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NHS Nottingham City Clinical Commissioning Group

Nottingham City Council

NOTTINGHAM CITY HEALTH AND WELLBEING BOARD

Date: Wednesday, 24 July 2019

Time: 2.00 pm

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

Contact: Kate Morris, Governance Officer **Direct Dial:** 0115 8764353

e	**Nottingham City Council Director for Public Health**	
9	**MINUTES** To confirm the minutes of the meeting held on 29 May 2019	139 - 148
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11	**ACTION LOG**	151 - 154
12	**MINUTES OF THE HEALTH AND WELLBEING BOARD COMMISSIONING SUB COMMITTEE HELD ON 29 MAY 2019 (DRAFT)** For information only	155 - 156
13	**NEW JOINT STRATEGIC NEEDS ASSESSMENT CHAPTERS - AIR QUALITY AND SMOKING & TOBACCO CONTROL**	157 - 164
14	**QUESTIONS FROM THE PUBLIC** Opportunity for members of the public to ask questions relating to matters within the Health and Wellbeing Board's remit. The maximum amount of time allocated to questions and responses is 30 minutes.	

The Nottingham City Health and Wellbeing Board is a partnership body which brings together key local leaders to improve the health and wellbeing of the population of Nottingham and reduce health inequalities.

Members:

<u>Voting members</u>

Councillor Eunice Campbell-Clark (Chair)	City Council Portfolio Holder with a remit covering health
Dr Hugh Porter (Vice Chair)	NHS Nottingham City Clinical Commissioning Group representative
Councillor Cheryl Barnard	City Council Portfolio Holder with a remit covering Children's Services
Councillor Leslie Ayoola	City Councillor
Councillor Adele Williams	City Councillor
Dr Marcus Bicknell	NHS Nottingham City Clinical Commissioning Group representative
vacancy	NHS Greater Nottingham City Clinical Commissioning Partnership
Hazel Buchanan	NHS Greater Nottingham Clinical Commissioning Partnership
Alison Michalska	City Council Corporate Director for Children and Adults

Catherine Underwood	City Council Director of Adult Social Care
Alison Challenger	City Council Director of Public Health
Sarah Collis	Healthwatch Nottingham representative
Samantha Travis	NHS England representative

Non-voting members

Lyn Bacon	Nottingham CityCare Partnership representative
Tracy Taylor	Nottingham University Hospitals NHS Trust representative
Hazel Johnson	Nottinghamshire Healthcare NHS Foundation Trust representative
Gill Moy	Nottingham City Homes representative
Ted Antill	Nottinghamshire Police representative
vacancy	Department for Work and Pensions representative
Leslie McDonald	Representing interests of the Third Sector
Jane Todd	Representing interests of the Third Sector
Craig Parkin	Nottinghamshire Fire and Rescue Service representative
Andy Winter	Nottingham Universities representative
Ian Curryer	City Council Chief Executive

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.

QUESTIONS FROM THE PUBLIC: WHILE IT IS NOT NECESSARY TO DO SO, SUBMITTING A QUESTION IN ADVANCE WILL ENABLE THE BOARD TO PROVIDE AS FULL A RESPONSE AS POSSIBLE. QUESTIONS SHOULD BE SUBMITTED TO CONSTITUTIONAL.SERVICES@NOTTINGHAMCITY.GOV.UK THE ACCEPTANCE OF QUESTIONS AT THE MEETING IS AT THE DISCRETION OF THE CHAIR AND ANY INAPPROPRIATE QUESTIONS, FOR EXAMPLE THOSE THAT ARE OUTSIDE THE REMIT OF THE BOARD OR VEXATIOUS WILL NOT BE CONSIDERED.

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HEALTH AND WELLBEING BOARD

24th July 2019

	Report for Action
Title:	Sexual Health Themed Report
Lead Board Member(s):	Alison Challenger
Author and contact details for further information:	Uzmah Bhatti, Public Health Insight Manager
Brief summary:	This report provides the board with an update on the Nottingham City Council mandatory duty to provide sexual health services.

Recommendation to the Health and Wellbeing Board:

The Health and Wellbeing Board is asked to:

- Conduct a sexual health commissioning review to ascertain if and where there are any gaps between local need and provision.
- Aim to protect the sexual health budget from further cuts.
- Health and Wellbeing Board to consider guidance in the House of Commons Health and Social Care Committee report on Sexual Health and identify long term opportunities around integrating commissioning of services mentioned in Figure 9.
- Support the RSE agenda mandatory roll-out and continue to work together to overcome challenges and resistance by addressing local people's concerns.
- Support recommendations from the Teenage pregnancy JSNA chapter upon completion later this year.

Contribution to Joint Health and Wellbeing Strategy:	
Health and Wellbeing Strategy aims and outcomes	**Summary of contribution to the Strategy**
Aim: To increase healthy life expectancy in Nottingham and make us one of the healthiest big cities	Reducing the prevalence of poor sexual health outcomes and improving the sexual health in the city's population is vital to achieve the Health and Wellbeing Board's ambition to improve healthy life expectancy and reduce health inequalities. Sexual health promotion and education empowers children, adults and vulnerable people with the knowledge and skills to have safe relationships and protect themselves from harm, exploitation and unwanted pregnancy. Open access to a choice of contraception
Aim: To reduce inequalities in health by targeting the neighbourhoods with the lowest levels of healthy life expectancy	
Outcome 1: Children and adults in Nottingham adopt and maintain healthy lifestyles	
Outcome 2: Children and adults in Nottingham will have positive mental wellbeing and those with long-term mental health problems will have good physical health	
Outcome 3: There will be a healthy culture in Nottingham in which citizens are supported	

and empowered to live healthy lives and manage ill health well	and early abortion services prevents unplanned pregnancy and late abortions which can have a detrimental impact on women and their families. Timely and effectively targeted STI and HIV testing reduces the risk of years of life lived with ill health and increases life expectancy.
Outcome 4: Nottingham's environment will be sustainable – supporting and enabling its citizens to have good health and 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
Vulnerable people with poor mental health may not be able to exercise choice in relationships thus being more at risk of STIs and unplanned pregnancies and repeat abortions as well as reinfections. Targeted outreach and health promotion work with such groups aims to enable healthy and safe intimate relationships. Psycho sexual counselling is provided for people whose mental wellbeing may have been affected by their sexual lifestyles.

Background papers: *Documents which disclose important facts or matters on which the decision has been based and have been relied on to a material extent in preparing the decision. This does not include any published works e.g. previous Board reports or any exempt documents.*	

Themed Report to Health and Wellbeing Board July 2019: Sexual Health

1. Introduction

Sexual health is defined by the World Health Organisation as:

> '*a state of physical, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled*'.[1]

Sexual health is an important and wide-ranging area of public health. Sexual health is a broader topic than sexually transmitted infections and includes areas such as contraception, termination of pregnancy (abortion), healthy relationships, sexual assault and the wider reproductive health of citizens. Good sexual health is an important aspect of health and wellbeing and it is vital that citizens have the information, confidence and the means to make choices that are right for them. It helps people to develop positive relationships and enables them to protect themselves and their partners from infections and unintended pregnancies that can have a long-term detrimental impact on an individual.

Some groups within the population are at higher risk of poor sexual health. The highest burden of sexually related ill-health is borne by groups who often experience other inequalities in health, including young people, men who have sex with men, black and minority ethnic groups, people with diverse gender identities and those living in socio-economically deprived areas. These groups often experience additional stigma, discrimination and obstacles in accessing services, which can further affect their sexual health.

2. National and local picture

2.1 Relationships and Sex Education

Relationships and sex education (RSE) is learning about the emotional, social and physical aspects of growing up, relationships, sex, human sexuality and sexual health. Good quality RSE equips children and young people with the information, skills and positive values to have safe, fulfilling relationships, to enjoy their sexuality and to take responsibility for their sexual health and well-being.

