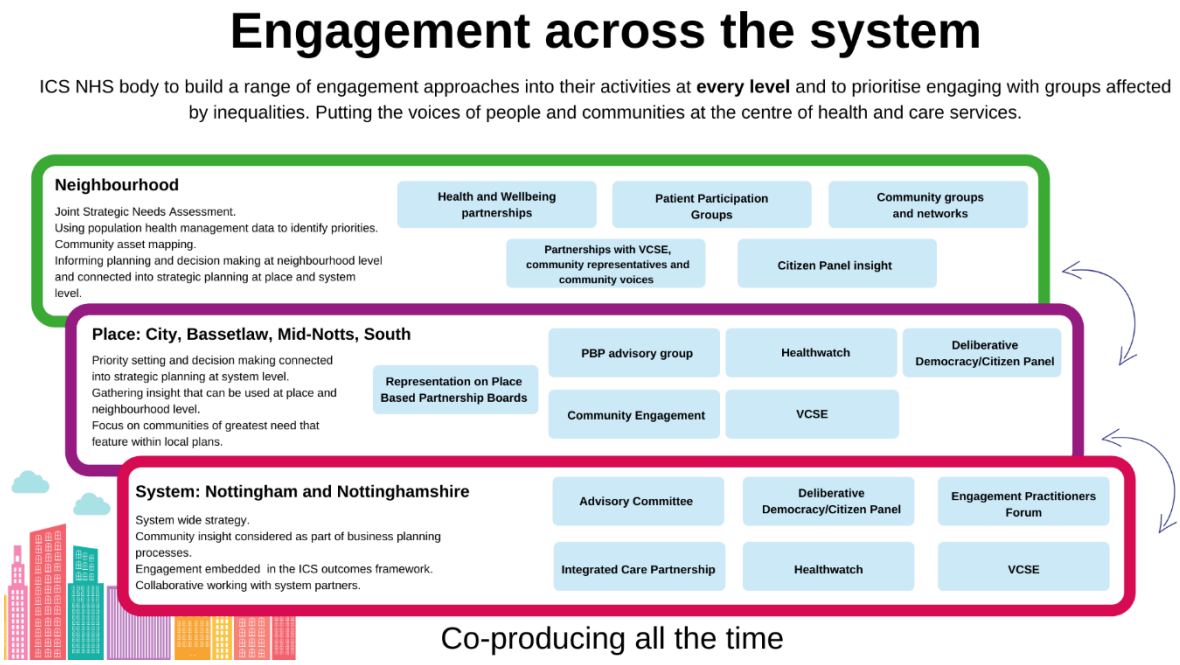



**Figure 1. Engagement Framework across the system**

## 3. Priorities for 2022-2025

The ICB priorities are still developing and will be reflected in this document when agreed. We will also ensure that the ICP Strategy when agreed (by March 2023) will be used to guide the focus areas of work for intelligence gathering.

## 4. People & communities in ICB workstreams and governance

### 4.1. Generating citizen intelligence

Our framework (see Figure 2) for generating qualitative and quantitative citizen intelligence involves a number of mechanisms of equal value, ensuring we are fully inclusive and have a strong focus on health inequalities, enabling the involvement of people and communities:


**Figure 2. Framework for generating citizen intelligence**

a) Working with system partners (for example, the ICS System Analytics and Intelligence Unit, Patient Experience Teams, Nottingham City and Nottinghamshire County Council Public Health colleagues etc.) to **collate and review existing data, research and evidence**, ensuring that existing knowledge and insights are maximised and gaps in our knowledge can be identified, including but not limited to:

   a. Census data
   b. Patient experience data (primary and secondary care providers and local authority service providers)
   c. Joint Strategic Needs Assessments
   d. Health and Wellbeing Board Strategies
   e. Population Health data
   f. Academic papers
   g. Non-academic research papers and briefings

b) **Targeted programmes of engagement** that seek to bridge the gaps in our understanding of communities' needs and aspirations for their health. These activities will often, but not always, be linked to specific proposed changes (e.g., major service change or the provision of new services in a different location) but may also be standalone pieces of learning and insights.

c) **Coproduction programmes.** Working in partnership with people who have relevant lived experience (expert patients, service users, unpaid carers and people in paid lived experience roles) and with learnt experience (staff), will enable us to directly connect with multiple and diverse voices including with those from underserved communities.

d) Our **Citizens' Panel** will provide a consultative body of 1000+ residents who are representative of the population of Nottingham and Nottinghamshire. Panel members will be part of an on-going engagement process whereby members opt-in and agree to engage on a regular basis. Our Citizens Panel will provide;

- A broad, representative and balanced input from our citizens to inform strategy and planning at system level
- Analyse insight via geographies to support Place-based partnerships and primary care networks
- Engage on areas/services of interest to support planning, commissioning and service provision
- Allow engagement to be conducted at relatively short notice
- Deliver potentially higher survey responses than one-off surveys
- Allow for the tracking of local views and sentiment over time

e) **Statutory engagement with elected members.** We will continue to regularly proactively brief and update (both verbally and in written form) Members of Parliament on system-wide topics. This will be complementary to the work of the Place-Based Partnerships and the ICB will continue to respond in writing to formal MP enquiries on system-wide matters. We will also continue to lead the formal process of involvement and consultation with Health Scrutiny Committees regarding Major Service Change as well as continuing an informal dialogue with HSC Chairs and providing updates and presentations to Committee on other topics. This goes alongside the usual responses and discussions with elected Councillors regarding service provision in their communities. Both of these sets of dialogue with public representatives are two-way processes and will involve the capturing of intelligence about the concerns and aspirations of communities in a systematic way.

f) Each of our four **Place Based Partnerships** have representatives from communities on their Boards, for example through VCSE representatives. The role of elected members at Place level will continue to be of critical importance in representing the voices of people and communities and Place Based Partnerships will continue to work with elected representatives at Borough/District level as well as Members of Parliament as appropriate.

g) All our citizen intelligence work will be **quality monitored**, to help us better understand how representative those views are. This can help understand if the intelligence generated is appropriate and whether new approaches need to be developed to address gaps.

h) **Equality Impact Assessments (EIA)** will inform and are informed by citizen intelligence. They help us understand who uses services and what views we have already heard, and which voices may be missing and how to reach those groups. Once completed citizen intelligence informs the EIA on the views of different groups and communities and the ways they may experience differential impacts. This can allow us to consider what can be done to mitigate or address these.

i) **Voluntary, Community and Social Enterprise Sector** have strong links with groups and communities, including those who are underserved and experiencing the greatest health inequalities. These strong links will facilitate the generation of citizen intelligence which may not be possible through other methods.

j) **Foundation trust governors and NHS organisation non-execs** are a critical part of how we hear from communities and staff groups. We will ensure that we utilise the expertise from these leaders in a similar way to how we work with elected members – ensuring we have a two-way dialogue.

### 4.2. Enabling citizen intelligence

We need to ensure that all of our Places and neighbourhoods are supported to develop skills and expertise in generating high quality citizen intelligence and understanding how this can influence health and care services. To enable this, we will develop a training package for individuals working with people and communities to ensure the necessarily skills, confidence and tools they need to generate and utilise high quality citizen intelligence and insight.

**Case Study – Developing an Engagement Toolkit**

In 2020, a Primary Care Network (PCN) Engagement toolkit was produced with our Patient and Public Engagement Committee and VCSE sector colleagues. This resource was developed to support PCNs to deliver targeted community engagement within their neighbourhoods. Consideration was given to the accessibility of the toolkit, to ensure that it could be used by many of our groups and communities. The toolkit also provided information to support engagement with underserved communities, including information on Equality, Diversity and Inclusion and a link to the East Midlands Academic Health Science Network page that provided a range of resources to support engagement of vulnerable groups. The toolkit was shared with the PCN Development Team and was well received.

A Task and Finish Group has been established to review the Engagement Toolkit to ensure it is fit for the future. It is envisaged that this will be refined to reflect the changes in the system and will be disseminated to support the generation of community intelligence at neighbourhood and place.

It will be important during the further development of this approach that we acknowledge and build on what we already have in place in our communities. We have huge strength and depth of community-based assets in our places and neighbourhoods and whilst we will always want to build and develop additional areas for the future, we should start from where we are and maximise the strengths that we already have. A 'strengths-based' approach will help us to guide where we can make the biggest difference in the fastest possible time.

### 4.3. Coordinating and understanding citizen intelligence

A great deal is already happening on the ground to generate citizen intelligence, but there is a need to better coordinate, collaborate and report on this activity.

This will be supported through the Engagement Practitioners Forum and Community Insight Hub described below:

a) The **ICS Engagement Practitioners Forum** will provide a platform for all system partners working with people and communities to work collaboratively, share resources, knowledge and expertise and maximise existing knowledge and insights. Membership will be inclusive of NHS, local government (District, Borough, City and County Councils), Healthwatch, VCSE sector and colleagues leading on patient experience and co-production.

b) Our **Community Insights Hub** will be a key resource for capturing and reporting community intelligence that includes findings drawn from all system partners including statutory sector, VCSE, Healthwatch, citizens' panel and networks at Place and neighbourhood level. It will also draw in data and insights created and published from outside our system, e.g., census data, ONS reports and wider public sector focussed reports and research. All of this will be captured and recorded in a database (to be developed over time) enabling a systematic record of what we know about certain communities or geographies. The Hub will be a key way that the primacy of Place will be delivered but that a system-wide view of our available insights would also be able to be produced.

   The Community Insights Hub would be to be able to answer the question: What do we already know about this community/demographic group/ patient group, and what more do we need to know? It will enable partners to identify where insight is already available to avoid duplication and avoid unnecessary community engagement.

   Insight reports will be systematically generated and presented to inform activity and decision-making at neighbourhood, Place and system level.

### 4.4. Embedding and assuring citizen intelligence

There is a commitment to embed citizen voice into commissioning decisions at Place and system level through the following ICB contract and commissioning committees:

- Nottingham and Nottinghamshire Integrated Commissioning Committee
- Strategic Commissioning Committee
- Bassetlaw Place-based Committee
- Mid-Nottinghamshire Place-based Committee
- Nottingham City Place-based Committee
- South-Nottinghamshire Place-based Committee

The CCG Equality, Diversity and Inclusion Policy recognises citizen engagement as a key business activity. The 2021/23 Equality Improvement Plan has a number of actions, further demonstrating the embedding of citizen intelligence. Furthermore, the CCG Service Benefit Review Policy considers citizen engagement throughout. These CCG policies will be transferred over to their new ICB context and it is anticipated that these requirements of these plans and strategies will continue to ensure the voice of citizens is clearly heard in the decision making process of the system.

**Citizen Intelligence Advisory Committee (CIAG)**

The CIAG will ensure that all proposals to change and improve healthcare services in Nottingham and Nottinghamshire are developed with appropriate and sufficient citizen and service user involvement and citizen intelligence and insights from patients, staff, carers and public that tell us what matters to them are taken on board and have influenced decision making.

The CIAG will have a formal link to the ICB and ICP, supporting the delivery of citizen intelligence and insight reports to inform the commissioning of health and care services. The ICP will, as part of its role as the 'guiding mind' of the ICS in line with the expectation that "a strong and effective ICS will have a deep understanding of all the people and communities it serves", receive reports summarising intelligence and insights gathered from citizens and communities over the period preceding each meeting of the ICP.

The membership of CIAG will reflect the four Places and have a strong focus on health inequalities and the wider determinants that impact on health and wellbeing. Representation would also include the VCSE sector and Healthwatch Nottingham and Nottinghamshire.

## 5. Roles, responsibilities and resources

As we diversify and strengthen the ways that we generate citizen intelligence, there is a clear need for strategic oversight of the public involvement work and wider system intelligence and insight. The following section sets out the governance for citizen intelligence aligned to the system's governance to enable the ICB to listen and respond to needs and aspirations of people and communities in Nottingham and Nottinghamshire.

### 5.1. Overview

In Nottingham and Nottinghamshire ICS, we believe citizen intelligence is everyone's business, and is not just relevant for those whose direct role is within this field. This ethos supports individuals within the system whose role it is to ensure that citizen intelligence is generated.

### 5.2. Integrated Care Board

The ICB Board has overall responsibility for the Citizen Intelligence Strategy and are responsible for ensuring adequate resources are available to ensure its implementation. The Nottingham and Nottinghamshire ICS Chair and Accountable Officer are both committed to ensuring that we hear the voice of people and communities.

#### Quality, People and Inequalities Committee

This committee is responsible for assuring the ICB in regard to its statutory duties for patient and public involvement.

#### Ownership of the Strategy

The ICB's Director of Communications and Engagement and ICB Director of Nursing jointly have overall responsibility for the development and implementation of the Working with People and Community Strategy. These two senior leaders own the Citizen Intelligence and Co-Production elements respectively of the overall strategy as outlined in Section 2.3. The two senior owners of this strategy are committed to working closely together to ensure that the two facets of the overall strategy are aligned and complementary whilst also respecting their separate roles and contexts.

#### Engagement Practitioners

The core team is led by a Head of Insights and Engagement, with an Engagement Manager to plan and coordinate citizen intelligence. However each of our Places has their own engagement leads. The role of the core team is to act as Relationship Managers with our

four Places, providing support, advice and guidance to colleagues undertaking citizen intelligence work at Place.

Most of our programmes also have a designated engagement contact, to ensure that any engagement work is planned and coordinated with expertise from the core team.

### 5.3. Working with system partners

The Citizen Intelligence Strategy will embrace the resource and expertise across all system partners. This will support the system to deliver an integrated, system wide approach to working with people and communities that makes best use of the time of everyone involved particularly, our people and communities who will be able to provide insight once that can be used intelligently across the system.

**Integrated Care Partnership (ICP)**

Proposals for the establishment of Nottingham and Nottinghamshire ICP are in the process of being agreed. The ICP will facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development. The Integrated Care Strategy that will be developed and owned by the ICP should be developed for the whole population using best available evidence and data, covering health and social care and addressing the wider determinants of health and wellbeing. There is an opportunity for citizen intelligence and insight to contribute to the development of this strategy. In addition, it is recommended that the ICP receives a report on insights gained from service users and citizens at each of its meetings to inform decision making. There is a commitment to ensure that citizen voice is heard in this forum, with Healthwatch Nottingham and Nottinghamshire and the VCSE Alliance Chair providing this.

**Citizen Intelligence Advisory Committee (CIAG)**

The CIAG will have a formal link to the ICB and ICP, supporting the delivery of citizen intelligence and insight reports to inform the commissioning of health and care services.

The membership of CIAG will reflect the four Places and have a strong focus on health inequalities and the wider determinants that impact on health and wellbeing. Representation would also include the VCSE sector and Healthwatch Nottingham and Nottinghamshire.

**ICS Engagement Practitioners Forum**

There are plans to develop an ICS Engagement Practitioners forum, made up of colleagues working across all health and care sectors, including the NHS, local government, VCSE sector etc. It is anticipated that in addition to scheduled meetings, members of the group will meet independently to undertaken specific tasks, for example, to analyse citizen intelligence and produce actionable insights for discussion as part of the core meetings.

The forum will:

- Build trust with clear, regular and accessible communications that can be shared across the system.
- Support the sharing of resources, knowledge, channels and expertise available to the ICS for community engagement.

- Establish community engagement programmes around the ICS transformation priorities and make these programmes collaborative across the ICS with a clear focus on reducing health inequalities.
- Work collaboratively on focused, priority programmes of work, initially piloting an approach, evaluating that approach and updating it as required.
- Ensure that existing knowledge and insights are maximised, prioritising limited resources on areas where we have gaps in our knowledge rather than going over old ground.
- Establish a systematic way of capturing and reporting community intelligence that includes findings drawn from a citizen's panel, VCS partners, statutory sector partners and networks at Place and neighbourhood level
- Invest in targeted programmes of engagement that seek to understand communities' needs and aspirations for their health, and involve them in developing solutions focus on health inequalities

Once established, a key priority for the ICS Engagement Practitioners Forum will be to critically appraise where we can do things once across our system to avoid duplication of cost. This may include a mapping and gapping exercise to understand priorities, joining up on programmes where possible. Where external funding opportunities arise and if it's appropriate to do so, we would look to submit whole system proposals.

We are also keen to understand from Engagement Practitioners how we can maximise the intelligence available from existing sources within or attached to their organisations. This will include from our system Foundation Trusts how best to generate and capture intelligence from Foundation Trust Governors plus working with all partners to access and assimilate insights from expert patient groups and other collectives. The Forum will develop and embed the most appropriate mechanism to enable this.

**Voluntary, Community and Social Enterprise (VCSE) Alliance**

The VCSE sector is key to the creation of successful ICSs. Work is currently underway to establish how the VCSE sector will be formally embedded within the ICS. It is envisaged that a VCSE Alliance will be formed - 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. The VCSE Alliance will be an essential part of how the system operates at all levels. This will include involving the sector in governance structures and system workforce, population health management and service redesign work, leadership and organisational development plans. The VCSE sector is already supporting delivery of the priority objectives through the community engagement work they are commissioned to deliver.

**Healthwatch Nottingham and Nottinghamshire**

The ICS will continue its close partnership work with Healthwatch Nottingham and Nottinghamshire. Alongside membership of the CIAG outlined above, Healthwatch will formally be part of the ICP. The system already benefits from Healthwatch membership of Place Based Partnership Boards and also the two Health Scrutiny Committees.

## 6. Monitoring and Evaluation

As the principles of this strategy are embedded in across the system, it is important that we are examining our citizen intelligence practices and the impact this is having both on our work and on our people and people and communities. An Evaluation Framework is currently

being developed, which will outline how we will measure and appraise our range of methods and how this will support ongoing improvement.

The Evaluation Framework is based around the key principle that we will feed back to citizens, staff, stakeholders and our partners on how their views have helped to influence service change or development. This is essential in demonstrating their value, will encourage them to continue to engage in and ongoing dialogue about their experiences. To do this we will:

- Where possible, feedback directly to those involved, via written correspondence or attending meetings. Our aspiration is that we give assure people and communities about the value of citizen intelligence, creating Ambassadors in neighbourhoods and Places.
- Following any consultation or engagement, whether formal or informal, a report will be produced detailing our methods, the views of those we consulted and engaged with, lessons learnt from the consultation and engagement, and any other key information relating to the consultation and engagement activity.
- Share reports with those who were involved in generating citizen intelligence as part of bespoke programmes of work, including direct distribution and publication on our website.
- Produce regular newsletters for colleagues across the system, so that they are aware of the work that is being done in this area.
- Develop “You Said, We Did” feedback reports to demonstrate how the views of citizens, staff, stakeholders and our partners have influenced change and improvement, ensuring that we are closing the loop.

## Appendices

### Appendix 1: Our legal duties to involve people and communities[11]

NHS Act 2006

Section 242 of 2006 NHS Act is the legal duty to involve current and potential service users or their representatives in everything to do with planning, provision and delivery of NHS services. The duty specifically applies where there are changes proposed in the manner in which services are delivered or in the range of services made available.

Section 244 of the NHS Act 2006 regarding the duty to consult the relevant local authority in its health scrutiny capacity.

Section 14T of the NHS Act 2006) Clinical Commissioning Groups (CCGs) have the duty to have regard to the need to reduce inequalities.

Health and Social Care Act 2012

The Health and Social Care Act 2012 introduced significant amendments to the NHS Act 2006, especially with regard to how NHS commissioners will function. These amendments include two complementary duties for CCGs with respect to patient and public participation.

Section (14Z2) outlines how this legal duty for involvement:

- in the planning of its commissioning arrangements
- in developing and considering proposals for changes in the commissioning
- arrangements that would impact on the manner in which services are delivered or on the range of services available
- decisions that affect how commissioning arrangements operate and which might have such impact

Public sector equality duty

The Equality Act 2010 prohibits unlawful discrimination in the provision of services on the ground of 'protected characteristics', these are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex and sexual orientation.

[11] Once the Health and Social Care bill is finally confirmed these will likely be updated and CCG references will become ICB references.

As well as these prohibitions against unlawful discrimination the Equality Act 2010 requires CCGs to have 'due regard' to the need to:

- eliminate discrimination that is unlawful under the Equality Act 2010
- advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it and
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

This is known as the 'public sector equality duty' (section 149 of the Equality Act 2010).

Reducing health inequalities

NHS England and CCGs are also under a separate statutory duty to have regard to the need to reduce health inequalities between patients in access to health services and the outcomes achieved (sections 13G and 14T of the NHS Act, as amended by the Health and Social Care Act 2012, respectively).

The Gunning principles

These principles, known as Gunning or Sedley, were confirmed by the Court of Appeal in 2001 (Coughlan case) and are now applicable to all public consultations that take place in the UK.

The principles are:

- Consultation must take place when the proposal is still at a formative stage
- Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response
- Adequate time must be given for consideration and response
- The product of consultation must be conscientiously taken into account.

**Appendix 2: Nottingham and Nottinghamshire Co-Production Strategy**

**Introduction**

**1.** This report provides update on the coproduction strategy work as part of the working with people and communities strategy.

**2.** The ICS is committed to working with people and communities and this is evidenced by the current work on engagement and coproduction taking place across the system. The two system-wide strategies for engagement (focused on citizen intelligence) and coproduction (involving people as equal partners to shape services and approach) will form our collective system approach to working with people and communities. It is implicit in all of this that co-production should be taking place at all levels of the system at all times.

**Definitions:**

- Citizen Intelligence: A process of active listening to citizens to understand their experiences of health and care services to enable a focus on areas that need improvement or changes. An ongoing cycle of activities that generate genuine citizen insights to guide the work of transformation and commissioning.
- Co-Creation: The act of working together between organisations and/or professionals to create integrated health and care services for citizens.
- Co-Production: A way of working that includes people who use health and care services, carers and communities in equal partnership; and which does this at the earliest (and all) stages of service design, development and evaluation.

In practice this means:

- Citizen Intelligence will identify areas that need attention …
- Using Co-Creation will mean that the widest possible range of partners can shape a solution…
- And a Co-Production approach ensures the views of citizens shape our services and approach…
- Which may well identify further areas for a deep dive and more detailed insights generation.

**Coproduction strategy**

**3.** Nottingham and Nottinghamshire ICS's vision is to embed coproduction in all work across the system as a move towards co-production being the default position. This means that the aspiration is for genuine coproduction to be embedded within all elements of system design and delivery, including transformational activity, commissioning activity, service/system redesign and quality improvement.

Our aim is for people to be involved in the co-design and co-commissioning of our system and services in a meaningful way, as a powerful voice alongside those of the professionals in the system.

**4.** As part of this, the ICS is in the process of developing a coproduction approach for the whole system and a plan to embed coproduction approaches in all areas.

**5.** This work will set the foundations for the longer term ICS approach for coproduction as default in everything we do and create the culture change in our staff teams across the system to embed coproduction. Current work will set the vision, strategy and key tools required for the ICS to grow and develop over the coming years with coproduction at its heart.

**6.** Coproduction is about ensuring that people with lived experience are empowered and involved in developing, shaping and making decisions about support and services as an equal partner to professionals. It is about valuing the insight and contribution of people that use services, and working with people, not doing to people, or doing for people. Coproduction supports a balanced relationship where both people with lived experience and professionals are experts in their own right, relocating power with staff becoming facilitators, rather than fixers.

**7.** Strategic coproduction is where a group of committed and knowledgeable people with relevant lived experience feel confident to contribute effectively and consistently. The collective voice of a strategic co-production group is significantly different from individual people inputting their own perspectives at meetings.

**8.** Working in partnership with people who have relevant lived experience (patients, service users, unpaid carers and people in paid lived experience roles) and with learnt experience (staff), enables us to directly connect with multiple and diverse voices including with those from disadvantaged and minority communities. Building equal and reciprocal partnerships from the very start of, and throughout, all our work will be crucial.

**9.** To achieve this aim, work will include the development of:

- **A system wide coproduction strategy and practical coproduction toolkit will be developed (for staff and people with lived experience) with expertise and learning from all elements of the system, including experts by experience.**

This will set out the coproduction principles and expectations for the system, with partner strategies on coproduction aligning to the system-wide strategy.

- **A training package for both staff and people with lived experience to ensure that people have the skills, confidence and tools they need to work together in partnership and coproduce effectively.**
  For staff this will mean ensuring they are confident at coproducing with people with lived experience, moving to a facilitator role rather than someone that knows all the answers. For people with lived experience this will mean ensuring that they are activated and confident in sharing the views of people with lived experience effectively and consistently in different meeting settings or in key communications. The toolkit will be accessible for staff, people with lived experience and the public.

- **Establishment of a strategic coproduction group to ensure that strategic decisions and planning around the future of the ICS includes people with lived experience as an equal partner.**
  Our intention is to establish a group of people with lived experience to advise on system design, delivery and commissioning. This group will be a core group that will be involved in key priority work across the system and will also report into and represent the group at ICS Board.

- **Culture change across the system to support the coproduction approach**
  This will form the basis of system wide culture change, supported by shared system commitment and ownership, along with key coproduction champions in key areas/organisations of the system.

**10.** People with lived experience and partners from across the system (health, local authority and voluntary sector) are involved in the development of the coproduction approach.

**11.** A system wide Coproduction Steering Group has been established with people with lived experience and executive director level partner representation to provide a strategic steer on the development of the approach.

**12.** A system wide Coproduction Working Group has been established with people with lived experience and partners to scope out and develop detailed proposals using local and national best practice. This will also include the development of a policy for ensuring a range of people with lived experience can access coproduction opportunities (removing barriers such as travel, childcare and care needs) to ensure we are directly

connected to multiple and diverse voices, including under-represented groups. The working group will also undertake work to develop a policy to support, recognise, reward and value people with lived experience's time and contributions.

**13.** The strategy and toolkit will build upon the coproduction work and learning that has taken place across our local health, social care and voluntary sector organisations, including (but not limited to):

- My Life Choices – a 'national exemplar' strategic coproduction group supporting the universal personalised care programme
- Maternity Voices Partnership – an equal partner in our Local Maternity and Neonatal System programme
- Learning Disability Programme – recently undertook work to coproduce a 3-year plan with people with lived experience
- Integrated Children's Disability Service – local authority led work to redesign the Short Breaks service
- SEND Accountability Board's coproduction charter
- Learning through our Covid Local Resilience Forum community response

**14.** To support this work, Nottingham and Nottinghamshire ICS are 1 of 10 sites to develop and embed coproduction (peer support and funding) via NHS England and NHS Improvement Experience of Care Team programme. The project benefits from access to peer networks, learning from other sites and national best practice, as well as £20,000 funding to support development of the strategy and involvement in national evaluation work.

**15.** Key outcomes of the work include:

- People with lived experience at the heart of the Nottingham and Nottinghamshire ICS
- A system that understands and owns the importance of coproduction in all that we do
- A clear vision and credible coproduction strategy will deliver quality improvement across the ICS, drawing together quality planning, quality control, quality improvement and assurance functions to deliver care that is high quality, personalised and equitable.
- System staff and people with lived experience will have the tools and skills required to effectively coproduce and work in partnership together
- People with lived experience will be embedded within our ICS Board and all Transformation Boards and working groups
- Services will be better informed, high quality, responsive and sustainable
- There will be improved patient experience and outcomes for people who access services
- A clear system direction for the future based on robust review and evaluation of the benefits and outcomes of coproduction

**Progress to embed in system**

**16.** To date here has been significant engagement in the coproduction strategy work from people with lived experience, as well as strategic programme areas and services across the system. This includes City Health and Wellbeing Board, PCN's, ICP's, mental health commissioning, Community Care Transformation, Ageing Well programme and medicines management.

**17.** Alignment with key areas, especially the community care transformation, has been key to ensuring coproduction work can develop at the pace required by priorities, without the formal strategy being in place.

**18.** During the level 4 response to Omicron, the work has not progressed to the previous timescales set out and these have now been revised and aligned with the ICB timetable. Progress against actions can be seen in appendix 1.

**Project timescale:**

| **Phase 1:** | |
|---|---|
| Coproducing the strategy | Strategy sign off |
| until May 22 | June |

| **Phase 2:** |
|---|
| Development of toolkit & training offer |
| May - Sep |

| **Phase 3:** |
|---|
| Embedding across system & continuous review |
| October & beyond |

**19.** Work to align with the engagement function is ongoing and is crucial to ensure that the ICB has a clear and aligned strategy for work with people and communities. There is opportunity to streamline this further to ensure that the system has robust and transparent approaches in place that are clear for stakeholders and prevent confusion. There is also an opportunity to embed coproduction within our system approaches to engagement. It is important that there is distinction between this separate activity where it is not coproduction, but it provides an opportunity for us to move to coproduction as default in exploring this further.

**Appendix 3: Development of this strategy**

A series of workshops took place during September 2021 with participants representing organisations across the health and care landscape:

- Bassetlaw Clinical Commissioning Group
- Nottingham and Nottinghamshire Clinical Commissioning Group
- Nottinghamshire Healthcare Foundation Trust
- Ashfield Voluntary Alliance
- Nottingham CVS
- Mansfield CVS
- Rushcliffe CVS
- Patient representatives/leaders
- Newark and Sherwood District Council
- Gedling Council

Feedback from these workshops has been reflected in the updated framework and includes but is not limited to;

- An expectation to work collaboratively, across the whole health and care landscape, maximising our collective resources.
- Clarification that any proposed citizens panel would be part of an overall range of activities, not the only way that insights would be gathered.
- Confirmation that the majority of activity to engage with citizens would take place at the level of Place but that this would need to be joined up at all levels of the system.
- An ambition to maintain a level of consistency in the way that the work is deployed within Places but to retain an appropriate level of flexibility and customisation as appropriate to each Place.
- Strive to make activities as simple as possible for citizens to get involved in to maximise our reach.

The richness of the feedback from the workshops and the ICS Board Development Session discussion has helped to shape the development of the Strategy and implementation process. The emerging strategy for citizen intelligence was discussed at the ICS Board in November 2021 and will be discussed again for sign-off in March 2022. The final formal adoption of this Strategy will take place on or after 1st July 2022 when the ICB formally comes into existence.

| | | | |
|---|---|---|---|
| **Item Number:** | 5 | **Enclosure Number:** | C1 |
| **Meeting:** | ICS Partnership Board | | |
| **Date of meeting:** | 3 March 2022 | | |
| **Report Title:** | Report from the Chair and Chief Executive | | |
| **Sponsor:** | Kathy McLean, ICB Chair Designate and Amanda Sullivan, ICB Chief Executive Designate | | |
| **Place Lead:** | | | |
| **Clinical Sponsor:** | | | |
| **Report Author:** | Joanna Cooper, Assistant Director, ICS | | |
| **Enclosure / Appendices:** | Enc C2: Nottingham and Nottinghamshire ICS presentation | | |

**Summary:**

The report provides an update on key messages relating to work across the ICS.

**Actions requested of the ICS Board**

To note the contents of the report.

**Recommendations:**

| | |
|---|---|
| 1. | None |

**Presented to:**

| Board | Transition and Risk Committee | Clinical Executive Group | System Executive Group | Finance Directors Group |
|---|---|---|---|---|
| ☒ | ☐ | ☐ | ☐ | ☐ |
| Quality Group | Bassetlaw Place | Mid Nottingham-shire Place | Nottingham City Place | South Nottingham-shire Place |
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Contribution to delivering System Level Outcomes Framework ambitions**

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

**Conflicts of Interest**

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

**Risks identified in the paper**

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

**Is the paper confidential?**

☐ Yes
☒ No
☐ Document is in draft form

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

**Report from the ICB Chair and ICB Chief Executive Designates**

**3 March 2022**

## Introduction

1. In light of the revised target date for the new statutory arrangements, ICS Partnership Board meetings have been reinstated to provide a framework for oversight of the ICS Transition Plan and 2022/23 Operational Planning requirements; also, to facilitate ongoing engagement with key stakeholders across the system and transparency for our citizens. To this end, a further formal meeting will take place in May 2022 in addition to today's meeting. A forward workplan for the Partnership Board has been developed and is included in the papers for colleagues to be sighted on.

2. Our report this month highlights some key areas for Board members to note, including key updates on system developments and details of several recent national publications.

## Pandemic response and winter pressures

3. Whilst the worst of the Omicron surge appears to be over, many colleagues across our system, in acute care and in general practice, in homecare and residential care are still managing considerable levels of Covid-19 demand as well as the more usual winter pressures.

4. As of 15 February, 303 beds in Nottinghamshire's hospitals were occupied by patients with Covid-19 (which compares to 485 beds at the peak during early January). Although hospitalisation rates are falling slowly, infection rates remain high and may rise again with the easing of social distancing restrictions.

5. Workforce absences are improving across system (4% covid-related). This has enabled staff to return to business as usual functions and the restoration of services. A number of derogations were in place in order to redeploy staff to respond to the Omicron wave.

6. Timely discharge from hospital remains a key priority for the system. Homecare capacity constraints continue to have an impact on the ability to secure support packages in people's homes. Short-term tactical actions and longer-term capacity building plans are in place. There is excellent engagement from system partners to find collective solutions.

7. GP practices continue to see high volumes of patients. Using the latest figures available, December saw 486,478 GP appointments taking place, 4% up on December 2020 which itself was considerably up on 2019. Of these appointments, 62% being face-to-face and 51% being the same day or next.

8. Latest figures show in Nottingham and Nottinghamshire 2,077,240 vaccinations (first, second, third and boosters) have been administered since the start of the

programme. This means that 84.6% per cent of over 18s have now received two doses and 66.6% of over 18s have had a booster dose. To protect as many people as possible from the Omicron strain, three additional walk-in facilities were opened in Nottingham and Newark offering booster vaccinations. These temporary sites have now closed; however, a range of dedicated sites, GP surgeries and pharmacies throughout the county continue to offer both booked appointments and walk-in facilities for first, second and booster vaccinations. The programme will continue to focus on working in areas of lower take up to boost vaccination rates.

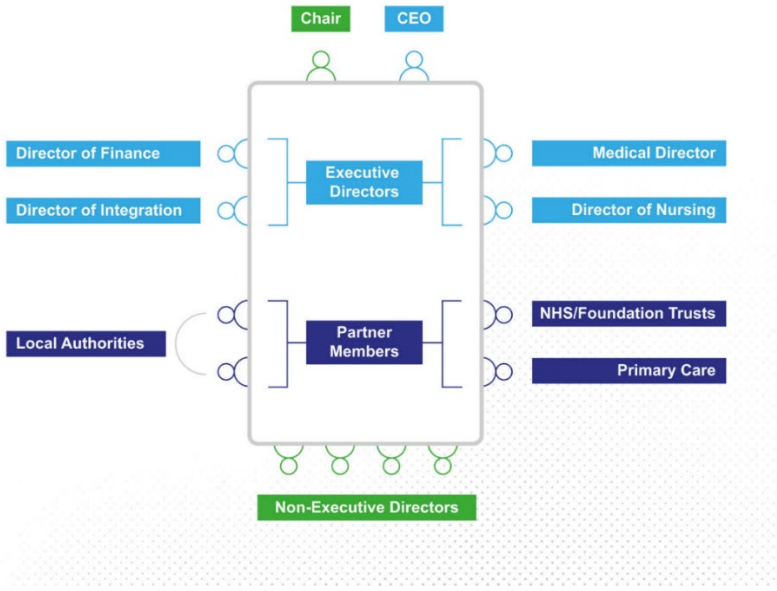
9. The Local Resilience Forum has stood down from Major Incident status, although multi-agency working remains strong where required.

**Establishing the Integrated Care System**

10. The Health and Care Bill, which intends to put Integrated Care Systems (ICSs) on a statutory footing is currently being considered by Parliament. To allow sufficient time for the remaining parliamentary stages, a revised target date of 1 July 2022 has been agreed for the new statutory arrangements to take effect and Integrated Care Boards (ICBs) to be legally and operationally established. This replaces the previously stated target date of 1 April 2022.

