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Nottingham City Council
Nottingham City Health and Wellbeing Board

Date: Wednesday, 31 May 2023

Time: 1.30 pm

Place: Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG

Councillors are requested to attend the above meeting to transact the following business

Director for Legal and Governance

Governance Officer: Phil Wye **Direct Dial:** 0115 8764637

1 Appointment of Vice-Chair

2 Change to membership
To note the following changes to non-voting members of the Board:

- Annie Jennings has replaced Emma Rowsell as the representative of the University of Nottingham.
- Damien West has replaced Mick Sharman as the representative of the Nottinghamshire Fire and Rescue Service
- Kevin Lowry is the new representative from Housing Services, Nottingham City Council

3 Apologies for Absence

4 Declarations of Interests

5 Minutes 3 - 10
Minutes of the meeting held on 29 March 2023, for confirmation

6 Minutes of the Commissioning Sub-Committee 11 - 12
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7 Hewitt Review findings 13 - 110
Report of the Director of Public Health

8	**Nottingham and Nottinghamshire NHS Joint Forward Plan** Report of the Director of Integration, Nottingham and Nottinghamshire ICB	111 - 114
9	**Nottingham City Place-Based Partnership Update** Update from the Nottingham City Place-Based Partnership	115 - 160
10	**Joint Strategic Needs Assessment (JSNA) and other Needs Assessments update** Report of the Director for Public Health, Nottingham City Council	161 - 236
11	**Joint Health Protection Board Update** Update from the Joint Health Protection Board	237 - 240
12	**Board Member Updates** Updates from Board Members	241 - 242
a	**Pharmaceutical Needs Assessment**	Verbal Report
13	**Work Plan**	243 - 244

14 Future Meeting Dates

To agree to meet on the following Wednesdays at 1.30pm at Loxley House, Station Street, Nottingham:

26 July 2023
27 September 2023
29 November 2023
24 January 2024
27 March 2024

If you need any advice on declaring an interest in any item on the agenda, please contact the Governance Officer shown above, if possible before the day of the meeting

Citizens attending meetings are asked to arrive at least 15 minutes before the start of the meeting to be issued with visitor badges

Citizens are advised that this meeting may be recorded by members of the public. Any recording or reporting on this meeting should take place in accordance with the Council's policy on recording and reporting on public meetings, which is available at www.nottinghamcity.gov.uk. Individuals intending to record the meeting are asked to notify the Governance Officer shown above in advance.

Nottingham City Council

Nottingham City Health and Wellbeing Board

Minutes of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 29 March 2023 from 1.33 pm - 3.34 pm

Attendance (✓ indicates present)

	Voting Members	
✓	Nottingham City Council's Portfolio Holder with a remit covering Health	Councillor Adele Williams (Chair) Portfolio Holder for Finance
✓	Nottingham City Council's Portfolio Holder with a remit covering Children's Services	Councillor Cheryl Barnard Portfolio Holder for Children, Young People and Schools
✓	Two further Nottingham City Councillors	Councillor Linda Woodings Portfolio Holder for Adult Social Care and Health
		Councillor Jay Hayes Executive Assistant for Health and Culture
✓	Four representatives of the NHS Nottingham and Nottinghamshire Integrated Care Board	Dr Dave Briggs Medical Director, Nottingham and Nottinghamshire Integrated Care Board
		Lucy Dadge Director for Integration, Nottingham and Nottinghamshire Integrated Care Board
✓		Dr Hugh Porter (Vice Chair) Clinical Director, Nottingham City Place-Based Partnership
		Michelle Tilling City Locality Director, Nottingham and Nottinghamshire Integrated Care Board
✓	Corporate Director for People, Nottingham City Council	Catherine Underwood
✓	Director for Adult Health and Social Care, Nottingham City Council	Sara Storey
✓	Director for Public Health, Nottingham City Council	Lucy Hubber
	Representative of the Healthwatch Nottingham and Nottinghamshire Board	Sarah Collis Chair
	Non-Voting Members	
✓	Representative of the Nottingham University Hospitals NHS Trust	Tim Guyler Assistant Chief Executive
	Representative of the Nottinghamshire Healthcare NHS Foundation Trust	Jan Sensier Executive Director of Partnerships and Strategy
✓	Representative of the Nottingham CityCare Partnership	Lou Bainbridge Chief Executive

	Representative of Nottingham City Homes	Stephen Feast Director for Transition
✓	Representative of Nottinghamshire Police	Superintendent Kathryn Craner Area Command for the City
✓	Representative of the Department for Work and Pensions	Matt Eburne (substitute) Disability Team Leader
	Representative of Nottingham Universities	Emma Rowsell Director for Student and Campus Life, University of Nottingham
	Representative of Nottinghamshire Fire and Rescue Service	Michael Sharman Assistant Chief Fire Officer
✓	Up to two individuals representing the interests of the Third Sector	Leslie McDonald Executive Director, Nottingham Counselling Centre
		Jules Sebelin Chief Executive, Nottingham Community and Voluntary Service
✓	Chief Executive, Nottingham City Council	Mel Barrett

Colleagues, partners and others in attendance:

Jane Bethea - Consultant in Public Health
Rich Brady - Programme Director, Nottingham City Place Based Partnership
David Johns - Public Health Registrar
Helen Johnston - Public Health Registrar
Phil Wye - Governance Officer

63 Apologies for Absence

Joanna Cooper
Lucy Dadge
Dr Mike Saunders
Michael Sharman
Ciara Stewart
Michelle Tilling

64 Declarations of Interests

None.

65 Minutes

The minutes of the meeting held on 25 January 2023 were confirmed as a correct record and signed by the Chair.

66 Minutes of the Commissioning Sub-Committee

The minutes of the Commissioning Sub-Committee, held on 25 January 2023, were noted.

67 Gambling health needs assessment

Helen Johnston, Public Health Registrar, presented the report and delivered a presentation highlighting the following:

(a) gambling means to risk loss for a possible gain in an activity of uncertain outcome, and includes casino games, sports bets, scratchcards, lotteries, bingo and more. It can cause harm and significantly affects health and wellbeing. The problems can easily be hidden and generally affect up to 10 others;

(b) disadvantaged groups and people with poorer health are more likely to develop a gambling problem. There is also a disproportionate impact for minority ethnic groups, relative to participation;

(c) gambling can have a negative impact on physical and mental health, relationships, finance and employment, and can lead to crime;

(d) approximately 4,500 Nottingham citizens aged 16 or over have a known gambling problem, and this is affecting more younger people and males. In addition almost 1000 citizens aged under 16 are showing signs of a problem;

(e) information and support is available and expanding. An NHS Clinic is due to open in Derby soon. However, far fewer people contacted the largest local support provider between April 2021 and March 2022. Nottingham callers reported multiple impacts, most commonly on finance and mental health;

(f) gambling premises in Nottingham are clustered in the City Centre, Bulwell and Clifton East. Deprived areas are more likely to contain licensed premises. Residents of Bulwell, Clifton East, Bestwood, Bilborough, Aspley and St Anns are estimated to have a higher risk of developing a gambling problem;

(g) the report contains a number of actions, which are already being acted upon.

The following points were raised during the discussion which followed:

(h) financial capability is taught in all schools as part of the national curriculum, and gambling risk could be included in this;

(i) gambling is often glorified through sponsorship of sports teams, which impacts particularly young people. The gambling industry alone cannot be relied upon to address problems;

(j) alternative diversionary activity such as sports and activities could help young people to avoid gambling.

Resolved to note the report.

68 Joint Health and Wellbeing Strategy Delivery Update - Year 1

Rich Brady, Programme Director for Nottingham City Place Based Partnership (PBP), introduced the report providing an overview of approach taken by the PBP to deliver the four priorities that make up the Joint Health and Wellbeing Strategy 2022-25, delivery progress to date and expectations in year 2.

Presentations were delivered on each of the four priorities of the Strategy by Jane Bethea, Helen Johnston and David Johns, highlighting the following:

Severe Multiple Disadvantage (SMD)

(a) the aim is to ensure that people living in Nottingham City who experience SMD receive joined up, flexible, person-centred care from the right services, at the right time and in the right place;

(b) a key delivery achievement for the programme in year 1 has been the establishment of the Changing Futures programme which includes specialist 1:1 intensive (including minority ethnic and gender specialist) support to people experiencing SMD;

(c) 133 people have benefited from intensive support in the last year, in addition to people that have been supported through the multi-disciplinary team (MDT) and statutory services;

(d) ensuring the voice of lived experience is key to this work, including in the design and delivery of services, and understanding the needs of women and Nottingham's diverse communities experiencing SMD, ensuring services meet their needs. There have been difficulties in recruiting people with lived experience from diverse communities in Nottingham City however this has improved.

Financial Wellbeing

(e) the programme's 10 year vision is to address lack of financial security by making Nottingham a place where people are able to meet their current need comfortably and have the financial resilience to maintain this in the future;

(f) Year 1 delivery has included a joint workshop on supporting a coordinated approach to the cost of living, linking up support like financial resilience sessions for NUH staff and informing organisational recruitment policies. Partnership arrangements have been developed to strengthen the resource and profile of the Nottingham Financial Resilience Partnership;

(g) Year 2 priorities have 5 key themes- increased incomes for those on low incomes, ensuring access to money help across the population, improved household finances, reduced food insecurity, and improved financial capability.

Eating and moving for good health

(h) in Nottingham 1 in 4 children at primary school are overweight, 2 in 5 at secondary school, and 7 of 10 adults. Around a quarter of adults are not active. The programme's vision is to be a city that makes it easier for adults, families, children and young people to eat and move for good health. This means

achieving lasting changes to the diet, physical activity and social environment;

(i) this will require ensuring all early years settings, schools and academies are enabling eating and moving for good health, supporting healthy choices in pregnancy and helping children and adults to achieve and maintain a healthy weight, promoting physically active lives and building active and green environments, creating a local environment that promotes healthy food choices, and promoting a sustainable food system that tackles food insecurity;

(j) the programme is helping schools to further their efforts through additional funding and support. It is also offering adult weight management through Slimming World, Aviva, and partnering with football clubs;

(k) healthy activity is being supported through active travel bids, mapping of walking routes around the city, and making cycling more accessible.

The following points were raised during discussion:

(l) some city communities have their own support networks and these need to be connected into this work. Some groups such as LGBTQIA+ people are harder to reach due to poor data;

(m) there will be a new workstream for young people and care leavers, including trauma informed practice;

(n) there are still people in the city who have not received their energy rebates, are not on the internet, do not have bank accounts or only pay in cash. The financial wellbeing priority work must take this into account;

(o) people can be overwhelmed by the amount of information provided on financial wellbeing, so messages must be kept simple so that it is taken in. Employers can disseminate messages to the employees on financial wellbeing, including small and medium sized businesses;

(p) it is important that people are able to walk and cycle around the city more easily and safely. Lowering speed limits and encouraging children and parents to walk to school are important steps in this, as well as making people feel safe to do outdoor physical activity. The national StreetSafe app is available from the police to report feeling unsafe, and community speedwatch is being re-launched to monitor speeding.

Resolved to

(1) note the progress of programme development and delivery in year 1 of the Joint Health and Wellbeing Strategy;

(2) note the key messages for the Health and Wellbeing Board;

(3) note the agreed Smoking & Tobacco Control and Severe Multiple Disadvantage programme delivery plans;

(4) **note the Year 1 programme delivery update reports.**

69 Smoking and Tobacco Control Vision Document & Delivery Plan

David Johns, Consultant in Public Health, presented the report and delivered a presentation on the Smoking and Tobacco Control priority of the Joint Health and Wellbeing Plan, highlighting the following:

(a) smoking remains the biggest preventable cause of all il-health in Nottingham, with 7% of adults and 13% of pregnant women smoking;

(b) the vision of this priority is to see smoking amongst adults reduced to 5% or lower by 2035 across Nottinghamshire and Nottingham City, and all born after 2022 to not be smokers;

(c) Stop Smoking services are helping vulnerable adults to stop smoking, along with a new Stop Smoking app for NHS staff and a new e-cigarette pilot as a quit aid. A new trading standards officer will promote effective regulation of tobacco products for tobacco control, in partnership with the police;

(d) to promote prevention and engagement with children and young people. The INTENT programme has been launched, a free smoking prevention programme for secondary schools. Schools have also been provided with information on the risks of vaping.

The following points were made during the discussion which followed:

(e) schools and early years settings are important to link into families;

(f) there is very little data available on vaping among young people. This could present a challenge in future and must be kept under observation.

Resolved to endorse and support the long-term ambition and delivery of actions.

70 Joint Health Protection Board Update

As no formal Board meeting had taken place, a written update will be provided at the next meeting.

71 Developing the Nottingham and Nottinghamshire Joint Forward Plan

Dr Dave Briggs, Medical Director, Nottingham and Nottinghamshire Integrated Care Board, presented the report on the Joint Forward Plan which provides an opportunity to create a longer-term shared sense of endeavour, a realistic and ambitious view of what is achievable and a sense of hope for teams and the public.

NHS partners would like to work with the Board in the development of this plan to ensure that the ambitions of the Integrated Care Strategy are reflected and it is proposed to schedule an item for discussion at the May meeting ahead of the document being finalised by 30th June.

Resolved to

(1) schedule an item for discussion at the May meeting of the Nottingham City Health and Wellbeing Board ahead of the document being finalised by 30 June;

(2) delegate to the Chair and Director of Public Health any engagement with NHS partners to support the early development of the Joint Forward Plan.

72 Board Member Updates

The written updates were noted.

73 Work Plan

The work plan was noted.

74 Future Meeting Dates

The proposed meeting dates for the 2023-24 municipal year were noted.

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Nottingham City Council

Nottingham City Health and Wellbeing Board Commissioning Sub-Committee

Minutes of the meeting held at Loxley House, Nottingham on 29 March 2023 from 3.45 pm - 4.01 pm

Voting Membership

Present	Absent
Katy Ball	Dr Dave Briggs
Sarah Fleming (Chair)	
Councillor Adele Williams	
Councillor Linda Woodings	

Non Voting Membership

Present	Absent
Sara Storey	Ailsa Barr
	Sarah Collis
	Lucy Hubber
	Ceri Walters

Colleagues, partners and others in attendance:

Karla Banfield	-	Head of Commissioning, Nottingham City Council
Naomi Robinson	-	Joint Commissioning Manager, NHS Nottingham and Nottinghamshire Integrated Care Board
Phil Wye	-	Governance Officer

18 Apologies for Absence

Dr Dave Briggs
Lucy Hubber
Hayley Mason

19 Declarations of Interests

None.

20 Minutes

The Committee confirmed the minutes of the meeting held on the 25th January 2022 as a correct record and they were signed by the Chair.

In reference to the short timeframe given to spend the Adult Social Discharge Fund, the Sub-Committee discussed having more strategic discussions around spend of the Better Care Fund.

Resolved to organise a strategic working group for the Better Care Fund

21 2022/23 Better Care Fund (BCF) Reconciliation + BCF Updates

Karla Banfield, Head of Commissioning, presented the report which provides the Sub-Committee with the reconciliation of the pooled Better Care Fund (BCF) budget as part of the 2022-23 financial accounts closure process, and changes to the Section 75 agreement. The following was highlighted:

(a) reconciliation against the planning template for the Nottingham City Council (NCC) schemes were required due to number of budgetary changes which were planned but not completed at the time of submission. There is no change to the ICB BCF schemes, which are forecast to end the year with no financial variance against the 22/23 plan;

(b) a root and branch review of the BCF has been undertaken to make sure that it is fit for purpose, accurately recorded and fit for the future. There has been a lot of work to increase transparency and avoid confusion, and to show a direct line from budgeting to positive outcomes.

Resolved to

(1) note and approve the financial end of year reconciliation to the 2022-23 Better Care Fund (BCF) Planning Template;

(2) note the work being undertaken on the Section 75 agreement.

22 Future Meeting Dates

The proposed meeting dates for the 2023-24 municipal year were noted.

Nottingham City Health and Wellbeing Board
31 May 2023

Report Title:	Hewitt Review Findings
Lead Board Member(s):	Councillor Linda Woodings – Portfolio Holder for Adults and Health
Report author and contact details:	Nancy Cordy – Nancy.cordy@nottinghamcity.gov.uk
Other colleagues who have provided input:	Lucy Hubber, Director of Public Health

Executive Summary:

An independent review of integrated care systems (ICSs), known as The Hewitt Review, was published by the Department of Health and Social Care in April 2023. The review identified 6 key principles that will create the context in which ICSs can transform our health and care system;

1) Collaboration
2) A limited number of shared priorities
3) Give local leaders space and time to lead
4) Systems need the right support
5) Balancing freedom with accountability
6) Enabling timely, relevant, high-quality and transparent data

The full report (Appendix A) sets out a series of recommendations as to how these principles can be translated into action. A notable recommendation includes a shift from focussing on illness to promoting health, including a shift in the share of total NHS budget at ICS level going towards prevention (recommendation that this should be increase by at least 1% over the next 5 years).

The government is currently considering the recommendations made by the review and it should be noted that the review is not currently government policy.

The King's Fund have published a short reflection on the review which can be found in Appendix B to support the Boards consideration, in line with the below recommendations.

Recommendation(s): The Board is asked to:

(1) Note the publication and content of The Hewitt Review: An independent review of integrated care systems

(2) Consider and comment on learning and reflections from the review which can be applied within the local Nottingham and Nottinghamshire ICS ahead

of a government response to the review and the recommendations contained within it.

The Joint Health and Wellbeing Strategy	
Aims and Priorities	**How the recommendation(s) contribute to meeting the Aims and Priorities:**
Aim 1: To increase healthy life expectancy in Nottingham through addressing the wider determinants of health and enabling people to make healthy decisions	The Joint Health and Wellbeing Strategy has a clear focus on improving outcomes in population health and preventing ill-health, as well as tacking inequalities. These are also the aims of the ICS. The Hewitt Review sets out a series of recommendations which it concludes will support ICSs to deliver against these aims, including a shift to upstream investment in preventative services and interventions.
Aim 2: To reduce health inequalities by having a proportionately greater focus where change is most needed	
Priority 1: Smoking and Tobacco Control	
Priority 2: Eating and Moving for Good Health	
Priority 3: Severe Multiple Disadvantage	
Priority 4: Financial Wellbeing	
How mental health and wellbeing is being championed in line with the Board's aspiration to give equal value to mental and physical health: The Hewitt Review recognises the importance of both physical and mental health, and identifies the need for close the health and care system to work together in different ways to address both.	

List of background papers relied upon in writing this report (not including published documents or confidential or exempt information)	None
Published documents referred to in this report	Hewitt Review: an independent review of integrated care systems Standing back from The Hewitt Review: six key take-aways, The Kings Fund

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The Hewitt Review

An independent review of integrated care systems

Rt Hon Patricia Hewitt

Published 4 April 2023

Contents

Foreword

It has been a privilege to carry out this review. Although the invitation to do so came as a complete surprise, it was an opportunity I could not turn down. As chair of the Norfolk and Waveney NHS integrated care board and deputy chair of its integrated care partnership, and previously one of the first independent chairs of a sustainability and transformation partnership, I have no doubt that the decision to put integrated care systems onto a statutory footing was the right one, widely supported across the political spectrum.

I stepped down as Secretary of State for Health over fifteen years ago. The biggest contribution I helped make to the health of the nation was the smoke-free legislation: an important reminder in the context of this review that we should never mistake NHS policy for health policy. And one of the most creative was the nation-wide public engagement through 'Our health, our care, our say' that confirmed public support for a health and care system that would enable them to be as healthy and independent as possible.[1]

ICSs have been born in difficult times. The answer is not simply more money, although of course that is needed, particularly in social care. Unless we transform our model of health and care, as a nation we will not achieve the health and wellbeing we want for all our communities - or have the right care and treatment available when it is needed.

ICSs bring together all the main partners - local government, the voluntary, community, faith and social enterprise sector, social care providers and the NHS - in a common purpose expressed in 4 main aims: to improve outcomes in population health and healthcare; to tackle inequalities in outcomes, experience and access; to enhance productivity and value for money; and to help the NHS support broader social and economic development.

This report shows how they are already making a difference and explains what needs to happen next to accelerate that progress.

As Secretary of State myself, I was a ‘window-breaker’ rather than a ‘glazier’.[2] Like today’s ministers, I was impatient for change - and rightly so. But my preferred style as a leader remains collaborative: bringing people together to understand each other’s perspective, learning from and challenging each other, and working through disagreements or conflict as honestly and openly as possible to agree the best way forward. That is how I have carried out this review, and as a result I believe that most of my recommendations will command widespread support. But there is a wide range of passionately held views and it would be surprising if there was unanimity on all points. Indeed, an independent review with which everybody agreed would be pointless.

Given the scope of my terms of reference, and the tight timescale, it is hardly surprising that the review has been an intense and sometimes challenging process. I am hugely grateful to the many hundreds of people who have been involved through engagement events, town hall meetings and the 5 review work streams as well as in preparing over 400 submissions in response to the call for evidence. I have also drawn upon the many preceding important reviews and papers, including the work of the King’s Fund, Professor

[1] Our health, our care, our say: a new direction for community services.
[2] Nicholas Timmins, Glaziers and Window Breakers: Former Health Secretaries in their own words, Health Foundation, May 2015

Sir Chris Ham, the Fuller Stocktake and the Messenger Review to name but a few. It has been a privilege to work with so many inspiring colleagues: every conversation has taught me something more. To all of you who have contributed to these rich discussions, thank you.

The time comes, however, when the drafting has to stop. I am painfully aware that it has not been possible to do justice to every insight and recommendation, or work through every issue raised in our discussions. Nonetheless, I hope everyone will feel that their efforts have been worthwhile, and that this report provides all of us committed to the success of ICSs with a platform for the next stage.

Many of my recommendations are designed to shape how we work together in the coming months and years, not only strengthening collaboration at local level but ensuring the breadth of partnership within ICSs is mirrored nationally. Real partnership starts with real work and I have made a number of recommendations for how the way we are learning and creating together within systems, should be embraced and embedded nationally: for instance, with DHSC, DHULC, NHS England, HM Treasury, ICSs and others working in concert on important areas of change including much-needed reform to the financial framework.

This review could never have happened without many people's exceptionally hard work. I am grateful to the Secretary of State for commissioning this review and his ministers, advisers and departmental officials for their support throughout. I am equally grateful for the active engagement of Amanda Pritchard and many senior colleagues at NHS England. Without them all, the review would not have been possible.

I am particularly grateful to the co-chairs of the 5 work streams: Sam Allen, Rt Hon Paul Burstow, Felicity Cox, Dr Penny Dash, Adam Doyle, Sir Richard Leese, Dr Kathy McLean, Patricia Miller, Cllr Tim Oliver and Joe Rafferty.

I want to thank Matthew Taylor, Annie Bliss, Ed Jones and others at the NHS Confederation whose ICS, primary care, mental health and other networks were invaluable and who provided additional policy and engagement support throughout. My thanks go equally to the Care Providers Alliance, the County Councils Network, the Health and Wellbeing Alliance of VCFSE sector representatives, Healthwatch, the Local Government Association, National Voices, NHS Providers, the Patients Association, the Social Partnership Forum, and the many others who have contributed and facilitated this work. I was also exceptionally fortunate in my DHSC Secretariat: Jason Yiannikkou, Jonathan Walden, Georgina Connah, Laura Bates, Alexandra Kirsima, Haleema Nazir and Thomas Savage, all of whom deserve immense praise.

As the review concludes, and despite the very real challenges that lie ahead, I am even more optimistic about what we can achieve together than I was when this process started. I look forward to working with you all on the next stage of our exciting journey together.

Rt Hon Patricia Hewitt

April 2023

Terms of reference

The review's terms of reference were published on 6 December 2022 and are set out below.

Objectives and scope

The review will consider how the oversight and governance of integrated care systems (ICSs) can best enable them to succeed, balancing greater autonomy and robust accountability with a particular focus on real time data shared digitally with the Department of Health and Social Care, and on the availability and use of data across the health and care system for transparency and improvement. It will cover ICSs in England and the NHS targets and priorities for which integrated care boards (ICBs) are accountable, including those set out in the government's mandate to NHS England.

In particular it will consider and make recommendations on:

- how to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending
- the scope and options for a significantly smaller number of national targets for which NHS ICBs should be both held accountable for and supported to improve by NHS England and other national bodies, alongside local priorities reflecting the particular needs of communities
- how the role of the Care Quality Commission (CQC) can be enhanced in system oversight

Engagement

The review will draw upon the expertise of ICSs, local government, the NHS, the voluntary sector, patient and service user representatives and other subject experts including in academia, government departments and relevant thinktanks.

Governance and timing

The review will be led by Rt Hon Patricia Hewitt and will be independent of government.

Secretariat support will be provided by the Department of Health and Social Care.

The review will report to the Secretary of State for Health and Social Care, with interim findings by 16 December 2022, a first draft by 31 January 2023 and a final report by no later than 15 March 2023.

Executive summary

Integrated care systems (ICSs) represent the best opportunity in a generation for a transformation in our health and care system. Effective change will require the combination of new structures with changed cultures. Everyone needs to change, and everyone needs to play their part.

The review has identified 6 key principles, that will enable us to create the context in which ICSs can thrive and deliver. These are: collaboration within and between systems and national bodies; a limited number of shared priorities; allowing local leaders the space and time to lead; the right support, balancing freedom with accountability and enabling access to timely, transparent and high-quality data.

From focusing on illness to promoting health

Delivering these principles will require genuine change in how the health and care system operates. While there will always be immediate pressures on our health care system, shifting the focus upstream is essential for improving population health and reducing pressure on our health and care system.

This will require a shift in resources - the share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years. It will also require cross-governmental collaboration to embed a national mission for health improvement and the establishment of a new Health, Wellbeing and Care Assembly.

Our use of data must also support this mission, with improved data interoperability and more effective use of high-quality data. Alongside this we need to empower the public through greater use of the NHS App and further long-term commitment for the development of citizen health accounts.

Delivering on the promise of systems

ICSs hold enormous promise, bringing together all those involved in health, wellbeing and care to tackle both immediate and long-term challenges. To do this effectively, national and regional organisations should support ICSs in becoming ‘self improving systems’, given the time and space to lead - with national government and NHS England significantly reducing the number of national targets, with certainly no more than 10 national priorities.

We should encourage and deliver subsidiarity at place, system, regional and national levels. We are currently one of the most centralised health systems in the world, and ICSs give us an opportunity to rebalance this.

The most effective ICSs should also be encouraged to go further, working with NHS England to develop a new model with a far greater degree of autonomy, combined with robust and effective accountability.

For every ICS, increased transparency is vital to enabling local autonomy. The availability of timely, transparent and high-quality data must be a priority, and NHS England and the Department of Health and Social Care (DHSC) should incentivise the flow and quality of data between providers and systems. The Federated Data Platform can provide the basis for a radical change in oversight, to replace situation reports (SITREPS), unnecessary and duplicative data requests.

Both the Care Quality Commission (CQC) and NHS England will continue to have a vital role to play in oversight and accountability, but they should ensure that their improvement approaches are as complementary as possible, and complementary to peer review arrangements between systems.

Finally, it will be vital to ensure the right skills and capabilities are available to ICSs as both systems and national organisations manage through a period of challenge for the nation's finances. There needs to be consideration given to the balance between national, regional and system resource with a larger shift of resource towards systems.

Unlocking the potential of primary and social care and their workforce

In order to make the promise of ICSs a reality, we also need to pull down some of the barriers that currently exist for primary care, social care and the way we train health and care workforce.

Given the interdependence of health and social care, the government should produce a complementary strategy for the social care workforce. More should also be done to enable flexibility for health and care staff, both in moving between roles and in the delegation of some healthcare tasks.

National contracts present a significant barrier to local leaders wanting to work in innovative and transformational ways. I have recommended that work should be undertaken to design a new framework for General Practice (GP) primary care contracts, as well as a review into other primary care contracts.

Work also needs to be done to ensure that there is the flexibility to competitively recruit and train more specialists in fields such as data science, risk management, actuarial modelling, system engineering, general and specialised analytical and intelligence.

Resetting our approach to finance to embed change

We are currently not creating the best health value that we could from the current investment in the NHS. Instead of viewing health and care as a cost, we need to align all partners, locally and nationally, around the creation of health value.

NHS funding remains over-focused on treatment of illness or injury rather than prevention of them and ICS partners struggle to work around over-complex, uncoordinated funding systems and rules in order to shift resource to where it is most needed.

Instead, it is important to identify the most effective payment models, nationally and internationally, with an aim to implement a new model with population-based budgets, which will incentivise and enable better outcomes and significantly improve productivity. There should also be a review into the NHS capital regime to address the inflexibility in use of capital and the layering of different capital allocations and approvals processes.

NHS England should also ensure that systems are able to draw upon a full range of improvement resources to support them to understand their productivity, finance and quality challenges and opportunities.

1. Introduction

1.1 Across the developed world, healthcare systems are facing the challenge of increasing pressures, public expectations and opportunities (including those opened up by new digital and data technologies). As other healthcare systems are finding, no matter how much money is invested in treating illness, unless we transform how we deliver health and care, we will not achieve the health and wellbeing we want for all our communities - or have the right care and treatment available when we need it.

1.2 In England, integrated care systems (ICSs) represent the best opportunity in a generation for that urgently needed transformation of our health and social care system. They provide the opportunity to break out of organisational siloes, enabling all partners to work together to tackle deeply rooted challenges, drawing together their collective skills, resources and capabilities around their 4 core purposes, to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- support broader social and economic development

1.3 If we allow the development of ICSs to become “just another NHS reorganisation”, we will let down patients, the public and everyone working in the health and care system.

Integrated care systems (ICSs) are partnerships that bring together local government, the NHS, social care providers, voluntary, community, faith and social enterprise (VCSFE) organisations and other partners to improve the lives of people who live and work in their area, in line with their 4 core purposes. Each ICS includes a statutory integrated care partnership (ICP) and integrated care board (ICB).

The ICP is a statutory committee jointly formed between the ICB and the relevant local authorities within the ICS area. The ICP brings together the broad alliance of partners and is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.

The ICB is the statutory NHS organisation responsible for bringing NHS and other partners together to plan and deliver integrated health and care services and accountable for the finances and performance of the local NHS as a whole.

Why we need a new approach

1.4 There are 3 main reasons why we need a new approach for the health and care system. First and foremost are the immediate pressures upon the NHS and social care, already visible before the pandemic, but greatly exacerbated as a result of it. The public's immediate priorities for the NHS - access to primary care, urgent and emergency care, cancer, other 'elective' care, and mental health services - are just as important to ICSs as they are to ministers and NHS England.

1.5 Second, there is a growing number of people living with complex, long-term physical and mental health conditions, often associated with serious disabilities or ageing.

1.6 Third, as a nation, we are becoming less, rather than more healthy, both physically and mentally. More people spend longer in ill-health and die too young, particularly the least economically advantaged and those most affected by racism, discrimination and prejudice.

> "Against the backdrop of those health challenges, we cannot just keep doing more of the same. The traditional way of operating a health system, where you have your hospitals and your primary care and you have your social care separate, and you have those things relatively siloed, is not a system that works in a world where people are living a long time with multiple health conditions. We know that the determinants of health are much broader than just what happens in a hospital. They include housing, wider care and education. Joining up is an imperative, both for improving health outcomes and for having a sustainable, affordable health system to get what we want."
>
> Helen Whately, MP, Minister of State for Social Care

1.7 ICSs are designed to tackle all 3 problems. As the examples throughout this report illustrate, many are already succeeding in doing so.

1.8 They are already starting to tackle immediate and often intractable problems - including ambulance queues and delayed discharges - which cannot be solved by any one organisation alone or by continuing to work in the same old ways. These problems require close partnerships between many parts of the health and care system - primary care, community health, mental health, acute hospital trusts, local government and social care providers - working together in different ways.

> Dorset ICS has halved the number of A&E and emergency admissions among elderly people through its Ageing Well programme, improving anticipatory, preventative care by integrating community, primary and social care teams at neighbourhood level. ICB investment enabled the anticipatory care programme to undertake upstream interventions for patients with long term conditions. Interventions were developed for specific risk groups

by a multi-agency partnership. The ICS is now using data to predict who might be a frail patient at risk of falling, and intervene to help prevent falls and promote self-care. A digital programme supports an out of hours clinical team to respond to care homes and prevent admissions. The ICS is also expanding the use of virtual wards and is piloting the use of Age Care Technologies which support independence in the home. This is saving approximately £33,000 per person per year in care costs.

1.9 Despite many impressive examples of innovative working, the NHS in general is not yet currently configured to optimise the management of complex, long-term conditions. The result is a system that is fragmented rather than integrated, making it frustrating, inefficient and often challenging for patients and families as well as staff. ICSs, by integrating health and social care services, and working more closely with VCFSE providers, should aim to ensure that services are joined up, pressures are actively managed, and the interests of patients and the public are prioritized.

1.10 It has also long been recognised that the NHS is, in practice, more of a National Illness Service than a National Health Service. Despite important and continuing efforts by NHS England, the reality is that we are a very long way from devoting anything like the same amount of time, energy and money to the causes of poor health as to its treatment. That cannot be done by the NHS alone and ICSs - established as equal partnerships between local government, the NHS, the voluntary, community, faith and social enterprise sector, social care providers and others - are the right vehicle to build on and reinforce existing work.

1.11 Faced with these challenges, but also with many inspiring examples of success, it is not surprising that throughout this review I heard such strong commitment from leaders in ICBs and ICPs, local authorities, providers and national bodies, to the core purposes of ICSs. As so many ICS leaders - both non-executive and executive - said: “This is why I applied for this job.”

1.12 At the same time, however, I heard real concern that the transformational work of ICSs and specifically the opportunity to focus on prevention, population health and health inequalities might be treated as a ‘nice to have’ that must wait until the immediate pressures upon the NHS had been addressed and NHS performance recovers. That is what has always happened before, and must not happen this time.

1.13 Prevention, population health management and tackling health inequalities are not a distraction from the immediate priorities: indeed, they are the key to sustainable solutions to those immediate performance challenges.

1.14 For too long, we have talked about the challenge of moving resources upstream to enable people to live independently for as long as possible, build more resilient communities and reduce health inequalities. This is how we can sustainably tackle

the causes and not just the symptoms of an over-burdened NHS, moving away from the constant cycle of 'winter crisis' management. Furthermore, the partnership working that is at the heart of ICSs is, itself, an essential means to tackle those symptoms of 'winter crisis', including delayed ambulance arrivals, handovers and delayed discharges. These and many other challenges do not just affect one organisation; they can only be effectively tackled by many organisations working together, integrating care across the entire pathway and making the best use of available resources to achieve better, safer outcomes.

Why it can be different this time

1.15 Many of us have talked over many decades about the need to focus on prevention, population health and health inequalities. We have called for a shift from a top-down, centralised system of managing the NHS to a bottom-up system responsive and responsible to local communities and engaging the enthusiasm, knowledge and creativity of staff along with patients, carers and volunteers. The creation of primary care trusts (PCTs) and then clinical commissioning groups (CCGs) were attempts to do exactly that, but each was reorganised and swept away in their turn.

1.16 There are many reasons, however, for believing it can be different this time. There is a welcome, and almost unprecedented, degree of cross-party support for ICSs, both nationally and locally. Although we often hear the plea to "take the NHS out of politics", that is neither possible nor desirable: in any democracy, different political parties will have different views on priorities for public spending as well as how best to fund public services. However, the extent of policy alignment now provides the basis for changes that will last well beyond one parliament, government or minister, giving ICSs the time and space to embed the new model.

"Local leaders are best placed to make decisions about their local populations… with fewer top-down national targets, missives and directives and greater transparency to help us hold the system to account."

Rt Hon Steve Barclay, Secretary of State for Health and Social Care

"There is no alternative to health and social care integration. Stakeholders and leaders across health, social care and wider public services know that pressing forward with broad-based integrated care systems and local partnerships in 2023 is the only long-term solution to creating a financially sustainable and successful NHS and social care system; improving the population's health and reducing health inequalities."

Annual report of the Health Devolution Commission, an independent cross-party and cross-sector body.[3]

1.17 By establishing ICSs in statute as broad local partnerships we now have the right structures for change. But there is also a growing understanding that while structures matter, culture, leadership and behaviours matter far more. The failure to recognise that in the past is one of the main reasons why previous attempts have not worked.

"Collaborative behaviours, which are the bedrock of effective system outcomes, are not always encouraged or rewarded in a system which still relies heavily on siloed personal and organisational accountability...the current cultural environment tends to be unfriendly to the collaborative leadership needed to deliver health and social care in a changing and diverse environment...a re-balancing towards collaborative, cross-boundary accountability is a pre-requisite to better outcomes."[4]

Messenger Review

1.18 NHS England has itself recognised the need for change and embarked on an important and welcome transformation in its size, focus and ways of working. The insightful review of NHS leadership by General Sir Gordon Messenger and Dame Linda Pollard, and the follow-up work, will help to accelerate that change. The Messenger Review stressed that although ‘command and control’ is occasionally essential, the most successful organisations need collaborative leadership, good management at every level and clear accountability for defined outcomes. In a similar spirit, when establishing this review, the Secretary of State for Health and Social Care himself stressed the need to reduce ‘top-down national targets, missives and directives’.

“This requires a cultural and behavioural shift towards partnership-based working; creating NHS policy, strategy, priorities and delivery solutions with national partners and with system stakeholders; and giving system leaders the agency and autonomy to identify the best way to deliver agreed priorities in their local context.”

NHS England, new operating framework, October 2022

1.19 The Health and Care Act (2022) has decisively changed the framework of policy and structures. Previous government policies over several decades have encouraged strong sovereign organisations, using competition to drive quality and

[3] Annual Report 'ICSs: a great deal done - a great deal more to do'
[4] Independent report by Sir Gordon Messenger and Dame Linda Pollard “Health and social care review: leadership for a collaborative and inclusive future”

outcomes - most keenly seen in the establishment of foundation trusts. There is no doubt that this has brought benefits: new models of care, greater clinical innovation and the creation of strong boards.

1.20 In many cases, incentives have encouraged leaders to think about their organisation's interests without regard for the wider system. The new, partnership-based structures for statutory ICSs, including the statutory duty to co-operate, recognises that problem and reinforces the need to place the interests of patients and the public first. The 2022 Act also includes significant changes in the procurement framework for healthcare services, giving commissioners more flexibility when selecting providers but retaining the freedom to use competitive processes in the best interests of patients and the public.

1.21 Finally, millions of people are becoming increasingly active in managing and improving their own health and wellbeing, often using ever more sophisticated digital monitoring tools and apps to assist them. This can provide the basis for a very different conversation with the public - including those who are disadvantaged or discriminated against - about what we need to do for ourselves and within our families and communities, and what health and care services can be expected to do for us.

How this review can help

1.22 The creation of ICSs, and the new approach they represent, is the right reform at the right time. But more is needed to enable them to succeed.

1.23 We have created ICSs but not yet the context in which they can thrive and deliver. We have a clear choice - either do what we have done before and create something only to almost immediately undermine its purpose, or back ICSs as part of a commitment to a different model of health policy and delivery.

1.24 This review has given all of us working within and with ICSs the opportunity to consider what needs to be done locally and nationally to create the conditions in which ICSs can succeed.

1.25 Critically, all of us need to change. Local partners within every ICS need to put collaboration and cooperation at the heart of their organisations. NHS England, DHSC and CQC need to support and reflect this new model in the crucial work they do; and central government needs to change, mirroring integration within local systems with much closer collaboration between central government departments and other national bodies.

1.26 In the first stage of this review, we agreed that specific recommendations needed to be based upon clear principles that would command widespread support and form a touchstone for all of us to use in considering how we behave within

systems, within national organisations and in the relationships between them. Six principles emerged clearly from our discussions:

- Collaboration: within each system as well as between systems and national bodies. Rather than thinking about national organisations, regions, systems, places and neighbourhoods as a hierarchy, we should view each other as real partners with complementary and interdependent roles and work accordingly. Subsidiarity within each ICS is therefore vital, recognising that particularly in larger systems, much of the work will be driven by Place Partnerships, building on the work of each Health and Wellbeing Board (HWB) within the wider system, as well as by Provider Collaboratives. Different local partners - notably local government itself, as well as the VCFSE sector - have different accountability and funding arrangements. Only ICSs can create mutual accountability between all partners around jointly agreed outcomes and targets for both the long-term health of the population and for immediate issues such as discharge and tackling the backlog. On the other hand, it is also essential to recognise that, while the role of national organisations should change, some things can only be done effectively and efficiently by them. NHS England's new operating framework and its emphasis on aligned support and collaboration managed by or with the ICS rather than direct to provider organisations is therefore extremely helpful.

- A limited number of shared priorities: the public's immediate priorities - access to primary care, urgent and emergency care, community, mental health and social care services and elective diagnostics and treatment - are priorities for all of us including ministers, NHS England and ICBs. The level of interest in these matters rightly makes them a central part of accountability for all ICBs and their partners in the wider ICS. Evidence-based guidance and best practice examples are, of course, invaluable to local leaders; but it is essential that those local leaders have flexibility about how they apply those lessons to their particular local circumstances.

- Give local leaders space and time to lead: effective change in any system - particularly one as complex as health and care - needs consistent policy, finances, support and regulation over several years. Adding new targets and initiatives, providing small funding pots (often with complex rules and reporting requirements), or non-recurrent funding makes it impossible to plan or even recruit, wastes money and time, and weakens impact and accountability. Multi-year funding horizons, with proportionate reporting requirements, are essential, as is recognising that statutory ICSs are less than a year old.

- Systems need the right support: ICSs require bespoke support geared to the whole system and the partners within it, rather than simply to individual providers or sectors. But there is considerable variety between systems, in maturity as well as size, geography, demographics, NHS configuration and

local government structures, relationships between partners and so on. Support and intervention from NHS England to ICSs, through ICBs, needs to be proportionate: less for mature systems delivering improving results within budget; more for systems facing greater challenges or with weaker relationships and leadership.

- Balancing freedom with accountability: with greater freedom comes robust accountability, including for financial spending and ensuring value for money. That accountability includes the local accountability that is hard-wired into ICSs - through Health Overview and Scrutiny Committees (HOSCs), local government, ICPs, Healthwatch, foundation trust governors and many other forms of patient and public involvement. Peer review, widely used in local government, should also have a much greater role for ICSs as a whole. Within the 2022 Act, accountability for NHS performance and finances within each ICS also involves the accountability of ICBs to NHS England. But the Act also includes a new role for CQC as the independent reviewer of ICSs as a system, as well as their existing functions in relation to social care, NHS and other healthcare providers. CQC is transforming its own working methods to meet these new responsibilities. This will need to be done hand in hand with NHS England's role in overseeing systems. It will also be essential to consider the vital, but different, role of supporting ICSs, ICBs and providers with great challenges to improve, particularly where there are major failings in care.

- Enabling timely, relevant, high-quality and transparent data: we recognize that timely, relevant, high-quality and transparent data is essential for integration, improvement, innovation and accountability. As high performing ICSs are already showing, high quality, integrated data collection and interoperable digital systems can initiate real change. NHS England, working in collaboration with DHSC and local government (including through the Department for Levelling Up, Housing and Communities (DLUHC), the Local Government Association (LGA) and other local government representative bodies or stakeholders) has a key role to play. By defining standards on data taxonomy and interoperability, and coordinating data requests to the system, they can create the conditions for wider transformation.

1.27 In the rest of this report, I set out how these principles can be translated into action.

2. From focusing on illness to promoting health

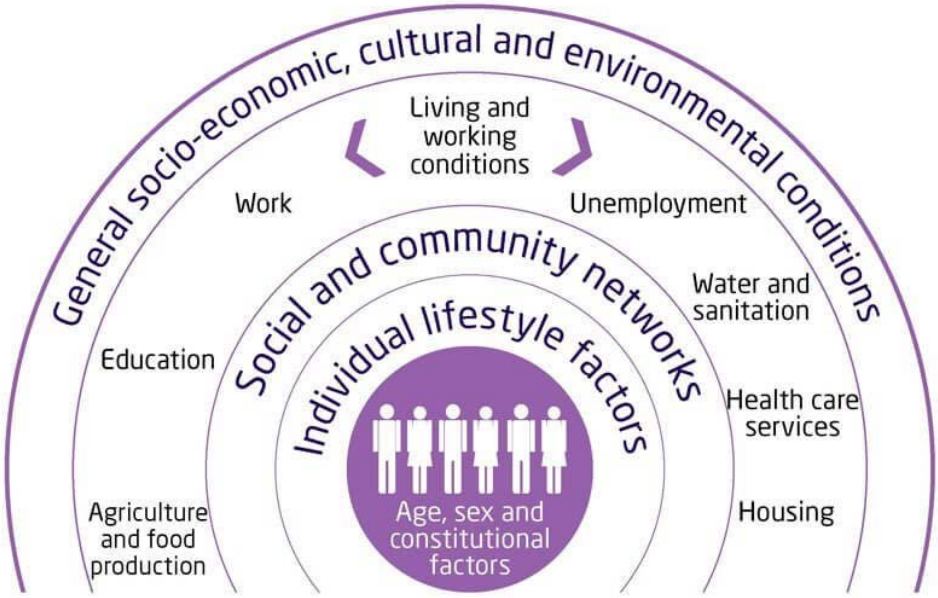
2.1 The review was specifically asked to look at how to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending, supported by high quality and transparent data.

2.2 The ultimate objective of health policy is that more people live longer, healthier and happier lives. But too many of our nation's population do not live as long or as healthily as they could, with improvements in life expectancy stalled or even declining amongst some groups, and unhealthy life expectancy increasing, particularly amongst disadvantaged communities. The COVID-19 pandemic starkly highlighted the human cost of health inequalities, with the mortality rates from COVID-19 in the most deprived areas being more than double those in the least deprived areas and death rates being highest among people of Black and Asian ethnic groups.[5]

2.3 In England today, there is a 19-year gap in healthy life expectancy between people in the most and least deprived areas of the country.[6] Those health inequalities, so damaging to the lives of individuals and their families, also impact on our society as a whole.

2.4 Both the Marmot review and the Dame Carol Black review highlighted the huge economic costs of failing to act on the wider determinants of health (see below for an illustration of the wider determinants of health).[7] Even before COVID-19, health inequalities were estimated to cost the NHS an extra £4.8 billion a year, society around £31 billion in lost productivity, and between £20 to 32 billion a year in lost tax revenue and benefit payments.[8]

[5] Public Health England. COVID-19: review of disparities in risks and outcomes. 2 June 2020
[6] Tabor, D. (2021) Health State Life Expectancies, UK: 2017 to 2019, Health state life expectancies, UK - Office for National Statistics. Office for National Statistics.
[7] Dahlgren, G. and Whitehead, M. (1993) Tackling inequalities in health: what can we learn from what has been tried?
[8] Public Health England. (March 2021) 'Inclusion and sustainable economies: leaving no one behind.'



2.5 For too long, however, we have mistaken NHS policy for healthcare policy. In reality, the care and treatment provided by the NHS, vital and often life-saving though it is, only accounts for a relatively small part of each individual's health and wellbeing. Significantly more important are the wider determinants of health. In many parts of the country, partnerships led by local government, the VCFSE sector and residents themselves have been working over many years to create healthier, more resilient communities, often with strong engagement from NHS primary care. The response to the pandemic brought communities, statutory and voluntary partners together to support people in many inspiring ways.

2.6 The creation of integrated care systems (ICSs), with their 4 purposes and a strong statutory framework for partnership working, provides a real opportunity to build upon this approach and suggests a welcome recognition of the need for a more holistic approach to improving the nation's health.

2.7 Indeed, ICS leaders are enthusiastic about maximising the contribution of the NHS to wider economic, social and environmental objectives. From economic regeneration to life sciences, from net zero to local labour markets, the NHS has a crucial role to play in creating thriving places.

2.8 Designing and creating services together with local residents and communities leads to more actively engaged citizens, able to lead and support change within their own lives, with a corresponding reduction in reliance on public services.

2.9 The Wigan Deal - an informal agreement between the council and everyone who lives or works there to work together to create a better borough - is an excellent example of this. In Wigan, the council invested £13 million in a Community

Investment Fund which funded bottom-up prevention ideas from local communities that supported physical activity, addressed social isolation and loneliness and promoted positive mental health. As a result of this sustained approach healthy life expectancy in Wigan bucked the trend and an additional 7 years was added in the most deprived wards.[9]

2.10 Similarly, through PCNs and Integrated Neighbourhood Teams, primary care can play an important leadership role in working with local communities to tackle health inequalities. In Tameside, Greater Manchester, Healthy Hyde PCN employs 34 people across many different disciplines, all working to tackle health inequalities. It has 6 health and wellbeing coaches working in foodbanks, schools, allotments, and providing ESOL lessons to asylum seekers and refugees. The team has clinical leadership, managerial and administrative support, and works together to identify people via clinical systems, local knowledge and working with multiple agencies.

2.11 However, empowering local leaders to work with and through their partners and local communities to improve outcomes for their populations can only happen at scale if the broader environment in which they operate is aligned to enable them to do so - something that is heavily dependent on policies pursued across government.

2.12 Particularly in view of the fourth core purpose of ICSs, to help the NHS support broader social and economic development, all parts of Whitehall should feel they have a stake in the work of Partnerships and Places and should equally strive to replicate the same sense of partnership being forged across the country in ICSs.

Enabling a shift to upstream investment in preventative services and interventions

2.13 There will never be a perfect time to shift the dial toward focusing more on preventative services and interventions. It is easy to argue - especially in the current climate of financial constraints and performance issues - that addressing these issues should be something we consider when the current pressures have died down. But that has always been the case.

2.14 The truth is, unless we make the change, the continual focus on improving flow through acute hospitals will simply channel more and more of an older and increasingly unhealthy population into acute hospitals, which will never be large or efficient enough to cope.

[9] Source: Professor Donna Hall, CBE Chair New Local, Former CEO Wigan Council; and Wigan CCG, ICS Transformation Advisor NHS England, January 2023

2.15 Despite the current pressures, I have also seen through the course of this review a greater appetite to grasp the challenge of shifting our focus to prevention, proactive population health management and tackling health inequalities than at any other time I can remember. It acts as the glue that binds all partners in ICSs. There are many things we can do now - both nationally and at system level - to create the collective conditions for us to capitalise on this.

2.16 In order to achieve a decisive shift ‘upstream’, towards prevention, proactive population health management and tackling health inequalities, we need to establish a baseline of current investment in prevention, broadly defined, within each ICS from which progress can be measured. This baseline would include the £200 million allocated nationally towards tackling health inequalities. This must also be done in a way that enables ICSs to be benchmarked against each other, helping to spread best practice and strengthen both local and national accountability.

2.17 We also need a clear and agreed framework for what we mean by ‘prevention’, broadly defined. We all recognise that ‘prevention’ involves a range of activity including primary, secondary and tertiary prevention, much of it carried out by local government and VCFSE partners as well as within the NHS itself. Furthermore, much ‘prevention’ work is embedded within other services that are also directly concerned with treatment. DHSC should establish a working group of local government, public health leaders, DHSC (including OHID), NHS England, as well as leaders from a range of ICSs, to agree a straightforward and easily understood framework. As part of this work, the group should consider the guidance to local government on the use of the public health grant.

2.18 Once this agreed framework is developed, ICSs should establish and publish their baseline investment in prevention. This should be delivered through the ICP and include both NHS and local government spending on prevention. Especially within larger ICSs, it will also be important to establish the baseline at place level; indeed the ICS view might be built up from place level. Different ICSs will approach baselining in different ways; what matters is that it is done in all systems using a consistent framework.

2.19 By autumn 2023, we should expect the framework to be completed, with all ICSs reporting their prevention investment on a consistent basis by 1 April 2024. Both the initial framework, and the baseline measures, should be reported to and considered by the proposed cross-government arrangements on health improvement I outline below.

2.20 Finally, the government, NHS England and ICS partners, through their ICP, should commit to the aim of increasing resources going to prevention. In particular, I recommend the share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years. Given the constraints on

the nation's finances, this is my most challenging recommendation; some ICSs will find it more difficult than others, depending on their current financial position as well as the strength of collaboration and common purpose between partners. But an ambition of this kind is essential if we are to avoid simply another round of rhetorical commitment to prevention.

2.21 As public finances allow, the public health grant to local authorities needs to be increased. The most recent government spending review represents the latest in 8 years of real-term squeeze on local authority funding for public health and other essential services. Investment in prevention and early help is essential if we are going to extend healthy life expectancy, reducing the financial burden to health and social care and strengthening local economies.

2.22 In addition, within the NHS itself, every opportunity should also be taken to refocus clinical pathways towards prevention. At the moment, pathways for different conditions often begin with diagnosis and focus on treatment. Instead we must shift the focus and resources towards preventing the condition occurring, diagnosing early and preventing avoidable exacerbation. I welcome the announcement of a major conditions strategy which seeks to address this issue. I also support the recommendation of the recent Health and Social Care Select Committee (HSCC) inquiry into the autonomy and accountability of ICSs that '… the major conditions strategy [should] put prevention and long-term transformation at its heart'. The prevention work done in secondary and tertiary care settings, rightly highlighted by NHS England as receiving increased priority and investment in recent years, must be seen within the wider work of an ICS on prevention. An example of this in action is the work being done under the Core20PLUS5 framework focusing on COPD, which has led to a reduction in unplanned respiratory admissions.[10] Refocusing clinical pathways on prevention will be supported by my points set out below on primary care, which has a particularly important role in embedding prevention.

2.23 ICS leaders should also challenge themselves - and expect to be challenged - to work together to use existing resources as effectively as possible. The Joint Forward Plans (JFPs) that ICBs have been asked to prepare by 30 June 2023, reflecting the system-wide priorities established through the ICP's integrated care strategy, provide an opportunity for ICSs to set out their ambitions to shift the model of care towards prevention. The process for developing JFPs has been underpinned by a much more permissive and collaborative approach from NHS England, compared with previous CCG planning exercises. The collaborative work on the 2024 to 2025 planning guidance provides another opportunity to agree how a further shift on prevention should be achieved, year on year.

[10] Core20PLUS5 (adults) - an approach to reducing healthcare inequalities

Embedding health promotion at every stage

2.24 There is currently no cross-government, national equivalent of the wide partnership involved in an ICS. To enable successful integration in systems, parallel integration across Whitehall is needed. I recommend that the government leads and convenes a national mission for health improvement designed to change the national conversation about health, shifting the focus from simply treating illness to promoting health and wellbeing and supporting the public to be active partners in their own health. To underline its importance, this could be led personally by the prime minister.

2.25 This new mission should be supported by appropriate cross-government arrangements, possibly including a revived Cabinet Committee that includes a senior minister from all relevant departments, as well as DHSC's Office for Health Improvement and Disparities, NHS England and the new Office for Local Government. An early priority should be the creation of a National Health Improvement Strategy, identifying priority areas and actions. I also support the HSCC's recommendation that DHSC should publish, as soon as possible, the proposed shared outcomes framework. This work should develop a small set of clear, high-level national goals for population health, with appropriate timescales and milestones for action. I would expect the government to consider how this framework could be used to consolidate current existing, fragmented outcomes frameworks to enable an aligned set of priorities across health and care.

2.26 These priorities should then be taken into account when setting the mandate for the NHS as well as developing NHS planning guidance and other material for systems.