From September 2020, there is a requirement that all secondary schools in England will teach RSE and the introduction of the new subject of 'relationships education' in primary school. Sex education will still be an optional element at primary level. There is also a new compulsory subject called health education, which includes preparing children for the changes of adolescence before onset. Parents and carers will still have the option to

[1] Department of Health. (2013) *A Framework for Sexual Health Improvement in England*. Available at: https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england [Accessed 16.07.18]

withdraw their child/ren from sex education, at both primary and secondary school, up until three terms before a child's 16th birthday when they can choose for themselves whether to attend sessions.

The Nottingham RSE Charter was launched in 2016 as a way of ensuring equity of RSE provision in schools. So far, 82 schools (80% of total schools) have signed the Charter to show their commitment to Relationships and Sex Education, with 37 at level 3 (45% of signed up schools) which is where the school has deemed itself to be providing effective provision. The Charter is to be refreshed to re-energise schools in the lead-up to statutory RSE 2020.

Public health funds an RSE consultant to work with schools on policy and programme development focusing on knowledge and skills to enable pupils to make informed decisions about sexual health issues. The work includes sessions for parents, networks, staff training, lesson modelling and resource development. A School Health Improvement Coordinator delivers a range of awareness training for staff in educational settings in addition to direct work with pupils and the NUH outreach team deliver RSE to vulnerable young people in a range of settings. An annual RSE Day celebrating good practice is held on the last Thursday in June each year.

2.2 Teenage pregnancy (TP)

In England, the calculation of teenage pregnancy statistics include under-18 conceptions that lead to a legal termination of pregnancy or birth. Teenage pregnancy is an issue of inequality as early parenthood is associated with poor health, wellbeing and wider life chances such as education and economic outcomes as well as increased levels of social exclusion, for both teenage parents and their children.[2]

Action to reduce unplanned teenage pregnancy and support teenage parents has been a local and national priority since 1998. During this time, teenage pregnancy rates have continued to fall, both locally and nationally.

In Nottingham in 2017, the most recent available annual conception data, there was a decrease of two conceptions from 127 in 2016 to 125 in 2017 in the under-18 (15-17) age group. This represents a rate reduction from 26.9 conceptions per 1000 girls aged 15-17 in 2016 to 26.5 in 2017. The rate reduction is illustrated in Figure 1.

[2] Hadley, A, Chandra-Mouli, V and Ingham, R (2016) *Implementing the United Kingdom government's 10-year teenage pregnancy strategy for England (1999-2010): applicable lessons for other countries Journal of Adolescent Health* March pages 1-7.

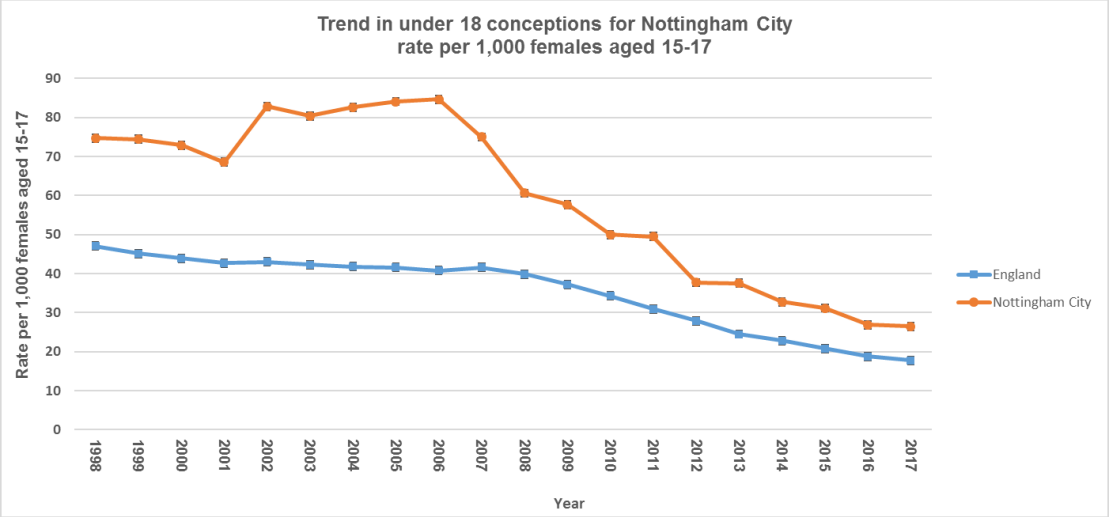

Figure 1: Teenage Conception Rate trends, 1998 - 2017
Source: Office for National Statistics (2019) [Dataset of conception statistics, England and Wales 2017]

However, Nottingham's under-18 conception rate is still higher than the England average rate of 17.8 conceptions per 1000 girls aged 15-17 in 2017 and the Core Cities average rate of 23.4 per 1000. The England average remains higher than in other Western European countries. Nationally 80% of under-18 conceptions are to 16 and 17 year olds and around 20% are to under-16s.

2.3 Contraception

Contraception is a highly cost-effective intervention, which plays an important public health role in improving the lives of individuals, families and communities.[3] Open access to a choice of contraception can prevent financial and social costs associated with unplanned births and terminations of pregnancy. A number of different contraceptive options are available, including short acting method such as pills, patches and rings and long acting reversible contraceptives (LARCs, these include the implant and 'coils'), barrier methods such as male and female condoms and diaphragms, and emergency contraception.

The rate of LARCS amongst women of all ages in Nottingham in 2017 was 54 per 1000, this was one of the best amongst comparators. LARCs accessed via GP were slightly lower than the national rate whilst those accessed at sexual health clinics was significantly higher than most comparators. User dependent contraception choices were similar to the national rate and the average rate of comparators (Figure 2).

[3] The Faculty of Sexual and Reproductive Healthcare, *A Quality Standard for Contraceptive Services* 2014, http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf

Indicator	Period	England	Neighbours average	3 - Leicester	11 - Sandwell	10 - Wolverhampton	4 - Salford	6 - Coventry	2 - Liverpool	8 - Sheffield	12 - Stoke-on-Trent	14 - Sunderland	7 - Southampton	5 - Kingston upon Hull	1 - Newcastle upon Tyne	Nottingham	15 - Derby	13 - Plymouth	9 - Bristol
Total prescribed LARC excluding injections rate / 1,000	2017	47.4	47.7*	25.8	32.4	37.5	38.9	42.3	43.3	43.4	46.0	49.8	49.9	53.2	53.7	54.0	62.4	64.2	68.1
GP prescribed LARC excluding injections rate / 1,000	2017	29.2	25.2*	7.5	3.5	20.1	14.4	25.8	13.1	36.6	22.0	15.9	26.1	3.0	30.0	27.2	42.1	40.1	54.4
SRH Services prescribed LARC excluding injections rate / 1,000	2017	18.2	22.5*	18.3	28.9	17.4	24.5	16.5	30.2	6.8	24.0	33.9	23.8	50.3	23.6	26.8	20.3	24.2	13.6
Under 25s choose LARC excluding injections at SRH Services (%)	2017	21.6	24.4*	29.6	17.0	34.1	21.0	34.0	14.0	27.8	23.3	27.9	40.2	33.1	27.5	27.7	36.3	25.1	22.7
Over 25s choose LARC excluding injections at SRH Services (%)	2017	38.0	41.7*	37.4	40.5	56.0	38.1	59.6	26.1	54.9	33.2	45.4	58.7	47.5	47.7	43.4	56.0	49.3	40.0
Women choose injections at SRH Services (%)	2017	9.6	10.0*	5.4	13.1	7.3	11.7	6.9	11.1	5.4	10.1	18.2	6.4	13.4	9.2	6.6	5.2	9.9	8.6
Women choose user-dependent methods at SRH Services (%)	2017	60.6	57.4*	60.5	56.8	44.2	58.6	45.4	69.7	57.2	61.5	44.4	44.0	46.5	56.1	58.7	49.0	54.5	61.8
Women choose hormonal short-acting contraceptives at SRH Services (%)	2017	45.3	42.9*	28.5	39.2	33.8	40.6	32.3	54.6	46.5	53.9	39.0	32.4	35.7	43.7	45.1	33.5	38.1	47.1

Figure 2: Contraception uptake rates. Source: Public Health Outcomes Framework

In 2018, just over 17,000 Nottingham city residents attended sexual health[4] services including outreach services. Approximately, 7% (n1,928) of attendees were aged 13-17 (75% female, 25% male). 75% of all people in this age group attended for contraception (excluding condoms) with around 10% being for emergency contraception.[5]

Clients received a range of other services including sexual health screening, pregnancy testing, termination of pregnancy counselling and other specialist counselling. Figure 3 shows the number of girls aged 11-17 years at ward level and the number of attendances at sexual health services. It should be noted that many girls choose to attend a clinic away from where they live to protect their anonymity.