11. Whilst having the legislation in place and our formal structures confirmed is a necessary step, it is important that we maintain our momentum in developing our system and that we continue to focus on creating the right culture and behaviours for successful collaborative and integrated working. An updated overview of our ICS is included in the appendices to this paper to support colleagues in sharing the key messages about our collective work.

12. In November 2021, we agreed the membership of our local ICB Board (as illustrated below), which has subsequently been approved by NHS England, subject to the legislative process.



| Member Type | Role |
|---|---|
| Independent Non-Executive members (5) | 1. Chair<br>2. Independent NED (Chair of Audit Committee)<br>3. Independent NED (Chair of Remuneration Committee)<br>4. Independent NED (Chair of the Quality, People and Inequalities Committee)<br>5. Independent NED (Chair of the Finance, Performance and Digital Committee) |
| Executive members (5) | 6. Chief Executive<br>7. Director of Finance<br>8. Director of Nursing<br>9. Medical Director<br>10. Director of Integration |
| Partner members (4) | 11. One member drawn from the primary medical services (general practice) providers<br>12. One member drawn from the NHS trusts and foundation trusts<br>13&14. Two members from the upper tier local authorities with statutory social care responsibility |

13. We're pleased to announce the designate appointments of three Non-Executive Directors for the ICB (you can read more in the latest edition of the ICS newsletter available here, https://healthandcarenotts.co.uk/news-from-notts-ics-edition-2/):
    - Professor Marios Adamou OBE, Chair of the Quality, People and Inequalities Committee.
    - Stephen Jackson, Chair of the Finance, Performance and Digital Committee.
    - Jon Towler, Chair of the Remuneration Committee and Strategic Commissioning Committee.

14. Recruitment processes are underway for a fourth Non-Executive Director (Chair of the Audit and Risk Committee) and for the ICB's four Executive Directors; we are hoping to confirm designate appointments to these roles by 31 March 2022.

15. Following early engagement on the ICB's proposed constitution, further discussions are now being planned with relevant system partners to finalise arrangements for nominating and selecting the Partner Members of the ICB Board. These arrangements will be subject to secondary legislation, which is anticipated in a timeframe that will enable local appointments to be made during April 2022.

16. In addition to the above developments relating to the ICB, significant progress is being made towards the establishment of our local Integrated Care Partnership (ICP), which is the second statutory element of the ICS. A paper providing the latest detail of proposals is included as a separate item on the agenda for today's meeting.

17. Work is also progressing well in relation to the development of our Provider Collaborative at scale and our Place-Based Partnerships. Updates on these core elements of our ICS are scheduled for our next meeting on 5 May.

18. We remain committed to ensuring that all system partners are able to continue to support the work of the ICS and its ongoing development, and as part of confirming the new structures for the ICS we are mapping stakeholder involvement across all aspect of the new system arrangements.

**Primary care strategy development**

19. Following initial developmental discussions with Partnership Board members, work continues to develop a local Primary Care Strategy for the next five years and a detailed timeline for the strategy development has been produced. The strategy will initially focus on General Practice, but will be broadened to incorporate pharmacy, optometry and dentistry as these responsibilities are delegated to the ICB by NHS England. The strategy will have 12 areas of focus, which are described at a high-level in the appendices to this paper.

**Key national publications**

20. On 2 February 2022, the government published *Levelling up the United Kingdom* (Levelling Up the United Kingdom - GOV.UK (www.gov.uk)), which sets out a moral, social and economic programme for the whole of government across four objectives to:
    - Boost productivity, pay, jobs and living standards by growing the private sector, especially in those places where they are lagging.
    - Spread opportunities and improve public services, especially in those places where they are weakest.
    - Restore a sense of community, local pride and belonging, especially in those places where they have been lost.
    - Empower local leaders and communities, especially in those places lacking local agency.

21. On 9 February 2022, the government published *Health and social care integration: joining up care for people, places and populations* (Health and social care integration: joining up care for people, places and populations - GOV.UK (www.gov.uk)). The White Paper focuses on integration arrangements at place level and aims to accelerate better integration across primary care, community health, adult social care, acute, mental health, public health and housing services which relate to health and social care. It covers governance and leadership requirements, budget pooling, oversight arrangements, and digital and workforce planning.

22. The integration White Paper invites views on several questions to support progress on the effective implementation of proposals. A system response is being discussed. Work is also being completed to produce a local roadmap for place development in the context of the White Paper.

23. NHS Confederation have published helpful overviews of both White Papers and what they mean for the health and care sector, which are available here:
    - https://www.nhsconfed.org/publications/levelling-uk-what-you-need-know
    - https://www.nhsconfed.org/publications/integration-white-paper-what-you-need-know

24. On 14 February 2022, the NHS Race and Health Observatory published *Ethnic Inequalities in Healthcare: A Rapid Evidence Review* (Ethnic Inequalities in Healthcare: A Rapid Evidence Review - NHS - Race and Health ObservatoryNHS – Race and Health Observatory (nhsrho.org)). The report sets out five major areas where NHS England, NHS Improvement and NHS Digital should take critical action to improve access, experiences and outcomes for ethnic minority groups:
    - Enforce guidelines on ethnic monitoring data
    - Produce better NHS statistics
    - Invest in interpreter services
    - Work to build trust with ethnic minority groups and key voluntary, community and social enterprise organisations
    - Invest in research to understand the impact of racism on healthcare

25. As a system we're committed to addressing inequalities for our citizens and welcome the review for its penetrating insight on ethnic health inequity. The review provides recommendations for NHS England and emphasises and supports what needs to happen through the ICS and across our partners. An item on our local plans to tackle health inequalities is scheduled for our next meeting on 5 May.

26. On 21 February 2022, the Department of Health and Social Care published details of proposed regulations for the Provider Selection Regime (Preview of proposals for the Provider Selection Regime - GOV.UK (www.gov.uk)). Subject to the passage of the Health and Care Bill through Parliament, the Provider Selection Regime will be a new set of rules for arranging healthcare services, which is intended to give decision makers a flexible, proportionate decision-making process for selecting providers to deliver healthcare services to the public. The Provider Selection Regime would replace the existing procurement rules for healthcare services, with the aim of making it easier to integrate services and enhance collaboration and ensure that decisions are:
    - Made in the best interest of patients, taxpayers, and the population
    - Robust and defensible, with conflicts of interests appropriately managed
    - Made transparently

27. Due to timing constraints, the Provider Selection Regime will not be established at the same time as ICBs, but will be established as soon as possible thereafter, subject to Parliamentary approvals and scheduling. A consultation on proposals is open until 28 March 2022.

**Partner updates and feedback on key meetings**

28. We would like to welcome Nick Carver, the new Chair of Nottingham University Hospitals NHS Trust, who joined the Trust on 1 February 2022. Nick has worked in the NHS for 42 years and has held several senior roles in the NHS in the East of England, West Midlands, West Country, and South Wales. He joined East and North Hertfordshire NHS Trust as Chief Executive in November 2002, retiring in December 2021 having held the role for 19 years. Nick will now lead the process to recruit a new, substantive Chief Executive for the Trust.

29. The Nottinghamshire County Health and Wellbeing Board last met on 9 February 2022. The meeting received reports on the countywide plan for physical activity - Making Our Move; the Nottinghamshire Food Charter 2022 and work towards becoming a Sustainable Food Place; progress and development of the Nottinghamshire Joint Strategic Needs Assessment in 2021/22; and on the 2021/22 Better Care Fund Plan. The papers and minutes from the meeting are published on Nottinghamshire County Council's website here: https://www.nottinghamshire.gov.uk/care/health-and-wellbeing/health-and-wellbeing-board.

30. The Nottingham City Health and Wellbeing Board last met on 26 January 2022. The meeting received reports on suicide prevention in the City; the Nottingham City Safeguarding Adults Annual Report; the development of the Health and Wellbeing Strategy; and the development of place-based partnerships. The papers and minutes from the meeting are published on Nottingham City Council's website here: https://committee.nottinghamcity.gov.uk/ieListMeetings.aspx?CId=185&Year=0.

31. Over the coming period, Kathy is having a further round of one-to-one engagement meetings with ICS Partnership Board members and Place Leaders, as well as visiting partner organisations and front-line services.

## Appendix 1 – Primary Care Strategy Focus Areas

| | |
|---|---|
| Establishing the culture, narrative and purpose | - Creating a culture that is motivated and committed to the vision – being an exemplar<br>- Building relationships and partnering across primary care and the wider ICS<br>- Understanding the health and care system |
| Clinical Delivery Model | -Delivering patient care that's co-ordinated, comprehensive, patient focused<br>-Developing a clinical delivery model that aims deliver for patients, professionals, and the system alike<br>-Uses clinical credibility to develop collaborative learning providing cost effective services that build career satisfaction<br>-Eye on future changes to anticipatory and personalised care |
| Person perspective – patients and population | -What have our patients told us, expectations for care received<br>-Engagement in the design of non-mandatory services<br>-Equity of access to services<br>-Refresh the patient/professional relationships<br>-Managing and working with expectations – core delivery and transformation of PC |
| Workforce Model | - Restoring the pride & ownership into GP & PODs – stewardship/ leadership<br>- Team approach, new/wider roles in practice teams including ARRS.<br>- Explore standardised T&Cs<br>- Recruitment and retention, "Nottingham" a place where people want to have a career and have professional development.<br>- Attract future students and Support succession planning<br>- Optimise workplace experience, managing workload. good work-life balance<br>- Maximise options for working at scale, improving PCN maturity, increasing capacity and capability and options for backroom function sharing. |
| Financial and contractual model | - Align incentives and schemes that benefit patients and clinicians alike<br>- Explore models to address inequality and equity in service delivery – address workload differences and shift<br>- Encourage risk sharing and management across PCNs/Place<br>- Re-establish utilisation performance monitoring, understand impact on system resource<br>- Refresh near-time clinical , financial data sharing and comparative performance transparency |
| Business model | Enhancing relational management and informational continuity<br>Consideration of scaling for resilience, efficiency and economies of scale<br>Re-engineering services, releasing time to care. Encourage entrepreneurialism<br>Reduce personal risk and unlimited liability – last man standing<br>Explore wider sharing of roles and functions |
| Provider model | - Ensuring principle of subsidiarity whilst increasing aggregation and association locally<br>- Develop fit for purpose structures: loose association, federations, merger and 'super partnerships'. Developing mature Primary Care Networks.<br>- Exploring provider collaborations and integration with Trusts, people centred networks<br>- Create an offer to support the strategy and change process that is underpinned by all enabling functions |
| Infrastructure – Estate & IT | - Consolidation of practice sites, better utilisation & shared facilities – improved standards & less isolation. Estate business ownership risk considered, options to terminate<br>- Ensure premises are fit for purpose to accommodate shifting care<br>- Exploit capital available to support estate and PCIT – maintenance and development needs<br>- Secure analytical data capacity and business digital technology (GPIT) to underpin PC – consider the benefits of Digital Hubs |

| | |
|---|---|
| Quality & Performance | - Quality Assurance & Quality Improvement – CQC Regulation Standards<br>- Performance against standards & deliverables – QOF, GP Indicators, ED attendances and Referrals<br>- Reducing Variation<br>- Learning from incidents and near misses |
| Communication and Engagement | - Communications with public and wider stakeholders – mandated service delivery – informing of "must do's", sharing information in relation to service delivery<br>- Engagement with public and wider stakeholders – gaining wider insight into patient expectations, needs and wishes for services delivered local to them |
| NHS Green – Primary Care impact | - Considering the impact PC has on NHS Green<br>- Understanding and reducing environmental impacts<br>- Engagement in the ICS/ICS Green programme |
| Research & Innovation | - Building capacity to engage fully in research & innovation<br>- Engagement in national programmes of research<br>- Link to academy & AHSN |

Integrated Care System
Nottingham & Nottinghamshire

ICS Board 3 March 2022:
Item 5. Enc C2

Enabling each and every citizen to enjoy their best possible health and wellbeing

# #TogetherWeAreNotts

Integrated Care System
Nottingham & Nottinghamshire

# What is an ICS (and Why?)

Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area.

They exist to achieve four aims:

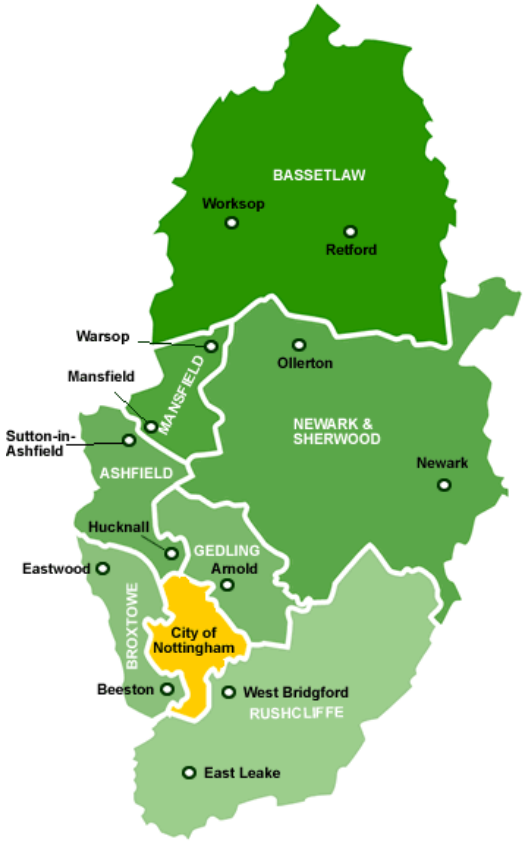
- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development.

Integrated Care System
Nottingham & Nottinghamshire

# Our goals

In order to realise our vision, we must deliver each of the following goals effectively and efficiently:

- Serve 1.2m people
- Support 70,000 staff in NHS and social care roles
- Integrate GP Practices into 23 Primary Care Networks (PCNs)
- Create four Place Based Partnerships (PBPs)
- Develop a Provider Collaborative at Scale
- Manage an annual budget of over £3billion for the commissioning and provision of health and care services



Integrated Care System
Nottingham & Nottinghamshire

# Our family portrait

This table highlights all the key organisations that make up our ICS.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Nottingham and Nottinghamshire ICS | | | | | | | |
| Nottingham City PBP 396,000 population | South Nottinghamshire PBP 378,000 population | | Mid Nottinghamshire PBP 334,000 population | | Bassetlaw PBP 118,000 population | | |
| 8 PCNs | 6 PCNs | | 6 PCNs | | 3 PCNs | | |
| Nottingham and Nottinghamshire CCG | | | | | Bassetlaw CCG | | |
| Nottingham University Hospitals NHS Trust | | | Sherwood Forest NHS Foundation Trust | | Doncaster and Bassetlaw NHS Foundation Trust | | |
| Nottinghamshire Healthcare NHS Foundation Trust (mental health) | | | | | | | |
| Nottingham CityCare Partnership (community provider) | Nottinghamshire Healthcare NHS Foundation Trust (community provider) | | | | | | |
| East Midlands Ambulance NHS Trust | | | | | | | |
| Nottingham City Council (Unitary) | Nottinghamshire County Council | | | | | | |
| | Broxtowe Borough Council | Gedling Borough Council | Rushcliffe Borough Council | Ashfield District Council | Mansfield District Council | Newark & Sherwood District Council | Bassetlaw District Council |
| Voluntary and community sector input | Voluntary and community sector input | | Voluntary and community sector input | | Voluntary and community sector input | | |

Integrated Care System
Nottingham & Nottinghamshire

# Our vision

Our neighbourhoods, places and system will seamlessly integrate to provide joined up care.

**Every citizen will enjoy their best possible health and wellbeing.**

Integrated Care System
Nottingham & Nottinghamshire

# Our ICS family

The organisations and professionals that have come together to form our ICS are now part of a family and will work together to achieve our goals.

**All parts of our family have different and vital roles, all rely on each other to maximise their potential, and all are equally valued.**

Integrated Care System
Nottingham & Nottinghamshire

# Different roles within the ICS health and care family

www.healthandcarenotts.co.uk @NHSNottingham

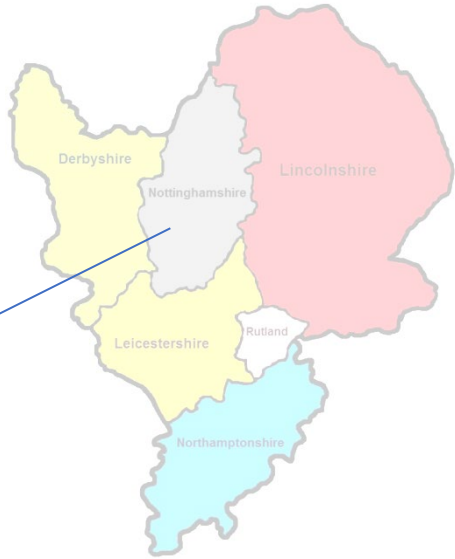
**Integrated Care Partnership** (from April 2022): develops an integrated care strategy to address health, social care and public health needs.

**Integrated Care Board**: (from April 2022) develops NHS plan (aligned to local government) and allocates NHS resources, agrees operational / service plans for the system to improve performance and quality, tackles inequalities and improves health outcomes, coordinates / supports for system working.

Hospitals work together in **Provider Collaboratives (at scale)** to provide hospital / specialist care, improve access, performance and quality.

Mental health, community and hospital services developed and delivered jointly through organisational alliances and by working with place-based partnerships.

NHS trusts host / participate in East Midlands Acute and Mental Health Provider Collaboratives and Clinical Networks for specialised services on a wider geography - mutual aid, pathway planning / delivery, resource management and quality improvement across networks.


Host / participate in East Midlands Acute and Mental Health Provider Collaboratives and Clinical Networks for specialised services on a wider geography - mutual aid, pathway planning / delivery, resource management and quality improvement across networks

**Place-Based partnerships:** (NHS, local government, public sector, voluntary sector) in Bassetlaw, Mid-Nottinghamshire, South Nottinghamshire and Nottingham City – partners work together to develop and deliver community-facing integrated care, join up community services across sectors and organisations / work alongside community leaders, locally tailored care for local needs, improve quality and performance, tackle inequalities and support delivery of ICS priorities.

Integrated Care System
Nottingham & Nottinghamshire

# Our journey so far

The Nottingham and Nottinghamshire ICS has been created to bring together health and care organisations and professionals from across the region.

Our ICS has evolved from a long history of local health and care integration.

**We believe this history of working together puts us in a strong position for the future.**

**2016**

In 2016, health and care systems came together as Sustainability & Transformation Partnerships (STPs).

ICSs as the main mechanism for delivering integrated care and place-based systems were defining features of the national NHS Long Term Plan which was published on 7 January 2019.

ICSs have developed from STPs and are driving integration at scale and pace.

**Today**

ICSs to be established on a statutory basis across England from 1 July 2022, bringing partners together to further support the integration of health and care.

# Key parts of the ICS – Primary Care Networks (PCNs)

- A PCN consists of groups of general practices working together with a range of local providers, including community services, social care and the voluntary sector. They will offer coordinated health and social care to their local populations.
- Under the leadership of Clinical Directors, PCNs will bring multidisciplinary teams together to coordinate care and take a proactive approach to managing the health of their populations.
- There are 23 PCNs across Nottingham and Nottinghamshire.

# Key parts of the ICS – Place Based Partnerships (PBPs)

- Place Based Partnerships are responsible for organising health and social care to deliver the outcomes set out by the strategic commissioner.
- Place Based Partnerships are established in Mid Notts, Nottingham City, South Notts and Bassetlaw.
- Place Based Partnerships are the delivery mechanism for the system and will be contracted to deliver integrated, population-based health and care. They will be held to account for the delivery of outcomes for the population.

# Key parts of the ICS – Provider Collaboratives at Scale

- We have agreed that our main NHS providers (e.g. Nottingham University Hospitals NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust, and Nottinghamshire Healthcare NHS Foundation Trust) will all be involved in three types of provider collaborative going forward:
  - Provider collaboratives at scale for specialised services;
  - An ICS provider collaborative at scale;
  - Placed based partnerships.
- Provider collaboratives are expected to join up provision:
  - Within places through place based partnerships;
  - Across multiple places, at scale, through a provider collaborative where similar types of provider organisations deliver common objectives. NHSEI's expectation is that all acute and mental health providers will be part of one or more provider collaboratives.

# Key parts of the ICS – Integrated Care Board (ICB)

- Will be established on 1 July 2022 as a new statutory organisation.
- Will take on CCG functions and some NHS England functions – but also new functions and duties .
- New ways of working through integration, collaboration and shared responsibility.
- New flexibilities to deliver commissioning activities differently – e.g. able to delegate functions and decision-making, has greater abilities for joint working.
- They commission providers, through Place Based Partnerships, to collectively deliver against a set of outcomes for the whole population, and hold providers to account.

# Key parts of the ICS – Integrated Care Partnership (ICP)

- ICP will form 'the guiding mind,' across the Nottingham and Nottinghamshire health and care system, and work jointly with Health and Wellbeing Boards.
- Build a broader approach to planning based on population need and put JSNA insights front and centre.
- Strengthens accountability to local people; focus on healthy life expectancy and addressing inequalities and inclusion; build on collaborative approaches developed during Covid19; and maximise collective endeavours including as anchor organisations and in the use of the one 'public purse.'

# What does it mean for me?

- We will pool our expertise, experience and efficiencies across acute, community and primary care so everyone benefits equally.
- Integrated service delivery will bring together skills and expertise into multi-disciplinary teams, providing scope for new and more varied career opportunities.
- The focus of service delivery will shift to become more preventative, proactive, and person-centred; focused on a specific geographic area around a common purpose to work holistically with people and communities.
- Complex change across the whole system will involve everyone working in partnership to understand and resolve different ideas and perspectives.

| | | | |
|---|---|---|---|
| **Item Number:** | 6 | **Enclosure Number:** | D1 |
| **Meeting:** | ICS Partnership Board | | |
| **Date of meeting:** | 3 March 2022 | | |
| **Report Title:** | ICS 2022/23 NHS Operational Plan | | |
| **Sponsor:** | Amanda Sullivan, Designate Chief Executive, Nottingham and Nottinghamshire Integrated Care Board And Accountable Officer, NHS Nottingham and Nottinghamshire CCG<br>Lucy Dadge, CCG Chief Commissioning Officer | | |
| **ICP Lead:** | | | |
| **Clinical Sponsor:** | | | |
| **Report Author:** | Jonathan Rycroft, System Planning Group Chair<br>Marcus Pratt, ICS Finance Programme Director | | |
| **Enclosure / Appendices:** | Enc D2: ICS Board 220303 NHS Op Plan Appendix 1 and 2 | | |

**Summary:**


NHSE/I published the **NHS 2022/23 Priorities and Operational Planning Guidance** on 24 December 2021 with technical guidance subsequently published on 14 January. The **Delivery plan for tackling the Covid-19 backlog for elective care** was published on 8 February.

The enclosed paper and appendices provide further detail on the 2022/23 NHS operational planning requirements and the local process to develop the plan. The latest position will be shared with the ICS Partnership Board on 3 March for review and key decisions.

The ICS Partnership Board is requested to delegate approval of the draft plan to the ICS System Executive Group (SEG) on 11 March to support submission on 17 March, and approval of the final plan by SEG on 22 April to support submission on 28 April.


**Actions requested of the ICS Board**

To discuss the report and agree the presented recommendations.

**Recommendations:**

| | |
|---|---|
| 1. | NOTE the national 2022/23 NHS operational planning requirements and arrangements which have been established to produce a high quality and ambitious plan. |
| 2. | NOTE the complexity introduced by CCG boundary changes which is further complicated by timing of ICB establishment. |
| 3. | REVIEW the latest position which will be shared on 3 March. |
| 4. | NOTE that the 2022/23 NHS operational plan is based on optimal national assumptions and will include significant delivery risk. |
| 5. | DELEGATE approval of draft and final plans to the ICS System Executive Group. |

| Presented to: | | | | |
|---|---|---|---|---|
| Board | Transition and Risk Committee | Clinical Executive Group | System Executive Group | Finance Directors Group |
| ☒ | ☐ | ☐ | ☐ | ☐ |
| Quality Group | Bassetlaw Place | Mid Nottingham-shire ICP | Nottingham City ICP | South Nottingham-shire ICP |
| ☐ | ☐ | ☐ | ☐ | ☐ |

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

**Conflicts of Interest**

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

**Risks identified in the paper**

| Risk Ref | Risk Category | Risk Description | Residual Risk | | | | Risk owner |
|---|---|---|---|---|---|---|---|
| | | | Likelihood | Consequence | Score | Classification | |
| Ref | e.g. quality, financial, performance | Cause, event and effect<br><br>There is a risk that… | L1-5 | L1-5 | L x I | Grading | *Person responsible for managing the risk* |
| | | See slide 15 in the enclosure | | | | | |

**Is the paper confidential?**

☐ Yes
☒ No
☐ Document is in draft form

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

**Nottingham and Nottinghamshire ICS**

**2022/23 NHS Operational Plans**

**3 March 2022**

## Introduction

1. NHSE/I published the **NHS 2022/23 Priorities and Operational Planning Guidance** on 24 December 2021 with technical guidance subsequently published on 14 January.

2. The NHS 2022/23 Priorities and Operational Planning Guidance sets out 10 ambitious NHS priorities for 2022/23 which build on those introduced in 2021/22 (further detail is included in **Enc D2 Appendix 1**):

    - Investing in the workforce and strengthening a compassionate and inclusive culture.
    - Delivering the NHS COVID-19 vaccination programme
    - Tackling the elective backlog.
    - Improving the responsiveness of urgent and emergency care and community care.
    - Improving timely access to primary care.
    - Improving mental health services and services for people with a learning disability and/or autistic people.
    - Developing approach to population health management, prevent ill-health, and address health inequalities.
    - Exploiting the potential of digital technologies.
    - Moving back to and beyond pre-pandemic levels of productivity.
    - Establishing ICBs and enabling collaborative system working.

3. The **Delivery plan for tackling the Covid-19 backlog for elective care** was published on 8 February providing further detail on how elective waiting lists will be tackled (further detail is included in **Enc D2 Appendix 2**).

4. Additional key points to note include:

    - Establishment of ICBs has been delayed until July 2022. It is understood that NHS operational plans are to be produced on the new ICB footprint for the full 12 months. It will however be necessary to disaggregate elements of the plan for the two CCGs and between Quarters 1 and Quarters 2 – 4.
    - There is a significant productivity and efficiency requirement in 2022/23.
    - A strong focus on addressing health inequalities needs to continue.
    - Whilst this is an NHS planning requirement it is important that it reflects ICS priorities and plans which have been agreed by ICS Health and Care partners.
    - The guidance also signals an expectation to require ICBs' refreshed five-year system plans in March 2023.

5. The guidance recognises the uncertainty around Covid-19 variants, transmission patterns and consequent demand on the NHS. The objectives within the planning guidance are based on Covid-19 returning to a low level and NHSE/I will keep these under review as the pandemic evolves.

6. The ICS approach is to develop credible operational plans which meet or exceed all national requirements and demonstrate a high level of ambition for the population by the end of April. In support of this, partners will need to collectively ensure that all the conditions for success can be met. The March submission will reflect a point in the iterative process to develop a fully compliant plan and as such there may be areas where further development is required to achieve compliance.

7. The purpose of this paper is to provide further detail on the 2022/23 NHS operational planning requirements and the local process to develop the plan. The latest position will be shared with the ICS Partnership Board on 3 March.

**Planning Requirements/Process**

8. Key submission milestones for NHS 2022/23 operational plans are as follows:

    - Outline Elective Hub proposals submitted by 18 February.
    - Draft operational plans submitted by 17 March.
    - Contracts to be signed by 31 March.
    - Final operational plans submitted by 28 April.

9. The submissions will comprise of a narrative and activity/performance, workforce and finance technical plans (capital and revenue). A national template is provided for the narrative which covers the assumptions, risks and issues for specific areas (Health Inequalities, People, Elective Recovery, Urgent and Emergency Care and Community Transformation and Discharge).

10. The System Planning Group is coordinating the NHS 2022/23 operational planning process providing the ICS Board and ICS System Executive Group and CEOs with regular progress updates. Risks and issues, including areas where compliance remains a challenge, will be escalated for detailed review and decision. Organisational and ICS approvals will be required for the draft and final operational plans.

11. The technical guidance requires systems to use national assumptions for consistency whilst recognising that these are not a forecast:

    - Overall non-elective demand from Covid-19 and non-Covid-19 returns to pre-pandemic (2019/20) levels from the beginning of the 2022/23, subject to the impact of any planned service developments.
    - Covid-19 general and acute bed occupancy remains at a low level across the year.

12. The submitted 2022/23 NHS operational plan will therefore be based on optimal national assumptions and will include significant delivery risk. It is therefore important that the planning process identifies, mitigates, documents and acknowledges delivery risks.

13. The draft 2022/23 operational plan will continue to be developed up to 14 March. The latest position will be shared with the ICS Board on 3 March. It will also be shared with individual partner organisations for approval of their organisational components.

14. Due to the timing of submissions the ICS Partnership Board is requested to delegate approval of the draft plan to the ICS System Executive Group (SEG) on 11 March to support submission on 17 March, and approval of the final plan by SEG on 22 April to support submission on 28 April.

**Financial Context**

15. 2022/23 will see a move away from the simplified financial and contracting arrangements seen through the pandemic response with a move back towards population-based allocations and a focus on service restoration.

16. The future financial framework will continue to support system collaboration, building on progress made by Integrated Care Systems (ICSs), and as such systems will continue to be the key unit for the purposes of allocations and financial planning.

17. Draft revenue financial allocations have been received for 2022/23. In addition, the system has been provided with a 3-year draft capital envelope, including ring-fenced amounts for diagnostics and digital.

**Summary & Recommendations**

18. The ICS Partnership Board is requested to note the national 2022/23 NHS operational planning requirements and arrangements which have been established to produce a high quality and ambitious plan.

19. The ICS Partnership Board is requested to note the complexity introduced by CCG boundary changes which is further complicated by timing of ICB establishment.

20. The ICS Partnership Board is requested to review the latest position which will be shared on 3 March.

21. The ICS Partnership Board is requested to note that the 2022/23 NHS operational plan is based on optimal national assumptions and will include significant delivery risk.

22. The ICS Partnership Board is requested to delegate approval of draft and final plans to the ICS System Executive Group.

Jonathan Rycroft, System Planning Lead
Marcus Pratt, ICS Finance Programme Director

Amanda Sullivan, Designate Chief Executive, Nottingham and Nottinghamshire Integrated Care Board And Accountable Officer, NHS Nottingham and Nottinghamshire CCG
Lucy Dadge, CCG Chief Commissioning Officer
3/3/22

# Appendix 1

## Summary of 10 National Priorities and the 167 Specific Requirements

# 2022/23 National Priorities

- The guidance sets out ten priorities for the NHS over 2022/23:

  A. Investing in the workforce and strengthening a compassionate and inclusive culture
  B. Delivering the NHS COVID-19 vaccination programme
  C. Tackling the elective backlog
  D. Improving the responsiveness of urgent and emergency care and community care
  E. Improving timely access to primary care
  F. Improving mental health services and services for people with a learning disability and/or autistic people
  G. Developing approach to population health management, prevent ill-health, and address health inequalities
  H. Exploiting the potential of digital technologies
  I. Moving back to and beyond pre-pandemic levels of productivity
  J. Establishing ICBs and enabling collaborative system working

- Within the 10 priorities there is an extensive list of specific requirements – extracts are highlighted in the following slides

# Highlights from the list of 167 requirements

**A - Workforce**

- Looking after our people, improving belonging in the NHS, working differently, grow for the future

**B – Covid**

- Covid vaccination, long Covid, covid treatments

**C - Elective/Diagnostics/Cancer**

- Deliver 10% more elective activity than 2019/20. Hold elective activity during winter and eliminate pandemic related productivity losses
- As a priority, complete any outstanding work on the post-pandemic cancer recovery objectives
- Improve performance against all cancer standards, with a focus on the 62-day urgent referral to first treatment standard, the 28-day faster diagnosis standard and the 31-day decision-to-treat to first treatment standard
- Increase diagnostic activity to a minimum of 120% of pre-pandemic levels across 2022/23 to support these ambitions and meet local need

**C - Maternity**

- Deliver interim Ockenden report and actions from future reports, Implement Better Births

**D - Urgent Care**

- Reduce 12-hour waits in EDs towards zero and no more than 2%, Improve against all Ambulance Response Standards, Minimise handover delays between ambulance and hospital
- Increasing capacity within NHS 111 to ensure the service is the credible first option for patients, Expanding urgent treatment centre (UTC) provision and increasingly moving to a model where UTCs act as the front door of ED
- Put in place integrated health and care plans for children and young people's services that include a focus on urgent care

# Highlights from the list of 167 requirements

**D - Community services and discharge**

- Develop detailed 2 year plans to maximise the rollout of virtual wards, improve 2 hr UCR, reduce delayed discharges
- Design, plan for and commission anticipatory care
- Develop and agree a plan for reduction of community service waiting lists

**E - Primary Care**

- Maximising the impact of the investment in primary medical care and primary care networks (PCNs) to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level

**F - Mental Health**

- Improving the operation of all age 24/7 crisis lines, crisis resolution home treatment teams and mental health liaison services in acute hospitals, alternatives to A&E and admission, ambulance mental health response
- Continue the expansion and transformation of mental health services, as set out in the NHS Mental Health Implementation Plan 2019/20–2023/24
- Continue to grow and expand specialist care and treatment for infants, children and young people
- Delivery of the Mental Health Investment Standard (MHIS)
- Produce a clear plan of requirements for CYPMH general adolescent and psychiatric intensive care in-patient beds to meet the health needs of their population, strengthen local services and eliminate out of area placements for the most vulnerable young people

**F - Learning Disability and Autism**

- Increase the rate of annual health checks for people aged 14 and over on a GP learning disability register towards the 75% ambition in 2023/24
- Maintain a strong commitment to reducing reliance on inpatient care for both adults and children with a learning disability and/or who are autistic

# Highlights from the list of 167 requirements

**G - PHM / Prevention / Inequalities**

- ICSs will drive the shift to population health, targeting interventions at those groups most at risk, supporting health prevention as well as treatment
- Develop robust plans for the prevention of ill-health, led by a nominated senior responsible officer (SRO) – tobacco, lifestyle services, hypertension, respiratory, LTP improvements
- Focus preventative services on socio-economically deprived populations and certain ethnic minority groups

**H - Digital**

- Exploit the potential of digital technologies to transform the delivery of care and patient outcomes – achieving a core level of digitisation in every service across systems

**I - Finances**

- NHS takes out cost and delivers significant additional efficiencies
- Address the excess costs driven by the pandemic response
- Moving back to and beyond pre-pandemic levels of productivity when the context allows this
- A collective local accountability and responsibility for delivering system and ICB financial balance

**J - System Development**

- A new target date of 1 July 2022 has been agreed for new statutory arrangements for ICSs to take effect and ICBs to be legally and operationally established
- CCG leaders and designate ICB leaders should continue with preparations for the closure of CCGs and the establishment of ICBs, working toward the new target date

**Strategy**

- We expect to require ICBs' refreshed five-year system plans in March 2023. This will give each ICB and its local authority partners sufficient time to agree a strategy for the ICP that has broad support, and to develop a plan to support its implementation including the development of place based integration

# Appendix 2

Headlines from the Elective Recovery Plan
(Feb 22)

# Delivery plan for tackling the Covid-19 backlog for elective care (Feb 22) - Ambitions

**National plan published 8th February 2022**

- Plan aimed at delivering 30% more elective activity by 2024/25 than before the pandemic

**The headlines are**;

- July 2022, no one will wait longer than two years (104 weeks)
- April 2023, aim to eliminate waits of over 18 months (78 weeks)
- March 2024, aim to eliminate waits of over 65 weeks (15 months)
- March 2025, waits of longer than a year for elective care eliminated

**Diagnostic tests**

- March 2025, ambition is that 95% of patients needing a diagnostic test will receive it within six weeks

**Cancer**

- March 2023, return the number of people waiting more than 62 days from an urgent referral back to pre-pandemic levels
- March 2024, 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days

# Delivery plan for tackling the Covid-19 backlog for elective care (Feb 22) – Delivery Focus

## Increasing health service capacity

A. growing and supporting the workforce

B. using digital technology and advanced data systems to free up capacity

C. working with UKHSA to safely adapt the UK's infection prevention and control (IPC) measures

D. making effective use of independent sector capacity.

## Prioritising diagnosis and treatment

A. Clinical prioritisation: ensure the order in which patients are seen reflects clinical judgement on need.

B. Managing long waits: targeting support to reduce the number of people waiting a long time.

C. Increasing the number of cancer referrals, to ensure we also prioritise those patients who have not yet presented to services.

