

## Mid-Nottinghamshire Integrated Care Partnership Board (ICP) Meeting

(Meeting held in Public)

Thursday 30 January 2020, 13:00 – 15:30

Function Room, South Forest Leisure Complex, Robin Hood Crossroads, Clipstone Road, Edwinstowe,  
NG21 9JA

### Agenda

Time	Reference	Item	Action/Paper	Lead
13:00	ICP/20/001	Welcome and Introductions	Note (Verbal)	Rachel Munton
	ICP/20/002	Apologies for Absence	Note (Verbal)	Rachel Munton
	ICP/20/003	Declarations of Interest	Note (Verbal)	All
	ICP/20/004	Notes and Action Log from the December 2019 Meeting of the Mid-Nottinghamshire ICP Board	Approve (Enc.)	Rachel Munton
13:10	ICP/20/005	Public Observations	Note (Verbal)	Volt Sacco, Managing Director, Fosse Healthcare and Members of the Public
13:20	ICP/20/006	Facilitator Feedback and Integrated Care Partnership Leadership Response	Note (To Follow)	Mike Chitty
13:30	ICP/20/007	Estates Update	Discuss and Endorse (Enc.)	Ben Widdowson
13:50	ICP/20/008	Invitation to Partner in a Musculoskeletal Value Improvement Project	Discuss and Approve (Enc.)	Peter Wozencroft and Rebecca Larder
14:00	ICP/20/009	Our Purpose and Processes – Next Steps	Discuss (To Follow)	Mike Chitty
14:30	ICP/20/010	Population Health Management	Discuss and Agree (Enc.)	Maria Principe, Programme Director PHM and Outcomes, Nottingham and Nottinghamshire Integrated Care System and Dr Mike O'Neil, GP Advisor
15:20	ICP/20/011	Nottingham and Nottinghamshire Integrated Care System (ICS) Update	Note for information (Enc.)	Rebecca Larder
	ICP/20/012	Primary Care Network Update	Note for information (Enc.)	David Ainsworth

Time	Reference	Item	Action/Paper	Lead
15:25	ICP/20/013	Chair Summary	Discuss (Verbal)	Rachel Munton
	ICP/20/014	Any Other Business		
15:30	Meeting Close			
<b>Date and Time of Next Meeting:</b> Thursday 27 February 2020, <b>14:30 – 17:00</b> , Ashfield Locality				

**Minutes of the Mid Nottinghamshire ICP Board meeting held on  
Monday 16 December August 2019, 2.30 – 5.00pm  
Champions Suite, Everyday Champions Centre, Unit 2, Jessop Close, Brunel  
Business Park, Newark, NG24 2AG**

**Present:**

Rachel Munton	Independent Chair
Kerry Beadling-Barron	Director of Communications and Engagement, Mid-Nottinghamshire ICP
David Ainsworth	Locality Director, Mid-Nottinghamshire CCGs
Peter Wozencroft	Director of Care Integration, Mid-Nottinghamshire ICP
Michael Cawley	Operational Director of Finance – Mid-Nottinghamshire CCGs
Tim Guyler	Director of Integration, Nottingham University Hospitals NHS Trust (up to agenda item ICP/19/060)
Rebecca Larder	Programme Director, Nottingham and Nottinghamshire ICS
Richard Mitchell	ICP Lead and Chief Executive, Sherwood Forest Hospital NHS Foundation Trust (from agenda item ICP/19/051)
Jane Hildreth	Partnership and Engagement Officer, Newark and Sherwood CVS
Paul Johnson	Service Director - Strategic Commissioning and Integration, Nottinghamshire County Council
Ben Widdowson	Mid-Nottinghamshire ICP Estates Lead
Sharon Creber	Deputy Director of Business Development and Marketing, Nottinghamshire Healthcare NHS Foundation Trust
Mariam Amos	Strategic Director, Mansfield District Council (up to agenda item ICP/19/060)
Jonathan Gribbin	Director of Public Health, Nottinghamshire County Council

**In Attendance:**

Karen Lynas	Facilitator
Jo Bradley	YMCA (for agenda item ICP/19/060)
Craig Berens	YMCA (for agenda item ICP/19/060)
Jaki Taylor	Nottinghamshire Health Informatics Service (for agenda item ICP/19/056)
Kathy Fulloway	Nottinghamshire Healthcare NHS Foundation Trust (for agenda item ICP/19/056)
Rosie Gilbert	Nottinghamshire County Council (for agenda item ICP/19/056)
Rebecca Tryner	Mid-Nottinghamshire CCGs (Minutes)

**Apologies for absence:**

Hayley Barsby	Chief Executive, Mansfield District Council
Matthew Finch	Director - Communities and Environment, Newark and Sherwood District Council
Theresa Hodgkinson	Director of Place and Communities, Ashfield District Council
Amanda Sullivan	Accountable Officer, Nottinghamshire CCGs

Thilan Bartholomeuz	Clinical Chair, Newark and Sherwood CCG
Steve Morris	Chief Officer, Mansfield CVS
Dr Kevin Corfe	Primary Care Network Representative
Dr Andrew Pountney	Primary Care Network Representative
Paul Robinson	Chief Financial Officer, Sherwood Forest Hospitals NHS Foundation Trust
Greg Cox	General Manager – Nottinghamshire Division, EMAS
Jane Laughton	Chief Executive, Healthwatch Nottingham and Nottinghamshire

### **ICP/19/049 Welcome and Introductions**

The Chair welcomed members to the meeting and thanked the members of the public in attendance for taking time to observe today's meeting. Members of the public were invited to introduce themselves and explain their reason for observing and what areas they were particularly interested in.

The Chair invited a full round of introductions.

### **ICP/19/050 Apologies for Absence**

Apologies for absence were noted as outlined above.

### **ICP/19/051 Declarations of Interest**

No declarations of interest were made. The Chair reminded members to declare conflicts as they arose throughout the meeting.

Mr Mitchell joined the meeting at this point.

### **ICP/19/052 Notes and Action Log from the November 2019 Mid-Nottinghamshire ICP Board Meeting**

The minutes of the Mid-Nottinghamshire ICP Board meeting held on 18 November 2019 were approved as an accurate record of discussion subject to the following addition:

Page 5, Agenda item ICP/19/043 Update/Feedback from Wigan – Kings Fund Evaluation Report, following paragraph three - **ACTION:** Mr Mitchell to liaise with colleagues in Wigan to confirm the critical friend arrangements.

Mr Mitchell confirmed that he had been in contact with colleagues from Wigan and the action could therefore be marked as complete.

Members noted the completed ICP Board actions and further discussion took place around the following:

ICP/19/039 (1) – Mr Wozencroft explained that all organisations had confirmed their principal and alternate ICP Board members with the exception of Nottinghamshire Healthcare NHS Foundation Trust's principal member. However, confirmation of Nottinghamshire Healthcare NHS Foundation Trust's membership was expected by January 2020.

ICP/19/041, ICP/19/044 (1), ICP/19/044 (2) and ICP/19/044 (3) – Members noted that Mr Wozencroft was working with colleagues to develop integrated reports for the Mid-Nottinghamshire ICP Transformation Board, Mid-Nottinghamshire ICP Operational Delivery Group and Mid-Nottinghamshire A&E Delivery Board. The integrated reports would then be submitted to the ICP Board on a quarterly basis, with the next update scheduled for February 2020.

ICP/19/045 – Mr Wozencroft clarified that Nottingham Emergency Medical Services Community Benefit Services Limited (NEMS CBS) and Primary Integrated Medical Services (PICS) had been invited to join the ICP Board. However, their designated members were unable to attend today's meeting due to the short notice period.

Members noted the Mid-Nottinghamshire ICP Board Update – November 2019 for information.

The Chair introduced the updated ICP Board Membership and highlighted the importance of continuity of attendance.

Miss Tryner noted that the afternoon of the fourth Thursday of the month had been identified as the most suitable meeting date for the majority of members, with the exception of January 2020 when the meeting would be held on the afternoon of the fifth Thursday.

#### **ICP/19/053 Chair's Update**

Mr Mitchell reported that Dr Thilan Bartholomeuz had been appointed to the role of Clinical Lead for the Mid-Nottinghamshire ICP and would commence in post early January 2020. Conversations were also being progressed around the Deputy Executive Lead role, with confirmation of the successful candidate expected by 19 December 2019.

The Chair noted that the Board sought to bring together colleagues from different disciplines and backgrounds, such as health care, social care and the voluntary and community sector. Therefore, it was important that the lead individuals represented both health and non-health sectors. One critique of organisations that try to work together collaboratively was that health could often dominate and despite best efforts within Mid-Nottinghamshire, the District Councils had felt isolated in conversations at the Board on previous occasions.

After six months in the role, the Chair felt that a positive start had been made, which was a real credit to all members. The Board had agreed to provide some focus on neighbourhoods, had made positive strides forward in terms of the ICP identity and acknowledged that there was more to do in terms of focussing on a relentless approach that served the local population and the way in which the Board would do this. Holding the meetings in public provided an opportunity to engage with communities. The Chair highlighted the importance of the Board continuing to work in a way that maintained focus on the things that only the Board could deliver.

Mr Mitchell noted an article, written by Sir Jim Mackey, in the latest edition of the Health Service Journal with a headline around the fact that staff care about workload and belonging, which brought home the significance of ensuring that the issues discussed by the Board mean something to both local citizens and the colleagues that we all work with.

**ACTION:** Mr Mitchell to share Sir Jim Mackey's Health Service Journal article with the ICP Board.

Members were informed that Sherwood Forest Hospitals NHS Foundation Trust was due to be inspected by the Care Quality Commission (CQC) in January/February 2020 and he was keen to share with them the things that had changed since the last inspection, particularly the way in which work with partners across the ICP and ICS was beginning to gain traction.

Mr Mitchell informed members that Dr Andy Haynes, Executive Lead for the ICS, was keen to attend a future ICP Board meeting to discuss the way in which he would like the system to be working.

Mr Gribbin suggested that it would be helpful to review in the spring whether District Council colleagues felt the ICP Board agenda was still relevant to their organisations. Members agreed with this suggestion.

**ACTION:** Mr Wozencroft to canvass views in the spring as to whether District Council colleagues felt the ICP Board agenda was still relevant to their organisations.

In response to a query from Mr Guyler, Mr Ainsworth confirmed that the Job Description and Person Specification for the Mid-Nottinghamshire ICP Clinical Lead had been shared with colleagues in the Nottingham City and South Notts ICPs.

The Board discussed membership principles for the ICP, and focused upon whether representation from the independent social care provider sector was a current gap. Comparisons were drawn with the engagement of high street pharmacists, optometrists and dentists. The Board concluded that the membership should remain as is. This did not in any way compromise the ability of the ICP to engage with a range of service providers in transformation projects to improve the health and wellbeing of Mid-Nottinghamshire citizens. In line with previous membership considerations, if and when it became clear that organisations or sector representatives had a strategic contribution to make beyond their commissioned service delivery role, Board representation was a potential consideration.

Ms Beadling-Barron reminded members of the ICP Board's vision to create happier, healthier communities with the goal to reduce the 14.9 year gap in healthy life expectancy (the amount of time people live in good general health) for men and 14.4 year gap for women in Nottinghamshire by three years.

Ms Bradley noted that nominated sector representatives had a duty to illicit the views of those who they represent.

#### **ICP/19/054 Introduction to Development Work**

Ms Lynas explained that she would be working with Mr Mike Chitty to provide organisational development support to the ICP Board through the East Midlands Leadership Academy. Ms Lynas and Mr Chitty were working to a brief around supporting the Board to focus on the things that it was uniquely positioned to do, the actions that were being taken and the impact on the way in which citizens were served as a result of the discussions held by the Board.

Ms Lynas would observe how the meeting operated and then provide interventions at various points throughout the meeting.

Members noted the key themes of the organisational development work, which were:

- What is to gain if we increase the performance of our partnership through collective working?
- What will we lose if we continue to operate as we are?
- How do we use our difference as an asset rather than a distraction?
- Can we operate with a relentless focus on purpose and outcome?

The framework for system and partnership working that partners would be following had been developed based on research by Peter Hawkins. Board members also needed to be clear about their relationships with stakeholders and responsibilities outside of the Board.

Ms Lynas asked members to consider whether the formality and structure of the Board served the ICP requirements in the best way as currently conducted.

Mr Ainsworth stated that the work was a positive move forward and highlighted the importance of the language that system partners used in order to provide clear, consistent messages to citizens and colleagues.

#### **ICP/19/055 Approaches to Engagement next steps – Community Insight Model**

Ms Beadling-Barron reminded members that in July 2019 the Board approve five engagement principles to demonstrate how partners should work together and the culture the Board wanted to achieve. A number of next steps were agreed, including meeting in public and in venues across Mid-Nottinghamshire. In addition to this, a task and finish group was established to agree a best practice model for engagement. The Community Insight Model was the result of the meetings held by the task and finish group over a number of months. The model was a framework that aligned with existing models used by organisations within the ICP. A number of colleagues across the ICP had already confirmed their support for the model, as highlighted on the front sheet.