[4] STI and contraception services
[5] Sexual & Reproductive Health Activity Dataset 2018

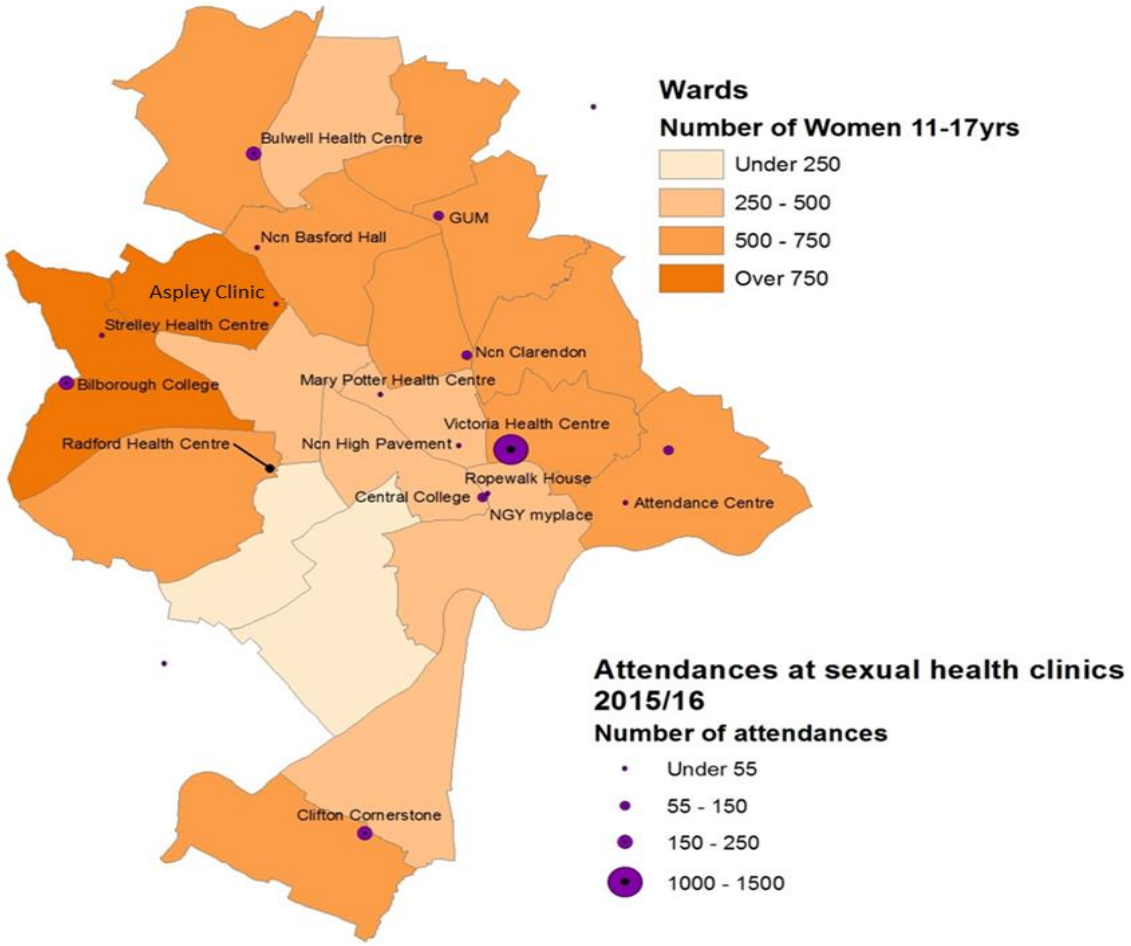

Figure 3: Attendances at health clinics across Nottingham's wards. Source: Nottingham City Council Service monitoring data.

In 2019, 29 out of 68 Nottingham pharmacies are signed up to provide free emergency hormonal contraceptive (EHC) to females aged between 13 and 25 years in order to reduce levels of unplanned pregnancy. There is an even geographical spread of pharmacies offering this service across the city.

2.4 Abortion/Termination of pregnancy (ToP)

Conceptions that are not planned may continue and become wanted, however many end in termination.

Termination of pregnancy services include counselling and support whilst making a decision, counselling and support after a decision to terminate a pregnancy has taken place and further counselling and support about their decision when a young person has decided to have a termination. Depending on the number of weeks pregnant the citizen is, the pregnancy is ended either by taking medication or by having a surgical procedure. Repeat

and late terminations may be an indicator of social complexities. Late terminations have additional associated medical and health risks and costs.

The abortion rate in Nottingham in 2017 (14.5/1000 women) was significantly lower that most comparators as was the proportion of women under 25 having repeat abortions (19.1%) indicating good access to contraception and exercise of choice of when to become pregnant. Early abortions were however lower than comparators and more women opting for a surgical procedure than in most other cities (Figure 4). A local audit of abortion services in 2018 suggested that late and/or surgical abortions can be an indicator of patient choice.

Indicator	Period	England	Neighbours average	Nottingham	1 - Newcastle upon Tyne	2 - Liverpool	3 - Leicester	4 - Salford	5 - Kingston upon Hull	6 - Coventry	7 - Southampton	8 - Sheffield	9 - Bristol	10 - Wolverhampton	11 - Sandwell	12 - Stoke-on-Trent	13 - Plymouth	14 - Sunderland	15 - Derby
abortion (%) New data	2017	52.0	42.1*	27.8	36.0	53.4	41.5	53.8	36.4	45.4	46.0	42.9	45.7	38.1	44.9	33.0	46.3	33.0	41.5
Under 18s abortions rate / 1,000	2017	8.4	9.8*	6.7	7.7	13.3	8.4*	14.7	10.0	12.8	13.6	8.2	5.2	11.2	12.6	8.2	10.6	8.0	7.4
Under 25s repeat abortions (%)	2017	26.7	26.1*	19.7	22.3	30.2	23.9*	30.6	20.8	27.8	26.2	24.4	24.3	28.5	32.4	32.7	22.1	19.1	22.3
Abortions under 10 weeks (%)	2017	76.6	75.7*	71.1	75.2	76.8	74.9*	82.0	74.5	67.7	79.5	74.8	79.0	68.9	69.9	83.4	83.6	79.5	76.8
Total abortion rate / 1000	2017	17.2	17.5*	14.5	14.1	21.3	17.2*	25.6	15.2	19.9	18.7	12.4	14.4	23.3	23.3	20.9	16.2	12.5	16.6
Under 25s abortion after a birth (%)	2017	26.7	29.3*	27.4	23.5	25.9	27.2*	27.8	37.1	29.9	25.1	28.3	17.8	35.3	36.6	39.9	26.9	34.4	39.3
Over 25s abortion rate / 1000	2017	15.0	15.9*	14.5	14.2	19.3	17.0*	21.4	12.1	18.1	18.6	10.8	13.5	21.1	19.9	18.8	13.7	10.4	14.0
Abortions under 10 weeks that are medical (%)	2017	79.4	77.2*	65.0	89.6	92.8	86.7*	83.3	59.7	80.9	83.5	81.5	63.6	80.9	77.3	77.6	50.9	80.1	49.2

Figure 4: Termination of pregnancy. Source: Public Health Outcomes Framework

Of the 125 under-18 conceptions in Nottingham during 2017, 27.8% led to a termination, the lowest rate in England; this equated to the termination of 35 conceptions in Nottingham. This is not a statistically significant change from 1998 when the under-18 termination rate in Nottingham was 28.4%. This proportion of conceptions resulting in termination is significantly lower than the 2017 England average under-18 termination rate of 52%.