2.27 It is not for this review to prescribe what this framework would look like, such a framework needs to be developed in collaboration with ICB and ICP leaders, as well as leaders from across the NHS, local government, social care providers and the VCFSE sector. It is vital that there is also full engagement and involvement with the public, patients, service users and carers (including unpaid carers), building upon the important work of Healthwatch, the Patients Association and many other patient and user advocacy groups. We should also learn from international examples, including the Australian Health Performance Framework which reports on the health of Australians, the performance of healthcare and the Australian health system, including health behaviours, socioeconomic factors and wellbeing as well as the safety, accessibility and quality of services. It provides an impressive, interactive online tool that allows the public to obtain information at national, state and local level, disaggregated by demographic and other factors.[11]

[11] The Australian Health Performance Framework (AHPF) is a tool for reporting on the health of Australians, the performance of health care in Australia and the Australian health system

2.28 The NHS Assembly, established by NHS England in 2019, brings together a wide range of partners from within and beyond the NHS, providing an invaluable private forum for advice and challenge to NHS England itself. This should continue and will be complemented by the new arrangements proposed below.

2.29 However, in view of the establishment of statutory ICSs, there is also a clear need for government to have an appropriate forum to engage with integrated care partnerships (ICPs) - the convenors of ICSs as a whole - more widely. This would provide the opportunity for a 2-way exchange between ICP leaders and the relevant government departments and agencies, allowing ICP chairs to raise matters of priority directly with ministers and officials. I therefore recommend that a national ICP Forum is established. This could be convened by government itself, if my recommendation is accepted, or alternatively by the ICS Network and the Local Government Association together. It should include representation from DHSC, DLUHC (including the Office for Local Government) and, in the context of the National Health Improvement mission, the Cabinet Office as well as NHS England.

2.30 To support the shift to a new focus on prevention, population health and health inequalities, I also recommend that the government establish a Health, Wellbeing and Care Assembly, with a membership that mirrors the full range of partners within ICSs, including local government, social care providers and the VCFSE sector as well as the NHS itself. It would also be helpful for the Assembly to be supported by a secretariat drawn from OHID and the Office for Local Government as well as DHSC and NHS England.

ICSs role in embedding population health management

2.31 Improving population health and tackling health inequalities is a complex task. While public health leaders and other experts in the field play and important role, to affect change in all parts of the system requires awareness, knowledge and skills at all levels. Population health, prevention and health inequalities should also be part of the training and continuing development for all professions and embedded in the national workforce plan to help develop the skills needed to improve health equity. ICSs themselves have the opportunity for health and social care professionals to learn from local communities, including VCFSE groups working with disadvantaged and marginalised groups, as West Yorkshire Health and Care Partnership is doing with its health inequalities academy and Cumbria and South Lancashire with their population health and equity academy.

2.32 Giving every child the best start in life, from pregnancy through to late adolescence, is crucial to reducing health inequalities across the life course. Starting with antenatal care, the first 1001 days provide a vital opportunity to support the health and wellbeing of the whole family. Barnardo’s and the Institute

of Health Equity, are partnering to shape the way ICSs improve health and address health inequalities among children and young people. In several parts of the country, local government with responsibility for children's services has led the way in establishing a Strategic Alliance for Children and Young People that brings together all the relevant NHS, education, VCFSE, childcare and other services, partnering with parents and young people themselves to create the most effective and integrated support. Every ICS should ensure that both their ICP's integrated care strategy, and through it their ICB Joint Forward Plan, include a clear articulation of the needs of children and young people within their population, and how those needs will be met through collaboration across the system.

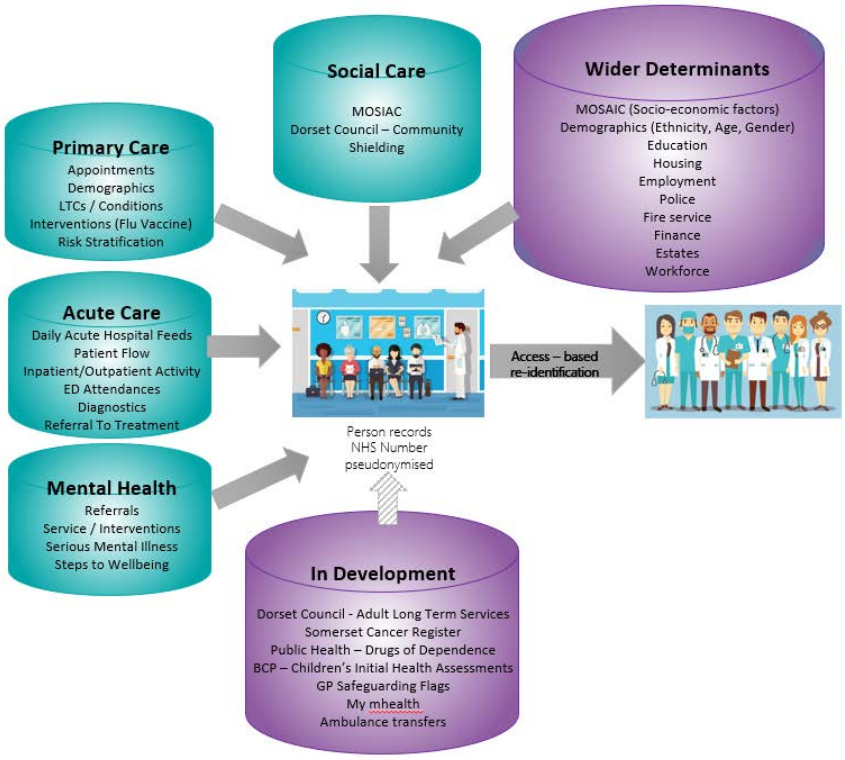
Role of data and digital tools to support the prevention of ill health

2.33 Shifting more of the focus onto prevention - underpinned by whole-system alignment on policy and funding - will radically improve our ability to do much more to tackle the determinants of poor health, with all of the associated health and economic benefits I have described.

2.34 That shift will be more impactful if we enable ICSs to connect data from multiple sources - while, of course, ensuring there are strong safeguards in place for individual privacy and confidentiality. This would transform their ability to accelerate their work around a whole suite of activity including improving individual care and outcomes; improving population health and wellbeing; tackling health inequalities; improving the wellbeing and engagement of staff; and, significantly, improving the productivity of the health and care system.

2.35 Many ICSs and partnerships within them are integrating data from multiple sources as the basis for integrated care and proactive population health management. Dorset ICS, for instance, has worked with its residents and partner organisations to establish a live linked data set, pulling in data from multiple sources, and using it as the basis for screening their fast-growing over-65's population, including for those at high risk of falls, and as a result significantly reducing the number of emergency hospital admissions. Norfolk and Waveney ICS has built on its award-winning COVID Protect approach, establishing Protect NOW, a GP-led collaboration that uses data analytics and risk stratification to

identify people at risk of undiagnosed or poorly managed Type 2 diabetes to improve patient engagement, care and outcomes.



Dorset Integrated Care System[12]

2.36 The North East and North Cumbria ICS is successfully joining up healthcare and social care data, using the OPTICA software, to streamline and simplify processes to effectively support discharge. Staff are using it as the single version of truth in hospital and community settings to help them understand where patients are in the discharge process, highlight blockages and provide actionable intelligence through comprehensive patient tracking and reporting modules. These and many other examples of excellent practice should be used both to support improvement and transformation across all systems and to contribute to work within DHSC and NHS England on wider policy development.

2.37 ICSs and NHS England need to work together to create a single view of population and personal health. To deliver this there needs to be a strong working partnership between ICSs, NHS England, local government, providers, and the VCFSE sector, which will enable systems and organisations locally to collect and utilise high-quality data. A strong partnership between different organisations locally and nationally will be vital for its success.

2.38 We welcome the proposed data framework for adult social care outlined in Care Data Matters, setting out what data the sector needs to collect, the purpose of

[12] Dorset ICS's presentation on a population health management approach to place-based care delivery

those collections and the standard to which it is collected. Adult social care providers should be fully involved in finalising the new framework, reflecting the diversity of the sector, and including those who are already making transformational use of digital and data tools as well as those for whom digitisation will be more challenging. DHSC should work collaboratively with the provider sector, alongside local authorities and other ICS partners to develop the framework, which will set out how we will improve the quality of data and rationalise collections so that we minimise the collection burden.

2.39 Further, building on the Care Data Matters Strategy, I recommend that NHS England, DHSC and ICSs work together to develop a minimum data sharing standards framework to be adopted by all ICSs in order to improve interoperability and data sharing across organisational barriers, particularly focusing on GP practices, social care provision and VCFSEs providing health and care services (who will need additional support in this work).

2.40 I also recommend DHSC should, this year, implement the proposed reform of Control of Patient Information regulations, building on the successful change during the pandemic and set out in the Data Saves Lives Strategy (2022). This reform, already agreed in principle, is essential to allow local authorities and the local NHS jointly to plan and deliver support by accessing appropriate patient information.

2.41 The Shared Care Record (ShCR), now established in all ICSs, should be a priority for further development. To support care that is integrated around individuals, there is an urgent need to enable social care providers, VCFSE providers of community and mental health services and local authorities to access the ShCR on an equal basis with NHS partners. As soon as possible, the ShCR should enable individuals (and their carers where appropriate) to access as much as possible of their own data and allow them to add information about their own health and wellbeing. Finally, the ShCR should expand beyond individual ICSs to support people being treated by a provider in a different system or needing care elsewhere in the country.

2.42 As part of the development of shared care records and EPRs, patients should be able to access their hospital as well as their GP record, for instance updating information held on the NHS Spine, checking where they are on an elective waiting list and removing themselves if they have already had their diagnostic test or procedure and so on.

2.43 NHS England has a crucial role in supporting ICSs, particularly smaller systems, with vendor management of large suppliers (including vendors of population health systems) relationships with industry and ensuring supplier accountability for building systems that conform to NHS - and wider ICS - standards including compliant reporting and interoperability with other key national systems including

the Spine. National user-groups should be established with strategic suppliers to leverage and aggregate demand, coordinate any need for changes, and ensure compliance. As part of the national framework, trusts need to adhere to international standards and the data dictionary for nationally mandated metrics and data submissions and ensure coding rules are not open to local interpretation.

2.44 There is a shortage of skilled professionals, including those who are expert at the cultural change that underpins digital transformation. In line with its new operating model, NHS England should therefore develop in-house skilled teams who can be embedded within a provider or system to train front-line staff and grow the new local capability needed to ensure successful digital and data-driven transformation.

2.45 The Data Alliance and Partnership Board, within the Transformation Directorate of NHS England, has a central role in the development of NHS digitisation and will therefore have a significant impact upon the ability of ICSs to succeed. As an immediate measure, I recommend NHS England should invite ICSs to identify appropriate digital and data leaders from within ICSs - including from local government, social care providers and the VCFSE provider sector - to join the Board. The aim should then be to develop the Board into an Integrated Data Alliance and Partnership Board, creating a national equivalent of the ICS partnership itself. Both are essential to ensure that integration and the vital shift of effort and resources described in this chapter are not held back by an NHS-dominated view of the world.

2.46 Public support and trust for this approach is essential - without it the real transformation opportunities on offer by digital and data will not be fully realised. It is vital that national and local systems work with and engage the public continually to ensure that we can have a data-literate population that we can draw upon.

Empowering the public to manage their health

2.47 The democratisation and personalisation of data and digital tools has created a population that both expects and is able to use digital tools and data to support their health and manage their care and treatment. Equally, the effort to improve the nation’s health can only succeed if we support people to become active and engaged partners in their own health, wellbeing and care.

2.48 Most people rely on increasingly sophisticated digital devices to support almost every aspect of their lives.

2.49 The nhs.uk website is the UK’s biggest health website, with an average 23 million visits a week and the NHS app is a world leading solution in the hands of over 31 million people in England - nearly 7 in 10 of the adult population. But the public can also tap into multiple sources of information and advice, of varying quality,

reliability and cost, and use increasingly sophisticated wearable and other devices to monitor and support their own health and wellbeing. Increasingly, health and care are ‘high tech’ as well as ‘high touch’.

2.50 At the same time, it is vital to recognise that many NHS patients and social care clients are amongst those least able to use digital solutions, whether because of frailty, economic disadvantage, language issues or physical, cognitive or other disabilities (including dementia). Their voice needs to be heard, within ICSs and nationally, to ensure that the design of digital and data solutions is as inclusive as possible. It is also vital for ICSs to provide digital support to people who cannot self-serve. From a high street pharmacy helping someone into a digital consultation booth and putting digital monitors on them for their remote outpatient consultation, to a dementia day centre supporting a carer to do a digital medicines assessment, digital patient engagement won’t be real until it works for the NHS’s most vulnerable users.

2.51 The response to COVID-19 rapidly accelerated digitisation, particularly in the NHS. The pandemic tapped into a deep sense of civic duty amongst millions of people who were willing to share data through real-time tracking systems in order to reduce the spread of the virus; to report their health status daily as ‘citizen scientists’, enabling faster identification of significant symptoms, the spread of the virus and new variants; and to participate in fast, large-scale and often world-leading clinical research trials to establish the most effective forms of treatment.

2.52 I therefore recommend that, building on the existing work of NHS England, the NHS App should become an even stronger platform for innovation, with the code being made open source to approved developers as each new function is developed. The NHS App is itself an open architecture, with 2 components already being open source. Extending this approach would allow innovators - including those with lived experience - to develop solutions to meet the needs of different communities, whether parents of a child with learning disabilities, adults supporting a parent with dementia or people whose first language is not English and so on. A national user group should be established for the NHS App, including people with lived experience and VCFSE groups supporting marginalized or overlooked groups, to ensure public involvement in future developments. With several ICSs developing ‘carers’ passports’, an electronic version within the app would also be invaluable.

2.53 I also recommend that the government should set a longer-term ambition of establishing Citizen Health Accounts. This should be done by requiring all health and care providers (whether NHS or local authority funded or otherwise) to publish the relevant data they hold on an individual into an account that sits outside the various health and care IT systems and is owned and operated by citizens themselves. This should go further than just EPR data and should become a mechanism to enable people proactively to manage their own health and care.

Such a Citizen Health Account would need to be linked into the NHS app functionality and should receive information from sources such as NICE; it could also be a gateway into clinical trials and improving health outcomes. Digital tools and Apps can play a vital role in enabling ICSs to improve population health outcomes, a point emphasised in my terms of reference. A practical next step would be to trial this proposed approach in a limited format working with the NHS app team and suitable third-party vendors under the oversight of an appropriately recruited citizens' panel.

Chapter 2: recommendations

1. The share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years. To deliver this the following enablers are required:

a) DHSC establish a working group of local government, public health leaders, OHID, NHS England and DHSC, as well as leaders from arrange of ICSs, to agree a straightforward and easily understood framework for broadly defining what we mean by prevention.

b) Following an agreed framework ICSs establish and publish their baseline of investment in prevention.

2. That the government leads and convenes a national mission for health improvement. I also support the Health and Social Care Select Committee's recommendation that DHSC should publish, as soon as possible, the proposed shared outcomes framework.

3. That a national Integrated Care Partnership Forum is established.

4. The government establish a Health, Wellbeing and Care Assembly.

5. That NHS England, DHSC and ICSs work together to develop a minimum data sharing standards framework to be adopted by all ICSs in order to improve interoperability and data sharing across organisational barriers.

6. DHSC should, this year, implement the proposed reform of Control of Patient Information regulations, building on the successful change during the pandemic and set out in the *Data Saves Lives Strategy* (2022).

7. NHS England should invite ICSs to identify appropriate digital and data leaders from within ICSs - including from local government, social care providers and the VCFSE provider sector - to join the Data Alliance and Partnership Board.

8. Building on the existing work of NHS England, the NHS App should become an even stronger platform for innovation, with the code being made open source to approved developers as each new function is developed.

9. The government should set a longer-term ambition of establishing Citizen Health Accounts.

3. Delivering on the promise of systems

3.1 The recommendation to place ICSs on a statutory footing was made following NHS England's engagement and then formal consultation with system leaders, partners and stakeholders, following a period of co-production and engagement in policy development that was widely welcomed. In making that recommendation, DHSC, NHS England and local government representatives all acknowledged that to deliver on the ambition for ICSs, the role of national government and national bodies, and the approach to oversight, assessment and performance management across the health and care system would also need to change.

3.2 I cannot emphasise too strongly the scale of the transformation involved in the establishment of statutory ICSs. Because ICSs are partnerships between all those involved in health, wellbeing and care, we can shift the dial on today's immediate and urgent problems, bringing people together to work in different ways. By doing so, we start to create a new virtuous circle of supporting health and wellbeing, and in the process reduce the pressures on NHS emergency care.

3.3 But the creation of ICSs also requires clarity about where accountability sits. Every partner and sector within an ICS operates within its own financial, regulatory and accountability framework, whether that is local government, a VCFSE organisation, a social care provider, or an individual NHS provider. ICBs and ICPs should - and in many instances already do - create the environment to support 'mutual' or 'collective' accountability: where system partners can, with mutual respect and transparency, support and challenge each other to deliver priorities they have agreed together, irrespective of where their statutory accountability sits. That local accountability can and should be strengthened in the ways described in this chapter.

3.4 The NHS, in particular, sits within a framework of national regulation and accountability that is already changing. The new and welcome NHS England operating framework reflects the move to system-based working, with NHS England expecting ICBs to identify the local shared priorities that sit alongside national NHS commitments and to play a key role in the support and oversight of NHS providers.

3.5 The framework also sets out further changes to NHS England's structure and operating model including the behaviours and values expected of all those within the NHS, with a 'One Team' philosophy and a clear expectation around behaviours - collaborative, trusting and empowering, transparent and honest, inclusive and diverse. Within each ICS, as part of their development, partners are working together to agree the values and behaviours for which they will hold themselves accountable; not surprisingly, they bear a striking resemblance in spirit, if not exact words, to those of the NHS England framework.

3.6 The need for faster, and in some cases further, change in the whole framework of oversight and accountability of the NHS itself and ICSs more widely, was a strong theme in my discussions throughout the review.

3.7 Although much of the following analysis and recommendations involve the NHS, this is not because I (or ICS leaders generally) believe the NHS is or should be the dominant partner in the new model. I believe quite the reverse. Instead, it simply reflects the fact that the necessary national oversight and accountability of the NHS needs to respect and allow space for local accountability within the whole ICS.

3.8 Integrated care boards (ICBs) have a particular position within this wider framework. They are a key partner within the wider integrated care system; with local government, they establish the integrated care partnership (ICP) that brings all partners in the system together to produce the integrated care strategy. As NHS statutory bodies, they have a statutory responsibility for arranging for the provision of health services for their residents; they take the lead in ensuring that all parts of the local NHS work together with each other and with social care and other partners; and they are accountable for the overall performance and finances of the local NHS.

3.9 They are simultaneously part of the 'one system' of an ICS while needing to see themselves - and be seen and treated as - part of the 'one NHS' team. Because ICBs are accountable for around £108 billion of the £150 billion made available annually by parliament for the NHS and for the performance of the local NHS, the need for accountability from the ICB to NHS England, and through NHS England to government, for NHS finances and performance is not in doubt.[13] But the mechanisms for accountability need to be both effective in themselves and also proportionate so that ICB leaders have the space and time to be effective partners and leaders within the wider ICS. The improvement-focused work of NHS England with ICBs needs to take full account of the need for ICBs to be 'great partners' within their ICS and not simply within the NHS itself (see below).

3.10 Where an organisation has a clear responsibility for most or all of an issue and controls the resources to deal with it, accountability sits with them. Many issues are matters for the NHS partners in a system rather than a single organisation and one of the benefits of ICBs taking statutory form is that they can provide clear accountability 'upwards' to NHS England and the government for delivery of those things that are national must-dos and which are wholly or largely the responsibility

[13] Data refers to CCG and NHS England spending for 2021 to 2022 financial year - NHS Commissioning Board Annual Report and Accounts 2021 to 2022 financial year - for the period 1 April 2021 to 31 March 2022 (england.nhs.uk) - to note £108 billion is the amount which ICBs were formally allocated in 22/23 the actual amount ICBs are responsible for is likely to be greater when considering funding streams from delegation or other one off in year funding packets.

of the NHS. It will be important to maintain clarity of accountability on these matters.

3.11 NHS England and the DHSC will continue to focus on the capability of the ICB and the effectiveness of all NHS partners, including the ICB, in ensuring clear accountability for NHS performance. The new role of CQC in relation to ICSs (see below) will include an assessment of how strong the mutual accountability between partners is within a system.

Approach

3.12 Conversations with system leaders towards the start of this review often focused on the need to reduce the top-down management of the NHS that reflects decades of hierarchical NHS management, a culture that NHS England's leaders are already changing. My recommendations build on, and are designed to deepen and entrench, their new approach. As the review progressed, however, the conversation moved from a negative view of autonomy ('freedom from') to a positive vision of self-improving systems ('freedom to') where partners work together, motivated by the common purpose of using the resources available to our communities to achieve the best possible outcomes.

3.13 It also became clear that the principle of subsidiarity must be embedded as part of this, enabling local leaders to make decisions at a level as close as possible to the communities that they affect.

3.14 In this chapter therefore, I set out the conclusions and recommendations I have reached from this review, starting with the need to work on the basis of subsidiarity, through strong, empowered Place Partnerships and neighbourhood teams.

Place

3.15 All ICSs are expected to define a clear role for 'place' level partnerships. As emphasised earlier, however, ICSs vary considerably in size and architecture, with corresponding differences in what 'place' means. At one end of the spectrum, there is a system covering around 750,000 people with a single upper tier local authority and one Health and Wellbeing Board. At the other end, there is a system covering over 3 million people, the ICS includes 13 places, 12 of which align with its own local authority area and Health and Wellbeing Board.

3.16 Although part of the impetus for this review came from concerns about top-down management of ICSs and the need for a new balance between greater autonomy and robust accountability, it is just as important that the principle of collaboration and subsidiarity is lived within systems themselves - and that the partnership

working and integration that is already delivering results locally is supported by further changes in the national framework.

3.17 In many ICSs, place partnerships, aligned with Health and Wellbeing Boards and building on their work over many years, will lead much of the work to transform local services and models of care, support population health and tackle health inequalities.

3.18 Some providers, however, report that they are finding it difficult to navigate between different versions of ‘place’ in different systems. While ‘place’ cannot and should not be defined by the DHSC or NHS England, it should be agreed by partners at system level so that there is visible and accountable leadership at place, underpinned by an integrated governance structure. place-based leaders must be enabled to feed directly into system-wide conversations, plans and funding arrangements. Where provider trusts and foundation trusts provide services within different places or systems, there needs to be close collaboration between providers, place, and system leaders to ensure the best outcomes for residents. As every system establishes its place governance and leadership, taking into account relationships with different providers, this information should be transparent and accessible for their communities.

3.19 The same ‘can do’ culture described in the operating framework should equally apply to ICSs’ relationship with their place partnerships and provider collaboratives. Indeed, we have seen examples through the course of this review where place partnerships are still ‘looking up’ to the ICB for permission and instructions instead of ‘looking out’ to the communities and neighbourhoods they serve. More mature systems are supporting their Place partnerships and provider collaboratives to drive initiatives and define their own priorities within the guardrails of the mutually agreed strategy of the ICB and ICP: this needs to rapidly become the norm across all ICSs.

3.20 In several systems, strong and mature provider collaboratives are an important engine of improvement and transformation. Collaboratives can bring together providers to improve access and reduce wait times, share best practice, staff and resources, and help overcome organisational barriers which can sometimes stop services being designed and delivered around the needs of patients and communities. While provider collaboratives, like ICBs, vary considerably in maturity and strength, they have the potential to become the core NHS delivery arm for achieving key system objectives. ICBs have an important role in convening, supporting and resourcing the development of effective collaboratives to help drive service transformation, increase provider resilience and embed a culture of collaboration across providers. It is also important for the relationship between provider collaboratives and the ICB to be clear within each system, with consistency between system objectives and the priorities of its constituent collaboratives.

Embedding a balance of perspectives

3.21 We have heard frustrations from a range of stakeholders at the limited number of mandated members of an ICB. Many feel it is impossible to have their voices heard if they do not have a seat at the table and that ICBs seem to be largely constituted from parts of the NHS rather than across the wider system; this is particularly felt by social care providers and public health leaders within local government.

3.22 It is important to remember that the 2022 Act created statutory ICSs with 2 separate, complementary bodies: an ICP bringing together the full range of partners through a statutory committee jointly created by the relevant upper-tier local authorities and the NHS, with members drawn from many other organisations and sectors; and an ICB, which is a statutory NHS body accountable for NHS performance and finances.

3.23 Given the variation in ICS constitution and size it was absolutely right that the government chose to be legislatively permissive. It was important to allow ICSs to create the architecture and governance for their ICP and ICB that enabled them best to serve their population. But as ICSs come towards the end of their first year as statutory entities, there is a valuable opportunity for them to learn from each other as well as from their own experience and adapt accordingly.

3.24 Crucially, regardless of membership, collaboration within an ICS should stretch wider than just those who are members of ICB boards. Wider partners, including social care providers, the VCFSE sector, and the independent healthcare sector should be fully engaged and their contribution better understood within the NHS.

3.25 However, I have heard a compelling case that social care providers should have a strong voice in every ICS. I agree, although reflecting the general principle of avoiding top-down directions, I believe that each system should decide how best that is done. Similarly, 20 of the 42 ICB constitutions do not specifically mention a role for public health. While public health is and should remain a crucial role of local government and may have been included through the recruitment of partner members on ICB boards, systems should also consider whether this expertise needs to be better embedded within their structures.

3.26 ICBs have been asked by NHS England to review their governance arrangements over the coming months, after their first year of operation. Each ICB should be encouraged to use this process (as many plan to do in any case) as an opportunity to engage with all system partners to consider how the ICB is operating within the overall ICS architecture. Many ICSs are using a process of self-assessment and mutual peer review to support their own self-development; this process should be actively encouraged while not forming part of any formal assessment. Within the governance review and its own self-assessment, each ICS should consider

whether it needs to do more to ensure that social care providers are involved in planning and decision making, that public health expertise is being effectively deployed within the system.

Local accountability and priority setting

3.27 Just as the care and treatment of individuals must be based on ‘no decision about me without me’, so local communities must be involved through a continual process of engagement, consultation and co-production in design and decision-making about local services. Strong and visible local accountability, recognising the principle of subsidiarity, also plays an important role in promoting legitimacy with the local population through empowering, accountable and transparent decision-making.

3.28 In many ways, local accountability is hard-wired into ICSs - through ICPs themselves as well as Health and Wellbeing Boards, Health Overview and Scrutiny Committees, Healthwatch, foundation trust governors and many other forms of patient and public involvement in system, place, provider and neighbourhood working. Health and Wellbeing Boards enable local councillors, alongside other partners, to set place-based priorities for improving health and wellbeing outcomes, to agree joint strategic needs assessments and health and wellbeing strategies for their residents. Where local government, healthcare and system boundaries do not coincide, it is particularly important that all concerned collaborate in the best interests of residents.

3.29 HOSCs are another important part of the local accountability framework, allowing councillors to scrutinise significant changes or issues in health and care provision and hold local NHS leaders to account. Although (like ICSs themselves) they may vary somewhat in effectiveness and maturity, it is important to the success of ICSs that they provide effective, proportionate scrutiny. In Greater Manchester, the HOSCs in all 10 unitary councils have already delegated this role of system oversight to a Joint Health Overview and Scrutiny Committee; a similar approach could be adopted in other equivalent systems. I therefore recommend recognising HOSCs (and, where agreed, Joint HOSCs) as having an explicit role as System Overview and Scrutiny Committees. DHSC should work with local government - through the LGA, the Office for Local Government and the Centre for Governance and Scrutiny - to develop a renewed support offer to HOSCs and to provide support to ICSs where needed in this respect. In assessing the maturity of ICSs, CQC should consider the effectiveness of system oversight provided by HOSCs or Joint HOSCs, or both.

3.30 In line with its statutory responsibilities, every ICS, through its ICP, has already developed an integrated care strategy, informed by Health and Wellbeing Board priorities (themselves reflecting their system JSNA) and co-developed by the ICP

ensuring engagement and involvement with those with lived experience, the wider local population, different tiers of local government and locally elected leaders, including elected mayors.

3.31 In response to the clearly expressed wishes of local leaders, I recommend that each ICS should be enabled to set a focused number of locally co-developed priorities or targets and decide the metrics for measuring these. These should be co-developed with place leaders and adaptable to complement place level priorities, and should be a natural extension of the ICP health and care strategy. These priorities should be treated with equal weight to national targets and should span across health and social care.

3.32 A mechanism for achieving this recommendation lies with the Joint Forward Plans. NHS England has asked ICBs in their JFPs to reflect local priorities agreed with their ICS partners, ensuring these have equal weight alongside national NHS commitments. Building on the integrated care strategy developed by the ICP, the JFP should describe the outcomes the ICS is aiming to achieve. This should include short, medium and longer-term measures that will be used to track progress as well as how different partners will contribute to these and how they will hold each other to account for doing so.

3.33 NHS England itself consulted with local government and other colleagues to develop the guidance for JFPs; as noted earlier, this was very different in tone and approach from earlier, pre-COVID approaches to local NHS planning. I have heard from several colleagues, however, particularly those in local government, social care and the VCSFE sector, that it is confusing or even inappropriate for guidance relating to ICSs as a whole, and ICPs in particular, to come from NHS England when, by statutory design, the local NHS is only one partner amongst many within the system. Initially, at least, the reference to a ‘joint’ plan prompted some confusion about whether ‘joint’ referred to all local NHS organisations, the local NHS and social care, or the system as a whole. Concerns of this kind underline the need for clearer cross-government arrangements in relation to ICSs as a whole.

Self-improving systems

3.34 In any large, complex organisation, whether national or global, it is essential to find the right balance between ‘national’ and ‘local’. ICSs, of course, are not a single organisation; they are a complex ecosystem. So is the NHS. As I have already described, the cross-sector partnerships of ICSs need to be paralleled by stronger cross-government working. But even for the NHS partners within each ICS, the ‘national centre’ is not a single entity: it includes NHS England, as the leaders and headquarters of the service, as well as DHSC and CQC. It is therefore essential

that the roles of each are clearly defined and delineated, in the way described below.

3.35 We know that high-performing organisations and systems combine high levels of autonomy with high levels of accountability. ICS leaders themselves increasingly want to create a self-improving system - empowered and strong enough to set strategy, agree plans and trajectories and to mobilise the collective time, talent and resource of system partners to realise them.

3.36 System leaders will succeed where they exercise the agency to define the ‘how’ and to deliver against agreed local and national priorities. The operating environment needs to allow system leaders the space to use their time and energy to collaborate, innovate, and tackle the problems their systems face and to determine together how improvement is best achieved in their local circumstances.

3.37 But recognising the considerable differences in maturity, relationships and strength of leadership across ICSs generally, and ICBs in particular, NHS England needs to reinforce the support it offers to the ICBs and other local NHS partners most in need of support. The goal should be to build the right leadership capability and partnership culture while recognising that, as a last resort, regulatory intervention by NHS England will be required.

3.38 I urge ministers, NHS England and ICSs to confirm the principles of subsidiarity, collaboration and flexibility that were set out when ICSs were being established and explicitly commit to supporting ICSs to become ‘self-improving systems’. This clear goal would align all national priorities behind a dynamic, collaborative approach, informed by smart data-driven insights, enabling innovation and imaginative solutions.

3.39 As a system matures and is able to manage a wider range of issues more effectively, it should operate with greater agency. We should not see autonomy as a binary state; as something you do or do not have. For complex organisations in complex systems, the balance between what they do for themselves and what they seek or need further support in achieving is always likely to vary from issue to issue.

3.40 Mature systems and organisations are those which have the shrewdest understanding of where autonomy or support are likely to work best for them. Craving autonomy for its own sake can often be a sign of immaturity. It follows that we should think less in terms of ‘earned’ or ‘assumed’ autonomy and more in terms of a tailored combination of autonomy and support that produces effective agency. As systems mature, far more of that tailoring can be done by the systems themselves, with NHS England playing a stronger role in the less mature systems.

3.41 Inherent in this model, therefore, must be a commitment to organisational and leadership development, with a clear expectation on providers and ICBs in particular to work together and share resources to support the development of the right cultures and relationships.

Accountability relationships at the heart of system working

3.42 In the course of this review, several colleagues stressed the need for clarity within ICSs, and with NHS England, about where accountability lies for NHS organisations and partners. The new NHS England operating framework states clearly that the role of ICBs includes:

- first line oversight of health providers
- to co-ordinate and help tailor support for providers
- assurance and input to regulators' assessment of providers
- liaison or escalation to NHS England

3.43 That remains, in my view, a helpfully clear statement. Building on this, and acknowledging that different systems are at different stages of operationalising these roles and relationships, several principles are clear:

- trust chief executives are accountable for what goes on inside their trust, crucially, the quality and safety of the services they provide to patients. This statutory accountability is to their board (and in the case of FTs, also to their governors and members), as well as to NHS England
- trust chief executives and boards are also accountable to system partners - within a provider collaborative or Place Partnership where appropriate, but also with and through the ICB. They are accountable for their part in agreeing and delivering plans to improve patient outcomes and the quality, safety and accessibility of care, as well as to solve performance and productivity issues (including ambulance handovers and delayed discharges) that can only be solved by multiple organisations working together
- trust chief executives and boards are accountable to partners across the ICS (including the ICB) for their part in shaping and helping to deliver the ICS integrated care strategy and Joint Forward Plan, including their focus on prevention, population health and health inequalities
- as the organisation accountable for the state of the local NHS as a whole, the ICB is uniquely placed to understand the connectivities and inter-dependence

between different providers. They have a crucial role as the convenor of the NHS, as the statutory partner with the upper-tier local authorities that also form the ICP and leader and partner in the wider ICS

- ICBs are accountable for the performance and financial management of the NHS in their area. ICB CEOs are accountable to their boards, to system partners and to NHS England for delivery of agreed priorities and plans - including elective recovery, urgent and emergency care plans and so on. This is different from being accountable for the performance of individual trusts. As set out earlier, ICBs are accountable to both NHS England (through NHSE regions) and to their local communities

- it is the role of all system leaders collectively to challenge and support each other in relation to meeting the agreed objectives. In a growing number of systems, this is realised through a distributed leadership model where different system members at system, place and neighbourhood level all have defined responsibilities and accountabilities within their eco-system and providing appropriate support to enable transformational change

- the ICB has a critical role as the vehicle to coordinate the activities of provider collaboratives and the NHS's contribution to place-based partnerships. ICBs are vital to support and enable these partnership arrangements to deliver faster progress on service transformation, recovery, and wider delivery on long-term plan objectives

- ICBs have a direct interest in and commitment to the success of NHS providers within their system. This is partly because, as 'commissioners', they are properly concerned with quality, safety and productivity within individual providers. More fundamentally it reflects the recognition that none can succeed unless all succeed. Rightly, there is now a clear expectation that ICB chairs will be involved in the recruitment of trust and foundation trust chairs, with ICB CEOs similarly involved in CEO recruitment, helping to ensure that provider leaders understand and are committed to system working

3.44 I hope that these principles will be helpful to ICS leaders as they clarify and operationalise roles and accountabilities between partners across their system, and to NHS England as they support ICBs in making their contribution to shared local priorities.

3.45 NHS England should therefore work 'with and through' ICBs as the default arrangement. ICBs should be the first point of support for providers facing difficulties, supporting (and if necessary, challenging) the trust to agree a plan of action, mobilising system partners to agree action on wider issues that affect the trust and calling in improvement resources if required. As described in the NHS England operating framework, within their 'adult to adult' relationship, the ICB will

want to keep their NHS England regional team (and CQC if appropriate) informed on a ‘no surprises’ basis, and seek their advice on occasion, while retaining the initiative and ‘first line’ responsibility. NHS England should continue to evolve the NHS oversight framework and ensure it is being implemented as intended. There will also be times when an ICB asks the region to intervene directly. In all cases, this must be done collaboratively, with both the ICB and the region ensuring there are ‘no surprises’, whoever is in the lead.

3.46 Many ICBs will need time to develop the capacity and capability to lead all aspects of system risk management, particularly when performance pressures are so apparent in almost every part of the NHS. In less mature systems - for instance where relationships are poor or where the ICB has not yet developed the necessary capability - NHS England, in agreement with the trust and ICB, should take the lead in dealing with a trust facing serious difficulties or catastrophic failure. They should continue to involve the ICB, both so they can build insights into the trust’s difficulties (including those caused by problems elsewhere in the system), and because working in this way will help to strengthen the ICB, improve the chances of success with the trust and help the whole system to develop more effectively.

3.47 Of course, there will be occasions when NHS England needs to communicate directly with providers on urgent or other specific clinical or operational issues. It is essential, however, for NHS England to avoid working directly with providers in a way that weakens or disrupts system working, for instance by bringing in support for a trust on delayed discharges without talking to or taking account of the partnership working tackling exactly the same problem.

3.48 I recommend that, in line with the new operating framework, the ICB should take the lead in working with providers facing difficulties, supporting the trust to agree an internal plan of action, calling on support from region as required. To enable this and recognising NHS England’s statutory responsibilities, support and intervention should be exercised in relation to providers ‘with and through’ ICBs as the default arrangement. Where relationships and leadership are less mature, ICBs will need more active support from NHSE regions.

ICSs develop their own improvement capacity

3.49 ICS leaders have the clearest view of what an ICS does, how it works, the interlinkages between different parts of the system and how best to craft solutions to meet the needs of their communities and resolve the challenges within local health and care services. It therefore follows that they should play a fundamental role in their own improvement.

3.50 Quality improvement should be supported by system leadership and at a system level, including through the adoption of common improvement methodologies across systems. However, this has often been deprioritised by other work and requires investment, capability building and drive amongst partners to accomplish. This will help ensure systems drive a learning culture in all system partners and enable future-focussed thinking.

3.51 The NHS Improvement Approach being developed by NHS England will ensure that the development and adoption of improvement methodologies is prioritised across each ICS. This improvement offer should align with the principle of self-driven improvement by establishing some overarching principles that can be adopted locally, rather than prescribing a 'template' for improvement (outlining the 'what' and the 'why' but not the 'how'). It should also build on, rather than duplicate, the work being done by various improvement focused organisations including the NHS Confederation, NHS Providers, Q Community, the Royal Colleges and Academic Health Service Networks (AHSNs), which should all be seen as leaders in driving and implementing this new approach.

3.52 CQC itself is committed to making its assessment of ICSs an opportunity to support and incentivise improvement, rather than a 'box-ticking' or compliance approach. Given the experience of many provider trusts who in the past have found themselves facing overlapping and sometimes conflicting requirements from CQC and NHS England, I also recommend that NHS England and CQC work together to ensure that as far as possible their approach to improvement is complementary and mutually reinforcing.

3.53 ICSs will naturally take different approaches to improvement - some driving this more directly through provider collaboratives and others in which ICSs are developing in-house capacity to support improvement initiatives or train provider staff. Cross-ICS sharing and learning via peer-to-peer networks and collaboratives will strengthen ICSs' approaches to collectively leading improvement. This work is happening - for example through the NHS Confederation's ICS Network - but there is great potential for the 42 ICSs to think of themselves and be supported to develop as a single learning system.

In West Yorkshire ICS, for example, there are clear arrangements for system improvement agreed between the ICB and the acute provider collaborative, the West Yorkshire Association of Acute Trusts (WYAAT), which leads on certain system priorities on behalf of the ICS including the planned care and diagnostics programmes.

WYAAT collectively has (and will continue to) reviewed and made interventions in specialities with workforce challenges to ensure that equitable access for patients continues. This is clearly led and owned by WYAAT as a collaborative, with ICB involvement for oversight of system risk where required and where changes to protect access may impact the way in which patients access services in the short, medium or

long-term. The oversight approach modelled by the NHS England regional team as well as the ICB is one of improvement support, trust and mutual respect, rather than top-down performance management. By adopting a clear, well-managed structure to facilitate partnership working on health inequalities and prioritising population groups' health at system level, the ICS has ensured it can deliver improved outcomes for key groups and maximise its effectiveness across a large population.

3.54 External peer review can be a powerful tool to incentivise and support improvement. The LGA's well-established local government peer review programme provides the basis for an equivalent ICS process for use by ICSs as a whole. Peer reviews should ensure the appropriate involvement of local populations and services users and have access to bench marking tools such as GIRFT and Model Hospital. I therefore recommend a national peer review offer for systems should be developed, building on learning from the LGA approach.

High Accountability and Responsibility Partnerships

3.55 As part of this work, I have heard a clear desire from ICBs and wider system partners to move towards a model with a far greater degree of autonomy, combined with robust and effective accountability. Such a model will need to balance a high degree of autonomy with the need to sustain and demonstrate both performance improvement and effective financial controls.

3.56 In order to make progress as quickly as possible, and reflecting what I have heard with ICB leaders, I recommend that NHS England works with ICB leaders to co-design and agree a clear pathway towards ICB maturity, to take effect from April 2024. Reflecting ICB leaders' views, I expect that this new approach will include self-assessment of maturity supported by peer review mechanisms.

3.57 I have already urged all partners, locally and nationally, to commit to the goal of developing 'self-improving systems'. I have also heard a clear desire, both locally and nationally, for systems as a whole to set a high level of ambition, with the most mature systems being enabled to go further and faster in creating the transformation that, as we have argued throughout, is the most sustainable route to solving immediate performance pressures.

3.58 I therefore recommend that an appropriate group of ICS leaders (including local government, VCFSE and other partners as well as those from the NHS) should work together with DHSC, DHLUC and NHS England to create new 'High Accountability and Responsibility Partnerships'. These should start to operate from April 2024. To reinforce the cross-government arrangements needed to parallel the broad partnerships of ICSs as a whole, this working group should report regularly to DHSC and DHLUC ministers together with the chief executive of NHS England.

3.59 The design of HARPs will, of course, depend upon the work of this group. But to give an idea of the scale of ambition that I have heard from colleagues, I suggest that the framework for HARPs should include:

- a radical reduction in the number of shared national priorities and corresponding KPIs
- a collective commitment by HARP systems, including the ICB, NHS providers, and, crucially, local government and other partners, committing themselves to a small number of priorities for which they would be held accountable both locally and nationally; with clear milestones and outcomes, and linked to Joint Forward Plans
- significantly greater financial freedoms to enable partners to make best use of the resources available to them, including the public estate
- an effective data-sharing approach across multiple partners, with linked data sets enabling proactive population health management, significantly improved outcomes for population groups and substantial reductions in demand for emergency and specialist services. These data sets would also, of course, provide appropriate warning systems to departments and regulators in case performance or finances begin to diverge significantly from agreed plans
- a light-touch national accountability framework, for instance with 6-monthly reviews between NHS England, the ICB and other ICS partners
- the process for ICSs to ask for additional support, and the support available to them

3.60 This approach also recognises that not all systems are ready for advanced levels of autonomy and responsibility, while allowing those who can go faster, to do so. It also recognizes that if circumstances change, and a system is struggling, there are processes in place to provide additional improvement-focused support and help.

3.61 Testing this approach in this way will not only provide crucial learning, it will mark out a clear path for all systems, showing what is possible, and what can be expected, from a high-performing system.

3.62 Although it would not be appropriate for this review to recommend how many ICSs should adopt these new arrangements, in order to test the approach, the scale of ambition needs to be clear. I would hope that around 10 systems would be able to work in this way from April 2024.

The right skills and capabilities for ICBs

3.63 This brings me to the capabilities needed for ICBs themselves.

3.64 As this review has confirmed, the 2022 Act gives ICBs a vital new role as convenors and catalysts for change. All ICBs need to work with their partners - including place boards, provider collaboratives and local government - as well as their own staff to establish and develop people in the roles that are needed in the ICB team to facilitate acceleration of and depth of performance improvement and wider transformation across the system - and to fulfil their multiple statutory duties - working in the new, collaborative ways required. ICBs are, of course, at different stages in this process.

3.65 On 2 March, NHS England announced that ICBs' running cost allowance - already frozen in cash terms for 2023 to 2024 financial year - would be further cut by 30% in real terms over the following 2 years, with at least 20% reductions delivered in 2024 to 2025 financial year, with no provision for redundancy payments.

3.66 Everyone I spoke to during this review is acutely aware of the intense pressures upon the nation's - as well as the population's - finances, and the stress upon VCFSE partners, social care providers and local government, as well as the NHS. Local government and NHS partners, including the ICB, need to work together within individual ICSs to share corporate services and other functions, create single teams and make better use of digital tools to improve productivity. Neighbouring ICSs need to consider similar arrangements, such collaboration helps to strengthen ICSs while achieving better value for public funds.

3.67 As the Wigan Deal demonstrates, financial constraints can and should be used as an opportunity for transformation. But the scale and timing of these reductions create a real threat to the successful development of integrated care systems (ICSs), with too much time and energy from all staff, including those most essential to improvement and transformation, diverted into a restructuring that is potentially too extensive and too fast. Instead, we need to focus on striking the right balance of capability between NHS England, NHSE regions and ICBs. As NHS England implements its new operating framework, I encourage a significant move of resource into systems, supported by smaller, more experienced and highly capable NHSE regions. Without that, the restructuring risks creating a new imbalance between the national, regional and ICB teams of 'one NHS', when the original intention was of course to rebalance resources towards ICBs and ICSs as a whole.

3.68 I therefore recommend that during 2023 to 2024 financial year further consideration is given to the balance between national, regional and system resource with a larger shift of resource towards systems; and that the required

10% cut in the RCA for 2025 to 2026 financial year is reconsidered before Budget 2024.

3.69 Finally, delays and complexity with respect to the appointments process for ICB senior leaders have made it difficult for ICBs to build the right capability and governance to fulfil their statutory functions. In some cases, this has led to many months delay in approving the appointment of ICB medical directors, non-executive members and other senior roles. I therefore recommend that NHS England and central government work together to review and reduce the burden of the approvals process of individual ICB, foundation trust and trust salaries.

The role of the regions

3.70 As the chair of an ICB in level 4 of NHS England's oversight framework (SOF4), with considerable challenges in performance, quality and finances, despite many achievements and real progress, I am particularly alert to the value of a senior NHS England regional team who can provide expert advice. Regional teams can help to mobilise, support and resource sustained improvement efforts across the whole system as well as in individual providers and challenge us, in the ICB and working with all NHS providers, to go further and faster. On occasion, of course, they may also need to exercise NHS England's statutory powers of regulatory intervention.

3.71 As 'one NHS', however, we need to make sure that there is the right balance of capability between NHS England, NHSE regions and ICBs. There are a number of fixed points in determining this balance - for example, NHS England will, and should continue to hold statutory regulatory functions in relation to ICB performance. However, there is also a clear need for flexibility - with different areas needing their regions to be structured in different ways, depending on the maturity, size and challenges facing them.

3.72 A region with a small number of large systems with mature relationships and effective, experienced leaders should work in a very different way from a region with several small, relatively immature systems - and both will be different from a region with a wider mix. For the North East and North West, NHS England has already established a single regional director and team in place of the previous 2. As systems mature, the regional arrangements will continue to change, with systems individually or collectively taking on the responsibility for system and regional leadership, with regional teams focusing on their statutory roles rather than on ICSs.

3.73 In other NHSE regions, particularly those with smaller and less mature ICSs, a small number of senior people at the region who know and understand each system (with its particular geography, history, demography, provider configuration and so on) and, crucially, have built strong relationships with the key people within

the system, will remain invaluable. Those NHSE regions should maintain a role as the collective agent for ICBs and the local NHS within ICSs, and should facilitate the resolution of particularly difficult issues, such as the best configuration of vital specialist resources.

3.74 In order to make this approach a reality, NHS England regional teams should work based on a collective set of principles to support systems in translating national expectations to fit local circumstances, brokering national support for ICBs with struggling providers, and supporting less mature systems to develop their own capacity and capabilities. If an ICB requires support or further escalation, or both, then this should be agreed between NHS England Region and the ICB. Only if further escalation is required should national NHS England be involved.

3.75 Improvement rather than 'performance management' should be the dominant approach and priority. NHSE regions should operate as equal partners with ICBs, aligned with the principles as described in its operating framework: "mature, respectful and collegiate, underpinned with effective lines of communication and a 'one team' philosophy".

3.76 There is good practice already of this with examples such as the Northeast and Yorkshire 4+1 scheme and a 'compact' in the South West. Arrangements should be agreed between NHS England and ICBs for the joint governance within NHSE regions.

3.77 Strong relationships and clear oversight arrangements in West Yorkshire are supporting the system to improve care for patients. West Yorkshire ICS has been a partnership since 2016 so has had several years to build up the trust and relationships between Place, providers, the ICB and NHS England regional teams. Within the wider region, they operate on the basis of a 4 ICSs + 1 region model, agreeing regional targets with NHS England regional team and other local ICBs which are then measured at a regional level. This approach helps facilitate peer learning between ICSs to compare local approaches to delivering regional targets. In line with this approach, I would expect all ICSs to continue co-designing arrangements for regional support that best support their continuing development.

3.78 An important part of the support that regional directors can mobilise sits within the many NHS England programmes focused on particular diseases, conditions and so on. The national cancer programme, for instance, is an example of the essential role for NHS England in convening leading clinicians and scientists, national cancer charities and patient advocacy groups to drive and support life-saving changes in prevention, early diagnosis, treatment, patient experience and access. Such work can only be done once, as NHS England's new operating framework explicitly recognises and it is a task for NHS England itself as the headquarters of the service.

3.79 But the multiplicity of national programmes has created real problems, with different national programmes reaching out directly to individual providers and systems, adding to the plethora of meetings, guidance, templates, demands for data and such like. It is helpful that NHS England is significantly reducing the number of national programmes, it is equally important that planning the future support and requests from these programmes will go through NHSE regions rather than directly to providers and systems.

3.80 It will be important for ICS partners themselves, working within NHSE regions, to reinforce this new and welcome way of working; as the Messenger Review underlined, these changes in culture and behaviours take time and sustained effort to bed in.

3.81 There is now an opportunity to build on the new NHS England operating framework to co-design the next evolution of NHSE regions. I recommend that ICS leaders should be closely involved in this work, to ensure that NHSE regions can operate as effective partners, and the collective agent of the local NHS within ICSs.

Organisational development

3.82 Real, lasting change happens because people come together around a common purpose. It is the job of leaders to create the culture and behaviours, backed by the right systems and processes, to enable that to happen. Realising the potential of ICSs - and the neighbourhood teams, place partnerships and other structures within them, including ICBs - needs substantial, sustained investment in organisational development, collaborative leadership and team working across different professions, sectors and organisations.

3.83 Local government and NHS leaders at place and system level can already draw upon the support provided in collaboration between the Local Government Association (LGA), the NHS Confederation and NHS Providers. NHS England has made some organisational development support available for ICBs, drawing upon a variety of change management partners and coaches.

3.84 Depending upon its starting point, each ICS needs to sustain, develop or create its own organisational development programme across the whole of the health and care system. This should include partners from neighbourhood, place and system level arrangements across the NHS, local government, the VCFSE sector and social care providers. Because of the fragmentation and siloed working between the NHS and social care, and within the NHS itself, there is a particular responsibility upon councils with social care responsibilities and NHS leaders - in foundation trusts, trusts and primary care, as well as the ICB - to work together as part of this process of creating a common culture.

3.85 I therefore recommend that NHS England work closely with the LGA, Confed and NHS Providers to further develop the leadership support offer. Investment of this kind is a necessity, not a luxury. But within each ICS, partners need to work together to make the best possible use of limited funds, including the training and development budgets of the ICB, individual NHS organisations and local council partners. The need for such support is echoed in the HSCCs most recent inquiry of ICS autonomy and accountability. Their recommendation calls for government and NHS England to set up and fund an ICS leadership development programme, specifically targeted at supporting leaders of and within ICSs to develop the skills required to be successful system leaders. Statutory partners in ICSs should consider how they support VCFSE and social care provider partners to be fully included in organisational development. Creating shared teams between local councils and the NHS (for instance, a single integrated health and wellbeing communications team) will help to build common purpose and understanding of the very different culture, governance and financial frameworks of different statutory organisations as well as making better use of scarce resources.

3.86 The previously described goal of self-improving systems also requires sustained investment in improvement capabilities. Quality improvement should therefore be supported by system leadership and at system level (or, in very large systems, at place level).

3.87 A few systems or place partnerships have already adopted a common improvement methodology. Others have started bringing together QI leads or teams across different organisations to create a QI community. Mutual understanding, sharing learning and building a common approach will be a powerful driver of improvement and transformation across the local health and care system. When assessing the maturity and effectiveness of ICSs, CQC should take into account the extent of collaboration around organisational development and quality improvement.

3.88 In further recognition of the need to sustain and deepen culture change, I recommend that the implementation groups for the Messenger Review should include individuals with significant experience of leading sustained cultural and organisation change in local government and the voluntary sector as well as the NHS.

National organisations

Relationship between DHSC, NHS England and ICSs

3.89 Consideration now needs to be given to the relationship between NHS England, the department and ICSs themselves. The 2012 Act separated NHS England from the department, placing operational leadership in an arm’s length body. Policy

making, including setting the mandate for NHS England, remained with the department. That arrangement, confirmed by the 2022 Act, reinforced the position that NHS providers, and now NHS ICBs, are accountable to NHS England which is, in turn, is accountable to the Secretary of State and, through them, to parliament. NHS England has also taken on new functions from NHS Improvement, Health Education England and NHS Digital - making clarity of responsibility and accountability even more important than before. It is increasingly clear, however, that these arrangements are not working as intended. From the standpoint of providers and systems the apparently clear distinction between the department and NHS England can feel increasingly blurred in practice.

3.90 Everyone wants ICSs to succeed: the department and its ministers, NHS England and ICS partners and leaders themselves. The fact that all 3 can, at times, have quite different perspectives on the central issue in my terms of reference - the balance between greater autonomy and robust accountability - does not flow from any difference in the outcomes they seek. All want the best outcomes for patients and the public, improved working lives for staff and the most effective use of public funds. Their differences of perspective are driven by differences in position within the health and care system rather than different goals.

3.91 I have therefore sought to understand all 3 perspectives and reflect them here, starting with ICSs.

3.92 I have been directly involved in the development of ICSs over the last 6 years, as independent chair of a sustainability and transformation partnership (STP) and then an ICS, and now as chair of an ICB and deputy chair of the ICP. The views of system leaders are reflected throughout this report, including the clear desire for greater autonomy alongside effective accountability. They want to look outwards, not upwards. ICS leaders themselves recognise ministers' personal commitment to ICSs and welcome their increased interest. It is not only helpful but essential that ministers become as familiar as possible with how different ICSs are working, their real achievements and the challenges they are encountering. Ministerial attention can itself help to reinforce partnership working, highlight and spread excellent practice and innovation and challenge ICS leaders to go further and faster. On the other hand, many ICB leaders are concerned by the growing number of requests for detailed performance data or explanations of exactly what they are doing on a specific performance issue, duplicating or conflicting with clearly established lines of accountability. I am therefore not surprised to hear a growing number of system leaders say that "it feels as if we have 2 centres now."

3.93 In relation to NHS England, from the start of this review, I saw how easy it would be to frame the issue as "ICSs good, NHS England bad". Easy, but wrong. In the announcement of the review itself, I stressed that the review would 'build on the welcome work already done by NHS England to develop a new operating model'. Both before and since 2012, I have worked closely with what is now NHS England.

I value their clinical and operational expertise and have great respect for their many outstanding leaders. It is clear to me that the leaders and staff of NHS England are committed public servants who have a real dedication to supporting the NHS. As both the headquarters for the NHS and as an arm's length body of government they face daily challenges, but it is to the great benefit of the system and to government that they continue to tackle those challenges. NHS England deserve a good deal of credit for the changes they have already made and are continuing to make, referred to in other parts of this report. They themselves initiated STPs in the first place, giving them welcome freedom to develop in response to local circumstances. As the headquarters of our National Health Service, they continue to have a vital role in relation to the NHS as a whole that must be recognised and supported.