Members noted that Ms Laughton had asked how the ICP Board would receive assurance that the ICP was engaging with citizens. Mr Beadling-Barron explained that there was potential for the ICP to utilise the engagement model immediately and test whether or not it was suitable. The model would be iterative and this version would be the first step to build upon.

Mrs Hildreth stated that the model underlined the work that CVS' would be doing with social prescribing link workers. Ms Beadling-Barron added that a key part of the model was the joining up of existing engagement pieces rather than creating new initiatives.

Ms Laughton had also queried how well the ICP would be held to account for engagement. Mr Wozencroft noted that the engagement model set out a way of working that could be adopted and embedded by organisations within the ICP from the outset. Checks could be introduced to ensure sufficient engagement and the Board could set out an expectation to see engagement activities outlined within future reports and presentations.

In response to a question from Mr Cawley, Ms Beadling-Barron explained that further work was required to agree ownership of the framework. It would support organisations to make engagement part of core business and evidence it appropriately.

Ms Creber stated that Nottinghamshire Healthcare NHS Foundation Trust was passionate about the collaborative change model and felt the model presented to the Board could be more descriptive about the “how”.

Ms Amos confirmed her support for the model and liked the fact that it wasn't too prescriptive as this enabled it to be adapted for different audiences. She suggested that the model could be used for the Healthy Mansfield campaign.

The Board confirmed their support for the model and agreed that the next step would be for Ms Beadling-Barron to meet with the task and finish group to agree the detail around the “how” and how assurance would be provided to the Board. The model would be tested on a couple of initiatives, such as the Healthy Mansfield campaign, and an update would be provided to the Board in a few months' time. The Chair noted that personal stories and testimonials would be helpful and powerful in future reports around engagement.

**ACTION:** Ms Beadling-Barron to pilot the new model on a small number of programmes and then arrange for an engagement update to be provided to the Board in a few months' time, which included personal stories and/or testimonials with suggestions of how assurance would be provided to the Board.

#### **ICP/19/059 ICS Update**

Ms Larder provided an ICS update highlighting the following key points of note:

- The November 2019 meeting of the ICS Board had one main agenda item; population health management. It was suggested that a population health management presentation be scheduled for the January 2020 meeting of the ICP Board to include the activities undertaken to date in regard to engagement;
- A system-wide session for elected members and non-executive directors was held recently which focussed on the NHS Long Term Plan and the ICS response. Lay members would be encouraged to own these sessions going forward;
- NHS England and Improvement would be undertaking an evaluation of the ICS accelerator sites early in 2020. One element of the evaluation would be a staff survey and the ICS was keen to ensure wide representation of staff. Mr Wozencroft and Ms Laughton had agreed to support the ICS in capturing the views of a wide representation of staff, particularly clinical and front line staff.

Mr Gribbin noted the role of healthcare organisations in making sure that individuals could participate in productive employment which would increase the prosperity of people in Mid-Nottinghamshire.

**ACTION:** Miss Tryner to add Population Health Management presentation to the Forward Programme for January 2020.



Ms Lynas asked members to consider the purpose of verbal updates going forward as it may be more beneficial to receive update reports in advance for noting when a discussion was not required. This would support time management within the meeting.

### **ICP/19/056 Digital Innovation**

Ms Taylor, Ms Fulloway and Ms Gilbert provided the Board with an interactive presentation on digital innovation across the ICP/ICS. The presentation covered:

- The way in which the digital collaborative supported people to use digital services in healthcare settings;
- The benefits realised from the development of the Nottinghamshire Health and Care Portal, which supported decision making through information sharing. Case studies were included to demonstrate the positive impact of the portal;
- The development of the NHS App, which provided a single digital front door to the public;
- The way in which digital innovation supported capacity and flow across the health and social care system.

Ms Taylor explained that colleagues were keen to understand what the ICP wanted to achieve in order to work together to develop digital innovations that would underpin those achievements and improve services for citizens and front line staff.

Discussion took place around digital inclusion and the work that had been taking place across the patch to get members of the public up and running digitally. Surveys had already been undertaken to identify groups that were not using digital services and inform work to focus targeted efforts in these areas.

Mr Gribbin noted that the neighbourhood profiles that had been published by public health, which included some analysis using the tool Mosaic, might support the digital engagement work.

Mr Johnson suggested that the digital interoperability ambition needed to be increased to include district councils, care homes and private social care providers.

Mr Ainsworth highlighted the opportunities to link the digital innovation work with the place based approach being led by District Councils, which had already identified the neighbourhoods with the greatest need.

Ms Taylor thanked members for their comments and agreed to look into the public health neighbourhood profiles and work with District Councils.

The Chair asked for a further digital innovation update in six months' time with a specific lens on neighbourhoods, digital inclusion and interoperability.

### **ICP/19/060 YMCA Health Village as a focus for improved health and wellbeing in Newark and District**

Mr Berens and Ms Bradley provided an overview of the YMCA Health Village, which was being developed to provide a place where children and young people belong, contribute and thrive. Members noted the following key points:

- The history and purpose of the YMCA;
- The YMCA's 40 developmental assets, including empowerment, positive values and commitment to learning;
- Positive youth development, including community priorities and programmes by design;
- The collaboration that had taken place to develop a tapestry of services for the YMCA Newark Health Village. Numerous businesses across Newark and Sherwood were supportive of the partnership and their commitment to the project was outstanding;
- Newark had been selected as there was an absence of facilities/services within the area, it had been identified as an area of need and the model could be replicated across other areas;
- It was anticipated that the health village would attract people to the area and support economic growth;
- The facilities located within the health village would include a climbing centre, community café, nursery and pre-school, swimming pool and skate park;
- The ambition to have dedicated space for health care services within the building.

Mr Ainsworth outlined the opportunity the health village presented to influence population health management, isolation, loneliness and life skills. The development may also present opportunities around estate.

**ACTION:** Mr Widdowson to liaise with Mr Ainsworth, Mr Berens and Ms Bradley regarding the potential estate opportunities presented by the development of the YMCA health village.

Members confirmed their support for the development, which they found positive and ambitious. The Board agreed to be an advocate for the development and asked for further updates as the facility progressed. Mr Ainsworth agreed to be the conduit for health integration and future updates.

### **ICP/19/057 Estates Strategy Development in the ICS and ICP**

This item was deferred to the January 2020 meeting.

### **ICP/19/058 PCN Update**

Mr Ainsworth informed members that the seven social prescribing link workers were already making a strong contribution, having dealt with over 100 referrals in their first month. The challenge would be to ensure that they had the capacity to pay attention to the prevention agenda while dealing with the here and now issues. The main referral themes included mental wellbeing and financial advice.

**ICP/19/061 Observations/how has it gone today**

The Chair noted that due to time constraints it would not be possible to gather the feedback from members of the public on this occasion. However, the January 2020 meeting would open with public observations.

**ACTION:** Miss Tryner to add public observations to the January 2020 agenda.

Mr Mitchell noted the progress made by the ICP over the last few months and thanked everyone for their attendance and contribution. He also thanked the Chair in particular for her contributions to the Board over the last six months.

Ms Lynas fed back to members that she had found it difficult to see from the meeting where the ICP Board had added value. While the Board had received two good presentations, which had been delivered well, the format and set up of the meeting had not provided the right setting to discuss and add value to the presentations. Engagement across partners was positive and the commitment from members to do more and do better was evident. Ms Lynas noted a couple of great interventions from members, but highlighted the need for the Board to strike more of a balance between being supportive and affirmative with challenging each other to do more. It was suggested that future meetings of the Board be set up in a way that created space to have more discussion on key topics.

The meeting closed at 5.10pm.

Key	
Red	Action Overdue
Amber	Update Required
Green	Action Complete
Grey	Action Not Yet Due

## Actions arising from the Mid-Nottinghamshire ICP Board

Agenda ref	Date of meeting	Name	Action	Progress	Status
ICP/19/041	18.11.19	Mr Wozencroft	To arrange for the ICP Transformation Board, ICP Operational Delivery Group and Mid-Nottinghamshire A&E Delivery Board to provide progress reports to the Board on a quarterly basis	The chairs and leads of the three groups will collaborate to produce a single highlight report to the ICP Board in February 2020, when the next quarterly update is due.	
ICP/19/044 (1)	18.11.19	Mr Wozencroft	To arrange for further system performance reports to include additional benchmark data	Benchmark data will be included in the highlight report referenced under ICP/19/041 where it is readily available.	
ICP/19/044 (2)	18.11.19	Mr Robinson and Mr Wozencroft	To include an overview of the financial position in future iterations of the system performance report	This will be included in the highlight report.	
ICP/19/044 (3)	18.11.19	Mr Wozencroft	To ensure that future reports focus less on the activity graphs and place greater emphasis on the actions being taken to resolve issues	Comments will be taken into account when producing the highlight report.	
ICP/19/048	18.11.19	Mr Ainsworth	To liaise with Ms Horobin around potential innovations to secure additional funding for Mid-Nottinghamshire	A meeting is to be arranged in the new year to explore this strand of funding opportunities	
ICP/19/053 (1)	16.12.19	Mr Mitchell	To share Sir Jim Mackey's Health Service Journal article with the ICP Board	Complete	

Agenda ref	Date of meeting	Name	Action	Progress	Status
ICP/19/053 (2)	16.12.19	Mr Wozencroft	To canvass views in the spring as to whether District Council colleagues felt the ICP Board agenda was still relevant to their organisations	This will be scheduled for the April Board cycle	
ICP/19/055	16.12.19	Ms Beadling-Barron	To pilot the new model on a small number of programmes and then arrange for an engagement update to be provided to the Board in a few months' time, which included personal stories and/or testimonials with suggestions of how assurance would be provided to the Board.	The model and toolkit has been circulated to communication and engagement leads across Mid Nottinghamshire for them to use. A meeting set up between Kerry Beadling-Barron and colleagues from Mansfield District Council to discuss how this can be linked to the Healthy Mansfield work. The model will be started to be used on the Undefeatables campaign.	
ICP/19/059	16.12.19	Miss Tryner	To add Population Health Management presentation to the Forward Programme for January 2020	Complete	
ICP/19/060	16.12.19	Mr Widdowson	To liaise with Mr Ainsworth, Mr Berens and Ms Bradley regarding the potential estate opportunities presented by the development of the YMCA health village	YMCA rents have been received by the ICP Estates leads and shared with SFHFT/NHCT Property leads for consideration within the wider Newark locality Estates plan	
ICP/19/061	16.12.19	Miss Tryner	To add public observations to the January 2020 agenda	Complete	

## **Mid-Nottinghamshire ICP Board Update – December 2019**

Below is a summary of the key items discussed. The full papers (and details of forthcoming meetings) can be found here: <http://bit.ly/ICPBoard>

### **Mid-Nottinghamshire Community Involvement Model**

In July 2019 the Board approved five key engagement principles with a number of next steps. One of these was to set up a task and finish group to agree a best practice model for engagement. This group was made up of representatives from NHS organisations, CVS', Healthwatch and Ashfield District and following several meetings proposed the Community Insight Model (see summary in Appendix 1) as a framework that aligns with existing models.

The Board agreed to endorse the model and discussed possible next steps. It was suggested that some areas for its use could be identified through the Mansfield Health Partnership which has held its first strategic group, chaired by PCN Deputy Clinical Director Dr James Mills.

It was agreed the model would be used on a small number of projects and feedback into later ICP Board meetings to see how it was working.

### **Digital Innovation**

Jaki Taylor from Nottinghamshire Health Informatics Service, Kathy Fulloway from Nottinghamshire Healthcare NHS Foundation Trust and Rosie Gilbert from Nottinghamshire County Council, all gave an interactive presentation on the importance of the digital transformation work being undertaken across the county. The issue of digital inclusion was discussed and it was agreed the Board would continue to support this work and receive updates in the future.

### **YMCA Health Village**

The Board received a presentation from Craig Berens, Chief Operating Officer of YMCA Newark and Sherwood and Jo Bradley-Fortune, Development Lead of YMCA Newark and Sherwood introduced by locality director David Ainsworth. The Board discussed the importance of using the YMCA village for community cohesion across the generations. The ground-breaking on the building is due to take place in June 2020 with it opening in May 2021. It agreed for partners to continue working with the YMCA to advise on the use of the health space.

The Board was also updated on the work of the new team of social prescribing link workers (see Appendix 2).

Next month's meeting will take place on January 30 at 1pm. Papers will be available a week in advance on the ICP website.