32% of under-16 conceptions in Nottingham in 2017 led to a termination compared to the national average of 60.5%, only Sheffield and North-East Lincolnshire have lower termination rates than Nottingham in this age-group. Further investigation is necessary to establish any potential reasons for these variations in the under-16 conception and termination rates as under-16 year old conceptions are not reducing as rapidly as in the 15-17 year old cohort.

2.5 Sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV)

STIs are passed from one person to another through unprotected sex or genital contact and can exist without symptoms for long periods.

Some highly prevalent STIs are of particular concern. Chlamydia is the most common STI in the UK and is transmitted easily during sex. Most people do not experience any symptoms, so they are unaware they are infected. Genital warts are caused by the human papilloma

virus (HPV) and are the second most common STI in England after Chlamydia. Gonorrhoea and Syphilis are bacterial STIs which are easily transmitted during sex; they are highly infectious but present very few symptoms in the early stages. Mycoplasma Genitalium (Mgen) has recently been identified as a cause for concern as it is appears to cause similar problems to Chlamydia, but is not routinely tested for at present in most services.

Diverse sexual lifestyles, the growing use of drugs during sex with multiple casual partners (chemsex) and infections that do not respond to general antibiotics (antimicrobial resistance) present challenges to managing the sexual health of the population. Reinfection with an STI within a 12-month period is also of concern and is an indicator of risk taking sexual lifestyles, therefore, preventing STI reinfection continues to be a priority.

In England, in 2018, there were 447,694 diagnoses of sexually transmitted infections (STIs) a 5% increase since 2017. Specifically there were:

- 56,259 diagnoses of Gonorrhoea reported in 2018, a 26% increase since 2017. There were three cases of extensively drug resistant *Neisseria Gonorrhoeae* identified in England in 2018.
- 7,541 diagnoses of Syphilis reported in 2018, a 5% increase since 2017.
- First episode genital warts in 15 to 17 year old young girls and heterosexual boys continued to decline largely due to the National HPV Immunisation programme.
- Chlamydia testing amongst 15 to 24 year olds declined, in 2018. However, the proportion of people testing positive increased, suggesting testing is being targeted appropriately.
- Whilst still significantly lower rates of diagnoses than younger age groups, the largest proportional increase in Chlamydia and Gonorrhoea between 2017 and 2018 was seen in people 65 years and older.
- The population diagnosis rates of syphilis, gonorrhoea and chlamydia are greatest in HIV-diagnosed MSM.

The impact of STIs remains greatest in young heterosexuals 15 to 24 years, black ethnic minorities and gay, bisexual and other men who have sex with men (MSM).

Nottingham has one of the highest STI testing rates (excluding Chlamydia) in the country, this paired with effective targeting of high risk groups has resulted in increased likelihood of detection. There has been no significant change in the STI diagnosis rate in recent years and Nottingham remains amongst the highest in line with comparators. Figure 5 compares Nottingham with the national average as well as similar cities (CIPFA Neighbours[6]).

[6] *Chartered Institute of Public Finance and Accountancy 'Nearest Neighbours' model Developed to aid local authorities in comparative and benchmarking exercises, the models provide a wide range of SSA based, socio-economic indicators upon which the specific family group is calculated*.

Indicator	Period	England	Neighbours average	Nottingham	2 - Liverpool	1 - Newcastle upon Tyne	4 - Salford	9 - Bristol	3 - Leicester	15 - Derby	13 - Plymouth	7 - Southampton	10 - Wolverhampton	12 - Stoke-on-Trent	11 - Sandwell	6 - Coventry	8 - Sheffield	5 - Kingston upon Hull	14 - Sunderland
New STI diagnoses (exc chlamydia aged <25) / 100,000	2018	851	910*	1003	1123	946	1237	1147	649	790	995	1227	960	623	809	878	652	869	662
STI testing rate (exc chlamydia aged <25) / 100,000	2018	18053	17724*	22272	21386	20855	20421	20413	18219	18201	17854	17490	16937	16335	16099	15215	14974	11877	11836
STI testing positivity (exc chlamydia aged <25) %	2018	2.3	2.4*	2.4	2.3	2.0	3.5	2.4	1.9	1.9	2.1	3.4	3.0	2.0	2.8	2.1	2.3	2.6	2.3

Figure 5: STI testing and detection rates (exc. Chlamydia). Source: Public Health Outcomes Framework 2019

In Nottingham, there was a statistically significant increase in Gonorrhoea diagnosis in 2018, which was higher than statistical neighbours and the England average. Based on local data, Gonorrhoea incidence was higher in males than females, with more than twice as many males aged over 25 years being diagnosed than females. Syphilis rates in 2018 were similar to the national rate, after seeing a significant and continuing decline since the 2016 exceedance, diagnoses were more prevalent in men aged 25-34. Genital warts in people of all ages remained higher than statistical neighbours and England average, as in previous years. Local data suggests that most diagnoses were in the 20-24 age group. A high detection rate for Chlamydia is desirable, in that it represents early detection and prevention of STIs. In 2018, Nottingham had a detection rate for Chlamydia amongst 15 to 24 year olds similar to the national rate. There has been a statistically significant drop in this in line with a decrease in the proportion of 15 to 24 year olds screened (Figure 6). Local data shows that Chlamydia diagnoses were around three times higher in males aged 45-64 than females in the same age group.

Indicator	Period	England	Neighbours average	Nottingham	2 - Liverpool	1 - Newcastle upon Tyne	4 - Salford	9 - Bristol	3 - Leicester	15 - Derby	13 - Plymouth	7 - Southampton	10 - Wolverhampton	12 - Stoke-on-Trent	11 - Sandwell	6 - Coventry	8 - Sheffield	5 - Kingston upon Hull	14 - Sunderland
Syphilis diagnostic rate / 100,000	2018	13.1	12.0*	12.8	17.1	11.2	30.6	12.8	7.9	4.7	6.5	30.5	6.2	16.1	8.0	8.1	9.5	8.4	5.4
Gonorrhoea diagnostic rate / 100,000	2018	98.5	108.9*	182.3	129.6	131.5	179.0	88.0	85.4	93.0	81.3	130.0	142.7	62.3	106.3	92.7	91.9	87.1	74.7
Chlamydia detection rate / 100,000 aged 15-24 <1900 1900 to <2300 ≥2300	2018	1975	1985*	1928	2557	1872	2477	1981	1934	2226	2350	2522	2165	1754	1698	1482	1609	1838	1651
Chlamydia detection rate / 100,000 aged 15-24 (Male)	2018	1336	1326*	1284	1864	1281	1701	1221	1238	1364	1607	1549	1334	1307	1149	944	1062	1408	1198
Chlamydia detection rate / 100,000 aged 15-24 (Female)	2018	2620	2628*	2578	3157	2485	3266	2720	2657	2782	3163	3177	3051	2241	2299	2087	2187	2302	2123
Chlamydia proportion aged 15-24 screened	2018	19.6	19.0*	18.3	24.9	21.8	23.6	26.8	16.3	15.9	24.0	20.3	13.5	18.8	11.4	13.5	18.0	10.0	16.6
Chlamydia diagnostic rate / 100,000	2018	384	485*	635	619	517	600	562	485	426	510	764	440	348	371	376	408	369	293
Chlamydia diagnostic rate / 100,000 aged 25+	2018	213	245*	321	277	218	378	353	219	184	221	394	258	184	252	176	197	162	131
Genital warts diagnostic rate / 100,000	2018	100.1	121.2*	149.1	168.9	167.3	138.1	163.5	84.0	97.7	163.8	159.3	69.3	81.1	71.6	119.7	92.2	108.6	81.5