3.94 Nonetheless, in matters affecting the success of ICSs, including how they are regulated and held to account, NHS England needs to go further and faster in some respects. They also need to recognise that, as the headquarters of the NHS, they cannot also be the headquarters of ICSs where the local NHS is only part of a far wider partnership.

3.95 Turning to the Department of Health and Social Care: I have been Secretary of State for Health myself, working closely with the many exceptional officials who then formed the ‘department’ team. Both as an ICS leader and particularly through this review, I have leant on the policy expertise, insights and dedication of today’s officials. It is clear that ministers are committed to lightening the load of ‘must dos’ and we have seen, for example, a welcome shortening of the mandate in recent years, a trend I am confident will continue this year. Personally, I have felt the same heavy weight of responsibility for the NHS and the social care system that ministers feel today. I know what it is like, being constantly summoned to the House of Commons to deal with urgent questions or facing media interrogations about serious problems in a particular area. Like ministers today, I held the NHS to account, seeking to understand and support them but also to challenge. I expected to have the information I needed to fulfil my role. For ministers, it can also often feel as if they are in a parallel centre that is being held publicly accountable for performance as well as policy.

3.96 Nonetheless, in matters affecting ICSs, including how they are regulated and held to account, it is essential that there is clarity on roles and responsibilities and clear boundaries between operational management and wider responsibilities. This makes alignment between the department, Secretary of State and NHS England vital. The department needs to accept that provider trusts and ICBs do not report to them, and maintain the distinction between operational performance management on the one hand, and accountability and challenge on the other. And, of course, there needs to be an open, trusting and respectful relationship between NHS senior executives and ministers themselves. Just as we should expect NHS England to work ‘with and through’ ICBs in their relationship with

providers, so we should expect the department to work ‘with and through’ NHS England in its relationship with systems and providers. In both cases that does not preclude direct engagement, but it does set a default expectation for how things should normally work.

3.97 My terms of reference specifically asked me to focus on ‘real time data shared digitally with the Department of Health and Social Care, and on the availability and use of data across the health and care system for transparency and improvement’. Although I had expected to find a broad measure of agreement on this point, this proved not to be the case. DHSC and its ministers are frustrated by their inability to get data that they want. NHS England itself has changed its stance on sharing data and information with DHSC, with automated data-sharing feeds updated regularly. ICB and trust leaders themselves are increasingly concerned about multiple requests for data and information, often extremely detailed and at very short notice. As the above account illustrates, however, what appears to be a duplicative request for information from one perspective can, from another point of view, be a reasonable action to ensure that parliamentary accountability is done properly. This helps to show why effective alignment can never be found solely in the rulebook or the legislation - it depends on building relationships of trust and on mutual understanding.

3.98 Digitisation of the health and social care system, together with the rapidly growing use of smart data analytics tools, will help to provide the ‘single version of the truth’ that is an essential part of aligning all partners, locally and nationally, around the same purpose and goals. I make recommendations on that and other matters that will help both ICSs and national bodies, including ministers.

3.99 The pandemic itself provides an example of successful data sharing between NHS England, No.10 and DHSC, integrating information from the NHS on cases, symptoms and outcomes as well as population and demographic data to create a ‘single version of the truth’, updated daily and used as the basis for ministerial press conferences as well as policy decisions. And this report provides examples of the impressive results achieved within systems from data-driven approaches to identify people and communities at risk and provide them with the early intervention that is both better for them and relieves pressure on health and care services.

3.100 In order to strengthen the alignment between the department, NHS England and ICSs, I suggest a rapid stocktake - potentially led by the No. 10 delivery unit - to assess data flows for timeliness and usefulness. Its conclusions should be shared with systems, Secretary of State and NHS England as a basis for agreeing actions for using data to further support the work of all 3.

3.101 As an ICS leader remarked to me ‘real change comes from real work’ and the more that systems, NHS England and ministers can do together to make sense of

the key issues and work through practical solutions, the easier it will be for partnership working to be sustained into future challenges. I therefore suggest that DHSC ministers (along with DLUHC colleagues) build on their work with NHS England and systems to undertake shared learning from this winter. This should take the form of shared conclusions and actions during this year, and should report to the Secretaries of State for DHSC and DLUHC and the chief executive of NHS England.

3.102 For the new system we have created to succeed, we need some honest conversations about what is working and what needs to change. There are many unsung examples of effective team working between the department and NHS England and systems in all and every permutation; but there are also examples of tensions, wasted time and needless frictional costs generated by uncoordinated pursuit of organizational goals that do not take account of their wider effects. This also makes it harder for vital partners outside of the NHS - including local government, the VCFSE and social care providers - to collaborate effectively with the NHS. It can often feel to them like looking in on a purely NHS conversation that absorbs enormous amounts of time and energy that could be devoted to joint working. Everyone needs to change, and everyone needs to give a little so that the system as a whole works better.

National planning guidance

3.103 As I've previously made clear the public's immediate priorities - access to primary care, urgent and emergency care, community, mental health and social care services and elective diagnostics and treatment - are priorities for all of us, ministers, NHS England and ICSs. The level of interest in these matters rightly makes them a central part of accountability for ICBs and their partners in the wider ICS.

3.104 However, effective change in any system - particularly one as complex as health and care - needs consistent policy, finances, support and regulation over several years. Adding new targets and initiatives, non-recurrent funding or small funding pots, makes it impossible to plan new services or even recruit staff, wastes money and time, and weakens impact and accountability.

3.105 The government of which I was part introduced national targets as part of a number of measures to improve NHS performance. Although controversial at the time, a small number of targets undoubtedly contributed to significant improvements in performance and productivity. Reflecting on that experience, 4 points stand out to me.

- few targets concentrate minds; the more that are added, the less effective they become

- the higher the performance standards (for instance on emergency department waits), the less they allow room for vital clinical judgement

- the combination of too many targets, performance standards that are not clinically supported and an excessive focus on hitting targets by managers or boards themselves can lead to ‘gaming’ of the targets or even a disastrous neglect of patients themselves[14]

- I also learnt that targets that focus on end-to-end pathways can be particularly powerful in joining up care between siloed organisations, such as the target initially set for patients with suspected cancer to be seen by a specialist within 2 weeks of referral by the GP

3.106 My terms of reference setting out that the review will ‘consider the scope and options for a significantly smaller number of national targets’ reflect the widely-held belief that national targets had become wholly excessive. This is exemplified with the 2022 to 2023 planning guidance expressing national NHS objectives in 133 asks across 10 domains. The 2023 to 2024 planning guidance, developed in close consultation with ICB leaders and this review itself, made welcome and significant progress, summarising national NHS objectives on a single page with 31 asks across 12 domains.

3.107 Further progress should be made in the planning guidance for 2024 to 2025. I recommend that ministers consider a substantial reduction in the priorities set out in the new mandate to the NHS - significantly reduce the number of national targets, with certainly no more than 10 national priorities. Given the need to integrate care around patients themselves, it would also be helpful if the planning guidance could focus on outcomes rather than individual NHS sectors (primary, community, acute and so on). In particular it would be helpful to focus even more rigorously on the ‘what’ and the ‘why’ rather than the ‘how’. I therefore endorse the recommendation of the Select Committee that "Targets for ICSs set by DHSC and NHS England should be based on outcomes". There may be times when greater prescription around how targets are achieved is needed, but we believe this should be done sparingly.

3.108 In turn, we can expect the planning guidance for 2024 to 2025 to reduce further the number of 'domains' and 'asks'. Building on the approach taken last year, NHS England should continue to work closely with ICBs themselves as well as the

[14]The Francis report found that the failures in Mid Staffordshire was ‘in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.' Mid Staffordshire NHS Foundation Trust Public Inquiry. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary (HC 947). The Stationery Office.

department to produce the new guidance. This focus on a small number of key priorities is particularly important in the current, highly-stressed circumstances.

3.109 I would also strongly urge that the necessary focus on reducing elective care waits be matched by an equal focus on reducing waiting times for acute mental health treatment.

3.110 I understand that the reduction of the number of 'domains' and 'asks' has itself caused concern, particularly amongst those whose area is not included. It is important to stress that national standards for clinical care, including those set by NICE, remain in place and will, of course, continue to guide the care provided to patients with different conditions.

3.111 I would also suggest harnessing the enthusiasm in both NHS England and systems for a more co-productive way of developing policy. In the development of its strategies and plans (for example the UEC strategy or the primary care recovery plan) NHS England works hard to engage a broad cross section of experts and stakeholders, with systems playing an increasingly strong role in the shaping of policy. Both NHS England and ICS leaders should build on this to deepen both the involvement of ICSs in shaping policy and the understanding within ICSs of that involvement. There should be very few ‘degrees of separation’ between an ICS leader and a new policy or strategy: either they or a peer should have had a hand in shaping it.

3.112 Building on the process of engagement used by NHS England in preparing the 2023 planning guidance, NHS England should commit to further deepening this collaborative approach in developing the 2024 planning guidance. Furthermore, where significant new plans and priorities directly impacting systems are added in-year to the planning guidance framework, these plans should also benefit from a process of collaborative co-design with system leaders.

3.113 Finally, I recommend that, to support this, NHS England and ICBs should agree a common approach to co-production, including working with organisations like the NHS Confederation, NHS Providers and the LGA.

Enhanced CQC role in relation to systems

3.114 Greater autonomy for ICSs - including, in particular, a radical reduction in central targets and top-down performance management together with an increase in financial autonomy and flexibility - will enable ICS leaders to deliver both short term performance and longer-term improvements in population health.

3.115 However, greater autonomy must come with more effective accountability to patients and the public as well as to NHS England and ministers.

3.116 Having started the review with a degree of scepticism about CQC, I now strongly support their enhanced role in relation to ICSs. This will build on their core mission to inform patients and the public about the quality of care and the effectiveness of services based on their oversight and inspection of health and social care providers.

3.117 The Health and Care Act 2022 included an important new role for CQC to review ICSs, alongside a further new role to assure local authority commissioning of social care. Once CQC has put in place arrangements to review systems, developing their approach and capability in partnership with a wide range of ICS leaders both from ICBs and ICPs, they should provide clear and transparent ratings on the quality of services within the ICS, across the key domains of care services - including primary care, mental health, community services, social care and both emergency and elective care at acute hospitals. They should also make an assessment of the level of maturity and effectiveness of each ICS as a whole, including a rating of the ICS leadership itself, based on an assessment of how far ICS structures (including of course the ICP and ICB) are adding value and enabling the system as a whole to meet its objectives and improve outcomes. CQC should then use these different ratings and assessments to inform an overall judgement on the achievement, challenges and areas for improvement for each ICS.

3.118 This work - which should be led by a Chief Inspector of Systems - should draw on multiple sources of quantitative and qualitative data, including CQC's existing inspections, as well as NHS England's information on ICB and providers use of financial resources. In its review of the ICS (effectively a 'well-led' review), CQC should assess how the ICS itself (including the ICP, ICP, place partnerships and Provider Collaboratives) adds value, enabling the whole to be more than the sum of its parts. Reporting should focus on helping ICS partners to improve more rapidly, as well as providing a basis for regulatory intervention where required. We know the most effective health and care organisations and systems are those where quality, performance and financial management go hand in hand, and so ratings must take account of all of these elements - and so we would not expect the highest ratings to be given to a system where the financial position is not being well-managed.

3.119 We recognise that this will be a significant shift for CQC, although building on the work that is already underway with ICS leaders to develop the right approach and capability for their new responsibilities. As a result, 2023 to 2024 should be a transitional year, allowing CQC and ICSs to co-design the most effective approach to CQC reviews, sharing learning as both CQC and ICSs embed system working and enabling it to generate ratings that the public, as well as ICS partners themselves, can trust.

3.120 We also recognise that ICSs, and ICBs within them, are at different levels of maturity, and differentiation between them will continue to be both necessary and important. As explained elsewhere, a ‘baseline’ of increased financial autonomy and flexibility should apply in all ICSs, with further freedoms also focussed on the more mature systems and ICBs during 2023 to 2024, so that NHS England can concentrate its improvement work and financial performance management on those ICBs where it is most needed, as well as fine tuning the arrangements for financial autonomy and flexibility.

3.121 CQC have been clear that they do not want to carry out 'compliance' inspections and have seen the opportunity to capture and help scale innovation. It is vital that assessment of ICSs does not become yet another set of tick-box capability and competency requirements but is a useful tool for enabling each system to develop and improve. I welcome CQC’s recognition of that risk and their commitment to understand the very different starting-points of each ICS, how each system stands in relation to its own stated ambitions and focusing on how each ICS is adding value and developing capability as a self-improving system.

3.122 In particular, as recommended in other parts of this review, CQC should include within its assessment of ICS maturity:

- how different partners - local government, the VCFSE sector, social care providers, other ICS partners and the local NHS including the ICB - themselves assess their engagement and relationships within the ICS itself, including the extent to which both public health expertise and the social care provider sector are involved in the leadership of the system

- the strength of the system-wide integrated care strategy with Joint Forward Plans, clear priorities, outcomes and timescales, providing a local outcomes framework against which the system can be held accountable by local residents and others

- the coherence, consistency and impact of arrangements at place and neighbourhood level within the ICS

- how far the system is making progress in shifting resources towards prevention, population health and tackling health inequalities

- how well systems work with and respond to support provided by the NHSE regions within the new operating framework, including the goal of supporting ICSs to become self-supporting systems

- practical examples of ICS partners identifying priorities, agreeing a diagnosis of the problem as well as a plan of action and making progress towards agreed outcomes. This should include looking at specific pathways of care

from a patient and service user perspective. It should also take account of Ofsted's assessment of children's social care services and whether or not system partners have developed an effective strategy for prevention, population health and tackling health inequalities amongst children and young people

- whether system partners are developing a framework of mutual accountability, sharing performance and financial data transparently in order to agree a single version of the truth; developing an ability to learn from mistakes and respond effectively to problems without blame within systems (in other words, focusing on quality improvement and creating a learning and improvement culture, building on peer review, 360-degree feedback, measurement of staff engagement, role of HOSCs and psychological safety)

- whether the system is finding ways of shifting emphasis and resources towards prevention, population health and tackling health inequalities

3.123 Reviews should also share best practice and insight from other systems in suggesting recommendations for improvement and identify good practice to be shared. This would support continuous improvement and stronger relationships. CQC should be mindful to ensure their reviews can help foster stronger relationships and how they can impact fragile relationships in still developing systems.

3.124 CQC has reviewed international experience of integrated care and engaged with a number of ICSs to develop a methodology for ICS inspection. Given the scale of change this represents for the CQC itself, however, at a time when statutory ICSs are in their infancy, CQC and ICSs should work together over the coming year to develop a long-term approach to inspections and ensure that CQC develops the capabilities and skill sets needed to support successful development of ICSs.

3.125 In their first year the focus of CQC should be on calibration of their assessments and supporting improvement and sharing best practice amongst systems within their reports rather than assessment and rating.

3.126 This should be driven by co-design between CQC and systems sharing learning as both CQC and ICSs embed system working. This should include engagement with ICBs in forming a view about the ways in which clinical risk are held and managed within and between providers and other partners, incorporating this into their judgements of registered services.

3.127 I would also suggest investment in training for the CQC workforce to upskill staff and bring in colleagues with experience from systems, including where appropriate other system leaders.

3.128 While I appreciate work is beginning already on CQC's new inspection regime for adult social care and reviews of ICSs, CQC should use this year to work closely with and learn from local authorities and systems while they continue to refine and develop their methods.

The role of data for system accountability

3.129 Transparent, accurate and accessible information enables patients and the public to know whether the services they are receiving are high quality, efficient and effective. Equally, clear and effective engagement with the public builds confidence that individuals' data contributions are creating real benefits for themselves and wider society, thus underpinning further improvement and transformation. Transparent data is a powerful incentive and enabler of improvement, reflected for instance in the work of the National Joint Registry (NJR) over the last decade. Using cutting-edge data analytics, and as a globally recognised exemplar of an implantable medical devices' registry, the NJR has already helped to improve patient outcomes, inform clinical practice, ensure the quality and value of joint replacement surgery and support orthopaedic research.

3.130 To develop integrated care with timely, relevant and high-quality performance data, it is essential to ensure that there is a two-way flow between systems and national bodies.

3.131 The new Federated Data Platform (FDP), currently under procurement, should make a significant difference. The automation of data in real time will drive consistency, free systems from administrative burdens and enable effective benchmarking across providers and systems. Although the first stage of implementation is focused on NHS acute trusts, I recommend that work begins at the same time to build a close partnership between NHS England, the FDP developers, and appropriate colleagues from ICSs, local government and the provider sector including primary care, community and mental health, adult social care providers and VCFSE providers to ensure that the full benefits of the FDP can be realised in future, with all parts of the health and care system involved in its development. The strategic objective should be to create a unifying digital architecture across the entire health and care system, with the FDP itself helping to support local systems to address key challenges while also offering the opportunity to share and scale innovative tools and applications.

3.132 In particular I recommend:

- NHS England and DHSC should incentivise the flow and quality of data between providers and systems by taking SITREP and other reported data directly from the FDP and other automated sources, replacing both SITREPS and additional data requests

- data required in real-time by NHS England and DHSC should be taken from automated receipt of summaries to drive consistency; and where possible without creating excessive reporting requirements, data should enable site-level analysis

- data collection should increasingly include outcomes (including, crucially, Patient Reported Experiences and Outcomes) rather than mainly focusing on inputs and processes

- data held by NHS England (including NHSE regions) about performance within an ICS, including benchmarking with other providers and systems, should be available to the ICS itself and national government

- DHSC and NHS England work with nominated ICS colleagues to conduct a rapid review of existing data collections to reset the baseline, removing requests that are duplicative, unnecessary or not used for any significant purpose. This work should be completed within 3 months

3.133 As I stressed earlier, I understand only too well the need for NHS England and DHSC to get up to date information from systems and providers. But it is essential that information-gathering itself does not distract senior leaders and their teams (including the scarce resource of digital and data experts themselves) from the key priority of actually improving performance. Given the scale of improvement required, the present manual reporting burden placed on providers and partners in ICSs is unacceptable. Notwithstanding the severe performance issues in December 2022, in one instance one ICS received 97 ad-hoc requests from DHSC and NHS England, in addition to the 6 key monthly, 11 weekly and 3 daily data returns.

3.134 Continuing automation of data provision, shared between NHS England, DHSC and No. 10, will itself improve matters. In the meantime, further action is required to reduce the number of uncoordinated, often urgent requests for data that can only be provided through time-consuming manual means.

3.135 Even high quality data needs to be supplemented by experience and insights to understand where investment and energy should best be directed, both within systems and between systems and national bodies. For instance, although data may show the same performance challenges in 2 systems or trusts, the causes may be very different (for instance, in one case a well-led trust or system struggling with a fundamental mismatch between demand and capacity; in the other, a combination of weak leadership, antagonistic relationships and poor culture). The support or regulatory intervention required would also be very different, despite the apparent similarity in performance. Insights from systems themselves, regional teams and CQC are vital in complementing performance and benchmarking data.

Chapter 3: recommendations

10. HOSCs (and, where agreed, Joint HOSCs) should have an explicit role as System Overview and Scrutiny Committees. To enable this DHSC should work with local government to develop a renewed support offer to HOSCs and to provide support to ICSs where needed in this respect.

11. Each ICS should be enabled to set a focused number of locally co-developed priorities or targets and decide the metrics for measuring these. These priorities should be treated with equal weight to national targets and should span across health and social care.

12. In line with the new operating framework, the ICB should take the lead in working with providers facing difficulties, supporting the Trust to agree an internal plan of action, calling on support from region as required. To enable this support and intervention should be exercised in relation to providers ‘with and through’ ICBs as the default arrangement.

13. NHS England and CQC should work together to ensure that as far as possible their approach to improvement is complementary and mutually reinforcing.

14. A national peer review offer for systems should be developed, building on learning from the LGA approach.

15. NHS England should work with ICB leaders to co-design and agree a clear pathway towards ICB maturity, to take effect from April 2024.

16. An appropriate group of ICS leaders should work together with DHSC, DHLUC and NHS England to create new ‘High Accountability and Responsibility Partnerships’.

17. During 2023 to 2024 financial year further consideration should be given to the balance between national, regional and system resource with a larger shift of resource towards systems; and that the required 10% cut in the RCA for 2025 to 2026 financial year should be reconsidered before Budget 2024.

18. NHS England and central government should work together to review and reduce the burden of the approvals process of individual ICB, foundation trust and trust salaries.

19. ICS leaders should be closely involved in the work to build on the new NHS England operating framework to codesign the next evolution of NHSE regions.

20. NHS England should work closely with the LGA, Confed and NHS Providers to further develop the leadership support offer.

21. The implementation groups for the Messenger review should include individuals with significant experience of leading sustained cultural and organisational change in local government and the voluntary sector as well as the NHS.

22. Ministers should consider a substantial reduction in the priorities set out in the new Mandate to the NHS - significantly reduce the number of national targets, with certainly no more than 10 national priorities.

23. NHS England and ICBs need to agree a common approach to co-production working with organisations like the NHS Confederation, NHS Providers and the LGA.

24. As part of CQC's new role in assessing systems, CQC should consider within their assessment of ICS maturity a range of factors (set out on page 58).

25. ICSs, DHSC, NHS England and CQC should all have access to the same, automated, accurate and high quality data required for the purposes of improvement and accountability. In particular:

a) NHS England and DHSC should incentivise the flow and quality of data between providers and systems by taking SITREP and other reported data directly from the FDP and other automated sources, replacing both SITREPS and additional data requests

b) Data required in real-time by NHS England and DHSC should be taken from automated receipt of summaries to drive consistency; where possible without creating excessive reporting requirements, data should enable site-level analysis

c) Data collection should increasingly include outcomes (including, crucially, Patient Reported Experiences and Outcomes) rather than mainly focusing on inputs and processes

d) Data held by NHS England (including NHSE regions) about performance within an ICS, including benchmarking with other providers and systems, should be available to the ICS itself and national government

e) DHSC and NHS England work with nominated ICS colleagues to conduct a rapid review of existing data collections to reset the baseline, removing requests that are duplicative, unnecessary or not used for any significant purpose. This work should be completed within 3 months

4. Unlocking the potential of primary and social care and building a sustainable, skilled workforce

4.1 The review terms of reference specifically asked to look at how to empower local leaders to focus on improving outcomes for their populations and making ICSs more accountable for performance and spending, much of which can be delivered though primary and social care.

4.2 Strengthening local leaders' ability to have greater and more flexible decision-making in primary and social care, supported through a more joined up national policy approach, will not only better enable them to deliver improvements in immediate performance, it will be key to improving outcomes in the communities they serve.

4.3 In order to enable the kind of integration, collaboration and autonomy we want to see integrated care systems (ICSs) embody, we need to pull down some of the barriers that currently exist for primary care, social care and the way we train health and care workforce. Breaking down these boundaries will be fundamental to unlocking the potential of system working and reinvigorating the much-needed focus on prevention and early intervention.

Primary care

4.4 Dr Claire Fuller's timely stocktake of primary care has already set out a vision and route-map for integrated neighbourhood working where teams from across primary care networks (PCNs), wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities.

4.5 My recommendations build upon the important work and recommendations of the Fuller Stocktake, focusing on what more needs to be done within ICSs to create integrated neighbourhood teams and integrate care across the whole patient pathway. I also make recommendations on the changes needed within primary care contracting (an issue not included within Dr Fuller's terms of reference).

4.6 On 1 April 2023, all ICBs will take on responsibility for commissioning community pharmacy, optometry and dentistry, through delegation of all primary care commissioning for the first time. Instead of each element of primary care being treated as a separate silo, ICBs now have the opportunity - and the responsibility - to work with all elements of primary care to achieve the accessible, high-quality

and integrated services that residents and local communities need. Much of this work, of course, will be led and delivered with local government and VCFSE partners through place partnerships and integrated neighbourhood teams, involving collaboration with community, health and social care services, and specialist acute services as well as primary care itself.

4.7 Despite currently being constrained by nationally negotiated and held contracts with care partners, ICBs through PCNs and place partnerships, as well as system-wide, can still consider the needs of their local population and determine the best use of resources for that population. They can support the joining up of different elements of urgent care, including 111, community pharmacies and walk-in centres and ensure the most effective provision of services to meet population need without focusing solely on one area of primary care when commissioning those services.

4.8 ICSs should also play a greater role in driving primary care transformation. The Fuller Stocktake included many inspiring examples of primary care organisations delivering at scale and through multi-partnership teams; others have emerged during this review, including Medicus in Enfield, North London.

Medicus Health Partners is the second largest primary care practice in England. Working in the London Borough of Enfield, it brings together 15 practices merged into a single PMS contract, with 34 partners, a managing partner, 23 salaried GPs and a multi-professional staff totaling 370. By working at scale to listen and respond to patients, provide development and support for staff and streamline administrative and digital support services, they have been able to improve the working lives of their staff while transforming the quality of care they provide. At a time when A&E attendances and emergency admissions of patients in care homes in other parts of Enfield were rising by around 30%, Medicus worked with care homes to reduce A&E attendances by over 10% and emergency admissions by 16%. Medicus have an estates strategy that consolidates fifteen surgery premises, some of them too small old and not fit for purpose to accommodate staff or patients properly, into 9 modern health and care hubs.

Primary care contracts

4.9 I have heard repeatedly that national contracts present a significant barrier to those within the GP partnership model who want to work in innovative and transformational ways, requiring a great deal of time, goodwill, ingenuity and workarounds from practice partners and ICBs. ICBs also lack effective levers to support and secure the services in practices where practices are facing difficulties in providing a good quality of service in their area.

4.10 With ICBs taking on responsibility for NHS dentistry on 1 April, it is essential that the next stage of dental reforms, which is currently being developed and builds on

the incremental reforms made last year, is implemented as soon as possible. Without this, ICBs are simply being handed the task of improving an unacceptable situation without sufficient tools to address this. The government has already made some welcome changes, giving ICBs some flexibility to create additional services where they are most urgently needed and announcing the first set of contractual reforms in July 2022 to support fairer remuneration for dentists and increase patient access to care.

4.11 Furthermore, the contract held by GP contractors for 'general medical services', which is negotiated nationally between government and the BMA, provides far too little flexibility for ICSs to work with primary care to achieve consistent quality and the best possible outcomes for local people.

4.12 Contracts with national requirements can have unintended consequences when applied to particular circumstances. For instance, the national requirements and funding of Additional Roles Reimbursement Scheme (ARRS) roles for community pharmacists within PCNs, has on occasion exacerbated the problem of a general shortage of pharmacists, with some now preferring to work within primary care rather than remain in community pharmacies or acute hospitals, compounding the problem of community pharmacy closures and delayed discharges. The new responsibilities for ICBs provide an important opportunity, at place or system level, to integrate the whole primary care offer for communities, making the best use of both the staffing resource available and the premises.

4.13 The Quality and Outcome Framework (QOF) points that were an important and useful innovation twenty years ago are now out of date and are seen by GPs as well as ICBs as an inflexible and bureaucratic framework. This needs to be updated with a more holistic approach that allows for variation. The new approach must also recognize that, in order to allow primary care to refocus resources on prevention, outcomes rather than just activity need to be measured.

4.14 As the GP contract is now entering its fifth year of a 5 year agreement, and the government will be shortly considering its intentions for the next iteration of the contract, radical reform is needed, and this is the right time to make it happen.

4.15 I therefore recommend NHS England and DHSC should, as soon as possible, convene a national partnership group to develop together a new framework for GP primary care contracts. This partnership group should include a diverse range of GP partnership leaders currently delivering excellence across a range of different regions and demographics, as well as ICB primary care leaders, local government and - crucially - a number of patient and public advocates. As part of this work, NHS England and DHSC should, of course, engage with key stakeholders, including the BMA and the RCGP.

4.16 Although of course the final decision on policy and funding rests with ministers, I would suggest that this framework should enable systems to find the right solutions to fit their circumstances, including building on the partnership model, rather than sweeping it away entirely.

4.17 In particular, I would suggest that the work of this group should consider:

- the outcomes that we want from primary care as a whole. While it is not for this review to specify the outcomes, they should be developed closely with patients and the public over the coming months and include patient reported outcomes and experience as some of the measures for success

- the balance between national specifications and local flexibility and decision making - greater flexibility and appropriate local autonomy within a framework of national standards is needed to improve equity of access and care and to enable PCNs to take a greater role and responsibility in reducing health inequalities and population health management. ICBs, working with primary care partners at neighbourhood and ‘place’ level, need to join up the many different elements of primary care, including urgent care, making best use of clinical and other professional staff as well as premises and budgets, and taking account of the particular needs of their population and its geography and demography, to get the most convenient access and best outcomes for residents

- national standards or specifications should include clear expectations around digital and data, in line with the recommendations elsewhere

- how to incentivise and support primary care at scale. There are many different ways of achieving primary care at scale, within the context of integrated neighbourhood teams and wider place partnerships. These include: practices coming together as a single group; GP provider federations, owned collectively by partners and providing support to all member practices; free-standing practices working together within a PCN, where in future the contract (whether for core GMS services or enhanced services) might be held with the PCN rather than individual practices and partners; GPs working as part of a multi-disciplinary primary care division within a wider NHS trust and so on. The new contract needs to allow for different models, in particular allowing tailoring to local circumstances in the patient facing offer, while ensuring we capture the benefits of an ‘at scale’ model behind the scenes. This work should consider how the system can make it simple for partners who wish to move in this direction to do so, while also encouraging and incentivising others to move in this way

- how best to support struggling practices to improve. Practices that are not delivering at a high enough standard need to be supported to improve and,

where necessary, to be replaced so that residents in every community receive the support from primary care they need. This should include creating a centrally-held fund to buy out contracts or premises, or both, where that is essential to improve access, care and outcomes in a particularly disadvantaged community

Social care

4.18 I have heard a lot throughout the review about the need for social care to be better understood within the NHS. This is critical as appropriately embedding social care is essential for effective integrated working in systems, in particular at place and neighbourhood level.

4.19 Social care at its best can be described in the following terms: “We all want to live in the place we call home with the people and things that we love, in communities where we look out for one another, doing things that matter to us”.[15] This definition is widely supported as describing the diverse range of support that social care offers to enable people to live as well and independently as possible. Social care is an important sector in its own right, employing around 1.5 million people, more even than the NHS, and making a significant economic contribution, estimated in 2021 to 2022 at £51.5 billion.

4.20 While local government has crucial commissioning and market-shaping responsibilities for social care, the provision of social care - both domiciliary and residential - is the responsibility of over 18,000 different organisations, mainly in the private sector, often small and family-owned, but including a small number of very large privately-owned providers as well as a significant number of not-for-profit, charitable and social enterprise organisations.

4.21 The social care landscape is complex. Many people in the UK currently do not know what level of care they are entitled to until they are faced with a family crisis. The government has published plans for social care charging reform, although implementation is currently paused.

4.22 As a society we need to face up to the challenge of providing a decent quality of care for everyone who needs it, including many of the most vulnerable people in our communities. It is not for this review to recommend the shape that any structural or financial reform of social care should take. Instead, we need a national conversation about what we expect from our care; and what we are willing to pay for it.

[15] Routledge, M, Social Care Future, Local Government Association. (Accessed: 17 March 2023).

4.23 It is clear, however, that if health and care are to be effectively integrated and delivered at ICS level, social care needs to be a national priority for investment and workforce development, enabling delivery of the reforms of the 2014 Care Act.

4.24 ICSs also have a vital role in supporting a more sustainable social care sector at system level, by taking an integrated approach to reducing the gap between demand for care and available supply, for example by encouraging the adoption of personalised, preventative and proactive models of care.

4.25 I would therefore urge an acceleration and expansion of existing work on understanding both need and the fair cost of care, before the proposed cap on adult social care costs is implemented. The fair cost of care work, commissioned as part of the government's now delayed implementation of charging reform, is a helpful model to move towards a fairer rate of care paid by local authorities to social care providers, and is helpful to understand the social care market - however, it is currently restricted to the older adults residential care market. While it will be beneficial to see the evaluation and assessment so far, it would also be helpful to expand this work to capture working age adults and potentially children's social care. It is vital we appropriately understand the cost of providing high quality care and support for those who need it. Whether this is paid for privately or through taxes and contributions, there is a clear need for this to be paid at a fair rate that reflects their vital role in enabling the dignity and independence of the people they support and their families.

Workforce

4.26 Further change will only be possible with a strong and supported workforce across both healthcare and social care.

4.27 The government is due to publish a long-term workforce plan for the NHS imminently. Given the interdependence of health and social care, I therefore recommend that the government should now produce a complementary strategy for the social care workforce as soon as possible. This plan should set the strategic direction for a more integrated health and social care workforce. This strategy can then support local authorities, who have responsibility for adult social care provision, and ICSs, who will play an increasingly key role in joined up workforce planning.

4.28 Shared training should be encouraged, together with the development of 'passports' reflecting qualifications and experience that make it easier for people to work within the whole health and care system rather than just one part of it.

4.29 The strategy should include integrated training and continuing professional development for social care and NHS staff, supporting the vital work of multi-

professional, multi-organisational teams and making it easier to integrate care around the needs of an individual. The strategy should also set out practical support for career pathways that include both NHS and social care.

4.30 Investment in workforce development in social care should be longer term, as a minimum based on a 3-year rolling planning cycle to support multi-year investment programmes.

4.31 The example of Derbyshire integrated care system shows the value of collaborative workforce planning:

In Derbyshire the integrated care system workforce team are working with Joined Up Careers, along with the Department for Work and Pensions, Jobcentre Plus and Futures for Business, to boost recruitment to the health and care Sector-based Work Academy Programme (SWAP). The programme, led by the local city council, prepares and places new entrants into the health and social care sector in Derby and Derbyshire, particularly targeting support to increase the employment rate for individuals unemployed and or on Universal Credit who are disabled, people aged 50+, ethnic minorities (BAME) and women. As a result of this programme, 299 participants signed onto the pathways into health and social care employment project, many of whom were previously unemployed or economically inactive.

4.32 Working in this way, at place or system level, ICSs can contribute to wider social and economic development - their fourth core purpose - as well as helping to solve immediate workforce challenges.

4.33 A similar partnership approach has been taken by the Suffolk and North East Essex (SNEE) ICS to the challenge of recruiting and training more NHS dental staff in a region that does not yet have its own university dental school. In collaboration with the ICB, the University of Suffolk have established a Centre for Dental Development, which will enhance local education and training opportunities in dental therapy and hygiene, apprentice dental technicians and post graduate dentists. The Centre will sit alongside a community interest company, created by the university, that will be able to bid for future locally commissioned dental services in line with usual NHS protocol. This initiative has the potential to improve the levels of NHS dentistry provision not only in SNEE but also in neighbouring systems such as Norfolk and Waveney. It is a further example of how an ICS has built an innovative local partnership solution to a major national challenge.

A joint venture community interest community has been established by Suffolk University and the ICB to create a dental training practice, where new recruits train as dental hygienists and dental hygienists can train as dental technicians, upskilling and expanding the existing workforce but also providing badly-needed dental care for local residents

under the supervision of qualified dentists and trainers. As in Derbyshire, the apprenticeship levy is a major source of funding for this work.

4.34 I support the Messenger Review's call for systems to improve mutual awareness and provide opportunities for staff to engage beyond their professional environment, to appreciate the totality of the system, and to value diverse professional approaches. For the NHS (itself a complex system within the larger complex system that is an ICS), there should be a clear expectation that part of the training and development budgets within each NHS entity (that is, primary care practices as well as trusts and foundation trusts) and within social care (at least commissioning and, ideally, provision) should be used for shared training and development of staff with other parts of the NHS and social care. This is an essential part of creating the multi-disciplinary, multi-organisational neighbourhood teams (as well as the coherent system-wide leadership) that are at the heart of effective integrated care.

4.35 Professionals and practitioners should be offered formal and informal opportunities to develop their understanding of other parts of the system as part of their continual professional development.

4.36 Integration also goes beyond training, with a need for clear and standardised policies, governance and frameworks to enable flexibility across health and care roles. Blending some of the tasks of health and care roles can enable a better experience for the patient, increased continuity of care and a more efficient use of resource. Teaching a home carer how to dress a wound is an example of how transferring a healthcare intervention from a clinically registered practitioner to a non-clinically registered individual can potentially improve services by enabling closer alignment of different aspects of a person's care.

4.37 While delegation for certain interventions is becoming more common, it often takes place through informal agreements. This causes challenges for providers (for example around indemnity cover) and complications for regulators. Although published guidelines on delegation do exist, they are disjointed and not applicable across the whole health and care system. Without standardised governance and frameworks, it is challenging for individuals to feel supported and confident in delivering these interventions.

4.38 I therefore recommend that DHSC bring together the relevant regulators to reform the processes and guidance around delegated healthcare tasks.

4.39 To speed up the onboarding of health and care staff and enable movement across the system where necessary, commissioners may consider requiring that providers maintain health and care workers DBS certification on the existing online database. This would mean there is no wait time when a person moves job as it is centrally stored and kept up to date, and therefore just minutes for agencies to

check, confirm or print a person's DBS certificate. Consideration should also be given to the passporting of training to reduce duplication and induction times.

The digital and data workforce

4.40 Although much of the focus and investment has been on digital and data systems within acute hospitals, it is essential that we level up basic digital infrastructure in all parts of the system, instead of expecting nurses, healthcare assistants and care workers looking after people with complex conditions and multiple needs to write down essential information on paper and then spend precious time going back to the office to input the data manually.

4.41 The skills needed to deliver data and digital transformation require a professional and highly skilled workforce at the system and provider level. Many health and care staff are well-versed in the use of digital tools; as the digitisation of health and care intensifies, staff at every level need to feel equipped and confident to use the tools available. As I heard frequently from clinical CIOs and other experienced leaders, new systems including electronic patient records are not primarily about technology: they are about transforming clinical and administrative processes to achieve better outcomes for patients, with digital tools enabling but not themselves delivering the necessary transformation. Major 'IT' programmes require substantial time and effort before, during and after implementation in culture, behaviours, and leadership, developing more medical, nursing and AHP CIOs and ensuring that all staff are comfortable with the tools they need to use.

4.42 The health and care system urgently needs to develop, train and recruit more specialists in fields such as data science, risk management, actuarial modelling, system engineering, general and specialized analytical and intelligence. Unfortunately, the Agenda for Change framework for NHS staff makes it impossible for systems to pay competitive salaries for these skilled professionals, with the result that too many ICBs and providers recruit the necessary staff on short-term contracts. I therefore recommend that ministers and NHS England work with the trade unions to resolve this issue as quickly as possible. National workforce planning needs to include steps to ensure that systems can build digital capability, upskill their current workforce and develop clear pathways for progression. ICSs themselves, working with local schools and further education providers, can create new routes into digital roles along the lines of the local academies that have successfully used apprenticeships to recruit and develop trainee nurse associates. As NHS England completes its own reorganisation, it would also be helpful if skilled staff could be seconded or transferred directly into those ICBs that need most support, with a specific focus on data science, cyber security, and analytical skills.

Chapter 4: recommendations

26. NHS England and DHSC should, as soon as possible, convene a national partnership group to develop together a new framework for GP primary care contracts.

27. The government should produce a strategy for the social care workforce, complementary to the NHS workforce plan, as soon as possible.

28. DHSC should bring together the relevant regulators to reform the processes and guidance around delegated healthcare tasks.

29. Currently the agenda for change framework for NHS staff makes it impossible for systems to pay competitive salaries for specialists in fields such as data science, risk management, actuarial modelling, system engineering, general and specialized analytical and intelligence. Ministers and NHS England should work with trade unions to resolve this issue as quickly as possible.

5. Resetting our approach to finance to embed change

5.1 Instead of viewing health and care as a cost, we need to align all partners, locally and nationally, around the creation of health value. That shift is entirely in line with cross-government public spending principles, with their strong focus on public value and the outcomes that are being delivered for citizens.[16] As individuals, there is nothing more valuable than our own health and wellbeing and that of the people we love. But good health also has a wider value to our society and economy. Recent analysis finds that every pound of public money invested in the NHS can generate £4 on average through gains in productivity and increased participation in the labour market.[17]

5.2 Today, however, we are not creating the best health value that we could from the current investment in the NHS. The evidence from other healthcare systems as well as our own demonstrates that there is a proven opportunity, whatever the total spend, to create greater health value by investing in primary and secondary prevention and by shifting care from acute to community and primary care settings ('allocative efficiency'). At the same time, within each element of healthcare, there are multiple opportunities to improve technical efficiency by enabling our most valuable resource - our people - to work more effectively (replacing paper systems with shared digital records, for example, or ensuring that every operating theatre session is fully utilised) and to significantly improve the use of our building and equipment.

5.3 Medicare, the publicly funded programme for people over 65 in the US, provides compelling examples of the improvements in outcomes, quality and value for money that can be achieved at scale through an integrated approach, with a single budget for the healthcare needs of a population group rather than fragmented payments to different providers. Such an approach typically involves earlier screening of older patients, with fewer ED visits and about 30% fewer hospital admissions. One of the Medicare providers demonstrating the value of this 'upstream' approach is the Florida-based group, ChenMed.[18]

Founded in Miami, Florida, ChenMed operates under the Medicare Advantage model, which as part of the wider government-funded Medicare programme specifically provides government funding to support those over 65 with more complex needs or in areas of high deprivation. ChenMed's care model invests heavily in primary care and prevention to

[16] HM Treasury, Managing public money, last updated September 2022
[17] NHS Confederation, Carnall Farrar, Analysis: The link between investing in health and economic growth. 2022.
[18] Commonwealth Fund - Transforming Care: Reporting on Health System Improvement (March 2016)

improve outcomes, experiences and the time patients spend at home. This model uses rigorous risk stratification combined with high intensity proactive care to deliver these outcomes. Prioritising high frequency, longer GP visits enables GPs and core care teams to evaluate patients and conduct risk stratification to ensure they can focus on patients at highest risk of inpatient admission. This approach focusing on primary care and prevention has had remarkable results, generated significant value for those supported by ChenMed and resulted in a 40% reduction in inpatient hospital days compared to the Miami average.

5.4 There are many other examples of the value of this kind of proactive, prevention and outcome-focused care, reflected in the Fuller Stocktake as well as this report and elsewhere. Working at many levels - through place partnerships, integrated neighbourhood teams and provider collaboratives, as well as system-wide, ICSs provide the opportunity for urgently needed improvements in both allocative and technical efficiency.

Financial accountability

5.5 As mentioned earlier, integrated care boards (ICBs) are accountable for £108 billion of the £150 billion made available annually by parliament for the NHS.[19] Ensuring that taxpayers' money is used to the best possible effect is a moral as well as a legal duty. Robust financial accountability, both to local residents and to parliament through NHS England and ministers, is therefore non-negotiable. But the creation of integrated care systems (ICSs) means that ICBs' accountability for NHS finances also needs to sit within a wider framework of local accountability for ICSs (including the mutual accountability of ICS partners to each other for achieving their agreed goals).

5.6 NHS England, DHSC and HM Treasury should therefore work with ICSs collectively, and with other key partners including the Office for Local Government and the Chartered Institute of Public Finance and Accountancy (CIPFA) to develop a consistent method of financial reporting that will give the public the information they need to hold their local systems to account, without creating burdensome new reporting requirements. Obviously much of local councils' budgets are devoted to responsibilities other than health and are therefore outside the scope of ICS-related work. We would also expect this group to review the implementation of recommendations related to greater financial autonomy and encourage proactive management of funds and good financial practice. Working across organisations and with ICSs in this way would provide a further opportunity to build in practice

[19] Data refers to CCG and NHS England spending for 2021 to 2022 financial year - NHS Commissioning Board Annual Report and Accounts for 2021 to 2022 financial year NHS Commissioning Board Annual Report and Accounts 2021 to 2022 financial year - for the period 1 April 2021 to 31 March 2022 (england.nhs.uk) - to note £108 billion is the amount which ICBs were formally allocated in 22/23 the actual amount ICBs are responsible for is likely to be greater when considering funding streams from delegation or other one off in year funding packets.

the collaborative arrangements that are needed at national level to support those within ICSs.

5.7 The aim should be for an ICS to show its residents, local Health and Wellbeing Boards, oversight committees and Healthwatch, as well as national bodies, how much it is collectively spending from all public funds on prevention, population health management and reducing health inequalities; or on supporting mental health as well as treating mental illness; as well as, within the NHS, how effectively money has been spent for instance with respect to rates of operating theatre utilisation. As the financial framework for ICSs develops, this information should be transparent and enable a clear link between spend and health outcomes, as well as between quality, safety and productivity within the NHS itself.

Funding settlements

5.8 One of the main themes in the submissions received in response to the call for evidence was the perverse effects of ‘penny packets’ of funding in particular. Concern has been raised in relation to funding for discharge, and for investment in digital transformation.

5.9 An additional source of frustration and inefficiency is ‘non-recurrent’ money that is in practice ‘recurrent’ but that cannot be properly planned for because it is not in the baseline allocations. For instance, ‘winter funding’ is often provided (in October or November) in order to ramp up community health and social care beds, that will then be stood down in April, before being restored the following winter - when the ‘new’ beds simply return the situation to what it was a few months earlier.

5.10 Instead, funding should be largely multi-year and recurrent. The approach taken by the 2023 to 2024 priorities and operational planning guidance in converting some key non-recurrent funding into recurrent funding has been particularly welcomed in supporting planning over a longer term.

5.11 I therefore recommend ending, as far as possible, the use of small in-year funding pots with extensive reporting requirements. Additional funding pots should be considered only in limited, carefully considered exceptions rather than the rule. If they are required, funding should have:

- a reasonable turnaround time and duration to have a realistic impact. When setting the duration national organisations must consider the length of time needed to mobilise and wind down funding

- restrictions and reporting requirements to be proportionate to the size and duration of the funds, to ensure they are not disruptive to system working, as well as to prevent non-take-up by some systems. In other words, small

amounts of time-limited money require maximum flexibility to get the best results

5.12 Further, the fact that funding settlements for the NHS, social care and public health are announced and allocated at different times throughout the year is a fundamental issue for the integration of services between and within the different parts of the system and impedes the ability of ICBs, ICPs and local authorities to plan effectively at system level. As well as this, differential approaches to funding across local authorities in the same ICB also impact on the system's ability to deliver equitable standards of care across an ICS.

5.13 I recommend that DHSC, DLUHC and NHS England align budget and grant allocations for local government (including social care and public health which are allocated at different points) and the NHS so that systems can more cohesively plan their local priorities over a longer time period.

Financial flexibility for intra-system funding

5.14 In order to facilitate greater self-governance, I recommend that systems should be given more flexibility to determine allocations for services and appropriate payment mechanisms within system boundaries, and the NHS payment scheme should be updated to reflect this.

5.15 Flexibility for intra system funding allocations should include the reduction in hypothecation of funding allocated to systems, either by provision or condition. This will enable local systems to allocate funding to maximise health value for their local populations.

5.16 While the reduction of hypothecation is crucial and should continue, I have heard mixed views over the course of this review as to how far this should be taken. On the one hand some called for an end to all hypothecation including mechanisms such as the Mental Health Investment Standard (MHIS) on the basis that local systems should be able to determine where and how monies should be spent to maximise health and care outcomes. On the other hand, much of the evidence I received identified the MHIS as an effective tool to incentivise spend in an area where there are clear issues in achieving parity of esteem and one which had been long underfunded. As such, at this stage I do not believe systems are in a place where we can remove all hypothecation, particularly the MHIS. However, where hypothecation remains there needs to be a clear focus on delivering outcomes for populations and moving spending upstream towards prevention within hypothecated budgets.

5.17 It is important to recognise the role for consistency, and as such I recommend national guidance providing a default position for payment mechanisms for inter system allocations should be further developed.

5.18 This will also require strengthened local analytical resource to assess what will deliver the greatest value for local populations. For smaller systems this analytical resource could be shared for instance across a regional footprint. This should be supported by national analysis drawing on national and international evidence.

5.19 These proposals do not imply a complete “letting go” by national organisations - rather, a move away from the volume of conditions that so often come with national funding and a move towards greater ICS autonomy, held to account by NHS England.

Simplifying and broadening delegation and pooled budget arrangements

5.20 As part of greater flexibility in managing funding within systems, pooling budgets allows local leaders to make holistic decisions about how best to allocate resources across their health and care systems - both to ensure better use of resources to address immediate needs, but also to support long-term investment in population health and wellbeing.

5.21 Pooled and aligned budgets have been routinely and successfully used across systems for some time; a minimum of £7.2 billion has already been committed to the BCF this year with 90% of local areas consistently agreeing that delivery of the BCF in other years has improved joint working between health and social care.[20] However, we have heard from the system that these methods for pooling budgets can be unnecessarily bureaucratic and narrow and do not allow for effective transparency.

5.22 Section 75 of NHS Act 2006 provides the legal mechanism for creating formal pooled budget arrangements between the NHS and LAs to carry out health and care related functions. I recommend that the government accelerate the work to widen the scope of s.75 to include previously excluded functions, (such as the full range of primary care services) and review the regulations with a view to simplifying them.

5.23 In the medium term reviewing the legislation would be helpful with a view to expanding the range of the organisations that can be part of s.75 arrangements to

[20] Department of Health and Social Care (2022) Better Care Fund Framework 2022 to 2023. (Accessed: 30 March 2023).

include social care providers, VCFSE providers and wider providers such as housing providers.

Ensuring efficient delivery of care

5.24 While there is considerable scope to improve public value through shifting resources “upstream”, there is also scope to improve public value by addressing the costs of delivering care.

5.25 There is an opportunity to address unwanted variation in cost and opportunities to improve ways of working through improvements in technical efficiency. The increasingly urgent need to maximise value for public money is hampered by the continuing difficulty in establishing the real cost of delivering care (for example whether fixed costs are included, how administrative costs are applied and so on.) and the narrow focus on episodes of care, rather than complete pathways that include prevention, early intervention and support in the community (including from the VCFSE sector).

5.26 There are fundamental productivity challenges that systems, if using the appropriate tools, can address. For example, with the exception of the height of the pandemic, performance against the 4-hour A&E target has been declining for a decade, despite the fact that emergency medicine has been the fastest growing clinical specialty in the NHS and, in that time, there’s been a near doubling in the number of (full time equivalent) emergency medicine doctors.[21] This combination of significantly more clinicians but declining productivity emphasises the need to move resources upstream (including by integrating appropriate specialist clinicians within wider neighbourhood teams) as well as rapidly improving productivity within emergency care and acute hospitals themselves.

5.27 Across all parts of the health and care system, there are many opportunities to use digital technologies to reduce administrative burdens on both clinical and other staff (for example moving to real time data dashboards rather than cumbersome paper based data collection); ensure that clinical and other staff are spending the maximum possible time on care and treatment (for example reducing journey times through smart scheduling or optimising theatre scheduling); and to support multidisciplinary working (for example using decision management tools to support a wider range of clinical staff to provide safe and effective care).

5.28 The 7-day-a-week, emergency ophthalmology service provided by Moorfields in partnership with the London Central ICB is a striking example of digitally-enabled, consultant-led transformation that has effectively eliminated waiting times for

[21] Rees, Sebastian, Hassan, Hashmath The A&E crisis: what’s really driving poor performance? Reform, (February 2023)

emergency care in one speciality. Equally, University Hospitals Birmingham has transformed its skin cancer pathway, using telehealth tools in the community and artificial intelligence support for diagnosis, significantly reducing the need for hospital appointments. By connecting primary, community, intermediate care and acute hospital teams through high-speed broadband networks, digital stethoscopes and similar smart diagnostic tools, we can bring the NHS to its patients.

5.29 Systems can play a crucial role in ensuring efficient delivery of care by their partners. Fundamental to this is improved data sharing accompanied by an actuarial approach to data and risk to understand how money is being spent and how effectively it can be spent across a system. The data sharing between NHS England, DHSC, ICBs and providers discussed previously helps to establish a 'single version of the truth' that will allow all concerned to understand the overall performance of the system and its component parts. There is already considerable benchmarking data available (for example GIRFT and Model Hospital Schemes) and this should be expanded to more areas, in particular in areas which are particularly data poor such as mental health, community services and primary care. Given this data, system leaders must feel empowered to work with partner organisations to drive improvements in productivity. Alongside such benchmarking and reflecting the fully integrated approaches of leading systems referred to earlier, it is also essential to adopt clean sheet design approaches or zero-based budgeting to set out what best practice care or processes should look like and calculate what different interventions should cost.

5.30 DHSC and NHS England should undertake work to share examples of pathway redesign where systems are moving to a 'could cost or should cost' funding model rather than what they 'do cost', based on efficient models of care and utilisation of staff or facilities - building on the analysis undertaken by GIRFT and others. These should increasingly look at the whole pathway, including the vital work of the VCFSE sector and local government, rather than individual episodes of care.

5.31 'Should cost' modelling should be indicative rather than compulsory, providing useful input for decision-making within ICSs as well as between ICS partners and helping to create the necessary level of ambition for multi-year transformation.

5.32 Further, to ensure effective and efficient care delivery, there needs to be improvement support for systems and the organisations within them. It is highly encouraging that NHS England's Recovery Support Programme has developed from a provider-facing programme to one that also supports systems facing the greatest challenges. The breadth of that programme - embracing financial challenges but also quality and productivity ones as well - is a very helpful reflection of the appreciation in NHS England and in systems of the interconnectedness of many of the challenges facing the health and care system. NHS England should ensure that systems are able to draw upon a full

range of improvement resources to support them to understand their productivity, finance and quality challenges and opportunities. This should include more robust productivity and sophisticated modelling tools which include but go beyond GIRFT and Model Hospital to enable all systems to understand their real productivity challenges and opportunities.

In NW London ICS, the ICB finance team are working closely with finance directors from across NHS trusts to understand the scope of productivity opportunities.

For example, the ICB supported the deployment of external support to quantify current utilisation of operating theatres across all 4 acute trusts and to work with clinicians and managers to realise this significant improvement opportunity. Work has also been funded to support community trusts to count and measure consistently to allow for productivity (costing, inputs and outputs) assessment and comparison beyond the historic approach that has focused mainly on the acute hospital productivity element of patient care. Similar work is being undertaken across mental health trusts and primary care providers. Across all local care providers the ICB is supporting local leaders to identify where the primary, community and mental health real estate could be used more effectively to allow poor quality buildings to be exited.

Across all areas of health and care, the ICB is supporting the wider system to drive consistency of approach by aligning commissioning decisions to standardise service specifications, and to simplify pathways and reduce variation.

Transparency of information enables more effective and consistent comparison and understanding of workforce and other cost inputs to an overall population- based approach to outcomes. This will, in turn, provide the means by which the ICB’s ambition to redistribute resources and enable investment in prevention and targeting health inequalities can be realised.

Payment mechanisms

5.33 Financial flows and payment mechanisms can play an important role in ensuring improved efficiency in care delivery. Responses to the call for evidence exposed contrasting views about the use of a payment by results including concerns that it creates perverse incentives for organisations, encouraging overtreatment of patients, discouraging joint-working focused on shifting towards early intervention and undermining efforts to address health inequalities.

5.34 What is clear is that current approaches are not effective in driving value-based healthcare and while payment by results can help drive activity in a particular direction, it is important to recognise that it needs to be adopted in the context of wider system reform, incentivising prioritisation of resources on upstream activity.