## Appendix 1



# OUR LINK WORKERS

**Saw over 100 referrals in their first month.**

The top five reasons were for:

- mental health/wellbeing
- social isolation/loneliness
- lifestyle change
- self care / management of a long term condition
- financial advice

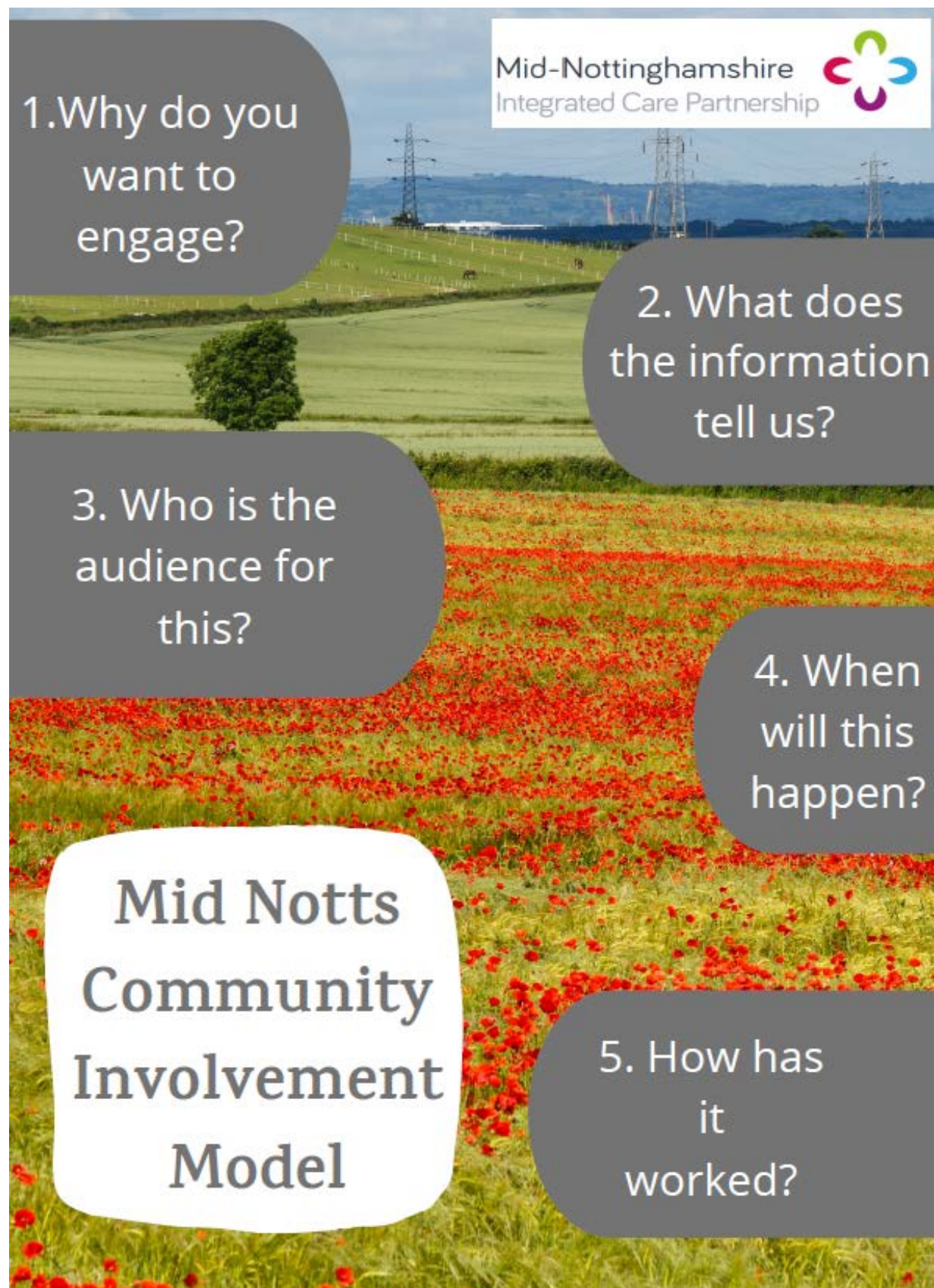


Mid-Nottinghamshire  
Integrated Care Partnership





## Appendix 2 – Mid-Nottinghamshire Community Involvement Model





## Community Insight Model: Why, What, Who, When, How

### 1. Why: Why do you want to engage?

There are many different reasons you may want to, from keeping people informed about general updates to having citizens co-produce a potential options.

### 2. What: What does the information tell us?

- a. Use data to understand a theme and the people it affects  
e.g. census, active life, JNSA, mosaic, Long Term Plan information etc. Make sure you come to data neutrally and do not use it to reaffirm your own biases.
- b. Understand what organisations and agencies are around that have an interest e.g. council, voluntary sector, county council, public health etc to build a team and that you can work in partnership with.
- c. Find local organisations and individuals e.g. churches, men in sheds and asset mapping of people, places, cycle paths.  
Who are the community ambassadors you can identify?

### 3. Who: Who is the target audience for this?

Gain the trust of the organisations that work with them to see how is best to involve them. Check with community if the asset map makes sense to them, what do they use (and how do they use it).

Understand and plan that some groups may need more resource and time to engage with e.g. those with English as a second language. Engage either directly or through the above groups in the best way for them e.g. focus groups, surveys, 121s.

### 4. When: When will this happen?

Empower groups and individuals to come up with actions based on the results of the above and to make the changes they need.

Evidence that people have the capability to make it better for themselves.

### 5. How: How has it worked?

Check the impact by evaluating how it has worked and what changes have been seen. This may be done throughout the process rather than just at the end.

Plan to share learning (positive and negative) with partners.





## Mid-Nottinghamshire ICP Board

<b>TITLE:</b>	Estates Update – January 2020
---------------	-------------------------------

<b>DATE OF MEETING:</b>	30 <sup>th</sup> January 2020	<b>PAPER REF:</b>	ICP/20/007
-------------------------	-------------------------------	-------------------	------------

<b>AUTHOR:</b>	Ben Widdowson ICP Estates lead	<b>PRESENTER:</b>	Ben Widdowson ICP Estates lead
----------------	-----------------------------------	-------------------	-----------------------------------

<b>EXECUTIVE SUMMARY (OVERVIEW):</b>
<p>The ICP recognise the Estates workstream as a key enabler in achieving the aims of the ICP.</p> <p>The attached presentation gives the ICP Board an update on the work of the forming ICP Estates Planning Group and poses questions to the ICP Board on how the Board can support the work of the Group.</p> <p>Next steps of the Group include wider engagement with Mansfield and Ashfield District Councils and strategic property ownership to flexibly meet the needs of the system and increase asset utilisation.</p>

<b>RECOMMENDATION:</b>
<input checked="" type="checkbox"/> To endorse



# Estates update January 2020

Ben Widdowson  
Estates & Facilities lead

Creating happier, healthier communities together



# Aims

1. ICS estates strategy
2. ICP estates group
3. Newark locality opportunities
4. Support required from ICP board



# ICS Estates Strategy

<b>Immediate term 1-2 years</b>	<b>Longer term 2-5 years</b>
<ul style="list-style-type: none"><li>• Maximise utilisation of fixed point assets leading to rationalisation of freehold and leasehold sites across ICS partners to align services to achieve revenue savings</li><li>• Clear prioritisation of capital plans to support transformational bidding processes</li></ul>	<ul style="list-style-type: none"><li>• Fit for purpose estate to meet the requirements of the 5-year strategic plan and clinical service strategy</li><li>• Likely requirement to invest in primary and community estate to enable new service models</li></ul>



# ICP Estates Group

- Inaugural meeting October 2019 – Newark focus
- Comprises
  - Local authorities
  - NHFT
  - SFHFT
  - CCG
- Chaired ICP Estates lead
- Other localities and neighbourhoods to follow in 2020



## Newark locality – early opportunities

Opportunity	Property Owner	Utilise/ Rationalise	Timescales	
Land adjacent to Newark Hospital	Private	Purchase and utilise	2020	N&SDC progressing bid for land adjacent to Newark Hospital (c. £850k). An element of the land will be transformed into a car park to support additional clinical services at the hospital.
Beaumont House	Charitable Trust	Rationalise	2021	Exploratory discussions between partners in the Mid-Notts End of Life Care Together service about better utilisation of the estate in Newark
65 Northgate	N&S District Council	Rationalise	2020	Poor condition estate – N&S DC keen to re-develop but will require a solution for Nottinghamshire Healthcare Trust (NHT) services currently sited here. Proposal to move to Byron House on the Newark Hospital site.
Balderton PCC	NHS PS – LIFT	Utilise	2020	High quality clinical building – top floor currently vacant space. Potential opportunity for NHT in relation to re-locating 65 Northgate services
Fountain Medical Centre	GP leased	Rationalise current estate	2023	New build option – potential to utilise land adjacent to Newark Hospital. Will incur additional cost to the CCG.
Newark Hospital	SFH – PFI	Utilise	2020	Potential to move Integrated Sexual Health and podiatry services to community setting – e.g. Balderton PCC
Byron House	NHT	Utilise	2020	Move MSK Together service from Byron House into the YMCA development to enable move of services from 65 Northgate to Byron House.



# ICP Board support

- What value can the ICP board add?
- Locality asset mapping exercise
- How can this work link into community engagement model?





Any questions?

[Ben.widdowson@nhs.net](mailto:Ben.widdowson@nhs.net)

## Mid-Nottinghamshire ICP Board

<b>TITLE:</b>	Invitation to Partner in a Musculoskeletal Value Improvement Project
---------------	--

<b>DATE OF MEETING:</b>	30 <sup>th</sup> January 2020	<b>PAPER REF:</b>	ICP/20/008
-------------------------	-------------------------------	-------------------	------------

<b>AUTHOR:</b>	Rebecca Larder and Peter Wozencroft	<b>PRESENTER:</b>	Peter Wozencroft
----------------	-------------------------------------	-------------------	------------------

<b>EXECUTIVE SUMMARY (OVERVIEW):</b>
<p>The paper and associated information pack give the background to an invitation for the Nottingham and Nottinghamshire ICS and the Mid-Nottinghamshire ICP to participate in a twelve month value improvement programme in partnership with the Oxford Centre for Triple Value Healthcare and Pfizer.</p> <p>Officers of the ICS and ICP, including the Head of Service for Mid-Nottinghamshire MSK Together, have been involved in the exploratory discussions and are keen to participate in this programme on the basis that our well-established service has the resources and capacity to meet its obligations and that participation will enable it to further improve the musculoskeletal health and wellbeing of local citizens. The ICP partners primarily involved in MSK Together are Nottinghamshire Healthcare NHS FT, Sherwood Forest Hospitals NHS FT, Nottingham University Hospitals NHS Trust and the Mid-Nottinghamshire CCGs, but it is important that all ICP partners have visibility of the programme and the opportunity to explore prospective benefits and risks.</p>

<b>RECOMMENDATION:</b>
<p>X To approve in principle and delegate to Transformation Board the finalisation of arrangements for participation, and reporting of outcomes at the conclusion of the programme.</p>

## **Mid-Nottinghamshire Integrated Care Partnership Invitation to Partner in a Musculoskeletal Value Improvement Project**

### **Introduction**

1. This paper and attached proposal outline the opportunity for the ICP to partner with the Oxford Centre for Triple Value Healthcare and Pfizer on an innovative 12-month MSK value improvement project.
2. The ICP is asked to consider and determine whether it wishes to pursue this opportunity.

### **Background**

3. The Nottingham and Nottinghamshire Integrated Care System (ICS) has been approached by the Oxford Centre for Triple Value Healthcare (3V) and the pharmaceutical company Pfizer with an invitation to partner with them on an innovative 12-month MSK (including Rheumatoid Arthritis) value improvement project.
4. 3V is a social enterprise which focuses on supporting healthcare organisations to improve value (outcomes, quality and cost of care). 3V is led by Professor Sir Muir Gray founder of the NHS Atlas of Variation and the NHS Right Care programme.
5. The ICS already has a relationship with 3V through its support to our Population Health Management programme. 3V has also delivered a number of well received clinical engagement events aimed at raising clinical awareness of, and engagement in, value improvement.
6. The partnership between 3V and Pfizer is understood to centre on Pfizer providing financial sponsorship to 3V to resource their leadership and expertise into the proposed improvement project. Pfizer has an interest in value based decision making in the NHS and therefore the work of 3V. Recognising Pfizer's interest – i.e. they have pharmaceutical products in this area – they would not be actively involved in any local value improvement project (refer to governance section below).

### **Exploratory Meeting**

7. An initial exploratory meeting has been held with 3V and Pfizer, which included representation from each ICP. Nottingham and Nottinghamshire meeting participants confirmed that:
  - The value improvement proposal aligns well with the system's strategic goals;
  - Musculoskeletal disease (including Rheumatoid Arthritis) is a significant contributor to the 'global burden of disease;' it is also a significant area of NHS and wider societal spend. Whilst there has been an improvement focus on MSK over recent years, more work is needed.
  - There could be real advantage in working with 3V on the development of value improvement frameworks and capability. There is also the expectation of wider local benefit, in time, related to other conditions that adversely impact upon the health and wellbeing of citizens.

8. From the outset, it was agreed that it would be for the ICPs to determine whether they wished to pursue this opportunity. 3V and Pfizer have reconfirmed their preference to work with the Nottingham and Nottinghamshire ICS and have advised that they would be willing to proceed on the basis of at least one ICP wishing to participate with them.