Figure 6: STI rates direction of change. Source: Public Health Outcomes Framework 2019

2.5.1 Human Immunodeficiency Virus (HIV)

HIV has now become a long-term condition rather than a fatal infection meaning that timely diagnosis can enable those with HIV to live disability free and for longer. Antiretroviral therapy (ART), improved HIV testing uptake at STI clinics and access to HIV Pre-exposure prophylaxis (PrEP) has led to a reduction in new HIV diagnoses amongst men who have sex with men (MSM) as one of the highest risk groups for HIV for the first time. However, national reporting indicates that guidelines around MSM being tested for HIV every three months were not universally followed and in 2017, 77% of MSM testing positive for a HIV test had not been tested in the preceding 12 months.[7] Nationally, there is a suggestion that some BME groups at high risk of HIV are increasingly declining the offer of HIV tests.[8] There is also a suggestion that HIV positive MSM are being increasingly diagnosed new STIs such as Chlamydia and Gonorrhoea, this may be due to increased condomless sexual contact associated with the use of PrEP or that this group may be more likely to engage in risk taking behaviours.

In Nottingham, 716 people were living with HIV in 2017, which is amongst the highest when compared to similar cities. 42% of all diagnoses were classed as late which is in line and better when compared to similar cities. New diagnoses rate of HIV amongst those aged 15 and over in Nottingham was amongst the highest at 18.1 per 100,000. The national rate was 8.7 per 100,000. The HIV testing coverage amongst the eligible population in Nottingham was amongst the highest in line with comparators (Figure 7).

Indicator	Period	England	Neighbours average	Nottingham	2 - Liverpool	1 - Newcastle upon Tyne	4 - Salford	9 - Bristol	3 - Leicester	15 - Derby	13 - Plymouth	7 - Southampton	10 - Wolverhampton	12 - Stoke-on-Trent	11 - Sandwell	6 - Coventry	8 - Sheffield	5 - Kingston upon Hull	14 - Sunderland
Chlamydia aged <25) %																			
HIV testing coverage, total (%)	2018	64.5	62.8*	71.8	72.4	56.1	47.5	72.6	52.4	71.0	62.2	63.7	67.3	53.6	42.5	72.2	81.9	63.0	76.9
HIV testing coverage, MSM (%)	2018	87.8	88.1*	86.6	92.9	91.8	83.7	87.7	89.0	87.5	91.4	80.0	90.3	87.5	82.7	89.1	91.5	82.8	87.4
HIV testing coverage, women (%)	2018	55.2	53.6*	64.1	65.8	45.1	33.9	66.2	44.1	62.0	56.1	56.2	57.8	43.6	33.1	68.7	78.4	59.4	72.6
HIV testing coverage, men (%)	2018	78.4	76.4*	80.6	79.4	75.8	70.2	79.4	66.9	85.2	71.1	75.0	84.5	73.9	68.6	76.7	84.9	68.0	81.8
HIV late diagnosis (%) <25% 25% to 50% ≥50%	2015 - 17	41.1	47.7*	42.0	48.5	39.1	46.2	49.0	56.9	41.7	39.5	49.2	49.4	46.7	56.1	55.1	41.2	56.5	38.2
New HIV diagnosis rate / 100,000 aged 15+	2017	8.7	11.2*	18.1	13.6	11.3	16.2	12.4	13.5	11.2	6.9	12.0	16.3	7.8	14.1	10.2	6.9	6.1	3.9
HIV diagnosed prevalence rate / 1,000 aged 15-59 <2 2 to 5 ≥5	2017	2.32	2.51*	3.25	2.15	1.99	4.71	2.55	3.93	2.49	1.45	2.43	3.41	2.13	2.75	3.22	1.72	1.27	0.91
Proportion of TB cases offered an																			

Figure 7: Nottingham and similar cities (CIPFA) HIV data. Source: Public Health Outcomes Framework 2019

3. Local services/actions/landscape

Under the provisions of the Health and Social Care Act (2012), from April 2013 Local Authorities, Clinical Commissioning Groups (CCGs) and NHS England each have a legal

[7] Public Health England. *HIV Testing in England 2017 Report. Available at:* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/666478/HIV_testing_in_England_2017_report.pdf [accessed 30.08.18]

[8] Public Health England, *Nottingham Local Authority HIV, Sexual and Reproductive Health Epidemiology Report (LASER): 2016*

responsibility for commissioning a range of sexual health services. Figure 8 provides a summary of organisational commissioning responsibility.

Local Authorities	CCGs	NHS England
• Contraception • STI testing and treatment • Chlamydia testing as part of the National Chlamydia Screening Programme • HIV testing • Sexual health including aspects of psychosexual counselling • Sexual services including young people's sexual health, teenage pregnancy services, outreach, HIV prevention and sexual health promotion work, services in schools, colleges and pharmacies	• Termination services • Vasectomy • Non sexual health elements of psychosexual health services • Gynaecology including use of contraception for non-contraception purposes	• Contraception provided as an additional service under the GP contract • HIV treatment and care including post-exposure prophylaxis after sexual exposure • Promotion of opportunistic testing and treatment for STIs • Sexual health elements of prison health services • Sexual Assault Referral Centres • Cervical screening • Specialist foetal medicine

Figure 8: Summary of Commissioning Responsibilities for Sexual Health Services. Source: Department of Health Commissioning Sexual Health services and interventions: Best practice guidance for local authorities, 2013.

Nottingham City Council (NCC) has a statutory responsibility to provide, or secure the provision of, open access sexual health services in its area[9] including:

- Preventing the spread of sexually transmitted infections (STIs)
- Treating, testing and caring for people with STIs and partner notification
- Contraceptive services including advice on preventing unintended pregnancy
- Sexual health promotion

As part of this duty, Nottingham City Council commissions a range of sexual health services including:

- Integrated Sexual Health Services (ISHS)
- Chlamydia Screening Programme
- Sexual health Promotion
- Psycho sexual counselling
- A range of Locally Commissioned Public Health Services (LCPHS) in GP practices and pharmacies
- Integrated Substance Misuse and Sexual Health Service (Health Shop)

[9] http://www.adph.org.uk/wp-content/uploads/2016/09/Interpreting-the-ringfenced-grant-conditions-and-mandateGATEWAY.pdf

- HIV community testing service (outreach and point of care testing)
- HIV home sampling
- Online Chlamydia and Gonorrhoea testing
- C-card Condom Distribution Scheme
- Relationships and Sex Education
- Participation in the NHS HIV PrEP impact trial

4. Good practice

- Nottingham City Council demonstrates good practice around working in partnership with Nottinghamshire County Council to co-commission sexual health services to maximise efficiency and improve access.
- Good practice around co-commissioning with other services is also seen in the integrated substance misuse and sexual health service providing opportunistic screening and testing for high risk people who inject drugs (Health Shop).
- Positive and constructive relationships are facilitated between primary and secondary care providers to manage demand ensure smooth care pathways for citizens.
- Addressing capacity issues such as shortage of 'coil' fitters by agreeing an inter-practice referral mechanism with the GP Alliance.
- Nottingham's RSE Charter encourages schools to sign up to basic RSE and progress to a 'gold standard'.
- Annual national RSE day led by Nottingham.