5.35 Many health systems in other parts of the world, including those that are entirely or largely taxpayer-funded, are developing payment models that support and incentivise a focus on health. Meanwhile, NHS funding remains over-focused on treatment of illness or injury rather than prevention of them and ICS partners struggle to work around over-complex, uncoordinated funding systems and rules in order to shift resource to where it is most needed. There are lessons from other systems that we should draw on.

5.36 I therefore recommend that NHS England work with DHSC, HM Treasury and the most innovative and mature ICBs and ICSs, drawing upon international examples as well as local best practice, to identify most effective payment models to incentivise and enable better outcomes and significantly improve productivity. It should consider a number of potential models including:

- incentives for individuals or communities to improve health behaviours
- an incentive payment-based model - providing payments to local care organisations (including social care and the VCFSE sector) to take on the management of people's health and keep people out of hospital
- bundled payment models, which might generate a lead provider model covering costs across a whole pathway to drive an upstream shift in care and technical efficiency in provision at all levels
- payment by activity, where this is appropriate and is beneficial to drive value for populations

5.37 This work should lead as quickly as possible to the testing of new models in practice within a selection of systems, enabling further development and refinement through collaborative learning and action.

Capital expenditure

5.38 The call for evidence repeatedly raised that a lack of capital, inflexibility in use of capital and the layering of different capital allocation and approvals processes from different departments and agencies are major barriers to improvement and productivity.

5.39 While ICS level CDEL allocations have been introduced to give greater ability to direct their operational budget in line with their systems priorities and local needs, there are still some issues around how providers work across system boundaries. In particular, accessing capital to support population need rather than just in their headquartered ICS. For instance, an ICS that urgently needs Tier 4 mental health beds within its own area for patients currently sent out of area finds that its mental

health partner trust is unable to develop the necessary provision simply because the trust is headquartered in a different system.

5.40 To take a different example, even with the hugely important Diagnostic Assessment Centres and Community Diagnostic Centres, some ICBs have found that the configuration that best meets the needs of their particular residents is rejected as not meeting the national specification. The laudable attempt by DHSC ministers to find faster, cheaper ways of creating urgently needed new services have, unfortunately, on occasion added further delays.

5.41 ICS leaders have the perfect opportunity to work together not only within the NHS but with local government partners to make the best possible use of the public estate and scarce public sector capital. I therefore recommend that there should be a cross-government review of the entire NHS capital regime, working with systems, with a view to implementing its recommendations from 2024.

5.42 This should build on findings from the independent review of the NHS capital allocation process conducted by Richard Murray in 2021, which I understand NHS England took forward in their planning guidance.

5.43 A cross-government review should consider:

- how government could move towards a 10-year NHS capital plan, with initial freedoms over larger sums for, say, 5 years tested and developed within more mature systems
- reviewing delegated limits and approval processes across HM Treasury Cabinet Office, DHSC, and NHS England with a view to having a simpler more streamlined approval process and giving more mature systems greater responsibility for prioritizing and managing capital expenditure
- how to allow greater year-on-year flexibility to support more efficient use of capital and support invest to save or save to invest
- clarifying the government position in use of private finance and government involvement in primary care capital
- how to enable providers working across systems (particularly mental health, specialised and ambulance providers) to access capital to support population need rather than just in their headquartered ICS
- incentives for more efficient system-wide property management and considering reform of CDEL to enable void space to be filled and co-location across the NHS and local authorities

Strengthening and embedding a culture of research and innovation

5.44 Throughout this review, I have heard about the need to embed innovation throughout the health and care system. As care pathways as transformed across systems, it is essential that ICSs build a culture of importing and exporting "what works", and that they innovate and transform in partnership with academia and industry. Academic Health Science Networks (AHSNs) should be seen as integral to that ambition, with ICBs ensuring that their AHSNs are aligned with local strategic priorities in order that best practice that meets the needs of their populations can be spread and adopted at pace and at scale.

5.45 To give just one example of this in practice, Imperial College Healthcare, itself an AHSN and part of the North West London Acute Provider Collaborative, has worked with primary care partners to transform its entire heart failure pathway. Equipped with a remote heart failure monitoring app to detect any abnormalities, patients are freed from multiple face-to-face follow-up appointments. Costly emergency hospitalisations have been significantly reduced. Above all, health outcomes have been improved.

5.46 Rather than each of the 42 systems to be constantly reinventing the innovation wheel locally, each investing relatively small individual budgets, ICBs can mobilise this expertise as a cost-effective and productive part of their contribution to system infrastructure. Regional AHSNs should work together, and with the national AHSN Network to identify and spread best practice, innovative pathways, enabling each system to import proven interventions including from academia and industry from elsewhere in the country, while ensuring that their own innovative approaches become part of the wider pool. Case studies such as West Yorkshire and South Yorkshire[22] demonstrates how embedding an AHSN to deliver an "innovation hub" for an ICB provides the right expertise for the system, as well as allowing the AHSN to efficiently transfer best practice between systems and regions.

5.47 Systems should feel empowered to engage with AHSNs, National Institute for Health and Care Research (NIHR) as well as regional and national academic communities to proactively draw on their support and skills. This should align and support ICBs with the duty placed on them to facilitate and utilise research for the improvement of health and care services. Therefore, it is vital that we build a thriving research community which can easily access and utilise the wealth of data that systems collect to undertake well-developed and valuable research to support systems to drive transformation and enable wider economic growth.

[22] NHS England Strengthening local partnerships and driving innovative solutions using innovation hubs

Specialised commissioning or tertiary services

5.48 I wanted to note briefly, that during this review, several clinical and other leaders expressed concerns about the place of specialised services within the new landscape of ICSs. Unfortunately, it has not been possible in the timescale of this review to consider this issue in detail.

5.49 Specialist units, whether free standing or within larger trusts, are global leaders within clinical research and care. They deliver cutting-edge care and are a catalyst for innovation, supporting pioneering clinical practice in the NHS. As such they need to be viewed and supported as national assets within the context of the life sciences strategy and plans for delegation of the commissioning of the services they provide.

5.50 Following extensive engagement over the last 2 years, NHS England is in the process of delegating some of its responsibilities for specialised commissioning to the new ICSs from 2024. I have heard both from some specialist leaders who still have concerns with the new approach, as well as from others who are supportive of the proposed delegation and believe ICB pathways can deliver improved outcomes and more efficient delivery of care.

5.51 During 2023 to 2024 joint committees of ICBs and NHS England are being established to take on a subset of those specialised services. As these new arrangements are put in place, it is essential that they are kept under review to ensure the critical role of these specialist service providers is appropriately maintained through any new arrangements and these provider organisations continue to be engaged.

Chapter 5: recommendations

30. NHS England, DHSC and HM Treasury should work with ICSs collectively, and with other key partners including the Office for Local Government and CIPFA to develop a consistent method of financial reporting.

31. Building on the work already done to ensure greater financial freedoms and more recurrent funding mechanisms, I recommend:

a) Ending, as far as possible, the use of small in-year funding pots with extensive reporting requirements;

b) Giving systems more flexibility to determine allocations for services and appropriate payment mechanisms within their own boundaries, and updating the NHS payment scheme to reflect this; and

c) National guidance should be further developed providing a default position for payment mechanisms for inter system allocations.

32. DHSC, DLUHC and NHS England should align budget and grant allocations for local government (including social care and public health and the NHS).

33. Government should accelerate the work to widen the scope of s.75 to include previously excluded functions (such as the full range of primary care services) and review the regulations with a view to simplifying them. This should also include reviewing the legislation with a view to expanding the scope of the organisations that can be part of s.75 arrangements.

34. NHS England should ensure that systems are able to draw upon a full range of improvement resources to support them to understand their productivity, finance and quality challenges and opportunities.

35. NHS England should work with DHSC, HM Treasury and the most innovative and mature ICBs and ICSs, drawing upon international examples as well as local best practice, to identify most effective payment models to incentivise and enable better outcomes and significantly improve productivity.

36. There should be a cross-government review of the entire NHS capital regime, working with systems, with a view to implementing its recommendations from 2024.

6. Annex A: the journey of the review

6.1 In November, during his autumn statement, the Chancellor of the Exchequer announced an independent review to consider the oversight and governance of integrated care systems (ICSs).

6.2 While the Secretary of State for Health and Social Care appointed me to lead this review, the report has only been possible due to the generosity of hundreds of individuals and organisations who have given up their time and engaged with us over the last 5 months.

6.3 During this review, I have engaged with over a thousand leaders from across ICBs, ICPs, local government, NHS trusts and foundation trusts, social care providers, VCFSE groups, academics and others with an interest in the success of ICSs.

6.4 We have also heard from over 400 respondents via our call for evidence - and we are grateful to everyone who responded from across the health and social care sector, patients, the public and wider voluntary sector. Throughout this review, we have been keen to capture the views of all partners involved in the day-to-day business of ICSs and their partners, and their responses has made this process richer and better informed at every step.

6.5 I am especially grateful to the work of colleagues who led and contributed to the 5 workstreams, that produced the majority of my recommendations. Colleagues from patient and service user groups, local government, the voluntary community faith and social enterprise sector and the social care provider sector, as well as the NHS, were included in the work streams, reflecting the partnerships that constitute ICSs.

6.6 Each workstream held a wide range of meetings in order to gather evidence from across the system. They reviewed the call for evidence responses, expert papers and data as well as a range of qualitative information from across the system.

6.7 From late January 2023, each workstreams also held a ‘town hall’ online event in which wider stakeholders were able to hear and contribute to the developing thinking of each workstream.

6.8 The review team also engaged with system partners more widely. This includes but is not limited to, engagement with:

- DHSC, NHS England and CQC
- chairs and CEOs of ICBs and chairs of ICPs

- trust and foundation trust leaders
- social care providers
- primary care providers (including general practise, dentistry, optometry, and community pharmacy) and leaders of primary care networks and partnerships
- a wide range of voluntary, community, faith and social enterprise stakeholders (including organisations representing children, mental health and the role of patient and public voice within health and care services)
- local government, including councillors, CEOs and directors of public health, adult social care and children's social care
- Healthwatch
- national trade union representatives

6.9 In engaging widely, and seeking a range of views, I believe that we have established a number of recommendations that can be widely supported, and which will enable ICSs to succeed.

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The much-anticipated Hewitt Review (https://www.gov.uk/government/publications/the-hewitt-review-an-independent-review-of-integrated-care-systems) into the oversight, governance and accountability of integrated care systems (/publications/integrated-care-systems-explained) (ICSs) landed last week, to surprisingly little fanfare and a somewhat muted reception. To anyone that has followed the path of the review since its launch in November 2022, it will come as no surprise that it is both comprehensive in its breadth and that it draws on extensive engagement with the sector and key partners, for which the review team and its leadership should be given due credit. Reflecting this, the final document weighs in at a hefty 89 pages. So, standing back from the detail, what are the key take-aways?

The central premise is to shift away from a culture of top-down performance management to one of learning and improvement. The ambition is for national and regional bodies to support ICSs to become 'self-improving' systems. One of the most eye-catching proposals is to vastly reduce the number of national targets and priorities, with Hewitt suggesting these should be limited to no more than ten. That isn't to say that systems would be left unchecked. The review advocates stronger local and mutual accountability within systems, underpinned by timely, transparent data (streamlined to address excessive and duplicative reporting), a national peer review offer (building on established approaches in local government), Care Quality Commission (CQC) assessments looking at how systems are creating cultures of learning and improvement, and an explicit role for overview and scrutiny committees (https://www.gov.uk/government/publications/health-overview-and-scrutiny-committee-principles/health-overview-and-scrutiny-committee-principles) (made up of local councillors) in scrutinising the work of ICSs.

The review calls for a reset in national/local relationships. In line with ambitions previously outlined in the NHS Operating Framework (https://www.england.nhs.uk/publication/operating-framework/) and elsewhere, the review envisages a shift from the current hierarchical approach towards a partnership of equals. As well as reducing the number of targets and streamlining reporting requirements, it suggests ICSs should co-develop local priorities, with these being given equal weight to national targets. Other steps to support the reset include largely ending the use of small, in-year funding pots and giving systems more flexibility to determine budget allocations within their boundaries, as well as rebalancing resources across central and regional bodies and ICSs, shifting a greater share into systems themselves. These ambitions may come as music to the ears of many local health and care leaders, but some will be disappointed by the absence of concrete changes to the powers of the Department of Health and Social Care and NHS England that could help bake this in. Furthermore, there is minimal focus on how to support the cultural and behavioural changes (https://www.kingsfund.org.uk/blog/2023/04/hewitt-turning-tide-performance-management-or-swimming-against-it) on which these ambitions will ultimately stand or fall.

Local variation will remain the name of the game when it comes to ICS development and ways of working. The development of ICSs so far has been marked by local flexibility, reflected in significant variation in their size, complexity and maturity. The review does not seek to change this. Indeed, it restates ambitions around subsidiarity (the idea that decisions should be taken as close to local communities as possible) and suggests systems could strengthen this by ensuring there is visible and accountable leadership at place (/publications/place-based-partnerships-explained) , and supporting places to define their own priorities and initiatives within their overarching ICS strategies. The most advanced ICSs would be supported to go further, with around ten systems selected as 'high accountability and responsibility partnerships' to take on greater local autonomy and trial new ways of working with regional and national bodies. This echoes the early development of ICSs (/publications/year-integrated-care-systems) (and other similar initiatives (/publications/developing-new-models-care-pacs-vanguards)), where new arrangements were tested in a small number of frontrunner areas.

A commitment to prevention is at the heart of the review. Although not central to its original terms of reference, the review makes a strong case for a greater focus on prevention, calling for a shift in resources to support this (specifically, recommending the share of ICS budgets going towards prevention should increase by at least 1 per cent over the next 5 years, as well as an increase in the public health grant allocation). It also calls for cross-government collaboration on prevention (which The King's Fund and has long-argued for (/publications/vision-

population-health)) with formal arrangements to underpin this, and the establishment of a national integrated care partnership forum and new health, wellbeing and care assembly to support engagement.

The review stops short of giving firm answers on the respective roles and responsibilities of providers and ICBs. There have for some time been differing views (/publications/first-days-statutory-integrated-care-systems) about how providers and ICBs should relate to one another, particularly the question of whether providers 'report into' ICBs. At points it seemed the review would offer direction on this, and the mood music of those privy to earlier drafts was that it looked likely to come down in favour of ICSs being responsible for the management of providers. however, perhaps unsurprisingly given the interests at play (https://www.hsj.co.uk/policy-and-regulation/how-to-read-between-the-lines-of-the-hewitt-review/7034577.article?mkt_tok=OTM2LUZSWi03MTkAAAGK6y6GR8erAWhhlHdUDkNF1TxIU3pYD9Fpz-sufVJcyrbTypzFDeGIZQQHTjjqa4p9CR5mQa-J6p3NLdg0g7mbqDxERjyazno4KNrZ7pf3BFsY) , the final draft reaches no such position. Local ICBs and providers will have to continue to live with and work through the complexities of how they relate to one another.

The impact of the proposals is by no means certain. The Hewitt Review is not short on ambition; in addition to the takeaways above, it makes proposals ranging from a strategy for the social care workforce, to new GP contracts, and a review of the NHS capital funding regime. It is both comprehensive and thorough and contains many well-thought-through policy ideas that could help progress the four purposes of ICSs (https://www.england.nhs.uk/integratedcare/what-is-integrated-care/) . But it is not yet government policy; indeed, the only response (https://www.gov.uk/government/publications/the-hewitt-review-an-independent-review-of-integrated-care-systems) so far is a commitment that ministers will review the recommendations 'in due course'. It's far from clear that those ministers would be willing to relinquish central control to give ICSs the freedoms Hewitt suggests. It therefore remains to be seen whether her work will translate into any real changes in the environment ICSs find themselves in.

Find out more

Is Hewitt turning the tide of performance management or swimming against it?

The recently published Hewitt review highlights the need to replace the current performance management culture in the NHS with a stronger focus on learning and improvement. Chris Naylor considers what needs to happen to make that a reality.

By Chris Naylor - 5 April 2023 4-minute read
(/blog/2023/04/hewitt-turning-tide-performance-management-or-swimming-against-it)

Integrated care systems explained: making sense of systems, places and neighbourhoods

Integrated care services represent a fundamental shift in the way the health and care system is organised. This explainer looks at how these bodies are structured, how they are developing and what the future holds.
By Anna Charles - 19 August 2022
(/publications/integrated-care-systems-explained)

The first days of statutory integrated care systems: born into a storm

Our new long read shares experiences of the earliest days of statutory integrated care systems from those who have been establishing and leading them.
By Nicholas Timmins et al - 1 December 2022
(/publications/first-days-statutory-integrated-care-systems)

Nottingham City Health and Wellbeing Board
31 May 2023

Report Title:	Developing the Nottingham and Nottinghamshire NHS Joint Forward Plan
Lead Board Member(s):	Lucy Dadge
Report author and contact details:	Victoria McGregor-Riley v.mcgregorriley@nhs.net Joanna Cooper joanna.cooper1@nhs.net
Other colleagues who have provided input:	Lucy Hubber Director of Public Health Nottingham City Council

Executive Summary:

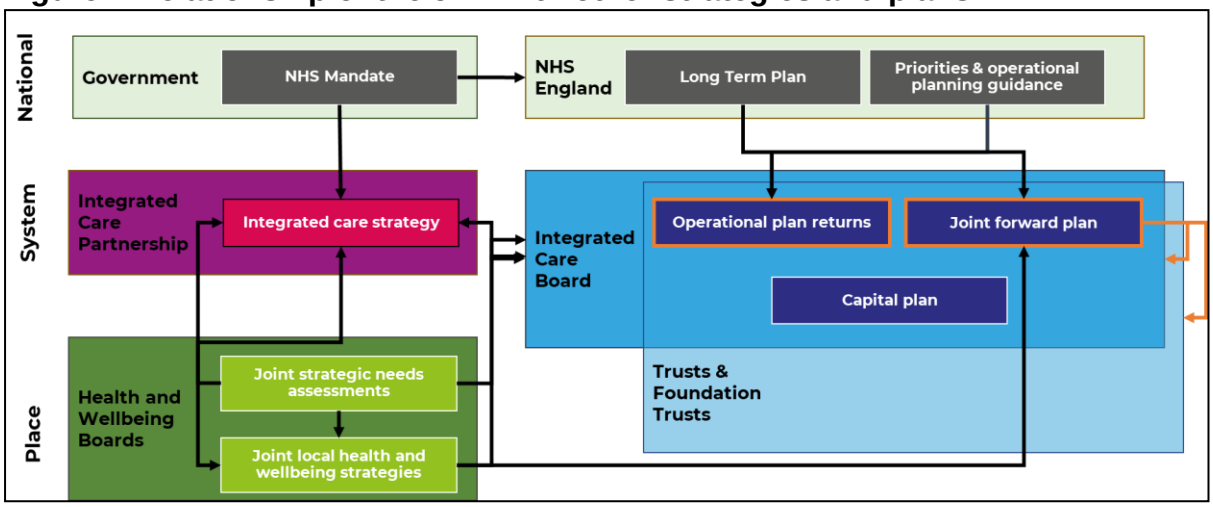
Purpose of the Briefing

1. To brief members of the Board on the development of the Nottingham and Nottinghamshire NHS Joint Forward Plan as required under the Health and Care Act 2022.

Information

2. The Board has previously received briefings on the provisions of the Health and Care Act 2022, under which Nottingham and Nottinghamshire Integrated Care Partnership was required to produce an Integrated Care Strategy (This was approved 17 March 2023). The Integrated Care Board is also required to produce a 5-year Joint Forward Plan which focusses on the NHS response to the implementation of the Integrated Care Strategy.

Figure 1: relationship of the JFP with other strategies and plans



3. Before the start of each financial year, each Integrated Care Board (ICB), together with partner NHS Trusts and NHS Foundation Trusts must prepare a Plan (hereafter referred to as the NHS Joint Forward Plan), detailing how they

propose to exercise their functions in the next five years. There is an expectation that this plan will be refreshed annually, in line with emerging national guidance.

4. Planning guidance for the Joint Forward Plan was published by NHS England on 23 December, which is available online here: B1940-guidance-on-developing-the-joint-forward-plan-december-2022.pdf (england.nhs.uk) Updated annually, the Joint Forward Plan is currently being worked up with NHS partners and both Nottingham and Nottinghamshire Health and Wellbeing Boards will have input into the Plan to ensure it aligns with the Integrated Care Strategy.

5. The NHS Joint Forward Plan provides an opportunity to create a longer-term shared sense of endeavour, a realistic and ambitious view of what is achievable and a sense of hope for our teams and our public. The ICS Executive Leadership Group has discussed and agreed the scope as:
    a. Delivering the NHS Mandate, whilst also tackling the most challenging issues for the system e.g. demand, capacity, performance, finance, sustainability.
    b. The NHS contribution to the four strategic aims of the Integrated Care Strategy and delivery of its three strategic guiding principles of Prevention, Equity and Integration.

6. NHS partners fully embrace the opportunity to continue to work in partnership with the Health and Wellbeing Board in the development of this Plan to ensure that the three strategic principles and four strategic aims of the Integrated Care Strategy are fully reflected. At the March meeting, the Board agreed to delegate to the Chair and Director of Public Health any engagement with NHS partners to support the early development of the NHS Joint Forward Plan. The Board also agreed to award delegated responsibility to the Chair and Director of Public Health to endorse the final version prior to submission.

7. Work is underway with partners to jointly develop the plan by **30 June 2023.** This represents a highly challenging timeframe in which to actively engage with key partners. The comprehensive nature of the Strategy has understandably created some complexity to ensuring engagement of those most able to contribute to the development of a Plan which outlines its delivery. We are keen to stress that whilst the development of the Plan represents another key milestone in our ongoing collaboration to mature our system approach to address health and wellbeing needs of our population, it is not an end point. Ongoing engagement of our Health and Wellbeing Boards, our Public Health teams and local authority colleagues will be critical to the consideration of interventions and initiatives to be outlined in the Plan during its development as well as its future implementation. The Plan will continue to evolve over the next few weeks with the intimate engagement of our Public Health colleagues until its submission to ensure all content fully reflects our shared commitment to the three strategic principles and four strategic aims outlined in the ICP Integrated Care Strategy which includes the NHS contribution to the Health and Wellbeing Strategies.

8. Key areas of focus include:

    A. Our approach - Repositioning the NHS in terms of how the component parts

work together and how the NHS will work with partners and other areas, how we will achieve equity, prevention and integration and specifics in relation to our approach to the 4 aims of the strategy.

B. Our ambition for the local NHS over the next 5 years – e.g. enabling every person to achieve their best possible health and wellbeing; an inclusive, diverse and innovative culture across the NHS, with a sustainable workforce and local skills pipeline; a real shift of NHS resources to prevention; demonstrable impacts on inequalities and health outcomes; working through collaboration to maximise health and wellbeing impact across the life course, physical and mental health holistic approach; High visibility and relevance in communities, effective partnerships with local organisations that drive change and contribute to social justice and economic development in our area

C. Our system – our architecture, geography and partners.

D. Our health needs – demographics and current outcomes.

E. Our care delivery

a. Integrated Care Strategy – how the NHS will deliver the three principles (Prevention, Equity and Integration) and four aims:
   i. Improve outcomes in population health and healthcare
   ii. Tackle inequalities in outcomes, experiences and access
   iii. Enhance productivity and value for money
   iv. Support broader social and economic development

b. Clinical Priorities – how the NHS will address the key priority areas
   i. Reduce illness and disease prevalence
   ii. Proactive management of LTC to avoid crises / escalation of care
   iii. Improve navigation and flow to reduce emergency pressures
   iv. Reduce elective waiting lists

F. Our delivery enablers – the ways in which the NHS will respond to the enablers of the ICP Strategy including workforce, primary care and research.

Recommendation(s): The Board is asked:

1. To receive an update on the developing NHS Joint Forward Plan in order to discuss and inform the development of the Plan.

2. To resolve to receive the final NHS Joint Forward Plan for formal endorsement at the next meeting of the Board, subject to the recommendation of the Chair and Director of Public Health (under their delegated responsibility).

The Joint Health and Wellbeing Strategy

Aims and Priorities	**How the recommendation(s) contribute to meeting the Aims and Priorities:**
Aim 1: To increase healthy life expectancy in Nottingham through addressing the wider determinants of health and enabling people to make healthy decisions	The NHS Joint Forward Plan is the NHS response to the Integrated Care Strategy, which focuses on improving prevention, equity and integration across the health and care system.
Aim 2: To reduce health inequalities by having a proportionately greater focus where change is most needed	
Priority 1: Smoking and Tobacco Control	
Priority 2: Eating and Moving for Good Health	
Priority 3: Severe Multiple Disadvantage	
Priority 4: Financial Wellbeing	
How mental health and wellbeing is being championed in line with the Board's aspiration to give equal value to mental and physical health: The NHS Joint Forward Plan covers all aspects of NHS provision and responds to national priorities, including mental and physical health.	

List of background papers relied upon in writing this report (not including published documents or confidential or exempt information)	Paper to the 29 March 2023 HWB meeting.
Published documents referred to in this report	Health and Care Act 2022 Nottingham and Nottinghamshire Integrated Care Strategy NHS England Guidance on the development of Joint Forward Plans

Nottingham City Health and Wellbeing Board
31 May 2023

Report Title:	Update on the Nottingham City Place-Based Partnership (PBP)
Lead Board Member(s):	Dr Hugh Porter, Vice Chair, Nottingham City Health and Wellbeing Board and Clinical Director, Nottingham City Place-Based Partnership Mel Barrett, Chief Executive, Nottingham City Council and Lead, Nottingham City Place-Based Partnership Lucy Hubber, Director of Public Health, Nottingham City Council
Report author and contact details:	Rich Brady, Programme Director, Nottingham City Place-Based Partnership rich.brady@nhs.net
Other colleagues who have provided input:	

Executive Summary:

This paper provides an update on the work of the Nottingham City PBP, including the launch of the PBP Strategic Plan, an update on the Joint Health and Wellbeing Strategy delivery plans and an overview of business cases put forward as part of the Nottingham and Nottinghamshire Integrated Care Board's inequalities and innovation fund. Also included, is an update on the PBP's Integrated Neighbourhood Models of Support Programme and a review of Nottingham's first Race Health Inequalities Summit

Recommendation(s): The Board is asked to:

Note the update from the Nottingham City Place-Based Partnership.

The Joint Health and Wellbeing Strategy	
Aims and Priorities	**How the recommendation(s) contribute to meeting the Aims and Priorities:**
Aim 1: To increase healthy life expectancy in Nottingham through addressing the wider determinants of health and enabling people to make healthy decisions	The Nottingham City Place-Based Partnership (PBP) is discharged responsibility for the oversight of the delivery of the Joint Health and Wellbeing Strategy (JHWS) 2022 – 2025.

Aim 2: To reduce health inequalities by having a proportionately greater focus where change is most needed	
Priority 1: Smoking and Tobacco Control	
Priority 2: Eating and Moving for Good Health	
Priority 3: Severe Multiple Disadvantage	
Priority 4: Financial Wellbeing	
How mental health and wellbeing is being championed in line with the Board's aspiration to give equal value to mental and physical health: The Place-Based Partnership has a programme focussed on supporting Nottingham citizens to better access preventative support to improve mental health and wellbeing. This programme is aligned with the programmes being delivered as part of the Joint Health and Wellbeing Strategy 2022 – 2025.	

List of background papers relied upon in writing this report (not including published documents or confidential or exempt information)	**Appendix 1** To be added **Appendix 2** Nottingham City Ethnic Health Inequ
Published documents referred to in this report	

Update on the Nottingham City Place-Based Partnership (PBP)

Introduction

1. This paper provides an update on the work of the Nottingham City PBP, including the launch of the PBP Strategic Plan, an update on the Joint Health and Wellbeing Strategy delivery plans and an overview of business cases put forward as part of the Nottingham and Nottinghamshire Integrated Care Board's inequalities and innovation fund. Also included, is an update on the PBP's Integrated Neighbourhood Models of Support Programme and a review of Nottingham's first Race Health Inequalities Summit.

Place-Based Partnership Strategic Plan

2. Since the formation of the Nottingham City PBP, partners have held a clear ambition to mature the partnership into a key delivery partner within the Integrated Care System. The delivery of the PBP programmes and projects continues to facilitate increased coherence, trust and confidence that the PBP can play a more supportive role in delivering partner and system priorities while helping to manage risk through an integrated partnership approach to delivery.

3. For this to happen, the partnership must demonstrate how it is adding value to system objectives but also how it is supporting the management of system risk. The population need informed approach the partnership has taken in its formative years has generated a high level of confidence that the activity of the partnership is adding value and that this is supporting system delivery. Partners recognise however, that there is more to do to systematically evidence impact and value.

4. To further mature the partnership and move to its next stage of development, the PBP Executive has recently signed off a strategic plan for 2023 – 25. The strategic plan has 6 objectives:
    - Accelerate integrated working in neighbourhoods
    - Build trust with communities
    - Continue to deliver the PBP population health and enabler programmes
    - Better evidence the impact the partnership is having on population health outcomes and supporting the delivery of system partner priorities
    - Formalise governance and reporting with partner organisations
    - Test methods of accountability and assurance

5. The plan has been developed as a tool for partners to use to raise awareness and understanding of the PBP and progress discussions within their organisations. This will help partners to explore the role the PBP can play in

supporting the delivery of partner and system priorities – and help manage risk. These discussions are scheduled to take place over the coming months.

Joint Health and Wellbeing Strategy: Delivery Plans

6. At the March meeting of the Health and Wellbeing Board, the programme leads for the four priority areas of the Joint Health and Wellbeing Strategy provided an overview of activity during the first year of the Strategy and outlined plans for the remaining two years. Included within this update were the agreed delivery plans for the Severe Multiple Disadvantage and Smoking & Tobacco Control programmes.

7. Since the March meeting, the 10-year strategy for the Eating and Moving for Good Health programme has been agreed, with the ambition for Nottingham to be a city that makes it easier for adults, families, children and young people to eat and move for good health. Included within this update is the agreed delivery plan for 2022 – 2025 (**Appendix 1**) which is the first in the series for the Strategy. The delivery plan sets out the actions that will be taken across the 5 strategic themes.

8. Building on a 10-year vision for improving financial wellbeing in Nottingham, a draft Financial Wellbeing delivery plan has been developed as part of the programme. Using the Nottingham Financial Resilience Partnership action plans (the basis for significant delivery activity in year 1), an overarching PBP delivery plan will now be produced setting out how PBP partners will support the programme ambitions. Partner activity will take place over the summer months with commitments made to actions that will improve financial wellbeing by Autumn 2023.

ICB Inequalities and Innovation Fund

9. On 18 January 2023, the Nottingham and Nottinghamshire Integrated Care Board (ICB) agreed to set aside a recurrent £4.5m 'inequalities and innovation fund' from ICB allocations. High-level expressions of interest for use of the fund were initially sought from across the Integrated Care System (including place-based partnerships) in January 2023.

10. In response, the Nottingham City PBP contacted its partners to raise awareness of the opportunity, with partners invited to put forward ideas and initiatives for the fund. In response, the City PBP submitted 28 high-level proposals, including eight core PBP proposals and 20 proposals submitted on behalf of partners.

11. On 15 March 2023, the PBP received a request to develop several proposals into business cases for the consideration of a health inequalities & innovation

investment fund prioritisation panel. The business cases submitted by the PBP were:

- Severe and Multiple Disadvantage Infrastructure and Delivery Model
- Co-designed Community Hypertension Case Finding
- Family Mentor Programme
- Emergency Department Social Prescribing Service
- Long-term Conditions Group Consultations
- Childhood vaccinations and immunisations programme

12. Business cases were submitted on 5 May 2023 with a decision expected as to which will be recommended for approval by the ICB's Strategic Prioritisation and Investment Committee in July 2023.

Integrated Neighbourhood Models of Support: accelerated design workshop

13. Since the formation of the eight Primary Care Networks (PCNs) in Nottingham City, these neighbourhood-level partnerships have brought together health, local government, voluntary sector partners and local citizens to work together to respond to the needs of the communities they serve.

14. In addition to implementing requirements set out in national Direct Enhanced Service specifications, PCNs have led on a range of partnership projects and initiatives to reduce health inequalities and improve the health and wellbeing of their local populations. These projects have helped PCNs to develop relationships and collaborate beyond the reach of traditional health and care partnerships, taking important steps towards developing integrated neighbourhood models of support.

15. As part of the suite of PBP 'enabler programmes', on 10 May, partners took part in an accelerated design workshop to explore opportunities for developing 'Integrated Neighbourhood Models of Support' in Nottingham.

16. The workshop, facilitated by NHS Horizons and attended by 45 colleagues representing all PBP partner organisations, provided an opportunity for partners to discuss and debate the opportunities and challenges associated with establishing integrated neighbourhood models of support in Nottingham.

17. Partners noted the multiple areas of good practice of integrated working happening across the city and a key enabler to success being the involvement of partners from across the PBP. As well as discussing areas of good practice, partners also tested each other's assumptions and perspectives of integrated neighbourhood working, including potential benefits and disbenefits.

18. An important area of debate was the extent to which the geographical location of services should impact the development of integrated models of support with emphasis was placed on the importance of the principle of working around the needs of people receiving care and support from multiple partners.

19. This was the first of what is expected to be a series of workshops that will inform the implementation plan for this PBP programme of work. Feedback from the session will now be analysed with further sessions and next steps be agreed by the PBP Executive Team.

Race Health Inequalities Summit

20. On 11 May, the PBP hosted Nottingham's first Race Health Inequality Summit. This event brought together PBP partners with community representatives in Nottingham to discuss health inequalities that disproportionately impact minority communities in Nottingham.

21. The Summit was informed by local data (**Appendix 2**) which highlighted inequalities in health outcomes such as black and Asian patients being twice as likely to be diagnosed with diabetes than white patients; and Black and patients from a mixed ethnic group three times more likely than white patients to be diagnosed with prostate cancer. Access to services is an area of concern in Nottingham with Asian and Black patients 37% less likely than white patients to attend A&E and 35-40% less likely than white patients to receive primary care.

22. Building on the work of the PBP to address structural racism though the development of a cultural competence maturity assessment, the Summit provided an opportunity for partners to work together with communities to determine where the PBP could focus future partnership programmes of work to improve areas of health inequality impacting minority communities in Nottingham.

23. 200 people attended the event, hearing powerful talks from a range of expert speakers. The day had a particular focus on mental health and maternity care, where health inequalities are known to disproportionately impact people from minority communities. While there was a focus on these two areas, there were varied discussions that took place, highlighting areas of opportunity for future programmes of work. Feedback will now be analysed and recommendations for future areas of focus for the PBP's Race Health Inequalities programme presented to the PBP Executive Team

24. Clive Foster MBE, PBP Programme Lead, joined others throughout the day, by paying tribute to Leslie McDonald, a member of the Nottingham City Health and Wellbeing Board, who sadly passed away in April 2023. A moment of silence was held for Leslie, an inspirational figure who held an unwavering commitment to realising health equity for all communities.

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Integrated Care System
Nottingham & Nottinghamshire

Nottingham City

Ethnic Health Inequalities

BLACK and MIXED patients

3x MORE LIKELY THAN WHITE patients

to be DIAGNOSED with PROSTATE CANCER

ASIAN patients

64% LESS LIKELY THAN WHITE patients

to be DIAGNOSED with PROSTATE CANCER

BLACK and ASIAN patients

37% LESS LIKELY THAN WHITE patients

to ATTEND A&E

ASIAN and BLACK patients

2x MORE LIKELY THAN WHITE patients

to be DIAGNOSED with DIABETES

BLACK patients

22% LESS LIKELY THAN WHITE patients

to be DIAGNOSED with BREAST CANCER

ASIAN and BLACK patients

35-40% LESS LIKELY THAN WHITE patients

to RECIEVE PRIMARY CARE

BLACK patients

2x MORE LIKELY THAN WHITE patients

to be DIAGNOSED with KIDNEY DISEASE

ASIAN patients

47% LESS LIKELY THAN WHITE patients

to be DIAGNOSED with COLORECTAL CANCER

ASIAN patients

62% LESS LIKELY THAN WHITE patients

to ATTEND CERVICAL SCREENING

BLACK patients

1.5x MORE LIKELY THAN WHITE patients

to be DIAGNOSED with HIGH BLOOD PRESSURE

ASIAN patients (aged 4-11 years)

36% LESS LIKELY THAN WHITE patients

to be DIAGNOSED with CHILD OBESITY

BLACK patients

35% LESS LIKELY THAN WHITE patients

to ATTEND CERVICAL SCREENING

MIXED patients

1.4x MORE LIKELY THAN WHITE patients

to be DIAGNOSED with SEVERE MENTAL ILLNESS

ASIAN patients

43% LESS LIKELY THAN WHITE patients

to be DIAGNOSED with SEVERE MENTAL ILLNESS

Data analysed from eHealthscope, a Nottingham and Nottinghamshire local source of GP data.

Notes on data sources

- Data is sourced from eHealthscope, a locally developed tool for clinical practice. eHealthscope collates GP practice data for direct patient care.
- Analysis has been extracted from the logistic regression tool in eHealthscope, which allows users to select a health event of interest (e.g. diabetes) and analyse odds of receiving a diabetes diagnosis when factors such as age, sex, deprivation are controlled for.
- Data obtained from the eHealthscope logistic regression tool might look different to nationally reported data because the outputs are from a local model. The data is only as accurate as captured in clinical records, results are presented as an interpretation of odds ratios, whereas national data is often presented differently.
- Metrics chosen for inclusion are those where there is a significant difference for the City minority ethnic populations compared to the white population.
- However, we note that none of the ethnicity groupings are monolithic and there will be individuals within the 'White' population that experience inequalities. There are also important variations in minority ethnic groups – broad categories like 'Black' and 'Asian' do not capture these differences and nuances.
- Mixed definitions are patients who identify themselves as:
    - Mixed - White and Black Caribbean,
    - Mixed - White and Black African
    - Mixed - White and Asian
    - Mixed - Any other mixed background

EATING & MOVING FOR GOOD HEALTH

DELIVERY PLAN

2023- 2026

Delivery Theme 1: Ensuring all Early Years Settings, Schools and Academies are enabling eating and moving for good health

What do we aim to do

We want Nottingham City early years settings, schools and academies to role model healthy eating, good hydration and plenty of physical activity. Together we want to create school environments that promote physical activity and good nutrition; whilst maximising the role schools play in communities and their potential to support families implement healthy choices.

Headline pledges

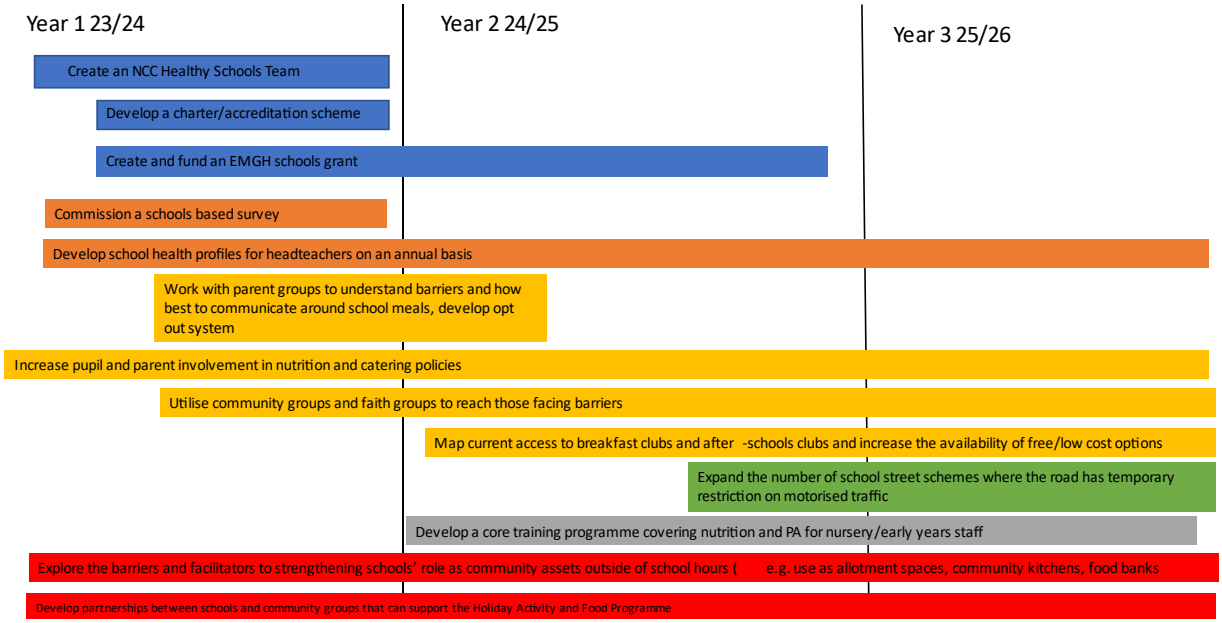
- **To launch a new Healthy Schools Plan for primary and secondary schools by 2024 that supports schools to identify goals for Health and Wellbeing and supports their progress towards meeting them**
- **By 2027, 85% of those eligible for free school meals in primary school take up the offer and by 2032, at least 90% of those eligible take up the offer.**

How will we do this?

Support education settings to engage in established programmes /accreditation schemes which recognise their commitment to adopting and embedding a 'whole school' approach to Eating and Moving for Good Health. To deliver this, we will offer a package of support:

1. **Create a Nottingham City Healthy Schools team to offer support, advice and share local best practice examples, around how to ensure children and young people develop a healthy and active lifestyle.**
2. **Using intelligence from the Health Behaviour Survey Data and the opening up schools facilities fund, design and fund a 2 year grant scheme for schools promoting healthy eating and physical activity in schools.**
3. **Work with schools and other local partners to increase the uptake of free school meals, including the development of an 'opt out' system. Map breakfast/afterschool clubs and improve availability of free and low cost options.**
4. **Expand the number of school street schemes where the road outside a school has a temporary restriction on motorised traffic at school drop-off and pick-up times.**
5. **Develop a core training programme covering the principles of good nutrition and physical literacy for all nursery school staff and those providing early years care.**
6. **Develop schools as key assets for the community including outside of school hours.**

Theme One Ensuring all early years settings, schools and academies are enabling eating and moving for good health



The foundation we are building on

- The food catering service provided by Nottingham City Council is utilised by 49 primary schools. At present, this service has achieved a Food for Life Silver award. Furthermore, Nottingham City Council is currently part of a national school food pilot looking at national food standards.
- Nottingham City Council was awarded School Swimming Lesson Provider of the Year Award in 2021 and 2022. It aims to ensure all children and young people can access swimming lessons and have the opportunity to learn to swim and leave primary school with water safety skills.
- School Sport Nottingham is a partnership of Nottingham City Council's Sport, Outdoor Learning, Life Skills, Adventure and Risk Management (SOLAR) Service, Ellis Guilford School and Sports College, The Farnborough Academy and NHS Nottingham City. School Sport Nottingham has a focus on increasing high quality PE, out of hours school sport, competitions, leadership development and informal play.
- The Sheriff's Challenge is a series of activities for all Primary school-age children encouraging them to be physically active. Each academic year a different challenge is set which encompasses a 'joint goal' for schools to cumulatively reach plus individual pupil targets. It's free for Nottingham City schools. In 2021/22, over 14,700 miles logged across 10 schools with 2,990 pupils taking part throughout the year.
- Schools work together with the public, private, community and voluntary partners to improve the outcomes for children and young people. A range of partnerships exist including with Nottingham Forest Community Trust who deliver the 'Premiership Stars' programme in 20 schools in Nottingham City.
- Individual schools and academies deliver a range of exciting and innovative activities designed to reinforce healthy eating and the benefits of physical exercise.

Indicator	Source	Frequency of reporting	Nottm value	England value	2027	2032
Output measures						
Number of primary schools signed up to the Nottingham City Health Schools Award Scheme	LA	Annual	N/A	N/A	↗↗	↗
Number of school street scheme in Nottingham City	LA	Annual		N/A	↗	↗
Proportion of eligible children who receive free school meals	LA	Annual	75% (2021/22)	76.9% (2021/22)	↗↗	↗
Number of schools with a free or low-cost breakfast club and after-school club	LA	Annual	TBC	N/A	↗	↗
Number of nursery school and early years staff receiving training on nutrition and physical literacy	TBC	Annual	N/A	N/A	↗↗	→
Outcome measures						
% of children who consume at least 5 fruit and vegetables a day	TBC		N/A	N/A	↗	↗
% of children and young people who achieve 30 minutes or more physical activity a day (in school)	Sport England		Sample size too small	32.4% (2020/21)	↗	↗↗
% of children and young people who are physically active	Sport England		Sample size too small	44.6% (2020/21)	↗	↗↗
% of children in reception class in living with overweight or obesity	NCMP		25.2% (2019/20)	23.0% (2019/20)	→↘	↘
% of children in year 6 living with overweight or obesity	NCMP		40.8% (2019/20)	35.2% (2019/20)	→	↘

Delivery Theme 2: Support healthy nutrition throughout the life course to enable all people to achieve and maintain a healthy weight

What do we aim to do?

We want children, families and adults to get the right information, support and help from the right person, at the right time, including during pregnancy. Nottingham will have a skilled workforce with weight management services that are developed through community co-design to ensure a holistic, person centred and compassionate approach to supporting individuals improve their health and wellbeing. We recognise the complicated relationship between food choices and other wellbeing related factors and will strive to make it as easy as possible for people to access support around mental health and financial wellbeing alongside weight management services.

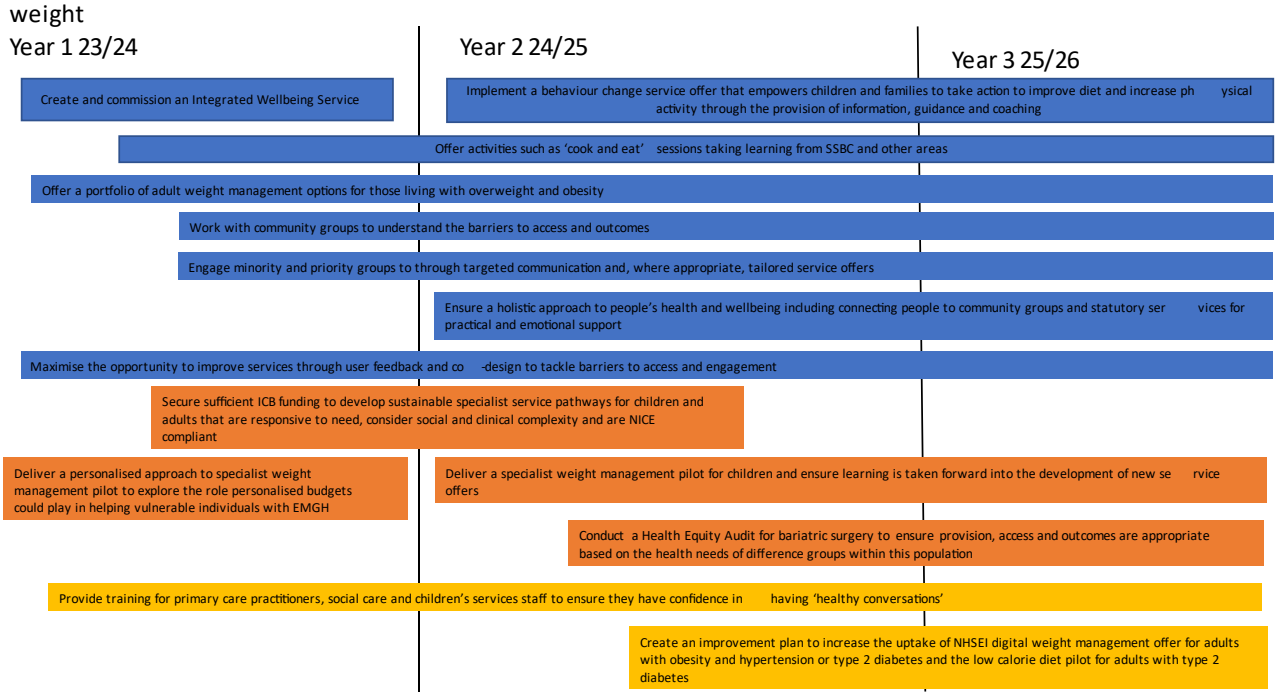
Headline pledges

- **Nottingham City will become a Breastfeeding friendly City with all public buildings and PBP health and care organisations delivering against a breast-feeding friendly charter by 2025.**
- **By 2025 Nottingham City's Integrated Wellbeing service will have supported its first 5000 citizens to make positive behaviour change towards a healthier lifestyle.**
- **By 2027, 90% of those eligible will be claiming healthy start vouchers.**

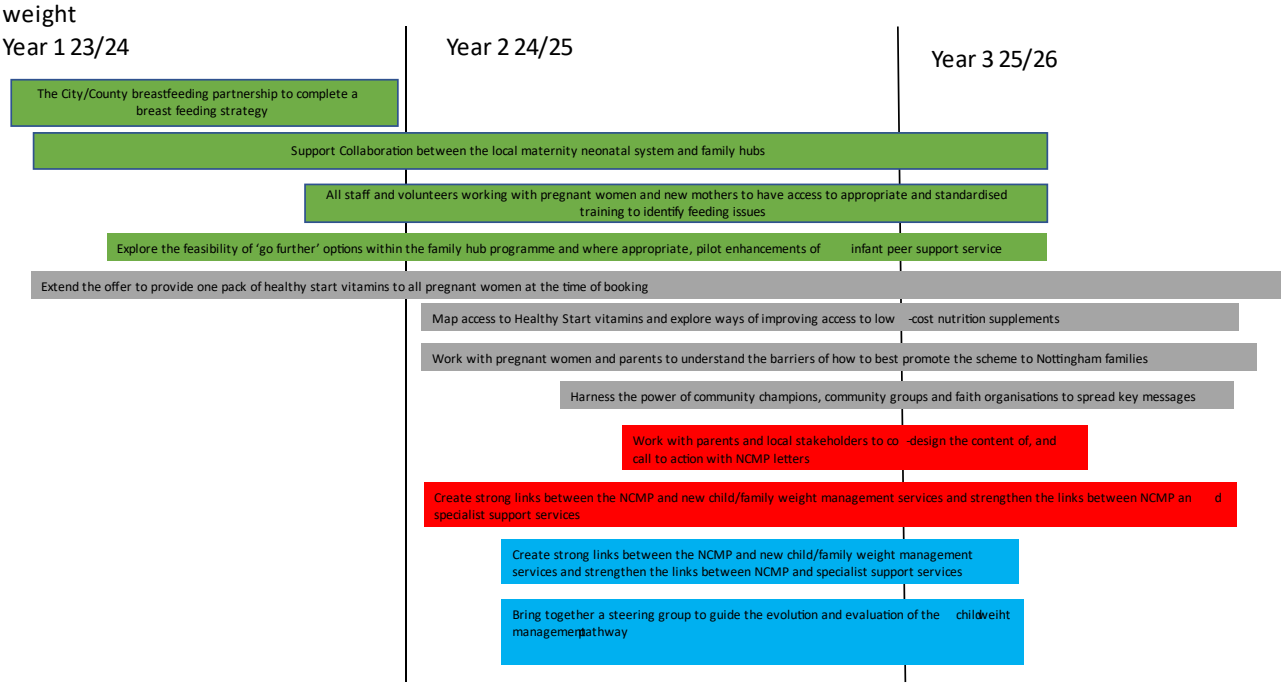
How will we do this?

1. **Provide an Integrated Wellbeing Service that ensures equitable access and outcomes for Nottingham City's diverse population.**
2. **Provide evidence-driven multi-professional specialist weight management services available for children and families, and adults. Ensure equity of access to bariatric surgery for people who require this intervention.**
3. **Increase the uptake of existing weight management offers**
4. **All new parents will have access to trustworthy information and support for commencing and maintaining breastfeeding and developing responsive feeding practices. The City/County breastfeeding partnership will complete the breastfeeding strategy. Development of the 'Feed Your Way' breastfeeding comms campaign including building partnerships with businesses and community groups to become a breastfeeding friendly city.**
5. **Increase the uptake of the Healthy Start scheme amongst those that are eligible**
6. **Ensure a proactive approach to the National Child Measurement Programme (NCMP) in a way that makes sure parents feel confident that they will be supported and not stigmatised.**
7. **Conduct a pilot of an enhanced healthy weight pathway for children under 5 years in SSBC wards .**

Theme Two: Support Healthy Nutrition throughout the life course to enable all people to achieve and maintain a healthy weight



Theme Two: Support Healthy Nutrition throughout the life course to support all people to achieve and maintain a healthy weight



The Foundation we are building on

- CityCare employ Nutrition Peer Support Workers and, as part of the local 'Best Start' offer, provide:
    - Peer support for mothers in the antenatal period that may make a difference to the beginning of their breast-feeding journey.
    - Peer support for new mothers 0-4 days postnatally to be able to enable a new mother to enjoy her breastfeeding journey with support, as required, up to the 6-8 weeks review by the Health Visitor.
    - A confidential text service for parents and caregivers who wish to talk about a range of topics including feeding and nutrition.
    - Virtual First Food sessions to support families as they begin their weaning journey.
- Small Steps Big Changes launched the '#FeedYourWay' breastfeeding campaign in October 2022. The campaign aims to help make Nottingham a breastfeeding-friendly city and was co-created with Nottingham families and residents, health professionals and business owners.
- Nottingham City Council offer free access to 12-week weight management programmes for adults who are motivated to lose weight and attend classes. In the last 12 months this has included:
    - Group based behaviour change programme (Slimming World)
    - Digital behaviour change programme with telephone support (Oviva)
    - Fit for Fans programme (Notts County Community Trust)
    - New programmes at Trent Bridge and Nottingham Forest

- A National, digital NHS weight management offer, with telephone support (for some), is available to individuals living with overweight or obesity and either Type 2 Diabetes or Hypertension. It is offered in a variety of different languages.
- In January 2022, the NHS low calorie diet programme became available to those living in Nottingham City diagnosed with Type 2 diabetes in the last 6 years. Patients are offered virtual one-to-ones, online help and group support.
- A specialist weight management service is available for people with severe and complex obesity. Patients with higher BMIs and associated clinical co-morbidity are provided with multi-disciplinary support with a focus on supporting readiness for bariatric surgical options.
- The East Midlands Bariatric and Metabolic Institute, located at the Royal Derby Hospital, provides bariatric services (i.e. weight-loss surgery) for patients from Nottingham and Nottinghamshire.
- A number of primary care networks such as Bestwood and Sherwood and Bulwell and Top Valley have prioritised 'Healthy weight'. They are having conversations with local communities to explore barriers to engaging in weight management services and, in some cases, using health coaches to offer physical activity group sessions.