### **3V Proposal for ICP Consideration**

9. The 3V proposal attached provides detail on:
  - i. What the improvement project seeks to achieve;
  - ii. Pfizer's sponsorship (also refer to governance section below);
  - iii. A summary of the eight proposed steps of the improvement project;
  - iv. Detailed information on the activities, inputs and outputs of each step;
  - v. The role of 3V and expectation of Nottingham and Nottinghamshire (i.e. any participating ICP) for each step;
  - vi. A summary of the commitment needed from any ICP wishing to pursue this project;
  - vii. An outline project plan and timeline. NB: this centres on a 1<sup>st</sup> January 2020 start date however 3V has been advised that this would not be feasible and would need to be changed to 1<sup>st</sup> April 2020;
  - viii. Information governance and data management. NB: one of the main outputs of the project is planned to be an Atlas of Value for MSK. 3V has engaged the North-East Commissioning Support Unit (NE CSU) to complete this work with the requirement that, should an ICP progress, data will need to be provided to support this work.
10. The 3V document is presented in the form of an agreement between Nottingham and Nottinghamshire and their organisation.
11. In agreeing to participate in the project, it will be important for any ICP to confirm that:
  - All of their organisations are willing and have the capacity to engage, especially relevant clinicians/professionals;
  - All of their organisations are willing to provide access to the data requirements;
  - The ICP has the necessary resources e.g. project management, finances to support the proposed engagement events etc;
  - The ICP is well placed to bring about the expected benefits from participation.

### **Governance**

12. Should any ICP wish to proceed, 3V and Pfizer have been advised that robust governance for such a project will be essential.
13. To support local consideration, the ICS team has requested:
  - a. A draft agreement between 3V and Nottingham / Nottinghamshire for comment and potential shaping. This is as shared;
  - b. A draft agreement between Pfizer and Nottingham / Nottinghamshire for consideration and potential shaping. This document is awaited.
  - c. The agreement between 3V and Pfizer for information. This is also awaited.

14. If any Nottingham and Nottinghamshire ICP does proceed there will also be a need for data sharing agreements with the NE CSU.
15. A number of governance issues have been identified including data ownership, publication rights and the requirement for the local system to be able to make public this work in any future procurement of MSK and/or Rheumatoid Arthritis services. It will be important to gain expert governance and procurement support prior to any agreements being signed.

### **Benefits to Mid-Nottinghamshire ICP**

16. The proposal set out by 3V and Pfizer is attractive and has the potential to identify further value improvement opportunities and help us to reduce the burden of Musculoskeletal disorders on the Mid-Nottinghamshire population served by the ICP.
17. Implementation of the MSK Together Service in Mid-Nottinghamshire aimed to reduce healthcare variability, the use of low value interventions and establish a streamlined pathway placing self-management strategies and shared decision making at the heart of clinical interactions. It has realised significant successes and encountered some difficulties. The MSK Together service would benefit from the opportunity to work with the expertise at 3V to maintain momentum and further develop for the benefit of citizens in Mid-Notts.
18. By creating an Atlas of Value for the Mid-Nottinghamshire ICP, any overuse, underuse, inequity, waste or required financial investment within the existing pathway can be identified to provide an evidence base to highlight further opportunities for improvement.
19. Partnership in the 3V value improvement project would systematically involve engagement with patients and patient groups to develop population and personalised health and social care in the shaping of MSK services; something that has yet to be achieved.

### **Recommendation**

20. The Mid-Nottinghamshire ICP is asked to:
  - a. Support the partnership with 3V and Pfizer in a 12 month MSK value improvement programme subject to appropriate governance arrangements.
  - b. Delegate to the Transformation Board the responsibility for ensuring that outstanding governance requirements are fulfilled and that the practical engagement in the project is properly managed.

# Collaborating to increase the value for people with MSK (including RA)

Discussion document outlining how 3V and Nottingham and  
Nottinghamshire ICS will work together

November 2019

# About the programme and this document

## What this programme seeks to achieve

This 12 month project aims to build the capacity and capability within an Nottingham and Nottinghamshire Integrated Care System CS (N&N ICS) to be able to deliver continuous value improvement, using the population of people with a Musculoskeletal problem (MSK), including Rheumatoid Arthritis (RA), need as the exemplar population subgroup. It also aims to test and create the conditions in which resources can be moved from lower value interventions to higher value. This is in line with the goal of an ICS *“to collectively manage resources to deliver NHS standards and improve population health”* (NHS England).<sup>1</sup>

In any ICS, people with an MSK (including RA) problem represents one of the largest population subgroups; in some ICS/ STPs they are spending £153 million per million population<sup>2</sup>; low value care represents over 10% of that spend.<sup>3</sup>

By the end of the project, N&N ICS will have:

- an Atlas of Value that describes, in a compelling way, the value opportunities for people with MSK (including RA) within a given budget;
- a team that is able to address issues of overspend and underspend (including inequity);
- have an approach through which disinvestment and reinvestment to improve value is the norm; and
- created a new culture of stewardship (see final page for an overview). Importantly, learning and the creation of a toolkit is core to this project, so the approach can be used across other population subgroups or in other geographies.

## This document outlines the roles of 3V and N&N ICS

Over the following pages the eight stages of the project are outlined, the activities, outputs and the respective role of 3V (and their analytical partner, NE CSU) and the ICS

A summary of N&N ICS commitment is also shown

An outline timeline is included, although this is subject to discussion with N&N ICS after project commencement

1. NHS England. Integrated care systems. <https://www.england.nhs.uk/integratedcare/integrated-care-systems/>  
2. NHS Rightcare Intelligence- <http://tools.england.nhs.uk/cfv2016/flash/atlas.html>  
3. OECD (2017), *Tackling Wasteful Spending on Health*, OECD Publishing, Paris

# Pfizer's sponsorship of this programme

## The nature of Pfizer's involvement

Pfizer is funding 3V's support to N&N ICS for this programme. Pfizer's aim is to understand how an ICS might approach the process of value-based decision-making. Pfizer, however, is clear it cannot be part of, or influence, any decision-making process. It is important that Pfizer does not receive and is not aware of any data prior to analysis, including patient identifiable or commercial data. Pfizer only wishes to see outputs of analysis.

Moreover, the programme has not been designed to increase the prescribing of Pfizer's products. These principles will be reflected in an agreement between Pfizer and the NHS site.

Finally, Pfizer is committed to the success of this programme and wants to ensure that the learning and programme outputs can be disseminated as widely as possible. Pfizer is comfortable for Nottingham and Nottinghamshire ICS to do likewise in terms of outputs.

The relationship between Pfizer and N&N ICS is subject to a separate agreement.



# Delivering population and personalised health and social care for people with MSK (including RA) problems through Triple Value- Summary of the 12 month programme

Activate  
~3 months

- 1. Establish senior leadership commitment to the new paradigm of population and personalised health and social care
- 2. Activate a group of clinicians, managers, patients and patient groups to establish a transformation team - the Community of Value for MSK (including RA) problems
- 3. Gain agreement on the major triple value priorities are through the creation of an Atlas of Value for MSK (including RA) problems

Mobilise  
~6 months

- 4. Design and build the Community of Value, including objectives, service specification, governance/ terms of reference and delegated authority for people in the population with MSK (including RA) problems
- 5. Agree and design 3V Improvement Projects for MSK (including RA) to reduce overuse, underuse, inequity and waste
- 6. Deliver 3V Improvement MSK (including RA) projects, continued learning and senior leadership oversight

Operationalise  
~2-3 months

- 7. Shape contractual and commissioning plans to support Triple Value health and social care
- 8. Develop a case study to promote spread and influence policy makers

# Detailed activities, outputs and inputs

## 1. Activate senior leadership to establish commitment to the new paradigm of population and personalised health and social care

### Activities

Orientation for leaders and senior staff in the health system (a mix of leaders, including CXOs, senior clinicians and senior finance team from commissioners and providers) on how triple-value health and social care might be incorporated into the health system. This will provide an opportunity to think about the changes necessary for the future. We would also encourage the involvement of (some) lay representatives/ NEDs.

Orientation will comprise insight into:

- The future of health and social care and the need for a new paradigm
- Unwarranted variation, underuse and overuse
- Triple-Value health and social care
- 3D-health and social care
- The need for a new culture of stewardship in N&N ICS
- Actions required to move to the new system
- Commitment to move to Triple Value

### Outputs

A shared understanding of, and summary of what Triple Value-based system for population and personalised MSK (including RA) problems care would look like. Overview of the actions needed and what needs to be done differently to deliver such a system.

Agreement on using MSK (including RA) problems as the “learning” programme

### Role of 3V

3V will design and deliver:

- A 1-day training and skills development session for up to 20 senior leaders in the chosen health system
- Produce the first draft of summary of the outputs of the day, outlining the actions that are required to move to a population and personalised health and social care system and agreeing work on MSK (including RA) problems

### Role of N&N ICS

Identify system leaders, senior staff, representatives from finance, planning and contracting, and lay representatives to attend training and skills development sessions

Review and agree the objectives for the session

Provide key data and information to support the delivery of skills development

Provide administrative support and pay for for meetings/events (sending invitations, room/venue hire, catering, printing materials, use of local webinar system)

Provide feedback on the summary report- sign off final version (by commissioner and provider leaders)

## 2. Activate a group of clinicians, managers, patients and the public to establish a transformation team for MSK (including RA) problems- the Community of Value

### Activities

At the heart of delivering Triple Value is the need to create a culture of stewardship, especially in amongst care professionals and patients.

A community needs to be formed to take responsibility, and be held accountable, for the investment of resources in their system of care for the people with MSK (including RA) problems

To do this, a Community of Value (CoV) will be established to drive Population and Personalised care for MSK (including RA) problems by:

- Gaining agreement about the issues facing health and social care, the need for Triple Value and the new culture required
- Outlining the design of an Atlas of Value for MSK (including RA) problems
- Gaining agreement on the key values and behaviours of the group
- Agreeing the broad remit of the group

### Outputs

Activated CoV for MSK (including RA) problems

Agreement on and documented values and behaviours of the CoV

Draft outline of the role and responsibility of the CoV

Agreement on the outline of the Atlas of Value

### Role of 3V

Design and deliver a one day workshop for a group of clinical leaders to understand and agree:

- This issues facing health and social care and the need for triple value based Population and Personalised Healthcare, using MSK (including RA) problems as an exemplar
- The need for stewardship
- Agreement on values and behaviours

Produce a summary document outlining the session and agreed actions and next steps.

### Role of N&N ICS

To provide introductions to key stakeholders – clinicians, members of the general public, patients' and carers' representatives

To provide administrative support and pay for meetings/events (sending invitations, room/venue hire, catering, printing materials)

To review and sign-off key documents

### 3. Gain agreement on what the major triple value priorities are through the creation of an Atlas of Value for MSK (including RA) problems

#### Activities

The production of an Atlas of Value (AoV) for MSK (including RA) problems, combining a range of existing data sources into one impactful document.

The AoV becomes a 'single version of the truth' of MSK (including RA) problems (that is all key stakeholders agree with the contents and conclusions), and describes the opportunities to incorporate Triple-Value health and social care by highlighting:

- unwarranted variation in structure, process and outcomes for the system, demonstrating underuse, overuse and inequity
- financial investments being made
- the narrative links between unwarranted variation and current resource investment to show what is happening and why it is happening in the system, the outcomes achieved, and the opportunities for improving Triple Value

#### Outputs

- An AoV for the population with MSK (including RA) problems
- Agreement on the challenges for MSK (including RA) problems, in all settings and services in N&N ICS, the opportunities for triple value improvement and key actions

#### Role of 3V

Provide specialist advice to N&N ICS and NE CSU on the design of the Atlas of Value (AoV)

Conduct up to 6 interviews with key informants across the health system to understand their perspectives on the system

Facilitate two 2 hour workshops to identify and agree on the content of the AoV, including the key issues

Facilitate a half day launch session for the AoV to share the conclusions with stakeholders and agree key actions

#### Role of NE CSU

Working with 3V, to provide, prepare and analyse the clinical, financial and other data needed to produce the AoV

To provide analytical support to conduct the data extraction and mapping work, to have the necessary software licences and to design the layout

#### Role of N&N ICS

To provide any data required in a timely fashion feedback on the AoV, participate in interviews and workshops

To provide administrative support and pay for AoV publication and meetings/events

## 4. Design and Build the Community of Value for MSK (including RA) problems with a culture of stewardship

### Activities

Now that we have activated the Community of Value for MSK (including RA) problems, they need to act. During this step, the CoV will be co-designed, checking in regularly with local provider and commissioner leaders to:

- Agree a specification for people with MSK (including RA) problems, including outcomes that matter to people with MSK (including RA) problems as well as the aim, objectives, criteria and standards for the service
- Establishing the terms of reference for the Community of Value, in particular the roles and responsibility for the CoV (including governance, delegation of authority, and accountability)
- If not identified in the AoV, understand the resources for the rheumatoid arthritis
- Agreeing the final composition of the Community of Value, including public, patient and carer involvement and institutional finance and planning teams (both commissioner and provider) in the CoV
- Agreed support (e.g. project management, analytical, finance) for CoV
- Agree sign off process of investment and improvement plans with institutional (provider and commissioner) leadership

### Outputs

The system specification, role responsibilities and accountability for the CoV is agreed and formally signed off

The processes and level of support to the CoV are agreed and signed off.