5. Challenges

- Increasing demand in sexual health services and budget cuts restricting capacity and the ability to pilot new approaches such as digitalisation.
- Community based (not restricted to faith groups) challenges in the lead up to the rollout of mandatory RSE.
- Ongoing high teenage pregnancy rates have continued to pose challenges.
- Skills in general practice to provide some sexual health services are becoming limited thus impacting on demand in specialist sexual health services.
- Fragmentation in commissioning responsibilities leading to fragmented services (see Figure 8).
- Increasing risk taking sexual behaviours such as frequent partner change, increase in numbers of partners, 'chemsex' and group sex facilitated by geosocial networking applications.
- Preventing reinfections due to partner change or non-compliance to treatment.
- Strains of infections resistant to antibiotics.

6. Next steps recommendations

- Conduct a sexual health commissioning review to ascertain if and where there are any gaps between local need and provision.
- Aim to protect the sexual health budget from further cuts.
- Health and Wellbeing Board to consider guidance in the House of Commons Health and Social Care Committee report on Sexual Health and identify long term opportunities around integrating commissioning of services mentioned in Figure 9.
- Support the RSE agenda mandatory roll-out and continue to work together to overcome challenges and resistance by addressing local people's concerns.

- Support recommendations from the Teenage pregnancy JSNA chapter upon completion later this year.

Contacts

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Uzmah Bhatti, Public Health Insight Manager, Nottingham City Council

Catherine Kirk, RSE Consultant, Nottingham City Council

Marie Cann-Livingstone, Teenage Pregnancy Lead, Nottingham City Council

HEALTH AND WELLBEING BOARD

24 JULY 2019

	Report for Resolution/ Report for Information
Title:	Nottingham City's Mental Health and Wellbeing Strategy 2019-2023
Lead Board Member(s):	Alison Challenger, Director of Public Health, Nottingham City Council
Author and contact details for further information:	Jane Bethea, Consultant in Public Health, Nottingham City Council Caroline Keenan, Insight Specialist – Public Health, Nottingham City Council
Brief summary:	Nottingham City's Mental Health and Wellbeing Strategy has been refreshed. The Health and Wellbeing Board is asked to endorse this refreshed strategy. As a means of demonstrating its commitment to taking a prevention-focused approach to improving citizens' mental health, the Health and Wellbeing Board is also asked to agree to commence the process of signing up to the prevention concordat for better mental health through the Mental Health and Wellbeing Steering Group

Recommendation to the Health and Wellbeing Board:

The Health and Wellbeing Board is asked to:

a) Endorse Nottingham City's Mental Health and Wellbeing Strategy 2019-2023 (Enc. 2)

b) Agree to commence the process of signing up to the prevention concordat for better mental health through the Mental Health and Wellbeing Steering Group, which will coproduce an action plan

Contribution to Joint Health and Wellbeing Strategy:	
Health and Wellbeing Strategy aims and outcomes	**Summary of contribution to the Strategy**
Aim: To increase healthy life expectancy in Nottingham and make us one of the healthiest big cities	Reducing the prevalence of mental health problems and improving mental wellbeing in the city's population is vital to achieve the Health and Wellbeing Board's ambition to improve healthy life expectancy and reduce health inequality, as set out in Nottingham City's Mental Health and Wellbeing Strategy 2016-2020.
Aim: To reduce inequalities in health by targeting the neighbourhoods with the lowest levels of healthy life expectancy	
Outcome 1: Children and adults in Nottingham adopt and maintain healthy lifestyles	
Outcome 2: Children and adults in Nottingham will have positive mental wellbeing and those with long-term mental health problems will have good physical health	
Outcome 3: There will be a healthy culture in	

Nottingham in which citizens are supported and empowered to live healthy lives and manage ill health well	
Outcome 4: Nottingham's environment will be sustainable – supporting and enabling its citizens to have good health and 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 refreshed mental health and wellbeing strategy 2019-2023 identifies parity of esteem as one of three important cross-cutting themes for focus.

Background papers: *Documents which disclose important facts or matters on which the decision has been based and have been relied on to a material extent in preparing the decision. This does not include any published works e.g. previous Board reports or any exempt documents.*	

Nottingham City Mental Health and Wellbeing Strategy 2019-2023

1. Background

Mental health problems are common and exist throughout the life course affecting children, adults and older people. Based on national estimates, over 110,000 adults aged over 16 (1) and more than 5,000 children aged 5 to 16 (2) living in Nottingham City are living with mental health problems. Those with serious mental illness are experiencing inequality in life expectancy, dying on average 15 to 20 years younger than the general population.

Mental health problems do not affect all groups of people equally; some experience worse mental health outcomes than others. For Nottingham citizens, this situation arises in part due to lifestyle factors that influence mental health such as substance misuse and levels of physical inactivity, social and cultural factors, the conditions in which citizens live and work and environmental factors such as poverty and deprivation. Furthermore, mental health problems are more likely to affect adults who are unemployed, from a black, Asian and minority ethnic group, those who are homeless or children who have experienced abuse, live in poverty or have witnessed domestic violence.

Reducing the prevalence of mental health problems and improving mental wellbeing in the city's population is vital to achieve the Health and Wellbeing Board's ambition to improve healthy life expectancy and reduce health inequality, as set out in *Happier, Healthier Lives*, Nottingham City's Mental Health and Wellbeing Strategy 2016-2020. Work has been undertaken to refresh the city's mental health and wellbeing strategy with the aim of achieving these goals.

2. Strategy development and consultation

The refreshed strategy builds on the previous mental health strategy for Nottingham City which covered the period 2014-2017. A strategy evaluation was conducted to inform future priorities and lessons that could be learnt. There were a number of areas where outcomes showed an improved trend over the strategy period as well as a number of areas that require ongoing focus and further improvement. The gap in employment between those with mental health problems and the overall population has increased, as has the life expectancy gap. Those with mental health problems experience higher morbidity and mortality than those without. Admissions to hospital for mental health problems in children under 18 have also increased.

An initial draft strategy was produced using elements of the consultation from *Happier, Healthier Lives*, Nottingham City's Joint Health and Wellbeing Strategy 2016-2020. It was also informed by key themes of national and local strategies, including the recently published Integrated Care System mental health strategy (3), as well as the membership of the relevant local partnership group, the Mental Health and Wellbeing Steering Group.

A public consultation on the initial draft strategy was held between 15 May and 12 June 2019, following which a refined draft was produced that takes into account feedback received as part of the consultation. The Health and Wellbeing Board is asked to endorse this refined draft strategy (Enc. 2).

3. Prevention concordat for better mental health

Public Health England (PHE) has led on establishing the prevention concordat for better mental health, which was recommended in the *Five Year Forward View for Mental Health*. The focus of the concordat is to promote good mental health and prevent mental health problems. Sign up to the concordat is aimed at partnerships (including health and wellbeing boards), organisations (such as local authorities, clinical commissioning groups and NHS trusts), communities (including faith groups) and national organisations.

In order for the Health and Wellbeing Board to sign up to the concordat, a local prevention concordat action plan must be completed and then approved by the Chair of the Health and Wellbeing Board. The action plan will highlight the Health and Wellbeing Board's commitment to take specific action on mental health prevention and the promotion of mental wellbeing. The action plan must be submitted to PHE for review and approval, after which it will be made publically available.

4. Recommendations

The Health and Wellbeing Board is asked to:

1. Endorse Nottingham City's Mental Health and Wellbeing Strategy 2019-2023 (Enc. 2)
2. Agree to commence the process of signing up to the prevention concordat for better mental health through the Mental Health and Wellbeing Steering Group, which will coproduce an action plan

5. References

1. **Office of National Statistics.** *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014.* NHS Digital, 2016.

2. **National Statistics.** *Mental health of children and young people in Great Britain, 2004.* NHS Digital, 2005. 1-4039-8637-1.