Indicator	Source	Frequency of reporting	Nottm value	England value	2027	2032
Output measures						
Number of JHWB organisations who are breast-feeding friendly	JHWB	Annual	N/A	N/A	↗↗	→
Number of businesses signing up to be breast-feeding friendly venues.	SSBC	Annual	N/A	N/A	↗↗	↗
Number of maternity and best start staff trained in healthy (and brief) conversations	NUH & CityCare	TBC	N/A	N/A	↗↗	→
Referrals to and uptake of a 0-4y healthy weight pathway (Pilot data)	CityCare & SSBC	Quarterly	N/A	N/A	TBC	TBC
Referrals to and uptake of the Tier 2 weight management services	LA PH	Quarterly	TBC	N/A	↗↗	→
Referrals to and uptake of the NHS digital weight management offer	ICB	Quarterly	TBC	N/A	↗↗	↗
Referrals to and uptake of Tier 3 weight management services	ICB	Quarterly	TBC	N/A	↗	↗
Referrals to and uptake of Low-Calorie Diet weight management services	ICB	Quarterly	TBC	N/A	↗	↗
Referrals to and uptake of the local National Diabetes Prevention Programme (NDPP)	ICB	Quarterly	TBC	N/A	↗	↗
Outcome measures						
% of babies in Nottingham that are being fully or partially breastfed at 6-8 weeks (Totally or partially)	PHOF	Quarterly	52.9% (2021/22)	49.3% (2021/22)	↗	↗
% babies who are initially breastfed in Nottingham	PHOF	Quarterly	58.7% (2018/19)	67.4% (2018/19)	↗	↗
% of children in reception class in living with overweight or obesity	NCMP	Annual	25.2% (2019/20)	23.0% (2019/20)	→↘	↘
% of children in year 6 living with overweight or obesity	NCMP	Annual	40.8% (2019/20)	35.2% (2019/20)	→	↘
% of adults in Nottingham who are overweight or obese	PHOF	Annual	66.9%	63.5%	↘	↘
% of pregnant women in Nottingham who were living with overweight/obesity at time of delivery	NUH	Annual	TBC	TBC	↘	↘

Delivery Theme 3: Promoting physically active lives and building active and green environments

What do we aim to do?

Transforming lives and communities through moving more and creating a greener, healthier, happier Nottingham whilst addressing inequality and empowering everyone to move in a way that works for them including through more active journeys. We will do this by building on and joining up our existing resources to increase accessibility for all. Insight gathering and co-production will sit at the heart of solutions for being active with groups who face the greatest barriers to physical activity such as women, those on low incomes, culturally diverse communities, the LGBTQ+ community and people with disabilities or long term health conditions (including mental health). This will also enable us to build a better picture of local level data and understanding across these groups throughout the duration of the delivery plan.

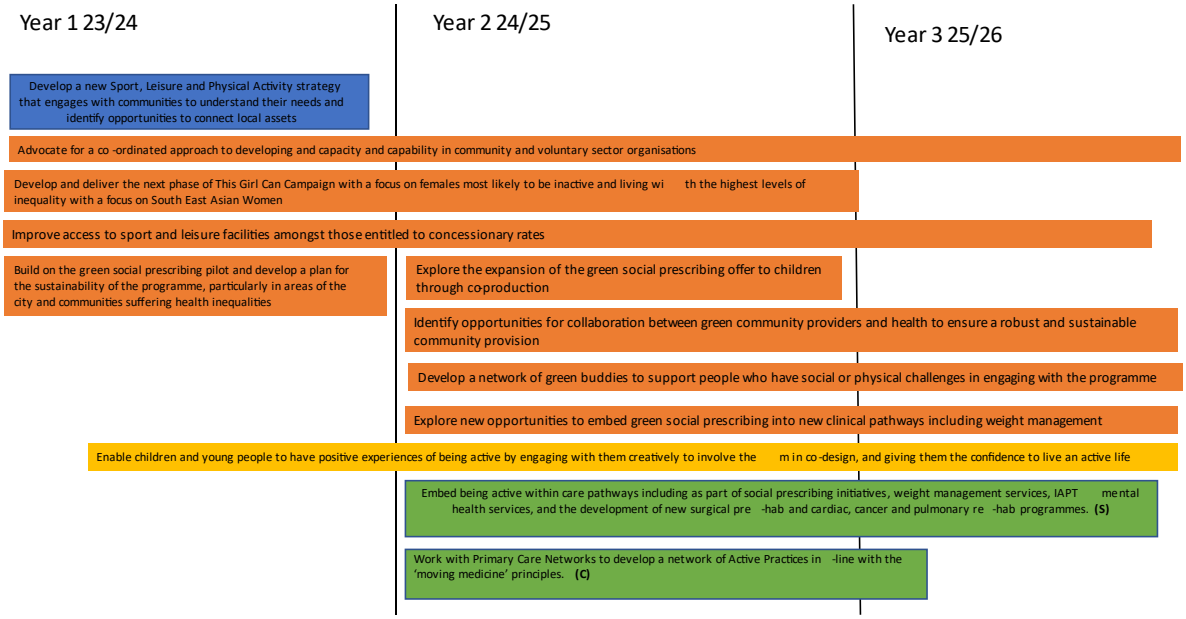
How will we do this?

Headline Pledge

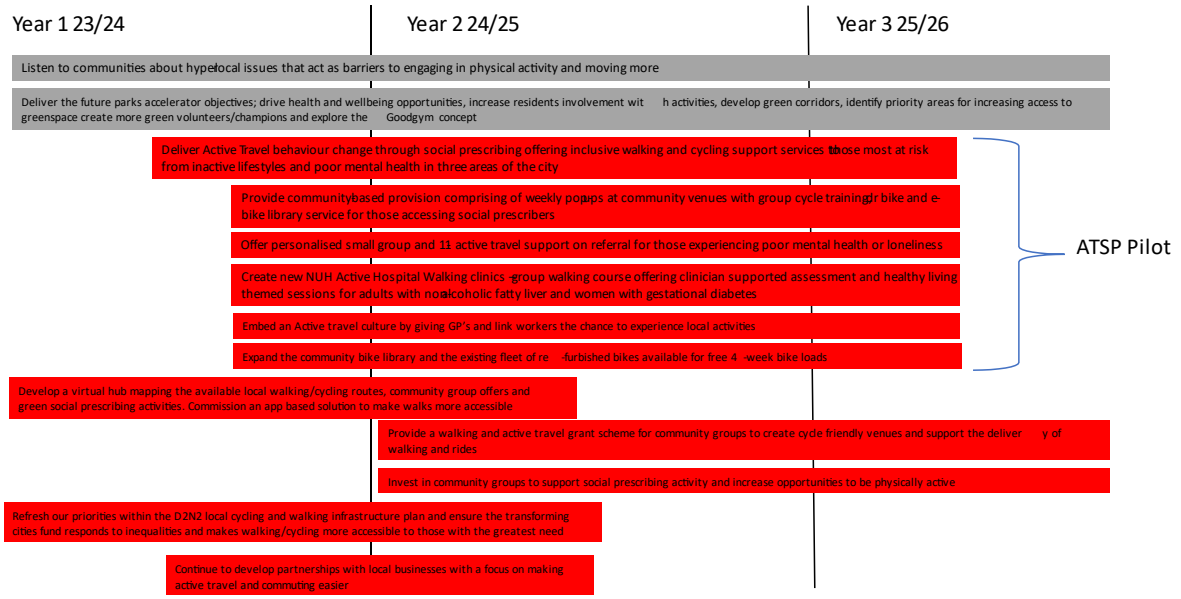
- **Halve the gap in the proportion of people who are inactive between our most active neighbourhoods (The Park, City Centre, Sherwood/Mapperley) and least active neighbourhoods (Beechdale, Broxtowe Estate, Bulwell, Bilborough and Aspley).**

1. **Create a culture where everyone can be active in a way that works for them by understanding the needs of inactive people through effective partnership working and co-production of solutions.**
2. **Working with people and communities who experience the greatest need.**
3. **Enabling children and young people to have positive experiences of being active throughout their childhood.**
4. **Ensure that health and care systems and strategies recognise, support and prioritise moving more for long term conditions and a priority within NHS prevention pathways.**
5. **Creating accessible, safe, and inclusive places and environments for physical activity.**
6. **Maximise the potential of walking and cycling to increase opportunities for a low impact, easily accessible way for people to increase levels of physical activity with confidence.**

Theme Three: Promoting Physically Active Lives and building Active and Green environments



Theme Three: Promoting Physically Active Lives and building Active and Green environments



The Foundation we are building on

- Social Prescribers can currently issue a fully funded three-month leisure centre membership to patients who would benefit from a physical activity intervention to better their physical, mental and emotional wellbeing along with reducing inactivity, social isolation and loneliness.
- Nottingham was selected as one of seven government Green Social Prescribing Test and Learn sites and awarded £500,000 to run this two-year pilot nature-based programme. Nottingham's intention is to make green prescriptions (using exercise in the fresh air to improve people's health and wellbeing) and nature connectedness (taking the time to notice and enjoy nature) a part of everyday life, an intervention of choice for healthcare professionals, and supporting those struggling with their mental health.
- Active Notts have created a shared vision, 'Making our move', to outline the principles behind how it and system partners in Nottingham and Nottinghamshire will work to empower everyone to be active in a way that works for them.
- Nottingham City Council is working with its communities and partners to ensure our parks and open spaces are sustainable for the future. This will form part of an ambitious 25-year strategy for the city's parks and open spaces service to make a Greener, Healthier and Happier Nottingham
- In 2021/22, leisure facilities (i.e. gym, fitness classes, swimming pool, and other facilities) were used 1,525,312 times across the six Nottingham City leisure centres. There are currently 15,765 users with memberships the majority of which are female (57.2%) and of white ethnicity (62.8%).
- Nottingham University Hospitals (NUH) is running one of four pilots across the country to promote activity of hospital-based staff and patients within the vicinity of hospitals to promote all-round better well-being. NUH links patients and staff to national resources; has developed campus walk maps; and has partnered with community groups to offer led walks.
- The Sport England Together Fund has invested £41,851 into community groups that work with disability, within areas of socio-economic deprivation or ethnically diverse communities, between June and October 2022. In addition, sporting community trusts have also funded initiatives using football, cricket and other sports to engage communities in sport and physical activity.
- Nottingham City Council was awarded School Swimming Lesson Provider of the Year Award in 2021 and 2022. It aims to ensure all children and young people can access swimming lessons and have the opportunity to learn to swim and leave primary school with water safety skills.
- The Sheriff's Challenge is a series of activities for all Primary school-age children encouraging them to be physically active. Each academic year a different challenge is set which encompasses a 'joint goal' for schools to cumulatively reach plus individual pupil targets. It's free for Nottingham City schools. In 2021/22, over 14,700 miles logged across 10 schools with 2,990 pupils taking part throughout the year.
- Nottingham City is one of eleven successful pilot areas invited to test approaches to delivering active travel behaviour change through social prescribing offering inclusive walking and cycling support services to those at most risk from inactive lifestyles and poor mental health.

- In 2020, Nottingham and Derby City Councils received funding through the Department

of Transport's Transforming Cities Fund. This included a £161m package of schemes to, amongst other things, improve options for people on foot or bike. An additional £16.7m has also been secured to trial electric scooters and e-bikes, and improvements to traffic information and ticketing.

- In addition to the Transforming Cities Fund, Nottingham has Active Travel Fund programmes. Nottingham is one of only five areas in England to have achieved a level 3 (out of 4) ranking by Active Travel England.

Indicator	Source	Frequency of reporting	Nottm value	England value	2027	2032
Output measures						
Number of participants in Active Travel social prescribing community activities	NCC	TBC	N/A	N/A		
Number of participants in NUH Active Hospitals walking clinics	NCC/NUH	TBC	N/A	N/A	↗	↗
Size of cycle fleet available via the bike library	NCC	Annual		N/A	↗↗	↗
Number of physical activity community groups taking place in our parks and open spaces	NCC	TBC	N/A	N/A	↗↗	↗
Total number of volunteering sessions in Nottingham parks and open spaces	NCC	Annual		N/A	↗↗	↗
Usage of parks and open spaces	NCC	Annual		N/A	↗	↗
Total mileage of designated cycle routes and cycle corridors	NCC	Annual	TBC	N/A	↗	↗
Number of people referred into green social prescribing activities and the number of people attending green social prescribing activities	NCVS	Quarterly		N/A	↗	↗
Additional outputs to be added via development of a sport, physical activity, and leisure strategy and from the Future Parks Accelerator outcomes framework currently under development						
Outcome measures						
% of children and young people who are physically inactive (less than 30 minutes)	Sport England	Annual			↘↘	↘
% of children and young people who are physically active (doing on average 60 minutes or more a day)	Sport England	Annual	Sample size too small	44.6% (2020/21)	↗	↗↗
% of adults who are physically inactive (less than 30 minutes a week)	Sport England	Annual	24.1% (2020/21)	23.4% (2020/21)	↘	↘
% of adults who are physically active (at least 150mins per week)	Sport England	Annual	64.1% (2020/21)	65.9% (2020/21)	↗	↗

Delivery Theme 4: Creating a local environment that promotes healthy food choices

What do we aim to do?

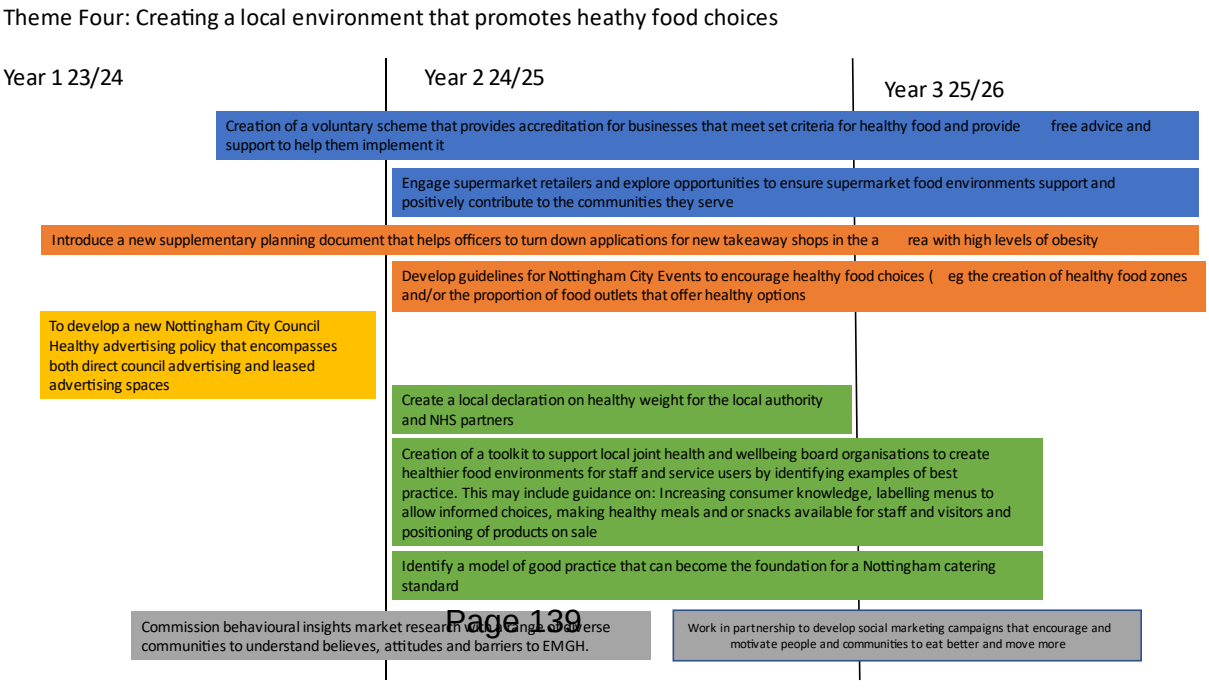
Create a diverse local food system where food choices are nutritious, affordable and desirable. We want to actively rebalance the influence on our eating habits to create a food environment that supports individuals' efforts to make food choices that positively effect their health and wellbeing , while simultaneously taking steps to limit the appeal of junk food.

How will we do this?

Headline pledges

- **By 2025, no adverts for Ultra Processed High Fat, Salt or Sugar Foods will appear on the Nottingham City Public Transport system or Nottingham City Council owned advertising spaces.**
- **By 2027, all Nottingham City events will include 'Healthy Food Zones'.**

1. **Support food businesses to improve Nottingham City's food environment and make healthy, options more widely available to those living in Nottingham.**
2. **Limit the 'density' of takeaway food outlets in Nottingham City to promote a more diverse food offer to Nottingham residents.**
3. **Support Nottingham City residents to make healthier choices by stopping unhealthy marketing that; in particular, influences what children eat.**
4. **Ensure local public buildings, hospitals and university buildings/campuses in Nottingham City promote a positive food environment.**
5. **Use behavioural insight to guide marketing campaigns aimed at improving diet quality and increasing physical activity levels.**



The foundation we are building on

- In 2014, NUH was the first NHS hospital to be awarded the Soil association's gold food for life catering mark.
- NCC attempted to include a restriction on takeaway outlets in it's town plan in 2018. This was dismissed by national planning authorities following an objection from national food chains.

Indicator	Source	Frequency of reporting	Nottm value	England value	2027	2032
Output measures						
Number of food outlets working towards Nottingham City Eating Better accreditation	NCC	Annual	N/A	N/A	↗↗	↗
Number of successful applications for fast-food outlets in areas of high obesity prevalence and in the vicinity of schools.	NCC	Annual		N/A	↘↘	→
Number of bus shelter advertising spaces promoting HFSS food products	NCC	Annual		N/A	↘↘	→
Density of fast-food outlets per 100,00 population	OHID	Annual	115.8	88.2	→	↘
Outcome measures						
% of adults consuming 5 or more portions of fruit and vegetables per day	OHID	Annual	50.1% (2019/20)	55.4% (2019/20)	↗	↗

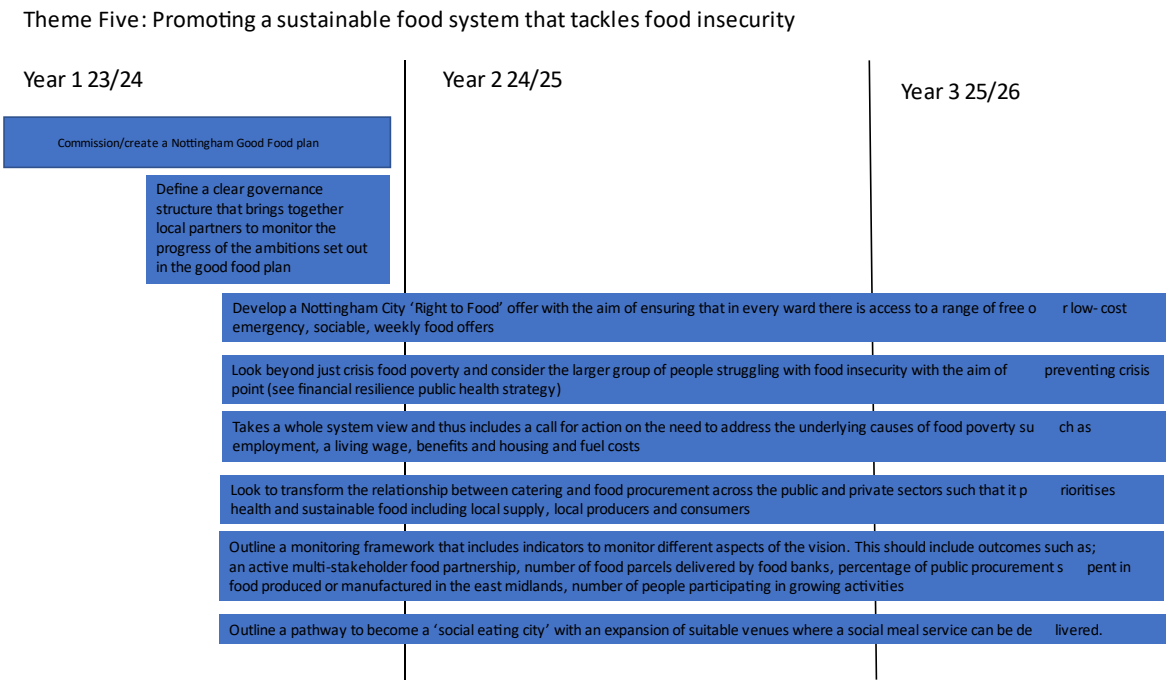
Delivery Theme 5: Promoting a sustainable food system that tackles food insecurity

What do we aim to do?

Ensure those living in Nottingham City have access to healthy, nutritious food produced with care for the environment and natural resources in a thriving local food economy that tackles rising levels of household food insecurity. This theme is also identified in the Financial Wellbeing delivery plan as it is an important feature in both of these Health and Wellbeing priorities. The review of the identified workstreams and subsequent delivery plans required on-going co-ordination between these two strategic areas.

How will we do it?

1. **Commission/Deliver a Nottingham City Good Food Plan developed in partnership between Nottingham City Council, local public sector organisations, the voluntary and community sector, and the business community. A Nottingham Good Food Plan should:**



- Define a clear governance structure that brings together local partners to monitor the progress of the ambitions set out in the Good Food Plan.
- Outline a monitoring framework that includes indicators to monitor different aspects of the vision. This should include outcomes such as: the presence of an active multi-stakeholder food partnership; number of food parcels delivered by food banks; percentage of public procurement spent in food produced or manufactured in the East Midlands; number of people participating in food growing activities.

The Foundation we are building on

- Since 2021, Nottingham City has received funding for a Holiday Activity and Food Programme – this programme enables children qualifying for free school meals to access free places in summer holiday clubs including a nutritious meal, helping with food insecurity.

- Nottingham City Council has joined forces with food redistribution charity FareShare Midlands to help produce meals for local people in need from food that would otherwise be thrown away. In full production, the kitchen team will prepare, process and cook 5,460kg of surplus foods to provide 13,000 meals per month. This project is funded by Sainsbury's.

- Since 2020, the Nottingham City Wellbeing Design Guide, developed by Nottingham City Council and the Nottingham Good Food Partnership, has assisted designers, developers & authorities in the delivery of healthy and sustainable places to live, full of food growing spaces, biodiversity, wellbeing, clean air and greenery.

Indicator	Source	Frequency of reporting	Nottm value (trend)	England value (trend)	2027	2032
Output measures						
Additional outputs to be added via development of a Nottingham City Food Plan						
Outcome measures						
Alignment to outcome measures to be part of an outcomes framework for the Nottingham City Food Plan						

EATING & MOVING FOR GOOD HEALTH

OUR LONG-TERM VISION FOR NOTTINGHAM CITY

2022- 2032

Vision

To transform Nottingham's systems, services and infrastructure so that they support eating and moving for good health as a part of everyday life, for everyone in the City.

Due to the broad nature of this task and the range of citywide systems that will need to collaborate, the strategy has been grouped into the following five themes:

1) Ensuring all Early Years Settings, Schools and Academies are enabling eating and moving for good health
2) Supporting healthy nutrition throughout the life course to support all people to achieve and maintain a healthy weight
3) Promoting physically active lives and building active and green environments
4) Creating a local environment that promotes healthy food choices
5) Promoting a sustainable food system that tackles food insecurity

An overall Strategic Alliance with senior leadership representation will over-see the strategy progression with operational sub-groups for each theme. It is fundamental to the success of the strategy that a range of key partners are included at both levels of governance.

Context

This Strategy was written and refined over a period of consultations and engagement with partners in the city in order to respond effectively to needs identified in local voice and robust data. The principles of being Responsive to need, Co-ownership and Inclusivity underpin the development of the Eating and Moving for Good Health strategy.

Responsive

There is a clear gap between the lifestyle habits of citizens in Nottingham and much of the rest of the country that impact on life expectancy, healthy life expectancy and long-term health conditions, with a disproportionate impact on some of our most vulnerable residents. Put bluntly, Nottingham City residents live shorter lives that are more impacted by poor health than their counterparts in other areas of the country, largely for reasons that are either directly or indirectly attributed to how we move and eat. A long-term strategy is needed to commit to significant change, with a series of three year delivery plans in place to allow service delivery that responds to emerging needs.

Both the data and our local consultations tell of a requirement for a system wide change to make eating and moving well easier for people in Nottingham. Individual choices play an important part in healthy lifestyles, but to make real change we need to consider all of the underlying factors that effect people's food and movement habits day to day, at every stage of their lives.

While supporting more people to achieve and maintain a healthy weight is a key goal, this ambition is broader. Helping those living in Nottingham have a positive relationship with food and physical activity will support a healthier, more equal society for all.

Co-owned

This strategy is owned by the people and the organisations that shape our city. Across Nottingham there is remarkable network of organisations and individuals who are committed to supporting improved outcomes for residents. The expertise, resources and co-ordinated energy of every part of this web are essential for success. Multiple organisations have been involved in the development of this strategy at different stages including:

- Small Steps Big Changes
- Notts County Foundation
- Active Notts
- The Youth Sport Trust
- Loughborough University
- University of Nottingham
- Notts Healthcare Trust
- British Triathalon
- The Renewal Trust
- Nottingham Trent University
- Home Start Nottingham
- Framework
- Nottingham Good Food Partnership

- Nottingham Community and Voluntary Service
- Bridges Community Trust
- Public Health England

Inclusive

This strategy identifies the ambition of partners across the city and unifies the direction of travel needed to make it easier for all people in Nottingham to eat and move for good health. It recognises the need for the further development of services and infrastructure to support everyone at a universal level, but also that the barriers faced by some of our citizens are greater than others. For example, people who are on a low income, experience long term health conditions or disabilities, have poor mental health or are from diverse ethnic backgrounds all face greater barriers to eating and moving well than their counterparts.

There are high levels of intersectionality meaning that in every Nottingham neighbourhood people face a unique picture of challenges that prevent them from living a healthier life. This means that co-designed interventions and targeted resources are required at both a geographical community level, and also within citywide communities where people with common ground come together.

There are gaps in our understanding of the barriers faced by different communities, and so we will strive to strengthen our relationships with partners who are best placed to amplify the voices of our least heard citizens. We will build equality audits and person-centred evaluations into our service delivery to ensure that we are continually growing our insight in a way that can shape future service provision.

The impact of diet and physical activity

In England, 63% of the adult population (aged 18y+) were classified as overweight with 25% classified as obese. The picture for the next generation is similarly worrying, with 1 in 10 (9.9%) children living with obesity when they start primary school and over a quarter (25.5%) leaving primary school living with obesity.

But you don't have to be classified as overweight or obese to be made ill due to diet; poor diet and being overweight or obese can lead to a range of physical health issues, such as increased likelihood of cancer, diabetes, cardiovascular issues and poor oral health, and can also result in a number of psychological problems.

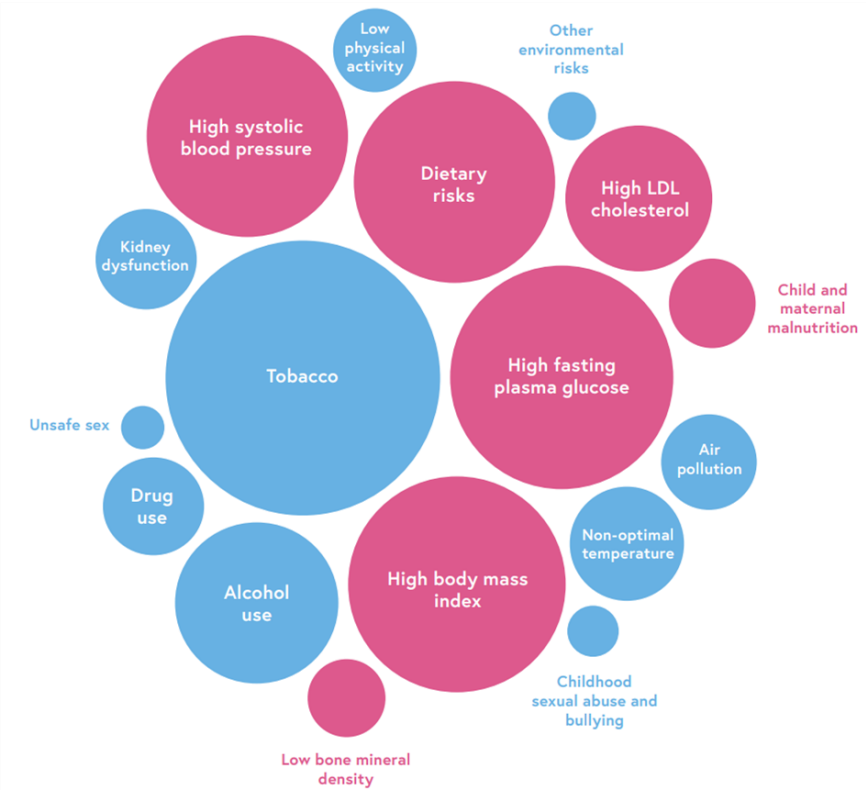
Regular physical activity is proven to help prevent and manage non-communicable diseases such as heart disease, stroke, diabetes and several cancers. It also helps prevent hypertension, maintain healthy body weight and can improve mental health, quality of life and well-being.

Unhealthy diet and lack of physical activity are leading global risks to health. Figure 1. shows the number of years lost to avoidable ill health or death in the UK. All the circles in pink represent conditions that are caused or exacerbated by poor diet; the estimated burden of food related ill health is large, compared with smoking. In addition, physical inactivity has been estimated to be directly responsible for 3% of Disability Adjusted Life Years (DALYs) lost in the UK. It is estimated that 1.5 million years of healthy life are lost to diet-related illness, disease and premature death each year.

The British diet has changed significantly over the last few decades and despite some recent positive signs that our diets may be becoming healthier, though there remain some concerning trends. Since 2008 there has been a steady decline in sugar intake in both children and adults; thanks in some part to a reduction in sugar sweetened drinks. However, the UK population overall continues to consume too much sugar and saturated fat and not enough fruit and vegetables and fibre.

Dietary ill health and physical inactivity carry a significant economic burden. It is estimated that the government will spend 8.4% of it's health expenditure on conditions related to a high BMI. In 2019/20, there were just over 1 million hospital admissions where obesity was recorded as the primary or secondary diagnosis – a 17% increase on 2018/19

Figure 1 Proportion of years lost to avoidable ill health and death by cause



The cost of diet-related ill health is not just limited to healthcare and the cost of conditions related to high BMI, in lost workforce productivity, reduction in life expectancy and NHS funds, is estimated to be £74 billion every year by the Organisation of Economic Co-operation and Development (OECD).

The impact of diet-related ill health, including overweight and obesity, is not just financial as it affects individuals' mental health and is associated with factors such as poorer school performance.

The suffering caused by the modern diet and physical inactivity is felt most acutely by the poorest in society. The proportion of people living with obesity is greater in areas with the lowest income (36%) compared to those in the highest (21%). The inequalities are even more stark amongst children where, by the age of 11, children from England's poorest neighbourhoods are three times more likely to be living with obesity than those from the richest ones.

Addressing diet and physical inactivity

What influences our ability to eat and move for good health is complex, with many contributing factors acting at individual, community, societal and even global levels. In this context, national strategy and policy are key to support and enhance the impact of local levers.

National strategy	Summary of priorities
Childhood Obesity: A Plan for Action	In 2016, the Government published, Childhood Obesity: A Plan for Action expressing the need for action taken nationally by government and large organisations such as food manufacturers. In the initial 2016 plan, the government proposed the following measures: ○ Implement a **Soft Drinks Industry Levy** ○ Take out **20% of sugar** in products ○ Support **innovation** of healthier food products ○ Update the **nutrient profile model** ○ Increase **availability of healthier options** in terms of location and cost ○ Increase **physical activity levels** of children ○ Instigate a **health rating system for primary schools** and make school food healthier ○ Clear **food labelling** ○ Focus on **early year's programmes** and structures ○ Use new **technology** e.g. apps for weight management ○ **Train health professionals** to reach out to patients regarding weight and health problems As a result, a soft drinks levy began in April 2018 to tax sugar-sweetened soft drinks.
Childhood Obesity: A Plan for Action, Chapter 2	In June 2018, the government released an extension of their original Childhood Obesity Plan with a more focused aim of halving childhood obesity and significantly reducing the gap in obesity between children by 2030. Added initiatives included: ○ Potential **extension of the Soft Drinks Industry Levy** to sugary milk-based drinks ○ Consult on a **ban on the sale of energy drinks** to children under the age of 16 years ○ Potential **mandatory and fiscal measures** if the 2019 progress report shows poor progress with voluntary sugar reduction

	○ Implement a **calorie reduction programme**, to reduce calories by 20% in a range of everyday foods consumed by children by 2024 ○ Consult on **mandated calorie labelling** for the out of home sector ○ Explore the opportunities 'Brexit' presents for **nutrition labelling** ○ Consult on the introduction of a **9pm watershed on TV advertising of HFSS products** and similar protection for children viewing adverts online ○ Consult on **banning price promotions**, such as buy one get one free and multi-buy offers of unhealthy foods and drinks in the retail and out of home sector ○ Consult on **banning the promotion of unhealthy food and drink by location** (at checkouts, the end of aisles and store entrances) in the retail and out of home sector ○ Develop a **'trailblazer' programme** with local authority partners as case studies of "what works" ○ Develop resources that **support local authorities** create healthy food environments ○ **Update the School Food Standards** to reduce sugar consumption ○ Consult on strengthening the nutrition standards in the **Government Buying Standards for Food and Catering Services** ○ Promote a national ambition for every primary school to **adopt an active mile initiative**, such as the Daily Mile ○ Invest over £1.6million during 2018/19 to **support cycling and walking to school** ○ Consult on plans to use **Healthy Start vouchers** to provide additional support to children from lower income families Following these consultations, the government introduced legislation to restrict the promotion of HFSS products by volume price (for example, 'buy one get one free') and location, both online and in store in England. However, the last year has seen progress on the plan stall. For example, the restrictions on the promotion of HFSS products by volume price (e.g. 'buy one get one free') and new restrictions on junk food advertising, have now been further delayed.
NHS Long Term Plan	In 2019, the NHS Long Term Plan set out additional action it would take on prevention and health inequalities, including for obesity. It made several commitments related to weight management: ○ The NHS will provide a targeted support offer and access to weight management services in primary care for

	people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+ (adjusted appropriately for ethnicity) ○ The NHS will fund a doubling of the NHS Diabetes Prevention Programme over the next five years, including a new digital option to widen patient choice and target inequality. ○ We will test an NHS programme supporting very low-calorie diets for obese people with type 2 diabetes. ○ The NHS will continue to take action on healthy NHS premises through Hospital Food Standards. ○ Ensure nutrition has a greater place in professional education training.
Sport England: Uniting the movement – 10-year vision.	Published in 2021, Uniting the Movement is a 10-year vision from Sport England to transform lives and communities through sport and physical activity. The report contains five 'big issues': 1. Recover and reinvent - Recovering from the biggest crisis in a generation and reinventing as a vibrant, relevant and sustainable network of organisations providing sport and physical activity opportunities that meet the needs of different people. 2. Connecting Communities - Focusing on sport and physical activity's ability to make better places to live and bring people together. 3. Positive experiences for children and young people - Unrelenting focus on positive experiences for all children and young people as the foundations for a long and healthy life. 4. Connecting with health and wellbeing - Strengthening the connections between sport, physical activity, health and wellbeing, so more people can feel the benefits of, and advocate for, an active life. 5. Active Environments - Creating and protecting the places and spaces that make it easier for people to be active.
National Food Strategy – The independent review	In 2018, the UK government asked Henry Dimbleby, the co-founder of restaurant chain Leon and a non-executive director of Defra, to carry out a comprehensive review of our food system. The first report, published in 2020, became an urgent response to the issues of hunger and ill health raised by the COVID-19 pandemic, as well as the trade and food

	standards issues created by the end of the EU Exit transition period. The government responded by acting on four of the seven recommendations: ○ Extend the Holiday Activities Fund Programme ○ Increase the value of the Healthy Start Vouchers ○ Collect and monitor data on the number of people suffering food insecurity ; and ○ Commit to commission an Independent report on any proposed trade agreement The second report, published in 2021, returned to the original brief and presented 14 recommendations across four key themes: ○ Escape the junk food cycle and protect the NHS ○ Reduce diet-related inequality ○ Make the best use of our land ○ Create a long-term shift in our food culture

The current picture in Nottingham City

- Just over one in four (25.2%) of children in reception in Nottingham were living with overweight or obesity in 2019/20 – this is significantly higher than the England average (23.0%).
- By the end of primary school (Year 6), four in ten (40.8%) children in Nottingham are living with overweight or obesity – significantly higher than the England average and 4th highest amongst statistical neighbours.
- Nottingham is currently predicted to miss the national ambition to halve childhood obesity by 2030.
    - The proportion of children in reception living with overweight & obesity is estimated to only decrease to 23.72% by 2030 and 22.15% by 2040.
    - The proportion of Year 6 children living with overweight & obesity is estimated to increase to 46.07% by 2030 and 51.14% by 2040.
- Almost seven in ten adults (66.9%) in Nottingham City are living with overweight or obesity and 28.4% with obesity; significantly higher than the England average (63.5% and 25.3% respectively)
- Only half (50.1%) of adults in Nottingham meet the recommended '5-a-day' on a 'usual day'. This is significantly lower than the England average (55.4%) and is a marker of overall diet quality.
- Just under one in four (24.1%) adults in Nottingham are inactive; similar to the England average.

- In 2020/21, there was insufficient participation by school children in the Active Lives survey in Nottingham. Across Nottingham and Nottinghamshire, 34.3% of children were inactive compared to 32.4% in England.

- Four of the top five largest causes of (preventable) death and disease in Nottingham are directly or in-directly related to diet and physical activity.

- Nottingham recorded 3145 admissions per 100,000 where obesity was a factor compared to a national rate of 1869 admissions per 100,000; this is the 4th highest in England.

Ways of working

We will create an Eating & Moving for Good Health Alliance. Partners agree to take collective ownership and will identify the resources needed to support their contribution to our shared ambition. As an alliance, we will represent a diverse spectrum of organisations in order to influence a breadth of local levers. We will ensure our strategies align and contribute to a shared set of long-term outcomes.

In implementing and delivering our strategy, we will underpin our work with several key principles to ensure we are tackling our shared challenges in a sustainable way:

i. **Collaboration as equal partners –** We will work in collaboration across NHS (primary and secondary care), local authority, the community and voluntary sector, and other public and private sector organisations. We will utilise our diverse set of expertise, experience and perspectives, to deliver our vision of a city that supports people to eat and move for good health.

ii. **Community focused** – We will communicate with people throughout Nottingham City to share our vision and our progress towards reaching this aim. We will engage with individuals, organisations communities to develop solutions to meet this aim.

iii. **Best use of resources** – Collectively we will find the funding required to drive programmes and new ways of working. There is an expectation that partners will focus local resources to ensure that investments are delivering in a sustainable way including exploring joint commissioning where it is beneficial to residents.

iv. **Outcome-focused** – A clear programme model has been produced to connect multiple interventions and policies acting across a complex system. Evaluation of programmes will be ongoing and based on continuous improvement principles.

v. **Data & Intelligence** – We will ensure that we use all available data sources and strengthen data collection systems so we accurately assess our progress across different themes and ensure that this data feeds into the monitoring of each 3-year delivery plan, to inform future delivery plans.

A whole system approach

Eating and Moving for Good Health is driven by a complex web of interconnected environmental, societal and individual factors. The causes of diet and physical activity behaviour exist in the places where we live, work, learn and play, where the food and built environment often makes it difficult to make positive choices. We know that there is no one single solution. Tackling such an ingrained problem requires a long-term, system-wide approach.

A whole system approach uncovers critical relationships between causal factors and helps identify the greatest levers for organisational and system change (i.e. Individual, Community, System and Built Environment levers).

A systems approach also means dispersing leadership throughout the system, so everyone is taking responsibility for action towards collective goals. The whole system approach also enables stakeholders to identify their contribution in achieving shared ambitions. Involving local community groups and residents in the approach helps ensure that the resulting programme of work takes account of the views, knowledge and priorities of the communities who are, ultimately, the beneficiaries of whole system efforts to address poor diet and physical inactivity.

Nottingham's approach to whole systems

There is already a lot going on across Nottingham City, but much needs to be done to truly change the whole system that influences our behaviours. Actions are needed at multiple levels working together and reinforcing each other to reshape what residents in Nottingham eat and drink and the activity they do.

Nottingham held two whole system workshops exploring 'Eating and Moving for Good Health'. These two workshops brought together a diverse set of stakeholders including elected members, residents, community groups, local health and care partners, and local authority officers, identified through network mapping. A third workshop was then held with partners to consult on a draft of this strategy.

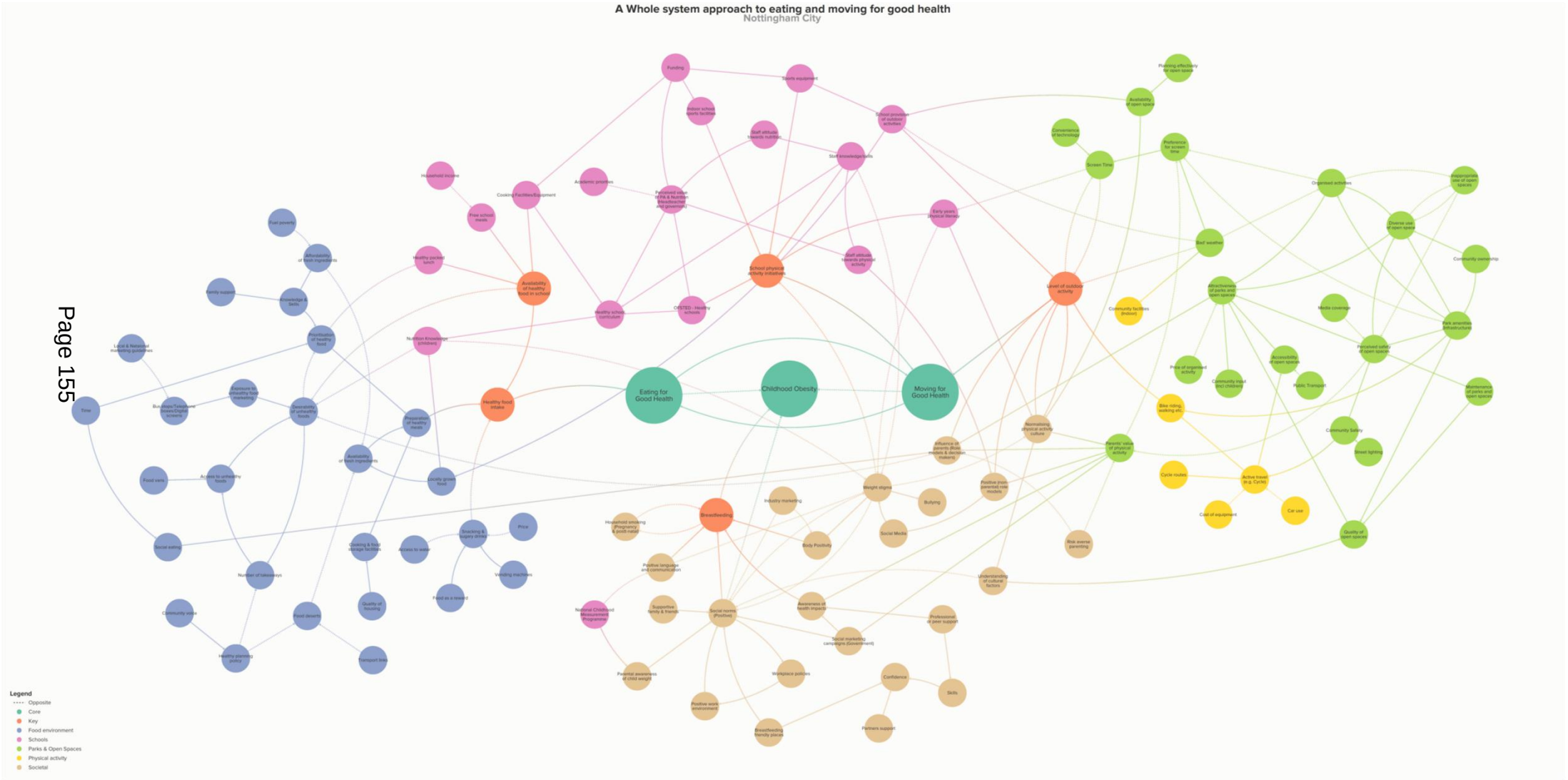
The first workshop held in 2019, introduced stakeholders to the concepts of systems thinking. Participants were asked to consider the key factors influencing poor diet and physical inactivity within their communities. Each table then discussed three of these factors in more depth and developed causal loop diagrams. Participants identified connections and the nature of the relationship between variables (i.e. a positive or negative association). These maps were then blended into one causal loop diagram with four primary domains: Food environment; Schools; Parks & Open Spaces; and Societal factors including breastfeeding (Figure 2).

The second workshop held in early 2020, gave stakeholders the opportunity to explore their 'Eating and Moving for Good Health' system map. They were challenged to prioritise the primary domains and identify actions that were or could be put in place to disrupt critical relationships. They were asked to consider interventions that focus on individual, community, policy levers as well as the relationships that exist within the system.

Work was paused during the COVID-19 pandemic but the output from these workshops was used following the publication of the Joint Health and Wellbeing Strategy to guide discussions between

system partners – since the COVID-19 pandemic we have involved over 20 organisations in themed working groups (Appendix 1). The third workshop was held in early 2023 where the draft strategy and first three year delivery plan was shared and feedback was gathered. These workshops and subsequent discussions have determined the delivery approach we will take to achieve our vision.

Figure 2. System map of ‘Eating and Moving for Good Health’ in Nottingham City (Children and Young People)



Our Vision for 2032 and beyond

To transform Nottingham's systems, services and infrastructure so that they support eating and moving for good health as a part of everyday life, for everyone in the City.

In order to meet this vision for Nottingham, we will be driving forward work focused on supporting changes to individuals, communities, the local system and the built environment and delivering across five key themes:

Delivery Theme 1: Ensuring all Early Years Settings, Schools and Academies are enabling eating and moving for good health

Establishing healthy habits early in life gives babies and young children the best possible start and reduces their risk of poor physical and emotional health throughout childhood and into adulthood. It is hard for any parent – let alone one on a low income – to make sure their growing child is eating and drinking the right things and being active enough.

Working with early years settings, schools and academies offers an amazing opportunity to support children in developing healthy eating habits for life as well as reducing sedentary behaviour and encouraging children to enjoy being active.

Delivery Theme 2: Supporting healthy choices in pregnancy and helping children and adults achieve and maintain a healthy weight

Breastfeeding reduces the risk of childhood obesity, as the mother produces milk to meet the individual nutritional needs of her child. The early diet of infants is also very important in developing children who are happy to eat a wide range of tastes and textures.

Supporting people to achieve and maintain a healthy weight is an important part of the system approach. Different services are needed to support people in different weight categories and need to be joined up to provide a patient-centred approach.

Delivery Theme 3: Promoting physically active lives and building active and green environments

Being more physically active can have a significant positive impact on mental and physical health yet many of us find it difficult to build regular activity into our daily routines. Through active lives, we can create a fairer, stronger, healthier and greener society for all.

Being active helps more than just individuals. It benefits communities and wider society, and has a knock-on effect on the environment. However, there are lots of blocks and barriers that mean some people are less active than others. Achieving a step change in how we are able to access and utilise our outdoor space is need to provide opportunities for people to be active and move more throughout their day.

Delivery Theme 4: Creating a local environment that promotes healthy food choices

Our food environment and our eating patterns have changed. We are living in an obesogenic environment, with an abundance of energy dense food. We are also constantly bombarded with

advertisements and offers which encourage us to eat unhealthily. These are often targeted at children and drive our behaviours and eating patterns. All of this means that it is increasingly difficult for us to make healthier choices in our daily lives.

Delivery Theme 5: Promoting a sustainable food system that tackles food insecurity

Food shapes our lives and city from what we eat, the way we produce it, how we package it, the distance it travels, the food we waste, the people and businesses we buy it from, to the strength of our local economy and the health and wellbeing of our people.

The cost of living crisis is a key current issue in the UK and brings the challenges many households face into sharp focus. It is important we find solutions to enable people to have access to affordable healthy and sustainable food that benefits individual health and the environment.

Monitoring and Delivery

This strategy has set out our ambitious to transform Nottingham's ecosystem into one that makes eating and moving for good health a part of everyday life, laying the foundations of a healthy life for every individual in City. To support the delivery of this strategy, we will put in place a series of three-year delivery plans, starting from 2022/23 to 2025/26 which will set out in detail the actions that we will undertake and support as we work towards our ambition.

We will use our programme model (Appendix 1) to be clear on the outputs that each delivery plan will achieve as we make progress towards our intermediate and long-term outcomes. We will continuously monitor and evaluate our actions to ensure that we are making progress.

Delivery of the strategy and the delivery plans will be the responsibility of the 'Eating and Moving for Good Health' Alliance. The Alliance will have representation from key partners and will have the right level of seniority and challenge to provide leadership, assess and make decisions which influence the direction of travel for delivery of the strategy and delivery plans.

An implementation group will also be established with the remit of supporting, monitoring and implementing delivery of the delivery plans, as well as undertaking the engagement and collaboration needed.

Appendix 1: A list of participating stakeholders since the COVID-19 pandemic

- Nottingham City Council
  - Public Health
  - Planning
  - Transport
  - Education
  - Sport & Leisure
  - Parks & Open Spaces
  - Health & Wellbeing
- Nottingham & Nottinghamshire ICB
- Primary Care Networks (various) and Clinical Directors
- Nottinghamshire Healthcare Trust
- Nottingham University Hospitals
- Slimming World
- City Care
- Nottingham City Homes
- University of Nottingham
- Nottingham Trent University
- Nottingham Community & Voluntary Sector
- Evolve
- Nottingham Forest Community Trust
- British Cycling
- Age UK
- First Steps ED
- CT4N
- Home Start
- EM Academic Health Science Network
- Nottingham Good Food Partnership
- Primary Schools (various)
- Active Notts
- Small Steps Big Changes
- Community Café
- Other community groups

Appendix 2: Eating and Moving for Good Health Programme model

Inputs

EXAMPLES

STRATEGIC:
- Executive Sponsorship
- Prioritisation of work within the ICS
- Strategic commitment as agreed JHWS priority

PARTNERSHIP:
- An engaged EMGH partnership group
- Engagement from partners across each workstream

INSIGHT:
- Data & Intelligence capacity
- Provider datasets
- National data sources
- Dental survey
- NCMP

RESOURCES:
- Public Health AND NHS investment in healthy weight pathways.
- Public Health AND Local Authority investment in capacity to deliver change across multiple agendas (i.e. parks, leisure, planning)
- Public Health grant funding for walking co-ordinator
- Public Health investment in EMGH school grants programme
- LMNS funding in breastfeeding pathway and breastfeeding projects
- SSBC funding in breastfeeding campaigns and a maternity support worker project

Activities

THEME 1: Healthy & sustainable food environment
EXAMPLES:
- Create a bank of trained volunteers who can support the community food sector.
- Create a Healthy Food Supplementary Planning Document.
- Create a network of social eating places.
- New, local food procurement charter.
- HFFS advertising policy for public body owned/leased advertising spaces

THEME 2: Healthy weight pathways
EXAMPLES:
- Commissioning of an integrated lifestyle service that enables a person centered approach.
- Training for health and social care professionals on healthy conversations and avoiding weight stigma.
- Commission a Tier 3 service that offers an alternative to bariatric surgery through intensive dietetic and psychological support.

THEME 3: Education settings
EXAMPLES:
- Provide school data packs on children's health (including overweight/obesity) within the catchment area.
- Launch an EAMFGH grant scheme for primary schools that enables piloting of 2-3 flagship EMGH champion schools.
- Re-launch the Sherriff's mile.

THEME 4: Parks, open spaces & physical activity
EXAMPLES:
- Run co-design sessions with communities to grow insight and understanding of the local barriers to physical activity.
- Offer training to healthcare and community and voluntary sector organisations on how to influence 'moving for good health'.
- Raise the awareness of opportunities to grow 'walking' and fund local walking initiatives.

THEME 5: Community and voluntary sector
EXAMPLES:
- Commission engagement work with CVS organisations and local communities.
- Develop an online network to facilitate collaboration and grant applications.

THEME 6: Food poverty
TBC

Outputs

TBC once activities have been confirmed. Examples may include:

Number of social eating venues/meals served

Number of HFFS foods adverts

Number of organisations adopting healthy and sustainable food procurement policies

Number of adults and children receiving cooking skills training

Number of healthcare staff receiving training on 'healthy conversations'

Number of children/adults receiving weight management support

Proportion of eligible families taking up healthy start vouchers and free school meals

Number of schools with EMGH champions

Number of families attending holiday food and activity programmes.

Number of successful (external) grant applications by CVS organisations

Number of A5 planning applications (fast food outlets) successfully refused

ASSUMPTIONS: There are numerous assumptions that underpin the mechanism bridging outputs and intermediate outcomes. Some of these focus on the effectiveness of the activities in question and the assumption that doing more leads to better outcomes.

Intermediate Outcomes

Increased number of 'healthy conversations' with Nottingham City residents

Source: TBC

Proportion of adults living within 'walking distance' of affordable fruit and vegetables

Source: GiS mapping

Increase in children and adults achieving 10% weight-loss or their goal weight

Source: Local provider data

Proportion of the population eating '5-a-day' (adults).

Source: Active Lives Survey

Breastfeeding initiation & Breastfeeding at 6-8 weeks

Source: NHS Digital

Percentage of physically inactive adults

Source: Active Lives Survey

Other outcomes (TBC)

EXAMPLE: Wellbeing of weight management service users

ASSUMPTIONS: It is a significant assumption that a change in attitudes and beliefs leads to a change in long-term outcomes. Long-term outcomes are the result of a complex interplay of multiple intermediate outcomes and external factors that describe the underlying conditions or resources that need to exist for planned change to occur.

Long-term Outcomes

Year 6: Prevalence of overweight (including obesity)

Source: NHS Digital, National Child Measurement Programme.

Reception: Prevalence of overweight (including obesity)

Source: NHS Digital, National Child Measurement Programme.

Percentage of adults (aged 18+) classified as overweight or obese

Source: Active Lives Adult Survey, Sport England

Hospital admissions where obesity was a factor

Source: NHS digital

Impacts

Integrated Care System Outcomes Framework – System indicators

Increase in healthy life expectancy

Reduction in health inequalities

Reduction in illness and disease prevalence
(In particular, Type 2 diabetes, cardiovascular disease and cancer)

Reduction in premature mortality

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Nottingham City Health and Wellbeing Board
31st May 2023

Report Title:	Joint Strategic Needs Assessment (JSNA) and other Needs Assessments update
Lead Board Member(s):	Lucy Hubber, Director of Public Health
Report author and contact details:	Hannah Stovin, hannah.stovin@nottinghamcity.gov.uk)
Other colleagues who have provided input:	Eka Famodile, David Johns, Catherine Jones, Hannah Stovin, Dana Sumilo

Executive Summary:
The Public Health team will provide the Board with an update as to progress on the creation of Joint Strategic Needs Assessment dashboards in conjunction with Nottinghamshire County and Integrated Care Board colleagues, and the proposals for continuation of this work.
Following the publication of the national Women's Health Strategy in 2022, Nottingham City will undertake a Women's Health Needs Assessment, and an update regarding planning and progress will be provided to the Board.
The update will also cover the completed Covid-19 JSNA chapter which is submitted for the Board's approval.

Recommendation(s):

1. The Board is asked to note the updates regarding the progress of the JSNA and other Needs Assessments.

2. The Board is asked to note the findings of the Covid-19 JSNA chapter report and the 'Learning for the Future' points, taking these into account during any future policy decisions.

The Joint Health and Wellbeing Strategy	
Aims and Priorities	**How the recommendation(s) contribute to meeting the Aims and Priorities:**
Aim 1: To increase healthy life expectancy in Nottingham through addressing the wider determinants of health and enabling people to make healthy decisions	The recommendations enable the Board to understand the work contained in the Needs Assessments in relation to the Aims & Priorities, and where information pertaining to these priorities might be

Aim 2: To reduce health inequalities by having a proportionately greater focus where change is most needed	sourced to assist with the work of the Board. Recommendation 2 relates to the Covid-19 JSNA which contains a specific finding regarding health inequalities and which the Board are asked to consider in future policy decisions.
Priority 1: Smoking and Tobacco Control	
Priority 2: Eating and Moving for Good Health	
Priority 3: Severe Multiple Disadvantage	
Priority 4: Financial Wellbeing	
How mental health and wellbeing is being championed in line with the Board's aspiration to give equal value to mental and physical health: All JSNA and Needs Assessments discussed in the update contain or are planned to contain specific sections relating to mental health & wellbeing in recognition of the impact this has to Nottingham City's population.	