## Transforming the way we provide elective care

A. Expanding community diagnostic centres with a focus on ease of access and convenience for patients.

B. Increasing surgical capacity through surgical hubs – separating out many of the low complexity surgical pathways through additional surgical hubs, improving outcomes for patients and reducing pressure on hospitals.

C. Improving patient pathways to reduce avoidable delays by ensuring we are making the best use of the latest technology, clinical time and expertise.

## Providing better information and support to patients

A. Targeted support information for patients, including through My Planned Care – initially delivering a new platform to increase transparency on wait times and provide a hub of support information for patients covering the entire pathway, before further development to integrate this with the NHS App.

B. Supporting patients to prepare for surgery – by co-developing personalised plans that provide them with the necessary information and guidance to prepare for the best possible outcomes.

C. Emphasising the expertise of NHS staff in providing high quality personalised and tailored support to patients, supported by the latest innovations in technology and improved data sharing.

# Delivery plan for tackling the Covid-19 backlog for elective care (Feb 22) – Delivering the Plan

- Clear accountability for delivery
- Consistent, co-ordinated interactions between national, regional and local teams
- An overarching support offer to rapidly share and scale best practice, with targeted support for systems and providers with significant challenges
- Putting reducing inequalities at the core of recovery plans and performance monitoring
- Collaboration within and across systems to improve access and tackle waiting times
- Being clear on what success looks like and putting in place a payment system that incentivises strong performance and value for money for the public

| | | | |
|---|---|---|---|
| **Item Number:** | 7 | **Enclosure Number:** | E1 |
| **Meeting:** | ICS Partnership Board | | |
| **Date of meeting:** | 3 March 2022 | | |
| **Report Title:** | Nottingham and Nottinghamshire ICS Green Plan | | |
| **Sponsor:** | Amanda Sullivan, ICB Chief Executive Designate | | |
| **Place Lead:** | | | |
| **Clinical Sponsor:** | | | |
| **Report Author:** | Duncan Hanslow, Programme Director, System Transformation, Nottingham and Nottinghamshire ICS and Janet Crowe, Strategic Programme Manager, Nottingham and Nottinghamshire ICS | | |
| **Enclosure / Appendices:** | Enc E2: ICS Draft Green Plan | | |

**Summary:**

The Draft Nottingham and Nottinghamshire Integrated Care System (ICS) Green Plan outlines the carbon reduction challenge facing the ICS and describes the actions that the ICS will take over the next 3 years to meet this and improve patient care and community wellbeing. It describes how the ICS will contribute to tackling climate change and improve sustainability to deliver the NHS ambition to achieve a Net Zero Health Service as outlined in '*Delivering a 'Net Zero' National Health Service'*.

The development of the Green Plan has involved contributions from stakeholders across health and local authority organisations in the ICS. The plan builds on commitments already made by statutory partner organisations, with the actions developed aiming to meet carbon reductions as defined by the NHS Footprint Plus for the ICS area. The plan considers nine areas of focus including: workforce and system leadership; sustainable models of care; digital transformation; travel and transport; estates and facilities; medicines; supply chain and procurement; food and nutrition and adaptation.

**Actions requested of the ICS Board**

To note the contents and agree the recommendations.

**Recommendations:**

| | |
|---|---|
| 1. | Approve the ICS Green Plan as described. |
| 2. | Discuss the approach for resourcing the delivery of the ICS Green Plan and agree next steps. |

**Presented to:**

| Board | Transition and Risk Committee | Clinical Executive Group | System Executive Group | Finance Directors Group |
|---|---|---|---|---|
| ☒ | ☐ | ☐ | ☒ | ☐ |
| Quality Group | Bassetlaw Place | Mid Nottingham-shire Place | Nottingham City Place | South Nottingham-shire Place |
| ☐ | ☐ | ☐ | ☐ | ☐ |

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

**Conflicts of Interest**

☒ No conflict identified

☐ Conflict noted, conflicted party can participate in discussion and decision

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

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

☐ Conflict noted, conflicted party to be excluded from meeting

**Risks identified in the paper**

| Risk Ref | Risk Category | Risk Description | Residual Risk | | | | Risk owner |
|---|---|---|---|---|---|---|---|
| | | | Likelihood | Consequence | Score | Classification | |
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**Is the paper confidential?**

☐ Yes

☒ No

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# Nottingham and Nottinghamshire ICS Green Plan 2022 to 2025

Integrated Care System
Nottingham & Nottinghamshire

# Control Record

## Document Control

| | |
|---|---|
| **Document Reference** | ICS GP22 |
| **Revision Date** | N/A |
| **Date of Review** | N/A |
| **Version** | 1.7 |
| **Document Owner** | Duncan Hanslow |
| **Author/Compiler** | Janet Crowe/ Kevin Robotham, Nicky Murray, Surinder Hunjan |

## Amendment Record

| Issue Status | Version | Date | Summary of Changes |
|---|---|---|---|
| Draft | 1.0 | | Initial draft |
| Draft | 1.3 | | First Draft |
| Draft | 1.4 | 28/01/2022 | First Draft formatted for circulation |
| Draft | 1.5 | 04/02/2022 | Final Draft amended for circulation |
| Final Draft | 1.6 | 08/02/2022 | Final Draft to be presented to System Executive Group |
| Final Draft | 1.7 | 22/02/22 | Final Draft to be presented to ICS Partnership Board |
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| Name/ Group | Description | Date | Version |
|---|---|---|---|
| ICS Green Programme Board | Draft circulated for review by Board | 28/01/2022 | 1.4 |
| ICS Green Programme Board | Final Draft circulated for review by Board | 04/02/2022 | 1.5 |
| ICS System Transformation Group | Final Draft circulated for comment by transformation programmes | 04/02/2022 | 1.5 |
| System Executive Group | Final Draft | 08/02/2022 | 1.6 |
| ICS Partnership Board | Final Draft | 22/02/2022 | 1.7 |
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## Table of Contents:

## Executive Summary

In '*Delivering a 'Net Zero' National Health Service'* the NHS sets out its ambitions to become the world's first Net Zero Health Service, with trajectories to reach net zero carbon emissions by 2040 for emissions it controls directly and 2045 for those it can influence. The trajectories are ambitious, while realistic with action and commitment to innovation. The Nottingham and Nottinghamshire ICS Green Plan outlines the specific actions and priority interventions for achieving carbon net zero to lay the foundation to deliver carbon emission reductions through the delivery of sustainable health and care services.

Climate change refers to the large-scale, long-term shift in the planet's weather patterns and average temperatures, and is the single biggest threat facing humanity. The Intergovernmental Panel on Climate Change (IPCC) has concluded that to avert catastrophic impact the world must limit temperature rise to 1.5°C.

The climate emergency is a health emergency. It threatens the foundations of good health, with direct and immediate consequences for our patients, the public and the NHS. Responsible for circa 4% of England's carbon emissions, the NHS has made a commitment to support the nation's response to climate change. Delivering a net zero NHS will not only reduce the impact on climate change, but will realise significant health benefits. By the year 2040, this trajectory would see an estimated 5,770 lives saved a year from reductions in air pollution and 38,400 lives saved per year from increased levels of physical activity. Addressing climate change has the potential to exacerbate conditions for the most vulnerable. Acknowledging the links between climate change, sustainable development and health inequalities is an important consideration in the development of priority actions within the ICS Green Plan, with a commitment to deliver joint action to reduce health inequalities.

The Nottingham and Nottinghamshire ICS Green Plan will support our diverse population of 1.2 million people. The development of the Green Plan has involved engagement and contributions from stakeholders across professions, organisations and in collaboration with local authorities and other system partners. Building on the commitments already made by our statutory partner organisations, the actions developed aim to meet the carbon emission reductions as defined by the NHS Footprint Plus for our local area and across nine areas of focus.

- **Workforce and System Leadership** - Success in delivering net zero depends on system leadership and the support of staff, with education to raise awareness and engagement to adopt sustainable practices. Our ambition is to: provide leadership to deliver net zero ambitions; engage the public and our workforce in the actions required to deliver sustainable healthcare locally; provide education and training to enhance carbon literacy.
- **Sustainable models of care** – 60% of carbon emissions are linked to clinical pathways and associated supply chain and human resource. Our ambition is to: develop holistic pathways to deliver quality care outcomes, with a focus on prevention, self-care and equity of access; meet the ambitions to deliver care closer to home; deliver lower carbon interventions where clinically relevant.
- **Digital transformation** – Critical priorities have been identified seeking to mainstream digitally enabled care across all areas of the NHS. Our ambition is to: deliver digital appointments and services where clinically relevant; connect clinicians and patients; digitise processes to enhance clinical care delivery.
- **Travel and transport** – Approximately 3.5% of all road travel in England relates to patients, visitors, staff and suppliers in the NHS. Our ambition is to: promote sustainable transport and reduce overall

transport, increase the use of ULEV and ZEV vehicles; develop the infrastructure to support lower carbon transport options; enhance understanding and communication via Green Travel Plans.

- **Estates and facilities** – NHS estate and its supporting facilities comprise 15% of the total carbon emissions profile. Our ambition is to: continue to reduce carbon emissions through smart energy strategies; correctly manage waste across the system with improved recycling and prevention; to recognise water as a valuable resource in the sustainability journey; promote green spaces and biodiversity in all estate developments.
- **Medicines** – Account for 25% of emissions within the NHS, with a small number of medicines accounting for a large proportion of emissions. Our ambition is to: develop strategies to support commitment to lower inhaler carbon footprint; deliver medicine optimisation for patients prescribed inhalers; reduce the environmental impact of inhaler waste; reduce carbon footprint from anaesthetic gases.
- **Supply chain and procurement** – The NHS supply chain accounts for approximately 62% of total carbon emissions, with the NHS England Procurement Roadmap outlining steps to achieve net zero supply chain by 2045. Our ambition is to: support SME's and social value; measure and reduce supplier carbon footprints; reduce consumption and switch to sustainable alternatives.
- **Food and nutrition** - Food and catering services in the NHS produces approximately 6% of total emissions. Healthier, locally sourced food supports wellbeing and reduces emissions. Our ambition is to: maximise social value through sustainable procurement; deliver strategies to continue to reduce food waste; strengthen community initiatives to re-allocate surplus food and promote community growing; implement plans to improve the health and wellbeing of the population.
- **Adaptation** – Strengthens the NHS's capacity to provide a high standard of care while the climate changes. Our ambition is to: complete comprehensive risk assessments for climate change; develop plans to mitigate the risks of effects of climate change on business and functions.

Our summary action plan outlines how we will achieve the actions described and by when. The governance framework has been developed to support delivery of the ICS Green Plan, under the leadership of the ICS Board Net Zero Lead. The Green Plan has strong connections with the work of the wider health and wellbeing board plans and arrangements will be made to ensure plans are connected in design and delivery. Staff from across the ICS have contributed to the production of the plan. An annual summit will be held so that staff and citizens can review progress and contribute to the next stage of development.

Many of the carbon reducing interventions in this plan are either cost-neutral or can provide immediate cost benefit. Further initiatives may require initial capital investment, followed by efficiency savings over the long run. To support the delivery and implementation of initiatives all funding opportunities will be explored. In addition, capital and revenue business cases will include a Sustainability Impact Assessment to describe how the case will contribute to our net zero pledge and used as a key principle in decision making.

Our Green Plan outlines the actions we will take over the next three years to support NHS net zero trajectories. The next steps of this ambitious plan includes a focus on commitment and ambition through the development of a communication strategy, developing governance arrangements and the structure to support development and implementation of plans to deliver the actions described.

# 1. Background and Context

## 1.1. Climate Change

Climate change refers to the large-scale, long-term shift in the planet's weather patterns and average temperatures.

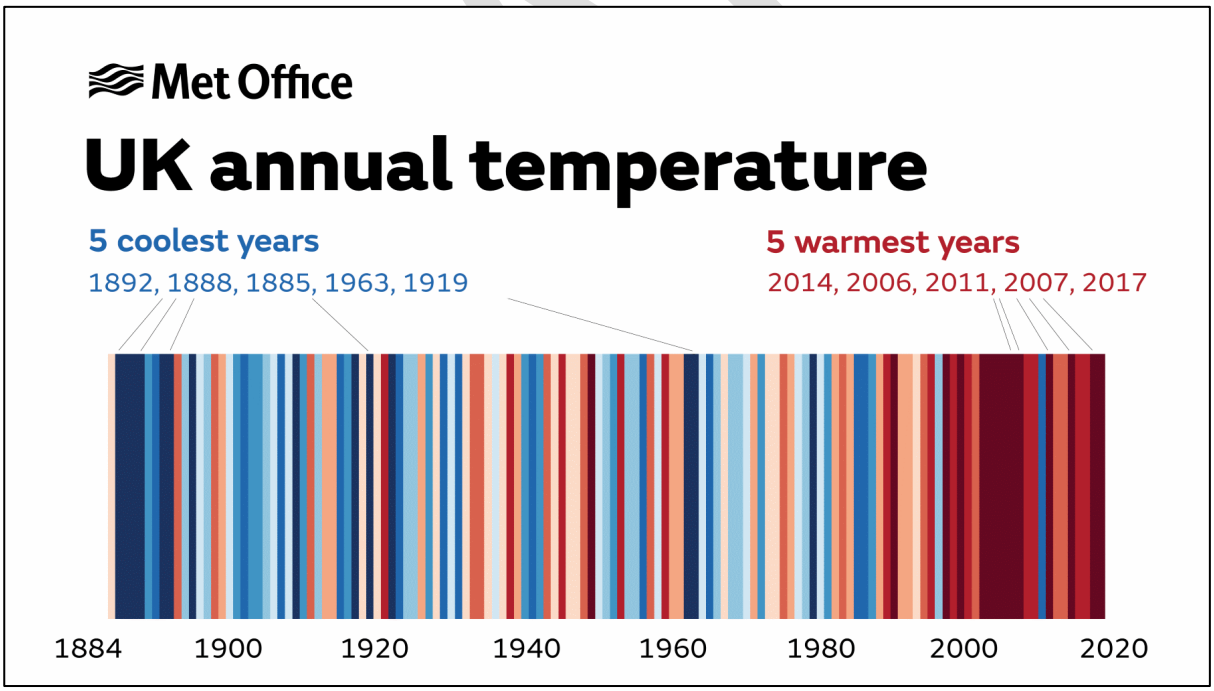
Burning fossil fuels produces energy, but also releases greenhouse gases such as carbon dioxide, methane, and nitrous monoxide into the air. Over time, large quantities of these gases have built up in the atmosphere.

Once in the atmosphere, greenhouse gases such as carbon dioxide form a 'blanket' around the planet. This blanket traps the heat from the sun and causes the earth to heat up. This effect was noticed as far back as the 1980s.

Evidence has shown that the high levels of greenhouse gases in the atmosphere are the leading cause of increasing global temperatures. In their most recent report, the International Panel on Climate Change (IPCC) states that human activity is unequivocally the cause of climate change.

Global temperatures are rising, with the 20 warmest years on record globally in the past 22 years. In the UK, the ten hottest years have all happened since 2002, as shown in Figure 1. (1)

**Figure 1 - UK Annual Temperature**




Source: Met Office

### How will climate change affect the UK?

In the future, we will still see a lot of the weather we experience today. The difference, though, is that whilst the weather will continue to be variable, the intensity of some weather types will change and make these conditions more likely. The Met Office expects that across the UK, we will see

warmer and wetter winters, hotter and drier summers and more frequent and intense weather extremes.

By 2070, the Met Office projects that:

- Winters will be between 1 and 4.5$^0$C warmer and up to 30% wetter
- Summers will be between 1 and 6$^0$C warmer and up to 60% drier

## Local context

In Nottingham and Nottinghamshire, the hottest summer day of the past 30 years' was 35.8$^0$C, if average temperatures increase by 2$^0$C average temperatures could increase to a maximum temperature of 37.5$^0$C. The warmest winter's day of the past 30 years was 18$^0$C; this could increase to 18.5$^0$C with a 2$^0$C increase in global temperatures. (1)

## Hot spells and the risk to public health

Heatwaves are a risk to health and, in some cases, life. There is evidence that proves this across the world but also right here in the UK.

During the summer heatwave of 2003, there were over 2,000 excess deaths over a 10-day period. In a 2006 heatwave, the Government estimated 680 excess deaths. And in 2009, there were approximately 300 excess summer deaths.

Many of these excess deaths are among older people. These are not people who would have died due to illness or old age. There is strong evidence that these deaths are the result of heat-related conditions. (2)

Climate change will make hot spells more frequent and severe. By 2070, the chance of exceeding 30°C for two days or more increases—a lot. That will have a large impact on our elderly population and public health.

That's prolonged heat, but extremes become more likely, too. By 2070, the chances of exceeding 40°C are similar to the chances of exceeding 32°C thirty years ago.

## Increased rainfall and risk of flooding

In the future, we project the intensity of rain will increase. When we talk about intensity, we mean how heavy rainfall is when it occurs. (3)

A greater risk of flooding will have large impacts, both on the environment and in our daily lives.

Floods are one of the most common environmental emergencies and have significant health impacts. Short term health impacts are usually due to injuries, infections, exposure to chemical hazards and disruption to health services. The longer term effects are less well understood and may arise from the impact of damage to homes, loss of domestic utilities, having to move out until the home is habitable and delayed recovery.(4)

## 1.2. Climate Emergency – Health Emergency

Climate change is the single biggest health threat facing humanity. The Intergovernmental Panel on Climate Change (IPCC) has concluded that to avert catastrophic health impacts and prevent millions of climate change-related deaths, the world must limit temperature rise to 1.5°C. Past emissions have already made a certain level of global temperature rise and other changes to the climate inevitable. Global heating of even 1.5°C is not considered safe, however; every additional tenth of a degree of warming will take a serious toll on people's lives and health.

While no one is safe from these risks, the people whose health is being harmed first and worst by the climate crisis are the people who contribute least to its causes, and who are least able to protect themselves and their families against it - people in low-income and disadvantaged countries and communities. (5)

The climate emergency is a health emergency. Climate change threatens the foundations of good health, with direct and immediate consequences for our patients, the public and the NHS. The situation is getting worse, with nine out of the 10 hottest years on record occurring in the last decade and almost 900 people killed by heatwaves in England in 2019. Without accelerated action there will be increases in the intensity of heatwaves, more frequent storms and flooding, and increased spread of infectious diseases. (6)

BMA representative body chair Helena McKeown September 2020

"With the pandemic this year, we have seen the devastating impact of a global health emergency. If we do not take decisive action immediately to work towards net zero the impact of climate change in the near future will wreak havoc on the planet taking an immeasurable toll on the health of people across the globe" (7)

## 1.3. Combating Climate Change – Commitment to Carbon Net Zero

The 2008 Climate Change Act set national targets for the reduction of carbon emissions in England. Since then, as the largest employer in the UK and responsible for circa 4% of England's carbon emissions, the NHS has been working to deliver on these to support the nation's response to climate change.

In October 2020, the Greener NHS National Programme published its new strategy, '*Delivering a Net Zero National Health Service*.' This report highlighted that left unabated climate change will disrupt care, with poor environmental health contributing to major diseases, including cardiac problems, asthma and cancer.

The Chief Executive Officer of NHS England and NHS Improvement stated that the NHS must confront longer term challenges head on…

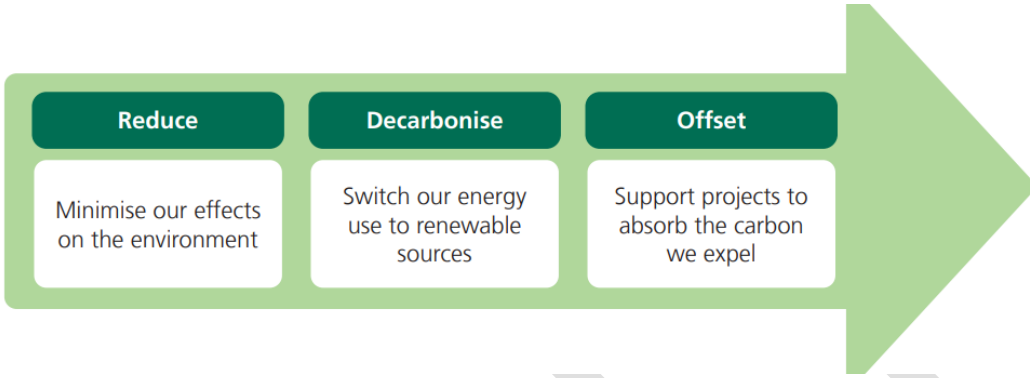
*"One of the most significant is the climate emergency, which is also a health emergency. Unabated it will disrupt care, and affect patients and the public at every stage of our lives. With poor environmental health contributing to major diseases, including cardiac problems, asthma and cancer, our efforts must be accelerated*

Sir Simon Stevens, Chief Executive Officer, NHS England and NHS Improvement October 2020 – Delivering a 'Net Zero' National Health Service.

## What do we mean by Net Zero?

Net zero refers to the balance between the amount of greenhouse gas produced and the amount removed from the atmosphere.

Net zero means achieving a balance between in greenhouse gases by reducing emissions and increasing absorption rates. Urgent and deep cuts to emissions and delivering Net Zero can be achieved using three strategies. (6)




*Source: Sherwood Forest NHS Foundation Trust*

## NHS Net Zero Targets

The report set out trajectories and actions for the entire NHS to reach net zero carbon emissions by 2040 for the emissions it controls directly, and 2045 for those it can influence (such as those embedded within the supply chain). Two net zero targets for the NHS have emerged, with a trajectory that is ambitious, while remaining realistic; and supported by immediate action and commitment to continuous monitoring, evaluation and innovation. (6)

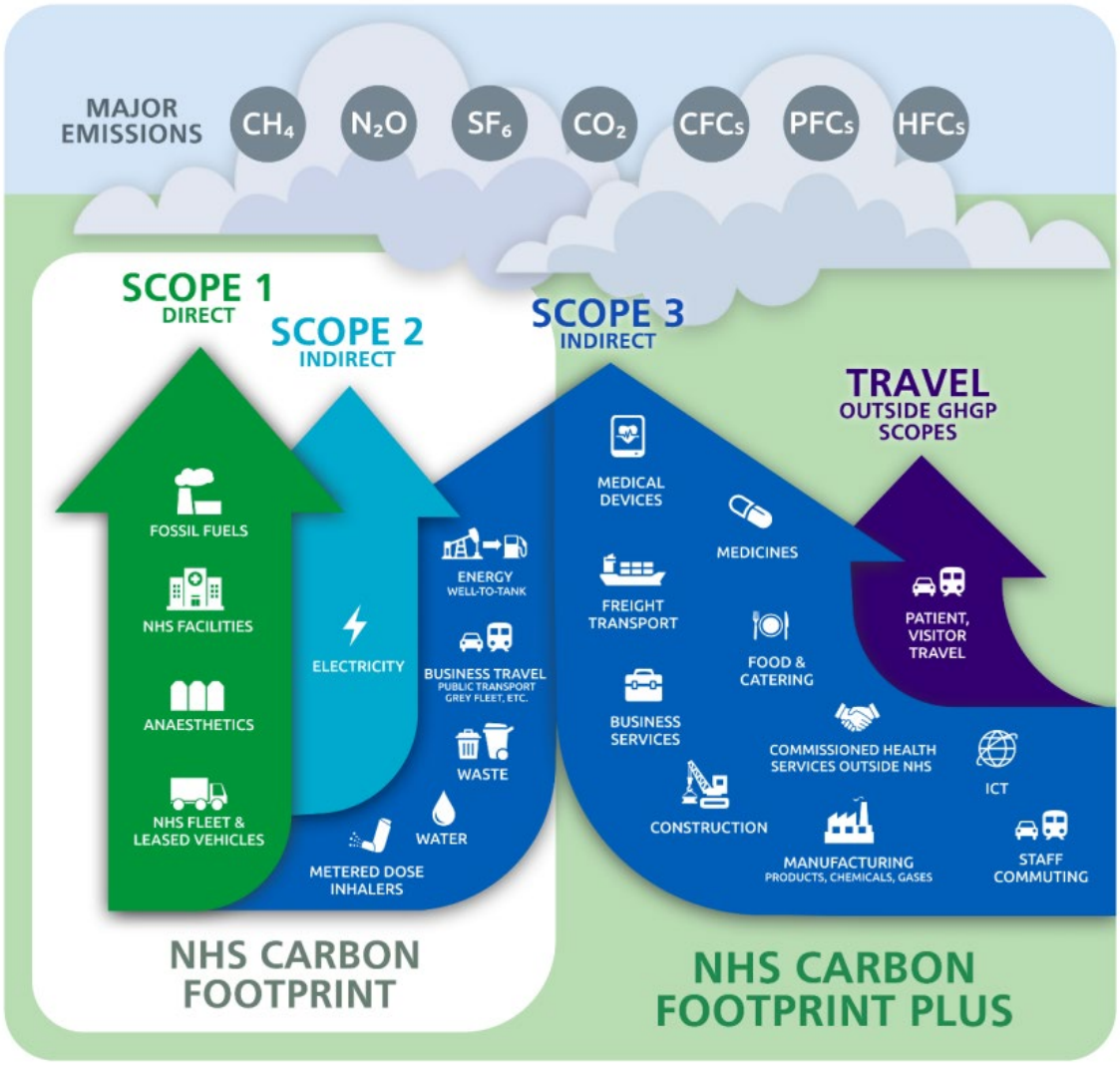
**The NHS Carbon Footprint (emissions under NHS direct control, net zero by 2040, with an ambition for an interim 80% reduction by 2028-2032**

**For the NHS Carbon Footprint Plus, (which includes our wider supply chain), net zero by 2045, with an ambition for an interim 80% reduction by 2036-2039**

## Carbon Footprint of the NHS

The NHS has been working to reduce its carbon footprint for a number of years, but earlier programmes did not cover the full scope of emissions attributable to the NHS. Under the new strategy the efforts to reduce carbon emissions now covers a wide scope of emissions as outlined in Figure 2.

**Figure 2: Full scope of NHS related carbon emissions**




*Source: Delivering a Net Zero NHS*

**Scope 1**: Direct emissions from owned or directly controlled sources, on site

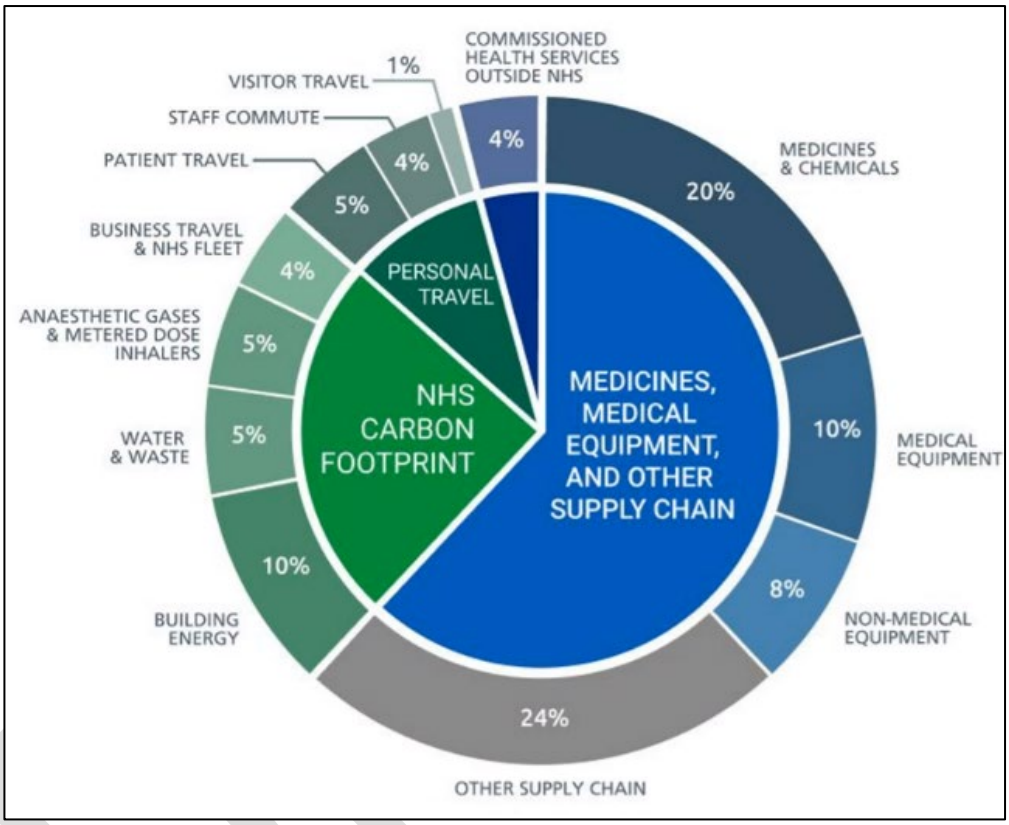
**Scope 2**: Indirect emissions from the generation of purchased energy, mostly electricity

**Scope 3**: All other indirect emissions that occur in producing and transporting goods and services, including the full supply chain.

Plus emissions related to patient and visitor travel

While travel and building energy use contribute to the NHS' emissions, as indicated in Figure 3, the NHS supply chain and the use of pharmaceuticals and medical devices are the source of the largest share of the NHS' emissions.

**Figure 3: National sources of carbon emissions by proportion of NHS Carbon Footprint Plus**




*Source: Delivering a Net Zero NHS*

## 1.4. Emissions related health impacts and opportunities for improvements to public health

While it is difficult to quantify the benefits that a net zero NHS alone can deliver in terms of lives saved, NHS analysis makes clear that reaching the national commitments under the Paris Climate Change Agreement and achieving a net zero UK economy will result in significant health benefits, by reducing the impact of climate change on health. (8)

By the year 2040, this trajectory would see an estimated: 5,770 lives saved per year from reductions in air pollution and 38,400 lives saved per year from increased levels of physical activity. (6)

Public Health England in 2018 modelled that air pollution for Nottingham City residents as an example, will cost health and social care £34M accumulatively over 10 years (2017-2027) and will also result in 3,000 additional deaths during this time. With the health costs made up of increases in

primary care, secondary care and medication. In 2027 this population can attribute 1,700 additional cases of diabetes, 1000 additional cases of Chronic Heart Disorder and 600 cases of COPD as well as smaller increases in stroke, asthma and lung cancer to the effects of air pollution. (9)

## 1.5. Health Inequalities

Delivering a net zero NHS has the potential to secure significant benefits across the population. Achieving all the stated targets will reduce the impact of climate change, but may exacerbate conditions for the vulnerable.

As a key priority, the NHS will work to reduce its own contribution to air pollution and work with partners on actions to improve air quality and improve local environments, thereby supporting the development of local economies in geographical areas of deprivation. Air pollution disproportionately affects people in these areas, many of whom are already at risk of poorer health outcomes. Examples of the links between climate change, sustainable development and health inequalities are seen across the country.

These benefits will only be fully realised through public participation, involvement and engagement with those communities as this work goes forward, having regard to the need to reduce health inequalities and taking into account the public sector equality duty.

For example:

- Access to green spaces has positive mental and physical health impacts, and these beneficial effects are greatest for those from socioeconomically disadvantaged groups. However, these groups also have the least access to green spaces.
- Black, Asian and minority ethnic groups are disproportionately affected by high pollution levels, and children or women exposed to air pollution experience elevated risk of developing health conditions.
- As climate change worsens the demand for energy will increase. This may increase the price of household fuel, which is likely to make it harder for poorer families to maintain good health, particularly in poorly insulated homes (6)

## 1.6. Our commitment to Net Zero

To support the co-ordination of carbon reduction efforts across the NHS and the translation of this national strategy to the local level, the NHS requires trusts to develop a Green Plan to detail their approaches to reducing their emissions in line with the national trajectories. Given the pivotal role that integrated care systems (ICSs) play, this has been expanded to include the expectation that each system develops its own Green Plan, based on the strategies of its member organisations.

The development of the Nottingham and Nottinghamshire ICS Green Plan has involved engagement and contributions from stakeholders across professions, organisations and in collaboration with local authorities and other system partners. This included two workshop events to:

- To raise awareness and gain commitment to the ambition to deliver a net zero NHS
- To seek contributions from system experts to identify the priority interventions for the next 3 years

**This is the first Nottingham and Nottinghamshire ICS Green Plan and outlines our shared vision and commitment to Nottingham and Nottinghamshire health system achieving net zero.**

**This plan covers our journey over the next three years as we lay the foundation for achieving net zero and outline our priority interventions to simultaneously improve patient care and community wellbeing while tackling climate change and broader sustainability issues.**

## 2. Nottinghamshire ICS Overview

### 2.1. Our Population

The Nottingham and Nottinghamshire ICS serves a diverse population of 1.2m, which going forward will include the people of Bassetlaw following a boundary change.

**City of Nottingham**

- There is a rich cultural mix across Nottingham City - 35% of the population are from black and minority ethnic (BME) groups.
- Nottingham City is the 11th most deprived district in the country. 56 of the 182 City Lower Super Output Areas fall amongst 10% most deprived in the country and 104 fall in the 20% most deprived.
- Life expectancy for males is 77 and females 82 years old, which is below the England average.
- 12% of the population are aged over 65, the England average is 18%, 30% of the population are aged 18-29 (full time university students comprise 1 in 8 of the population).
- In the short to medium term, Nottingham City is unlikely to follow the national trend of large increases in the number of people over retirement age, although the number aged 85+ is projected to increase.
- Despite its young age structure, Nottingham has a higher than average rate of people with a limiting long-term illness or disability.
- City has the 13th highest unemployment rate in the country, 12.7% of people are claiming out of work benefits.
- Over 2 in 5 households do not have access to a car, with the highest level of bus use per head outside of


**Nottinghamshire**

- Across Nottinghamshire 4% of the population is from black and minority ethnic groups.
- Deprivation levels as a whole are comparable with England, however there are some communities with the highest levels of deprivation in the country and some in the lowest levels – 31 Lower Super Output Areas are in the 10% most deprived areas in England that are concentrated in the districts of Ashfield (12), Mansfield (10) and Newark and Sherwood (5).
- Life expectancy for males is 80 and females 83, which is similar to the England average. Locally in regions of Nottinghamshire life expectancy varies considerably with more deprived districts

having a shorter life expectancy than less deprived districts For example in 2013-2015, life expectancy in Ashfield, Bassetlaw and Mansfield was significantly lower than for the East Midlands.

- 20% of the population are aged 65+, compared to the England average of 18%. The population is predicted to continue to age over the next 5 year, with the population aged 65+ expected to increase by circa 7% and the population over 85 by circa 8%.
- Older people are more likely to experience disability and limiting long-term illness. More older people are anticipated to live alone, increasing by 41% between 2015 and 2030.
- Job Seekers Allowance claimant rate (May 18) is 1.1%, which is the same as the national figure.