The relationship(s) of the CoV with commissioner and provider finance and planning teams is agreed

### Role of 3V

Facilitate one workshops and two follow up conference calls to agree and iterate draft document (prepared by 3V) to determine the CoV: system for MSK (including RA) problems specification, terms of reference including governance, delegation of authority and accountability

Work with provider and commissioner leadership to validate and gain official approval for the document, associated processes and level of support

### Role of N&N ICS

To provide administrative support and pay for for meetings/events (sending invitations, room/venue hire, catering, printing materials)

To review and sign-off key documents, and to commit to moving towards Triple Value Healthcare

To provide CoV members with time – clinicians, members of the general public, patients' and carers' representatives - to be able to contribute to the design and review of documents

## 5. Agree and design 3V Improvement Programme for people with MSK (including RA) problems

### Activities

The CoV must start to work on improving Triple Value, especially addressing population and personal value through agreeing measures to address overuse, underuse, inequity and eliminate waste

- Over one month, the CoV will design a Triple Value improvement Programme (3VIP), based on the Atlas of Value
- The 3VIP will include a plan that includes activities they will establish immediately, activities that will take longer, and activities that involve changes in fixed, or semi fixed, clear milestones and criteria for success, and elements of the health system that require changes to current commissioning and regulatory structures- the intention being to identify what can be done by the CoV
- Whilst value improvement, especially in health, is a process of continual improvement (i.e. it never ends), 3VIP will have a timeline of ~6 months to complete its main, short term activities.

### Outputs

A 3VIP plan, clearly describing how the CoV will reduce overuse, underuse, inequity and waste in the care for people with MSK (including RA) problems. Including clear milestones and an understanding of how they will need to work with commissioning and finance teams. It will be designed by the CoV and be signed off by senior leaders

### Role of 3V

Provide a template and guidance on Triple Value projects for the CoV to start to develop their 3VIP

Through weekly teleconference and two x 2 hour meetings, provide coaching and support on issues relating to how the 3VIP might be achieved

Review the draft document and provide feedback

### Role of N&N ICS

The CoV will have ultimate responsibility for designing 3VIP

There should be adequate support for the CoV to do this; including analytical, financial and administrative support

Provide leadership sign off to the 3VIP plan

To provide administrative support and pay for meetings/events (sending invitations, room/venue hire, catering, printing materials)

## 6. Deliver 3V Improvement projects, continued learning and senior leadership oversight

### Activities

#### The CoV

- starts to improve Triple Value in their system, working on activities to reduce underuse, overuse, inequity and waste
- Is learning together, and understanding how to become a network working across the system
- Making investment decisions to use resources most wisely in their system

More information is being collected to inform system leaders on the commissioning and regulatory changes required

### Outputs

Work on 3V Improvement projects to make a material impact on overuse, underuse, inequity and waste

Establish areas where improving Triple Value will have implications on fixed or semi fixed elements of health and social care provision, and the actions required to change these elements.

Establish where changes are required to commissioning and regulatory rules

Working and learning together as a CoV, building trust and a new culture

### Role of 3V

Over a six month period, run bi-monthly half day workshops, bi-weekly conference calls and provide email support to the CoV to:

- Review progress against plan,
- Create the environment to share ideas,
- Provide coaching and critical review,
- Train in new concepts and ideas to support 3V- including Sociotechnical allocation of resources supported by NE CSU evidence base and pathway models

Identify specific areas where commissioning and provider leaders will need to intervene to support the project

Help shape outputs where commissioning or regulatory changes are required

Facilitate final celebration workshop with system leaders

### Role of N&N ICS

There should be adequate support (time, analytical, programme management) for the CoV to run 3V Improvement Projects- in addition to current commitments to MSK (including RA), bi-weekly calls and monthly workshops

Provide timely support where permission is required or simple barriers are found

To provide administrative support, including reporting of 3VIP, and pay for any required meetings/events (sending invitations, room/venue hire, catering, printing materials)



## 7. Turn outputs of 3V Improvement Projects into contractual and commissioning plans

### Activities

The use of contracting and payment mechanisms is an important means by which barriers to Triple Value can be removed.

Although evidence suggests contracting and payment mechanisms are less important than culture change, they do create perverse incentives, and can send the wrong message about what the goal is (Triple Value health and social care).

Therefore, new contracting and payment mechanisms need to be designed to remove any barriers towards the opportunities outlined in the Atlas of Value, or emerging from the 3VIP

### Outputs

Summary report of nature and feasibility of changes to contracting and payment mechanisms and/or introduction of new ones

Outline of contracting and payment mechanisms that deliver Triple Value to N&N ICS

### Role of 3V

Ascertain existing mechanisms and cycle for contract renewal, together with feasibility for change in the short, medium and long term

Working with the CoV, and finance, planning and commissioning teams, we will provide a report on different commissioning considerations including:

- using outcomes within contracts and payment mechanisms
- supporting Triple Value through contractual forms and payment mechanisms
- reviewing and commenting on draft contracts and payment mechanisms

### Role of N&N ICS

To provide necessary documents in a timely manner

Provide feedback on early drafts

To arrange meetings and telephone calls in a timely manner

## 8. Develop a case study and supporting materials to promote spread and influence policy makers

### Activities

It is important that you have materials to spread the story of how the Triple Value approach supported a local community and refocussed how resources were invested in the treatment of people with MSK (including RA) problems

A case study, with supporting materials, will allow you to describe what you have done to internal and external audiences, including policy makers

### Outputs

A case study of the work done with supporting material.

### Role of 3V

To bring together the material for and develop a draft case study

To refine and supply a final case study. The case study will comprise an executive summary, a description of what was done, and outcomes of the project. It will include any outcome or financial impacts (or projected impacts) readily available as part of the 3VIP.

We will also facilitate a meeting to discuss the case study (e.g. roundtable), provide supporting materials (e.g. pre written blogs/podcasts) and attend up to two meetings with senior policy makers to discuss the case study and what was done

### Role of N&N ICS

Review the materials produced and provide feedback

# Summary of Nottingham and Nottinghamshire ICS commitment

# Summary of N&N ICS commitment

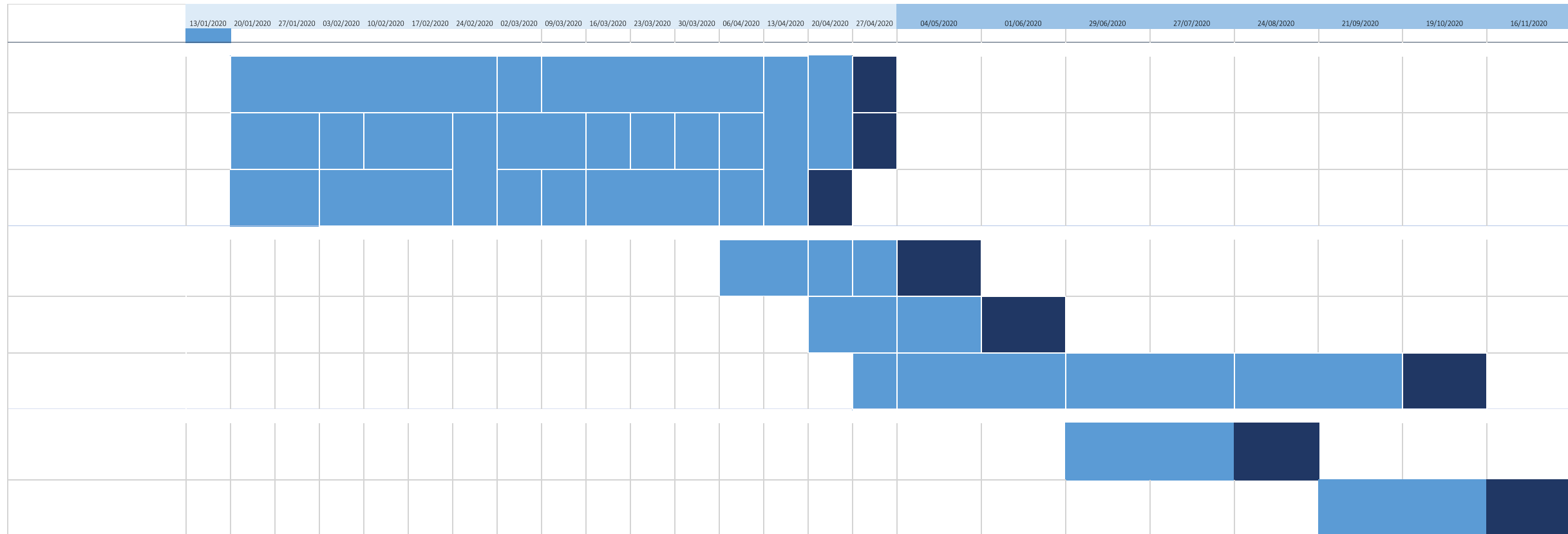
The MSK (including RA)/RA triple-value improvement programme is about fulfilling the NHS England goal for an ICS of taking “collective responsibility for managing resources”. To be successful, the programme requires active involvement of N&N ICS and partnership organisations. Therefore, the following level of commitment is required:

- N&N ICS have a support team for this project, able to join weekly 30 minute calls and provide advice and logistical support
- Senior leaders in N&N ICS and partnership organisations (e.g. Trusts, GP practices, social care) are ready to explore this population approach. It may mean this project is a standing agenda item on N&N ICS meetings;
- There finance leadership support for this programme of work;
- There a team of clinicians, managers and finance staff able to focus on this programme. [In addition to present MSK (including RA) commitments, 3V would organise bi-weekly catch-up calls with clinical and population management leads and monthly half-day meetings with the broader team during mobilise phase]
- Senior leaders in N&N ICS and partnership organisations willing to support the MSK (including RA)/RA transformation team and ICP communities of value, by ensuring they have the necessary time and resources to undertake the work, make timely decisions in support of the programme, and communicate to their organisation.
- N&N ICS and partnership organisations willing to provide data in a timely fashion and facilitate access to linked data sets as applicable.
- There is additional analytical support available if needed [NB: support from 3V will be provided for the Atlas of Value and STAR]

# This is an outline of the 12-month programme; 3V would seek to develop a detailed programme plan with N&N ICS

This is based on project initiation mid January, and light engagement with clinicians and leadership teams through January and February. During a step labelled prepare, this is generally work completed by 3V.

Through the programme, 3V would want to have weekly, 30 minute, calls with the N&N ICS team supporting this work



# Information governance

# Information Governance and data management

The purposes of this project is to improve the value care of people with musculoskeletal problems. This will necessitate the analysis of data to better understand where resources are being used in the health and social care system, and where need is greatest. It is hoped that this project will therefore benefit from the data linkage that has already been done by N&N ICS.

No data will be seen or handled directly by 3V, instead all data handling will be managed by 3V's subcontractor NE CSU, an NHS organisation. 3V will only see outputs of analysis. It is particularly important that 3V do not see patient identifiable or commercially sensitive data.

Proper IG protocols need to be put into place between N&N ICS (and its partnership organisations) and NECSU. This table outlines core areas of consideration:

Subject matter of the processing	Patient level data for patients receiving services related to Musculo- Skeletal conditions in an ICS (to be specified)
Duration of the processing	One year from commencement of the project (estimated start in January 2020)
Nature and purpose of the processing	Mainly using pseudonymised data from sources such as HES Possibility of receipt of patient level identifiable data into DSCRO with pseudonymisation and linkage of data subject to information governance controls within NECS and organisations within the ICS. Pseudonymised data would be transferred to NECS for analysis.
Type of Personal Data	Record level data for patient receiving Musculo-Skeletal services: NHS number Date of birth (to be pseudonymised within DSCRO if required)
Categories of Data Subject	Personal confidential health data

# Agreement



# Agreement

Nottingham and Nottinghamshire ICS and 3V have read the contents of this document including:

- The roles and responsibilities of each party
- The commitment made by N&N ICS leadership
- The outline timetable

and agree to make all reasonable efforts to meet these commitments.

Signed and dated

Dr Andy Haynes  
Managing Director  
Nottingham and Nottinghamshire ICS

Dr Tim Wilson  
Managing Director  
Oxford Centre for Triple Value Healthcare Ltd

# POPULATION HEALTH MANAGEMENT

**Maria Principe**  
Programme Director PHM and  
Outcomes

**Dr Mike Oneil**



# PURPOSE OF THIS PRESENTATION?

- To describe population health management
- To provide a brief overview of our local PHM methodology
- To briefly discuss, outcomes, segments and interventions
- To reflect and discuss some of the hurdles to overcome

# POPULATION HEALTH MANAGEMENT?

Population Health Management, is the approach in which data is used to understand the needs of the population, enabling focus and resources to be tailored to areas where the impact can have maximum impact”



## SEGMENT AND STRATIFICATION

Modeling to identify local  
"at risk cohorts"



## TARGETTED IMPACTABLE INTERVENTIONS

Targeting interventions to  
achieve maximum benefit



## INTEGRATE HEALTH AND CARE

Improve care and support for  
people with ongoing health  
conditions



## REDUCE UNWARRANTED VARIATION

Identify variations in  
outcomes/health inequalities

# PHM and Public Health

**Population health management** improves **population health** (the **health** of an entire **population**) by data-driven planning and delivery of proactive care to achieve maximum impact. (Andi Orlowski NW London).