List of background papers relied upon in writing this report (not including published documents or confidential or exempt information)	None.
Published documents referred to in this report	Re: Covid-19 JSNA chapter - An extensive list of references is contained at the end of the document.

The Health Impact of COVID-19 on Nottingham City

Nottingham City Council JSNA May 2023

Nottingham City Council

Contents

Executive Summary

The COVID-19 pandemic and the restrictions introduced to curb it, have had an enormous impact on many aspects of life in this country. Whilst everyone in the UK has been affected by the pandemic, the effects were unevenly spread throughout society, with vulnerable and at risk groups being disproportionately impacted. COVID exacerbated the health inequalities already present within our communities and made them worse, so that people from deprived and vulnerable backgrounds were more likely to be infected, hospitalised with a severe illness and die from the virus.[4]

Nottingham has been particularly hard hit by the pandemic with over a thousand deaths due to COVID-19. The relatively high levels of deprivation experienced by many communities within the city have led to health inequalities, which have catalysed the negative impacts of the virus in terms of mortality, morbidity, access to services, financial resilience and mental health.

Against this background, this chapter of the Nottingham City JSNA, focuses on the health impacts of the COVID pandemic from a variety of perspectives, taking health inequalities, wider determinants and population health into consideration. The initial drafts of this chapter were written in 2021, a further version based on refreshed data and content produced during the summer of 2022, and a final update undertaken in Spring 2023.

It is hoped that this document will contribute towards a greater understanding of the way that both the society and health and care systems within Nottingham City were impacted by COVID-19. Through this insight and the shared understanding that develops from it, the city may then work towards a meaningful, effective and sustainable recovery from the detrimental effects of the pandemic.

Key Findings

The structure of this report is based on the King's Fund framework of four pillars of population health[7]:

- Wider determinants of health
- Our health behaviours and lifestyles
- The places and communities we live in, and with
- (An Integrated Health and Care System) Public Health Services

A separate section devoted to "The Impact on Mental Health and Wellbeing" has also been included in this JSNA chapter, as we believe that this ongoing effect of the pandemic will continue to have short, medium- and longer-term consequences for our society.

This assessment of the impact of COVID-19 on the lives and health of people of Nottingham City has highlighted the areas that have been most affected by the pandemic. To help aid our understanding we asked several questions, which form the framework for this chapter:

- What has been the impact of COVID-19?
- Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?
- What learning can we take from this period for the future?

Learning for the Future

The connection between the four pillars of population health is important and underpins some key findings from this report:

- An integrated recovery will provide the most effective impact. The idea that recovery should be focussed on one sector would be short-sighted. Health and wellbeing have been impacted across all areas of society and a recovery process that is integrated is likely to have the greatest chance of success.
- The recovery should have the community at its heart. A personalised approach can be more successful in engaging certain population groups and areas of the city. Engaging in co-production by using local assets such as volunteers, social networks and charity, faith and community groups could play a vital role.
- The pandemic has increased the awareness of pre-existing inequalities and the disproportionate effect on some groups, including disabled people, ethnic minority communities, care home residents, people in forms of insecure work and people experiencing homelessness. This learning should be captured and applied to future policy; in particular, the need to focus on reducing health inequalities experienced by ethnic minority groups.
- The impact that COVID-19 has had on the mental health of the population should be acknowledged. In the short, medium and long-term, the pandemic may result in an increase in demand for not only mental health, but other services. In some areas the effects on mental health may result in negative engagement of services, directed towards certain health promotion and health protection services. Each public health service area should acknowledge this within future policy and where possible try to optimise engagement.

Introduction

On 11th March 2020, The World Health Organization (WHO) declared the novel coronavirus (COVID-19) outbreak as a global pandemic.[1] The attempts to control the spread of this new highly contagious infectious disease has been challenging for governments around the world. As stated in "The Marmot Review 10 Years on," the UK had a difficult starting point with evidence of increasing health inequalities and a reduction in life expectancy in the most deprived communities before the pandemic had even begun. [2]

The COVID-19 pandemic and subsequent measures have drastically changed the functioning of British society. The introduction of social distancing and isolation measures, an emphasis on working from home, suspension of routine healthcare, school closures, business and community facilities shut down and shielding of vulnerable communities has changed the lives of most of the nation. There were several national lockdowns and in between, local restrictions consisting of a tiered system with varying limits placed on civil liberties all over the United Kingdom.

The COVID-19 pandemic has led to not only a loss of liberties but a loss of livelihoods and for some, tragically, a loss of life. By August 2022, the pandemic had led to over 201,000 deaths in the UK.[3] The effect of the pandemic has not been an equal one. Not everyone faced the same risk of exposure to the virus or if infected faced the same severity of disease.[4]

The pandemic has exposed the increasing wealth and health gap in our society. In 2019, there was a 19 year gap in healthy life expectancy between the most and least affluent in the country.[5] During the pandemic, COVID-19 mortality rates in England were more than twice as high for people from the most deprived 10% compared with people from the least deprived, and almost four times as high for people younger than 65.[4]

From 8th March 2021, England (and other devolved nations) proceeded with a Roadmap out of lockdown.[6] The success of the COVID-19 vaccination programme allowed England on 19th July 2021 to move to step 4 of the 'road map', lifting most legal restrictions that had previously been used to control the spread of the virus. This has resulted in the removal of legal requirements related to social distancing, no limits placed on social events, no limit on the number of people you can meet indoors, no legal requirement to wear a mask and people are no longer required to work from home. It also has allowed the opening of all businesses including night clubs, hospitality venues and even large events held at sports stadiums and music festivals. Despite this 'opening up' of society there should be an awareness of the consequences of limits placed on our community and how this has affected the mental, emotional, physical, and financial wellbeing of Nottingham City's population. At the point of publication (May 2023), the virus persists, cases continue, and the potential for future restrictions cannot be ruled out.

The Health and Wellbeing Board endorsed a refresh of the JSNA at its March 2021 Board meeting and stated that '*ultimately, the health priorities and impacts of Coronavirus must be made as clear as possible.'*

To work towards an effective and meaningful recovery for Nottingham City, there needs to be an informed and shared understanding of how the pandemic has impacted both society and the health and social care systems. There needs to be an awareness of how these areas were operating prior to the pandemic, what the pre-pandemic limitations were and how the pandemic has further impacted on this.

We have considered the approach of the Population Health Model. Population Health is an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population.[7]

The report covers some of the key pillars of population health[7]:

- Wider determinants of health
- Our health behaviours and lifestyles

- The places and communities we live in, and with
- Public Health Commissioned Services

We have also included a separate section devoted to The Impact on Mental Health and Wellbeing as we feel this has had and will continue to have short, medium- and longer-term consequences on our society.

This assessment of the impact of COVID-19 on the lives and health of people of Nottingham City has highlighted the areas that have been most affected by the pandemic. To help aid our understanding we asked several questions:

- What has been the impact of COVID-19?
- Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?
- What learning can we take from this period for the future?

It should be noted that this chapter focuses on breadth of discussion, rather than depth of information reported. Please see the Appendices and Hyperlinks for useful information relating to further work that has been completed.

Thank you to the wide range of stakeholders and service providers for providing a wealth of information based on first-hand experience of working with residents of Nottingham City.

We hope this will be a JSNA chapter that has the potential to influence key strategic thinking, start new areas of work and shape services in the future for the benefit of our population.

The COVID-19 pandemic has infected over 765 million people and caused over 6.9 million deaths globally, according to the World Health Organisation (WHO).[8] According to the Gov.uk website, as at May 2023 22.2 million people had tested positive within the UK, over 178,400 people had died within 28 days of a positive test for COVID-19 and over 222,600 deaths were recorded with COVID-19 on the death certificate in the UK.[9]

In December 2020, the Institute for Health Equity published "Build Back Fairer: The COVID-19 Marmot Review"[10] which highlights that the pre-existing socio-economic inequalities in our society have led to a disproportionately high number of deaths from COVID-19 in disadvantaged communities. Key findings include that inequalities in society are increasing and life expectancy is stalling or worse is falling in the most deprived areas. [10]

The COVID-19 pandemic has exposed existing health inequalities and in some cases has increased them.[11] Public Health England (PHE) published a report called "*Disparities in the risk and Outcomes of COVID-19,"* in August 2020.[12] This report related to the first wave of the pandemic and identified that those who were male, older and from a black or ethnic minority group, with an underlying health condition, working in high risk occupations and living in deprived areas were at greater risk of COVID-19 infection and had a higher rate of mortality. [13]

Highlighted areas of risk include:

Age and sex:

Older people are at a significantly higher risk of developing severe illness if they become infected with COVID 19. Among people with a positive test, when compared with those under 40, those who were 80 or older were seventy times more likely to die.[12] COVID-19 diagnosis rates increased with age for both males and females. Working age males diagnosed with COVID-19 were twice as likely to die as females.[12]

Geography

In the early stages of the pandemic the highest number of cases and deaths from COVID-19 were in more urban areas of England. London had the highest rates followed by the North West, the North East and the West Midlands. The South West had the lowest.

Deprivation

There is evidence that there are underlying health inequalities driving poorer outcomes as COVID-19 mortality rates are higher in more deprived areas.[13] People who live in deprived areas have higher diagnosis rates and death rates than those living in less deprived areas. The mortality rates from COVID-19 in the most deprived areas were more than double the least deprived areas, for both males and females.[12] This is greater than the inequality seen in mortality rates in previous years, indicating greater inequality in death rates from COVID-19.

Ethnicity

People from Black ethnic groups were most likely to be diagnosed. Death rates from COVID-19 were highest among people of Black and Asian ethnic groups. An analysis of survival among confirmed COVID-19 cases and using more detailed ethnic groups, shows that after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Black Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British. These analyses did not account for the effect of occupation, comorbidities or obesity. The complexity of these interconnecting factors means that there is not a simple solution that will solve health inequalities amongst Black, Asian and Minority Ethnic populations. [13]

Occupation

There is a clear link between occupations which increase the risk of exposure to the disease and mortality from COVID-19.[13] Office for National Statistics (ONS) reported that men working as security guards, taxi drivers and chauffeurs, bus and coach drivers, chefs, sales and retail assistants, lower skilled workers in construction and processing plants, and men and women working in health and social care had significantly high rates of death from COVID-19. [12]

Inclusion Health Groups

When compared to previous years, there has been a larger increase in deaths among people born outside the UK and Ireland. The biggest relative increase was for people born in Central and Western Africa, the Caribbean, South East Asia, the Middle East and South and Eastern Africa. This may be one of the drivers behind the differences in mortality rates seen between ethnic groups. Data on rough sleepers suggested a higher diagnosis rate when compared to the general population.

People in care homes

In the early stages of the pandemic, data from the ONS showed that deaths in care homes accounted for 27% of deaths from COVID-19 up to 8 May 2020. Analysis showed that there were 2.3 times the number of deaths in care homes than expected between 20 March and 7 May 2020 when compared to previous years, which equated to over 20,000 excess deaths nationally. The number of COVID-19 deaths over this period was equivalent to 46.4% of the excess suggesting that there are many excess deaths from other causes or an under-reporting of deaths from COVID-19. With the introduction of restrictions to access to care homes, introduced later in the pandemic, the number and proportion of deaths was overshadowed by those dying in hospitals.

Co-morbidities

Among deaths with COVID-19 mentioned on the death certificate, a higher percentage mentioned diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease and dementia than all cause death certificates.

This assessment from PHE provides a good overview, but as there is limited availability of more detailed data, it demonstrates a breadth rather than a depth of understanding as to how each factor is implicated. The inequalities of the impact of the COVID-19 pandemic need to be considered and overall, the national data is reflected in our local demographics.

Disproportionate effects of COVID-19

Since the *Disparities in the risk and Outcomes of COVID-19* was published regarding the first wave there has been further work analysing subsequent waves and areas of enduring transmission. One such piece of work is Risk factors associated with places of enduring prevalence and potential approaches to monitor changes in this local prevalence published in April 2021. Nottingham City ranks as the 11th most deprived local authority out of 317 local authorities in England. It meets many of the risk factors outlined in this paper and so is likely to be disproportionately affected by COVID-19.

The risk factors identified in areas of enduring prevalence are complex, however they are generally areas with higher deprivation than the England average.[51] The drivers for high prevalence can be static (e.g. housing density) or dynamic (changes in intervention). Some occupation settings e.g. factories may serve to coalesce risk factors which can extend transmission networks to additional settings or communities. The proportion of people working in the manufacturing sector is highest in six regions of Great Britain, the highest being the East Midlands (13.1% of employment).[52] Analysis of workplace outbreak rates has shown consistently high rates of outbreaks in manufacturing sectors and warehouses. These sectors are part of the key national infrastructure and have been in operation throughout the pandemic. Focussing on workplace interventions to support COVID-safe practices is important, including small and medium sized businesses.

The type of occupation has been highlighted as a barrier to containment measures. Those on lower incomes were less likely to get a test if they developed symptoms or self-isolated when contacted by NHS Test and Trace.

Self–isolation was also associated with financial disincentive. Those on lower incomes are often in more precarious/ insecure employments (e.g. agency staff, zero hours contracts, cash in hand) which then results in insufficient financial support. Removing financial costs and disincentives would tend to reduce risk factors in areas of enduring COVID prevalence.

The risk factors outlined above rarely operate in isolation and, in areas of enduring transmission there may be multiple factors at play combining together to increase risk. It is vital to identify the emergence of new areas at risk of enduring prevalence; identify the rate of change in prevalence for existing and new variants of the virus and to assess how effective interventions may be developed. Directors of Public Health have valuable knowledge about the combination of risk factors which emerge in their local areas. An understanding of the specific nature of the socio-economic structure of a region can provide insights into the links between communities, ethnicity, work transport and housing which may not be identifiable otherwise. Many public health teams are already engaged in the investigation of local health inequalities and supporting community engagement through community champion schemes. Local public health team interventions should be supported by access to appropriate data to inform and support local decision making.

Disproportionate vaccination uptake

Disproportionate effects of COVID-19 extend into disproportionate vaccination uptake. For example, in one of the most deprived areas of Nottingham City, Radford, 44.3% of the population had received their first dose of the COVID-19 vaccination by November 2021. Compare this to one of the most affluent areas of Nottingham City, Wollaton Vale, where the uptake was 82.7%, by November 2021.[53] This contrast is significant and concerning.

Disproportionate vaccine uptake has the potential for short, medium- and long-term consequences. Those who are unvaccinated are more likely to become severely unwell or die from the disease. Vaccination status affects the implications of being identified as a close contact. From 16th August 2021 those who were double vaccinated were not legally required to self-isolate if they were identified as a close contact of a positive COVID-19 case. Another implication is the effect on one's occupation, as from 11th November 2021 the Government made it mandatory for care home workers and (from April 2022) all NHS staff in England to have the COVID-19 vaccination or risk losing their job. There were also social, lifestyle and travel implications with the use of mandatory vaccine passports to fly, and to attend events in the devolved nations (Wales and Scotland).

Recognition of Positive work within Nottingham City

Nottingham City increased vaccination uptake amongst its most deprived citizens with the use of a Vaccination Bus. This programme has been incredibly successful and was held as a positive example to be replicated nationally.

Impressively, more than a million vaccinations have been delivered through Nottingham and Nottinghamshire. The national picture of inequalities in vaccine uptake was reflected locally, with lower levels of uptake in those from Black, Asian, Mixed and White Other groups and higher uptake in White British people. The large gaps however closed over time, as a result of engagement and interventions undertaken within the local community.

Nottingham City has a racially diverse population with 43% of the population from ethnic minority groups. It became apparent that key to improving uptake in vaccination rates was to build and maintain trust within communities. Dedicated community champions were selected to promote the importance of vaccination. This in conjunction with translation of material, questions and answers with community groups on media channels, social media, myth busting publications and webinars proved to be effective. A particularly successful intervention was the ability to offer the vaccination in local trusted venues. Over 2000 vaccines were delivered in two City mosques and three black community venues. In addition, the vaccination bus visited places such as the Indian community centre, mosques and the Nottingham Refugee Forum.

As discussed previously, the national picture of lower vaccination uptake in more deprived areas is reflected in Nottingham City. To tackle this, pop-up clinics were provided and the vaccination bus was sent to the most deprived areas where uptake was low. In addition, local volunteers/ elected members and door knocking/ targeted communications prior to vaccination 'events' such as the Big weekends were particularly effective.

One particular group presenting a challenge around vaccination were the most vulnerable in our society: the rough sleepers, homeless, refugees and asylum seekers. This population who may have no fixed address, means of contact, or GP registration had multiple potential barriers to vaccination. To overcome this the public health department, voluntary sector providers and experts such as 'Framework', the YMCA and primary care teams, worked together to overcome this. Specific vaccination clinics were delivered in primary care settings and via the vaccination bus.

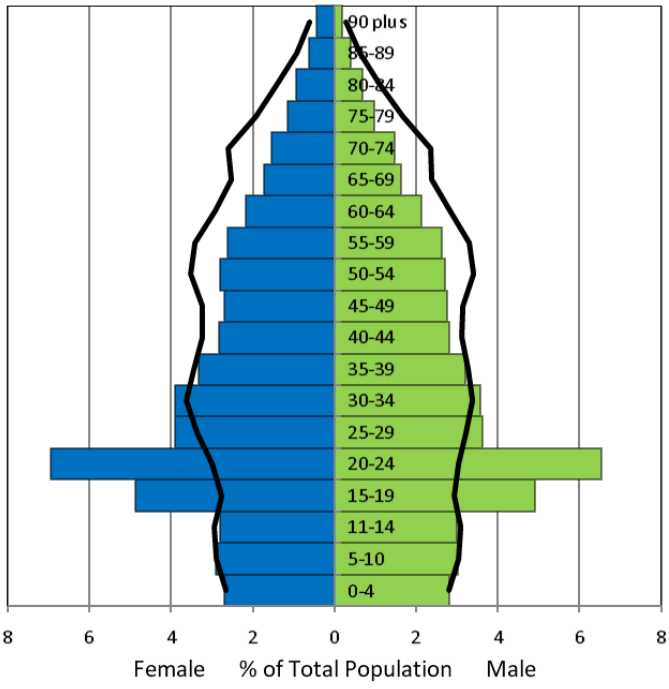
Local Demographics

At a local level the Joint Strategic Needs Assessment (JSNA) analyses the current and future health and social care needs of the population. Demographic information is collected in this process. The data below highlights key demographics where the inequalities may impact local communities. Consideration should be given to this information when planning the recovery from the Pandemic.

Further demographic information can be found on the Nottingham Insight JSNA webpage.

Age and Gender

Figure 1 highlights that the City has a very high proportion (29.9%) of people aged 18 to 29. This is largely due to the presence of the two universities: full-time university students account for approximately 1 in 8 of the population. The percentages in other age-groups are lower than the average for England. In particular, compared to England there are a lower number of adults aged between 65 and 79.



Source: ONS Census 2021

Figure 1: Nottingham City Age – Gender Distribution (bars) compared to England (lines)

The gender balance generally follows national patterns. More boys are born than girls (about 108 boys for every 100 girls), but as men tend to die younger, for age-groups aged over 70 there are more women than men; there are almost twice as many women aged 85 and over as men. However, the percentage of men aged 25 to 39 is unusually high in Nottingham (e.g. 116 men to every 100 women in the 25 to 29 age-group). This is particularly the case in some city centre and inner city areas, including those with high proportions of students or significant numbers of houses in multiple occupation which may be favoured by single, and often male, migrant workers.

Ethnicity

Ethnicity figures are taken from the 2021 Census.

Table 1 demonstrates that Nottingham has a larger percentage of people who identify as from an ethnic minority compared to the East Midlands and England national average. This indicates that a higher proportion of the Nottingham population may be at risk of contracting and subsequently dying from COVID-19 due to the additional risk factors associated with ethnicity.

	Nottingham City	East Midlands	England
Population	323,625	4,880,045	56,490,050
White: English, Welsh, Scottish, Northern Irish or British	57.3%	79.6%	73.5%
White: Gypsy or Irish Traveller	0.1%	0.1%	0.1%
White: Irish	0.7%	0.6%	0.9%
White: Roma	0.3%	0.1%	0.2%
White: Other White	7.4%	5.3%	6.3%
Mixed	5.9%	2.4%	3.0%
Asian	14.9%	8.0%	10.0%
Black	10.0%	2.7%	4.2%
Other	3.3%	1.3%	2.3%

Table 1: Population ethnicity estimates for Nottingham City
Source: ONS Census 2021

Figure 2 The above data has been summarised and a graph created to show a visualisation of Nottingham's more diverse population when compared to the East Midlands and England average.

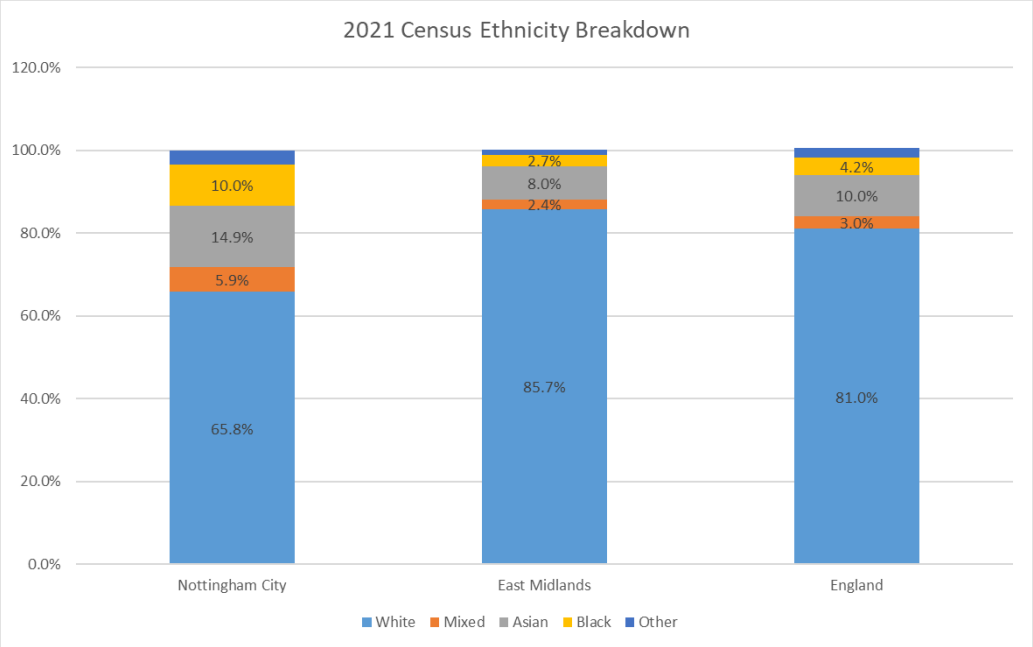


Figure 2: Comparison of population ethnicity for Nottingham City, East Midlands region and England
Source: ONS Census 2021

Deprivation

Based on the 2019 Indices of Multiple Deprivation, Nottingham City ranks as the 11th most deprived local authority out of 317 local authorities in England. Nationally higher levels of deprivation have been associated with an increased risk of mortality due to COVID-19.

As highlighted in **Figure 3** below, 30.8% (56/182) of Nottingham City's Lower Super Output Areas (LSOAs) fall within the 10% most deprived in England and more than half (57.2%, 104/82) of the City's LSOAs fall within the 20% most deprived in England. The Lowest ranking LSOA in the City is in Bulwell, which ranks 130th nationally out of 32,844 LSOAs. See **Appendix A** for a map illustrating areas of deprivation within Nottingham City.

The following figures highlight areas of deprivation in Nottingham. Nationally higher levels of deprivation have been associated with an increased risk of mortality due to COVID-19.

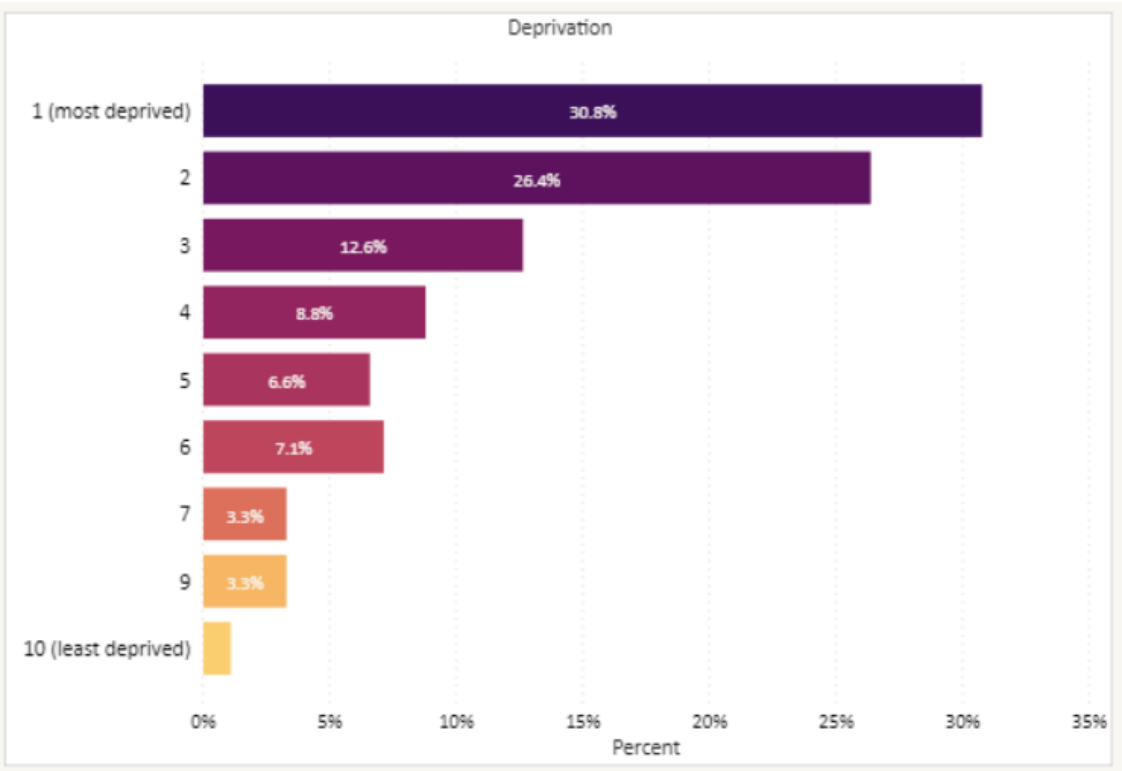


Figure 3: Proportion of Nottingham City LSOA by National Deprivation Deciles
Source: ONS, 2019 Indices of Multiple Deprivation

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The first Covid-19 case in Nottingham City was recorded on the 28th February 2020, since then, a total of 106,701 cases have been recorded in the City up to 31st of March 2022. **Figure 4** below shows a daily case count and a 7-day moving average for Nottingham City from 28th February 2020 to 31st March 2022.

It highlights five waves of different sizes and two periods of very low case numbers referred to as 'recovery'.

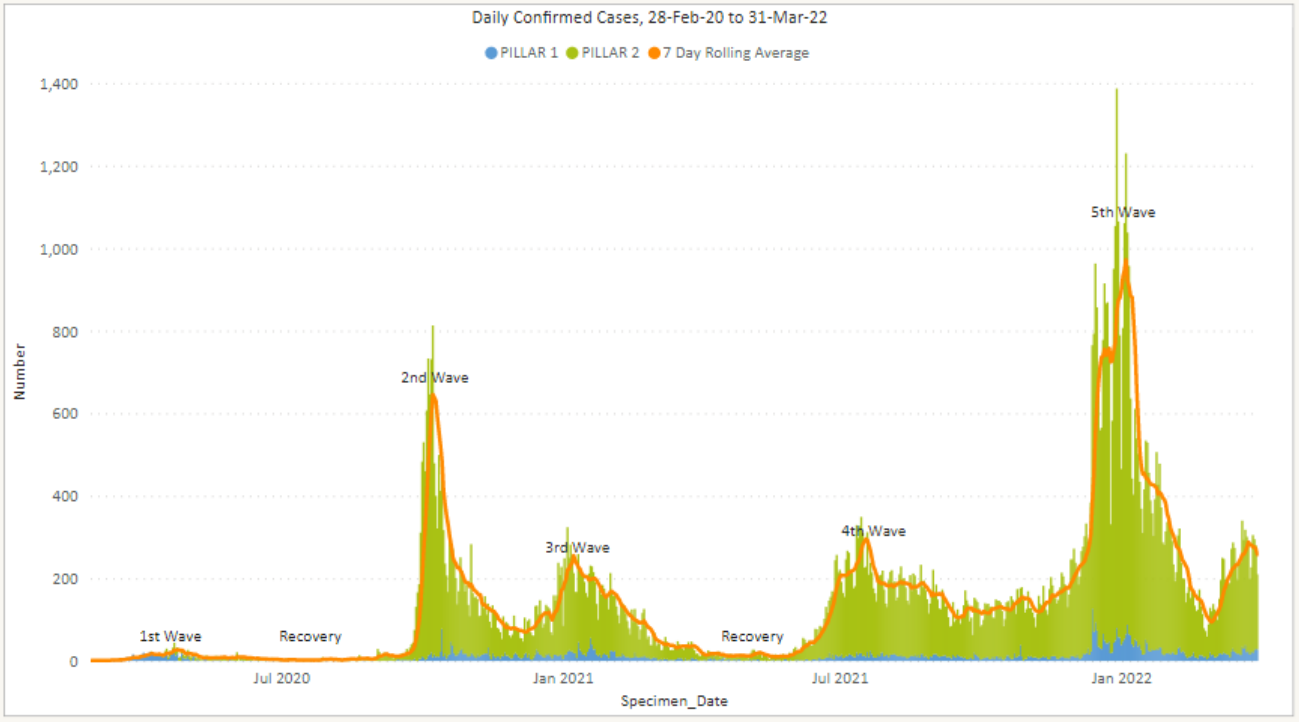


Figure 4: Daily case count and a 7-day moving average for Nottingham City from 28th February 2020 to 31st March 2022

The first (1st) wave was between 28th February 2020 to 30th June 2020 and recovery period followed from 1st July to 31st August 2020. The second (2nd) and third (3rd) waves were between 1st September 2020 to 31st March 2021 and the recovery following 3rd wave is illustrated from 1st April 2021 to 28th May 2021. The number of cases started to increase again from the 29th of May 2021, indicating the start of a 4th Wave. The 4th wave peaked in mid-July 2021 and was followed by a gradual, prolonged decrease in cases till early November 2021. A 5th wave started around the 9th of November 2021 when case numbers started to increase rapidly and peaked in early January 2022. Thereafter a rapid fall in cases occurred up to the end of February 2022. In early March 2022, case numbers start to increase again giving rise to a potential 6th wave. The most up to date information can be accessed via the Public COVID-19 Dashboard here.

For the purpose of this report, waves and recovery periods will be considered together.

Office for National Statistics (ONS) COVID-19 Deaths

COVID-19 deaths in this report include all deaths due to COVID -19 that occurred within 28 days of a positive COVID-19 test. The first recorded death due to COVID-19 in Nottingham City occurred in the week ending the 27th March 2020. Between the week ending the 27th March 2020 and the week ending the 1th of April 2022, a total of 985 Covid-19 deaths of Nottingham City residents were recorded.

As demonstrated in **Figure 5** below, the majority of deaths 74.5% (734) occurred in hospital, 17.9% (176) in care homes, 6.4% (63) at home and less than 1.2% (12) occurred in other settings.

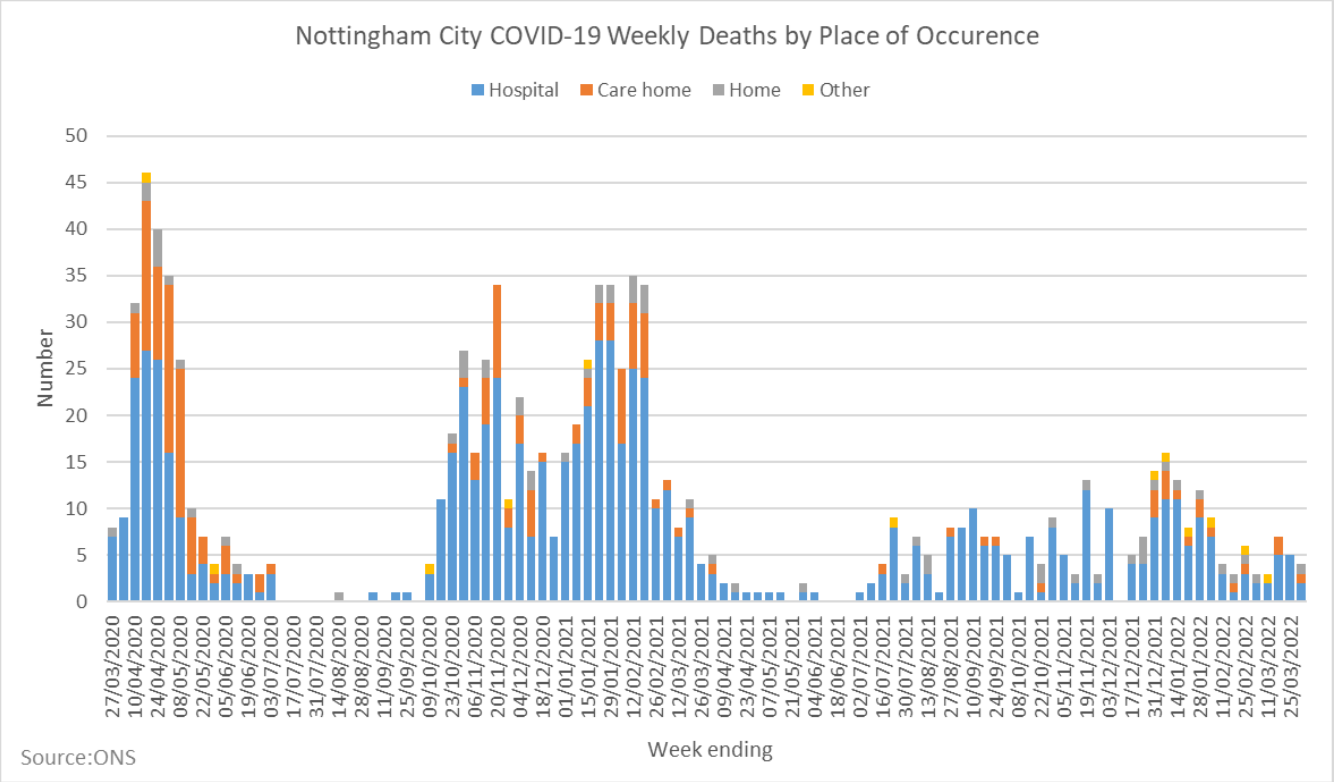


Figure 5: Weekly COVID-19 Deaths by Place of Occurrence, 28th February 2020 to 1st April 2022
Source: ONS

First Wave and Recovery

Between the 28th February 2020 and 31st August 2020, a total of 1,377 COVID-19 cases in Nottingham City were recorded. As illustrated in **Figure 6** below, a steady increase in case numbers was seen particularly due to a focus on Pillar 1, hospital testing and limited community testing. Case numbers peaked about mid to late April 2020 with the start-up of community testing. Thereafter there was a steady decrease in case numbers up to the 31st of August 2020. Case numbers were notably at their lowest between July and August 2020 and mainly community cases identified by Pillar 2 testing.

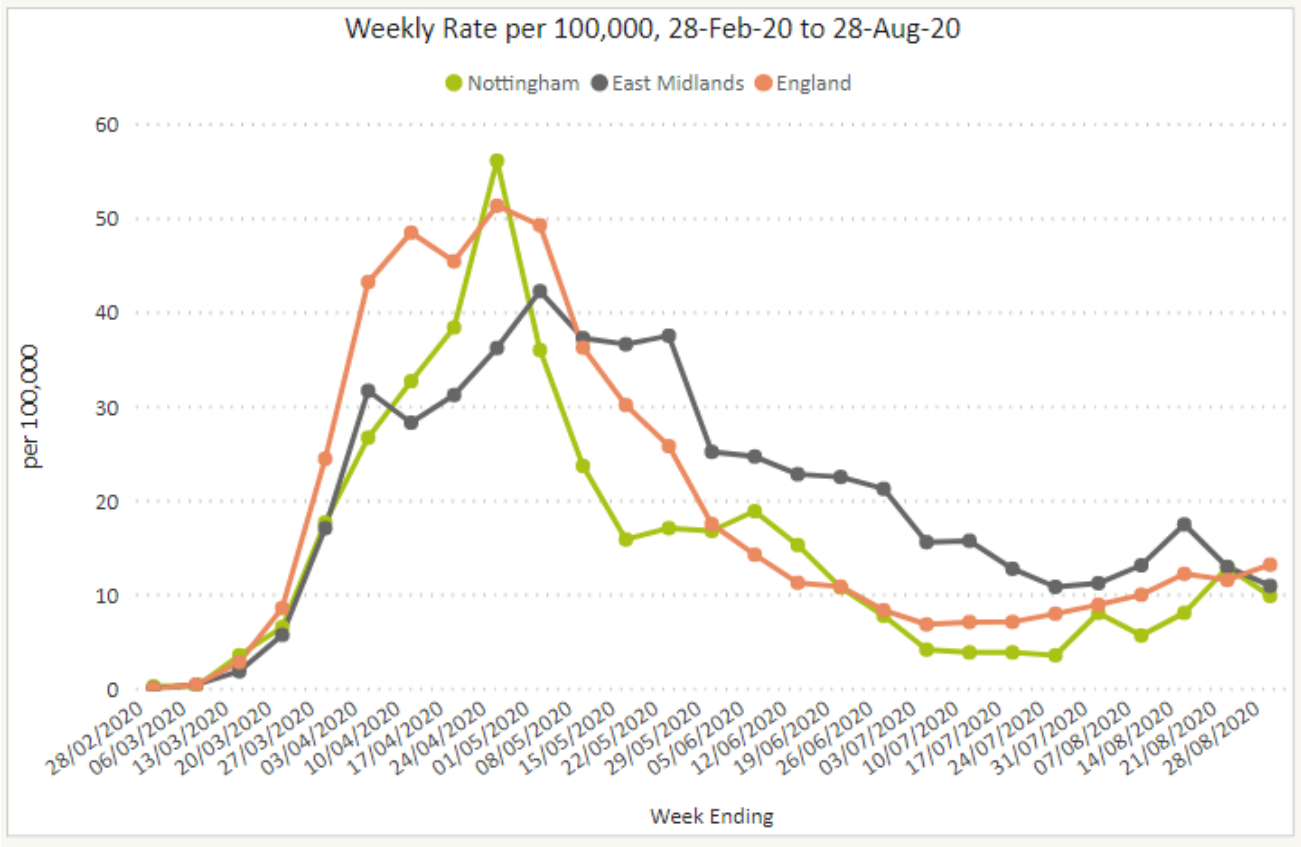


Figure 6: First Wave and Recovery: Weekly COVID-19 cases per 100,000 for Nottingham, East Midlands and England, 28th February 2020 to 28th August 2020

Demographic characteristics of cases in the 1st wave: Age and Gender

Most cases (12.3%) were in the most vulnerable age group, 85 years and over. This could be as a result of testing approach adopted at the time with limited access to community testing and outbreaks in several care homes. Overall, 55.5% were females, 34.9% aged 60 years and over and 50% aged between 25 and 59 years.

See **Appendix B1** for the age and gender distribution of COVID-19 cases in the 1st wave.

Demographic characteristics of cases in the 1st wave: Deprivation

Deprivation is defined using Indices of Multiple Deprivation (IMD). For the purpose of this report, quintiles of deprivation within Nottingham City have been assigned at lower super output area (LSOA) based on the LSOA of residence of cases.

42.8% (582/1,377) of cases in the 1st wave resided in LSOAs within the 3rd and 4th least deprived quintiles of the City and the lowest proportion (17.9%) of cases resided in the most deprived quintile of the city. See **Appendix B2** for a graphical representation.

This does not correlate with the national findings that in areas with higher levels of deprivation [51] there were higher levels of COVID-19, in fact it seems to suggest the opposite. There could be many reasons for this, including possibly lower levels of uptake of symptomatic testing within more deprived areas in the first wave, which would require further investigation and analysis to be fully understood.

Demographic characteristics of cases in the 1st wave: Ethnicity

Of 1,377 cases recorded in the 1st wave, 49.2% (678) were of White British ethnic background, 32.0% (440) from Black, Asian and minority ethnic groups (BAME) and 18.8 % (259) without a stated ethnicity (excluded from the analysis reported in this section). Compared to the ethnic makeup of Nottingham City, 'Asian', 'Black' and 'Other' ethnic groups were slightly over-represented whilst 'Mixed' ethnic group were underrepresented. See **Appendix B3** for more information and graphical representation of this data.

Second and Third Waves

Cases started to increase again in early September 2020, indicating the start of a second (2nd) wave in the City. As shown in **Figure 7** below, there was a rapid increase in numbers, with a peak in October 2020 and then a decrease in numbers thereafter. A third (3rd) wave albeit a much smaller wave started in early December and peaked in January, and gradually decreased up to the end of May 2021. A total of 30,329 cases were recorded during this period.

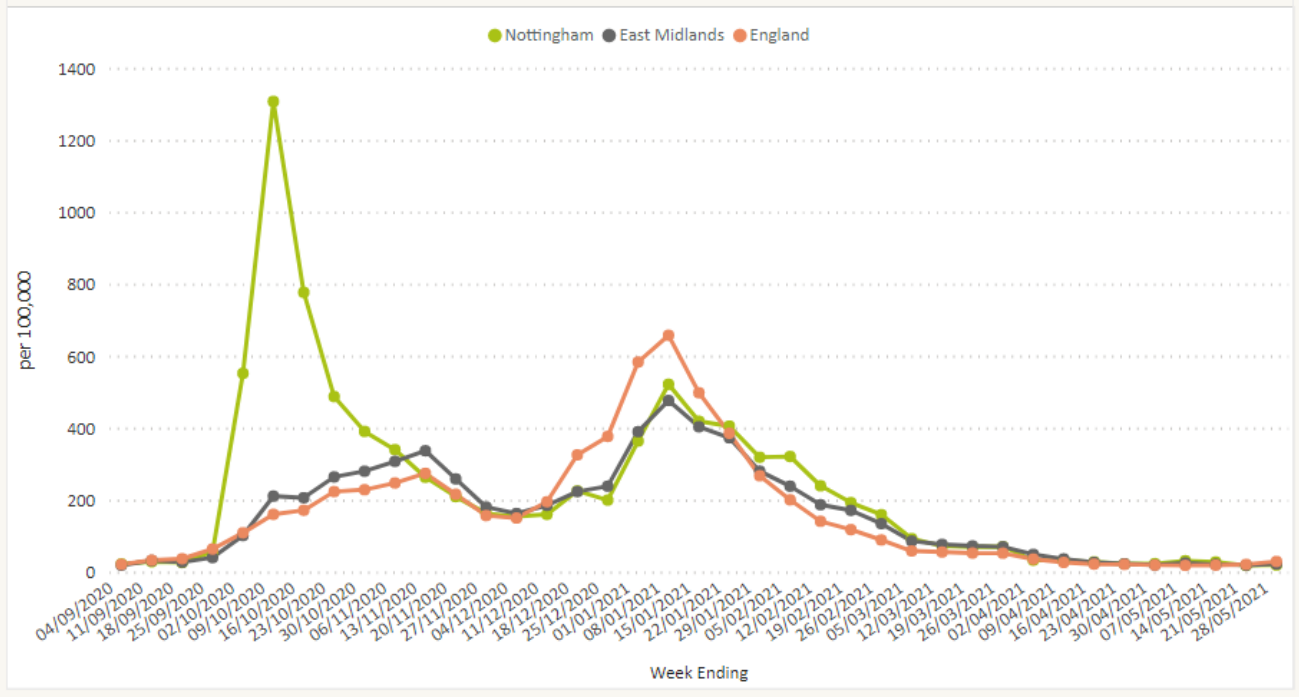


Figure 7: 2nd and 3rd Waves: COVID-19 cases per 100,000 for Nottingham, East Midlands and England, 4th September 2020 to 28th May 2021

Demographic characteristics of cases in the 2nd and 3rd wave: Age and Gender

The 2nd wave in the autumn of 2020 was driven by very high rates in the student population coinciding with the return to schools, colleges and universities. In October 2020 Nottingham City had the highest rate in the country. Compared to the 1st wave, there is a stark difference in the age–gender distribution of cases with most cases (37%) aged 15 to 24 years. More than half (53.7%) of all cases were females and 10.5 % (3,200/30,329) aged 60 years and above. See **Appendix C1** for more information.

The third wave demonstrates a more prolonged peak in rates and is more consistent with the national picture.

Demographic characteristics of cases in the 2nd and 3rd wave: Deprivation

Like the 1st wave, the lowest proportion (16%) of cases resided in most deprived quintile of the city and the highest proportion (23%) in the 4th quintile. This is not reflective of the national data, but perhaps the rates are similar in the five IMD quintiles as Nottingham overall has higher levels of deprivation. See **Appendix C2** for more information. Data is potentially skewed due to the prominence of young adults within this wave.

Demographic characteristics of cases in the 2nd and 3rd wave: Ethnicity

47.5% (14,401/30,329) were from White British ethnic background, 24.9% (7,551/30,329) BAME and 27.6% (8,377/30,329) without a stated ethnicity. See **Appendix C3** for more information.

Fourth and Fifth waves

A 4th wave started around the 29th of May 2021 when case numbers gradually rose, peaking in July 2021 at a level similar to the 3rd wave **(Figure 8)**. After an initial drop in cases, Nottingham's case rates fell more gradually eventually plateauing at a significant level. In early December, case numbers began to rise rapidly giving rise to a 5th wave with a peak in the 1st week in January 2022. The number of new cases quickly dropped in February 2022 before increasing again in March 2022.

The 5th wave was notably the highest wave since the start of the pandemic, being 3 times the 4th wave; 3.5 times the 3rd wave; and 1.5 times the 2nd wave.

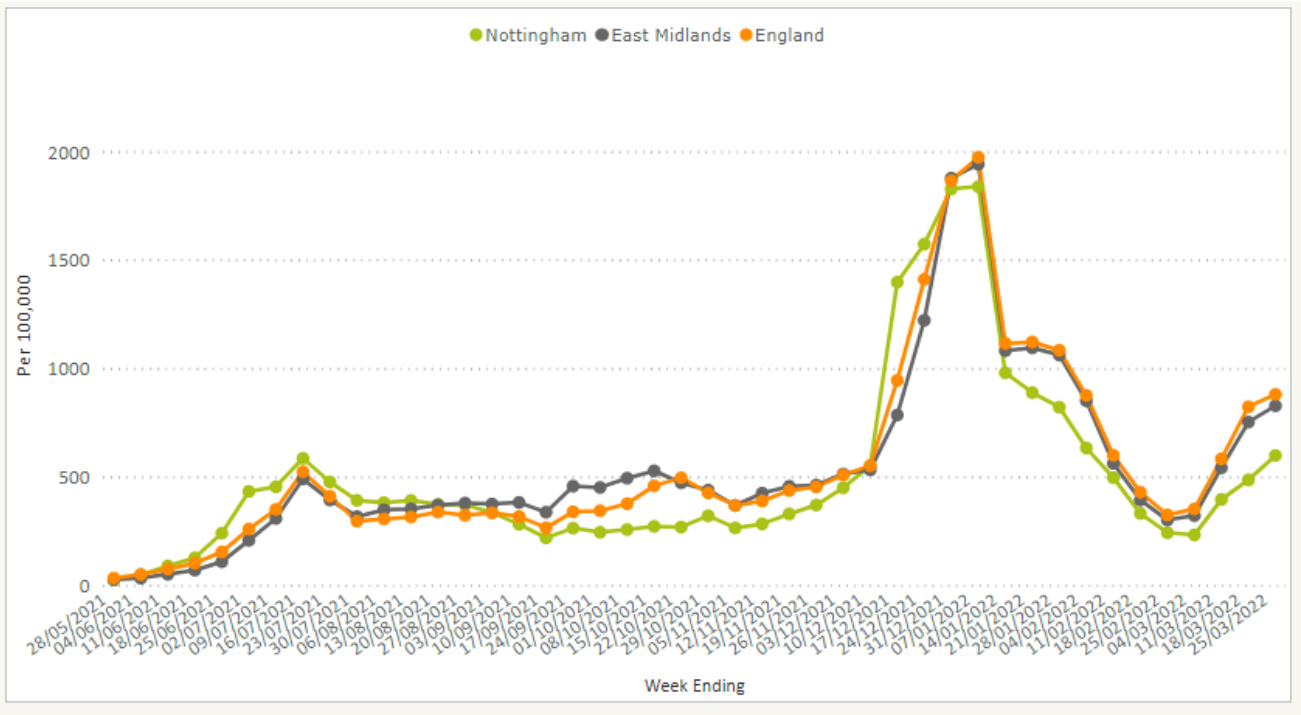


Figure 8: 4th and 5th Waves: COVID-19 cases per 100,000 for Nottingham, East Midlands and England, 28th May 2021 to 31st March 2022

Demographic characteristics of cases in the 4th and 5th wave: Age and Gender

The age-gender distribution for both 4th and 5th waves were to some extent similar with the highest proportion of cases seen in the 20-24 age group. More than half of the cases were in the working age groups 23-59 years in both 4th and 5th waves, accounting for 53.1% and 58.3% of cases, respectively. Similar to other waves, majority of cases in both 4th and 5th waves were females (52% in 4th wave and 54.5% in 5th wave). 60+ age groups accounted for less than 10% of cases in both waves. See **Appendix D1** for more details.

Demographic characteristics of cases in the 4th and 5th wave: Deprivation

In the 4th wave, highest proportion of cases resided in the least deprived quintile and in the 2nd quintile accounting for 21.0% and 20.3% respectively. Likewise, the 5th (least deprived), 4th and 3rd quintiles accounted for over 60% of the cases in the 5th wave with 20% or more of recorded cases residing in each of the quintiles. See **Appendix D2** for more information. Data is potentially skewed due to the prominence of young adults in both waves.

Demographic characteristics of cases in the 4th and 5th wave: Ethnicity

In the 4th and 5th waves, 49.3% (11.933 of 24,190) and 48.8% (24,809 of 50,746) were from White British ethnic background respectively, 24.7% (5,976 of 24,190) and 22.9% (11,638 of 50,746) BAME and 26.0% (6,281 of 24,190) and 28.2% (14,299 of 50,746) without a stated ethnicity. See **Appendix D3** for more information.

When analysing rates of COVID-19 against ethnicity for the start of the pandemic up to the 31st Mar 2022, COVID-19 rates in 'Other' ethnic recording category were significantly higher compared to rates in White, Black, Mixed and Asian ethnic groups. The rate ratio for COVID-19 was 4 times as high in 'Other' ethnic group as in the 'Mixed' ethnic group and approximately 1.5 times as high in Asian and Black ethnic groups as in the 'Mixed' ethnic group. For graphical representation of this see **Appendix E1.**

Education

Early Years

What has been the impact of COVID-19?

In March 2020, little was known about the long-term impact of the pandemic and its associated public health measures. Over time, we are beginning to understand which groups have been the most significantly impacted. Children aged 0 to 5 years old from financially vulnerable families are among those who will live with the greatest long-term impacts. From birth to age 5, the brain makes around 80% of the connections that it will make during a person's lifetime. The increased poverty, isolation, missed early childhood education and poor maternal mental health, are all factors that will have had a lasting negative impact on this cohort of young children.

The social and emotional development of these children, as well as their spoken language and communication skills, are likely to have been severely impaired when compared to expected levels of development in these areas pre-pandemic. Service disruptions in some cases have meant child development may not have been monitored or supported.[14]

The process of digitalisation has accelerated throughout much of society. While this has undoubtedly presented some benefits, these have not been universal. For pregnant women and mothers of new-born babies, virtual midwife, health visitor and GP appointments have contributed to a sense of isolation already being experienced. Families may have found it more difficult to access resources, services and support to enable early childhood development, and may have been at greater risk of loneliness.[15] New parent groups and toddler groups which normally operate on a face to face basis were paused, removing valuable sources of support for new families.

The disruption to early childhood education and care (ECEC) and increased social isolation have had significant impacts on the school readiness of children across the country. Research from the Education Endowment Foundation with parents and teachers found that there were significant concerns from both parties about the spoken language and communication (SLC) skills of pre-school children prior to the start of the academic year in September 2020. The same research found that teachers needed to implement additional support for children once the children actually started their schooling that September. Children who started school in September 2021, who have been impacted by 18 months of restrictions will likely be even further behind.[63]

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

Prior to the first and for subsequent lockdowns, provisions were made for childcare places to remain open to support the needs of critical workers, vulnerable pupils and those children with an Education, Health and Care Plan (EHCP).

There was a focus on safety and all childcare providers completed health and safety and risk assessments. The 'Bubble' model was introduced to reduce risk of transmission and mitigate against effects of close contact and isolation. Systems were established to ensure direct reporting into the LA (Local Authority) of new infections to manage outbreaks.

School years

What has been the impact of COVID-19?

The full impact of school closures and disruption to education is unlikely to be apparent for years to come. School is much more than education and there are some concerns about what effect the disruption will have in the wider sense on children's health and wellbeing.

For some, the loss of routine in lockdown may have caused or exacerbated loneliness and developmental regression. It has been reported that there have been social, emotional and behavioural challenges in moving between home and formal learning settings. The lack of access to regular physical activity may have negatively impacted important aspects of health, such as obesity and mental health. It is not only children that have been impacted by school closures. The suspension of enhanced support to parents may have increased stress and anxiety for both parents and children.

There is evidence to suggest that school closures may have a differential impact on families in deprived communities or on a low income.[15] In some cases there has been unequal developmental or education provision and access to teaching or training.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

During the first lockdown, guidance was issued to schools concerning minimum staffing and attendance monitoring protocols. A specific COVID-19 telephone hotline and email inbox was also established for schools. Overall, 95% of city schools remained open.

Nottingham City Council (NCC) worked in collaboration with the Nottingham Schools Trust (NST) to respond to the government position on re-introducing specified year groups back into school from June 1st 2020. Following significant discussion with Teachers Unions (TU), Nottingham LA delayed the return to school by 3 weeks, due to high rates of infection at that time compared to national figures.

During the 2020 school summer holiday, a city wide COVID-19 safe holiday activity programme was created which ran for five weeks Monday-Friday. A project team was set up to facilitate a programme incorporating sport, arts and crafts, as well as mental health and wellbeing support for children.

Other innovative projects to date include the publication of the Pupil views on their education in the context of the COVID-19 pandemic. NCC Education Psychology Service worked with Southend Council Education Psychology Service, to survey the experience of 1000 pupils between March and May 2020. The key findings were that many were concerned about the "potential impact on learning" from being at home; a need to "catch up", have "extra lessons" and feared that they might "fail exams". This has provided an important insight into how the pandemic has affected pupils and hopefully will be used to inform policy and to guide the next steps in supporting education, learning and emotional wellbeing.