3. **The Nottingham and Nottinghamshire Integrated Care System.** *Everyone's different, everyone's equal. All-age integrated mental health and social care strategy 2019-2024*, 2019. Available from: https://www.nottinghamshirehealthcare.nhs.uk/latest-news/ics-mental-health-strategy-launched-2218

Nottingham City's Mental Health and Wellbeing Strategy 2019-2023

Contents

Foreword

This Mental Health and Wellbeing Strategy 2019-2023 for Nottingham City builds on our previous strategy, Wellness in Mind 2014-2017. The strategy sets out our ambition in conjunction with Happier Healthier Lives, Nottingham City's Joint Health and Wellbeing Strategy 2016-2022, which identifies adult, children and young people's mental health as one of our four outcomes.

Good mental health is an essential aspect of overall good health for all our citizens. However, we know that mental health problems affect certain groups of people more than others; for example, people who are unemployed or homeless are more likely to experience mental health problems and those that live in more deprived areas tend to experience worse mental health outcomes. This is not acceptable and we aspire to see overall improvements in the mental health of our citizens.

Currently, and for the foreseeable future, Nottingham City faces substantial challenges that impact upon mental health including higher levels of deprivation, child poverty, unemployment, a population living longer with more ill health and greater levels of physical and mental health co-morbidities. This challenge is further accentuated by the fact that there are fewer financial resources available to public and voluntary sector organisations enabling us to respond to the level of need. However, where we can make a difference, and where there is good evidence of return on investment, this must be considered. It is now more apparent than ever that health and especially mental health is everyone's responsibility.

We, as the organisations that serve our city and in partnership with our citizens, intend to focus resources on addressing mental health through three key areas:

- Preventing mental health problems
- Mental health promotion and early intervention
- Treatment and recovery

In addition, action across three crosscutting themes aims to tackle disparities in mental health:

- Employment
- Mental health stigma
- Parity of esteem

This strategy reinforces our commitment to equal status to mental health and physical health across the local health and care system.

We would like to thank all of those who have contributed towards devising this strategy and, most importantly, to everyone involved in making commitments and delivering action that bring about improvements in the mental health of our citizens.

Executive summary

This strategy outlines the overarching approach to improving the mental health and wellbeing of the citizens of Nottingham City. Its purpose is to provide a shared direction of travel that consolidates existing local plans and aligns to wider partnership strategies whilst identifying nuances specific to Nottingham City.

The strategy is not specific to a particular sector or organisation. Instead, it sets our collective approach as organisations that have a role to play in improving the mental health and wellbeing of citizens and employees. Many of the organisations that are pivotal to the delivery of this strategy are those represented on the Nottingham City Health and Wellbeing Board, which includes representatives of:

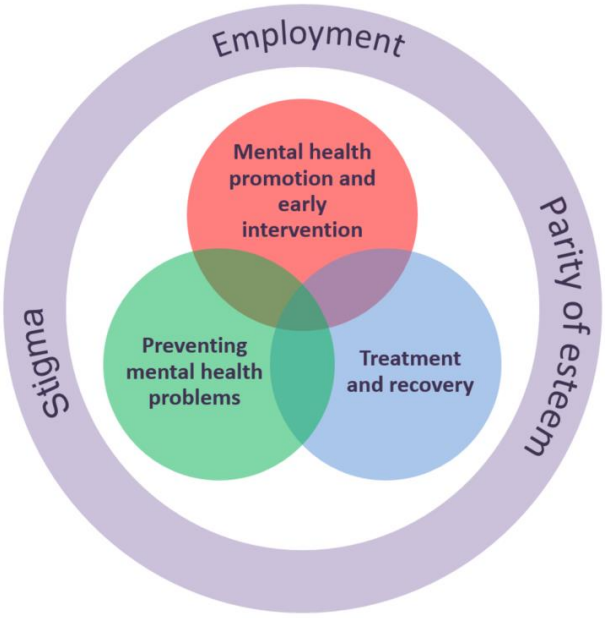
- Nottingham City Council;
- Nottingham City Clinical Commissioning Partnership;
- Healthwatch Nottingham & Nottinghamshire;
- NHS England;
- Nottingham CityCare Partnership;
- Nottinghamshire Healthcare NHS Foundation Trust;
- Nottingham University Hospitals NHS Trust;
- Nottingham City Homes;
- Nottinghamshire Police;
- The Department for Work and Pensions;
- Nottingham Counselling Centre;
- Nottingham Community Voluntary Services;
- Nottinghamshire Fire and Rescue Service;
- University of Nottingham; and
- Nottingham Trent University.

Mental health problems are common and exist throughout the life course affecting children, adults and older people. Based on national estimates, over 110,000 adults aged over 16 and more than 5,000 children aged 5 to 16 living in Nottingham are living with mental health problems. Those with serious mental illness are experiencing inequality in life expectancy, dying on average 15 to 20 years younger than the general population.

Mental health problems do not affect all groups of people equally; some experience worse mental health outcomes than others. For Nottingham citizens, this situation arises in part due to lifestyle factors that influence mental health such as substance misuse and levels of physical inactivity, social and cultural factors, the conditions in which citizens live and work and environmental factors such as poverty and deprivation. Furthermore, mental health problems are more likely to affect adults who are unemployed, from a black, Asian and minority ethnic group, those who are homeless or children who have experienced abuse, live in poverty or have witnessed domestic violence.

There is evidence to suggest that investing in mental health interventions results in improved citizen outcomes and savings. This strategy for Nottingham City aims to address and improve the mental health of all our citizens through priority action across three principal routes supported by three crosscutting themes. To illustrate this we have developed a conceptual model (Figure 1) based on the World Health Organisation framework, highlighting action for the health and social care system to ensure that all citizens have the opportunity to experience good mental health and wellbeing without stigma or discrimination.

Figure 1 - Conceptual model of Nottingham City's framework for mental ill health prevention, promotion and treatment



Identified actions in each of the following key areas and themes are set out in Table 1:

Table 1: Summary of proposed actions across Nottingham's strategic framework for mental health

Preventing mental health problems	– Ensure comprehensive perinatal and infant mental health pathways are commissioned and delivered. – Ensure all children, young people and families have easy access to timely, evidenced-based treatment of emotional/mental health difficulties. This should include educating other professionals to offer lower level and preventative emotional wellbeing support, whilst ensuring children and young people gain access to more specialist mental health treatments where required. – Provide support to build resilience amongst Nottingham City's citizens most at risk from the impacts of social exclusion. – Improve housing standards for Nottingham City citizens in private and rented accommodation. – Promote self-help and ensure resources and signposting are available to help Nottingham City citizens improve and maintain their own mental health and wellbeing. – Ensure that a strategic, needs-led training offer for mental health is available to organisations including suicide prevention, mental health first aid and trauma-informed practice. – Develop a making every contact count prevention model that includes an emphasis on mental health. – Adopt a mental health in all policies approach to emphasise mental health and wellbeing through all local public policy developments and not solely through healthcare policy. – Become a signature to the Government's Prevention Concordat for Better Mental Health consensus statement.