## 2.2. The ICS Partnership

At present the ICS continues to be a non-statutory partnership that brings together public health, general practice and primary care, acute hospitals, community and mental health services, social care and wider partners - including housing - to better serve population needs and achieve quality and sustainable care provision through collective endeavours.

With a combined annual budget of over £3billion for the commissioning and provision of health and care services, the partners collaborate at:

- A neighbourhood level through 23 primary care networks (PCNs) covering populations on the whole of between 30,000 and 50,000
- At a place level through four Place Based Partnerships (PBPs): Bassetlaw, Mid Nottinghamshire, Nottingham City, and South Nottinghamshire. Each PBP serves a population of ~120,000-350,000 people
- Through provider collaboratives at scale (see later section)
- At a whole system (ICS) level.

**Statutory partner organisations**

***9 Local Authorities***

- Nottinghamshire County and District/Borough Councils (x7)
- Nottingham City Council

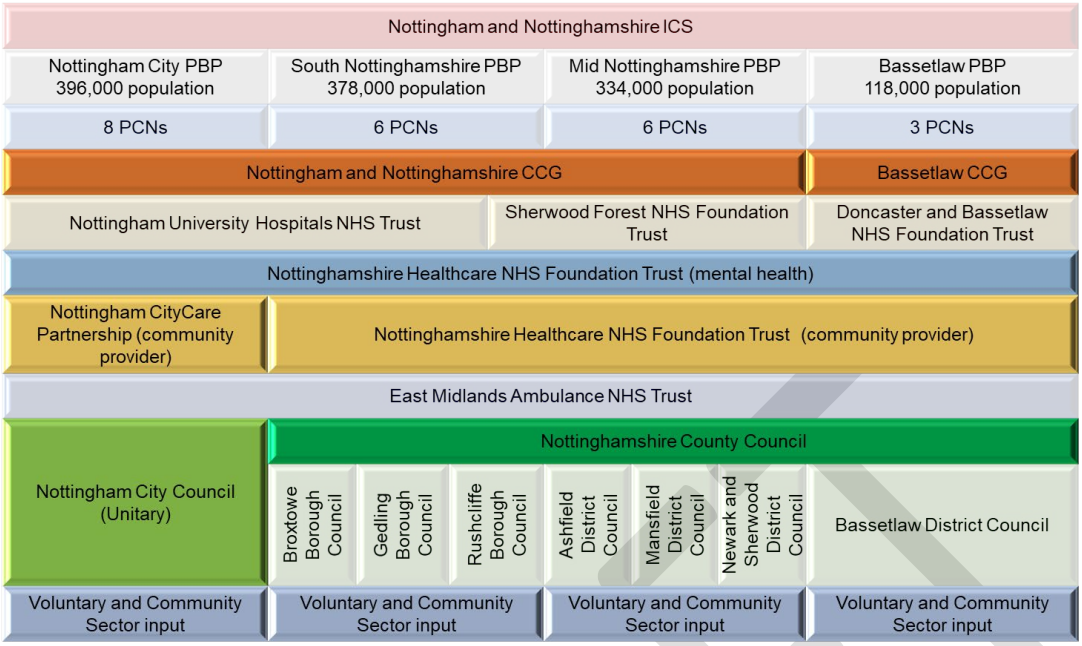
**2 NHS Clinical Commissioning Groups**

- NHS Bassetlaw CCG
- NHS Nottingham and Nottinghamshire CCG

***NHS Providers / Providers of health and care Services***

- Nottinghamshire Healthcare NHS Foundation Trust
- Nottingham University Hospitals NHS Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- Doncaster and Bassetlaw NHS Foundation Trust
- East Midlands Ambulance NHS Trust
- Nottingham CityCare Partnership CIC
- Primary Care including General Practice
- *Social Care Providers*
- *Community and voluntary sector organisations*

The graphic below provides an appreciation of our current set up and geographical arrangements.

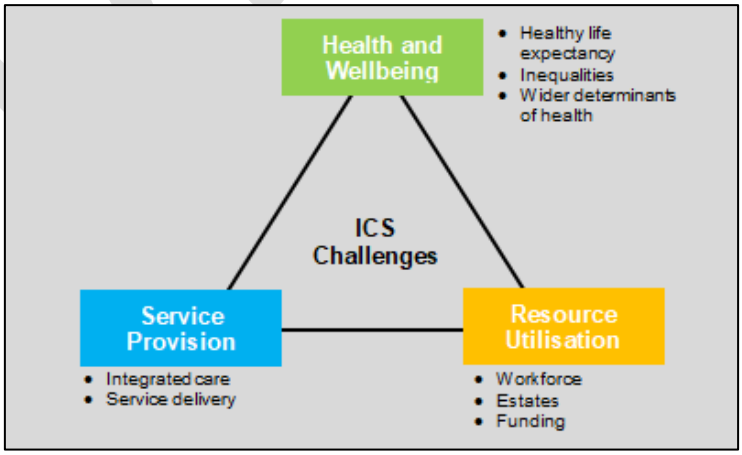



## 2.3. Our strategic context

Our five-year strategy confirms the key challenges that need to be addressed by the Nottingham and Nottinghamshire ICS. These are grouped into three categories, summarised in Figure 4, with a reinforcing effect on each other and are:

- The health and wellbeing of the population, including addressing inequalities and wider determinants.
- The provision of high quality services, including recovery from Covid19.
- The effective utilisation of system resources namely our workforce, estate and financial resources.

### Figure 4 – Key challenges




*Source: Nottingham and Nottinghamshire Health Inequalities Strategy*

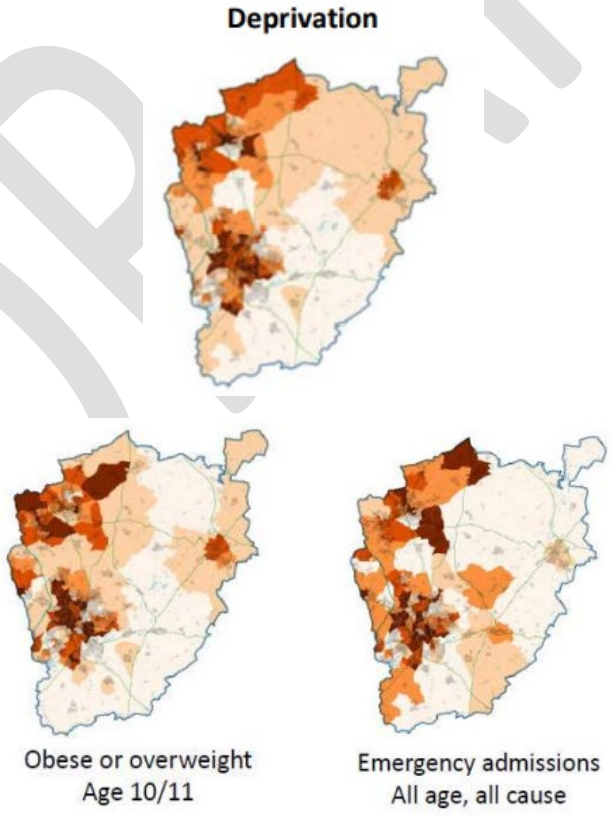
Achieving excellence in these three areas and meeting the triple aim is central to our ambitions. The approach taken by the ICS is one of incremental change, based on self-discovery and going on the journey, with a shared purpose underpinned by the triple aim to identify improvement opportunities. Nottingham and Nottinghamshire is renowned for innovation at a Neighbourhood and Place level, with considerable experience of operational collaboration across Local Authority and NHS organisations. Over the coming period there will now be increased opportunity for shared learning between Mid Nottinghamshire; Nottingham City and South Nottinghamshire with best practice from Bassetlaw as a confirmed Place within the ICS going forward.

## 2.4. Our Health Inequalities Strategy

Access to and the quality of health care services is only a small contributor to overall health outcomes, with the wider determinants of health contributing to 80% of health outcomes. These include:

**Deprivation** is a key driver of illness and ill health, with deprived communities having greater exposure to factors that impact on their health, including fuel poverty, poor housing, higher unemployment and poorer access to services. Lifestyle factors such as smoking, physical inactivity and poor diet are also more prevalent in these communities. Figure 5 shows the health and healthcare usage indicators in areas of higher deprivation in parts of our ICS, with a similar pattern emerging.

**Figure 5 – Patterns of deprivation and health and healthcare factors in our ICS**

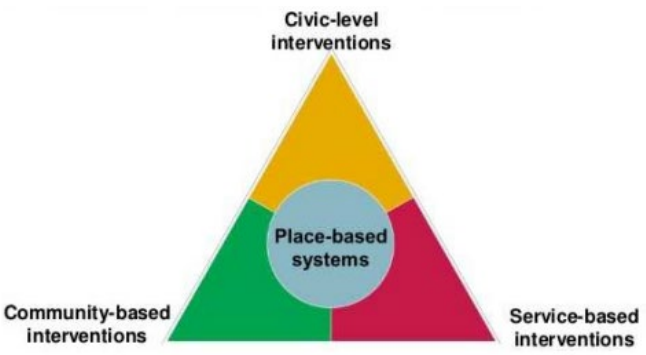



*Source: Nottingham and Nottinghamshire ICS Health Inequalities Strategy*

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

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

Our Health Inequalities Strategy has adopted a Population Intervention Triangle to guide and shape the specific actions to address the health inequalities identified and defined and will be co-produced with our communities. The model bringing together important elements of effective place-base working delivered through ICPs and PCNs. (10)




Acknowledging the links between climate change, sustainable development and health inequalities is an important consideration in the development of the Green Plan for Nottingham and Nottinghamshire ICS.

**We will:**

- Deliver joint action to reduce health inequalities through defined links between ICS Greener and Health Inequalities Leads

## 2.5. Our Carbon Footprint

The following section outlines the Nottingham and Nottinghamshire Carbon Footprint as of 2020/21 to inform progress and opportunities to deliver net zero ambitions, as summarised in Figures 6, 7 and 8.

### Figure 6 – ICS Carbon Footprint

| | NHS Carbon Footprint * ($ktCO_2e$) | | Reductions required from current levels ($ktCO_2e$) | |
|---|---|---|---|---|
| Area | 1990 | Current (2019/20) | by 2028-2032 | by 2040 |
| Midlands | 3,127 | 1,179 | -554 | -1,179 |
| Nottingham and Nottinghamshire ICS | unavailable at ICS level | 165 | -132 | -165 |

*These figures will need to be revised to include the carbon footprint in Bassetlaw.

In line with England, the Midlands have committed by 2028-2032 to an 80% reduction in Carbon footprint (from the 1990 baseline) requiring a further carbon reduction of 554 $ktCO_2e$. As the 1990 baseline data is not available (and will not be available in the future) at an ICS level, the 80% reduction

target uses the 2019/20 baseline equating to Nottingham and Nottinghamshire reducing carbon emissions by 132 $ktCO_2e$ by 2028-2032 and a total 165 $ktCO_2e$ reduction by 2040 to achieve net zero for our ICS.

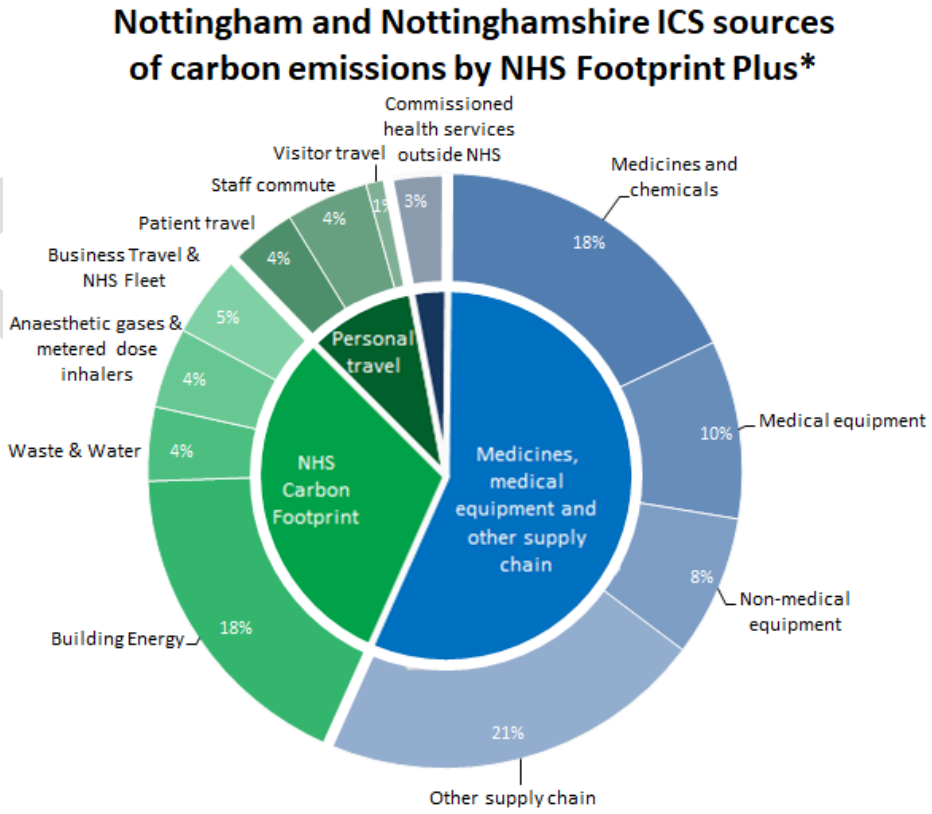
### Figure 7 – ICS Carbon Footprint Plus

| | NHS Carbon Footprint Plus ** ($ktCO_2e$) | | Reductions required from current levels ($ktCO_2e$) | |
|---|---|---|---|---|
| Area | 1990 | Current (2019/20) | by 2036-2039 | by 2045 |
| Midlands | 6,255 | 4,631 | -3,380 | -4,631 |
| Nottingham and Nottinghamshire ICS | Unavailable at ICS level | 553 | -442 | -553 |

* These figures will need to be revised to include the carbon footprint and carbon footprint plus in Bassetlaw (and to remove EMAS carbon footprint plus arising from their procurement which resides in Derbyshire ICS as they are the lead commissioner). EMAS carbon footprint from their fleet has already been removed from these figures.

In line with England, the Midlands region have committed by 2036-2039 to reduce their *carbon footprint plus* by 80% (from the 1990 baseline), requiring a further carbon emissions reduction of 3,380 $ktCO_2e$. Similarly to the carbon footprint, the carbon footprint plus 80% reduction by 2036-39 uses the 2019/20 data as the ICS baseline, therefore requiring Nottingham and Nottinghamshire ICS to reduce carbon emissions by a further 442 $ktCO_2e$ and a total of 553 $ktCO_2e$ reduction by 2040 to achieve net zero.

### Figure 8 – ICS Carbon Footprint Plus




The carbon figures for the above can be found in Appendix 1 at the end of this document.

## 2.6. Our Organisations and Commitment to Net Zero

A number of organisations in the Nottingham and Nottinghamshire ICS have acknowledged the scale of the challenge and a commitment to take action, including the declaration of a climate emergency:

In 2019, **Nottinghamshire Healthcare NHS Foundation Trust** became the first Mental Health Trust to declare a Climate Emergency, stating an ambition to be Net Zero carbon by 2040.

On the 13th January 2020, Nottingham City Council acknowledged the scale of the challenge presented by climate change by declaring a Climate and Ecological Emergency at Full Council and in March 2020 made a commitment to become the first city in the UK to become carbon neutral by 2028. In doing so, Nottingham will be one of the healthiest places to live with clean air, green open spaces and locally produced healthy food. New networks of safe cycling routes and high quality vehicle free public spaces will make it easier for people to get regular exercise. Good quality homes, high employment, attractive public spaces and biodiverse ecosystems will improve the overall wellbeing of citizens and communities.

In May 2021 **Nottinghamshire County Council** passed a motion formally agreeing to declare a Climate Emergency and committing to achieve carbon neutrality in all its activities by 2030. The Council is working now on a strategy to deliver this ambitious goal.

On the 2nd December 2021, **Sherwood Forest NHS Foundation Trust,** declared a Climate Emergency, with board commitment to net zero ambitions as outlined in its organisational Green Plan.

NHS Trusts and Local Authorities in our ICS have responded through the development of organisational-level Green Plans to support net zero ambitions within our system, with an outline organisational context and summary of ambitions provided:

### Nottinghamshire County Council

The Council has set out its ambitious plan and aim of developing a healthy, prosperous and greener future for all. Over the next 10 years the local authority will focus on:

- Improving health and wellbeing in all our communities
- Growing our economy and improving living standards
- Reducing the County's impact on the environment
- Helping everyone access the best of Nottinghamshire

While many residents enjoy the best that Nottinghamshire has to offer, health and prosperity are spread unevenly, and some residents miss out. Under the plan, the council will aim to reduce inequality and support vulnerable and disadvantaged communities.

Over the next four years the council will:

- Use its influence to create healthy and sustainable places: Ensuring that the environment we grow, live, work and age in promotes good health and wellbeing. We'll use the planning and transport system, along with economic planning, licensing and policy decisions, to create

places that do this. This will also help to reduce health inequalities and benefit the environment, for a better quality of life.

- Support individuals to improve their health and wellbeing: We'll provide services that support people in improving their health and wellbeing. These will address the biggest causes of ill-health – smoking, poor diet, physical inactivity, being overweight, harmful alcohol use and substance misuse. While these will improve the health and wellbeing of everyone in Nottinghamshire, we'll focus on where the need is greatest. We'll also address the social and environmental factors that cause differences in people's health. Finally, we'll support other organisations to deliver services which better prevent poor health, loss of independence and unnecessary hospital stays.

## Nottingham City Council

Nottingham City Council has responded to the climate and environmental crisis by setting an ambition to become the first carbon neutral city in the UK by 2028. At the heart of the shared vision is an approach that not only positively addresses wider environmental challenges, but improves quality of life and continues to create a prosperous, fair and resilient city for this and future generations.

An action plan has been developed, building on Nottingham 2028 Carbon Neutral Charter, which sets out high-level objectives to achieve the ambition for carbon neutrality by 2028. These include:

**Carbon Reduction Measures** – focussing on five activities to achieve emission reduction rates in excess of 22.3% per year and including transport, the built environment, energy generation, waste and water and consumption.

**Carbon Removal –** focussing on capturing carbon and offsetting residual greenhouse gas emissions that cannot be removed entirely. These are broken down into three groups: local carbon sequestration, carbon capture and large scale carbon offsetting.

**Resilience and Adaptation –** addresses the actions Nottingham must take to protect against avoidable harmful impacts of climate change, with the impact of flooding and extreme temperatures already experienced locally.

**Ecology and Biodiversity –** outlining the importance of green and open spaces, and biodiversity, for climate change mitigation and adaptation – unlocking other positive outcomes such as improvements in physical and mental health and enhancing local landscape.

## Sherwood Forest NHS Foundation Trust: Green Plan 2021-2026

The Trust provides outstanding healthcare in modern buildings and increasingly across the community to 500,000 people in Mansfield, Ashfield, Newark, Sherwood and parts of Derbyshire and Lincolnshire.

5,000 colleagues work across three hospital sites – King's Mill, Newark and Mansfield Community and have well established relationships with partners in health and social care through the Mid Nottinghamshire Integrated Care Partnership.

As a committed member of the Nottingham and Nottinghamshire Integrated Care System (ICS) the Trust works with NHS organisations, local councils and others to take collective responsibility for resources, delivering NHS standards, and improving the health of the population they serve.

The Trust has acknowledged this responsibility by developing a Trust-wide Green Plan, which clearly defines plans, commitments and targets. These will be monitored and reviewed to ensure sustainability obligations are met.

The Climate Action Project Group will undertake a regular review to ensure that the plans, objectives and targets in the Green Plan and action plan remain current and valid to the Trust. By adopting a continual improvement approach with respect to sustainability, performance will continue to develop incrementally.

At the Trust, awareness of and compliance with all current and any future legislation that will impact on sustainability position will be considered. A Sustainable Development Assessment Tool is used to ensure compliance criteria are met and, where feasible, exceeded.

The Trust recognises the impact on the local economy, society and environment, and is committed to continually work to integrate public health and sustainability into core business. Climate change is one of the most pressing challenges facing our society today and in the future. There are considerable implications for health, both directly and indirectly, across the population. There are also implications for widening health inequalities. We have a responsibility to maximise our contribution to creating social value and ensure efficient use of resources. Planning now will help to ensure critical care pathways remain accessible, growth in service use can be resourced sufficiently, and risk is minimised.

## Nottinghamshire Healthcare NHS Foundation Trust: Our Journey to Net Zero Green Plan 2022-2025

The Trust is a provider of integrated healthcare services, including mental health, intellectual disability, and physical health service. Over 10,000 staff provide services in a variety of settings, ranging from the community through to acute wards, as well as secure settings. The Trust manages two medium secure units Arnold Lodge in Leicester and Wathwood Hospital in Rotherham, and the High Secure Rampton Hospital near Retford. It also provides healthcare in prisons across the East Midlands.

The size of the estate managed by the Trust (for all freehold, leases and licences excluding freehold residential housing at Rampton Hospital) totals 111, 500m$^2$. Trust services are currently present on 260 locations, the breakdown of which is detailed as follows:

- 58 Trust owned properties
- 69 Leased properties where the Trust has sole rights to use rooms
- 5 Licences where the Trust has shared rights to use the rooms
- 90 Locations where the Trust has a 3$^{rd}$ party presence (drop in/touch down space for example in Care Homes and GP's)
- 28 Trust owned residential properties at Rampton Hospital

In terms of service provision and the scale of delivery, during 2020/21 the number of "seen appointments" was just over 1.6 million and for the same period, the total number of occupied bed days was 302,093. The local population served by the Trust totals just over 2.1 million. With sites and services provided in Nottinghamshire, Derbyshire, South Yorkshire, Lincolnshire and Leicestershire, the estate is vast and varied but so are potential opportunities for change and improvement.

The Trust has been working hard to reduce emissions over several years and has delivered these reductions strategically through the implementation of a Sustainable Development Management Plan (SDMP). The first SDMP was approved in 2015 and following a number of successes was reviewed and refreshed in 2018. In 2019, the Trust became the first Mental Health Trust to declare a Climate Emergency, stating an ambition to be Net Zero carbon by 2040, with a Green Plan based on ten areas of action, each with a nominated lead.

## Nottingham University Hospitals NHS Trust: Green Plan 2022-2025

The Trust is one of the largest acute teaching hospitals in England. With a budget of just under £1billion, it is one of the largest employers in the region, employing circa 15,000 people at QMC, City Hospital, Ropewalk House and the Nottingham Treatment Centre.

The Trust has 90 wards and around 1,700 beds across three main sites:

- QMC is where the Emergency Department (ED), Major Trauma Centre and the Nottingham Children's Hospital are based. QMC is also home to the University of Nottingham's School of Nursing and Medical School and the Nottingham Treatment Centre acquired in 2019.
- Nottingham City Hospital is the planned care site, where the cancer centre, heart centre and stroke services are based.
- Ropewalk House is where a range of outpatient services is provided, including hearing services.

The Trust delivers services to 2.5 million residents of Nottingham, Nottinghamshire and its surrounding communities. It also provides 92 specialised services to 4-5 million people from across the East Midlands region, including Derbyshire, Lincolnshire, Leicestershire, and nationally for a handful of services.

Since its creation, sustainability has been at the core of NUH's activities bringing social, economic and environmental benefits in line with its business priorities.

In line with the ambition to deliver a net zero NHS, NUH is going through a transformational process seeking to address the new challenges. Sustainability is a core principle NUH continues to permeate across the whole organisation and must inform (and be aligned with) the wider organisational strategy aiming to address the new challenges.

The NUH Green Plan 2022-2024 builds on previous achievements ensuring good practice and successful initiatives have continuation. The strategy also re-focuses NUH's efforts in response to the changes in both the local and the national policies.

The structure of this strategy identifies the main drivers, themes and action plan for NUH to achieve the main goals of its sustainability agenda.

## East Midlands Ambulance Service NHS Trust (EMAS)

EMAS provides emergency and non-emergency services for approximately 4.8 million people. The Trust operates from over 70 premises across the East Midlands, including ambulance stations, educational centres, and administrative offices.

In its Green Plan, EMAS provides an overview of the actions it will take throughout the next 3 years to tackle its carbon footprint. EV technology and infrastructure is currently being developed, so the Trust's fleet-based emissions are largely unavoidable. However, EMAS plans to take several

proactive measures to facilitate the speed at which EVs can be integrated, including the identification of Trust-wide providers, regional schemes, and locations. To tackle business travel emissions, travel policies will be revised to include environmental considerations, work will be conducted online where possible, and awareness over the impact of avoidable business travel will be promoted amongst staff. Lastly, anaesthetic gas use will be reduced through the exploration of alternatives, whilst building energy will be made more sustainable through the procurement of renewable alternatives and site upgrades.

## Doncaster and Bassetlaw Teaching Hospitals Trust

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust is an acute NHS Foundation Trust operating within the Yorkshire region. It hosts one of the busiest emergency services in the county, as well as being a teaching hospital, working closely with the University of Sheffield and Sheffield Hallam University.

The Trust employees 6,000 staff across its three main hospital sites; providing the full range of district general hospital services and some specialist tertiary services, including vascular surgery. We also provide a number of community services including sexual health services, therapies, aortic aneurysm screening and audiology.

The Trust delivers healthcare to a population of more than 420,000 across two geographical areas South Yorkshire, North Nottinghamshire, and the surrounding areas, including the towns of Doncaster, Worksop, and the rural towns of Retford and Mexborough. Except for the urban town of Doncaster, the area the Trust predominately serves is rural.

Doncaster has a population of approx. 440, 000 and Bassetlaw a population of approx.117, 000. The Government's Indices of Multiple Deprivation 2019 has ranked Bassetlaw as 106 out of the 317 Local Authorities in England making it within the 35% most deprived areas, Doncaster is one of the 20% most deprived districts/unitary authorities.

The Green Plan is a Board Approved strategic document, which sets out the Trusts commitment and approach to achieving net zero and to improving the sustainability of the Healthcare Services we provide.

The Trust aims to prioritise interventions that reduce carbon emissions and improve sustainability performance; the strategy outlining an intention to implement direct interventions within estates and facilities, travel and transport, supply chain and medicines to reduce carbon emissions and to improve sustainability performance and to adapt to a changing climate.

Alongside these interventions, enabling actions will include the development and training of our workforce, providing system leadership, developing sustainable models of care, and improving access to preventative health advice and access to fresh and health food on their Estate.

## Our pledge

As the ICS transitions into Integrated Care Board (ICB) arrangements and under the leadership of our designated board-level net zero lead, our system commits to the actions described to support the ambitions of delivering a net zero NHS across health and care. This will include, consideration to declaring a climate emergency as a system, building on the commitments already made by many of our system partners.

# 3. Areas of Focus

## 3.1. Workforce and system leadership

### Context

Success in achieving Net Zero depends on System Leadership and the support of staff. Clear leadership and strategic direction are vital for the ICS is to act on climate change and deliver financial and environmentally sustainable healthcare services.

Staff engagement with the Green Plan is essential for the delivery of sustainable healthcare. All staff have a role to play in delivering our vision.

Engaging staff to adopt sustainable practices will enable them to take ownership within their own area of influence. With 1 in 20 of the UK population working for the NHS, a carbon literacy educated workforce can act as a catalyst for spreading the sustainability message.

### Where we are now

### Leadership

All organisations within our ICS have board level net zero leads.

An ICS Green Programme Board has been established and chaired by an ICS Sustainability Lead to develop the Green Plan for Nottingham and Nottinghamshire. This is supported by an ICS Green Development Group formed to bring together local sustainability knowledge and expertise to drive the development of the plan now and into the future.

Clear leadership, strategic direction and support to all stakeholders and decision makers will support the delivery of actions to deliver net zero ambitions. A number of organisations have incorporated a Sustainability Action Plan into their governance processes to identify the carbon impact of service developments and transformation projects to support decision making, with an ambition to develop this at a system level.

### Engagement

The development of the Green Plan has taken a co-design approach, to develop a shared vision to gain commitment to its ambitions, share best practice and with a commitment to working together to maximise actions that are mutually beneficial to deliver net zero across the ICS. A commitment to engagement builds on commitments already made locally to engage broadly to understand challenges and opportunities. For example, **Nottinghamshire County Council** conducted the 'Big Notts Survey' during the summer of 2021; with 12,000 respondents, it has supported the development of its commitment to protecting and enhancing Nottinghamshire's environment, supporting more sustainable lifestyles and reaching net carbon neutrality in all Council activities by 2030.

The ICS is also looking at digital schemes to incentivise citizen and staff behaviour and encourage them to learn more about climate change and how they can help lower carbon levels.

## Education

Organisations across the ICS have made a commitment to raise awareness of climate change and are encouraging staff to undertake carbon literacy training.

**Nottingham City Council** is aiming to train as many of its staff in carbon literacy, including climate change e-learning for all new starters, supported by regular internal communication messaging to maintain awareness.

**Sherwood Forest Hospitals** has established a Climate Action Project Group and Climate Action Teams. They are supporting the roll out of Environmental Awareness Training, with e-learning to accessible to staff on induction. This is to be extended to incorporate e-learning as part of annual appraisals to support the delivery of sustainable development objectives. This ambition is supported by other NHS organisations within our system, including Nottinghamshire Healthcare NHS Foundation Trust committing to reflect sustainable healthcare in appraisals, inductions and job descriptions by October 2023.

Raising awareness at all levels of the organisation is fundamental to delivering sustainable healthcare actions, with **Nottingham University Hospitals NHS Trust** making a commitment to develop a network of Green Champions, as well as including e-learning as part of induction and a statement on Green NHs in job descriptions. **Nottinghamshire Healthcare NHS Foundation Trust** have over 600 Green Champions, the largest staff champion group in the Trust, who are kept up to date on Trust, sector and national sustainability initiatives through a monthly bulletin. The Trust has also signed up to Green Impact, a sustainability behaviour change campaign for staff and patients for a third year this year supporting carbon reduction ambitions.

**Case Study:**

**Nottinghamshire Healthcare NHS Foundation Trust** was the first mental health Trust to be involved, in Green Impact, a sustainability toolkit which has been developed by the National Union of Students (NUS) and run by SOS-UK, with the scheme being very successful in the University sector and, in the last 5 years, in the NHS too. Staff, patients, volunteers and service users agree to take part in teams and work their way through a bespoke online toolkit, submitting evidence of their achievements. Teams are recognised with a Bronze, Silver, Gold or Excellence Award depending on the number of actions completed.

Green Impact helps Trust staff and patients understand the whole sustainability agenda and social responsibility, it shows them what they can do to make a difference and supports them in achieving these actions. The Trust first launched Green Impact in 2019 after feedback from our 600 strong network of Green Champions told us that staff wanted to be directly and actively involved in making positive change locally.

## Our Ambition

| | |
|---|---|
| Leadership to deliver net zero ambitions | •Designated board-level net zero lead to be appointed to support the ambitions of delivering a net zero NHS<br>•Maintain ICS Green Board and Delivery Group arrangements to deliver ambitions<br>•Explore the use of digital schemes to incentivise citizen and staff |
| Engaging the public and our workforce in the actions required to deliver sustainable healthcare locally | •Annual summit to encourage and enable to staff to generate ideas and lead on them<br>•Co-design with the public to understand and respond to carbon impact through the life course |
| Education and training to enhance carbon literacy | •Delivering carbon literacy training, with a tiered e-learning approach to deliver meaningful training effectively<br>•Developing a network of Green Champions to raise awareness |
| Sustainability as a core dimension of service management/delivery | •Completion of Sustainability Impact Assessments mandatory for service developments<br>•Carbon monitoring 'scorecard' undertaken locally<br>•Sustainability actions supported by PMO |

## 3.2. Sustainable models of care

### Context

60% of carbon emissions are linked to clinical pathways and associated supply chain and human resource.

The NHS Long Term Plan sets out a commitment to deliver a new service model for the 21st century. If the NHS is to reach net zero emissions, that new service model must include a focus on sustainability and reduced emissions.

As part of the new NHS service model for the 21st century, multiple commitments are in progress, including boosting 'out-of-hospital' care; empowering people to have more control over their health; digitally enabling primary and outpatient care; and increasing the focus on population health. Optimising the location of care ensures that patients interact with the service in the most efficient place, which may be closer to, or even in, their home. Not only does this improve patient experience

and often offer greater access to care, but it also reduces emissions by helping to avoid unnecessary hospital visits and admissions.(6)

## Where we are now

A Clinical Advisory Group has been established for the ICS to provide advice and expertise on the development and coordination of components of the Green Plan, with specific attention to Sustainable Models of Care, Food and Nutrition and Medicines, but also understanding interdependencies with other areas of focus e.g. Supply Chain, Digital Transformation and Health Inequalities. Membership of the group includes clinical representation from acute, community and primary care services, as well as public health input.

A Clinical and Community Services Strategy has been completed for the ICS. This sets out how we will provide care in the future to achieve this. It aims to develop a model of care that is delivered by the whole health and care system as a whole, being more proactive, focusing on prevention and early intervention and providing services closer to home; this supporting people to live longer, happier, healthier and more independent lives. Twenty service reviews have been undertaken, as summarised in Figure 9, with transformation plans emerging from these which can support carbon reduction plans for the system. (14)

**Figure 9– ICS Clinical and Community Services Strategy**


*Source: ICS Clinical and Community Services Strategy*

## Prevention and Health Inequalities

As described, an ICS Health Inequalities Strategy has been published, with an ICS Prevention and Health Inequalities Transformation Programme supporting the delivery of local ambitions, with a commitment to align to the ICS Green Plan.

One of the nine ambitions in the new **Nottinghamshire County Council** Plan is 'Helping our people live healthier and more independent lives.' As part of this ambition the council aims to support individuals to improve their health and wellbeing, by providing services that support people in improving their health and wellbeing. These focusing on the biggest causes of ill-health – smoking, poor diet, physical inactivity, being overweight, harmful alcohol use and substance misuse. With an

ambition to improve the health and wellbeing of everyone in Nottinghamshire, a focus will be placed on where the need is greatest and addressing the social and environmental factors that cause differences in people's health. Working with other organisations the council aims to deliver services which better prevent poor health, loss of independence and unnecessary hospital stays, all leading to a positive environmental benefit.

## Care Pathways

Future models have been developed which describe ambitions to deliver care closer to home. A cross ICS Programme is underway to develop this further, for example optimising opportunities in the ophthalmology pathway. Other innovative services, such as the Alcohol Care Team are contributing to carbon reductions, with plans to extend across the ICS aligned with NHS LTP ambitions. (11)

**Case Study**

The Alcohol Care Team in **Nottingham University Hospitals NHS Trust** achieved a two-thirds reduction in hospital admissions due to detoxification and alcohol-related cirrhosis, saving 36 bed days per month. Over a year, this would lead to estimated carbon savings of 0.27 $ktCO_2$.

The COVID-19 pandemic has also transformed the way we deliver outpatient services, supporting the NHS LTP ambition to reduce attendances by a third (11). Working with Connected Nottinghamshire, opportunities for digital transformation can be optimised, including virtual appointments, but also other functionality such as Patient Knows Best (PKB) to connect clinicians and patients to support self-care and smooth transitions of care across settings.

## Lower Carbon Interventions

Supply chain requirements within clinical pathways contribute to overall carbon emissions. Progress is being made to seek alternative products to reduce waste. **Sherwood Forest NHS Foundation Trust** is working closely with procurement colleagues to adopt items such as zero plastic food utensils. **Nottingham University Hospitals NHS Trust** is also embedding sustainability principles into its Quality Improvement and Waste Reduction Initiatives.