Prior to re-opening in September 2020 all Nottingham schools were supported with health and safety advice and risk assessment support. Systems were established to ensure direct reporting of infections and pupils in self-isolation to the LA. Public Health led outbreak management arrangements were deployed following the first reported outbreak in Nottingham primary schools during first week of autumn term. Subsequent outbreaks led to re-introduction of hybrid learning (in class/ online) due to the high number of pupils self-isolating with symptoms or as close contacts within a class 'bubble.'

During the January 2021 lockdown, attendance amongst all groups of eligible pupils was generally higher than during the first lockdown. This in itself did create additional demands upon school staff as hybrid learning was more challenging to deliver with larger cohorts of "in school pupils" requiring supervision and teaching.

From March 2021, with the lifting of restrictions all Nottingham schools were re-opened. The measures to support bubble-based arrangements were reactivated and supported by pre-return lateral flow testing in secondary and special schools.

On initial return to school attendance was reported at around 90% (compared to pre-pandemic levels of 95%). However, there were some reports of hesitation due to anxiety, from those living in multi-generational households. There have also been concerns around the rise in pupils becoming electively home educated. During the course of the year, this rose to over 400 pupils, compared with a pre-pandemic average of around 250.

Access to learning resources

What has been the impact of COVID-19?

Recurrent lockdowns and learning from home have meant differential access to digital platforms and suitable home environments to receive remote learning. The ability of younger people from poorer backgrounds to access computers and the internet at home, may have hampered their ability to complete schoolwork and maintain peer relationships during remote learning, when compared to their more affluent counterparts. In larger families, where resources are often shared, this disadvantage may have been compounded.[15]

For some disabled children access to learning is supported through adaptations in school, e.g. differentiated IT and learning resources or adapted material for children with dyslexia, and these may not have been available at home.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

An audit was completed to identify pupils who required access to IT equipment and internet access. For those in need, there was a distribution of digital devices through government schemes and other sources e.g. universities and business donations. Around 2,000 laptops were delivered through the government scheme and use of Pupil Premium Plus funding. Mobile internet access was also provided through a local agreement with Vodafone (1,500 unlimited access dongles supplied) before the national scheme was established.

SEND (special educational needs and disabilities) learning support teams within local authorities worked directly with special schools and parents of SEND pupils in mainstream schools, to ensure pupils had access to either suitable digital access or non-digital learning resources and physical activities, if not attending in person.

Higher Education

What has been the impact of COVID-19?

Many students had concerns around the impact of moving to online teaching during the pandemic, and how this may affect their educational outcomes, as well as social and developmental experiences. The convenience and accessibility of online teaching and engagement was recognised, however some students reported feeling less engaged or motivated to complete their academic work during periods of isolation.[58-60]

The issues related to social and self-isolation impacted on students in a number of ways. Social isolation meant that students were unable to mix and make new friends, and generally be involved in university life - this particularly impacted on first year and international students, many of whom may have been in the UK for the first time. The mental and physical wellbeing of students was also a concern, many of whom spent long periods of time isolating and disconnected from human contact. Those living in shared accommodation reported worries about potentially testing positive and being the cause of others then having to isolate or miss out on seeing family and friends e.g. during Christmas holidays.[58-61] As teaching had moved largely online, opportunities for identification of issues (academic or pastoral) were reduced, increasing the risk around poor wellbeing for this cohort. Due to the impacts on both social and academic development, some university staff observed different levels of independence, confidence and autonomy on students' arrival at university.

Practical issues impacted on deliveries of shopping or medication, and some students suffered financial instability arising from issues such as the loss of part-time jobs, as well as concerns about reduction in family income that may have been used to support them through study.

Impacts for higher education were not limited to students - staff also reported being impacted in terms of higher workloads and resulting stress, combined with anxiety about catching the virus.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19

On a practical basis, universities implemented measures such as delivery of food parcels and setting up testing and vaccination centres on or near campuses alongside NHS partners to make it easier for students to get tested and isolate where required, and then to receive vaccinations in due course.

Teaching was moved largely online, some lectures were recorded, enabling students to watch them at convenient times. Many student support services were also offered online, offering options such as virtual appointments and live chat, as well as dedicated COVID-19 information pathways to provide information and reassurance to students, parents and members of staff.

Social and extra-curricular activities were set up across a variety of areas to fill time for those isolating including additional events over the winter break and perks such as goodie bags. In some instances of subscribed activities i.e. gym membership, refunds were organised.

Vulnerable Children and Young People

What has been the impact of COVID-19?

Prior to the pandemic children were visible at school and for many it was a safe space which allowed better surveillance of potential safeguarding issues.

Children in need may have had limited and reduced visibility of, and access to health professionals (e.g. health visitors, school nurses, social workers) during the pandemic.[15] It has been postulated that an

increased number of families were at risk of increased safeguarding issues, due to financial pressure/stress of being at home.[15]

The disruption of education has the potential to widen the inequality of outcomes based upon deprivation, ethnicity, SEND and other vulnerabilities.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

Prior to lockdown, support was provided for schools to support key worker children, vulnerable pupils and EHCP (Education Health and Care Plans) learners. There was critical planning to ensure that there was sufficient safeguarding oversight by schools and childcare providers of those children and young people. The aim was to ensure that vulnerable children were visible, in a safe place and that where possible, families were supported to access school and nursery for vulnerable children in line with Department of Education (DFE) guidance.

These groups of children are often vulnerable learners and the approach aimed to provide a connection to purposeful learning and engagement with schools, to narrow the potential gap in good educational outcomes. There was development of social work home visiting guidance and risk assessments, devised to allow services to continue to run.

During the first lockdown (March - June 2020) additional work was undertaken to identify any of the 0-5 year old vulnerable children cohort who were not accessing childcare. Measures were in place to ensure that places were available, should normal provision have been closed by the provider.

Within Nottingham City, 15-18% of vulnerable children attended school in the first two weeks of lockdown. Collaborative work between social workers and schools meant this increased to 24-26% in May 2020, which was above national average rates.

What was the situation prior to COVID-19?

Air quality is an indicator of ambient air pollution. Air pollution is created by a mixture of gases (e.g. SO_2, NO_2, NO, CO_2) and particles (e.g. PM_{10}, $PM_{2.5}$) that have been emitted into the atmosphere by natural processes, as well as those produced by human activity.

The administrative area of Nottingham City is subject to Smoke Control Orders, which prohibit or limit the emission of sulphur dioxide and smoke/particles from chimneys, and an Air Quality Management Area for nitrogen dioxide. Nottingham has implemented a range of general and specific measures to reduce emission of NO and NO_2.

Air quality monitoring data from 2015-2020 is presented in **Figure 9.**

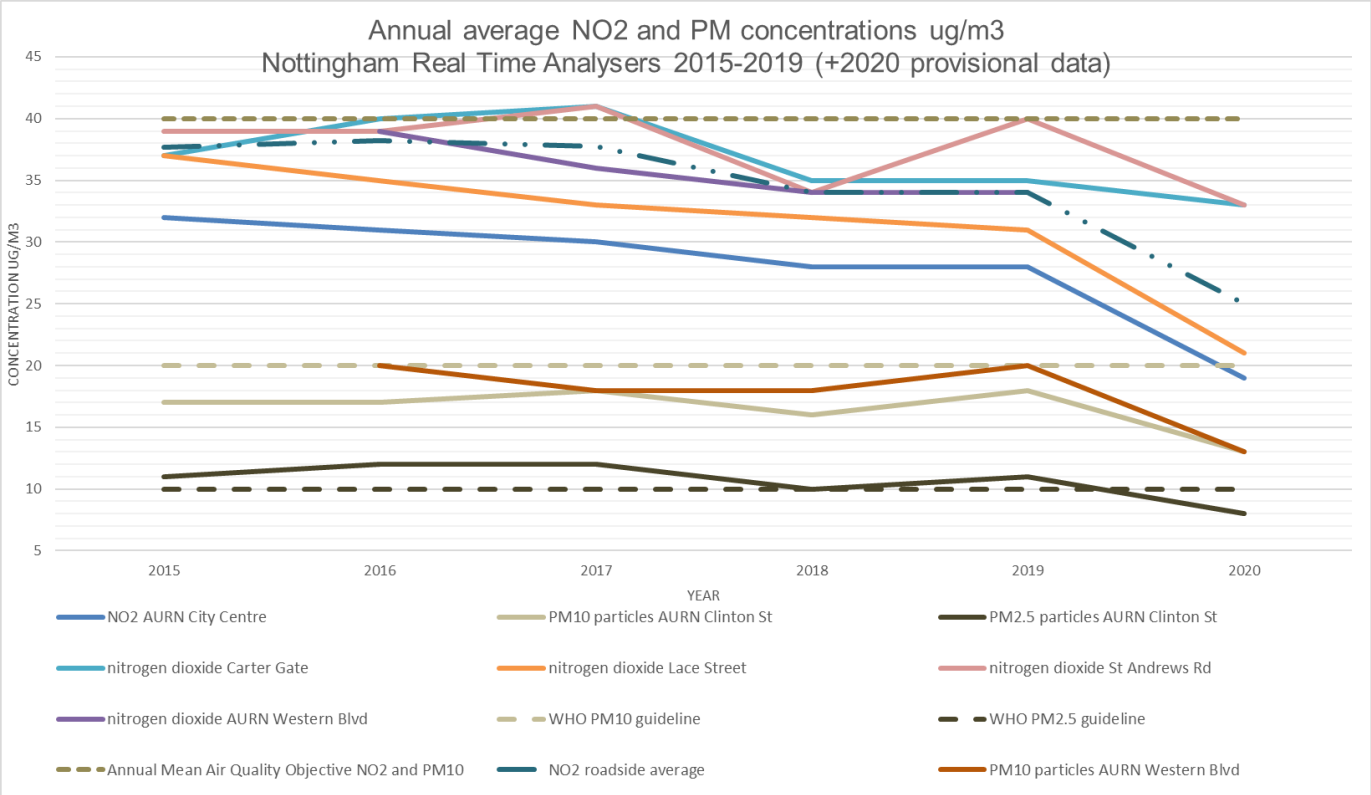


Figure 9 : Trend analysis of data for 2015-20 indicating a gradual reduction in NO2 and particles
Source: (https://www.nottinghaminsight.org.uk/d/aaxcfkbI)

What has been the impact of COVID-19?

NCC was able to maintain its air quality monitoring programme, collecting and publishing the provisional air quality data throughout 2020. The provisional monitoring data indicates a large reduction in measured concentrations (**Figure 9**).

Studies into the impacts of COVID-19 on air pollution (using provisional air pollution data) have been published concluding that the measured reduction in ambient pollutant concentrations in the UK were most probably due to measures taken by government(s) to reduce the transmission of COVID-19 e.g. extended periods of 'lockdown' and limited travel, which reduced road transport emissions of NO_2 and particles, and NO_2 emissions from the leisure/hospitality sectors (cooking/heating/hot water).

Further work is being undertaken at a national level to ascertain the overall impact COVID-19 has had, and will have, on air quality due to the significant changes to work behavior (home/hybrid working), commuting behaviour (particularly future use of public transport) and a sustainable economic recovery.[61, 62]

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

Whilst there was a noticeable and measurable improvement in air quality during the first lockdown, it has been reported that COVID-19 symptoms can be worsened by air pollution. Community Protection and Environmental Health Officers prioritised the investigation of complaints about air pollution (bonfires, smoke and dusts emissions) in order to minimise possible increased risks to health for those in the vicinity of the usually unnecessary emissions.

Current provisional air quality monitoring shows a slow increase in air pollution, comparable to pre-COVID-19 levels, and the need therefore to deal with unnecessary emissions as quickly as practicable, whilst also dealing with the range of competing COVID-19 compliance and other priorities faced by Community Protection and the Council as a whole.

What was the situation prior to COVID-19?

Financial vulnerability refers to an individual, family or household's exposure to financial difficulty and an inability to withstand financial 'shocks' (i.e. unplanned expenditure or loss of income) without significant adverse impact on fundamental areas of their lives (e.g. physical / mental health, housing, family life etc).

There are a number of established indicators that point to a high proportion of Nottingham's citizens being vulnerable to financial difficulty in comparison with populations in other areas of England. For example, based on Index of Multiple Deprivation (IMD, 2019) score, Nottingham is the 11th most deprived area out of all 317 districts in England (English Indices of Deprivation 2019). Nottingham is also the 6th highest out of all 317 districts in England for the proportion of children growing up in income deprived households, based on Income Deprivation Affecting Children Index (IDACI) score (English Indices of Deprivation 2019).

Nottingham's underlying economy is strong, but a relatively high proportion of the workforce (particularly in more stable and better paying jobs) are comprised of people who live outside of the city.

What has been the impact of COVID-19?

The COVID-19 pandemic has created changes to employment with many employees becoming home-based. Some occupations have been unable to operate and workers have faced either redundancy or furlough with a consequent decrease in financial wellbeing. Others who are part of the "gig economy "and on zero hours contracts will also have been negatively affected. The flexibility of these working practices means they provide less financial and job security compared with permanent roles.

The impact of the pandemic on financially vulnerable citizens is still uncertain. However, it is reasonable to expect a significant adverse effect on financial circumstances of people living in the city (e.g. reduced incomes, increased debts) with the greatest impact on those already in low paid and insecure employment.

The number of people claiming unemployment benefits in Nottingham City rose rapidly from 10,900 people (4.7% of the working age population) in February 2020 to 18,840 (8.1%) in June 2020. Unemployment increased at a faster rate nationally (105.6% in England compared to 72.8% locally) but Nottingham's unemployment rate remained higher than the national average.

The Coronavirus Job Retention Scheme (CJRS) has complicated the interpretation of the unemployment figures. At March 2021, 16,400 Nottingham City residents were furloughed from work and supported by the CJRS. However, the furlough numbers cannot be added to the unemployment figures as it is possible for someone to be included in both groups as furloughed staff may also have been able to apply for universal credit if their furlough wages were insufficient to live on (i.e. to support housing costs). Equally, some people on furlough will still be earning enough to be ineligible for unemployment related benefits and will not be included in the unemployment benefits figures.

More detailed reports on unemployment and furlough figures are available.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

Certain protections were put in place (including the furlough scheme, the evictions ban and stays on debt action) which have helped prevent surges in financial difficulty in the short-term.

In particular, advice services, including the Council's Welfare Rights Service, which help people to avoid/resolve acute financial difficulty, had its own funding reduced pre-pandemic due to wider funding challenges faced by the NCC. To mitigate against this, there was a £30,000 one off increase in funding for commissioned advice services in 2020/21.

Additional funds were awarded through Department for Environment, Food and Rural Affairs (DEFRA) to help people facing hardship during the pandemic which will have had most impact in 2021/22.

What was the situation prior to COVID-19?

The teams were office-based undertaking inspections and responding to complaints from tenants living in the private rented sector (PRS), processing and determining licences and providing support to tenants and landlords.

What has been the impact of COVID-19?

Due to the enforcement of Government restrictions the majority of work was conducted virtually including inspections. Only the most serious and significant property complaints affecting tenant health and safety were inspected in person.

Initially there was a drop in complaints about poor property conditions, but these have since increased, probably driven by people spending more time in their home.

With the changes to eviction processes there has been an increase in calls about tenancy rights and more support given to landlords and tenants trying to navigate new processes. It is likely that some landlords have undertaken illegal evictions during the pandemic and unfortunately some vulnerable tenants may have not had access to the right level of support and have been made homeless.

It is predicted that with evictions allowed again (See Housing Advice for COVID-19 from the charity Shelter), there is likely to be a significant increase in tenants seeking new homes.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

Due to the increased risk of COVID-19 infection, there has been action to support houses in multiple occupation in collaboration with advice from local authorities and Public Health teams.

Throughout the pandemic, advice and support has been disseminated to landlords and agents through the team's landlord newsletter re-enforcing the Government guidance and changes to legislation.

Diet and Nutrition

Children

What was the situation prior to COVID-19?

The World Health Organisation states that "nutrition is a critical part of health and development."[16]

Pre-pandemic there were local concerns about the number of children eligible for Free School Meals who were not fed nutrient rich meals during the school holiday periods and the high rates of childhood obesity within Nottingham City. More in depth information of the situation prior to the COVID-19 pandemic can be found in the Joint Strategic Needs Assessment (JSNA) chapter: Diet and Nutrition.

During 2019-20, NCC ran workshops supported by Small Steps Big Changes (SSBC) to support children to '*eat and move for good health'* and explored parent's views on breastfeeding and healthy weight in children. The full report can be seen here: Parent Voice Report 2020 | SSBC (smallstepsbigchanges.org.uk).

What has been the impact of COVID-19?

Research on children's nutrition during the pandemic is mainly based on international studies, with most studies showing significant changes to diet quality and eating habits.[17]

From limited UK evidence, a study which surveyed 14-19 year olds found that 60% of young people felt that eating as a family and cooking together had had a positive impact; 4 out of 10 said they had snacked more in lockdown, with those from less advantaged families more likely to eat junk food and take-away and less likely to eat fruit.[18]

According to The Nottingham Forest Community Trust, the lack of provision of regular healthy school meals and access to quality physical activity has further reduced the opportunity for children to enjoy a balanced and nutritious diet.

SSBC and Nottingham CityCare noted that the Children's Public Health 0-19 Nursing Service had a reduced ability to deliver the Healthy Child Programme and so had limited opportunities to give dietary advice and monitor children's weight. Similarly, reduced contact and a pause of children's centre groups limited the support, information and advice available to families.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

Where possible, support was provided virtually. Nottingham CityCare set up virtual First Foods groups for parents keen to attend for weaning advice. Innovative work with the Bulwell Family Mentor service has allowed for virtual practical follow-on sessions with parents.

The Nottingham Forest Community Trust utilised virtual learning sessions and a wide range of activities to keep children and young people engaged and active.

SSBC committed to continuing to support families with the cost of healthy food through the Healthy Start scheme. The SSBC Healthy Start project, which started in April 2020, has aimed to raise awareness of the scheme amongst eligible families, via social media channels and printed flyers. In addition, it has provided workforce training to enable staff to confidently discuss the scheme and signpost appropriately. In March 2020, 4,498 families were eligible for healthy start food vouchers and 2,933 were accessing them. Between April and May 2020, this had risen to 4,970 families being eligible and 3,419 accessing the vouchers.

Adults

What was the situation prior to COVID-19?

Prior to the pandemic, there were specific unmet needs and service gaps such as an increasing prevalence in obesity and diabetes in the local population. More in depth information of the situation before the COVID-19 pandemic, can be found in the Joint Strategic Needs Assessment (JSNA) chapter: Diet and Nutrition.

What has been the impact of Covid-19?

There appears to have been a mixed picture regarding the dietary behaviour of UK adults during the COVID-19 pandemic.[19-24]

Many people reported cooking homemade meals more often, eating more fruit and vegetables and consuming less fast food.[19,21,25] Others reported increased snacking, greater consumption of foods high in salt, sugar and saturated fats, overeating and consuming less fruit and vegetables.[19,22-23,25]

Self-reported reasons for changes in adult eating behaviour included loneliness,[26] eating to control mood[27] and difficulties controlling food intake.[21,28] These changes were more likely to be reported by those with mental health issues,[29,23] lower levels of educational attainment[26] and lower socioeconomic status.[29] Younger people, females and those with a higher BMI, reported a poorer quality diet.[19.29]

There was a national shift towards increased reliance on takeaway foods during periods of the pandemic. For example, from January to April 2021, there was a near-doubling in orders from "Just Eat Takeaway.com".[30] This trend was found internationally across Europe with 200 million orders being placed; a rise of 79% compared with the same period in 2020.[30] Some of this increase in the ordering of take away meals is likely to have resulted from a decrease in people eating out and in some areas may have led to a rise in the number of fast food outlets.

Evidence published by Public Health England (PHE) during the early stages of the pandemic, despite its limitations, suggests excess weight is associated with an increased risk of the following for COVID-19: a positive test, hospitalisation, advanced levels of treatment (including mechanical ventilation or admission to intensive or critical care) and death.[31] For more in depth information, please refer to: Excess Weight and COVID-19 Insights from new evidence.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

According to Public Health England (PHE), face-to-face Weight Management Services (WMS) were suspended as a result of the COVID-19 pandemic and the impact of remote provision on client engagement and uptake appeared variable in England.[32] Some services rapidly adapted to continue providing support through remote delivery, offered via a variety of different approaches including activity packs, telephone, social media and online support.[32]

Slimming World, for example, enabled 4,500 self-employed Consultants to run temporary virtual groups for their members. Over 400,000 members joined 'virtually' within the first few weeks of lockdown and this level was sustained across the lockdown periods. Slimming World also maintained contact with those members not wishing to engage in the digital online service in a variety of ways including calls, texts and post from their consultants, as well as closed member Facebook groups.

The Healthier You NHS Diabetes Prevention Programme (NHS DPP) is a free 9month behaviour change programme which supports individuals at increased risk of developing type 2 diabetes. NHS DPP adapted its referral criteria in order to reduce the impact of the various lockdowns. For example, the requirement for a confirmatory blood test indicating Non-Diabetic Hyperglycaemia to be within 12 months was increased to

24 months, until March 2022. In addition, instead of referring solely through the GP, eligible participants were encouraged to self-refer online, via the Diabetes UK Know Your Risk Tool.

Food Poverty

What was the situation prior to COVID-19?

Before the pandemic there was a strong network of established food banks and social eating projects within Nottingham City. This was complemented by many local organisations, including charities, faith and church groups, local community centres and some businesses who provided food to those in need.

What has been the impact of COVID-19?

In early 2020, a response team called the Mobilising Civic Society working group (MSC) was established within Nottingham City. This included key officers from across the council, to focus on supporting residents through the pandemic.

In order to understand the acute need of Nottingham City Residents, a questionnaire was distributed to the largest food banks in April 2020. The main findings were: an increase in demand; problems sourcing specific food items and a reduction in donations from the general public. Interestingly, several food banks noted a change in demographic of those presenting, from predominantly single males to families.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

The MSC group considered how it could work to support vulnerable residents within the city, including those identified as shielding. Multiple work streams were identified for the group to focus on, including:

- Key council support information for residents, including a 'Golden Number' and relevant contact centre support, including signposting for support such as where to access food banks and social eating projects.
- Emergency Food Parcels for those who were eligible were arranged through the council's in-house catering service in liaison with leisure services for storage and packing arrangements and fleet & transport for delivery. Between the dates of 31st March and 29th July 2020, 2,179 food boxes were delivered locally incorporating all dietary requirements, including Vegetarian, Vegan and Halal meals.

Early discussion with "FareShare" enabled a citywide programme of support for all food banks and social eating projects to help cope with increased demand during the pandemic. The "Robin Hood Fund" provided financial support for food banks and social eating projects across Nottingham, and additional funding was provided by Nottingham City Council to support delivery and distribution.

Nottingham City Council used various grants to support a number of programmes including;

- to provide Free School Meal pupil vouchers to help during school holidays,
- for FareShare support, for additional Welfare Support and Advice,
- to provide energy vouchers, supermarket vouchers for food and essential supplies as well as
- support to specific projects to help vulnerable groups in the city.

Working closely with "Hope Nottingham" and "Nottingham Forest in the Community," food and supplies were centrally purchased and then distributed to a number of different food banks, including: NG11 Clifton Foodbank, Meadows Foodbank, Grace Church, HOPE Nottingham, Bestwood & Bulwell Foodbank, Himmah / Muslim Hands, Arnold Foodbank and St. Ann's Advice Centre.

The situation prior to Covid-19?

Levels of physical activity in Nottingham are measured through Sport England's Active Lives Adult Survey

. Before the coronavirus pandemic, physical activity levels were increasing in the city. Further examination of the data, however, shows that there are stubborn inequalities in physical activity in specific groups such as: disabled people and those with long term conditions; people from lower socio-economic groups; older people; women and people from Black, Asian and Minority Ethnic groups.

What has been the impact of Covid-19?

Positively, during the pandemic there has been increased recognition of the value of physical activity and how it benefits an individual's physical health, mental health and wellbeing. For example, during the first lockdown, many people took the opportunity to be active outside, predominantly through walking and cycling.

The Active Lives Adult Report from November 2020 to November 2021, showed a rise in levels of physical activity in Nottingham (from 58.3% to 60.7%), compared with the previous 12 month period. In contrast, over the same period, levels of inactivity showed a slight decline from 28.1% to 27.7%. When the latest data is compared with the pre-pandemic figures from 2018-19, levels of physical activity fell by 2.2 percentage points (from 62.9% to 60.7%), whilst levels of inactivity in Nottingham adults rose by 3.4 percentage points (from 24.3% to 27.7%) (see **Figure 10** below). These patterns of activity within Nottingham adults (aged 16+) may reflect ongoing effects arising from the closure of sports facilities, schools, and the community and voluntary sector led clubs during lockdown restrictions.

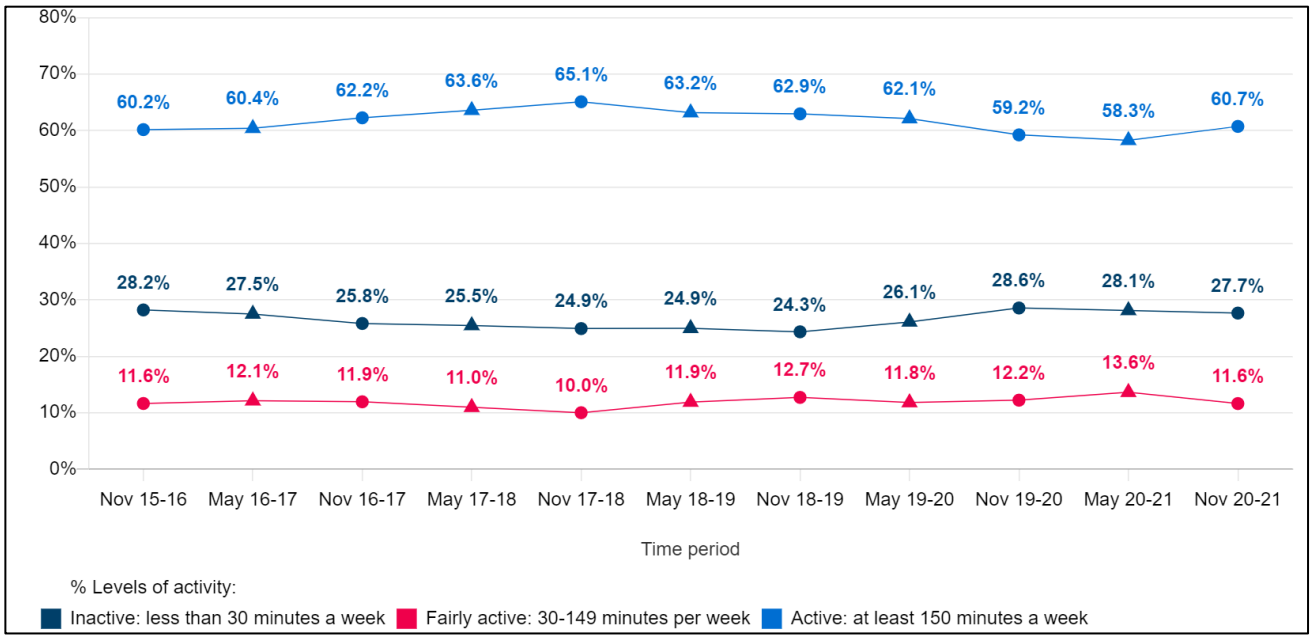


Figure 10: Trends in activity and inactivity for Nottingham City, 2015-16 to 2020-21

Source: Sport England (2022). Active Live Adult Survey. Available at: https://activelives.sportengland.org/Result?queryId=74267

There is also emerging evidence that the pandemic has exacerbated pre-existing inequalities in physical activity. The available activity data for Nottingham City (November 2020-21) shows physical activity levels increasing across IMD 2019 deciles from most to least deprived, and the opposite pattern for physical

inactivity levels in the city (with levels decreasing from most to least deprived deciles). New groups have also been identified as being disproportionately affected such as: people living alone; people without children in the household; those shielding and people without access to private outdoor space.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

Sport England has supported the sport and physical activity sector through a series of funding streams. Locally, Active Notts helped organisations to access this funding.

Around 70,000 "Active@Home" resources were distributed through the local vaccination sites, targeting older adults and those who were shielding. Nottingham City Homes supported their tenants to move more using the Active@Home resource.

Linking into Sport England's campaigning work around keeping the nation moving, Active Notts distributed an "Autumn and Winter Activity Campaign" toolkit to partners, to use with their workforce, clients and customers. The "Bike Aid Scheme" delivered by "Ridewise" provided bikes for health care providers and low-income workers during the pandemic. The Renewal Trust worked with partners to deliver "Feel Good Packs" to families across St Ann's providing resources and encouragement to help them get active.

What was the situation prior to COVID-19?

The adult substance misuse service ran two key pathways through the Wellbeing Hub, the Community Service – Nottingham Recovery Network (NRN) and the Criminal Justice Service (Cleanslate). Ancillary services were also in operation including Hospital Alcohol and drug Liaison Team (HALT)) operating out of Nottingham University Hospitals (NUH) , the specialist needle exchange service and shared care surgeries.

Pre-pandemic, service users would be referred or self-refer, attend a triage assessment and commence treatment within 24 hours. The specific treatment would be dependent on the substance(s) of choice and would include medical, pharmacological and psychosocial support, alongside sign posting and referrals to other support agencies (housing, mental health etc.).

What has been the impact of COVID-19?

The Government restrictions led to an emphasis on remote working with the team contacting the majority of service users by phone or through social media apps. Despite this, service users were retained in treatment, with access to pharmacological interventions alongside psychosocial treatment.

There have been some positive impacts from the pandemic, such as a more diverse service user group and a greater proportion of opiate users and alcohol users engaging and staying in treatment.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

The Wellbeing Hub operated a service operation protocol which was refreshed weekly to ensure the safety of staff and service users. The staff operated virtually as well as in person via a 'bubble' system ensuring continuity of care was delivered to mitigate the effects of staff testing positive or needing to self-isolate.

Certain high risk groups were prioritised and continued to have face to face contact, such as victims of domestic violence, pregnant women, those with safeguarding concerns identified or those manifesting self-harm or suicidal ideation.

Gambling

The situation prior to Covid-19?

In the UK, there has been a clear shift from gambling in land-based establishments (betting shops, bingo halls) to online gambling.

There are approximately 1,350 problematic gamblers in Nottingham and around 9,450 people (adults and children/young people) affected by their gambling. Nottingham's problematic gambling figures puts it alongside the highest rates for the country, rated in the 5th Quintile (Problematic Gambling Severity Index – PGSI). The reported demand in relation to the take up of treatment support does not reflect the stated levels of need. Therefore, prior to the pandemic people were not accessing, or could not access, appropriate treatment interventions.

What has been the impact of Covid-19?

The cancellation of real-life sporting events and the closure of physical premises in line with lockdown restrictions has increased traffic towards remote gambling apps.

The COVID-19 pandemic has resulted in behavioural changes in terms of people's reasons for gambling. These include consumers using gambling or betting as an escape mechanism, or an activity to mitigate boredom due to the social isolation and lack of mobility in lockdown restrictions.

Consequently, there has been an increase in consumers gambling online.[54] In turn, this could heighten the 'silent', 'hidden', or 'invisible' nature of gambling disorder.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

In December 2020, a review of the Gambling Act was launched to ensure that the regulation is fit for the digital age and that more emphasis is placed on the online gambling sphere. Key themes included: National Lottery minimum age raised to 18 to protect young and online stake limits, gambling advertising and age limits to be considered.

GamCare is the leading provider of information, advice and support for anyone affected by gambling harms.[33] Supportive organisations, such as GamCare, continued to offer online services, video consultations, telephone and text chat support. Gamblers Anonymous, has traditionally delivered a face-to-face model, but during the pandemic also moved this online, before moving back to a physical model with the easing of restrictions.

Smoking

What was the situation prior to COVID-19?

Based on data from the Office for Health Improvement and Disparities (OHID), the prevalence of smoking in Nottingham among adults (aged 18+) is significantly higher than the national average (20.9% compared to 13.9 % in England for 2019). This pattern is reflected in significantly higher rates of smoking attributable hospital admissions and smoking attributable mortality (see Local Tobacco Control Profiles).

The number of women in Nottingham who smoke while pregnant is significantly higher than the England average (13.9% compared to 9.6% in 2020/21). Risk factors for smoking in pregnancy are: younger mothers, living in a deprived area, lower educational level, working in routine and manual occupations, living in rented accommodation, women of white and mixed ethnicity, being single and having a partner who smokes. Evidence shows that few pregnant women take up the offer of smoking cessation support, and a significant number do not attend appointments, resulting in poorer outcomes for mother and baby. An action plan to reduce the number of women smoking in pregnancy is underway via the Local Maternity Neonatal System (LMNS), focusing on the uptake of stop smoking services.

What has been the impact of COVID-19?

The COVID-19 pandemic has raised awareness of the links between not smoking and quicker recovery from COVID-19 infection, which affects the lungs.

Stop smoking services adapted to restrictions by providing telephone appointments and prescriptions for stop smoking medication being sent to service users' nearest pharmacy or through postal deliveries. This shift away from face-to-face appointments has seen increased access to services generally, with fewer people not turning up for appointments.

Whilst stop smoking services have been affected during the pandemic, all pregnant smokers continued to be given evidence-based support. Midwives and health visitors engaged women with virtual appointments, leading to an increase in the number of women taking up the offer and a reduction in the number not attending appointments. Carbon Monoxide (CO) monitoring, a helpful tool to identify those who might benefit from stop smoking advice and support, had to be paused along with face-to-face appointments. This suspension of monitoring may have lowered the number of smokers identified and hindered verification of attempts to quit.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

The Nottingham City Smoking Stakeholder group has continued to meet monthly throughout the pandemic, to support stop smoking service providers and share learning. A mapping exercise of how providers responded to restrictions was undertaken and reviewed periodically. Campaigns such as "*Quit for Covid"* and "*Stoptober"* were shared via social media and other communication channels, to amplify the message across Nottingham.

In addition, local services provided pregnant women with their own single use CO monitor to support their quit attempt.

Children and Young People's mental health

Overview

Nationally, mental health problems affect around one in six children.[34] They include depression, anxiety and conduct disorder and are often a direct response to what is happening in their lives. The pre-pandemic need can be illustrated as follows:

- 13% of 5 to 19 year olds experienced at least one mental disorder
- children living in poverty were over three times more likely to suffer from mental health problems
- 20% of children were living at risk because of a vulnerable family background, due to domestic violence, substance use or severe mental health problems.[35]

The Mental Health Foundation produced a report on the "*Impacts of lockdown on the mental health and wellbeing of children and young people".*[36] The direct effects identified were increased levels of distress, worry and anxiety, with some increased feelings of loneliness and worries about schools in the future.[36] The impacts within the family context involved families where the experiences of lockdown may have been particularly difficult for children and young people. These included families where parents/ carers were key workers, were younger, and/ or had a history of mental or physical illness. Families within disadvantaged communities, ethnic minority groups and those subject to domestic violence were more likely to be affected by lockdown.[36]

A number of recommendations have emerged from the work conducted by The Health Foundation including:

- those children for whom lockdown has been particularly challenging should be identified and provided with more support
- Children and Young People would benefit from the opportunity to validate their experiences of lockdown with peers
- there should be a focus on clear communication about the pandemic, especially when returning to school
- there is a need for ongoing research to track the impact of the pandemic on children and younger people and research into the effectiveness of support developed for children and young people.

Children and Adolescent Mental Health Services (CAMHS)

What was the situation prior to COVID-19?

Based on the national Mental Health of Children and Young People survey in 2017 and ONS population data, 8,067 (12.5%) of the 64,419 five to nineteen year olds in Nottingham City are thought to be dealing with a mental disorder.

In Nottingham, waiting times for CAMHS sat within commissioned waiting times and the majority of work was provided face-to-face, including specific groups such as "TRANS4ME" and parent groups. There was more flexibility within the system such as the ability to engage parents through open door sessions.

There was a joint protocol in place for the Single Point of Access (SPA) - and an emphasis on prevention, containing risk and early intervention. Within schools, self-harm clinics and Time4 me sessions ran face-to-face appointments which provided another opportunity for early intervention and prevention. The Mental Health Support Schemes (MHST) - within schools provided another route of referral alongside the SPA.

What has been the impact of COVID-19?

The enforcement of Government restrictions and closure of buildings severely reduced the ability to have face to face appointments. By early April 2020, services were adapted to offer virtual support through MS Teams appointments and telephone appointments.

Those with critically urgent needs, such as individuals presenting with immediate self-harm, suicidal ideation and/ or a safeguarding risk, were prioritised and continued to be assessed face-to-face.

The closure of schools and initial reduction in numbers presenting to the GP at the start of the pandemic led to a reduction in referrals. However, there was an increase in referrals after both lockdown periods, particularly those relating to self-harm, eating disorders and suicidality. Overall, referral rates have risen to the highest recorded levels, creating substantial service pressures.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

By early April 2020, services were adapted to offer virtual support through MS Teams appointments and telephone appointments.

There has been an innovative use of different platforms to engage CYP (children and young people) and their families during the pandemic, such as Podcasts for schools; YouTube clips and online workshops for parents and CYP.

The W4ER (Wellbeing return for education) project provided government funding for Local Authorities to better equip schools and colleges to promote children and Young people's wellbeing, resilience, and recovery in response to COVID-19. This project was delivered to schools from September 2020 through a partnership model involving the Educational Psychology Service, Mental Health Support Teams, CAMHS and a mental health consultant. It included training, webinars, staff peer support clusters and wellbeing sessions.

The findings from the survey Pupil views on their education in the context of the COVID-19 pandemic led to the implementation of "#nottinghamyouvebeenmissed" - a social media campaign to promote mental health and wellbeing support in the local area. The aim was to ensure people knew that CAMHS services were still open and operating and to advise how to self-refer to CAMHS.

Nottingham City and Nottinghamshire W4ER used funding to develop the Nott Alone website to provide advice and help for young people's mental health all in one place. Co-produced with young people and parents, the Nott Alone website was developed for children and young people, parents and carers, and professionals to access information and resources for improving mental health.

The Voluntary Sector and Mental Wellbeing

What was the situation prior to COVID-19?

A number of voluntary organisations contribute to the support for CYP wellbeing within Nottingham City and we are not able to mention all within the scope of this document. We will focus on feedback from a few local organisations including Base 51, Kooth and Small Steps Big Changes.

Base 51 delivered face-to-face counselling to young people aged over 11, along with confidential advice and learning support delivered by a range of qualified counsellors and counsellors in training.

Kooth Face-to-Face ("Kooth F2F") Nottingham City and Kooth online Nottingham City ("Kooth") offered online and face-to-face counselling for children and young people.

Small Steps Big Changes (SSBC) funded through the National Lottery Community Fund's "A Better Start" Programme provides a range of activities designed to give every child the best start in life.[37]

Perinatal mental health services had worrying gaps even before the crisis, exacerbated by cuts to statutory services, such as health visiting and also voluntary and community sector organisations.

What has been the impact of COVID-19?

BASE 51 and Kooth were adapted to operate virtually, enabling counselling and youth teams to provide ongoing support to current and new service users. Both Kooth.com and BASE 51 have seen an increase in complexity and rise in CYP attending their services. There has been a change in initial presenting issues; with a reduction in issues relating to peer relationships, bullying and issues relating to school, coupled with an increase in those experiencing anxiety, issues within the family, self-harm and suicidal ideation, domestic violence, abuse and increased deprivation.

Notably, SSBC has observed that the pandemic has posed mental health challenges for families during pregnancy and early parenthood, which have been experienced unequally, with the following groups being more vulnerable:

- women
- those identifying as BAME and
- those who are already disadvantaged.[38]

All families who responded to SSBC commissioned research conducted by Nottingham Trent University reported worrying about the virus, either catching it themselves or passing it on to their baby or child.[39] Reductions in family income, unstable employment, threats of redundancy and increased living costs are likely to have acted as stressors during the pandemic and contributed to an erosion of mental health in some people.

At a time of increased need, some traditional mental health support mechanisms were disrupted. During the first national lockdown, there was a decrease in the amount of face-to-face contact between health visiting and other early intervention services, decreasing the amount of contact time with professionals for making mental health disclosures. Some assessment was done remotely, but services felt the early identification of mental health concerns benefited from face-to-face contact, allowing a greater opportunity for observation, assessment and sensitive discussion.

Postnatal mental health issues are often attributed to loneliness, which is perpetuated during national and local lockdowns. New parent groups and toddler groups which normally operate on a face-to-face basis were paused, removing valuable sources of support for new families.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

Both Kooth and Base 51 have adapted to offer digital delivery through a range of platforms including telephone, video conferencing sessions and text based services (once identity had been confirmed). Face-to-face sessions were still available to vulnerable young people, where this was deemed necessary.

BASE 51 were able to mitigate some of the risks for young people who experienced issues around isolation, technology poverty, and lack of privacy, by promoting the presence of their Youth Workers in local parks. These Youth Workers were available for 1-2-1 support, well-being activities and arranging the delivery of devices, credit and connectivity packages.

Kooth has specifically included content on its website related to COVID-19 and the impacts of lockdown, which has resulted in a marked increase in CYP accessing peer to peer support on the site. In addition, there has been recruitment of service delivery staff to maintain the average wait times for a chat session.

Within SSBC, family mentors during the initial lockdown were able to provide some ongoing support to parents, through wellbeing calls. Services were operating some groups via a virtual model, but it is uncertain at this time whether virtual delivery confers similar benefits to parents' wellbeing.

SSBC commissioned a new parent-infant relationship service within Nottingham which started in September 2021. This service prioritises the needs of the baby and the attachment with main caregivers. It is accessed through referral from 20 weeks of pregnancy, up until the infant's 2nd birthday, through the CAMHS Single Point of Access. Families can expect support in the form of 1:1 and group interventions, which includes both antenatal and postnatal attachment-based interventions.

Overview

What was the situation prior to COVID-19?

According to the charity MIND, each year around 1 in 4 people in England will experience a mental health problem (see Mental Health Statistics). Before the pandemic, mental health problems were responsible for over a fifth of the burden of disease in England costing over £105 billion.[35]

Nottingham City has a significantly higher prevalence of common mental health disorders when compared to the national average.[40] This is partly due to the many factors that increase the risk of mental health problems throughout life, such as higher rates of deprivation, greater ethnic diversity; high levels of unemployment, increased youth offending and more looked-after-children in Nottingham.

More in depth information of the situation prior to the COVID-19 pandemic can be found in the Joint Strategic Needs Assessment (JSNA) chapter: Adult Mental Health (2016).

What has been the impact of COVID-19?

Self-reported mental health and wellbeing has worsened during the pandemic and remains worse than pre-pandemic levels.[41] In a survey by the charity Mind, more than half of adults (65%) and over two thirds of young people (68%) have said their mental health got worse during lockdown, with this rising to three quarters (74%) of people aged 18–24.[41]

There are multiple factors that may have worsened mental health during the pandemic. The restrictions that have been brought about due to the lockdowns may have exacerbated feelings of loneliness and social isolation.[42] Some groups that have been disproportionately affected by loneliness include working-age adults living alone, those in poor health and people in rented accommodation.[42]

The direct impact of the virus itself on those infected has likely impacted mental health, for those acutely unwell, those suffering from the impact of long COVID and the grief experienced by those who have lost loved ones to the virus.

The pandemic has higlighted pre-existing inequalities and the subsequent pandemic's effects on mental health have been disproportionate. Young people and women, people with no work or low income, those living in social housing, frontline workers and people with pre-existing mental health problems were more likely to see their mental health worsen.[41] Access to support and treatment has also been impacted as one in four people of all ages who tried to access mental health support during lockdown were not able to do so.[41]

A more in-depth review of the local impact can be found in the Nottingham and Nottinghamshire Mental Health COVID Rapid Assessment.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

Nationally, the Every Mind Matters website was established to support people with mental health during the COVID-19 outbreak. In addition to tips on dealing with stress and anxiety, the hub included support on how to cope with money worries and job uncertainty and how to look after your mental wellbeing while staying at home.

At a local level, there has been work to ensure the provision of mental health advice and support, and promote awareness of these services in the city. Nottingham's Ask LION Directory developed dedicated mental health pages that include a range of contact details for local services and national helplines. One example is the Nottingham Mental Health Helpline, which provides personalized advice, emotional support and information on coping mechanisms. Other services available for advice and support include Wellness in Mind, The Grief Line (for those who needed immediate support following bereavement), the CRISIS Helpline (for people in mental health crisis) and the Harmless Tomorrow Project (offering support for those in suicide crisis).

The NHS Long Term Plan describes plans to enhance the number of roles within Primary Care Networks (PCN's) specifically relating to mental health. Two of these additional roles are "*Social prescribers"* and "*PCN Mental Health Practitioners*".[43]

Social prescribing enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services to support their health and wellbeing.[43] During the pandemic within Nottingham City there were 12 Link Workers recruited within PCNs.

From April 2021, PCN's were able to recruit to *PCN Mental Health Practitioners* via the Additional Roles Reimbursement Scheme. The aim of the role is to improve the provision of mental health care and support in primary care, alongside improving partnerships between primary care and the Local Mental Health Teams and wider mental health services including IAPT. Within Nottingham City, a total of 8 PCN Mental Health Practitioners have been recruited.

Older People's Mental Health

What was the situation prior to COVID-19?

Mental health problems in older people are common and are often more apparent in settings such as hospitals and care homes. In a 500-bed general hospital on an average day, estimates suggest that 330 beds will be occupied by older people, of whom 220 will have a mental disorder, 100 will have dementia and depression, and 66 will have delirium. Depression affects 4 in 10 people living in care homes and in nursing homes around 1 in 10 residents have psychotic symptoms such as delusions and hallucinations.

Depression is the most common mental health condition in older people. Depression and other mental health conditions in older people often go underdiagnosed and undertreated. However older people with mental health problems are likely to respond to treatments as well as or better than the younger population. A greater proportion of older people (42%) complete treatment than their working age counterparts (37%) after being referred to Improving Access to Psychological Therapies (IAPT) services. Additionally, older people achieve good outcomes from IAPT treatment, e.g. in 2014 to 2015, 56% of over-65's showed 'reliable recovery' after receiving psychological therapies compared with 42% of working age adults.

What has been the impact of COVID-19?

Being restricted at home for long periods has left significant numbers of older people with reduced mobility through deconditioning, muscle weakness, and joint pain, and previously independent older people have become reliant on walking aids to move short distances. This has impacted on the mental wellbeing of older people, e.g. 34% older people reported that their anxiety was worse than before the start of the pandemic and an increase in those feeling depressed. The associated lack of mental stimulation and social contacts, has resulted in one in five older people reporting that since the start of lockdown, they found it harder to remember things.

Bereavement has affected all age groups, but particularly older people who were not only unable to say goodbye to family and friends but were often left to grieve by themselves without support. During lockdown, being separated from support networks was especially distressing for those who are reaching the end of their life and those who feared they would spend their last months away from their loved ones. In addition, it may have been challenging for some older people to connect virtually or take the advantage of opportunities through new technology without the prior skill and without being able to get in person support to learn new skills due to restrictions.

Older people living with dementia have been significantly impacted by the changes to their routine, access to services, and reduced ability to maintain regular contact with family and friends. A survey conducted by the Alzheimer's Society found 82% of people affected by dementia reporting an increase in dementia symptoms during the pandemic, including memory loss, difficulty concentrating, and agitation or restlessness.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

The mental health services commissioned to support all adults were promoted to older people through various networks, such as "Age Friendly Nottingham".

Community and voluntary organisations such as "Age UK Nottingham and Nottinghamshire" or "Good Companions" in Clifton, have continued to support older people throughout the pandemic and signpost them to services as appropriate.

Loneliness

What was the situation prior to COVID-19?

The annual Nottingham Citizens Survey measures loneliness in the city. In 2019, 15% of respondents reported feeling lonely some or all of the time. This is a 9% increase from 2014. Highest rates of loneliness were for people living with a disability or long-term illness or not in paid employment. Increasing age or living with long-term conditions or a disability are some of the main risk factors for loneliness, but there is also clear evidence around poverty and deprivation.

What has been the impact of COVID-19?

Higher levels of loneliness and poorer wellbeing have been reported for all ages during the pandemic. This included young people particularly associated with urban areas outside London. Although the restrictions were universal, their impact on loneliness was unequal. People who were already lonely were likely to get lonelier, but those with strong social connections were likely to feel less lonely.

Based on ONS data from the Opinions and Lifestyle Survey, the percentage of adults (aged 16+) in Nottingham reporting that they were often or always felt lonely (between October 2020 and February 2021) was 12.80%, which was considerably higher than the regional (7.83%) and national (7.26%) figures.

Suicide prevention

What was the situation prior to COVID-19?

In England, approximately one person dies every two hours as a result of suicide.[45] Suicide has a significant, lasting and often devastating impact on individuals, families, communities and wider society.

Suicide rates tend to vary over time. In Nottingham City, they reached an historical low in 2010, before increasing in the years to 2013 and reducing thereafter. In 2019, the rate was higher than in previous years and similar to the higher rates observed in 2004 and 2013 (see **Figure** 9).

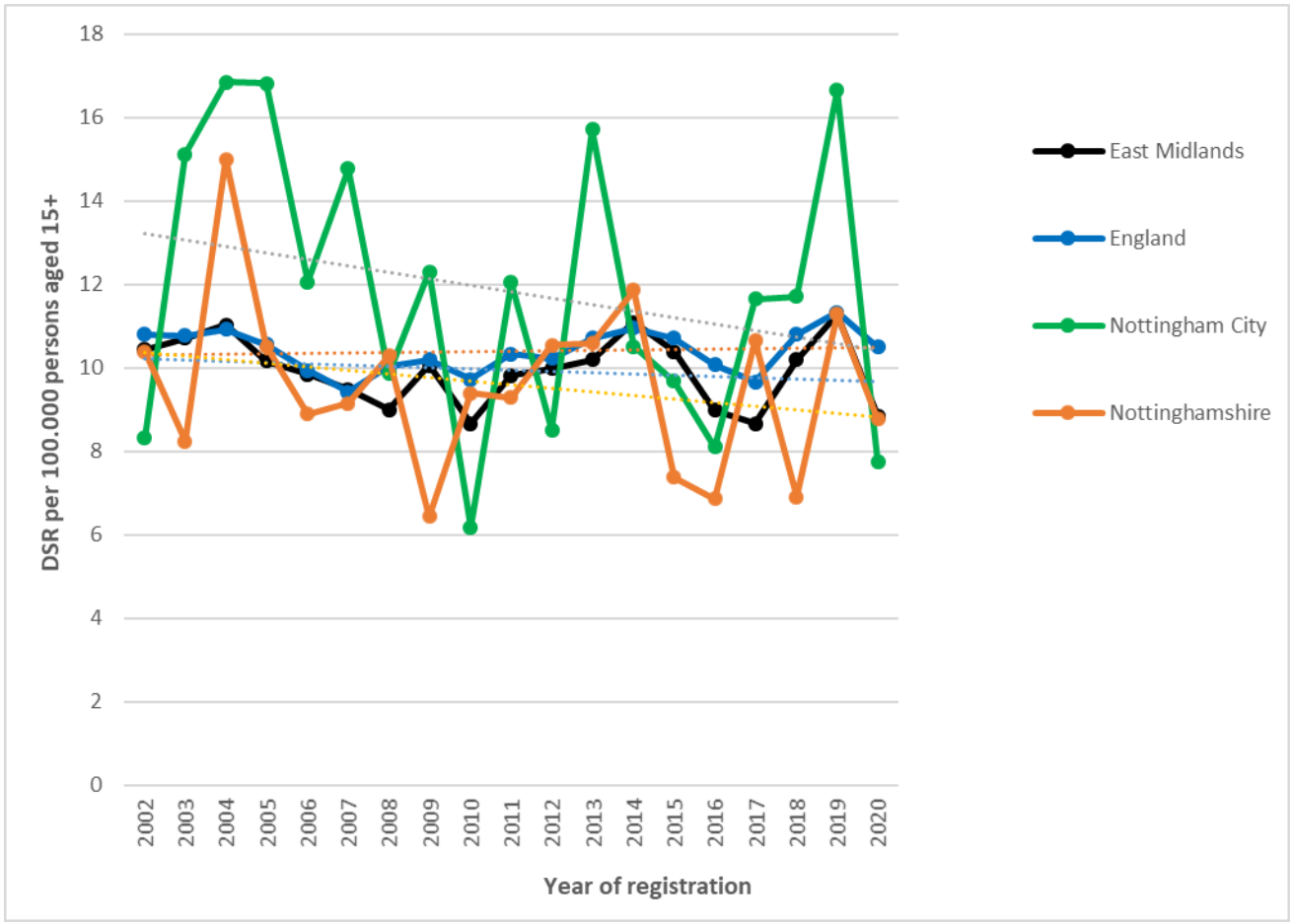


Figure 11: Trends in directly standardized rates (DSRs) for mortality due to suicide and unintended injury per 100,000 persons (aged 15+) for Nottingham, Nottinghamshire, East Midlands and England, 2002-2020

Source: NHS Digital (2022). Mortality from suicide and injury undetermined: directly standardised rate, 15+ years, annual trend, MFP (based on ONS data). Available at: https://digital.nhs.uk/data-and-information/publications/statistical/compendium-mortality/current/mortality-from-suicide-or-suicide-and-injury-undetermined/mortality-from-suicide-and-injury-undetermined-directly-standardised-rate-15-years-annual-trend-mfp

There are many well-recognised risk factors and at-risk groups for suicide. There is a notable socio-economic gradient, with those in the poorest group subject to ten times the risk of suicide than those in the most affluent group.[46] Men account for around three quarters of all registered suicides and this has been a consistent trend since the mid-1990s.[47] Self-harm is another recognised risk factor for suicide – the biggest single risk factor for many groups – with UK studies estimating that in the year after an act of self-harm, the risk of suicide is 30–50 times higher than in the general population. Non-fatal self-harm leading to hospital attendance is the strongest

single predictor for completed suicide. National evidence also highlights increased risk to those from ethnic minority communities.[48]

More in depth information of the situation prior to the COVID-19 pandemic can be found in the Joint Strategic Needs Assessment (JSNA) chapter: Suicide.

What has been the impact of COVID-19?

During such unusual times of societal stress with those at risk of suicide potentially having less access to supportive networks, the local situation needs monitoring closely. However, it is possible that the true picture might appear over a longer timescale than in the immediate response to the pandemic.

Some studies have predicted a rise in suicide rates associated with the COVID-19 pandemic.[49] Particular emphasis has been placed on the impact of the pandemic on young people, due to evidence that their mental health has been disproportionately affected.[50]

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

The Nottingham City and Nottinghamshire County Real-Time Surveillance Working Group meets regularly to review real-time local data and intelligence to enable the identification of high-risk locations and high-risk groups (including young people who self-harm) and plan action to mitigate concerns as they arise. It is through this partnership working that an increase in concern for suicide risk in younger people associated with the impact of COVID-19 has been identified.

While there has not been a statistically significant increase in suspected suicides in younger people, services, further education and higher education settings have reported an increase in acuteness of need for suicide prevention support.

Two partnership meetings have taken place to explore the issue and determine action, which has included:

- Skills sharing: Nottingham City Council Child and Adolescent Mental Health Services and Self-Harm Awareness Resource Project have offered to support the two local universities in tailoring support to students.
- Communications: Nottingham City Council Public Health funded and developed a poster for students setting out the support available locally.
- Support for substance use: Substance use services will engage with universities to support students who are reporting drug and alcohol use.