**Public Health** has looked at promoting, protecting and prolonging healthy life through coordinated programmes (normally offered to the whole population)

Population health management focuses on:

- Outcomes for identified groups or segments
- Healthy population as much as those who are sick
- Resource planning that includes the wider determinants of health
- Risk management approach promoting well-being, preventing ill health

# THERE ARE 3 CAPABILITIES OF PHM



## Infrastructure

*What are the basic building blocks that must be in place?*

- **Organisational Factors** - defined population, shared leadership & decision making structure
- **Digitalised care providers and common health and care record**
- **Integrated data architecture** and single version of the truth
- **Information Governance** that ensures data is shared safely, securely and legally



## Intelligence

*Opportunities to improve care quality, efficiency and equity*

- **Supporting capabilities** such as advanced analytical tools and software and system wide multi-disciplinary analytical teams, supplemented by specialist skills
- **Analyses** - to understand health and wellbeing needs of the population, opportunities to improve care, and manage risk
- **Interpretation** of evidence to identify targeted, high impact interventions



## Interventions

*Care models focusing on proactive interventions to prevent illness, reduce the risk of hospitalisation and address inequalities*

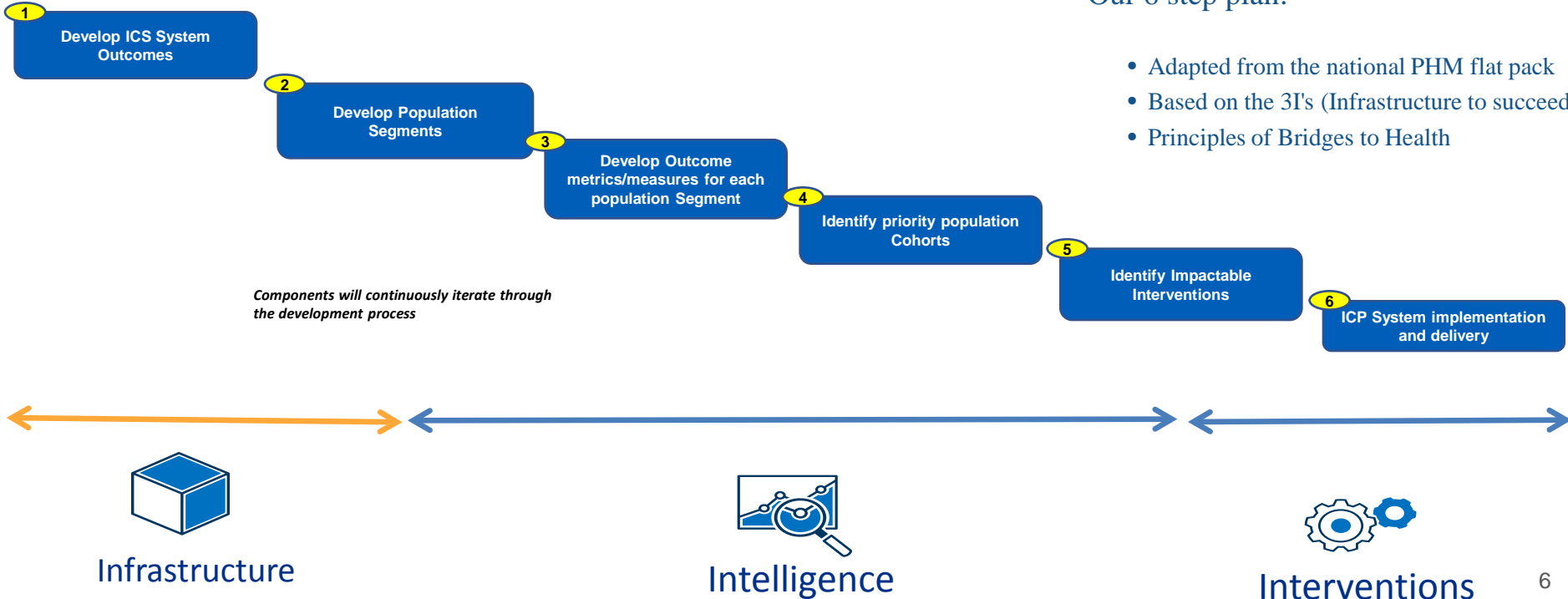
- **Care model design** - delivery of integrated personalised care and interventions tailored to population needs
- **Community well-being** - asset based approach, social prescribing and social value projects
- **Workforce development** - upskilling teams, realigning and creating new roles

# NOTTINGHAMSHIRES PHM FRAMEWORK - AS A PLANNING PROCESS

## • Our 6 step plan:-

- Adapted from the national PHM flat pack
- Based on the 3I's (Infrastructure to succeed)
- Principles of Bridges to Health

*Components will continuously iterate through the development process*



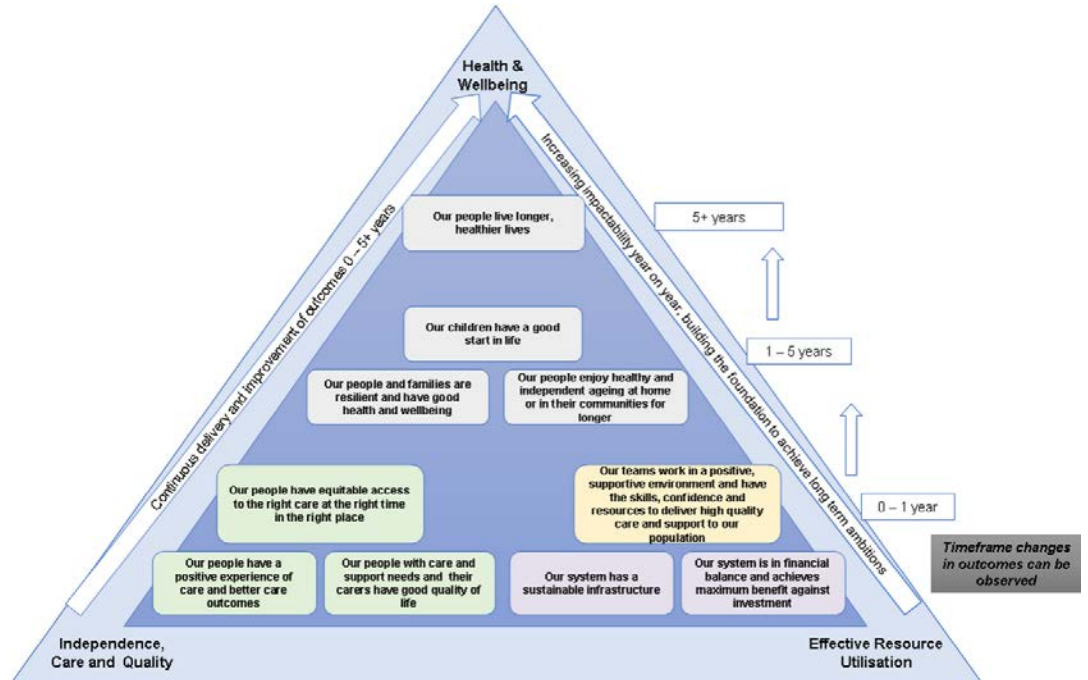
# PHM as 6 step process exemplified

<b>Establish Goals and Outcomes</b>	<ul style="list-style-type: none"> <li>• System goals</li> <li>• Segment goals</li> </ul>
<b>Establish Metrics</b>	<ul style="list-style-type: none"> <li>• Life expectancy in years at birth</li> <li>• Rockwood Clinical Frailty score</li> </ul>
<b>Establish Segments</b>	<ul style="list-style-type: none"> <li>• Population-wide: Healthy, Disability, Women &amp; Children, LTC, EoL</li> <li>• Within each cohort e.g. Diabetes (With complications, Well-controlled, Pre-diabetes, Healthy)</li> </ul>
<b>Identify priority cohorts</b>	<ul style="list-style-type: none"> <li>• Diabetes</li> <li>• Frail elderly people</li> </ul>
<b>Identify impactful interventions</b>	<ul style="list-style-type: none"> <li>• Urgent referral to foot clinic</li> <li>• Pre-diabetes education program</li> </ul>
<b>Implement</b>	<ul style="list-style-type: none"> <li>• Identify care gaps, care opportunities</li> <li>• Ensure adequate capacity</li> </ul>





# OUTCOMES



# Outcomes: Data driven

“PHM ... improves **population health** by data-driven planning ...”

Data driven only works if:

- Data is available from all providers
- Data is accurate – best if used for direct patient care
- Data is categorised – not swathes of free text.
- Data is timely – within 24 hours of recording
- Data is integrated – needs a team to housekeep

GPRCC:  
care gaps,  
workflow for  
GPs,

These are the basics for working out KPIs, care gaps, care opportunities

## Outcomes ... process measures

.. To really know what is going on (especially if a provider) you need:

- Process measures
  - Number of people on carers' register
  - Flow through ED
  - % Diabetes patients on metformin

KPIs are a mix of:

- High level outcomes (e.g. Healthy Life Expectancy)
- Proxy outcomes (e.g. HbA1c in diabetes)
- Process measures

Should be able to drill down from top to bottom (via segments)

## Outcomes: sharing metrics

If the baton of care passes between HSCPs we need to share metrics:

- Clinical Frailty Scale – success!
- EQ5D screening tool
- Memory testing
- Activities of Daily living (inc. mobility, feeding, continence)
- Common carer register across social care, GP, acute, etc.

Then we can:

- Monitor a patient's progress over time across organisations
- Reduce duplication of work
- Predict patients at risk (*computer stuff*)

... and an incentive scheme tailor made for shared delivery of care

## Outcomes: the bad bit

There is a limited pot of money.

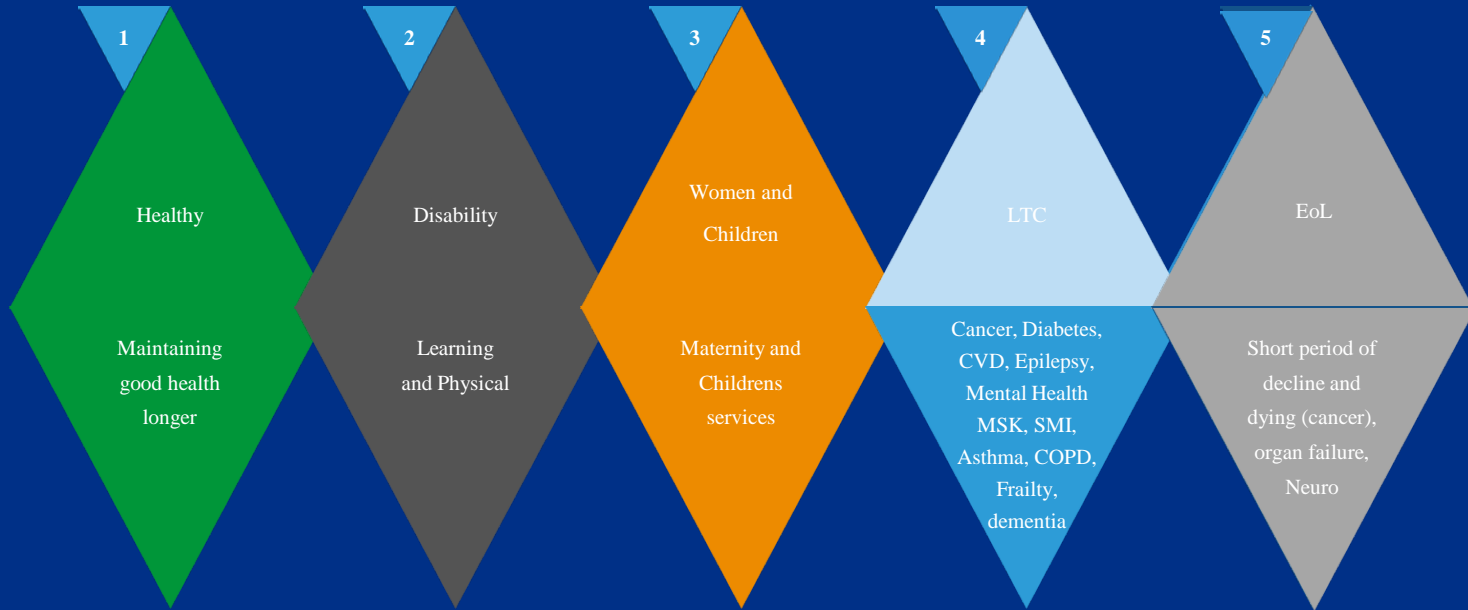
When (not if) limited funds force us to choose will we spend £1m on:

- An intervention which delivers lots of benefit in 10 years?
- An intervention which delivers a little benefit this year?