**Case Study:**

**Sherwood Forest Hospitals NHS Foundation Trust** Waste Contracts Manager at observed that a huge number of waste items being brought out of the hospital for disposal sometimes appeared not to be broken and were simply unopened or unwanted. These items were quarantined during a one month period, and presented before the SMT, Chief Nurse, Head of our Consumables Group and Procurement. Following on from the meeting a value was placed on the items by working alongside the procurement team. Both financially and ethically it didn't make sense to continue with the needless disposal of items. A campaign highlighting the issue, sharing knowledge of unwanted items and offering the surplus stock to other hospital departments was commenced

The Academic Health Science Network (AHSN) supports the adoption and spread of innovations which can benefit clinical carbon reduction. This knowledge is being used within our organisations to reduce carbon emissions, such as the use of manifold systems to reduce Nitrous Oxide emissions.

**Case Study**

**Sherwood Forest NHS Foundation Trust** has sought advice from the Yorkshire & Humber Academic Health Science Networks (AHSN) presentations on Nitrous Oxide Emissions Reductions, and is using the knowledge to take action working with a multi-disciplinary team to develop plans to monitor / test manifold systems, and calculate the actual v estimated consumption values

**Our Ambition**

| | |
|---|---|
| Developing holistic pathways to deliver quality care outcomes, with a focus on prevention, self-care and equity of access | • With a focus on prevention and addressing health inequalities to reduce unnecessary carbon emissions and inequity of access<br>•Promoting self-care ambitions |
| Meeting the ambitions to deliver care closer to home | •Optimising digital enabled care accelerated as part of COVID-19 pandemic response<br>• Working with Connected Nottinghamshire to optimise connectivity across digital platforms and use of Patient Knows Best(PKB) to connect clinicians and patients<br>•Transforming pathways to deliver care closer to home e.g. Ophthalmology as an early adopter |
| Delivering lower carbon interventions where clinically relevant | •Clinical engagement and collaborative procurement to optimise carbon reduction opportunities<br>•Build on carbon reduction innovations developed in collaboration with the AHSN |

## 3.3. Digital transformation

**Context**

The NHS Long Term Plan has set a number of critical priorities to support digital transformation, seeking to mainstream digitally-enabled care across all areas of the NHS. New digital technology is opening to the healthcare sector opportunities to be more efficient and productive, from improving communication to storing information digitally. (11)

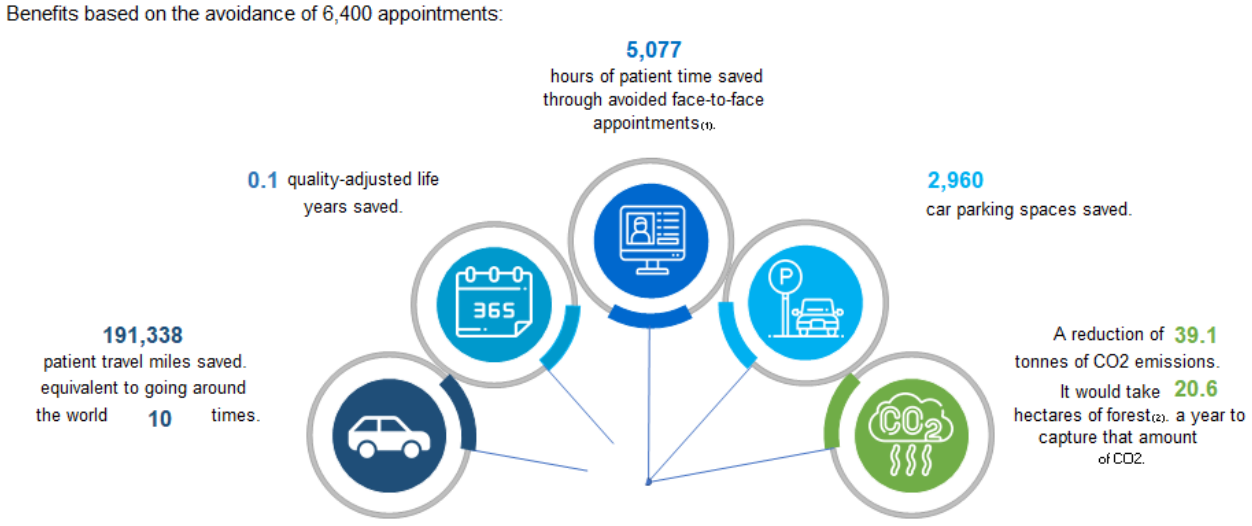
The direct alignments between the digital transformation agenda and a net zero NHS are clear. The ICS will focus on ways to harness existing digital technology and systems to streamline service delivery and supporting functions while improving the associated use of resources and reducing carbon emissions, as outlined in the Sustainable ICT and Digital Services Strategy (2020 to 2025) objectives. (15)

For example, patient travel accounts for 5% of the NHS Carbon Footprint Plus. Increased use of remote consultations where clinically appropriate will assist in reducing the need for patients to travel for healthcare appointments, reducing travel related emissions and saving patients time and money.

Enabling patients to manage their own health and wellbeing through digital technology also contributes to reduction in carbon by up to 25.59kg $CO_2$ per registered patient. (17)

The impact of avoided appointments, both in terms of a reduction in carbon emissions and the benefits to patients' health and wellbeing has been described by NHS England East of England, as shown in Figure 10, below.

### Figure 10 – Impact of the reduction in outpatient attendances

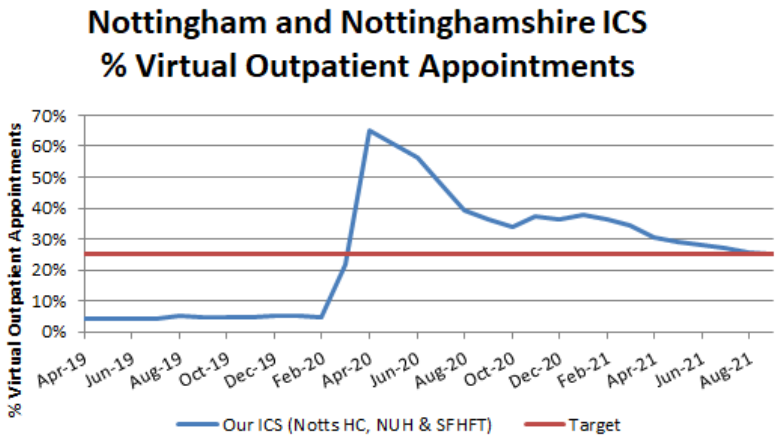



*Source: NHS England East of England*

## Where we are now

The need to transform the delivery of services during the COVID-19 pandemic has accelerated the development and use of remote consultations across healthcare where clinically appropriate. This supports the drive to reduce patient related travel.

### Figure 11 - % Virtual Outpatient Appointments



A significant increase in virtual outpatient appointments was seen in response to the COVID-19 pandemic, with the ICS achieving 25% of outpatient activity delivered remotely.

The move to home working and adoption of virtually meetings has reduced staff travel and increased productivity through saving time lost through travel. Though there will be a stepped return to some site based working and face to face meetings, great strides have been made in reducing travel needs.

For **Sherwood Forest Hospital's** patients, appointment letters are being sent into the NHS App so they don't need to be posted to patients. Virtual appointments are already in use within the Trust where their use is considered appropriate. Opportunities for remote monitoring are also being developed to reduce the need for patients to travel by the ability to monitor their condition and connect with clinicians remotely.


Telemedicine is already in place in **Nottingham University Hospitals.** The trust will see the installation of new facilities to maximise sustainable access to the trust and will push to achieve easier access to its services with a new established telemedicine platform. The trust is also advancing plans to digitise clinical records, streamline correspondence with patients and implement robotic processes e.g. reducing the use of desktop phones by migrating to JABBER software, centralising emergency response through the use of EVERBRIDGE. The organisation's Green Plan also includes actions that are in line with NHSX's *"What Good Looks Like"* framework to digitise, connect and transform services safely and securely. (17)

There were significant changes in practice at **Nottinghamshire Healthcare** as a result of the pandemic, with many services still being undertaken remotely.

Cross system and cross partner projects introducing digital transformation of services are delivering service efficiencies and reducing emissions and wastage. These include the East Midlands Radiological System (EMRAD) which supports the digital storage and sharing of images.

Underpinning Nottingham and Nottinghamshire's Integrated Care Systems Public Facing Digital Services vision is the programmes Digital and Social Inclusion Project. Recognising that many of the people who could benefit most from these digital services are the least likely to be online, or lack the skills and confidence to utilise these tools. This project developed to support the improvement of Digital and Social Inclusion across Nottingham and Nottinghamshire, and, to ensure digitally disempowered communities can access and take advantage of digital opportunities.

## Our Ambition

| | |
|---|---|
| Delivering digital appointments and services where clinically relevant | • Optimising digital appointments across settings<br>• Developing virtual services e.g. medical retina solution<br>• Enhancing inter-operability between systems |
| Connecting clinicians and patients | • Empowering patients through digital literacy e.g. PKB, but with consideration to health inequalities<br>• Extending access to self-monitoring functionality and with connection to clinicians<br>• Access to educational materials and creating a virtual environment for care delivery e.g. exercise classes |
| Digitising processes to enhance clinical care delivery | • Enhanced digital solutions for administration e.g. patient letters<br>• Digitising health records and developing shared care records<br>• Developing alternatives to the 10 data centres run across trusts and councils |

## 3.4. Travel and transport

### Context

Approximately 3.5% (9.5 billion miles) of all road travel in England relates to patients, visitors, staff and suppliers to the NHS, contributing around 14% of total emissions (13% locally). Locally, this includes approximately 3% for business travel and fleet transport, 4% for patient travel, 5% for staff commutes and 1% for visitor travel (6). This underlines the key responsibility we have to reducing travel to support the delivery of net zero and to reduce air pollution.

National programmes to reduce travel related emissions include a move by the NHS to purchasing or leasing low and ultra-low emission vehicles. Greater use of digital solutions to avoid unnecessary patient travel will also help in reducing emissions.

Sustainable forms of travel, and the reduction in the number of journeys necessary, have in addition to reducing carbon emission, a range of benefits including improving public health from reduced air and noise pollution.

In 2019, nearly a third of Nottingham's total $CO_2$ emissions came from transport of which, nearly all come as a result of road transport from cars, vans, lorries and buses.

Action is needed to reduce car journeys, increase cycling and walking and improve public transport and more low emission vehicles. Through this, we can achieve better air quality, mobility and health for citizens. (18)

## Where we are now

### Clean Air

In Nottingham the whole of the city centre is an ultra-low emission area, supported by the implementation of the UK's first Workplace Parking Levy and the construction of two new tram lines leading to 9.7 million additional public transport journeys each year.

NHS trusts are continuing to implement plans to reduce patient transport mileage, aligned with the ambition to reduce outpatient attendances to 25%, contributing to improvements in local air quality and aligned to the clean air hospital framework.

### Ultra-low (ULEVs) and zero emission vehicles (ZEVs)

Efforts have been made to increase ULEV or ZEV vehicles within fleet across the ICS. 46% of the **Nottingham City Council** fleet is ULEV.

At **Sherwood Forest Hospitals** at least 10% of the fleet and pool vehicles are fully electric. The trust now also offers ULEV & EV to staff through the salary sacrifice scheme.

**Nottingham University Hospitals** sees the implementation of sustainable travel though the minimisation of private car usage and elimination of emissions from motor vehicles by moving to emissions free vehicle. The Trust offers staff, through the salary sacrifice scheme, the option to have an ultra-low or zero emission vehicle

**Nottinghamshire Healthcare NHS Trust** is purchasing fleet vehicles to support the NHS national targets, with an ambition to ensure 90% of Trust fleet to be Low Emission Vehicles with at least 25% Ultra Low emission by 2028. The trust has only ultra-low emission vehicles (<75g/km or below) on the staff salary sacrifice scheme.

**EMAS** plans to take several proactive measures to facilitate the speed at which EVs can be integrated into its fleet, including the identification of Trust-wide providers, regional schemes, and locations.

### Infrastructure

Local authorities are working to ensure there is high quality infrastructure to enable low emission and low carbon transport and investment in charging infrastructure to manage demand.

**Sherwood Forest Hospitals** is working to install EV points in car parks to offer more opportunities for staff and patients to use electric vehicles EV, with chargers currently available at 2 of the 3 trust sites.

**Nottinghamshire Healthcare NHS Foundation Trust** have EV charging points installed at 8 key hospital sites and charging points awaiting installation at the trust's latest hospital acquisition, Sherwood Oaks in Mansfield.

## Sustainable Travel

Both local authorities are working to reduce the need to travel, particularly by car, through promoting the uptake of active travel and availability of safe and green walking/ cycle networks and other low-carbon and healthy travel options to encourage people to try healthier, more environmentally-friendly ways of travelling. This will include promoting options for cycling and walking to school and raising awareness of the harm to health, especially children's health, caused by poor air quality and the benefits of an active lifestyle.

Both local authorities and all NHS organisations offer cycle to work schemes, with infrastructure in place, such as cycle parking. Other schemes are in place to support sustainable travel:

**Nottinghamshire County Council** has a new Hybrid working strategy that encourages staff to work from home, and if commuting to consider active travel options

**Sherwood Forest NHS Foundation Trust** is utilising the Kinto app, originally used for car sharing, to promote tracking walking and cycling to work. To encourage staff to switch from diving to work

**Nottinghamshire Healthcare NHS Trust** is reviewing and updating the Trust Expenses Policy to ensure measures are in place to encourage sustainable travel.

## Public transport

**Nottingham City Council** is working with operators to increase the quality, accessibility and frequency of public transport. This includes access to a Medilink service that connects the two **Nottingham University Hospitals NHS Trust** sites and is free for staff and students.

To encourage daily bus travel, **Sherwood Forest NHS Foundation Trust** supports Stagecoach Smart Commute which saves 30% on bus fares.

**Nottinghamshire Healthcare NHS Foundation Trust** offers staff an Easy Rider/Robin Hood travel card. The Travel Pass Scheme enables staff to obtain a 12 month travel card with significantly reduced fares. With this card staff are also entitled to other benefits including free use of Citycard Cycles, which enables free cycle rental in Nottingham.

## Communication

Awareness of all schemes to increase the use of low emission vehicles and alternative sustainable transport solutions is vital to support increased uptake to reduce carbon emissions. Organisations are working to incorporate communication within Green Travel Plans to support staff, patients and visitors to get to sites more sustainably.

## Our Ambition

| | |
|---|---|
| Promoting sustainable transport and reducing overall tranport | •Promoting active transport solutions to reduce carbon emissions and support health and wellbeing<br>•Reducing patient and business transport through reduction in attendances and hybrid working practices |
| Increasing the use of ULEV and ZEV vehicles | •Increasing the % of ULEV and ZEV in fleet through new lease opportunties and considering options to procure centrally<br>• Extend offer of ULEV and ZEV vehicles in salary sacrifice schemes and working towards only providing low emission options |
| Developing the infrastructure to support lower carbon transport options | •Ensuring adequate EV points to support transition to ULEV and ZEV within fleet<br>•Providing appropriate infrastructure to support active transport within community and organisations<br>•Developing a consistent approach to anti-idling principles |
| Enhancing understanding and communication via Green Travel Plans | •Promoting the health and wellbeing benefits of active transport<br>•Educating on lower carbon solutions and how to access these |

## 3.5. Estates and facilities

### Context

The ICS continues to seek opportunities to develop system-wide estate infrastructure through rationalised estate with full utilisation of high quality, flexible long term estate and is committed to ensure this aligns to achieving a net zero carbon for the NHS and public sector estate. An Estates Strategy will be developed that enables planned review for suitability renewal where needed including sustainability impact assessments of developments for the ICS estate to deliver modern, energy efficient services over the coming years. Developing frameworks to ensuring estate is genuinely utilised on a System basis to improve services and generate efficiencies that reduce demand for energy across the system economy through lowered demand for carbon intensive activities. Estates and facilities need to be focused on providing the infrastructure to deliver the best care for the ICS population against the objectives defined within the NHS *"Delivering a 'Net Zero' National Health Service".* (6)

The NHS estate and its supporting facilities services – including primary care, trust estates and private finance initiatives – comprises 15% of the total carbon emissions (22% locally) profile.(6) National programmes to delivery emissions reductions will include upgrading lighting across the NHS estate, including a move to 100% LED lighting; and a move to purchasing 100% of electricity from renewable sources.

## Where we are now

**Nottingham City Council** has responded to the climate and environmental crisis by setting an ambition to become the first carbon neutral city in the UK by 2028. Each year, city wide emissions data published by BEIS will be used to measure progress towards achieving carbon neutrality in 2028.

The Carbon Neutral Charter (www.nottinghamcity.gov.uk/CN2028) recognised that tackling climate change needs to be done in a way that is fair and sustainable - improving and protecting our environment, economy and society.

The most recent figures from 2019 show a reduction of 52% per person reduction in the amount of $CO_2$ emitted in Nottingham since 2005. This represents a reduction of over 1 million $tCO_2$ in 15 years. The city has already exceeded its target of generating 20% of the City's energy demand through low and zero carbon sources.

By March 2019, over 6,200 solar photovoltaic (PV) installations had been deployed across the city covering 4.5% of domestic properties, with an installed capacity of 21MW. Moving forward, Nottingham will continue to increase its local renewable generation, with a particular focus on solar PV combined with energy storage.

Across Nottingham the **City Council** has helped families to reduce their emissions and improve their well-being, through installing 14,221 boilers, 4140 loft installations and 12,588 cavity wall measures.

**Sherwood Forest Hospitals** purchases 100% electricity generated from renewable sources. During the rebuilding of the King's Mill Hospital in 2011, the trust incorporated a geothermal system from an adjacent reservoir. The geothermal system provides one-third of all the heating requirements, and 90% of the cooling requirements for the complex.

**Nottinghamshire Healthcare NHS Foundation Trust** has been purchasing renewable energy since April 2019. Other measures to reduce estate related emissions include the installation of LED lights and the installation of solar panels on seven of its building. The Trust will ensure at least 50% of Estates and Facilities (E&F) staff have completed relevant carbon literacy training.

**Case Study:**
**Nottingham University Hospitals NHS Trust** is actively progressing delivery of the City Energy Project (CEP) to promote decarbonisation of the City Hospital campus. This includes replacement of its obsolete coal fired and gas back up boilers to a state of the art Energy Centre. This provides improved distribution across the site via 3 new steam boilers and 2 combined heat and power (CHP) units. This is expected to provide a reduction in emissions of 14,000 $tCO_2$ by 2030.

For nearly three years both **NHFT** and **SFH** have been purchasing its electricity from renewable energy source suppliers and **NUH** since 2021. All healthcare trusts are in advanced stages of changing to LED light use. Nottinghamshire County Council are delivering a programme that will see completion of its conversion of street lighting to LEDs by 2026, with City Council already embarking on a programme to replace all its office lighting with LEDs.

The Green Social Prescribing programme is the practice of supporting patients to engage in nature-based activities, and plays an important role in recovery following the COVID -19 pandemic as we build back better and greener. Nottingham and Nottinghamshire ICS has been identified as a test

and learn site to explore the ways in which connecting people with nature can improve mental health and wellbeing. Green Space, the scheme commenced in the ICS, is all about improving people's mental health, with green providers, social prescribers, voluntary organisations and community initiatives helping to connect many more people with nature-based activities.

### Our Ambition

| | |
|---|---|
| Continue to reduce carbon emissions through smart Energy strategies | •Ensure 100% renewable energy is used across all ICS organisations by April 2022<br>•Increase energy generation (photovoltaic), whilst making services more efficient to reduce energy demand<br>•Consider sharing or shifting power generation sources |
| Correctly manage Waste across the system with improved recycling and prevention | •Build on existing and developing recycling and waste prevention initiatives across the ICS<br>•Reduce cost of waste management through more efficient processes e.g. work with suppliers to reduce use of single use plastics, paper, re-use items |
| To recognise Water as a valuable resource in the sustainability journey | •Responsible and efficient use of water across the ICS, modernising infrastructure to prevent excess or uncontrolled water waste, e.g. leaks, dripping taps<br>•Consider local impact of estate developments on flood defences, e.g. plant trees |
| Promote Green Spaces and biodiversity in all estate developments | •Create estate with green space and actively promote Green Social Prescribing - raise awareness of these benefits<br>•Recognise the importance of and actively conserve and protect biodiversity within the system estate footprint |

## 3.6. Medicines

### Context

Medicines account for 25% of emissions within the NHS (22% locally). A small number of medicines account for a large portion of the emissions, and there is already a significant focus on two such groups – anaesthetic gases (2% of emissions) and inhalers (3% of emissions) – where emissions occur at the 'point of use'. (6)

Anaesthetic gases used in surgery, such as Desflurane, have a particularly high carbon footprint, with the emissions from one bottle equivalent to those from burning 440 kg of coal. However, low carbon alternatives exist, and are clinically appropriate in a wide variety of settings. The NHS therefore requires ICSs to have plans in place to reduce the use of Desflurane in surgery. (6)

In England, more than 65 million inhalers are prescribed every year, with the most frequently prescribed being Metered Dose Inhalers (MDI) and Dry Powder Inhalers (DPI).(6) Inhalers are used in a variety of respiratory conditions, ranging from asthma to chronic obstructive pulmonary disease. The majority of the emissions come from the propellant in metered-dose inhalers (MDIs) used to deliver the medicine, rather than the medicine itself. (12)

Metered doses Inhalers (MDI) contain potent hydrofluorocarbons (HFCs) that have significant global warming potential up to 3000 times more potent that CO2. (70% of inhalers prescribed in the UK are MDIs compared to just 13% in Sweden, who opt for lower carbon alternatives such as dry powder inhalers which provide a fraction of the carbon footprint of MDIs. (12)

When used MDIs are often disposed of in domestic waste, the residual HFCs, typically 30% of the original propellant, are likely to be released into the atmosphere due to them being crushed during refuse collection or when disposed of via landfill. Inhalers returned to pharmacies for safe disposal can be incinerated at high temperature's using NHS E and I's waste contractor to destroy propellant gases, with the added option of recycling components from some inhalers. (19)

The NHS Long Term Plan set targets to deliver significant and accelerated reductions in the total emissions from the NHS by moving to lower carbon inhalers, such as dry powder inhalers. (11)

The 2021/22 NHS Standard Contract set out inhalers and anaesthetic gases as two key areas for early action in this area:

- Every trust to reduce its use of Desflurane in surgery to less than 10% of its total volatile anaesthetic gas use, by volume.
- Every ICS to develop plans for clinically appropriate prescribing of lower carbon inhalers.

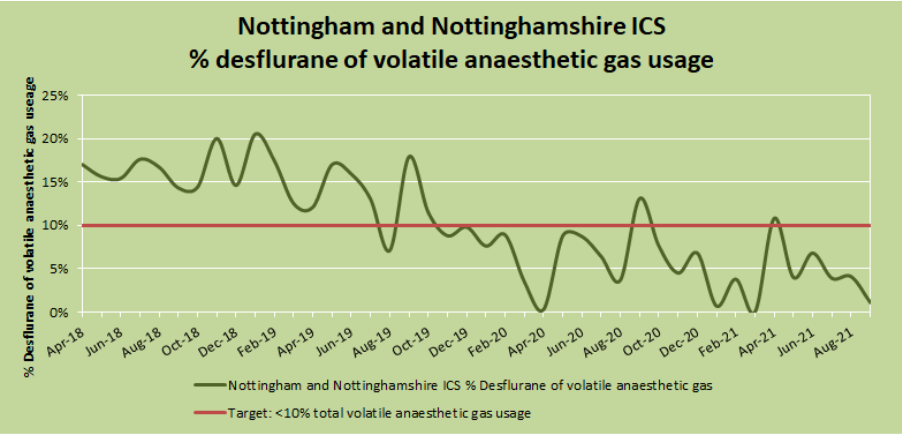
## Where we are now

The Nottingham and Nottinghamshire ICS has established a Clinical Advisory Group which will provide the clinical oversight to developing and implementing plans for carbon reduction from medicines. As well as representation across settings, colleagues include physicians, anaesthetists, pharmacists and GPs to provide expertise and oversight to ensure delivery of clinically appropriate changes to both anaesthetic gas and inhaler use across the system.

## Medical Gases

The system has achieved a reduction in Desflurane use to less than 10% of its volatile anaesthetic gas use by volume, as shown in Figure 12, with peaks linked to purchasing rather than use. **Acute trusts** have removed access to Desflurane, with use agreed on a patient specific basis. Further work is underway to change prescribing behaviour to reduce use further.

**Figure 12 – Desflurane use in the ICS**

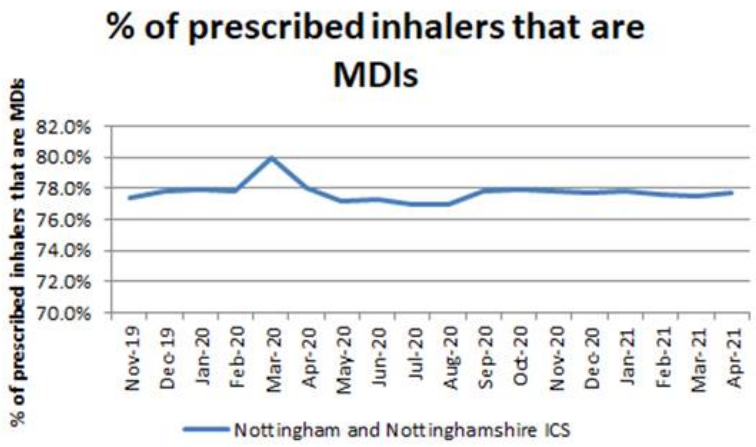



**Sherwood Forest NHS Foundation Trust** has plans in place to reduce Nitrous Oxide emissions by reviewing a manifold system which delivers the medical gases to identify leaks, and also considering the feasibility of novel gas capture systems which have recently been brought to market.

## Inhalers

MDI Inhaler use in the ICS is summarised in Figure 13, below:

**Figure 13 - % of MDI Inhalers**




Work is underway to develop plans for clinically appropriate prescribing of lower carbon inhalers in line with the commitment of a 50% reduction by 2028. A dedicated Inhaler Group has been formed and is working with the ICS Clinical Advisory Group to develop and implement initiatives to achieve this target.

## Medicine Disposal

**Nottingham University Hospitals** has implemented a scheme to maximise the recovery of unused pharmaceuticals that is currently saving circa £50,000 per year. This is equivalent to 130 $tCO_2$/year.

**Nottinghamshire Healthcare NHS Foundation Trust** is working to reduce the quantity of medicines waste across all sites. This will include implementation of a new pharmacy dispensary system and

implementation of an electronic prescribing and administration system. The latter will reduce duplicate requests and over ordering of medicines.

**Primary Care** and **Community Pharmacies** are educating and speaking with patients regarding the safe disposal of inhalers to GP practices and community pharmacies, as per the 2021/22 Pharmacy Quality Scheme which requires pharmacies to speak with all patients, their carer or representatives, who have been dispensed an inhaler between 1st September 2021 to 31st January 2022.

### Our Ambition

| | |
|---|---|
| Strategies to support commitment to lower inhaler carbon footprint | •Area Prescribing Committee (APC) changing formulary and guidance to support a commitment to lower carbon inhaler use |
| Medicine optimisation for patients prescribed inhalers | •Achieving optimal asthma and COPD control through patient reviews<br>•Agreeing local respiratory pathways aligned with APC formulary and clinical best practice guidance<br>•Demonstrating and checking inhaler technique<br>•Implementing shared decision-making principles with patients to support prescribing of lower carbon inhalers |
| Reduce the environmental impact of inhaler waste | •Education of patients, carers or representatives to return used or unwanted inhalers to community pharmacies for safe disposal<br>•Encourage appropriate ordering of inhalers to prevent over supply |
| Reduce carbon footprint from anaesthetic gases | •Changing prescribing practice to reduce Desflurance use to a named patient basis<br>•Trial and implement systems to reduce emissions from other anaesthetic gases e.g. Nitrous Oxide |

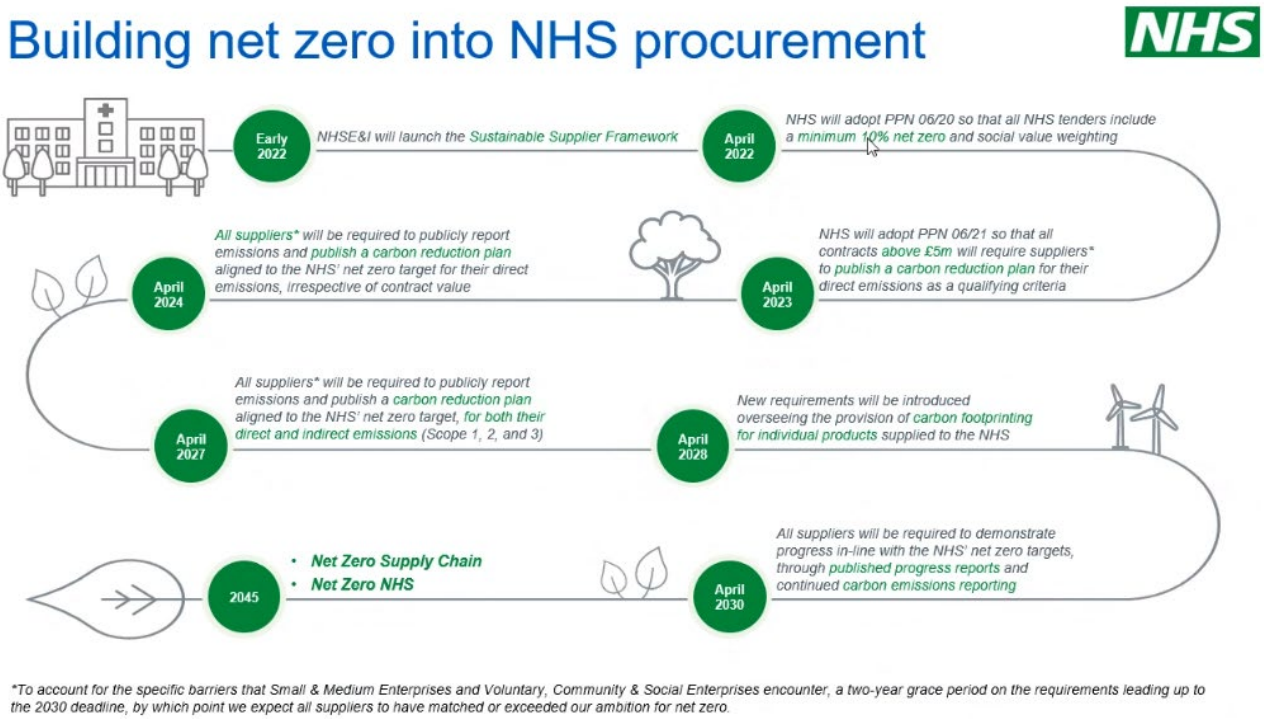
## 3.7. Supply chain and procurement

### Context

The NHS supply chain accounts for approximately 62% of total carbon emissions (57% locally) and is a clear priority area for focus in every Green Plan. (13)

The NHS England Procurement Roadmap, Figure 14, outlines the steps to achieve a net zero supply chain by 2045. (20)

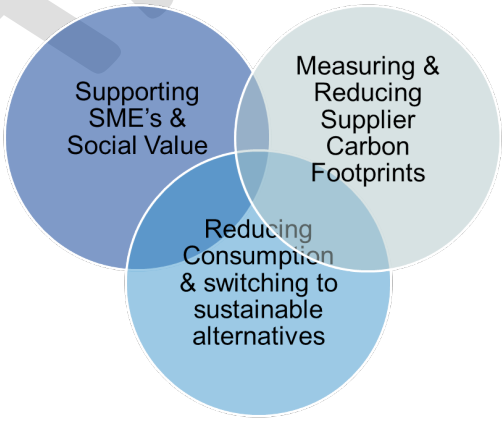
**Figure 14 – Building a net zero into NHS procurement**




*Source: NHSE and I - Delivering a Net Zero NHS – One Year Progress.*

## Where we are now

The Nottingham and Nottinghamshire ICS has developed procurement targets to deliver net zero across three areas.




All organisations in the ICS have made a commitment to inform suppliers and adhere to the commitments in the supply chain roadmap, including the 10% minimum social value weighting.

Organisations in the ICS have developed sustainable procurement strategies to support these ambitions and review of consumption and demand to inform sustainable procurement opportunities.

A number of internal projects have been completed or underway to reduce consumption and switch to sustainable alternatives. For example, all organisations are working to using only 100% recycled paper in their operations. Single use plastics are being ceased where possible e.g. plastic cutlery. Initiatives are also underway to adopt leaner practices to reduce waste, reuse items and utilise remanufactured devices where possible.

**Case Study:**

In the past **Sherwood Forest Hospitals NHS Foundation Trust** were procuring disposable sharps containers. Once full the whole unit and its contents were incinerated, which is the standard disposal method for sharps within the NHS, which is not a sustainable system. The Waste Contract Manager researched the market to see what alternative options were available to the NHS, whilst there was the option to use disposable cardboard boxes (which would reduce plastic use); waste hierarchy was applied to seek a re-usable system. The Bio Systems reusable sharps containers offered the opportunity to reduce the Trusts single-use-plastics consumption, and reduce incineration costs by offering a safely managed re-usable sharps container system

## Our Ambition

| | |
|---|---|
| Supporting SME's & Social Value | •Inform suppliers and adhere to the commitments in the supply chain roadmap announced at the NHSE/I Sept 2021 board, including the 10% minimum social value weighting from April 2022<br>•Adopt a common Social Value Policy for Procurement across the ICS<br>•Engagement and support to help local SME's to understand commissioning goals/requirements and identify social value (incl carbon footprint) |
| Measuring & Reducing Supplier Carbon Footprints | •Develop understanding of procurement carbon footprint /whole life costs<br>•Collaborative work on target carbon reduction categories |
| Reducing Consumption & switching to sustainable alternatives | •Only purchase 100% recycled paper, and reduce paper usage<br>•Take action to address single use plastics, reduce and specifically eliminate unnecessary clinical / catering plastics<br>•Ensure all organisations are using Multi-Functional devices as their core printing infrastructure instead of stand-alone printers<br>•Adopt programmes looking to reuse items, such as reusable gowns and other clinical protective clothing.<br>•Establish a walking aids reuse programme or build on an existing programme to increase the rate of return<br>•Adopt programmes to use remanufactured medical devices |

## 3.8. Food and nutrition

### Context

It is estimated that food and catering services in the NHS produces 1,543 ktCO2e each year, equating to approximately 6% of total emissions. Healthier, locally sourced food can improve wellbeing while cutting emissions related to agriculture, transport, storage and waste across the supply chain and on NHS estate.