Sexual Health Services

What was the situation prior to COVID-19?

Prior to the pandemic, there were a range of open access sexual health services. This included the main Genito-Urinary Medicine (GUM Hub) at Nottingham City hospital (NCH), a number of bespoke clinics around the city and numerous outreach clinics situated in GP practices and health centres. The service covered six days a week and provided some evening access. Service users were able to book appointments via the telephone or online.

What has been the impact of COVID-19?

The emergence of the pandemic led to closure of clinics with only the main Hub site being kept open. There were also staffing capacity concerns due to redeployment. The online booking system facility was paused. Primary care sexual health services also saw significant reduction in activity due to national guidance on scaling back.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

At the beginning of the pandemic, Public Health (PH) in Nottingham City Council (NCC) enhanced the existing online offer to include oral contraception and chlamydia treatment.

In NUH Sexual Health clinics, the existing Nurse Triage function was utilised more to provide telephone based support and only face-to-face appointments when absolutely necessary. A young people's email sexual health support service was also set up. Health promotion activity was carried out virtually. Support was provided to the C-Card free condom distribution service by implementing a postal condom service.

The Health Shop which supports people with complex needs and high-risk factors such as sex workers, rough sleepers, and people who inject drugs, moved the service to a COVID-19 secure location so people could still drop in. Further outreach work in the form of testing kits and information packs were carried out in hotels and hostels where people were temporarily housed. Partnership work with the Prostitute Outreach Workers (POW) enabled more support to sex workers who struggled to adhere to lockdown restrictions.

Furthermore, sexual health services in community pharmacy and online services saw age restrictions lifted to enable wider access. National guidance on Long Acting Reversible Contraception (LARCs) was provided to extend the recommended lifetime of devices so women were able to avoid having to access clinics for removal/replacement of devices.

Locally, some intelligence was received regarding the surge in sales of pregnancy testing kits, NCC responded by developing information posters on emergency hormonal contraception (EHC) and contraception services for pharmacies and local retailers in that area.

What was the situation prior to COVID-19?

Since 2013, effective and high-quality Screening and Immunisation services have been delivered in Nottingham and commissioned by NHS England and NHS Improvement (NHSEI). Programme Boards for each service are held quarterly, led by the Screening and Immunisations Lead, with representation from key stakeholders. Performance, access, safety, or health inequality issues are identified and discussed by the programme boards and addressed by providers with support from the relevant stakeholders.

Due to Nottingham's high levels of deprivation, there is a lower uptake of screening and immunisation appointments, within local services, compared with national averages. Local project work is usually developed to mitigate against this, with stakeholders coming together, such as the Children's Flu group. Projects have been implemented to increase uptake (e.g. in diabetic eye screening for young diabetics, GP endorsement in breast and bowel screening, and targeted work with LD patients in bowel screening).

What has been the impact of COVID-19?

In general, a negative impact has been observed across all screening programmes. At the beginning of the outbreak, some screening programmes had a period where services were paused and only high-risk patients were invited. NHSEI have been working with providers to support the full recovery of the programmes. Significant progress has been made, and all screening programmes have continued to invite and screen their eligible population during COVID-19.

To protect clients attending and staff working in screening, Infection Prevention and Control (IPC) measures such as PPE, extended appointment times and cleaning between clients, were put in place. This was of paramount importance to ensure the safety of NHS clients and staff and to enable the programmes to continue to screen. Due to these additional safety measures, and due to some staff being required to socially isolate or being ill themselves with Covid-19, capacity within the screening services decreased and this created a backlog. Appointments needed to be rescheduled, which caused a potential for a delay in diagnosis. Services found that they could not initially use some of their community venues (due to social distancing measures). Services also found that it took a while for the eligible population to feel confident enough to attend NHS sites for screening, due to the fear of contracting Covid-19.

Immunisation programmes have also been impacted due to the pandemic. Schools were closed for long periods of time, which had a negative effect on the school age immunisation programme. The service was able to offer immunisation appointments via community clinics, which were well attended, but with the added issue of groups of students having to isolate when they were back in school, a reduction in uptake was expected.

A review of childhood immunisation data, during the pandemic, found reduced uptake in March/April 2020 and September/October 2020, which can be related to lockdown periods. Data suggests that falls in uptake strongly relate to deprivation and this is reflected in the Nottingham data.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

Programme Boards were paused, and monthly restoration meetings were held with screening and immunisation providers, to support them in restoring their services. Assistance was provided by NHSEI in the form of national guidelines, financial support to recruit extra staff, open extra venues, and fund equipment to enable more staff to work from home, where possible. End dates for achieving full restoration were agreed with services.

Data tools were developed to support the services in understanding their uptake and what they needed to achieve to ensure that they were returning to business as usual and that all patients were being captured and offered appointments.

Venue locations were reviewed to ensure that they were accessible for all, that they had appropriate lead times and that communications were shared with the eligible populations around services being Covid-19 safe, with social distancing measures implemented. Stakeholders were also kept abreast of the status of the screening services, so they could support referrals and encourage people to attend.

What was the situation prior to COVID-19?

Pre-pandemic there was a successful drive to increase the number of NHS health checks. Local GP practices were encouraged to use primer and reminder texts to eligible patients which national research suggests encourages uptake.

What has been the impact of COVID-19?

Due to the impact of lockdown, enforcement of government restrictions, the ability to perform day-to-day NHS work was badly affected with an emphasis on emergency care only. This resulted in NHS Health checks being paused at several points during the pandemic. It is expected that GP practices will catch-up over the 5-year programme, however this will be challenging given the backlog of routine care.

There is emerging evidence that cardiovascular disease and COVID-19 severity are interconnected and share underlying risk factors[55] which was highlighted in Health Matters. Those with pre-existing cardiovascular disease, diabetes, obesity and hypertension experience more severe outcomes from COVID-19.[55]

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

Certain sections of society have faced increased impact and more adverse outcomes from the pandemic, such as minority ethnic groups. Nottingham City Council has attempted to mitigate these effects by changing the pay structure to ensure ethnic minority groups for example have been prioritised. Alongside this, there has been national funding to local authorities and general practice to deliver adult weight management services to more people.

Long COVID

Long COVID is a broad term that encompasses ongoing symptomatic COVID-19 (5-12 weeks after onset) and Post COVID-19 Syndrome (12+ weeks after onset), which can have long term effects. Based on ONS data, there are an estimated 1.8 million people in the UK (2.8% of the population) with long COVID. A full discussion about this novel condition is outside the scope of this paper and more information can be found in the Long COVID: the NHS plan for 2021/22.

Nottingham CityCare Partnership launched a Post COVID Syndrome Assessment Clinic in March 2021 as a six-month pilot. Based on the national prevalence estimate for Long COVID, the expectant demand was around 625 people, who would require long term support from the NHS. The actual number of referrals from within Nottingham City was 219. The low number of referrals could be due to the fact that this is a new condition and the lack of GP awareness of the condition and that the service exists and reduced patient awareness of the condition and that there is support services for them to access. Those referred to the clinic within the first six months were predominantly women (68%); white (75%); and aged between 35-65 years. Furthermore, the majority of referrals come from a limited number of Nottingham City communities with the highest levels of deprivation.

Supporting the Clinically Extremely Vulnerable

What was the situation prior to COVID-19?

Pre-pandemic, a joint City and County model was in place to support residents.

What has been the impact of COVID-19?

The pandemic has been a difficult time for everyone, but it has been particularly hard for those who have been advised to take extra precautions. The City's Clinically Extremely Vulnerable (CEV) cohort doubled in size over the course of the pandemic due to the addition of people based on risk factors of deprivation, ethnicity and obesity. By March 2021, Nottingham City had nearly 25,000 CEV citizens.

Self-isolation has been an integral part of the COVID-19 response. Nottingham City Council (NCC) has recognised that self-isolation is not easy for anyone, and for a variety of reasons can be particularly challenging for some, therefore support is required to optimise the chances of sustained self-isolation.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

On 23rd March 2020, NCC launched its own Community Hub telephone number, supported by Neighbourhood Development Officers (NDOs). The NDOs utilised their close and strong working relationships with the local community organisations, resident groups and community champions to create Local Resilience Teams in each ward to mobilise volunteers to help and support vulnerable citizens.

Those who required support and/ or were self-isolating could access this via a dedicated telephone number, known as the "Golden Number," Monday to Friday (9am - 5pm) or via the website running alongside the hub and operational 7 days a week. This provided a wide range of practical, social and emotional support. The support services range from access to food banks, collection of prescriptions, PPE storage and distribution for essential services, welfare calls, assistance with online activities, access to mental health services and bereavement support to supermarket provision. There was even localised doorstep support through mobilisation of volunteers and directed visits to vulnerable and shielding residents, via Community Protection teams and Nottingham City Homes colleagues. More information can be found here.

Domestic Abuse

What was the situation prior to COVID-19?

Domestic and Sexual Violence and Abuse (DSVA) need is high in Nottingham, as outlined in the JSNA chapter on DVSA. Demand is met via the 24-hour Juno Women's Aid helpline; women's' refuges and outreach services; sexual violence support services, prevention services and perpetrator programmes. DSVA provision in Nottingham is funded through partnership funding streams, including income generated through bids to the government and charitable foundations. Commissioning, grant aid and funding are coordinated for the wider partnership through the Joint Commissioning Group, chaired and lead by the Crime and Drugs Partnership (CDP).The DSVA Strategy Group, currently chaired by Public Health reports to the CDP Board under the new Statutory Duty.

What has been the impact of COVID-19?

The Domestic Violence Bill published in 2019 became an Act of Parliament in April 2021. The Domestic Abuse Act 2021 provides further protections to survivors of domestic abuse, as well as strengthening measures to tackle perpetrators. During lockdown, calls to the police in Nottingham decreased, but calls to the specialist DSVA helpline for services increased by 57%. Overall domestic abuse reported crimes have decreased by 6%, however domestic abuse reported incidents have increased by 7% (which is 459 more incidents).

National feedback indicates that survivors are finding it difficult to contact services for help, whilst at home with the perpetrator. An increase in single females (without children) was seen in accommodation-based services. The overall volume of reported sexual offences has reduced by 28%, although lack of reporting is not an indicator of need. This reduction in reporting to the police is a cause for concern and more must be done to encourage survivors to contact both the police and support services for help. During the initial stages of the pandemic, there was a drop in calls to Sexual Violence Support Services, but this began to increase at the end of 2020.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

There was a focus on communications and training during lockdown periods to raise awareness that stay-at-home restrictions do not apply to DSVA survivors who need to access services. This has been led by Equation (A Nottingham based charity) with weekly updates to professionals and communities and a regular monthly meeting, ensuring all statutory and voluntary sector agencies were coordinating and amplifying their messages. To increase confidence in reporting, local partners are delivering joined up messages to citizens across social media through the "Consent Coalition," lead by the CDP to both encourage reporting and discourage sexual violence and abuse.

What was the situation prior to COVID-19?

The Nottingham City JSNA chapter on Asylum seekers, refugees and migrant health was published in 2018 and identifies health and care needs for these groups.

Local provision has included face-to-face support, with a triage service daily at the Nottinghamshire, Nottingham Refugee Forum (NNRF), group sessions, English for Speakers of Other Languages (ESOL) courses, and support to destitute asylum seekers. Hotels were not routinely used as an accommodation setting.

Nottingham Arimathea Trust (NAT) accommodates and supports destitute asylum seekers who have had their asylum claim refused and vulnerable newly recognised refugees who experience homelessness. NAT offers a room and support to many of these individuals, enabling them to either resubmit their asylum claim by providing new evidence in the case of the asylum-seeking residents, or to develop the skills and independence to take on their own tenancies, if they are refugees.

What has been the impact of COVID-19?

Services were reduced and moved to virtual support. This was challenging, as service users may not have had access to mobile phones or devices with internet access, through lack of resources or finances.

There were also challenges around GP registration, dental and doctors' appointments due to lack of support, language barriers and knowledge of the NHS. Regarding physical health, there was a higher risk of COVID-19 spreading due to confined areas within large groups who lacked an understanding of the virus. There was also a notable increase in mental health issues, due a lack of social networks, confinement in one area and access to adequate provisions including translation services.

Children could not access education, as parents struggled to access online programmes, which resulted in low engagement and school applications. There was also no Wi-Fi or digital equipment provided in most asylum accommodation. New arrivals who completed school applications could take up to 3 months and during this period missed out on the school voucher system. There was also confusion about where they could use the vouchers. If it was online vouchers, parents had difficulty with this due to lack of internet access.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

A hotel partnership group was initiated, consisting of private, public and the voluntary sector, to support individuals. Workers funded via the voluntary sector also supported the service users. This helped address the needs of both individuals in the hotels and projects, i.e. COVID- 19 testing and vaccinations.

Support services had to adapt and move to remote working, setting up telephone advice services to allow for continuation of support. The Multi Agency Forum meetings were increased to monthly to ensure the needs of both services and service users were addressed.

The recruitment of an Asylum Seeker and Refugee co-ordination officer by Nottingham City Council, meant that information could be shared during appointments with parent/carer, including the vaccination bus.

Since March 2020, NAT has completed work to mitigate against the negative impact of COVID-19. Concerning digital exclusion, NAT ensured all their properties had internet access and those residents that did not have SMART phones or tablets, were provided with a device. This enabled residents to maintain contact with loved ones overseas. NAT has also arranged mental health checks for residents, catching up with other health and dentistry issues and needs, deep cleaning of properties, creating volunteering opportunities, and offering ESOL classes.

What was the situation prior to COVID-19?

Prior to COVID-19 all homeless accommodation across the city was full and homeless prevention services were working at capacity. There is a lack of affordable accommodation in Nottingham, which in turn increases the length of stay in supported housing, increases rough sleeping, and the number of families living in temporary accommodation.

People deemed not to be in priority need or found intentionally homeless by the local authority experienced considerable difficulty in finding accommodation. Prison leavers would regularly return to the streets, due to a lack of suitable and appropriate accommodation for them, as most would not be considered a priority need.

The monthly count of rough sleepers averaged 40-50 in Nottingham City with a further 100 people accessing shared space hostels or supported accommodation across several different provisions. The direct access accommodation offers several levels of support depending on needs identified through assessment. Emergency winter measures were provided through a shared space communal shelter or accommodation appropriate to individual needs.

What has been the impact of COVID-19?

With no evictions taking place, those at risk of homelessness were able to stay in their accommodation. Some illegal evictions still happened during this period and services such as Homeless Prevention Teams and The Law Centre were able to assist.

There was substantial concern about the impact of the eviction ban being lifted and the uncertainty and possibility of eviction for many individuals and households.

There have been several immediate challenges to our rough sleeper cohort. Many of the accommodation options previously used for winter emergency shelters were deemed unsafe due to their communal nature. Following the government's instruction to provide COVID-19 safe accommodation for all rough sleepers, the only available option was to accommodate 140 rough sleepers in hotels located within the city centre. The Nottingham 'Everyone In' scheme was stood up at short notice, with multiagency involvement overcoming substantial challenges on staff capacity and budget contingency. This scheme also had lower thresholds for eviction in line with hotel guidance, whilst ensuring access to ongoing support or treatment programmes. In partnership with the local voluntary sector, practical needs were met such as providing food and prescription collections and additional staffing. The outcomes of this work are described in the Director of Public Health Annual Report 2021: COVID-19 an opportunity for change – tackling severe multiple disadvantage in Nottingham City.

Has there been implementation of potential mitigating actions to reduce the impact of COVID-19?

Support has been given to people to engage with their landlords regarding rent arrears in order to avoid evictions when the courts opened. Support was also provided to access vital services, sometimes via digital communication methods, for those previously digitally excluded. Support in accessing COVID-19 vaccinations was provided for those experiencing homelessness and those vulnerably housed. This has included specific clinics, use of the vaccination bus, support with booking appointments and travel arrangements.

Work with the health sector has been ongoing to register rough sleepers with GP services. Vaccine access has been facilitated through a local GP surgery to vaccinate our rough sleeper cohort using food vouchers to encourage uptake. Second dose vaccines were provided by mobile vaccination buses, able to locate close to our rough sleeper hotel accommodation.

Local volunteer networks were established in each area of the city to provide emergency food deliveries and medication/prescription collections for rough sleepers. Additional emergency food provision was provided in several locations across the city centre to facilitate and encourage social distancing.

Healthwatch Nottingham and Nottinghamshire (HWNN) gather experiences from health and social care service users to inform providers and commissioners how to improve their services. Healthwatch have created several reports related to COVID-19, since the start of the pandemic:

COVID-19 GP answer machine messages survey April 2020

At the start of the pandemic there was evidence that some patients were unsure as to whether their GP practice was still operating.

Aim: The aim of this survey was to find out what information was shared on GP answer machine messages across Nottingham and Nottinghamshire during the COVID-19 pandemic.

Results: Only 7% of surgeries stated they were open and provided their operational hours. Over a quarter (27.3%) of surgeries did not provide clear COVID-19 information on important symptoms, when to isolate or when to call 111. Full details about the survey can be accessed here.

Information Needs of Vulnerable People during the COVID-19 pandemic May 2020

In order to understand the impact of COVID-19 on vulnerable people in Nottingham and Nottinghamshire, and to inform local and national responses, Healthwatch Nottingham and Nottinghamshire (HWNN) carried out a short survey between 17th April and 4th May 2020 to find out:

- Whether people knew if they were in the highest risk or increased risk group when read the NHS definition
- Whether those in the highest risk group received an NHS letter on 'important advice to keep you safe from Coronavirus' letter
- Whether people surveyed understood official COVID-19 information
- What is the unmet information needs of people surveyed?
- Whether GP and hospital appointments had been cancelled or changed.

A total of 435 people from Nottingham and Nottinghamshire responded to the survey - 383 via an online survey and 52 were reached through phone calls. The vulnerable groups included: people with long term conditions; people with one or more disabilities; people over the age of 70; people in the high-risk group; those who are Black, Asian, Minority Ethnic (BAME) refugees, those who are lesbian, gay, bisexual, trans-gender or questioning (LGBTQ+) and young people with mental health issues.

Results: 12.6% in the highest risk group did not know they were at risk and 28% had not received a letter. 42.3% had unmet information needs and 56.8% had had their routine appointments changed or cancelled. Further information can be accessed here.

Communicating with relatives of care home residents during the COVID-19 pandemic April 2021

Healthwatch Nottingham & Nottinghamshire (HWNN) became aware that some friends and relatives of care home residents were having increasing problems communicating with the residents they usually visit, during the COVID-19 pandemic, when visits were either stopped or became very limited in scope.

Using an agreed short (pre-trialled) questionnaire, HWNN interviewed 21 friends and relatives of care home residents. Nottinghamshire County Council helped identify care home managers, who then promoted the survey using a specific WhatsApp group; it was also promoted through HWNN's own contacts. Further information can be accessed here.

Health and Social Care Needs of People with Long COVID August 2021

This report presents the lived experiences of people with Long COVID, identifying their ongoing symptoms and the response from health and social care services to meet their needs. It builds on the findings with recommendations to local health and social care service providers and commissioners.

The findings from the survey responses highlighted:

- When people first experienced COVID symptoms, whether they were tested and the outcome.
- The main ongoing symptoms people experienced since having COVID-19.
- How health and social care services responded to them when they first contracted COVID-19.
- The support they received since having COVID-19.
- The type of support they would like to receive to meet their healthcare needs.

Full details of the report can be accessed here.

As we emerge from the pandemic and focus on the recovery, we look to the Nottingham City Joint Health and Wellbeing Strategy April 2022 – March 2025. This strategy has recognised the renewed importance of inequalities, which have been highlighted by the pandemic. A personalised approach focussing on the community, as well as population health, is recommended. For our recovery to have the greatest impact, we also recommend an integrated recovery with a broad focus, incorporating multiple, not single sectors alone.

Here is a summary of the key learning points:

- The Community at its heart
  - A Personalised approach: The COVID-19 pandemic has demonstrated that in terms of policy, a centralised or 'one size fits all' strategy, may not be the most effective. Our communities are unique and require communication and intervention tailored to them. The vaccination programme is a good example of how we can achieve more when we work with communities and tailor our messages and approaches accordingly. While scaling solutions is sometimes incredibly important, we can often lose the 'magic' offered by passionate and influential members of our communities.

  - Co-production: Communities are fantastic assets and a rich source of volunteers, social networks and charity, faith and community groups that each play a vital role in the health of a community. The pandemic shone a light on the importance of community and how, with some support and co-ordination, communities can play an important role in supporting their most vulnerable members. Working with communities we have the opportunity to co-design and ultimately co-produce community led solutions to social and health challenges.

- Focus on inequalities:
  - Health Inequalities: The pandemic has increased the awareness of pre-existing inequalities. This awareness can open the conversation on how to address these issues and make employers, service providers, and local communities become part of the solution. The ethnic minority inequalities framework identified a need to tackle health inequalities through the lens of community, services and policy. This approach supports individuals, while recognising the need for the council to address structural inequalities and work with the neighbourhoods that are subject to them.

  - Re-Focus on financial resilience: Those worst affected by the pandemic are those on low pay, insecure employment and zero-hours contracts. As such, it is important that we re-fresh and re-invigorate our approach to financial resilience and supporting the most vulnerable in our society.

  - An inclusive workforce: A focus on inclusivity within the workforce and exploring the barriers to good employment, ensuring these are accessible to all Nottingham communities. This includes working with all businesses across the city and commencing strategic conversations about skills development, the living wage, and the role of 'anchor' institutions.

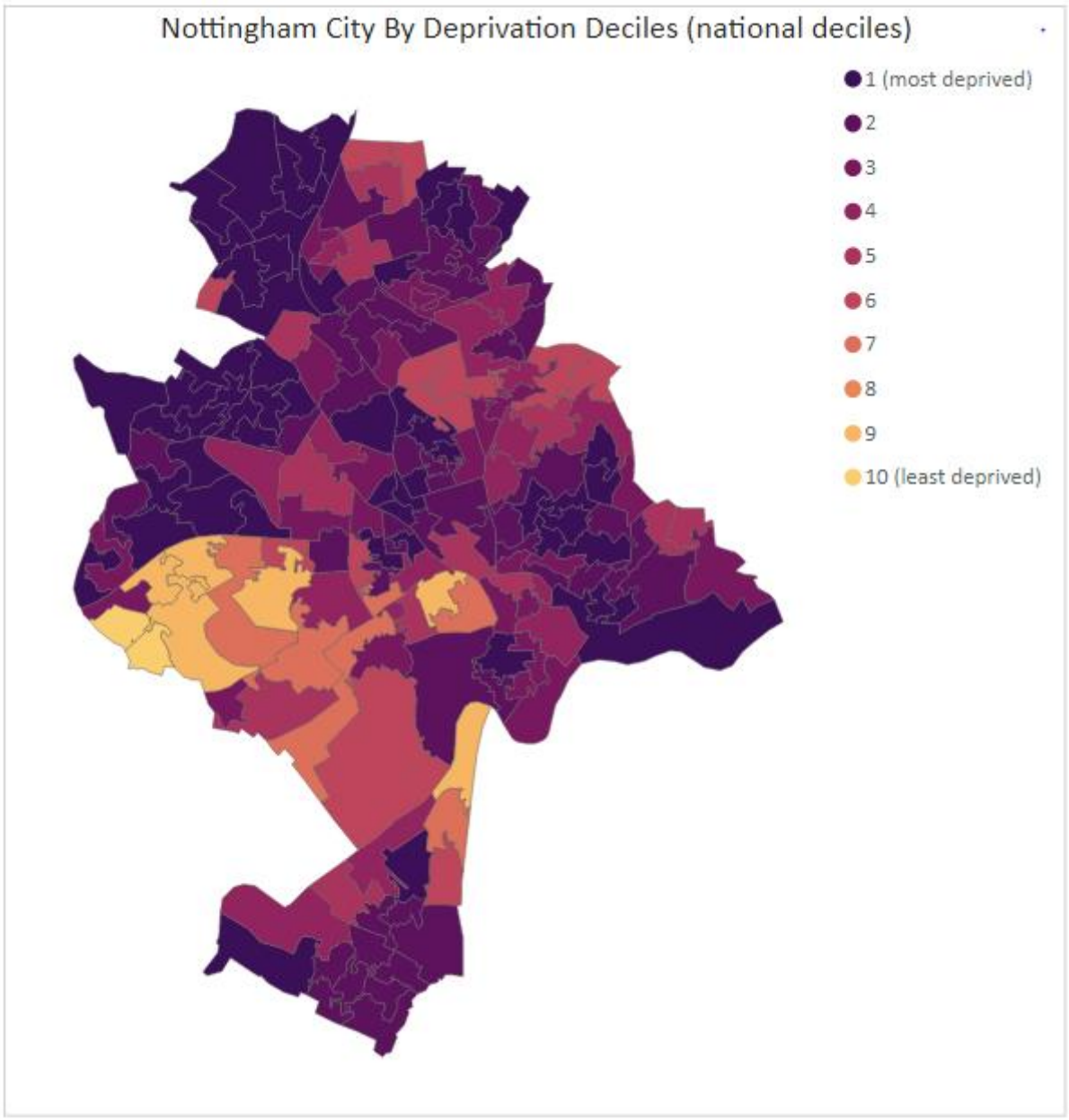
- Mental Health
  - Living through the COVID-19 pandemic has been challenging for many: people have lost loved ones, have lived in isolation, and lived with the anxiety and worry the pandemic has brought. Furthermore, some of those who have had COVID-19 have seen long-term physical impacts that have also impacted on their mental wellbeing. It is important that all our public services recognise this and integrate mental

wellbeing into their thinking. Furthermore, it is important we understand the impact this has had on the trust and relationships with public bodies and people's willingness to engage and listen to them.

- Education: It is highly likely that reduced formal pre-school attendance and school attendance and social isolation has negatively impacted school readiness and overall educational outcomes. A holistic approach to education should be adopted, centred on a recovery curriculum, a focus on emotional health and well-being and the enjoyment of, and motivation for, life-long learning. In addition, there needs to be an extra focus on children from deprived backgrounds, who may have been disproportionately affected.

- Digital delivery of services: One of the positives of the pandemic has been the way services and workplaces have adapted to the unique circumstances. In many areas this has pushed services to think creatively – we should review the approaches taken from the pandemic to keep and learn from the best examples. However, this method of delivery has not worked for everyone and we have seen 'digital exclusion' that has impacted people from across the life course due to lack of resources. The digital delivery of services also presents challenges for those with a sensory impairment or learning disability. When looking at modes of delivery we should therefore remember to begin with understanding the needs of our population to ensure polices are inclusive and support those with greatest need.

Appendix A: Map of Nottingham City by National Deprivation Deciles



Appendix A: Map of Nottingham City by National Deprivation Deciles
Source: ONS, 2019 Indices of Multiple Deprivation

Appendix B1: Demographic characteristics of cases in the 1st wave: Age and Gender (Nottingham)

Figure B1 below shows the age and gender distribution of COVID-19 cases in the 1st wave. It shows that majority of cases (12.4%) were in the most vulnerable age group, 85 years and over. Overall, 55.8% (762/1,366) were females, 35.1% (479/1,366) aged 60 years and over and 50% (683/1,366) aged between 25 and 59 years.

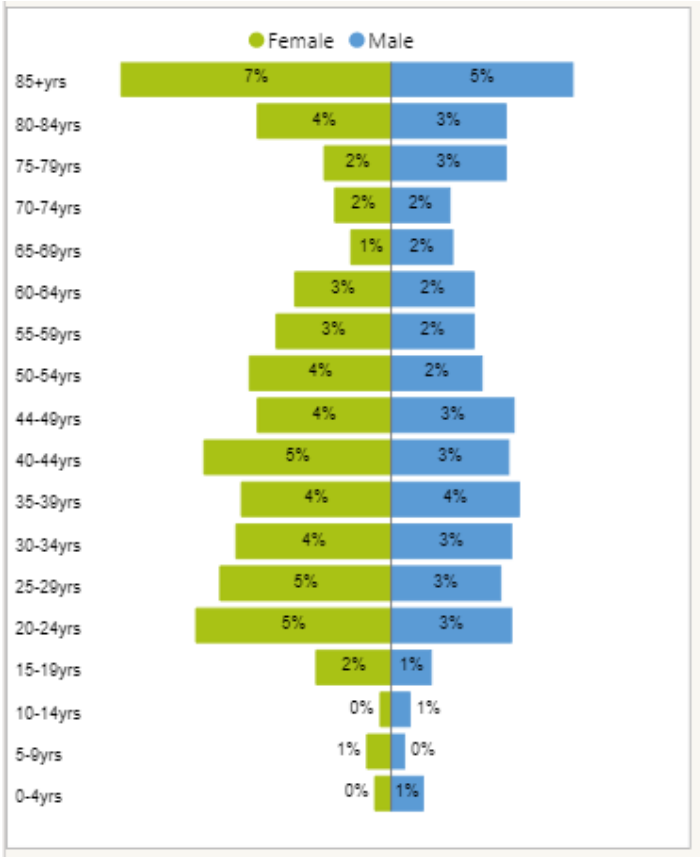


Figure B1: COVID-19 Cases, Age –Gender distribution, 28th February 2020 to 31st August 2020
Source: OHID (formerly PHE)

Appendix B2 Demographic characteristics of cases in the 1st wave: Deprivation (Nottingham)

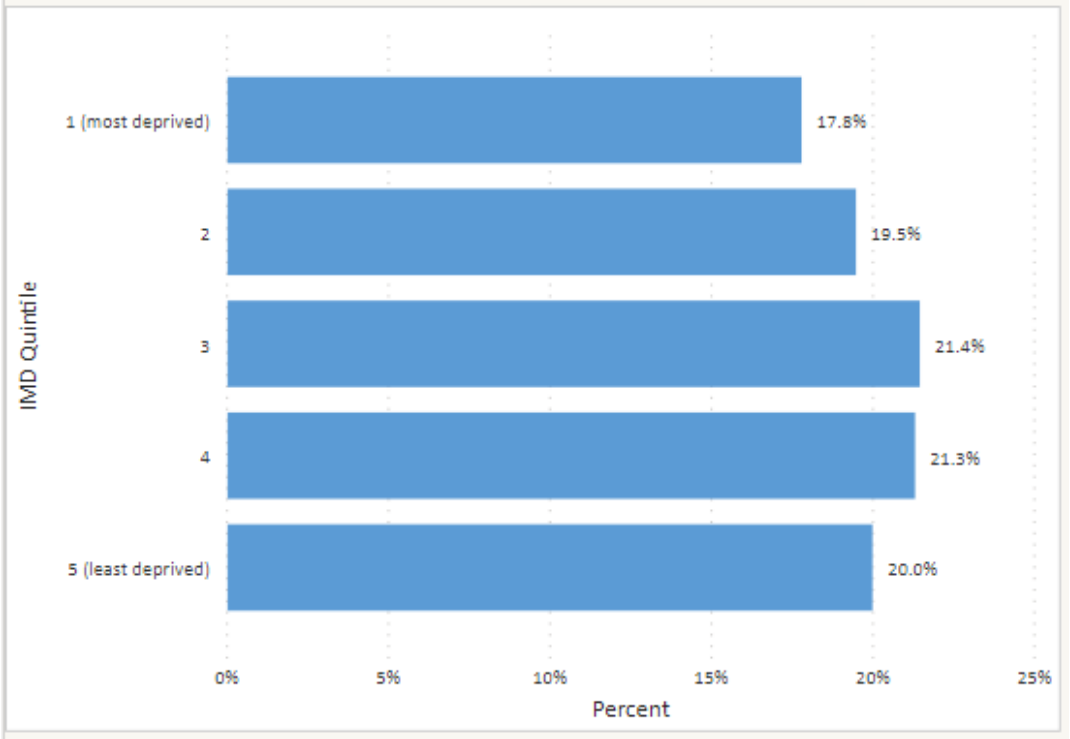


Figure B2: COVID-19 Cases by Deprivation Quintile, 28th February 2020 to 31st August 2020
Source: OHID (formerly PHE)

Appendix B4: Demographic characteristics of cases overall: Ethnicity

The figure below reveals that directly age standardised COVID-19 rate (DSR) in 'Other' ethnic group is significantly higher compared to rates in White, Black, Mixed and Asian ethnic groups. The rate ratio for COVID-19 is 8 times as high in 'Other' ethnic group as is in the 'Mixed' ethnic group and approximately 2 times as high in Asian and Black ethnic groups as is in the 'Mixed' ethnic group.

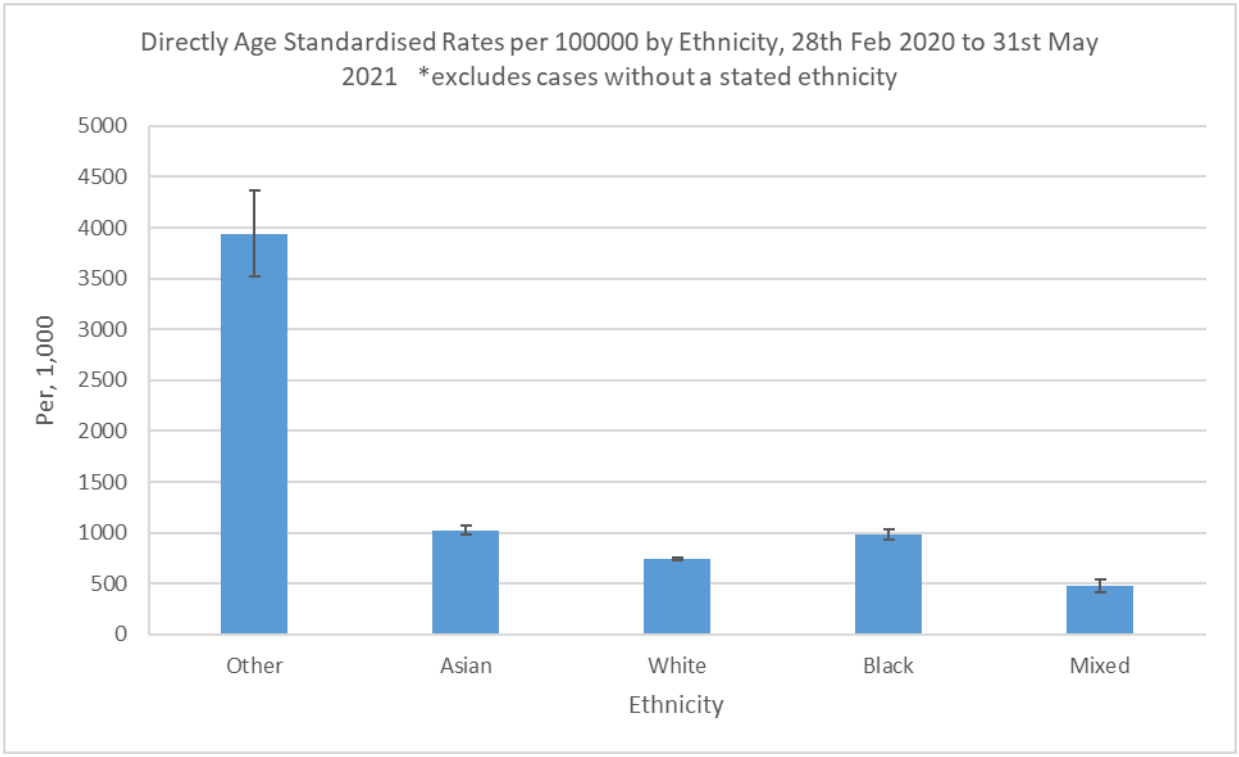


Figure B4a: COVID-19 Directly Age Standardised Rates (per 100,000 pop) by Ethnicity, 28th February 2020 to 31st May 2021

Source: OHID (formerly PHE)

Over the 15-month period (28th February 2020 to 31st May 2021), Covid-19 infection Rates were significantly higher in BAME group compared to White British ethnic group (20% higher).

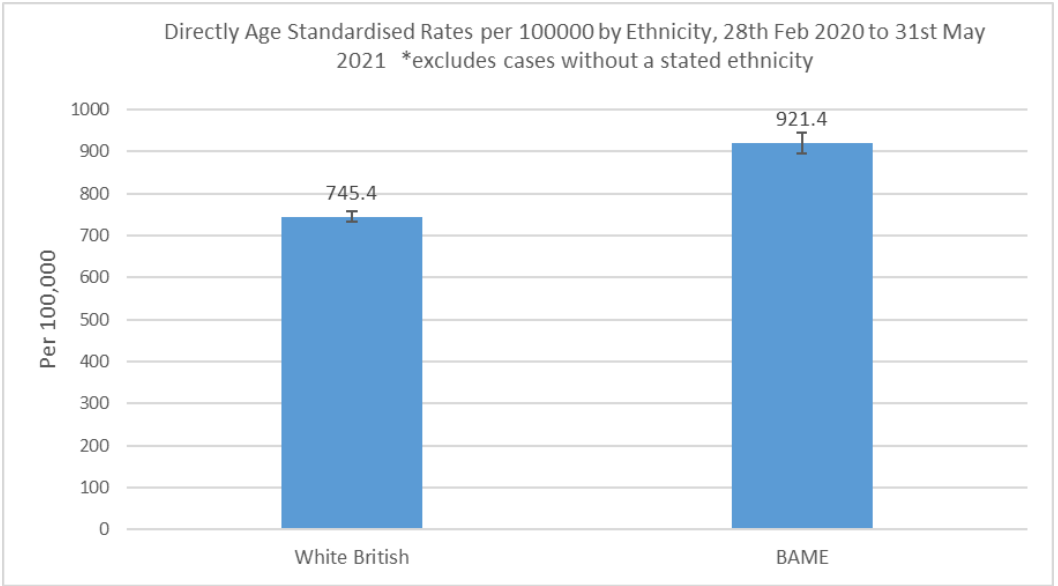


Figure B4b: COVID-19 Directly Age Standardised Rates (per 100,000 pop) by Ethnicity, 28th February 2020 to 31st May 2021

Source: OHID (formerly PHE)

Appendix B5: Demographic characteristics of cases in the 1st wave: Ethnicity

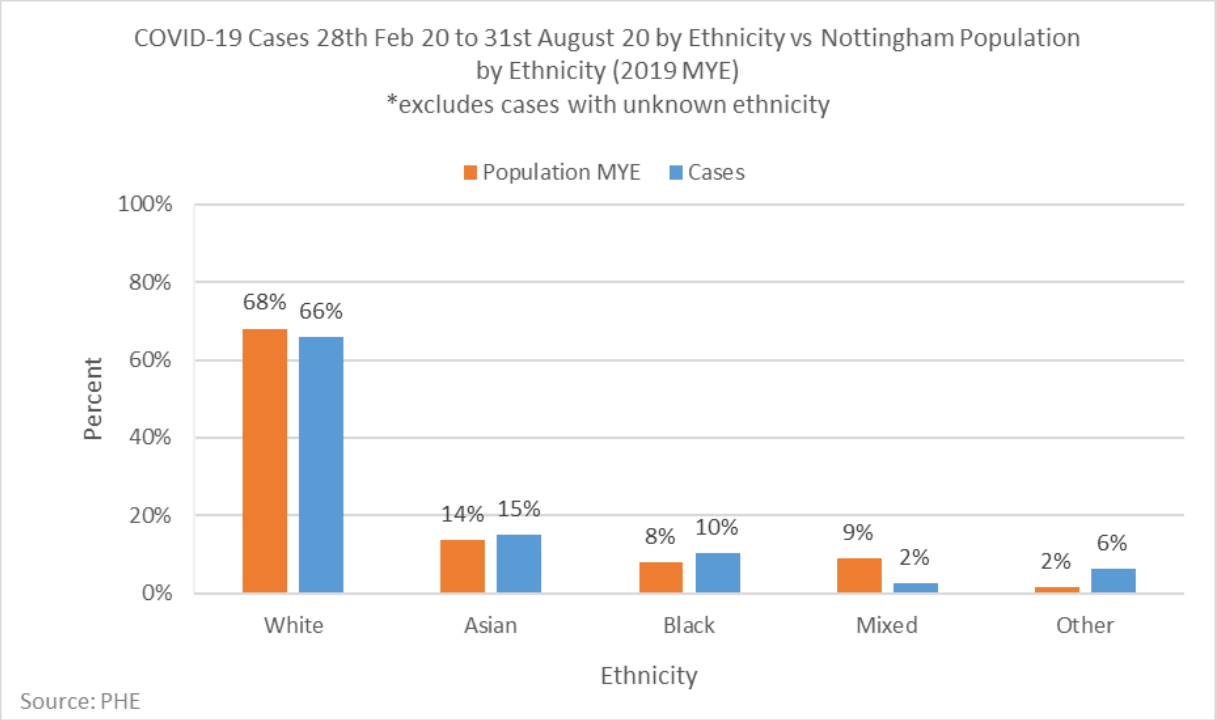


Figure B5: COVID-19 Cases by Ethnicity, 28th February 2020 to 31st August 2020
Source: OHID (formerly PHE)

Appendix C1: Demographic characteristics of cases in the 2nd and 3rd wave: Age and Gender (Nottingham)

Compared to the 1st wave, there is a stark difference in the age–gender distribution of cases with a majority of cases (37%) aged 15 to 24 years. More than half (53.7%) of all cases were females and 10.5 % (3,137/29,732) aged 60 years and above as shown in the **Figure C1** below.

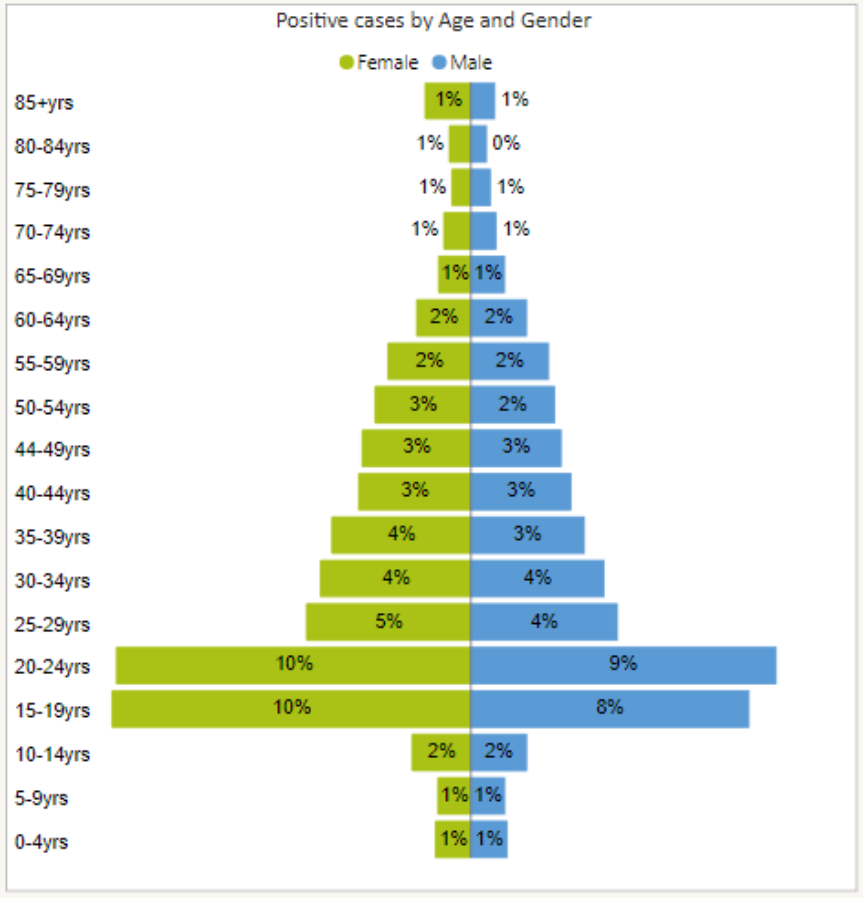


Figure C1: COVID-19 Cases, Age –Gender distribution, 1st Sept 2020 to 31st May 2021
Source: OHID (formerly PHE)

Appendix C2: Demographic characteristics of cases in the 2nd and 3rd wave: Deprivation (Nottingham)

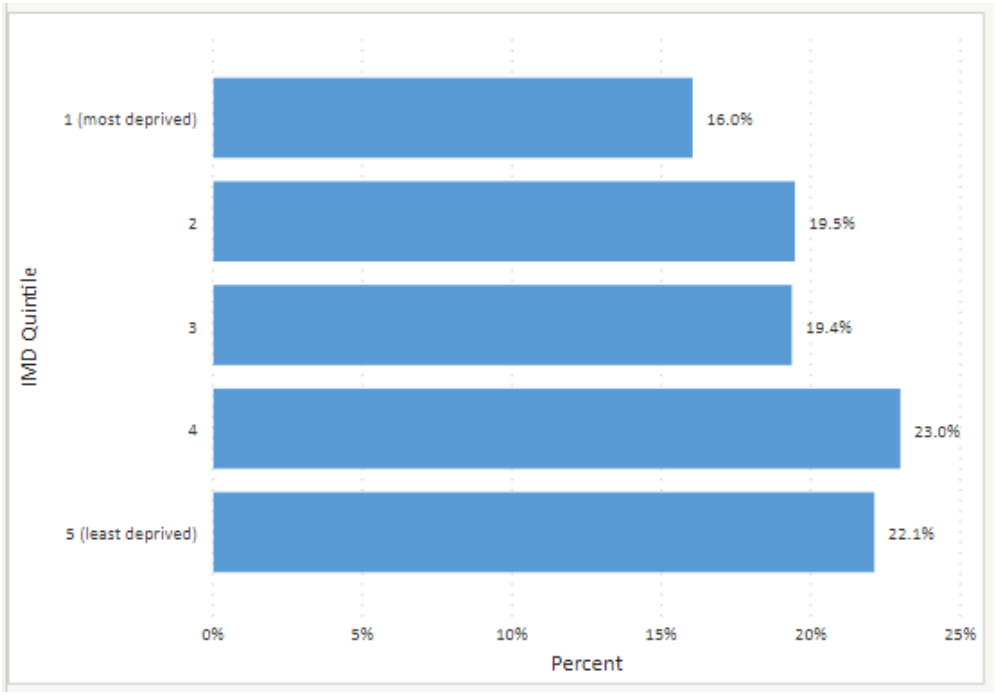


Figure C2 : COVID-19 Cases by Deprivation Quintile, 1st September 2020 to 31st May 2021
Source: OHID (formerly PHE)

Appendix C3: Demographic characteristics of cases in the 2nd and 3rd wave: Ethnicity (Nottingham)

47.9% (14,240 of 29,731) are from White British ethnic background, 28.6% (8,493) BAME and 23.5% (6998 of 29,731) without a stated ethnicity. Excluding records without a stated ethnicity, 'Other' ethnic group are overrepresented and 'Mixed' ethnic group under-represented when ethnic makeup of cases are compared to the ethnic makeup of the City as shown in **Figure C3** below.

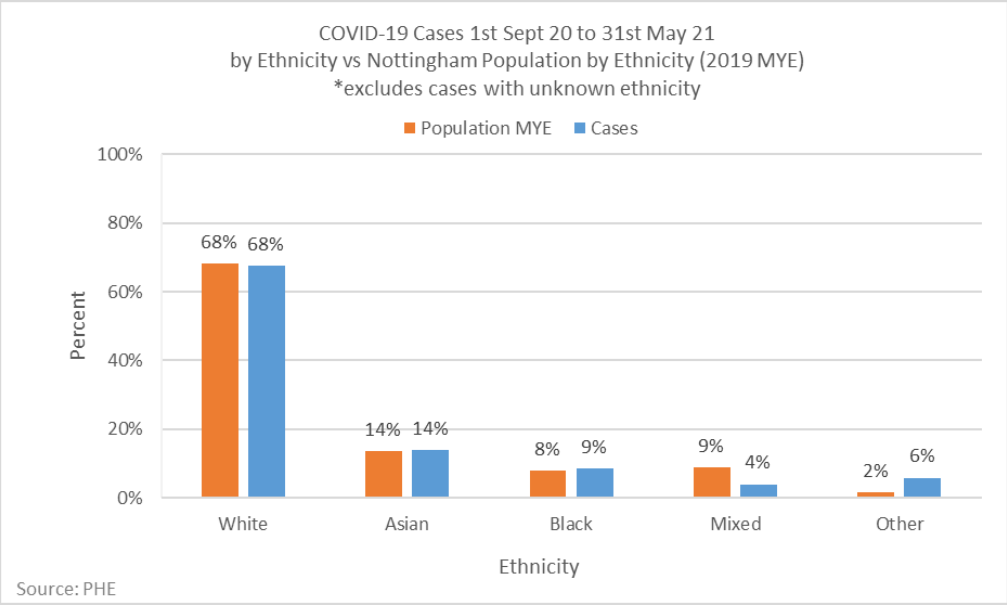


Figure C3: COVID-19 Cases by Ethnicity, 1st Sept 2020 to 31st May 2021
Source: OHID (formerly PHE)

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Nottingham City Health and Wellbeing Board
31 May 2023

Report Title:	Update from the Health Protection Board
Lead Board Member(s):	Lucy Hubber, Director of Public Health
Report author and contact details:	Tracey Lamming Public Health Principal Tracey.lamming@nottinghamcity.gov.uk
Other colleagues who have provided input:	
Executive Summary: This report is provided to the Board to provide an update on the statutory responsibilities to assure adequate protection of the health of the local population.	
Does this report contain any information that is exempt from publication? No	
Recommendation(s): The Board is asked to: Note the report	

The Joint Health and Wellbeing Strategy	
Aims and Priorities	**How the recommendation(s) contribute to meeting the Aims and Priorities:**
Aim 1: To increase healthy life expectancy in Nottingham through addressing the wider determinants of health and enabling people to make healthy decisions	Providing assurance on adequate services to protect the health of population contributes to increasing healthy life expectancy.
Aim 2: To reduce health inequalities by having a proportionately greater focus where change is most needed	
Priority 1: Smoking and Tobacco Control	
Priority 2: Eating and Moving for Good Health	
Priority 3: Severe Multiple	

Disadvantage	
Priority 4: Financial Wellbeing	
How mental health and wellbeing is being championed in line with the Board's aspiration to give equal value to mental and physical health:	

List of background papers relied upon in writing this report:	Terms of Reference and Minutes of the Board
Published documents referred to in this report:	N/A

Background

The statutory assurance role at local level for health protection sits with local government through the Director of Public Health and exercised through the Health Protection Board, reporting to the HWBB. For Nottingham and Nottinghamshire there is a joint Health Protection Board, chaired in annual rotation by a Director of Public Health. The Terms of Reference are attached for reference.

The purpose of the Health Protection Board is to:

1. Provide suitable assurance regarding outcomes and arrangements for the protection of the health of the population to Nottingham City Health and Wellbeing Board and Nottinghamshire County Health and Wellbeing Board.
2. Provide system challenge.
3. Facilitate information sharing and collaborative working between stakeholders.
4. Ensure health protection opportunities for early intervention are maximised.
5. Make recommendations for action where opportunities for improvement are identified.

Update from meeting held on 15th May 2023

Screening and Immunisation:
Screening programmes are back to BAU activity with some maintained COVID19 measures.

- Screening for Aortic Aneurysm has no performance concerns and the programme has an 86.8% uptake for 2021/22.
- Breast screening providers have moved back to timed appointments as there had been slippage in uptake, the timed appointments were having a positive impact on uptake. NHSE had provided additional staff for the programme.
- No current performance issues with the Diabetic programme.

- Cervical cancer screening programme continues to experience lower than national targets and some targeted work being undertaken.
- Work on developing demographic level data to inform targeted uptake across programmes.
- Reports on immunisation and ante-natal screening were noted.
- The Board discussed a mapping assessment of all immunisation and vaccinations groups in the City and County would provide assurance, Governance arrangements and report directly into the HP Board

Local vaccination and screening dashboard

- The City & County are developing a dashboard board to review the available data

Health protection future direction including roles & responsibilities

- A task and finish group will meet in the next few months to review current and future arrangements to enhance the culture of mutual support and work plan

UKHSA Health Protection Team update

- Measles case in the UK, there were 53 cases in 2022 and there have been 49 cases so far in 2023
- UKHSA Midlands Weekly Epidemiological Bulletin is a service to review cases and incidents of infectious diseases and available to the HP Board

Next meeting:

The next meeting of the Board in scheduled for September 2023

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Statutory Officers Report for Health and Wellbeing Board
Corporate Director of People
May 2023

Children's Integrated Services and Education

1. Volunteer for Nottingham Youth Justice Service

Nottingham Youth Justice Service (YJS) is looking for committed, caring people representing the diverse communities throughout Nottingham who are willing to give their time to challenge youth crime in the city, in the role of a Volunteer Panel Member. We hope you will take this opportunity to join the YJS as a volunteer to develop in this valuable role. Training is provided and no experience is necessary.

To find out more about the role and for an application form, please go to https://www.nottinghamcity.gov.uk/VolunteerForYJS.

Adult Social Care

2. Nottingham City Council successfully selected for CQC Pilot Assessment Scheme

Following requests from Care Quality Commission for Local Authorities to put themselves forward for the pilot assessment scheme this summer, Nottingham City Council has been selected to take part in this phase of the assurance scheme.

This is an opportunity to engage early with the new assessment framework as part of the Council's overall improvement journey, focusing on the work that we do to improve the lives of citizens in Adult Social Care. Furthermore, we will be able to provide feedback to CQC on their assessment planning and methodology as they shape the full assessment scheme when it is implemented nationwide.

By taking part in the pilot phase of the assessment scheme, we will receive a shadow rating which will be published at the end of the pilot phase with other Local Authorities. We will receive a full report detailing all the different areas of Adult Social Care, which will be integral to our future service improvement planning.

The pilot assessment will take place between now and September 2023. After September 2023, the full assessment scheme will launch with Local Authorities across England.

Catherine Underwood
Corporate Director for People
(May 2023)

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Nottingham City Health and Wellbeing Board
Work Plan 2023/24

Recurring Agenda Items	Lead Officer
Joint Strategic Needs Assessment – New Chapters	Dana Sumilo (NCC)
Joint Health and Wellbeing Strategy – Delivery Update (July, November and March)	Rich Brady (PBP)
Nottingham City Place-Based Partnership Update	Rich Brady (PBP)
Joint Health Protection Board Update	Lucy Hubber (NCC)
Board Member Updates	All Board Members
Work Plan	Governance Services (NCC)

Meeting Date	Agenda Item	Lead Officer
Wednesday 26 July 2023 1.30pm	Small Steps Big Changes Legacy Plans Public Health – annual report	Karla Capstick/David Johns Lucy Hubber (NCC)
Wednesday 29 November 2023 1.30pm	Nottingham City Safeguarding Adults Board Annual Report	Emma Coleman/Lesley Hutchinson

Potential items to be scheduled	Substance Misuse – Strategic Commissioning Review	Helen Johnston (NCC)
	Neurodiversity	
	Joint Commissioning Plan/Review	Katy Ball (NCC)

Annual Reports	Month of Reporting
Public Health – Annual Report	May

Joint Health and Wellbeing Strategy – Annual Performance Review	May
Joint Strategic Needs Assessment – Annual Report	September
Safeguarding Adults Board – Annual Report	January

Items for the Board's work plan should be forwarded to Governance Services, Nottingham City Council, constitutional.services@nottinghamcity.gov.uk.

Authors MUST discuss their proposed reports (and any supporting presentation) with Lucy Hubber (Director for Public Health, Nottingham City Council, lucy.hubber@nottinghamcity.gov.uk) before submitting the report to a Board meeting. Reports and their recommendations must be produced in the form of a formal, written document, headed by a standard cover sheet (which is available from Governance Services). Presentations to help illustrate reports must be no more than 10 minutes in length.