There are many variations on this theme

Perhaps now is the time to stop looking for 'low hanging fruit' ?

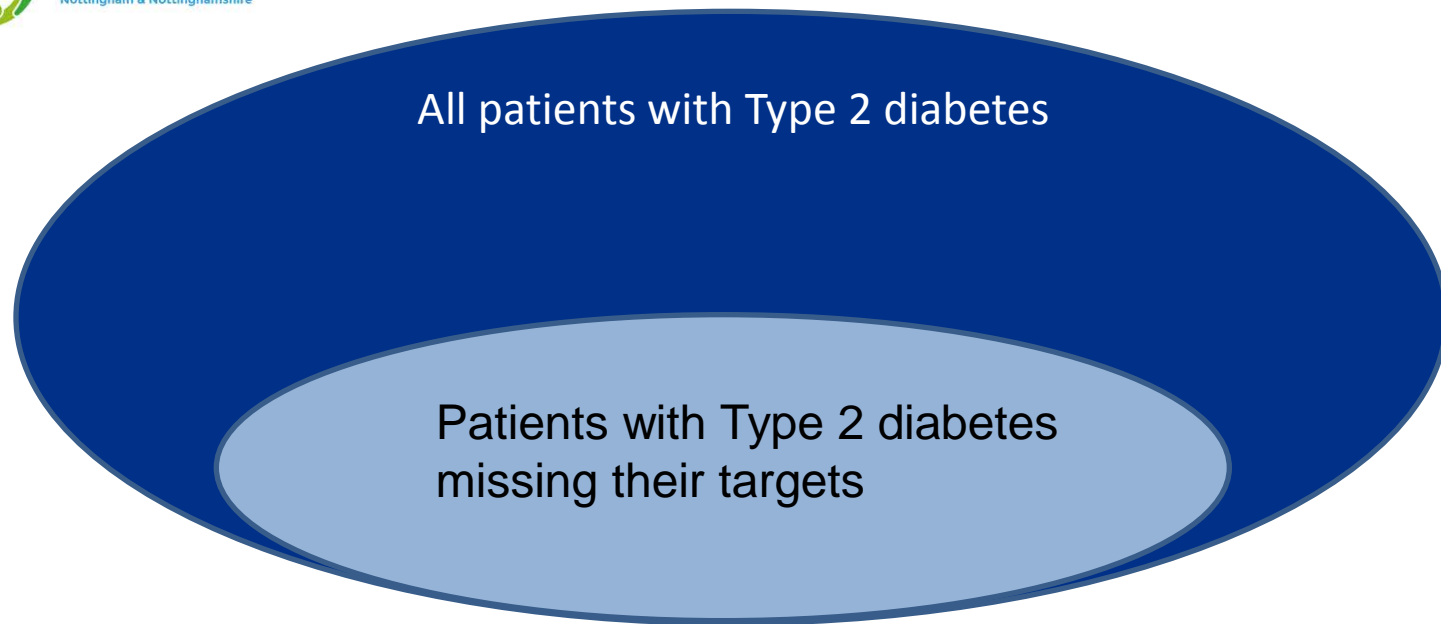
# POPULATION SEGMENTATION



“**Segmentation** is grouping the local population (DATA) by what kind of health and care they need”

The above segmentation approach was agreed by the ICS board, and is based on the principles of “Bridges to health”,  
\*Our population will rarely remain static\*

## Segments: level of detail



## Segments: Cross cutting segments

We might want to understand:

- Ethnicity of the group
- Languages the group speaks
- Deprivation of the group
- Residential areas these people are living in
- Educational attainment
- Vulnerability (care home, safeguarding, frailty, homeless)

Do these differ between groups who meet/don't meet targets?

Is there capacity in the area to deal with the care gap?

How do we best reach those populations?

Are the right interventions being used?



# Outcomes and segments: wood and trees

***All citizens*** (500 out of 702 outcomes achieved)

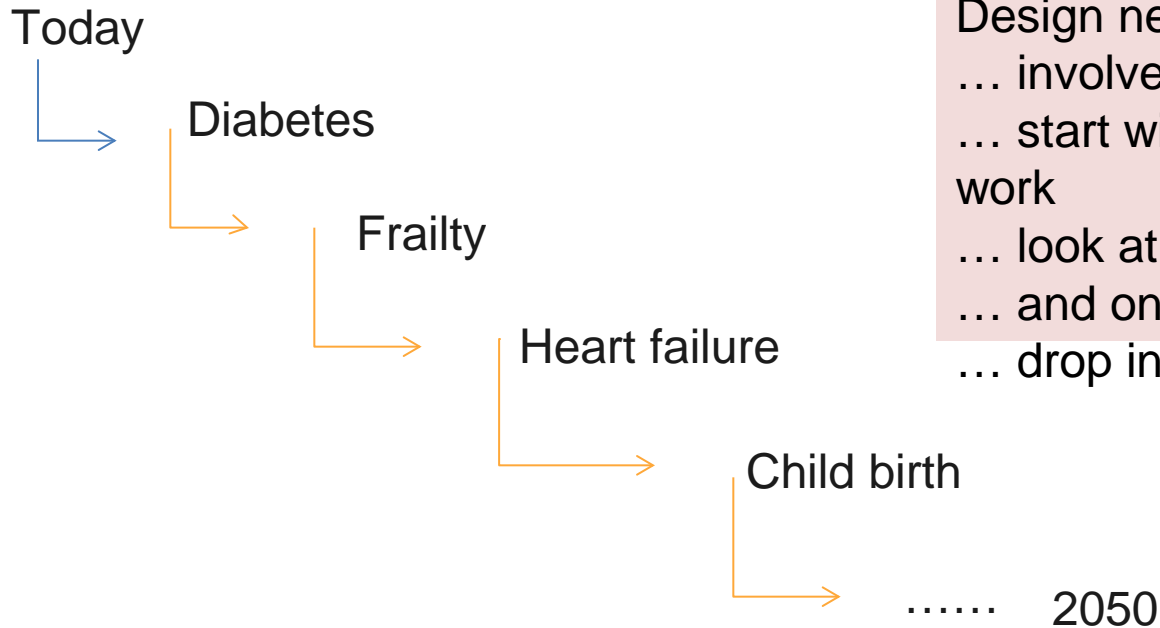
***All citizens with Long Term Conditions*** (100/135 outcomes achieved)

***All patients with type 2 diabetes*** (14 out of 17 outcomes achieved)

***All patients with T2D in deprived deciles*** (5 out of 17 outcomes achieved)

... and a clinician can see the caseload to cover the care gap for each indicator

## Segments: Getting started



Design needs to:

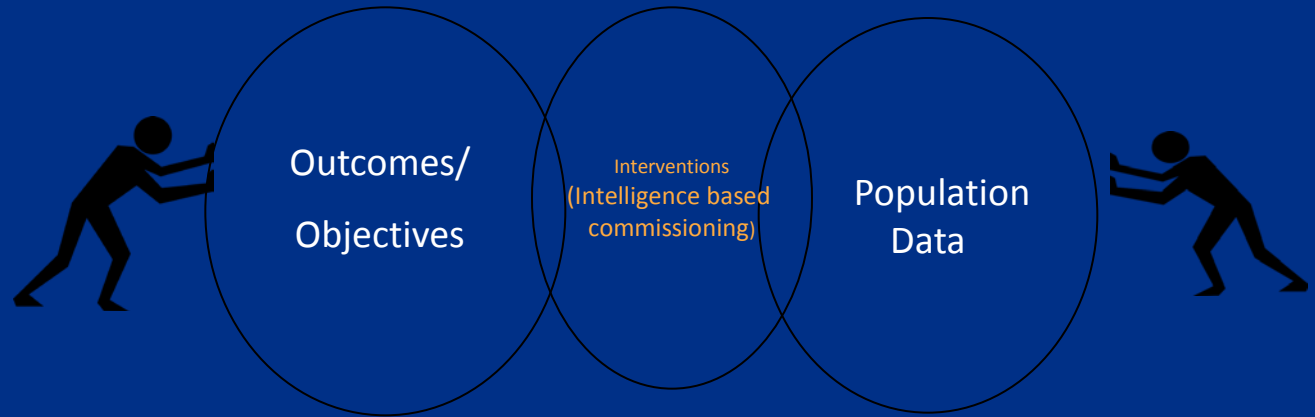
- ... involve the whole workforce
- ... start with KPIs for current work
- ... look at segments in parallel
- ... and on all new interventions
- ... drop interventions

## Segments: a summary

Segments allow us to:

- Group together our indicators into an overview
- Come at different levels of detail e.g. type 2 diabetes
- Can be cross-cutting e.g. deprivation, ethnicity
- We should always check that we have covered the right segments:
  - drug dependence
  - sex workers
  - homeless
  - low educational attainment

# IMPACTABLE INTERVENTIONS



# IMPACTABLE INTERVENTIONS

- ▶ **PEOPLE ARE DIFFERENT**  
One approach will not suit everyone...
- ▶ **POPULATIONS HAVE DIFFERENT NEEDS**  
Different outcomes, require different interventions
- ▶ **COSTS VARY**  
20% of the population could be costing 80% spend?
- ▶ **MAXIMISE IMPACT**  
Quality, cost, resources, activity
- ▶ **MAXIMISE RESOURCES**  
Enables more focus on area of need/prioritisation
- ▶ **WE NEED TO WORK COLLECTIVELY TO HAVE A BETTER IMPACT**  
Health influences only 10% of an individuals wellness, therefore how “impactful” is a health only model?

# Impactability: choosing between interventions

Which interventions:

- have the **greatest** impact (for a given cost)?
- deliver the **earliest** impact (for a given cost)?
- are we going to decommission

Which citizens:

- are most likely to agree to an intervention?
- are most likely to benefit from an intervention?
- most need an intervention?
- most want an intervention?

# Impactability: Issues

How many people will potentially be investigated? 70,000 (GPRCC warehouse)  
What will the total cost be? £3m

What will the health gains be?

- Some people will become lose weight after given advice
- A few people will be at risk of bleeding from the oesophagus (and death) and treatment can reduce the risk of bleeding

Which outcomes (and metrics) are we going to monitor?

- BMI, patient empowerment, mortality

How much health gain is there for a given cost?

- NICE struggled to quantify these gains (cost per health benefit).

Might there be better ways of spending £3m to reduce obesity?

Ensure that:

- There is a body through which all new/pathway revisions pass (Clinical Design Authority including Public Health, Social services)
- There is a sound methodology in place to make decisions between alternative options (measuring **impactability**)
- There is sufficient **analytic capability** in place to do impactability studies
- There is software in place that any manager/board member can monitor the effectiveness of all (new) pathways



# Impactability: bang for buck

## QALY: Quality Affected Life Years

- 1 QALY = 1 year of life expectancy gained in full health
- 0.5 QALY if 1 year of life gained but e.g. bed-ridden
- Takes into account physical, mental, emotional well-being

Cost per QALY	Intervention
£25k	NICE threshold for new interventions
£13k	Average for all NHS interventions
£7k	Diabetes pre-education

# Impactability: Issues

## Impactability

- Time consuming to gather evidence
- Doesn't apply to all processes

Should we spend money on transport, computers, managers?

- Some interventions are enablers.

# Implementation: sharing workload

## Annual review for diabetes

- Warm homes
- CBT for LTC with anxiety
- Social prescribing
- Frailty assessment

## Secondary care, Community care share workload

- Prediabetes education
- Community nurses giving influenza jabs at home
- Advice and impactful moments

## Holistic approach common to all proponents of PHM

- Establish who will be carrying the **interventions**
- Generate the workflows that expose **care gaps**
- Ensure capacity available to deal with **workflows**
- Procure with requirement for common **measurement scales**
- Measure how Trusts/PCNs/ICPs are faring (ICP)
- Measure how each segment is doing: BME, gender, deprivation (ICS)

Design the delivery so that HCPs:

- See rapid feedback (daily)
- See the workflow early
- See a trickle flow of cases where possible
- Don't do something that someone else has already done



# SESSION 1

# OUTCOMES

## What does good look like?

- PHM should have a system wide, outcome focus, driven by need and not by existing services. In order to deliver improved outcomes for its population, the “system” should consider the whole life course from addressing the wider determinants of health to early intervention, primary, secondary and tertiary disease prevention.
- In order to improve outcomes the distribution of health across a population should be considered. Understanding and addressing inequalities in health has a positive impact on outcomes overall, therefore the system should have a clearly defined outcomes framework where Population health and health inequalities is at the heart of the systems vision.
- The system is able to monitor and evaluate its outcomes quickly

## Discussion points

1. What commitment will each ICP partner make to changing its approach to embrace PHM and reap the greatest benefit from its adoption –
2. How will we manage the tension between statutory organisation priorities and local delivery...
3. How will we manage the tensions between partner organisations when prioritising/tackling inequalities?
4. What part can and should the community engagement model adopted by the ICP play in the implementation of PHM in MN?