The Department of Health and Social Care has recently published the "*Report of the Independent Review of NHS Hospital Food"* highlighting the role that food and nutrition plays in improving the nation's health, tackling health inequalities and meeting net zero ambitions. (21)

The government is currently exploring the issue of sustainable food and agriculture in the UK through the "*National Food Strategy"* which supports sustainable ambitions, with Part One featuring a commitment to improve public sector procurement of food and drink and Part Two focussing on the delivery of healthy and sustainable food and the role that public sector food procurement might have in restoring and enhancing the natural environment for the next generation. (22)

This overlaps with recent policies to improve the diet of the general population, which aim to promote health and wellbeing, prevent ill-health and reduce health inequalities, as outlined in the obesity strategy. (23)

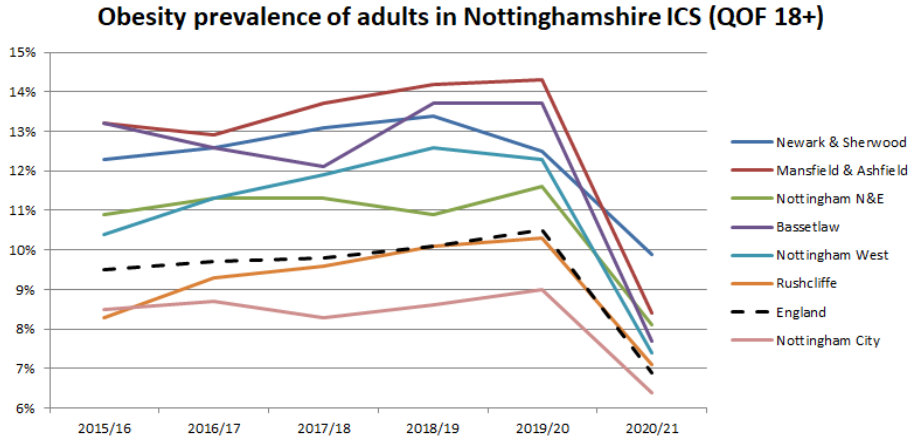
Food waste represents a cost to the UK healthcare sector of £230 million each year, which includes food procurement, labour, utilities and waste management costs. Estates Returns Information Collection (ERIC) data, published by NHS Digital, shows that 14 million kilograms of unserved meals were thrown away in 2018 to 2019. Currently, plate waste is not measured nationally, so overall waste is likely to be higher. (24)

### Where we are now

### Health and Wellbeing

Locally, a number of actions are being taken to improve the health and wellbeing of the population, with obesity identified as a key area of focus. The incidence of obesity in adults in our ICS is above the England average as shown in Figure 15 15 (the reduction in prevalence is likely due to less face to face GP appointments in the pandemic in order to be weighed). Childhood obesity highlights future health issues; this is especially concerning in Nottingham City, with 12% children 4-5 years old obese and 1 in 4 children 10- 11 years obese. This compares to the national figures of 9.9% and 1 in 5 respectively.

**Figure 15 - Local Obesity Incidence in Adults**




Working in partnership with the Health and Wellbeing Board, transformation programmes plans are underway to reduce the incidence of obesity for children and adults across the ICS.

**Nottinghamshire County Council** have developed a Nottinghamshire Food Charter and partnership action plan to shows the role food can play in creating healthier lives, richer economies and a sustainable environment. Nottinghamshire is also one of five local authorities involved in the Child Obesity Trailblazer programme focussing on ways to improve food environment for children in early years. Testing with local charities has commenced, with 26 food clubs across Nottinghamshire to enable families in disadvantaged areas to access good quality, healthy food.

**Nottingham City Council** is working with food charities to ensure school meals encourage children to eat more fruit and vegetables and offer healthy options**.**

## Sustainable Food

Sustainable food procurement plans are considered by NHS organisations and local authorities in the ICS.

**Nottingham University Hospitals NHS Trust** was the first trust to implement a sustainable food procurement programme built around locally sourcing produce and maximise local ingredients via the introduction of seasonal menus. This has been recognised by the Soil Association, with the Trust being the first recipient of the Bronze medal. Both acute trusts change their menus on a regular basis to include seasonal products.

**Nottinghamshire County Council** has achieved the Food for Life Silver Award for meeting school food standards, with ambition to achieve gold through increased use of organic food, supply permitting.

Sustainable food choices are being enabled in a number of ways across both acute trusts.

**Nottingham University Hospitals NHS Trust** has developed a Memory Menu, developed in partnership with patients and the public, to provide meal choices, with an increased request for the incorporation of plant based options.

**Sherwood Forest NHS Foundation Trust** has implemented meat free Monday's into staff restaurants, with the aim of extending plant based options into hospital menus, as well as a trial of the removal of processed meat.

**Nottinghamshire Healthcare NHS Foundation Trust** continues to provide plant based options on patient and staff menus and has a programme of engagement programmes to promote the take up of these options.

Community Food initiatives are accessible across **City** and **County** with place based initiatives that link into local food supply chains. Family Action is also partnering with Fair Share to re-allocate surplus food. Work is also underway within acute trusts to re-allocate food to food banks.

**Case Study:**

**Sherwood Forest Hospitals NHS Foundation Trust** initiated a Hope Orchard led by the Hospital's Climate Action Team to link the importance of planetary health on human health. The initiative brought together various parties from across the county to make a positive impact on both climate change and wellbeing, and promote the association of healthy food (fruit in this case) with health and the environment. We asked participating organisations to share their news using Twitter #HopeOrchard.

This initiative is an example of linking climate health and the environment and could be extended further for example linking food growing and allotments, exercise, healthy plant based diet, and carbon reduction. This scheme could be rolled out across all ICS partners across Nottinghamshire and the Midlands.

## Waste

A number of initiatives are in place to reduce food waste and its associated impact on carbon emissions.

Domestic food waste collection will be a statutory function of all English local authorities, including **Nottingham City Council** in 2023. Nottingham City Council is also exploring plans for the use of food waste in anaerobic digestion to generate bio gas fuel locally.

Food waste recycling is already in place at key sites across **Nottinghamshire Healthcare NHS Foundation Trust.**

Digital food ordering is established at **Nottingham University Hospitals NHS Trust**, with plans to implement at **Sherwood Forest NHS Foundation Trust** in the near future. Pre-ordering of school meals is also in place to reduce food waste.

## Our Ambition

| | |
|---|---|
| Maximising social value through sustainable procurement | •Implement national guidance in relation to food procurement<br>•Consider opportunities for collaborative procurement to provide local produce and support local producers<br>•Seasonal produce incorporated in all menus |
| Strategies to continue to reduce food waste | •Implement and embed digital ordering to reduce food waste<br>•Scope opportunities to recycle food waste |
| Strengthening community initiatives to re-allocate surplus food and promote community growing | •Optimise the reallocation of surplus foods at place and in conjunction with local charities<br>•Scope opportunities to extend community growing initiatives |
| Implement plans to improve the health and wellbeing of the population | •Develop and implement transformation plans to address obesity incidence across the ICS<br>•Education of the population, and with a focus on early years, to support healthier lifestyle choices |

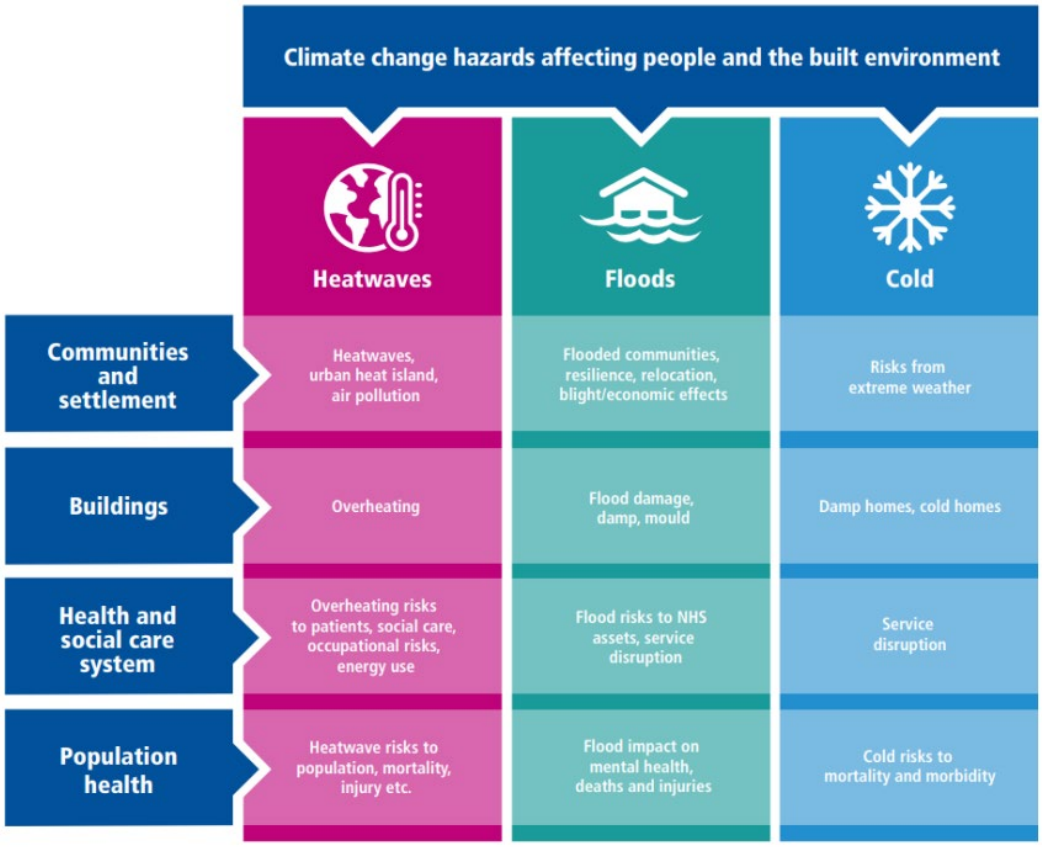
## 3.9. Adaptation

### Context

Adaptation in relation to health and social care are actions or processes that reduce mortality and morbidity associated with climate change, while strengthening the sector's capacity to provide a high standard of care while the climate changes.

From the Met Office's national climate projections, we are likely to see an increased chance of hotter and drier summers and milder but wetter winters. These changes are expected to present challenges to keeping patients safe and delivering high quality healthcare, as outlined in Figure14.

**Figure 16 - Climate Change Hazards**




*Source: Met Office*

This requires the NHS to plan on how to mitigate the associated risk on its ability to deliver safe patient care.

## Where we are now

All NHS organisations have developed climate change risk assessments to understand the risks of the effects of climate change and severe weather conditions on its business and functions, which are incorporated into their assurance frameworks. These supporting organisations to identify assess and implement adaption measures described in their Climate Change Adaptation Plans and business continuity plans.

**Nottingham City Council** has detailed plans on mitigating flood risk in the city through infrastructure improvements, natural solutions and educating. The council is working on understanding the communities at risk such those in poor housing; fuel and food poverty. It will publish a revised adaptation strategy in 2023.

Under its 10 year plan **Nottinghamshire County Council** working with its partners will work to protect communities most at risk of flooding.

**Our Ambition**

| | |
|---|---|
| Comprehensive risk assessment process for climate change | •Risk assessments developed for all climate change events<br>•Risks captured on risk registers with continual review and iteration of plans in response<br>•Risk assessment completed in the development of new buildings to incorporate climate adaptation measures |
| Plans to mitigate the risks or effects of climate change on business and functions | •Consideration to the socio-economic and population impact of climate change<br>•Plans respond to risk likelihood and impact to understand future pressure on services and avoid disproportionate impact on the most vulnerable<br>•Plans outline physical changes to properties to mitigate against risks<br>•Challenge plans to ensure they are sufficient to mitigate impact<br>•Develop system thinking to enable flexibility and agility in response and incorporated in emergency planning |

## 4. Governance and Reporting Progress

**Context**

In '*Delivering a 'Net Zero' National Health Service'* the NHS set out its ambitions to become the world's first Net Zero Health Service. The publication of this ambition set in motion the establishment of arrangements across the NHS to deliver this ambition. In the Midlands a Regional Board has been established to deliver this work across the Midlands Region and to hold ICS's to account for delivery. In turn ICS's are expected to hold organisations to account through their own structures for the delivery of organisation Green Plans.

A strong governance framework is essential across the ICS to ensure that sustainability becomes integral to decision making processes and that reducing carbon usage is considered as part of all ICS work. Strong connections will also be required between NHS and non-NHS partners in the ICS to deliver this agenda, including the work of health and wellbeing boards.

**Where we are now**

The ICS has considered staff engagement in the early stages of developing its first Green Plan to be essential and workshops have been held to encourage staff to contribute to the work. This will be a continuing theme through the cycle of Green Plan development and delivery.

The ICS has a Transformation Programme to develop the Green Plan and in 2022/23 this will move to a System Delivery Group as part of the ICS Governance Structure under the leadership of the ICS Director of Finance, with membership evolving to include other ICS organisations. This group will monitor the delivery of Green Plans from across the ICS.

Staff from across the ICS have contributed to the production of the Green Plan and in 2022/23 the ICS will develop a Green Plan delivery function to develop systems to monitor, manage and reduce carbon usage across the ICS. The ICS will hold an annual summit so that staff and citizens can review progress with the Green Plan delivery and contribute to its next stage of development, both within health and care but also in the development of climate change ambitions as part of the wider community.

The nature of the Green Plan is that it will have strong connections with the work of the ICS on health inequalities, the wider health and wellbeing board plans in the ICS and the sustainability plans of ICS partners from outside the NHS. The ICS will aim to set up suitable arrangements to ensure the plans are well connected in design and delivery.

## Our Ambition

| | |
|---|---|
| Establish clear governance for the ICS Green Plan delivery | •Establishment of Greener ICS as a System Delivery Group in the ICB governance structure<br>•NHS Organisations will be held to account for plan delivery by the ICS, with membership evolving to include other ICS organisations<br>•Provide annual reports to the ICB on progress with plan delivery |
| Develop an infrastruture to understand carbon use in the ICS and manage its reduction | •Commit to resourcing a Green Plan Delivery function to lead on the development of carbon reporting in the ICS<br>•Develop systems, including sustainability impact assessments, to ensure that carbon impact is considered in all ICS activity |
| Ensure that staff and public engagement is at the heart of ICS Green Plan delivery | •Hold an annual ICS Sustainability Summit for attendance by staff and the public to review progress with Green Plan delivery and contribute to its future development both within health and care and as part of the wider community<br>•Ensure that stakeholders from across the ICS are included in delivery groups for each of the chapter areas |
| Ensure effective working on the sustainability agenda with non NHS partners in the ICS | •Establish formal ICS Green Plan connections to health and wellbeing boards<br>•Ensure the sustainability work of non NHS partners is included in planning and delivery |

# 5. Finance

## Context

Many of the carbon reducing interventions described in this plan are either cost-neutral or can provide an immediate cost benefit. These range from efforts to reduce plastics and food waste through to low-carbon procurement and optimisation of medicine usage. Yet more are directly aligned with existing priorities – such as the digital transformation agenda and the commitment within the NHS Long Term Plan to reduce polluting emissions from the NHS fleet. These are areas where we need to make quick progress across the system and its partner organisations.

A further set of initiatives may require initial capital investment, followed by efficiency savings over the long run. Examples of this include investments in LED lighting, systems to manage and reduce energy consumption, and the electrification of transport fleets as costs fall.

## Where we are now

To support the implementation and delivery of green initiatives, from 2022/23 all capital and revenue business cases developed within the ICS will include a Sustainability Impact Assessment. This will describe how the case will contribute to our net zero pledge and should be used as a key principle in decision making.

In addition, plans for allocation of the System Capital Envelope over a 3-year period (2022-2025) will have a particular focus on decarbonisation with a proportion of the envelope set aside to support this agenda.

The capital envelope will be used to support heat decarbonisation and to ensure that heating systems, insulation and ventilation are upgraded to reduce carbon emissions where possible as part of backlog maintenance, and that LED lights are used in place of less efficient systems.

However, internal capital resources are limited in value and to truly transform our estate we will need to access capital funds from other sources. In recent years we have been successful in applying for SALIX decarbonisation funding at Nottingham University Hospitals. The capital project at NUH has enabled us to implement the City Energy Project, removing the coal-fired boilers at Nottingham City Hospital.

We will continue to explore opportunities for funding from the Public Sector Decarbonisation Scheme to support delivery of plans described in this document. We will actively work with our local partners, within and outside of the NHS, to access funds directed towards the UK wide ambition for net zero and explore alternative ways to fund this investment.

The investment needed for a net zero health service clearly extends beyond its buildings alone. It will require investment in our people, ensuring they understand what they can do to respond to climate change, and have the expertise needed to implement new ways of working and to embed behaviour changes.

## Our Ambition

| | |
|---|---|
| Sustainability will be included in the assessment of all service developments | •From 2022/23 Sustainabilty Impact Assessments will be required for all ICS capital and revenue business cases to increase the priority place on sustainability in decision-making |
| The prioritisation of capital expenditure will include decarbonisation impact | •A proportion of the System Capital Envelope will be set aside to focus on the decarbonisation agenda through to 2025 |
| Development of external funding sources | •The ICS will work on sourcing external funding from beyond the ICS to support decarbonisation |

# 6. Summary Action Plan

| **Workforce and Leadership** | | |
|---|---|---|
| **Objective** | **How** | **By when** |
| 1. Leadership to deliver net zero ambitions | • Designated board-level net zero lead to be appointed to support the ambitions of delivering a net zero NHS<br>• Maintain ICS Green Board and Delivery Group arrangements to deliver ambitions | • April 2022<br>• Already in place |
| 2. Engaging the public and our workforce in the actions required to deliver sustainable healthcare locally | • Annual summit to encourage and enable to staff to generate ideas and lead on them<br>• Co-design with the public to understand and respond to carbon impact through the life course | • November 2022<br>• December 2022 |
| 3. Education and training to enhance carbon literacy | • Delivering carbon literacy training, with a tiered e-learning approach to deliver meaningful training effectively<br>• Developing a network of Green Champions to raise awareness | • April 2024<br>• March 2023 |
| 4. Sustainability as a core dimension of service management/delivery | • Completion of Sustainability Impact Assessments mandatory for service developments<br>• Carbon monitoring 'scorecard' undertaken locally<br>• Sustainability actions supported by PMO | • September 2022<br>• September 2022<br>• September 2022 |
| **Sustainable Models of Care** | | |
| **Objective** | **How** | **By when** |
| 5. Developing holistic pathways to deliver quality care outcomes, with a focus on prevention, self-care and equity of access | • With a focus on prevention and addressing health inequalities to reduce unnecessary carbon emissions and inequity of access<br>• Promoting self-care ambitions | • March 2024<br>• March 2024 |
| 6. Meeting the ambitions to deliver care closer to home | • Optimising digital enabled care accelerated as part of COVID-19 pandemic response in line with national targets<br>• Working with Connected Nottinghamshire to optimise connectivity across digital platforms and use of Patient Knows Best(PKB) to connect clinicians and patients<br>• Transforming pathways to deliver care closer to home e.g. Ophthalmology as an early adopter | • September 2022<br>• April 2023<br>• March 2024 |

| | | |
|---|---|---|
| 7. Delivering lower carbon interventions where clinically relevant | • Clinical engagement and collaborative procurement to optimise carbon reduction opportunities<br>• Build on carbon reduction innovations developed in collaboration with the AHSN | • September 2024<br>• September 2023 |
| **Digital Transformation** | | |
| **Objective** | **How** | **By when** |
| 8. Delivering digital appointments and services where clinically relevant | • Optimising digital appointments across settings<br>• Developing virtual services e.g. medical retina solution<br>• Enhancing inter-operability between systems | • September 2022<br>• March 2024<br>• March 2024 |
| 9. Connecting clinicians and patients | • Empowering patients through digital literacy e.g. PKB, but with consideration to health inequalities<br>• Extending access to self-monitoring functionality and with connection to clinicians<br>• Access to educational materials and creating a virtual environment for care delivery e.g. exercise classes | • April 2023<br>• March 2024<br>• March 2024 |
| 10. Digitising processes to enhance clinical care delivery | • Enhanced digital solution for administration e.g. patient letters<br>• Digitising health records and developing shared care records<br>• Developing alternatives to the 10 data centres run across trusts and councils | • April 2023<br>• March 2024<br>• September 2024 |
| **Travel and Transport** | | |
| **Objective** | **How** | **By when** |
| 11. Promoting sustainable transport and reducing overall transport | • Promoting active transport solutions to reduce carbon emissions and support health and wellbeing<br>• Reducing patient and business transport through reduction in attendances and hybrid working practices | • October 2022<br>• September 2022 |
| 12. Increasing the use of ULEV and ZEV vehicles | • Increasing the % of ULEV and ZEV in fleet through new lease opportunities and considering options to procure centrally<br>• Extend offer of ULEV and ZEV vehicles in salary sacrifice schemes and working towards only providing low emission options | • October 2023<br>• September 2022 |
| 13. Developing the infrastructure to support lower carbon transport options | • Ensuring adequate EV points to support transition to ULEV and ZEV within fleet<br>• Providing appropriate infrastructure to support active transport within community and organisations<br>• Developing a consistent approach to anti-idling principles | • January 2025<br>• January 2025<br>• January 2024 |
| 14. Enhancing understanding and communication via Green Travel Plans | • Promoting the health and wellbeing benefits of active transport<br>• Educating on lower carbon solutions and how to access these | • September 2022<br>• September 2022 |
| **Estates and Facilities** | | |
| **Objective** | **How** | **By when** |
| 15. Continue to reduce carbon emissions through smart Energy strategies | • Ensure 100% renewable energy is used across all ICS organisations by April 2022<br>• Increase energy generation (photovoltaic), whilst making services more efficient to reduce energy demand<br>• Consider sharing or shifting power generation sources | • April 2022<br>• March 2025<br>• March 2025 |
| 16. Correctly manage Waste across the system with improved recycling and prevention | • Build on existing and developing recycling and waste prevention initiatives across the ICS<br>• Reduce cost of waste management through more efficient processes e.g. work with suppliers to reduce use of single use plastics, paper, re-use items | • October 2023<br>• September 2024 |
| 17. To recognise Water as a valuable resource in the sustainability journey | • Responsible and efficient use of water across the ICS, modernising infrastructure to prevent excess or uncontrolled water waste, e.g. leaks, dripping taps<br>• Consider local impact of estate developments on flood defences, e.g. plant trees | • March 2025<br>• March 2025 |

| | | |
|---|---|---|
| 18. Promote Green Spaces and biodiversity in all estate developments | • Create estate with green space and actively promote Green Social Prescribing - raise awareness of these benefits<br>• Recognise the importance of and actively conserve and protect biodiversity within the system estate footprint | • March 2025<br>• March 2025 |
| **Medicines** | | |
| **Objective** | **How** | **By when** |
| 19. Strategies to support commitment to lower inhaler carbon footprint | • Area Prescribing Committee (APC) changing formulary and guidance to support a commitment to lower carbon inhaler use | • September 2022 |
| 20. Medicine optimisation for patients prescribed inhalers | • Achieving optimal asthma and COPD control through patient reviews<br>• Agreeing local respiratory pathways aligned with APC formulary and clinical best practice guidance<br>• Demonstrating and checking inhaler technique<br>• Implementing shared decision-making principles with patients to support prescribing of lower carbon inhalers | • March 2024<br>• March 2024<br>• March 2024<br>• March 2024 |
| 21. Reduce the environmental impact of inhaler waste | • Education of patients, carers or representatives to return used or unwanted inhalers to community pharmacies for safe disposal<br>• Encourage appropriate ordering of inhalers to prevent over supply | • September 2022<br>• September 2022 |
| 22. Reduce carbon footprint from anaesthetic gases | • Changing prescribing practice to reduce Desflurane use to a named patient basis<br>• Trial and implement systems to reduce emissions from other anaesthetic gases e.g. Nitrous Oxide | • September 2022<br>• September 2023 |
| **Supply Chain and Procurement** | | |
| **Objective** | **How** | **By when** |
| 23. Supporting SME's & Social Value | • Inform suppliers and adhere to the commitments in the supply chain roadmap announced at the NHSE/I Sept 2021 board, including the 10% minimum social value weighting from April 2022<br>• Adopt a common Social Value Policy for Procurement across the ICS<br>• Engagement and support to help local SME's to understand commissioning goals/requirements and identify social value (including carbon footprint) | • April 2022<br>• April 2022<br>• April 2024 |
| 24. Measuring and Reducing Supplier Carbon Footprints | • Develop understanding of procurement carbon footprint /whole life costs<br>• Collaborative work on target carbon reduction categories | • April 2024<br>• April 2024 |
| 25. Reducing Consumption and switching to sustainable alternative | • Only purchase 100% recycled paper, and reduce paper usage<br>• Take action to address single use plastics, reduce and specifically eliminate unnecessary clinical / catering plastics<br>• Ensure all organisations are using Multi-Functional devices as their core printing infrastructure instead of stand-alone printers<br>• Adopt programmes looking to reuse items, such as reusable gowns and other clinical protective clothing.<br>• Establish a walking aids reuse programme or build on an existing programme to increase the rate of return<br>• Adopt programmes looking to utilise remanufactured medical devices | • September 2022<br>• March 2024<br>• October 2023<br>• October 2023<br>• March 2023<br>• March 2023 |
| **Food and Nutrition** | | |
| **Objective** | **How** | **By when** |
| 26. Maximising social value through sustainable procurement | • Implement national guidance in relation to food procurement<br>• Consider opportunities for collaborative procurement to provide local produce and support local producers<br>• Seasonal produce incorporated in all menus | • March 2023<br>• March 2024<br>• Already in place |
| 27. Strategies to continue to reduce food waste | • Implement and embed digital ordering to reduce food waste<br>• Scope opportunities to recycle food waste | • October 2022<br>• September 2022 |

| | | |
|---|---|---|
| 28. Strengthening community initiatives to re-allocate surplus food and promote community growing | • Optimise the reallocation of surplus foods at place and in conjunction with local charities<br>• Scope opportunities to extend community growing initiatives | • April 2023<br>• October 2022 |
| 29. Implement plans to improve the health and wellbeing of the population | • Develop and implement transformation plans to address obesity incidence across the ICS<br>• Education of the population, and with a focus on early years, to support healthier lifestyle choices | • March 2024<br>• March 2023 |
| **Adaptation** | | |
| **Objective** | **How** | **By when** |
| 30. Comprehensive risk assessment process for climate change | • Risk assessments developed for all climate change events<br>• Risks captured on risk registers with continual review and iteration of plans in response<br>• Risk assessment completed in the development of new buildings to incorporate climate adaptation measures | • September 2022<br>• September 2022<br>• March 2023 |
| 31. Plans to mitigate the risks or effects of climate change on business and functions | • Consideration to the socio-economic and population impact of climate change<br>• Plans respond to risk likelihood and impact to understand future pressure on services and avoid disproportionate impact on the most vulnerable<br>• Plans outline physical changes to properties to mitigate against risks<br>• Challenge plans to ensure they are sufficient to mitigate impact<br>• Develop system thinking to enable flexibility and agility in response and incorporated in emergency planning | • March 2023<br>• September 2022<br>• October 2023<br>• October 2024<br>• March 2025 |
| **Governance and Reporting Progress** | | |
| **Objective** | **How** | **By when** |
| 32.Establish clear governance for ICS Green Plan delivery | • Establishment of Greener ICS as a System Delivery Group in the ICB governance structure<br>• NHS Organisations will be held to account for plan delivery by the ICS, with membership evolving to include other ICS organisations<br>• Provide annual reports to the ICB on progress with plan delivery | • September 2022<br>• September 2022<br>• September 2022 |
| 33.Develop an infrastructure to understand carbon use in the ICS and manage its reduction | • Commit to resourcing a Green Plan Delivery function to lead on the development of carbon reporting in the ICS<br>• Develop systems, including sustainability impact assessments, to ensure that carbon impact is considered in all ICS activity | • March 2023<br>• March 2023 |
| 34. Ensure that staff and public engagement is at the heart of ICS Green Plan delivery | • Hold an annual ICS Sustainability Summit for attendance by staff and the public to review progress with Green Plan delivery and contribute to its future development both within health and care and as part of the wider community<br>• Ensure that stakeholders from across the ICS are included in delivery groups for each of the chapter areas | • November 2022<br>• September 2022 |
| 35. Ensure effective working on the sustainability agenda with non NHS partners in the ICS | • Establish formal ICS Green Plan connections to health and wellbeing boards<br>• Ensure the sustainability work of non NHS partners is included in planning and delivery | • September 2022<br>• September 2022 |
| **Finance** | | |
| **Objective** | **How** | **By when** |
| 36. Sustainability will be included in the assessment of all service developments | • From 2022/23 Sustainability Impact Assessments will be required for all ICS capital and revenue business cases to increase the priority place on sustainability in decision-making | • July 2022 |
| 37. The prioritisation of capital expenditure will include decarbonisation impact | • A proportion of the System Capital Envelope will be set aside to focus on the decarbonisation agenda through to 2025 | • March 2023 |
| 38. Development of external funding sources | • The ICS will work on sourcing external funding from beyond the ICS to support decarbonisation | • March 2023 |

## 7. Next Steps

The Nottingham and Nottinghamshire ICS Green Plan outlines the actions we will take over the next three years to support NHS net zero trajectories. Led by our board-level net zero lead the system will take the following next steps to support delivery of our ambitious plan to deliver sustainable health and care for future generations:

- **Focus on commitment and ambition:** The plan has been developed with staff across our system to support developing actions that reflect our collective ambition. The development of a communication strategy will outline our plans to raise awareness and gain commitment by continuing to engage with our workforce and communities as we progress through the cycle of Green Plan development to delivery.
- **Governance:** The governance and reporting arrangements have been described, with a move to a System Delivery Group as part of the ICS Governance Strcture. This will be implemented to support decision making processes and monitoring as we move to delivery of the actions described. This will nclude connection with health and wellbeing boards and other transformation programmes to ensure connection with sustainability plans.
- **Structure:** Key actions have been described across nine areas of focus within the plan. Delivery groups will be established across all areas, including representation from organiations, sustainability leads and with appropriate expertise across our workforce to develop and implement plans to deliver the actions described.

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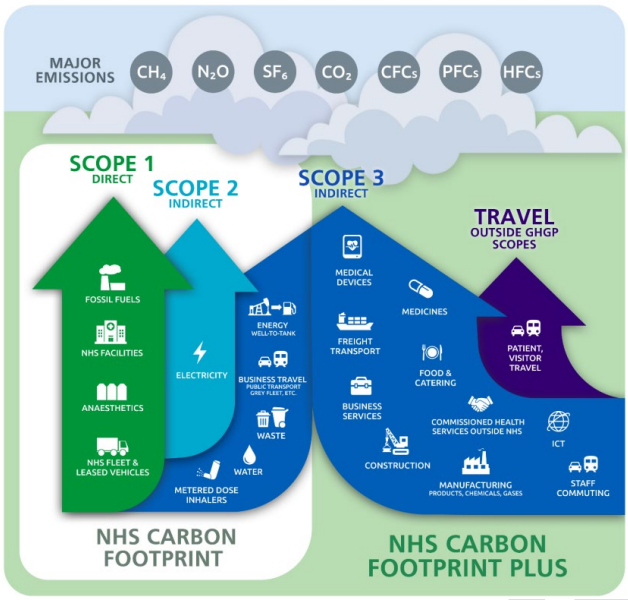
# 9. Appendix 1

Figures 15 and 16 showing Nottingham and Nottinghamshire ICS Carbon Footprint and Carbon Footprint plus is explained again in the chart below the Direct Scope 1, Indirect Scope 2 and Indirect Scope 3.




**Scope 1:** Direct emissions from owned or directly controlled sources, on site

**Scope 2**: Indirect emissions from the generation of purchased energy, mostly electricity

**Scope 3**: All other indirect emissions that occur in producing and transporting goods and services, including the full supply chain

Plus emissions related to patient and visitor travel

*Source: Delivering a Net Zero NHS*

## Figure 16 – Nottingham and Nottinghamshire's Carbon Footprint

| Nottingham and Nottinghamshire ICS's NHS Carbon Footprint 2019/20 (tCO2)* | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Building Energy | | | | | Business Travel & NHS Fleet | | | | |
| | Metered Dose Inhalers | Anaesthetic gases | Coal | Electricity | Gas | Heat and steam | Oil | Business Travel | NHS Fleet | Waste | Water | Total Carbon Footprint |
| Scope 1 | | 9,660 | 0 | | 63,870 | | 1,570 | | 3,210 | | | **78,310** |
| Scope 2 | | | | 23,830 | | 0 | | | 0 | | | **23,830** |
| Scope 3 | 14,770 | | 0 | 2,820 | 8,090 | | 290 | 12,660 | 1,870 | 21,350 | 1,210 | **63,060** |
| **Total** | **14,770** | **9,660** | **0** | **26,650** | **71,960** | **0** | **1,860** | **12,660** | **5,080** | **21,350** | **1,210** | **165,200** |

*These figures will need to be revised to include the carbon footprint in Bassetlaw.

## Figure 17 – Nottingham and Nottinghamshire's Carbon Footprint Plus

| Nottingham and Nottinghamshire ICS's NHS Carbon Footprint Plus 2019/20 (tCO2)* | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Nottingham and Nottinghamshire ICS Carbon Footprint | Supply chain | | | | | | Patient and visitor travel | | Staff commute | Commissioned health services outside NHS | Total |
| | | Business services | Food and catering | Medicines and chemicals | Medical equipment | Construction and freight | Non-medical equipment | Patient travel | Visitor travel | | | |
| Scope 1 | 78,310 | | | | | | | | | | | **78,310** |
| Scope 2 | 23,830 | | | | | | | | | | | **23,830** |
| Scope 3 | 63,060 | 55,940 | 28,610 | 100,360 | 54,330 | 34,690 | 43,080 | 14,390 | 6,400 | 25,080 | 17,610 | **443,550** |
| Total | **165,200** | **55,940** | **28,610** | **100,360** | **54,330** | **34,690** | **43,080** | **14,390** | **6,400** | **25,080** | **17,610** | **545,690** |

* These figures will need to be revised to include the carbon footprint and carbon footprint plus in Bassetlaw (and to remove EMAS carbon footprint plus arising from their procurement which resides in Derbyshire ICS as they are the lead commissioner). EMAS carbon footprint from their fleet has already been removed from these figures.

| | | | |
|---|---|---|---|
| **Item Number:** | 8 | **Enclosure Number:** | F |
| **Meeting:** | ICS Partnership Board | | |
| **Date of meeting:** | 3 March 2022 | | |
| **Report Title:** | Nottingham and Nottinghamshire Integrated Care Partnership (ICP): Recommendations for the Establishment of the ICP | | |
| **Sponsor:** | Melanie Brooks, Corporate Director, Adult Social Care and Health, Nottinghamshire County Council | | |
| **Place Lead:** | | | |
| **Clinical Sponsor:** | | | |
| **Report Author:** | Joanna Cooper, Assistant Director, ICS | | |
| **Enclosure / Appendices:** | Annex A – Proposed Membership of Nottingham and Nottinghamshire Integrated Care Partnership | | |

**Summary:**


A working group was established to develop proposals for the Nottingham and Nottinghamshire Integrated Care Partnership (ICP). This group has been led by Melanie Brooks as SRO and involved key colleagues from Nottinghamshire County Council, Nottingham City Council and Integrated Care Board (ICB) designates.

An ICS Partnership Board development session was held on 3 February and the proposals were considered. This paper reflects the key points highlighted in the discussion.