## REFLECTION

Do we have more clarity on our “discussion topics” or an agreement on how we move forward?:-



# FEEDBACK





## SESSION 2

# SEGMENTATION

## What does good look like?

- The system has a clear understanding of the data sets that are available and how they can be used collated and stored.
- The system is able to collate the information on population need and share across the system.
- Population segments includes all population intelligence including where possible wider determinants (e.g. housing related data) as per bridges to health.
- The system has an agreed and clear Information Governance (IG) structure that meets the needs of future data collation, storage and mining.

## Discussion points

1. Wider determinants of health and wellbeing – the two initial priority areas identified concern people with identified clinical need and/or a diagnosis. Does this methodology maintain its relevance for wider determinants and how would the ICP adapt it?
2. How do we ensure all relevant data is accessible to inform our population view?
3. How will the system manage conflicting information from multiple sources. I.e “one version of the data truth” (a baseline)?
4. Consistent, high quality analytics and data sits at the heart of this approach. How can we make the most of local knowledge and analytical expertise to supplement ICS and other sources?



# FEEDBACK



## SESSION 3

# IMPACTABLE INTERVENTIONS

## What does good look like?

- A realisation that a 'one-size-fits-all' approach may not work for all
- Combine information on need with views from across the system in a transparent way to summarise the agreed need for the population.
- The system is able to use PHM intelligence and adopt this as part of its commissioning processes when developing transformational plans, interventions with contributing resources agreed at all tiers.
- Research and modelling is available to support impactability findings, using local population data
- Plans, transformations and interventions have workforce model maps to determine gaps and new role definitions
- Implementation plans include a framework on which ongoing monitoring and evaluation will be included to ensure the programme being implemented remains fit-for-purpose as the population evolves and changes

## Discussion Points

1. How can PHM support and be supported by the priority neighbourhoods approach that has been embraced by the ICP. What barriers are there to holistic care?
2. How does the ICP balance delivering now, while meeting tomorrow's needs? ie how does it ensure it considers the whole health and care of the population, ie prevention vs cure..
3. The health and care system has supported the concept of integrated care services. PHM gives us the tools and local understanding to be able to deliver **impactable** interventions. How will the ICP adopt this as part of its processes and how will the board ensure delivery is different this time?



# FEEDBACK





**Integrated  
Care System**  
Nottingham & Nottinghamshire

## **Integrated Care System (ICS) Board Summary Briefing – January 2020**

### **Introduction**

The Chair of the ICS, David Pearson, welcomed a number of citizens and staff from across the system to the Board meeting – reminding colleagues that the meeting was held in public and all the papers for the meeting are available at <https://healthandcarenotts.co.uk/about-us/ics-board/>. Patients, citizens and staff from organisations across the system are always welcome to the Board to hear the discussions. The Chair also welcomed several new members to the Board: Dr Nicole Atkinson as ICS Clinical Director, Paul Robinson as ICS Finance Director and Paul Devlin in his role as Chair of Nottinghamshire Healthcare NHS Foundation Trust.

### **Patient Story – Zephyr’s and Maternity Voices Partnership**

Becky Gray, Local Maternity and Neonatal System Delivery Manager and Carly Williams from Zephyr’s joined the Board to share Carly’s experience of stillbirth and the impact that this had on her and her family. Following the tragic loss of her son, Zephyr, Carly and her husband established a charity in his name to provide support to other parents in similar situations, all of whom have experienced baby loss in some way. Carly powerfully articulated the impact her experience had and how she has translated that into the work of the charity. The Board was keen to understand how the good work of Zephyr’s could be spread more widely across the system, eliminating variability of provision in terms of both physical facilities and staffing. More details of Zephyr’s Appeal can be found at: <http://www.zephyrsnottingham.org.uk/>

### **Prevention**

Previous Boards have strongly endorsed Prevention activities, halting ill health before it has a chance to take hold and promoting healthy choices, as a key focus for the system and Prevention is the first priority of the system’s Five Year Strategic Plan. The Board therefore welcomed an update on activities in this space. Smoking and alcohol have been identified as priorities for the next two years. Tackling use of tobacco and abuse of alcohol has the potential to eliminate over 10,000 admissions to hospital over the next five years. Diet and physical inactivity have been identified as areas of focus from year three of the system’s strategy, again due to their impact on healthy life expectancy. More than a third of years lived with a disability are linked to risk factors including diet and physical inactivity and are therefore preventable.

The Board discussed the proposed approach and approved it as an outline for the period ahead and also approved the governance of the programme.

### **Five Year Strategic Plan and Planning for 2020/21**

The ICS’s joint leads for System Value Improvement, Tom Diamond and Helen Pledger, updated the Board on the ICS’s Five Year Strategic Plan and the planning for the year ahead. Whilst the system’s Five Year Strategic Plan has not yet been published and the planning guidance for the year 2020/21 has not yet been issued by NHS England / Improvement, detailed work has been underway for a number of months on ensuring that the year 2020/21 cements the foundations for delivery of the Strategic Plan in the period ahead. To that end, the Board received an update on how the ICS will be enhancing the development of organisational planning processes conducted by system partners, adding a layer of system-level planning and delivery measurement over the top of those organisational plans. This will enable the Board to ensure that the right plans are being delivered for citizens and patients and that progress against the overall plan is measured and monitored.

The Board discussed this approach and sought reassurance that the correct planning interfaces were in place between the ICS and the individual organisations. The Board also sought to confirm that the financial impacts of the planning process were fully considered. The approach was approved and endorsed by the Board following this discussion.

## Winter Planning

Following the Board's approval of the system's overall approach to Winter at the October 2019 meeting, this meeting received an interim update on Winter performance against those plans. There will be a full update on the delivery of the system's Winter plans later on in the year, but the interim findings are as follows;

- The activities to prepare for Winter across the system were executed as planned
- These activities were guided by the national framework and influenced by learnings from previous years
- Partners from all across the system including Local Authority colleagues contributed to the delivery of plans
- The performance of the Call For Care service following its roll-out across the ICS geography is ahead of expectations
- Direct booking from 111 into urgent care services is performing ahead of expectations
- Despite this planning and delivery of activities, throughout December the system has remained pressured, including 12 days at Operational Pressures Escalation Levels (OPEL) level 4 at Nottingham University Hospitals (NUH).
- The pressure was exacerbated by the Norovirus outbreak and an increase in flu and respiratory cases
- Throughout December Sherwood Forest Hospitals (SFH) did not escalate to OPEL 4, however performance against the 95% A&E four hour standard was below 80% on five occasions.

The Board also received an update on performance in vaccinating local populations against Flu – performance was variable across the ICS but often fell below the expected levels;

Locality	65 and over	Under 65	2-3 yr olds	4-10 yr olds	Pregnant Women
<b>Target</b>	<b>75%</b>	<b>55%</b>	<b>50%</b>	<b>65%</b>	<b>55%</b>
City	69%	39%	39%	37%	35%
South Notts	75%	46%	45%	66%	48%
Mid Notts	73%	43%	44%	58%	39%

Board members welcome the update and looked forward to a fuller update in due course once the winter period had passed.

## General Practice Development

Further to the update in Primary Care Networks (PCNs) received at September's Board meeting, Dr Nicole Atkinson, ICS Clinical Director, presented to the Board a detailed update on General Practice including investment in Practice development and resilience. As part of the *NHS Long Term Plan* and the *GP Forward View*, a total of £2.3bn is being invested additionally into General Practice – Nottingham and Nottinghamshire's share of this is £2.2m in 2019/20 growing to £2.9m in 2023/24. Full details of where this money is being spent can be found in the Board papers with the largest slice of £0.8m being directed to support Primary Care Networks in all neighbourhoods across the ICS. The Board noted the update and thanked the team for their work on this important topic.

## ICP Updates

The Board received updates from all three of the system's Integrated Care Partnerships (ICPs) and discussed the City update in particular. The Board congratulated the leadership of the ICP for the successful delivery of the launch event in November 2019 and noted that plans were advanced for further events in January and February to develop the ICP's strategic focus and priorities, in line with the overall ICS strategy.



## **Governance Review**

The Board briefly discussed the ongoing review of its Governance and members were encouraged to respond to the initial questionnaire that had been circulated. The Board will be discussing the findings from the questionnaire in the planned Development Session later in January.

***David Pearson,***  
***Independent Chair, Nottingham and Nottinghamshire ICS***

***Dr Andy Haynes,***  
***Executive Lead, Nottingham and Nottinghamshire ICS***

## Mid-Nottinghamshire ICP Board

<b>TITLE:</b>	Primary Care Network Update
---------------	-----------------------------

<b>DATE OF MEETING:</b>	30th January 2020	<b>PAPER REF:</b>	ICP/20/012
-------------------------	-------------------	-------------------	------------

<b>AUTHOR:</b>	Stephanie Haslam	<b>PRESENTER:</b>	David Ainsworth
----------------	------------------	-------------------	-----------------

<b>EXECUTIVE SUMMARY (OVERVIEW):</b>	
The Primary Care Networks (PCN) 2019/20 transformation programme has four work streams:	
PCN Development & Assurance	Primary & Secondary Care Integration
Non-Health Partners	Community & Mental Health
This report provides the Mid-Nottinghamshire ICP Board with an update against the key priorities in each work stream.	

<b>RECOMMENDATION:</b>
<input checked="" type="checkbox"/> To note

## Mid Nottinghamshire Primary Care Network Update – January 2020

### PCN Development & Assurance

#### Social Prescribing Link Workers

A further 99 referrals in December brings the total so far to 196. The top three referral reasons remain Mental Health, Social Isolation and Lifestyle Change.

This month the Link Workers have received Gambling Awareness training and attended the launch of the Working Age Dementia Hub in Edwinstowe.

Discussions are taking place with the integrated Community and Voluntary Sector for the future development of services such as the Home Visiting Befriending Service in Ashfield. This is a critical element to the model of social prescribing

#### TeamNet

TeamNet has been agreed across Nottingham and Nottinghamshire with Mid-Notts, Nottingham West and Rushcliffe contracts in place. The implementation plan is underway for Mid-Notts with the aim of going live by the 1<sup>st</sup> February 2020. TeamNet is a single internet based portal for all communications, updates and storage of pathways and policies.

#### Data Sharing Agreements

The final version of the Data Sharing Agreement has been issued from the Information Governance team to the PCNs for signature. The Locality team are working with PCN Clinical Directors to ensure every practice has this signed and in place as part of making robust the system for sharing non registered patients data between practices. Such an agreement allows free flow of patients between PCN practices and out of hospital service provision.

#### Group Consultation

Two cohorts of group consultation training have now taken place with the focus on implementing group consultation within practices to support patients with long term conditions; in total 11 practices have attended the training.

The first cohort of practices has successfully run their first group consultation sessions with diabetes patients. Patient feedback was very positive – “I have a better understanding of my results”, “Informal session, informative and a great way to meet others in the same position”.

We are planning to contact practices to obtain initial feedback from practice staff and patients.

A third cohort group consultation training event is planned for 30<sup>th</sup> January 2020.

## Community & Mental Health

### PCN Enhanced Service Specifications

Two of the Mid-Notts Clinical Directors are holding discussions on behalf of the Mid-Notts PCNs and working in close collaboration with Nottinghamshire Healthcare NHS FT and members of the wider Primary Care networks on the co-delivery of the new PCN Enhanced Service Specifications from April 2020 with particular emphasis, initially, on the Enhanced Health in Care Homes (Dr James Mills) and the Structured Medication Reviews and Optimisation (Dr Andrew Pountney).

This is early work and further feedback can be expected at future Board meetings.

## Primary & Secondary Care Integration

### First Contact Practitioners on track – Physios

The MSK Hub is working in close collaboration with the Locality team and PCN Clinical Directors to implement an exciting integrated workforce model that achieves the PCN contract requirements without destabilising the MSK Hub model. This work is on track and provides a career development pathway through to autonomous practitioner level.

This is new ground and the introduction of a physiotherapist option in general practice aims to tackle the estimated 33% appointments that are taken up with common MSK presentations such as lower back pain. Most of which can be managed through self-care. Early intervention and exercise advice could have an impact of lost hours through sickness. The Board can expect to receive updates on the evaluation through the year.

## Non-Health Partners

### Alcohol related harm in Nottinghamshire and IBA

Mid-Notts Clinical Directors are working with CGL (the provider of Nottinghamshire Substance Misuse Service) on the promotion and support of training Alcohol Champions in non-health environments across Mid-Nottinghamshire. At a recent meeting an opportunity was identified to train Link Workers and Health Care Assistants as well as CCG staff, carers, Social Workers, Housing Benefit Officers, etc. Once champions are trained in how to engage in successful conversations, it is anticipated that referrals for brief intervention will be targeted and increase.

### The Children's Centre in Bellamy

The County Council are consulting with families on the closure due to poor uptake. Formal communication has been sent from the CCG and Mansfield District Council setting out concerns about the lack of engagement with partners. The Bellamy Estate is one of our 'Place Based' priority areas and as an ICP we are keen to work on new approaches to improve the offer. The consultation has now closed and we await further feedback from the lead officer.