It is advised that Nottingham City Council, Nottinghamshire County Council and the NHS ICB (in shadow operating) approve the recommendations for the local Nottingham and Nottinghamshire ICP as detailed in this report, mainly:

a) The Nottingham and Nottinghamshire ICP forms the 'guiding mind' of the health and care system, in creating an integrated care strategy.
b) The set of principles and ways of working, outlined in paragraph 16, underpin the operation of the local ICP.
c) Membership of the ICP joint committee comprises five key representatives of each of the LAs and ICB together with citizen representatives and senior representatives from each of the four Place Based Partnerships.
d) The joint committee receives a report on insights gained from service users and citizens at each of its meetings
e) Pragmatically, only a small number of formal meetings be arranged and held in public at key points of the planning cycle. These will be supplemented by development sessions as needed.
f) The initial arrangements be reviewed after 12-months of operation to ensure that they are working well.
g) The initial chair arrangements take the form of a shared arrangement between an Elected Member from each LA and the Chair of the ICB which initially will be that the ICB Chair chairs the ICP supported by two Vice-Chairs who are Elected Member representatives from each of the two (Upper Tier) Authorities.

| Actions requested of the ICS Partnership Board |
|---|
| To note the contents of the report and agree the recommendations. |

| Recommendations: | |
|---|---|
| 1. | To discuss and agree the proposals for the Nottingham and Nottinghamshire Integrated Care Partnership (ICP) for formal approval from Nottingham City Council, Nottinghamshire County Council and the NHS ICB. |

**Presented to:**

| Board | Transition and Risk Committee | Clinical Executive Group | System Executive Group | Finance Directors Group |
|---|---|---|---|---|
| ☒ | ☐ | ☐ | ☐ | ☐ |
| Quality Group | Bassetlaw Place | Mid Nottingham-shire Place | Nottingham City Place | South Nottingham-shire Place |
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Contribution to delivering System Level Outcomes Framework ambitions**

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

**Conflicts of Interest**

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

**Risks identified in the paper**

**Is the paper confidential?**

☐ Yes
☒ No
☐ Document is in draft form

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

**Nottingham and Nottinghamshire Integrated Care Partnership (ICP)**
**Recommendations for the Establishment of the ICP**

## Purpose of the Report

1. The purpose of this report is to set out key recommendations relating to the establishment of a Nottingham and Nottinghamshire Integrated Care Partnership (ICP) within statutory arrangements for Integrated Care Systems.

## Information

2. The Health and Care Bill, which intends to put ICSs on a statutory footing and create Integrated Care Boards (ICBs) as new NHS bodies, is currently being considered by Parliament. To allow sufficient time for the remaining parliamentary stages, a new target date of 1 July 2022 has been agreed for the new statutory arrangements to take effect and ICB to be legally and operationally established. This replaces the previously stated target date of 1 April 2022.

3. Subject to the passage of the Health and Care Bill through Parliament, each ICS will have an Integrated Care Partnership (ICP) operating at system level.

4. By the end of March, Integrated Care Systems (ICS) are expected to agree the initial ICP arrangements, including principles for operation from 1 July 2022, in line with relevant guidance.

5. ICPs will be a critical part of ICSs and the journey towards better health and care outcomes for the people they serve. ICPs will provide a forum for NHS leaders and Local Authorities (LAs) to come together with important stakeholders from across the system and community. Together, the ICP will generate an integrated care strategy to improve health and care outcomes and experiences for its populations, for which all partners will be accountable.

6. The ICP will be formed by the NHS Integrated Care Board (ICB) and LAs responsible for social care services as equal partners. It will be a joint committee, not a statutory body.

7. ICPs are expected to provide opportunity to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for local populations. ICPs will facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development. Such joined-up, inclusive working is central to ensuring that ICS partners are targeting their collective action and resources at the areas which will have the greatest impact on outcomes and inequalities as England recovers from the pandemic.

8. Integrated care strategies should be developed for the whole population using best available evidence and data, covering health and social care (both children's and adult's social care), and addressing the wider determinants of

health and wellbeing. The integrated care strategy should be built bottom-up from local assessments of needs and assets identified at place level, based on Joint Strategic Needs Assessments (JSNAs).

9. The expectation is for the integrated care strategy to be focused on improving health and care outcomes, reducing inequalities and addressing the consequences of the pandemic for communities. The ICP will champion inclusion and transparency and will challenge all partners to demonstrate progress in reducing inequalities and improving outcomes. It should support place and neighbourhood level engagement, ensuring the system is connected to the needs of every community it includes.

10. The strategy must have regard to the NHS mandate and any guidance published by the Secretary of State; Healthwatch and people who live or work in the ICP's area must be involved in its preparation. The ICP must consider revising its strategy whenever it receives a new JSNA. The Integrated Care Strategy must be published and shared with the ICB and each Local Authority.

11. The Health and Care Bill places a duty for each Local Authority and the ICB, in response to the integrated care strategy, to prepare a Joint local Health and Wellbeing Strategy that sets out how the Local Authority, ICB and NHS England will meet the assessed needs in the Local Authority's area. Each Local Authority and the ICB need not prepare a new Joint Local Health and Wellbeing Strategy if, having considered the Integrated Care Strategy, they consider that the existing Joint Local Health and Wellbeing Strategy is sufficient.

12. The Bill also places a duty for the ICB to have regard to the JSNA, Integrated Care Strategy, and Joint Local Health and Wellbeing Strategies when exercising its functions.

13. Further guidance from DHSC for Health and Wellbeing Boards is anticipated.

14. The ICP will need to be established – at least in interim form – by 1st July 2022 with the initial integrated care strategy developed by April 2023.

## Recommendations for the Nottingham and Nottinghamshire ICP

### *The Purpose of the ICP*

15. It is recommended that the local ICP forms 'the guiding mind,' across the Nottingham and Nottinghamshire health and care system, in creating an integrated care strategy.

16. The ICP provides opportunity to build a broader approach to planning based on population need, particularly across the NHS, putting JSNA insights front and centre. It also provides opportunity to strengthen accountability to local people; to focus on healthy life expectancy and addressing inequalities and inclusion; to build on collaborative approaches developed during Covid19; and

to maximise collective endeavours including as anchor organisations and in the use of the one 'public purse.'

17. The local ICP should complement, not duplicate, the work of the Health and Wellbeing Boards and provides opportunity to strengthen alignment of the ICS and Health and Wellbeing Boards. Current legislation does not change the role or duties of Health and Wellbeing Boards nor does it change Local Authority structures or commissioning arrangements.

18. Specifically, the ICP will have an important role in bringing together the JSNAs, population health management and citizen insights and synthesising both Health and Wellbeing Strategies into one Nottingham and Nottinghamshire integrated care strategy. The new NHS ICB will pay due regard to this integrated care strategy in commissioning services including from Providers Collaboratives, Place Based Partnerships and Primary Care Networks going forward.

***ICP Operating Principles***

19. A set of principles and ways of working are recommended to underpin the ICP's operation. These are based on a combination of what has been deemed important by local stakeholders together with national expectations:

<u>Principles</u>

i. Act as the 'guiding mind' of the health and care system.
ii. Focus on improving outcomes for people, including improved health and wellbeing, supporting people to live more independent lives, and reduced inequalities.
iii. Support the triple aim (better health and wellbeing for everyone, better care for all and efficient use of the collective resource).
iv. Enable consistent standards and policy across the ICS (strategically sound) whilst allowing for different models of delivery in accordance with diverse populations served (locally sensitive).
v. Ensure all delivery mechanisms (e.g. place-based partnership arrangements) are equally respected and supported, and have appropriate resource, capacity and autonomy to address priorities, in line with the principle of subsidiarity.

<u>Ways of working and behaviours</u>

a. Come together under a distributed leadership model and commit to work together equally.
b. Accountable to one another and the public including through transparency and building trust.
c. Champion co-production and inclusiveness throughout the ICS.
d. Put at the forefront the experience and expertise of professional, clinical, political and community leaders and promote strong clinical and professional system leadership.

e. Use a collective model of decision-making that seeks to find consensus between system partners with and make decisions based on unanimity as the norm, including working through difficult issues where appropriate.
f. Create a learning system, fostering a culture of innovation, bravery, ambition and willingness to learn from mistakes.

### *ICP Establishment, Membership and Ways of Operating*

20. The ICP will be established by Nottingham City Council, Nottinghamshire County Council and the Nottingham and Nottinghamshire NHS ICB. It will take the form of a joint committee between these three statutory bodies. It is for these organisations to determine wider membership and this may change overtime as the ICP matures and to take account of the areas of priority focus.

21. By July 2022, as a minimum, the local ICP will need to be established. In addition, the initial integrated care strategy needs to be developed by April 2023, which allows for the current refresh of both Nottingham City and Nottinghamshire County Health and Wellbeing Strategies.

22. For Nottingham and Nottinghamshire, it is recommended that - from the outset - membership of the joint committee not only comprises key representatives of the Local Authorities and ICB but also citizen representatives and senior leaders/representatives from other organisations and partnerships key to the delivery of health and care whilst not replicating Health and Wellbeing Board membership. A draft list of proposed membership was agreed at the ICS Partnership Board development session on 3 February 2022 and it outlined in Annex A.

23. The process of formation of the ICP will have a large effect on its success: the approach taken at the early stages of development therefore needs to be inclusive and iterative – open to different perspectives and willing to adapt. An inclusive joint committee will enable engagement, ownership and collective accountability for the development and delivery of the integrated care strategy.

24. It is also recommended that a pragmatic approach be applied to the initial set-up with only a small number of formal meetings arranged and held in public at key points of the planning cycle (e.g. to support the strategy development, sign off and to review progress). These meetings will be supplemented with development workshops/meetings as needed. The terms of reference for the committee will need to detail how decisions are made / how consensus decisions are reached.

25. It is recommended that the joint committee will receive a report on insights gained from service users and citizens at each of its meetings.

26. To enable wider engagement in, and co-production of, the integrated care strategy it is recommended that further mechanisms are also put in place to enable all stakeholders a point of influence:

- A wider assembly of partners, to be held at least twice a year, to inform the creation of the integrated care strategy. Broad participation should be sought to include 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.
- Linkages should be made with existing networks, groups, and governance structures, including staff forums and insights gained from place and neighbourhood engagement.

27. These arrangements will need to be flexible, able to develop and evolve over the initial months and to take account of best practice. The ICP will build on the expertise, relationships and engagement forums that already exist across local areas, building priorities from the bottom up, to ensure those outlined in the integrated care strategy resonate with people across the ICS.

28. It is recommended that each Statutory Partner (ICB and LAs) nominate five Members of the ICP which will include Elected Member, Officer and partners each organisation considers crucial to delivering the ICS Strategy. Over the coming period further work will take place to define these arrangements based on discussions with the ICS Partnership Board at a development session on 3 February.

***Ways of Operating and Administration***

29. The ICP will have designated resources and capabilities in accordance with its duties and remit agreed. By necessity, the ICP will need to draw on, and be aligned with:

    - The Health and Wellbeing Boards, JSNAs, HWBS, and public health.
    - The ICB's System Analytics and Intelligence Unit working with public health to provide population health and wellbeing insights.
    - Joint planning and commissioning capabilities across NHS and Local Authority partners; communications and engagement resources from across these statutory organisations.
    - Administration resources.

30. A plan is being developed for the mechanisms and structure to support the ICP.

***Leadership and Accountability***

31. The Chair of the ICP will need to be accountable for:

    i. Ensuring that there is an integrated care strategy in place which is reflective of population needs, recovery from Covid19 and addressing

inequalities, and which optimises the role of health and care as anchor organisations within the local community.

ii. Ensuring that the core health and care organisations, together with broader partners, are mutually accountable for the implementation of the strategy focusing on improving outcomes in population health and healthcare, tackling inequalities in outcomes, experience and access, enhancing productivity and value for money and supporting broader social and economic development.

iii. Championing and being an ambassador of effective partnership working for local population benefit.

32. It is for the (two Upper Tier) LAs and ICB to agree who chairs the ICP but with the expectation that all jointly convene and are equal partners. It is also for these organisations to confirm the initial tenure for the preferred chair arrangement.

33. It is recommended that the local arrangements be reviewed after 12-months of operation to ensure that they are working well. In addition, it is recommended that the initial chair arrangements take the form of a shared chairing arrangement between an Elected Member from each (Upper Tier) LA and the Chair of the ICB. It is further recommended that the ICB chairs the ICP for the first 12 months supported by two Vice-Chairs who will be Elected Representatives of the two Local Authorities.

34. The ICP will be transparent with formal sessions of the joint committee held in public and papers published on-line in advance.

**Transition Path**

35. The transition path now focuses on:

- Approving the ICP scope, purpose and operating arrangements.
- Establishing the Partnership.
- Aligning JSNA development across our health and care system and embedding into planning processes across health and care.
- Operationalising mechanisms for the integrated care strategy to be developed with, and reflective of, all the communities served.
- Aligning public health and ICB data and intelligence to determine health needs, population health management and inform system priority setting processes.
- Developing and agreeing the first integrated care strategy by September 2022, enabling operational planning to have due regard for overall population health needs and priorities.

36. Given the extension to the implementation of the Health and Care Bill, it is recommended that the current Integrated Care System Board continues to meet in public until the point at which the ICP and ICB can be fully constituted.

This will ensure the momentum is maintained for system leadership and oversight of the new arrangements.

**Recommendation**

37. It is recommended that Nottingham City Council, Nottinghamshire County Council and the NHS ICB (in shadow operating) approve the recommendations for the local Nottingham and Nottinghamshire Integrated Care Partnership as detailed in this report:

h) The Nottingham and Nottinghamshire ICP forms the 'guiding mind' of the health and care system, in creating an integrated care strategy.
i) The set of principles and ways of working, outlined in paragraph 16, underpin the operation of the local ICP.
j) Membership of the ICP joint committee comprises five key representatives of each of the LAs and ICB together with citizen representatives and senior representatives from each of the four Place Based Partnerships.
k) The joint committee receives a report on insights gained from service users and citizens at each of its meetings
l) Pragmatically, only a small number of formal meetings be arranged and held in public at key points of the planning cycle. These will be supplemented by development sessions as needed.
m) The initial arrangements be reviewed after 12-months of operation to ensure that they are working well.
n) The initial chair arrangements take the form of a shared arrangement between an Elected Member from each LA and the Chair of the ICB which initially will be that the ICB Chair chairs the ICP supported by two Vice-Chairs who are Elected Member representatives from each of the two (Upper Tier) Authorities.

## Annex A - Proposed Membership of Nottingham and Nottinghamshire Integrated Care Partnership

Draft list of proposed membership of the Nottingham and Nottinghamshire Integrated Care Partnership agreed at the ICS Partnership Board development session on 3 February 2022.

| Organisation / Partner | Member(s) |
|---|---|
| Nottingham City Council | • Elected Member Representative (Vice-Chair)<br>• Director of Public Health<br>• Directors for Children's and Adult Social Care<br>• City Partner<br>• City Partner |
| Nottinghamshire County Council | • Elected Member Representative (Vice-Chair)<br>• Corporate Director, Adult Social Care<br>• Director of Public Health<br>• County Partner<br>• County Partner |
| Nottm & Notts NHS Integrated Care Board | • Chair (Chair)<br>• Chief Executive<br>• ICB to nominate<br>• ICB to nominate<br>• ICB to nominate |
| Citizen Representatives | • HealthWatch Representative<br>• Chair of the VCSE Alliance |
| Place Lead one from each Place Based Partnership | • Bassetlaw<br>• City<br>• Mid Notts<br>• South Notts |

| | | | |
|---|---|---|---|
| **Item Number:** | 9 | **Enclosure Number:** | G |
| **Meeting:** | ICS Partnership Board | | |
| **Date of meeting:** | 3 March 2022 | | |
| **Report Title:** | ICS Clinical and Care Professional Leadership Framework | | |
| **Sponsor:** | Rosa Waddingham ICS Chief Nurse and Co-Chair of the CCPEG<br>Stephen Shortt CCG Clinical Chair and Co-Chair of the CCPEG | | |
| **Place Lead:** | | | |
| **Clinical Sponsor:** | | | |
| **Report Author:** | Joanna Cooper, Assistant Director, ICS | | |
| **Enclosure / Appendices:** | None | | |

**Summary:**

This report provides the ICS Partnership Board with an overview of work taking place within the ICS transition programme for Clinical and Care Professional Leadership.

NHSEI has set the expectations that the ICS will:

- Agree a system framework and plan for Clinical and Care Professional Leadership
- Ensure leaders from all clinical and care professions are involved and invested in the vision, purpose, and work of the ICS.

The local ICS Clinical and Care Professional Leadership framework and plan is developing well. Key components of this plan are:

- The continued support and growth of a diverse and well engaged clinical and care executive group within the system with representatives from all places and partners – Clinical and Care Professional Executive Group (CCPEG).
- The co-creation through CCPEG of a clear leadership framework which identifies the principles of our system working and provides a clear plan
- An 'immersion programme' which provides OD and infrastructure support.

Further details on this work will be shared at the meeting.

**Actions requested of the ICS Board**

To note the contents of the report and receive a presentation on the Clinical and Care Professional Leadership Framework.

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**Recommendations:**

| | |
|---|---|
| 1. | **NOTE** the continued work to develop the system approach to Clinical Care Professional Leadership and a framework in support of this |
| 2. | **SUPPORT** the next steps to further develop this framework and report into the ICS transition board |
| 3. | **NOTE** the work being taken in relation to the Year in the ICS |

**Presented to:**

| Board | Transition and Risk Committee | Clinical Executive Group | System Executive Group | Finance Directors Group |
|---|---|---|---|---|
| ☒ | ☐ | ☒ | ☒ | ☐ |
| Quality Group | Bassetlaw Place | Mid Nottingham-shire Place | Nottingham City Place | South Nottingham-shire Place |
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Contribution to delivering System Level Outcomes Framework ambitions**

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

**Conflicts of Interest**

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

**Risks identified in the paper**

| Risk Ref | Risk Category | Risk Description | Residual Risk | | | | Risk owner |
|---|---|---|---|---|---|---|---|
| | | | Likelihood | Consequen | Score | Classificati on | |
| Ref | e.g. quality, financial, performan ce | Cause, event and effect<br><br>There is a risk that… | L1-5 | L1-5 | L x I | Grading | *Person responsible for managing the risk* |
| | | | | | | | |

**Is the paper confidential?**

☐ Yes

☒ No

☐ Document is in draft form

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

**The ICS Clinical and Care Professional Leadership Framework**
**3 March 2022**

1. The Nottingham and Nottinghamshire Integrated Care System (ICS) brings together NHS, Local Authorities, and wider partners with the stated shared purpose of *'enabling each citizen to enjoy their best possible health and wellbeing.'* This shared purpose is underpinned by three strategic aims:

   - Improve the health and wellbeing of the population, including addressing inequalities and wider determinants.
   - Ensure the provision of high-quality sustainable services, including recovery from Covid19.
   - Enable the effective utilisation of system resources namely workforce, estates, and financial resources.

2. The ICS's development and transition programme includes a focus on 'Clinical and Care Professional Leadership' with recognition that this is a key component of a high performing ICS. Additionally, NHSEI has set the expectations that the ICS will:

   - Agree a system framework and plan for Clinical and Care Professional Leadership
   - Ensure leaders from all clinical and care professions are involved and invested in the vision, purpose, and work of the ICS.

3. Five national principles underpin these expectations:

   - Clinical and Care Professional Leaders from diverse backgrounds are involved in decision making
   - There is a culture of collaboration, innovation, and shared learning incl. with patients / communities
   - Clinical and Care Professionals are involved and invested in planning and delivery (with time, support, and infrastructure)
   - Multi-professional development is in place at all levels of system
   - Recruitment and talent management is in place with a focus on promoting equality and diversity.

4. The local ICS Clinical and Care Professional Leadership framework and plan is developing well. Key components of this plan are:

   - The continued support and growth of a diverse and well engaged clinical and care executive group within the system with representatives from all places and partners – Clinical and Care Professional Executive Group (CCPEG).
   - The co-creation through CCPEG of a clear leadership framework which identifies the principles of our system working and provides a clear plan

- An ‘immersion programme’ which provides OD and infrastructure support. NB: this immersion programme is based on learning from the ICS’s recent participation in the King’s Fund international series, through an initial programme entitled *A Year in the ICS* but recognising that this will further iterate.

## Leadership Framework Development

5. Several workshops to outline the system asks from a Clinical and Care Leadership framework have been undertaken by NHS Elect and the ICS Chief Nurse, supported by the CCG clinical chairs in the absence of an ICS Medical Director. The outputs of these workshops was a strong narrative and clear sense of what was important in 'Our ICS'.


6. From this a clear professional leadership charter has been established which is clear on the following principles.

- Person and patient centred care remain an unswerving commitment
- ICS represents move away from separate thinking and activities to connectedness, the whole continuum of care and its interfaces
- There is no "right way" to achieve integration and we will need to constantly re-calibrate, and course correct as we understand progress against intended outcomes
- Decisions will be made at the right level; engagement close to the patients they affect
- Quality and safety are at the heart of what we do, all day and every day
- Clinical governance and delivering high quality care are everybody's responsibility at an individual, team and organisational level
- Clinical-managerial alignment will be created to ensure effective identification and implementation of transformational practices
- Standards will be agreed, monitored, evaluated, and managed with openness and accountability
- We will strive for safe, productive, engaged and appreciated staff

- The statutory accountability and responsibilities of individual organisations remain
- We will value diversity - cultural, professional, organisational

7. There has been work to develop a clear narrative and organising principles and further work to make explicit connections horizontally and vertically connecting system, place, neighbourhood (including the provider collaboratives), to build relationships and trust and avoid duplication and make best use of valuable and finite resources.

8. As the system structures and strategies emerge, having clear clinical accountability for prioritisation and investment as well as clinical and professional decision making is essential for the CCPEG to move to deliver. Within the next three months CCPEG will further evolve the framework to:

    - Make explicit connections horizontally and vertically connecting system, place and neighbourhood (including the provider collaboratives), to build relationships and trust and avoid duplication and make best use of valuable and finite resources
    - Develop the structures for collaborative and distributed leadership and decision making which clarifies the role and remit of cabinets and the clinical transformation partnership
    - Establish interfaces to emerging ICS / ICB governance and deliverables, including the key roles of ICB Nurse and Medical Director and future role and remit of the Clinical and Care Professional Leadership Group
    - Ensure clinical oversight of decision making and links to transformation programmes and quality arrangements is made clear
    - Produce a technical document outlining in greater detail the concepts and bodies outlined in the

## Clinical and Care Professional Engagement and Participation

9. It is a feature everywhere strong integrated systems have been built, that innovation and collaboration between all clinicians and professionals is at the heart of transformation. It is also true that many clinicians locally, know very little about the system they work in. System wide change can only occur if everyone understands and connects with the drivers for change and understands how to engage.

10. It is essential that mechanisms are developed to engage all clinical and care colleagues across the ICS in the continued evolution of our health and care system.

11. The CPEG is supporting the development of two Nottingham and Nottinghamshire professional engagement programmes of work which place the health and care system in context and gives life to Nottingham & Nottinghamshire ICS's 'living values'. They are framed around the common

transformation task and what it takes for our system to become high performing, the model for improvement and developing a change culture.

12. The aim of this 'immersion' programme is to build a sense of belonging through developing involvement mechanisms and 'one team' mindset within our system for all clinical and care professionals to

- Connect and engage ICS staff, clinical and care professional leaders
- Embed a strong and agreed set of values which are manifest at all levels of work and connect professionals to the objectives of ICS
- Regenerate connections between clinicians across organisations and connect diverse professionals of different grades and disciplines
- Embed a strong message of teamwork orientated around the shared goal of improving health and care together so we can create a change culture, and stimulate innovation and engagement

13. '*A Year in the ICS'* is another programme whose aim is to create a sense of identity and belonging across our communities. The aim is to increase patient and public activation with the aim of progressing the ICS health and wellbeing outcomes and the strategic priorities around prevention, self-care and tackling health inequalities. In addition, the aim is to:

- Develop links with communities, utilising local knowledge to gain understanding of how best to engage, especially with underserved cohorts
- Embed an educational programme, including into primary and secondary schools
- Develop a network of local ICS Health and Wellbeing champions
- Align with the other ICS programmes of work and key national and local campaigns

## Recommendations

14. The ICS Partnership Board is asked to:

- **NOTE** the continued work to develop the system approach to Clinical Care Professional Leadership and a framework in support of this
- **SUPPORT** the next steps to further develop this framework and report into the ICS transition board
- **NOTE** the work being taken in relation to the Year in the ICS

| | | | |
|---|---|---|---|
| **Item Number:** | 10 | **Enclosure Number:** | H1 |
| **Meeting:** | ICS Partnership Board | | |
| **Date of meeting:** | 3 March 2022 | | |
| **Report Title:** | ICS Executive Lead Report – Integrated Performance | | |
| **Sponsor:** | Amanda Sullivan, ICB Executive Lead, Accountable Officer, Nottingham and Nottinghamshire CCG | | |
| **Place Lead:** | | | |
| **Clinical Sponsor:** | | | |
| **Report Author:** | Sarah Bray – Associate Director for System Assurance, Nottingham and Nottinghamshire CCG | | |
| **Enclosure / Appendices:** | Enc H2 – ICS Delivery Dashboard<br>Enc H3 – ICS Health Inequalities Access Dashboard | | |

**Summary:**


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

This report supports the ICS Partnership Board in discharging its four core purposes of:

a. Improving population health and healthcare
b. Tackling unequal outcomes and access
c. Enhancing productivity and value for money
d. Helping the NHS to support broader social and economic development.

In addition, oversight is provided for the collective management of system resources and performance and delivery against the system plan.

Updates are provided for:

- System Vaccination
- 2022/23 Planning and Transformation.
- Integrated Performance (quality, service delivery, finance, people);
- ICS Development and Transition


**Actions requested of the ICS Board**

To note the challenges and progress made during 2021-22.
To note the approach to NHS Planning for 2022-23 and the years ahead.

**Recommendations:**

| | |
|---|---|
| 1. | To note the report. |
| 2. | To note the challenges and progress made during 2021-22. |
| 3. | To note the approach to NHS Planning for 2021 – 22 and the years ahead. |

**Presented to:**

| Board | Transition and Risk Committee | Clinical Reference Group | System Executive Group | Finance Directors Group |
|---|---|---|---|---|
| ☒ | ☐ | ☐ | ☒ | ☒ |

| Quality Group | Bassetlaw Place | Mid Nottingham-shire Place | Nottingham City Place | South Nottingham-shire Place |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Contribution to delivering System Level Outcomes Framework ambitions**

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

**Conflicts of Interest**

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**Risks identified in the paper**

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

**Is the paper confidential?**

☐ Yes
☒ No
☐ Document is in draft form

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# ICS Executive Lead Report

## 23 February 2022

## ICS Executive Overview

1. The system continued to experience increased pressure through emergency activity and the impact of Covid-19 during the winter period. The ability of the system to respond to the surge in demand was further impacted upon by the difficulty in ensuring appropriate home care and care home placements are available, which has led to more people staying in the acute hospitals longer than necessary. In addition, Covid-19 caused a significant impact on staff availability across all areas of the system and also led to planned care capacity being repurposed for urgent care demand. This has had a significant impact upon the system's ability to deliver elective services and tackle the rising numbers of patients waiting for treatment. Patients have been clinically prioritised to access the treatment capacity available, with safeguarding measures in place for those remaining on waiting lists, including routine contact with patients, assessments of potential harm, and joint system prioritisation reviews.

2. The reduced capacity to undertake planned elective care has also had a detrimental impact upon the system finances as Elective Recovery Funding has not been able to be received during this period.

3. The key risks which continue to be managed by the system include the ongoing pressures from Covid-19, staff availability, potential harm to patients from extended waits, challenges meeting increasing demand (e.g. Primary Care, Long Covid, mental health and cancer), patients delayed in hospital longer than medically necessary and financial risks.

4. The ICS also continues to progress towards the changes outlined in Integrating Care and are planning for the changes ahead, with an ICS Development Plan now in place. This has been refreshed for the System Design Framework, actions arising from the System Progression Tool and the 'ICS Readiness to Operate Statement' which systems will be required to complete as assurance as progress towards statutory status from July 2022.

5. The assignment of the ICS and NHS organisations into the System Oversight Framework Segments has been undertaken at a national level. The system was categorised at level 2.

### Covid-19 Vaccination Programme

6. Latest figures show in Nottingham and Nottinghamshire 2,077,240 vaccinations have been administered since the start of the programme.

    - 84.6 per cent of over 18s have now received 2 doses.

- 65.5 per cent of 18-29-year-olds have had two doses.
- 90.4 per cent of those aged 30 and over have had two doses.
- 58.8 per cent of 12-15-year-olds in Nottingham and Nottinghamshire have had one dose of the vaccine.
- 66.6 per cent of over 18s have had a booster dose.

7. The programme is reshaping the delivery model from a small number of large hubs into a place and community-based model led by Primary Care services including GPs, PCNs and pharmacies. These are supported by two vaccination hubs and two hospital hubs, a roving vaccination service, school age immunisation teams and the vaccination bus.

8. Bespoke offers are in place to improve the uptake across different population groups. This includes groups with a lower profile and who do not have a strong voice, including dementia, serious mental illness or learning disability. Messaging to women of childbearing age and pregnant women. Leafleting low take up communities and vaccinations from medivans.

9. The forward plan is to ensure all care home residents and housebound are vaccinated and progression of plans for the vaccination of 5-11 year olds.

**System Transformation**

10. The ICS established a programme structure to oversee development and delivery of the ICS 2021-25 Transformation and Efficiency plan in January 2021. A very senior SRO (usually CEO level) was identified for each programme, together with clinical lead, programme director and subject specialists. Where appropriate programmes have joint health and local authority leadership.

11. The Transformation and Efficiency Plan is a prioritised delivery plan for the NHS Long Term Plan and the ICS Outcomes Framework. It must improve health and wellbeing, the quality of services and the experience of our staff whilst also addressing the system financial deficit. It should proactively address health inequalities and further develop our approach to Population Health Management.

12. The ICS made significant progress developing the Transformation and Efficiency Plan. In support the ICS Strategy and Delivery Group adopted a stronger programme assurance and programme discipline to accelerate and grip progress. Each programme developed an ambitious multi-year transformation pipeline which was being systematically developed in detail through Project Charters and Project Initiation Documents, however the system response to Covid during the winter months has led to some delays in further progressing these plans. Focussed work can start to be undertaken as the system emerges from the Covid-19 response, and detailed plans will be progressed Transformation due to deliver in 2022/23 and this will continue to be driven at pace.

**2022/23 System planning**

13. NHSE/I published the 2022/23 priorities and operational planning guidance on 24 December 2021 and technical guidance on 14 January. The national Elective Recovery Plan was published on 8 February. Draft plan submissions are expected on 17 March and final plan submission on 28 April 2022. A number of separate plan submissions are due on specific dates (e.g. 18 February for Elective Hub plans).

14. The System Planning Group (SPG) has produced a detailed timeline and is overseeing activities to develop the plan. A more detailed description of the planning process is included in a separate ICS Board paper. The latest position will be shared with the ICS Partnership Board on 3 March. As the plan will continue to be developed all the way up to the 22 April progress will be shared with the ICS Board and SEG for review, decisions and approval as appropriate. A weekly CEOs group will oversee progress and receive escalations.

**System Performance**

15. The integrated performance report reflects the 2021-22 system plan and performance for the system.

**Quality**

16. There are three areas of enhanced surveillance within the system which have a system-wide assurance group in place: Nottingham University Hospitals (including Maternity Safety and Quality Improvement); Nottinghamshire Healthcare NHS FT as part of their organisational-wide improvement; and Mediscan (non-obstetric ultrasound independent provider) due to concerns identified by CQC and actions taken.

17. There remains significant pressure within the system due to high volume of patients, Omicron surge and workforce shortages. To support, additional capacity beds have been made available or commissioned across the system. Transfer of patients outside of pathways are being continuously monitored and a continual review of service change is in place. Support with IPC and derogations is underway (100% of SFH requests approved and 83% NUH requests approved), and community services derogations and their impact on services remains under review (such as the 0-19 service focusing on core offer in City and related service impact).

18. There has been a reduction in Covid-19 related outbreaks across the system, in line with the national, regional and local picture where community rates remain high but are slowly decreasing. W/C 14.2.22 - 57 outbreaks in care homes and supported living services, 1 primary care, 6 NUHT, 5 SFHT and 25 NHCT.

19. The Local Maternity & Neonatal System programme remains under enhanced surveillance due to capacity concerns to transform services in line with requirements given operational pressure and demands. Transformation work

remains reprioritised to support key priorities that have continued throughout level 4 including Safety work including Serious Incidents, Perinatal Quality Surveillance Group; Covid-19 vaccines in pregnant women; Embedding of Ockenden recommendations and system digital developments and dashboard reporting. Achieving full implementation of Continuity of Carer (CoC) continues to remain a considerable risk. The continued impact of Covid and the Level 4 incident has compounded workforce challenges regarding re-modelling and it is anticipated that the LMNS will be at least a year behind target achievement. A plan is under development based on the recruitment campaign to ensure BirthRate+ compliance. This will be the focus of a discussion at LMNS executive partnership in March to refocus the priorities for continuity of carer with system partners.

20. The Learning Disability/Autism (LDA) Partnership programme remains under enhanced surveillance due to adult Inpatient performance, rapid response to the Five Eyes recommendations, and increased Host Commissioner responsibilities. Current forecasts indicate that there will be 50 adult inpatients in the system by 31 March 22, against a target of 43. This is due to the numbers of admissions that we have seen throughout the year, as well as slow progress of discharges from secure inpatient settings compounded by community placement capacity and workforce challenges. Extraordinary Inpatient Oversight meeting is in place for exec level to review discharges and unblock challenges along with a system action plan to address issues in place.

21. The system has completed 39 reviews Safe and Well Reviews to date. Key themes from the reviews are informing the development of key transformation activity that will help the system tackle some of these themes that are being highlighted.

22. Annual Health Check performance continues to be a challenge due to Primary Care capacity. This is an area of scrutiny by LDA Board and actions are being taken to explore additional investment to GP practices, as well as engagement of BAME communities via pilot to increase Q4 performance.

23. Personal Health Budget performance remains off track with scrutiny in place by the Personalisation Oversight Group and an action plan to increase PHBs in line with Long Term Plan metrics.

24. Work has resumed on the ICS Coproduction strategy, following a pause during the level 4 incident an updated work plan has been produced to align with new ICB timescales. The focus at working group has been on coproducing the role of the strategic coproduction group, including role, remit and function. Discussions with engagement/comms team continue to align coproduction strategy with engagement strategy work as part of the ICB strategy for working with people and communities.

25. These areas are reviewed through the ICS Quality Assurance and Improvement Group.

**Service Delivery**

26. Pressures have continued across all areas of the system, with increased numbers of patients requiring access to services and the continued impact of Covid-19. Pressures across urgent care has led to increased numbers of patients waiting over 12 hours in A&E and taking longer waiting on ambulances prior to handover with the Trust. Flow through hospital is also being impacted by the difficulties in obtaining home care or community care for patients. This increased system pressure has also impacted upon the ability of the system to see as many patients as intended for planned appointments. As a result, waiting lists continue to rise as referrals have returned to or increased over pre-covid levels, with 100,530 patients on the waiting list as of December 2021. Focus is being maintained on treating priority patients and time critical surgery patients first, with work to reduce those waiting the longest ongoing. Recovery of services continues to be constrained due to staffing gaps, availability of theatre and critical care capacity, and bed capacity issues due to patients staying in hospital longer than medically necessary. Health and Social Care partners are working in collaboration to address funding for care assistants, stimulate the home care market and source additional interim beds in the community to improve discharges from hospital.

27. As part of the recovery of services, all areas are being asked to recover services having regard to inequities and inequalities which may exist in access to services. Work has been undertaken to review waiting lists and cancer referrals across health inequalities factors, with actions being taken to address issues identified relating to age and deprivation. To support the Board in retaining oversight of potential inequality in access to services, a high-level summary has been provided to reflect how different cohorts of patients across Nottinghamshire have accessed services on a 12 month rolling basis, since August 2020 (Enc H3). This will be routinely reviewed as services continue to increase capacity and develop new services and ways of treating patients.

**Finance**

28. At the end of January, the ICS is reporting an adverse variance of £9.7m for performance purposes against the H1/H2 plan. The key driver of the deteriorating position is the impact of elective recovery in M10 alongside the H1 deficit position of £7.5m, offset to some extent by underspends against Covid-19 resources.

29. The system is forecasting a £23.2m year-end shortfall due to the Elective Recovery Fund (ERF) income and the additional costs managing the level 4 operational response.

30. Discussions have taken place with NHSE/I colleagues to understand the system position and discuss any potential mitigations.

31. The ICS received £24m of ERF in H1. This was short of planned levels and was the main determinant of the deficit experienced at the end of H1.

32. Total ERF income in H2 was planned at £17.2m. ERF receivable in October to January is £1m, £9.9m adverse to the YTD plan of £10.9m. This is due to urgent care pressures early in Q3 and the impact of the Omicron wave.

33. No further ERF is expected in Q4 due to the continuing need to respond to the pandemic and high levels of staff absence. However, significant levels of uncertainty remain and there may be some pick up towards the end the quarter.

34. The ICS capital envelope, totalling £82.5m for 2021/22 is now expected to underspend by £2.5m. This is due to slippage in the compliance works and fit-out of the Sherwood Oaks facility. As we are approaching year end, with longer than normal lead times for materials and equipment, the ICS is unable to use this in any of its organisations.

35. At M10, the County Council is forecasting a £2.4m year-end deficit & Nottingham City Council a £3m year-end surplus. This is driven by non-recurrent funds receivable in 2021/22.

**People and Culture**

36. The workforce report predominantly focuses on the three acute trusts within the system reporting on the January 2022 position.

37. Sickness absence significantly increased from November 2021 through to January 2022, with a position of 6.8%. This was the highest sickness level over the past 24 months and was as a direct impact of Omicron variant. These remain above usual levels however are starting to improve. Organisations have invested in dedicated Occupational Health and Health & Well-Being resource to support the further return to pre-pandemic levels.

38. Substantive vacancies have increased to 8.7%, with increases across nursing and HCA posts. The position against the H1 plan shows lower than expected staff in post of -8% (2,350.9). An increased focus on international recruitment for registered nurses, midwives and mental health nursing, with regional support to trusts is being put in place which will support the recovery of the intended system position already included in the workforce plans.

**System Development Plan**

39. On 6 July 2021 the Health and Care Bill was introduced to Parliament and is an important step on our journey to becoming a statutory ICS. This Bill formalises policies set out by NHSEI, in particular the Long Term Plan and White Paper 'Integration and Innovation: Working together to improve Health and Social Care for all' published in February 2021.

40. NHSEI have published further guidance to support transition to becoming a statutory ICS. Guidance and supporting materials to support legal establishment and operational readiness for 1 July 2022 are now available.

41. Work continues to develop and confirm the new structures for the ICS. ICS Transition work-streams have continued to develop in line with the Health and Care Bill and national guidance.

42. During this transition year, the system are required to submit a System Development Plan (SDP) to NHSEI on a quarterly basis. The last iteration was submitted on 22 December 2021 alongside progress against the NHSEI Readiness to Operate Statement (ROS) checklist. The ICS has confirmed readiness to meet all transition requirements in line with national timescales, with no red RAG rated risks to delivery at this stage. This submission was made with two caveats:
    - The programme's size, complexity and number of interdependencies at a time when the NHS and Local Authorities are managing significant Covid19 and operational pressures.
    - Leadership capacity with colleagues currently being reassigned to the local Covid19 and winter response.

43. For this submission NHSEI have put in place a light touch assurance process. There are no concerns to escalate at this time. The next submission is anticipated to be 31 March 2022 and early work is underway.

**System Buddying Arrangements**

44. Within the Midlands region, Nottingham and Nottinghamshire ICS have been matched with Herefordshire and Worcestershire ICS for peer buddying. Colleagues leading key aspects of ICS transition have been linked with their counterparts and informal discussions are underway to share and learn.

45. Regular meetings are in place with the ICB Chair Designate, ICS Executive Lead, and Assistant Director and their counterparts in Herefordshire and Worcestershire.

46. Relationships are also developing with two systems in the South West with a workshop held on system outcomes and performance.

# SYSTEM DELIVERY DASHBOARD

Integrated Care System – Nottingham & Nottinghamshire

ICS Partnership Board 3 March 22: Item 10. Enc H2

| RAG | KPIs Achieved |
|---|---|
| | >75% |
| | 50%-74% |
| | <50% |

## February 2022

## Quality of Care, Access and Outcomes

**Urgent Care -** Dec 2021: Pressures continued across A&E, ambulance and primary care services. 420 patients waited over 12 hours in A&E

**Mental Health -** Focus on improving length of stay for in-patients with MDT model and in-reach, crisis sanctuary and team provision. CYP eating disorders actions in place, including recruitment

**Planned Care -** December 2021, elective 96%, outpatients 94% of 19/20. 18 week backlog increased to 28849. +52 weeks increased to 3963 people. Diagnostics waiting list is currently stable.

**Quality -** LD&A inpatients - risk to achieving reductions required due to bed capacity and building supply issues. LD&A health checks below planned levels

**Cancer-** 2 week wait referrals remain at 125% pre-covid levels, therefore cancer waits have increased. Capacity is targeted towards cancer and priority patients, welfare calls are being conducted.

**486478 GP Appointments** reported in December 2021 which is as planned, and 4% more than December 2020. **62% Face to Face, 44% Same Day**

| CQC Assessment Ratings | CQC - NHS Trusts | CQC - Nursing Homes | CQC - Residential Homes | CQC - GPs |
|---|---|---|---|---|
| Latest Assessment Period | 14-Sep-21 | 01-Dec-21 | 01-Dec-21 | 01-Dec-21 |
| Outstanding | 0 | 6 | 17 | 19 |
| Good | 2 | 50 | 162 | 102 |
| Requires Improvement | 3 | 24 | 37 | 0 |
| Inadequate | 0 | 6 | 3 | 1 |
| Not Rated | 0 | 3 | 7 | 5 |

## Preventing Ill-Health and Reducing Inequalities

**2021-222 Covid Programme (Feb 22)**
All cohorts have been offered vaccines, including +12 years.
**2,077,240 vaccinations**
System focus - Booster vaccines & 12+ vaccines

**Health Inequalities -** Targeted areas of work include elective recovery (focus on cardiology and urology), tobacco dependency, personalisation, diabetes, CVD and respiratory and the vaccine programme

## Leadership & Capabilities

| NHSEI SOF Assessments | ICS | NUH | SFHT | NHT |
|---|---|---|---|---|
| Segmentation Level | 2 | 4* | 2 | 3 |

*Assessments undertaken through the new System Oversight Framework (Levels 1-4)

** Level 4 = Recovery Support Programme

## Finance and Use of Resources

**Finance -**
**YTD M10 £14.7m deficit & Forecast position @M10 £23.2m deficit** – mainly attributed to impact of ERF income shortfall and additional costs associated with managing Omicron variant. No ERF income is expected in Q4. Discussions have taken place with NHSEI to understand the system position and any potential mitigations.

## People

**Workforce -**
Sustantive staffing is off plan for June, with vacancy rate at 7.9%. Agency has continued to be used due to continued covid pressures and impact upon staff absence. Focus remains on international recruitment and staff well-being support.

## Local Strategic Priorities

**Quality Improvements -** Enhanced surveillance is in place across NUH and NHT - Quality improvement and actions plans are in place, as well as system wide Quality Assurance Groups.

**Elective Recovery -** Recovery progressed well in Q1, however was significantly impacted by the increased Covid pressures since Q2. All available capacity is being utilised, with prioritisation of patients undertaken at system level, based on clinical need.

**Financial Sustainability -** Underlying deficit is being addressed through ICS FD Group. Focus on 'drivers of the deficit' and benchmarking to inform transformational programmes

**Constitutional, Long Term Plan and H2 Plan Metrics Delivery**

| Service Area | No. KPIs | % Achieved | Delivery RAG | Assurance Level | Oversight Group |
|---|---|---|---|---|---|
| Planned Care (incl Cancer & Diagnostics) | 20 | 45.0% | | | Performance Oversight Group |
| Urgent & Emergency Care | 11 | 45.5% | | | |
| Mental Health | 13 | 46.2% | | | |
| Primary Care | 3 | 100.0% | | | |
| Personalisation | 4 | 50.0% | | | Quality Group |
| LD & Autism | 2 | 0.0% | | | |
| People | 8 | 62.5% | | | People |
| Finance & Use of Resources | 9 | 55.6% | | | Finance |

**ICS System Oversight Framework (SOF) - awaiting assessment**

| Best Performimg | Worst Performing |
|---|---|
| 3/42 - Dementia Diagnosis Rate (202111) | 40/42 - Diabetes NICE Treatments (20-21) |
| 3/42 - Cancer Cervical Screening (Q1-2122) | 40/42 - Maternal Neonatal Deaths (2019) |
| 5/42 - Cancer Faster Diagnosis (202111) | 39/42 - % Maternity Continuity of Care (202109) |
| 7/42 - % Outpatients Delivered Remotely (202110) | 38/42 - +90 day LOS Older Adult MH (202110) |
| 7/42 - Broad Spectrum Antibiotics (Nov20-Oct21) | 37/42 - Covid 19 Vacs % Adults (w/e 12/9/21) |

Based upon data as at 26th January 2022

## Progress against System Plan

| Finance Group<br>Finance | | YTD Var<br>£m | YTD RAG | FOT Var<br>£m | FOT RAG |
|---|---|---|---|---|---|
| -NHS System - Non-COVID | H1&2 | -12.8 | | -22.1 | |
| -NHS System - COVID | H1&2 | 3.2 | | -1.1 | |
| NHS System - Total | H1&2 | -9.6 | | -23.2 | |
| Local Authorities* | Plan B/E | 0.4 | | 0.6 | |
| Capital Envelope | Spend v Plan | 21.9 | | 2.5 | |
| Mental Health Investment Std | Spend v Plan | 0.3 | | 0.4 | |
| Elective Recovery Funding | Income v Plan | -43.1 | | -49.2 | |

*As at 31st January 2022*

| Peo | People & Culture<br>Workforce *(NHS Provider Based)* | YTD Plan | YTD Actual | Variance | YTD RAG | |
|---|---|---|---|---|---|---|
| | -No. Substantive Staff | 29326 | 28488 | -838 | | |
| | -No. Bank Staff | 1644 | 1932 | 288 | | |
| | -Agency Staff | 1014 | 954 | -60 | | |
| | Primary Care Workforce* (Quarterly) | 2594 | 2453 | -141 | | *June 2021 |
| | Trends (12 month rolling) | Nov-21 | Dec-21 | Jan-22 | | |
| | -Staff Sickness Absence % | 5.4% | 5.6% | 6.4% | | |
| | -Staff Turnover % | 11.8% | 12.2% | 12.3% | | |

*As at 31st January 2022*

**Capacity Cell**

| NHS Activity* *(Population Based)* | In Month Plan | In Month Actual | In Month Variance | In Month Var % | In Month RAG |
|---|---|---|---|---|---|
| - GP Referrals* | 14,078 | 11,465 | -2,613 | -18.6% | |
| - Elective | 10,894 | 10,573 | -321 | -2.9% | |
| - Outpatients | 91,055 | 93,024 | 1,969 | 2.2% | |
| - Non-Elective | 10,863 | 9,442 | -1,421 | -13.1% | |
| - A&E | 32,452 | 27,973 | -4,479 | -13.8% | |

*As at 31st December 2021*

*GP Referrals compared to 2019/20 referrals

**Capacity Cell**

| Capacity (Provider Based) | Period | Plan | Actual | Prior Yr | In Month RAG |
|---|---|---|---|---|---|
| -Primary Care Appointments | Dec-21 | 476,669 | 486,478 | 465,913 | |
| -Acute Beds Available per day | Dec-21 | 2,189 | 2,184 | 2035 | |
| -Adult Critical Care Beds Available per day | Dec-21 | 71 | 88 | 84 | |

*Increased primary care appointments, as well as beds made available, highlights the continued pressures across the system*

*H2 Plan = the plan for the second half of 2021/22*

## System Readiness to Operate

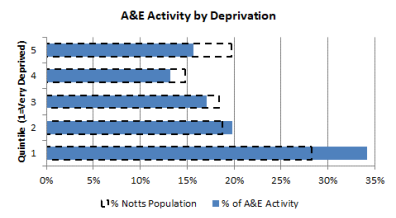
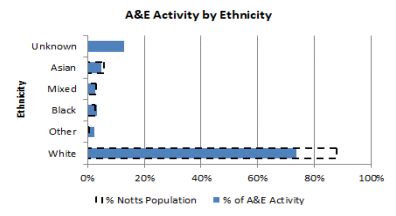
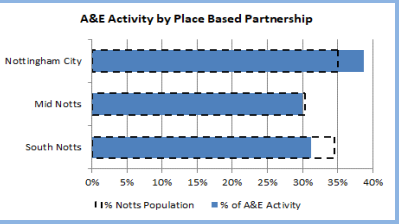
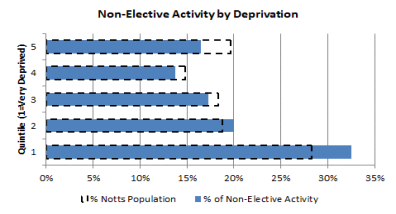
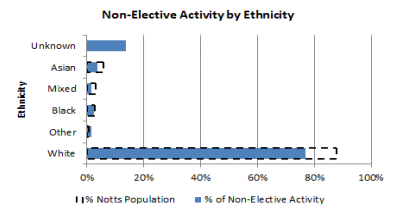
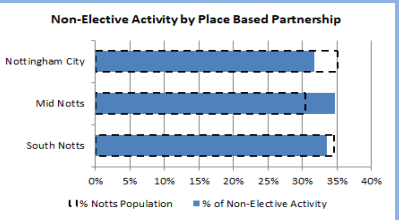
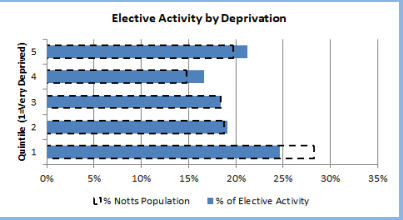
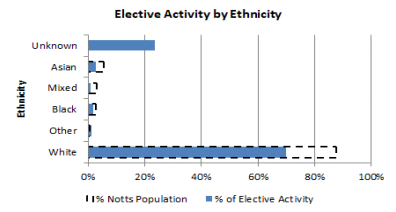
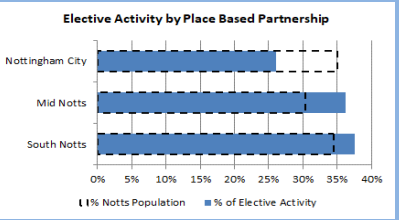
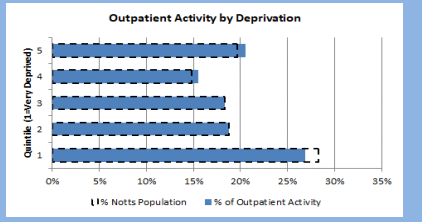
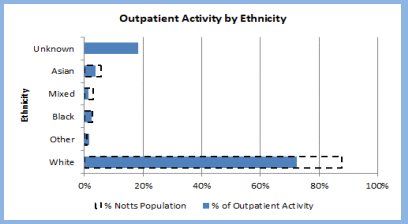
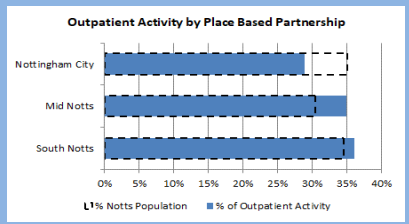
NHSEI have published an ICS Readiness to Operate Statement (ROS) with accompanying guidance, which will provide the basis of providing assurance to NHSEI and the ICS Board during the transition period. The ICS has confirmed readiness to meet all transition requirements in line with national timescales.

# HEALTH INEQUALITIES VIEW OF SYSTEM PERFORMANCE

## February 2022

**Total Activity as % of population segment v system demographic profile**

Purpose of the report is to determine whether there is unequal access to diagnosis and treatment across Nottinghamshire

| | Deprivation Quintile (1 Most Deprived -5 Least Deprived) | Ethnicity (using groupings from National Pop Health) | Place Based Partnership (Location) |
|---|---|---|---|
| **A&E Attendances:** February 2021 - January 2022 Activity |  |  |  |
| **Non-Elective Admissions:** February 2021 - January 2022 Activity |  |  |  |
| **Elective Admissions:** February 2021 - January 2022 Activity |  |  |  |
| **Outpatients:** February 2021 - January 2022 Activity |  |  |  |
| | A system review of 'Did Not Attends' has been undertaken by deprivation and age, with targeted actions being developed to focus on younger patients in areas of highest deprivation.<br>A self referral line for lung checks is to be introduced, it is expected that this will particularly benefit patients from deprived communities and support earlier diagnosis.<br>A review of emergency presentation for cancer diagnosis is being undertaken, as more people from deprived communities are now presenting for cancer treatment through emergency routes. Actions from this review will target specific communities through PCN engagement. | Annual Health Checks for patients with Serious Mental Illness have been reviewed across age and ethnicity, with targeted actions for those who have not received their annual health checks.<br>System improvements are being made for the recording of ethnicity data, including engagement with the public and clinical staff.<br>Learning from population cohort response to the vaccination programme roll-out is being utilised for population engagement to support earlier diagnosis | The review of 'Did Not Attends' is being refreshed across PCNs to support targeted engagement and action. To support obesity related conditions identification, which have increased during covid lockdown, a 'population health' review is being undertaken to identify individuals who may require additional support and earlier intervention.<br>The work relating to cancer emergency presentations will also inform PCN workplans, in targeting actions towards specific cohorts of the population for earlier engagement. |

| | | | |
|---|---|---|---|
| **Item Number:** | 11 | **Enclosure Number:** | I |
| **Meeting:** | ICS Partnership Board | | |
| **Date of meeting:** | 3 March 2021 | | |
| **Report Title:** | ICS Finance Highlight Report | | |
| **Sponsor:** | Stuart Poynor, ICS Chief Finance Officer | | |
| **Place Lead:** | N/A | | |
| **Clinical Sponsor:** | N/A | | |
| **Report Author:** | Marcus Pratt, Programme Director - Finance, Nottingham and Nottinghamshire ICS | | |
| **Enclosure / Appendices:** | None | | |

**Summary:**

The ICS Finance Directors Group continues to meet on a regular basis to provide executive oversight of the current financial position and forward strategy. The group continues to meet on a fortnightly basis with additional meetings as required to respond to emerging issues, such as 2022/23 planning.

Current areas of focus of the Finance Directors Group include:

**Financial Position (Revenue)**

At the end of January, the ICS is reporting an adverse variance of £9.7m for performance purposes against the H1/H2 plan. The key driver of the deteriorating position is the impact of elective recovery in M10 alongside the H1 deficit position of £7.5m, offset to some extent by underspends against Covid-19 resources.

In H2, the system is forecasting a £23.2m year-end deficit due to the Elective Recovery Fund (ERF) income shortfall and the additional costs of managing the level 4 operational response.

Discussions have taken place with NHSE/I colleagues to provide an understanding of the system position and discuss any potential mitigations. At this stage no central income is expected to cover the forecast deficit.

Further detail can be found in the Integrated Performance Report. Item 8.

**Financial Position (Capital)**

Year to date capital expenditure is lower than planned levels with £47.0m of the capital envelope spent at month 10 (57% of total annual envelope). The current forecast is to spend £80.0m in 2021/22, which is £2.5m below the envelope value. The underspend stems from slippage in the compliance works and fit-out of Nottinghamshire Healthcare's Sherwood Oaks facility.

Notable capital projects funded by the system envelope include £8.5m for Sherwood Oaks alterations as above; £5.1m relating to the replacement of linear accelerators at NUH and £15.8m for the build and purchase of a modular elective surgical ward and 3 theatres at Nottingham City Hospital to support the elective recovery programme.

The ICS has also been able to attract additional capital funding from outside its capital envelope supporting digitisation in social care and health, diagnostics and further elective support and a £20m new build at City Hospital from carbon reduction funds to eradicate the use of coal-fired boilers.

**Financial Planning and Strategy**

Financial Planning processes are underway for 2022/23 as described in the wider planning paper shared with the ICS Partnership Board, Item 6, Enc D1 and D2. One year draft revenue allocations and 3-year draft capital allocations have been received, which are being used as the basis for planning.

These draft allocations include a clear efficiency requirement as well as an expectation to return to pre-pandemic levels of productivity through increased utilisation of existing capacity and resource levels.

This will be challenging ask for the whole system and as such productivity and efficiency plans are under development to support this requirement. This will include removing covid related costs where it is safe to do so.

Allocations beyond 2022/23 will not be received was part of the planning process. However, the ICS will continue to focus on the underlying financial position throughout the process and the ambition to deliver recurrent financial balance through system transformation.

**ICB Transition**

The finance teams continue work towards the establishment of the Integrated Care Board (ICB) ensuring that processes are in place to meet all requirements of the ICS Design Framework. The Readiness to Operate Statement includes 3 requirements relating to finance:

- Planning for 2022/23 has been carried out in line with relevant guidance
- Activities as outlined in the NHS SBS finance / ledger reconfiguration programme plan as due by 1 July 2022 have been delivered
- Plan for Electronic Staff Record changes in place

All activities remain on target for delivery with some revision of timescales to take into account the revised transition date of 1 July 2022.

| **Actions requested of the ICS Board** | |
|---|---|
| Note the contents of the paper. | |
| **Recommendations:** | |
| 1. | Note the contents of the paper. |

| Presented to: | | | | |
|---|---|---|---|---|
| Board | Transition and Risk Committee | Clinical Executive Group | System Executive Group | Finance Directors Group |
| ☒ | ☐ | ☐ | ☐ | ☒ |
| Quality Group | Bassetlaw Place | Mid Nottingham-shire Place | Nottingham City Place | South Nottingham-shire Place |
| ☐ | ☐ | ☐ | ☐ | ☐ |

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

**Conflicts of Interest**

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

**Risks identified in the paper**

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

**Is the paper confidential?**

☐ Yes
☒ No
☐ Document is in draft form

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

| | | | |
|---|---|---|---|
| **Item Number:** | 12 | **Enclosure Number:** | J |
| **Meeting:** | ICS Partnership Board | | |
| **Date of meeting:** | 3 March 2022 | | |
| **Report Title:** | ICS Quality Assurance and Improvement Group Highlight Report | | |
| **Sponsor:** | Rosa Waddingham, Chief Nurse, Nottingham and Nottinghamshire ICS and CCG | | |
| **Place Lead:** | | | |
| **Clinical Sponsor:** | | | |
| **Report Author:** | Danni Burnett, Deputy Chief Nurse, Nottingham and Nottinghamshire CCG | | |
| **Enclosure / Appendices:** | None | | |

**Summary:**

This paper provides a highlight report from the Quality Assurance and Improvement Group (QAIG) which met on 25 November 2021. Due to system pressures, the January QAIG meeting was stood down however, quality touchpoints and safe today conversations continued. This group works collaboratively on behalf of the ICS to:

- Ensure the fundamental standards of quality are delivered – including review of information trends and themes, identification of system quality risks, oversight of shared system action plans, addressing inequalities and variation
- Improve continually the quality of services, in a way that makes a real difference to the people using them

- This month's highlight report provides an overview of the providers under enhanced surveillance and the areas of concern or risk, and those providers under routine surveillance and any emerging concerns.

System quality and transformation projects are summarised, including key actions in relation to maternity transformation and learning disabilities/autism.

**Actions requested of the ICS Board**

To note the contents of the report.

**Recommendations:**

| | |
|---|---|
| 1. | To note that Nottingham University Hospitals NHS Trust, Nottinghamshire Healthcare Foundation Trust, and Mediscan remain under enhanced surveillance with improvement and action plans in place. |
| 2. | To note that system-wide enhanced surveillance is in place for Care Sector, Local Maternity and Neonatal System, and Learning Disabilities and Autism Partnership. |

**Presented to:**

| Board | Transition and Risk Committee | Clinical Executive Group | System Executive Group | Finance Directors Group |
|---|---|---|---|---|
| ☒ | ☒ | ☒ | ☐ | ☐ |

| Quality Group | Bassetlaw Place | Mid Nottingham-shire Place | Nottingham City Place | South Nottingham-shire Place |
|---|---|---|---|---|
| ☒ | ☐ | ☐ | ☐ | ☐ |

**Contribution to delivering System Level Outcomes Framework ambitions**

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

**Conflicts of Interest**

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

**Risks identified in the paper**

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

**Is the paper confidential?**

☐ Yes
☒ No
☐ Document is in draft form

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

**System Quality Assurance and Improvement (QAIG) Highlight Report**

**3 March 2022**

- This report reflects the highlights and exceptions from the Quality Assurance and Improvement Group (QAIG) which met on 25 November 2021. Due to system pressures, the January QAIG meeting was stood down however, quality touchpoints and safe today conversations continued.

- Key Issues and Risks (KIARs) are developed based on quality and safety information and intelligence across providers and the wider health economy. As a partnership the group agree surveillance ratings plus develop system actions and support plans.

## Enhanced Surveillance (Single Item Provider Assurance Group)

- There continue to be three areas of enhanced surveillance within the system which have a system-wide assurance group in place:

### Nottinghamshire Healthcare NHS Foundation Trust

- Organisational Learning: The number of open incidents continue to be addressed. The Quality Standards Team (QST) is now well established with 'Quality First' visits recommenced. Information observers working with the QST to ensure data and intelligence informs assurance and triggers.
- Safety: Governance and information continue to improve, actions include implementation of a Trust Strategy to *Prevent and Reduce Violence and Restrictive Interventions*, refresh of the Suicide Prevention Training and review of the Suicide Prevention Strategy Group.
- Wells Road & Lings Bar: Quality Improvement Groups in place with Executive leadership and external partners involvement. Evidence of improvements in culture however more work to do to progress the improvement plan.
- Highbury Hospital (Adult Mental Health) and Hopewood Child and Adolescent Mental Health Services (CAMHs): Focus on supporting staffing levels to deliver safe care.
- Subcontracted Services: Refreshed oversight model based on the IMPACT approach to be in place during Q4.

### Nottingham University Hospitals NHS Trust

- Nottingham University Hospitals remains under considerable pressure operationally and in response to external scrutiny in the main in relation to maternity services, an action plan to address the *Must* and *Should Do* CQC recommendations has been developed with NHSEI. An overarching NUH Quality Assurance Group (QAG) was established during December 2021 co-chaired by ICS/CCG Accountable Officer and NHSEI Regional Medical Director. Three sub-groups were formed for progression of the relevant action plans: i) Emergency Department (ED) Assurance; ii) Maternity Assurance; iii) and Well-

Led & Governance Assurance. The QAG[1] is accountable for gaining assurance for the delivery of the actions being taken to address the CQC conditions and Trust-Wide Improvement Programme.

- Operational Pressures: Continued pressure and demand within the urgent and emergency care pathway has impacted waiting times in Emergency Departments (ED) including trolley waits. Continuous focus on the increase risk of Covid-19 related harms and preventing mixed sex breaches. ED taskforce in place to address flow.
- Organisational Culture: Ongoing support to deliver the NHSEI Culture and Leadership Programme through the six core work streams. Focus is on Just Culture and Civility; meaningful and motivating appraisals and talent management; framework of support; management and leadership skills framework; team development model and staff engagement framework.
- Patient Safety: Focus on the number of open incidents, and development of the NUH Learning Academy.
- Patient Experience: Monitoring of Duty of Candour (DoC) compliance and better understanding of the issues; discussion and identification of themes; and increased oversight of actions being taken as a result.
- Maternity: Concerns persist due to the lack of pace and assurance seen across the NUH Maternity Improvement Programme particularly in the Trust's ability to focus on impact and outcomes. Progress continues to be hindered by operational demands, pandemic response, and the impact of change in critical leadership roles. Limited assurances have been gained for workforce however there have been steps forward with actions to address safety such as fetal monitoring training, risk assessments, and the implementation of the triage line for women.

- **Mediscan** (non-obstetric ultrasound (NOUS) provider) received a Section 31 notice from the CQC. The CCG suspended the contract with Mediscan on 9 July 2021 and work is continuing to ensure that alternative services are available. All the Nottingham and Nottinghamshire patients identified as affected by the suspension of Mediscan services have now been followed up by their referrers. No harms have been noted although the service will remain on 'enhanced' surveillance.

## Enhanced Surveillance (System-Wide)

- In addition to the providers above, the group recognised that there are continuous challenges in three other parts of the system requiring additional support:

- **Care Sector:** Capacity and availability of the workforce (clinical and non-clinical) and the fundamentals of care being delivered. Limited homecare capacity and hours of unmet need having a significant impact on flow across the system and links directly to the discharge of patients from acute environments. Sickness, mandatory vaccine requirements; recruitment challenges; and outbreaks has been the focus for the Care Sector Taskforce. Improved visibility of capacity and data has informed tactical actions

[1] QAG does not replace the statutory accountabilities of the Trust, CCGs, or partner organisations.

for the system. ICS Care Sector Strategic Partnership are working closely with Urgent & Emergency Care, Ageing Well Programme, and Community Transformation to work together to mitigate and plan.

- **Local Maternity and Neonatal System:** Due to capacity to transform services in line with the NHS Long Term Plan and National Maternity Transformation Programme; delivery of all the Ockenden recommendations; plus, operational pressures and demands surrounding neonatal bed capacity, maternity and neonatal workforce, and vaccination programme/Covid-19 cases across maternity. Work continues on the system Equity Strategy and planning in addition to the Digital bid for systemwide improvements.

- **Learning Disabilities / Autism (LDA) Partnership** noted system and regional challenges around bed capacity for adult and child placements. System partners are currently on trajectory to meet children inpatient discharge targets however the target for adult inpatient reduction is not anticipated to be achieved. Enhanced executive oversight has commenced and a deep dive on all inpatient discharge plans is underway. Building materials (impacted by Covid-19 and Brexit) has been a significant contributing factor and this has been escalated to NHSEI. Annual Health Checks and implementing Learning from Learning Disability Mortality Reviewers (LeDeR) continues to be closely monitored. Assurance and oversight continue for those inpatients outside of areas. As part of the NHS response to the Norfolk Safeguarding Adults Review (SAR) concerning the deaths of three patients at Cawston Park Hospital, a national priority was set that all children and young people and adults with a learning disability and/or who are autistic, who are currently in an NHS or independent mental health, learning disability or autism inpatient setting (including those on section 17 leave) must undergo a thorough review of their care & support needs by the end of March 2022. The impact of Covid-19 has limited the ability of case managers to conduct face to face meetings which must be done as part of the safe and well check review. ICS Scrutiny and Review Panels have been implemented and learning will inform wider improvements.

## Routine Surveillance

- The QAIG reviewed key issues and risks (KIAR) in relation to other system providers including Sherwood Forest Hospitals, Nottingham CityCare, primary care, and other transformation programmes, whilst there were issues flagged no items that required further escalation.

## System Quality Working Groups

### Patient Safety Specialist Steering Group (PSSSG)

- Building/strengthening relationships through peer support and safe space discussions in readiness to co-create a system plan to deliver the National patient safety strategy objectives/ambitions through the ICS patient safety specialists steering group (PSSSG) and national and regional network meetings.

**Infection Prevention and Control System Assurance Group (IPCSAG)**

- Support and Discharge: A Standard Operating Procedure (SOP) was presented to provide a process to support safe and timely discharge that requires a system approach to decision making in times of excess demand.

- Healthcare Acquired Infections (HCAI): Continued focus on managing Covid-19 and increased patient throughput which may have contributed to the increase in other HCAI cases. HCAI contributes to longer periods of patient hospitalisation and increases risk of co-morbidities and mortality. Assurances being sought through the IPCSAG.

**ICS Safeguarding Assurance Group (SAG)**

- Update from system partners on the development of the plans to support the delivery and development of Safeguarding for the system (Safeguarding Blueprint) and an update from the Liberty Protection Steering System Steering Group.

**Nottingham and Nottinghamshire Covid-19 Vaccination Programme**

- An update was provided on safety oversight and patient experience. The Vaccination programme Team continue to support quality improvements. A pathway has been produced in relation to ‘prolonged arm pain’ with consideration to pastoral and clinical elements. Further work is also underway to address needle stick injuries.

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| **Item Number:** | 13 | **Enclosure Number:** | K |
| **Meeting:** | ICS Partnership Board | | |
| **Date of meeting:** | 3 March 2022 | | |
| **Report Title:** | Highlight Report from the ICS Transition and Risk Committee | | |
| **Sponsor:** | Jon Towler, Chair of ICS Transition and Risk Committee. | | |
| **ICP Lead:** | N/A | | |
| **Clinical Sponsor:** | N/A | | |
| **Report Author:** | Joanna Cooper, Assistant Director, Nottingham and Nottinghamshire ICS | | |
| **Enclosure / Appendices:** | None | | |

**Summary:**


The Health and Care Bill, which intends to put ICSs on a statutory footing and create Integrated Care Boards (ICBs) as new NHS bodies, is currently being considered by Parliament.

To allow sufficient time for the remaining parliamentary stages, a new target date of 1 July 2022 has been agreed for the new statutory arrangements to take effect and Integrated Care Boards (ICBs) to be legally and operationally established. This replaces the previously stated target date of 1 April 2022.

This new target date will provide some extra flexibility in preparing for the new statutory arrangements and in managing the immediate priorities of the pandemic response; however, it is also recognised as important for momentum to be maintained towards the new arrangements. As such, designate ICB leaders have been asked to continue to prepare for the formal establishment of ICBs in line with the guidance previously set out but working to the revised target date.
National plans for ICS implementation are being adjusted to reflect the new target date; this includes a revised ICB establishment timeline. NHSEI will support systems to re-set their implementation plans and to identify any support needed to manage the new timetable.

ICS Transition and Risk Committee continue to meet monthly and last met on 23 February 2022. The Committee **received** and **noted** for information and assurance a number of reports relating to the ICS Transition, namely:

- ICS Boundary Change – the deadline for the boundary change has now been aligned to the establishment of the ICB on 1 July 2022. Plans are being developed to ensure a smooth transition and aligned operation of the CCGs until the ICB becomes established.
- ICS Transition Work-streams reported by exception and there are no red rated risks to highlight at this time. Work-streams have considered the risks and opportunities as a result of the deferred ICB establishment timeline. Good progress on joint commissioning between the NHS and Local Authorities was highlighted as a success.
- Public Involvement and Engagement Strategy which is presented to the Board under item 4 of the agenda.

- Readiness to Operate Statement (ROS): Data, Analytics and IT, and Financial Framework and Arrangements presentations to provide assurance that the programmes and ROS requirements are on track to be achieved within the national timescales.

The Terms of Reference were refreshed at the January meeting to ensure that they remain fit for purpose to support the transition.

## Key Messages for the ICS Board

- Nationally the timeline for ICB establishment has moved from 1 April 2022 to 1 July 2022 and a new detailed timeline with some revised dates has been published by NHSEI. Work has been completed within the transition programme to refresh and rework plans to meet national expectations. Work-streams have considered the risks and opportunities as a result of the deferred ICB establishment timeline.
- The Committee continues to focus on ensuring that the different elements of the ICS and transition are fit for purpose. Over the next period Committee will focus on key elements of the ROS Checklist and evidence requirements.
- Committee support the re-establishment of the ICS Partnership Board during this time. It will be helpful to ensure that there is opportunity to debate strategic priorities and their delivery over the next six months.
- There are no red risks for the ICS Transition programme at this time. This remains a complex programme in relation to the amount of work, emerging timescales in line with policy and legislation, and the number of interdependencies between complex work-streams.
- The following key areas for development are highlighted:
    - The need for ongoing discussion on Integrated Care Partnership membership to ensure a consensus.
    - Clarity on the relationship between ICB and Place Based Partnerships. A deep dive on the Place work-stream is planned for Committee at the March meeting and an item scheduled for the May Partnership Board meeting.

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