Mental Health Promotion and Early Intervention	– Establish clear and consistent universal messages to help citizens understand how best to look after their mental health. – Work towards becoming a trauma-informed health, care and education system. Identify citizens at risk of worse mental health through identification and appropriate interactions with citizens that are at risk of and experience trauma. – Enable children and adults with, or at risk of, mental health problems to access the appropriate level of support as and when they need it. – Enable children and adults with, or at risk of, mental health problems to lead healthier lifestyles through increased levels of physical activity, improved nutrition, reduced weight, reduced alcohol consumption and stopping smoking. – Ensure the Improving Access to Psychological Therapies programme is expanded in response to local need in adults, children and high-risk groups, including people accessing substance misuse treatment and people with long-term conditions. – Expand the primary mental health care offer to include social prescribing, debt advice, peer support and system navigation. – Work with NHS England and the criminal justice system (including the Youth Offending Service) to better identify and support those who have or are at risk of mental health problems. – Intervene earlier through improved information sharing at an organisational level and on an individual care basis. – Promote greater integration of case management systems to improve decision-making and wider adoption of the single care record.
Treatment and Recovery	– Ensure universal and targeted Child and Adolescent Mental Health Services are appropriate for local need. – Reduce out-of-area placements in mental health services for adults in acute inpatient care. – Ensure an appropriate response is available for people with multiple complex needs (mental health, substance misuse, homelessness and offending). – Utilise trauma-informed approaches consistently across health and social care settings and the wider workforce. – Ensure crisis support for children, young people and adults is available, effective and timely. – Ensure all those identified as at risk of self-harm have safety plans. – Ensure follow-up support is appropriate for those transitioning between settings including inpatient mental health, prison and the wider criminal justice system (including the Youth Offending Service), university and children's care. – Establish integrated working between mental health and social care in order to provide high quality joined up planned care. – Use relevant research and evidence to improve mental health outcomes. This will include research into improving the mental health outcomes of Nottingham's lesbian, gay, bisexual and transgender populations undertaken in 2019 by the University of Leicester and the University of Brighton.
Employment	– Enable those with, or at risk of, mental health problems to secure and maintain employment. – Establish financial resilience as a component of good quality care for people experiencing mental health problems. – Develop a strategic approach to improving the mental health of people in employment so that they remain employed. This might include the widespread adoption of reasonable adjustments. – Provide support to navigate benefits and universal credit, especially for those with debt and financial issues. – Take action to improve the mental health and wellbeing of our workforce and, in doing so, provide an example of good practice to other local employers.

Parity of Esteem	– Enable those with serious mental health problems to lead healthier lives and ensure those with long-term physical health conditions have their mental health needs addressed. – Support the implementation of smokefree settings at Nottinghamshire Healthcare NHS Foundation Trust and Nottingham University Hospitals NHS Trust. – Develop a strategic approach to a mental health training offer for front-line staff to understand mental health problems and mental health stigma. – Establish a greater emphasis on mental health across universal health and care services, including provision of training for staff about emotional development, trauma-informed approaches and mental health (accompanied by access to consultation and advice from clinical specialists where required).
Stigma and discrimination	– Raise awareness of mental health stigma and discrimination via the Time to Change programme, ensuring actions are embedded and sustained. – Reduce the level of stigma experienced by citizens, including: those with learning disability; those in black, Asian and minority ethnic groups; older people; the homeless; offenders; those affected by trauma; those affected by substance misuse and lesbian, gay, bisexual and transgender people. – Develop mental health champions within the statutory and non-statutory workforce. – Develop and support public-facing campaigns that raise awareness of mental health problems and challenge stigma.

Vision

Nottingham aspires to be a city where improving mental health is everyone's responsibility and all citizens have the opportunity to experience good mental health and wellbeing without stigma and discrimination.

Aim

We aim to ensure that mental health acquires equal status to that of physical health over time, with a greater understanding of and commitment to integration of the two. We want to ensure that mental health problems are prevented as far as possible and, where they do arise, individuals receive support and access to treatment early. We want to inspire confidence in those citizens, their families and carers accessing our mental health services by ensuring they experience high quality care that is person-centred, safe, effective and promotes recovery.

Our aim will be achieved through actions relating to three key areas:

- Preventing mental health problems
- Mental health promotion and early intervention
- Treatment and recovery

As well as by our three crosscutting themes:

- Employment
- Mental health stigma
- Parity of esteem

Assessing progress

Assessment of progress against our aim will be monitored through the existing mechanisms for mental health reporting. This aim, along with the themes described in this strategy are closely aligned to the following existing strategies and plans:

- Nottingham and Nottinghamshire Integrated Care System All-age Integrated Mental Health and Social Care Strategy 2018
- The Five Year Forward View for Mental Health
- Happier Healthier Lives, the Nottingham City Joint Health and Wellbeing Strategy 2016-2020
- The Black and Minority Ethnic Community of Practice Mental Health Action Plan

The progress of actions relating to this strategy will be monitored through the existing action plans and reporting processes in the strategies and plans listed above. This is illustrated in Figure 2.

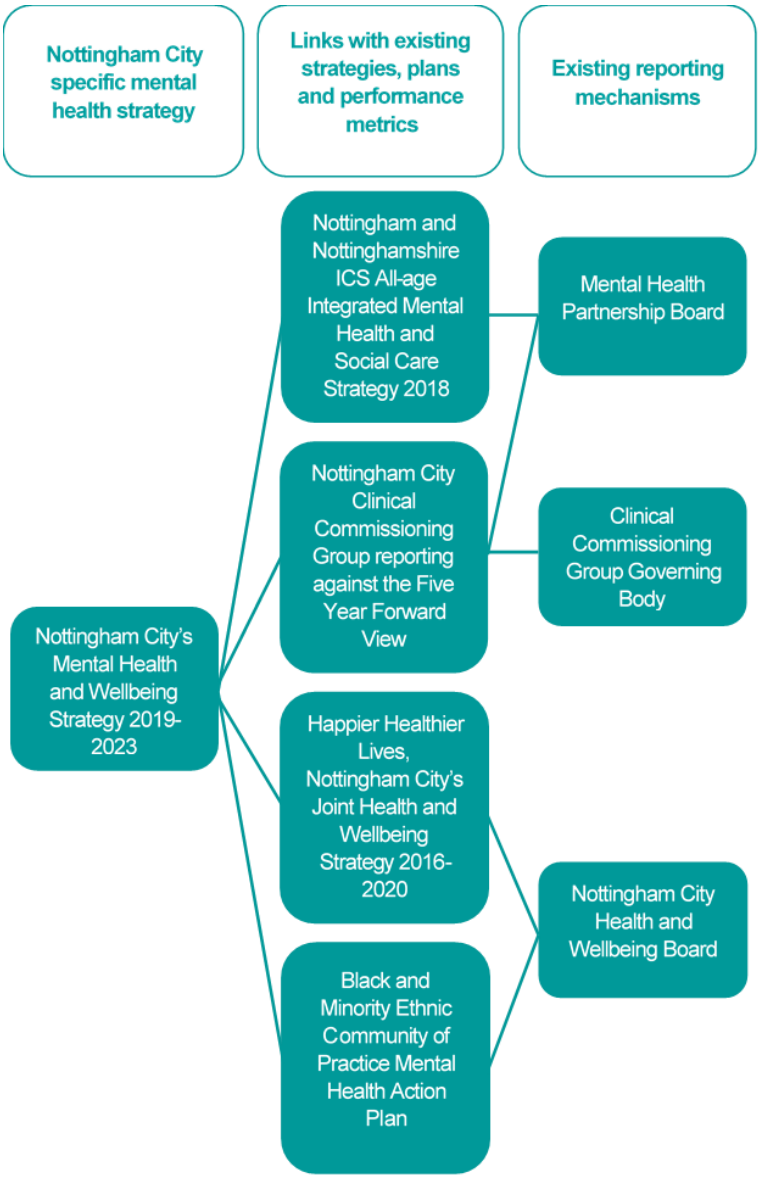


Figure 2: Reporting mechanisms for mental health performance indicators and metrics

Terms and definitions

What do we mean by mental health?

The World Health Organisation defines mental health as

> *a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community* (1)

Poor mental health is strongly linked with poor physical health, resulting in over three times the risk of dying early for those with long-term mental health problems (2).

What is mental wellbeing and resilience?

There is no universally agreed definition of mental wellbeing. Wellbeing is to do with how we feel and cope with everyday life. Mental wellbeing is a broad term that can be defined as

> ***….a dynamic state, in which an individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their communities*** (3)

Many different aspects of life contribute to mental wellbeing and it is usual for it to fluctuate. Resilience is the ability to cope with life's challenges and to adapt to adversity. It is important because it can help protect against the development of some mental health problems. Resilience helps us to maintain our wellbeing during difficult circumstances (4).

Many people who live with mental health problems experience good mental wellbeing. Poor mental wellbeing does not necessarily lead to mental health problems, but if it continues over a long period, it can make us more susceptible to them.

What do we mean by mental health problems?

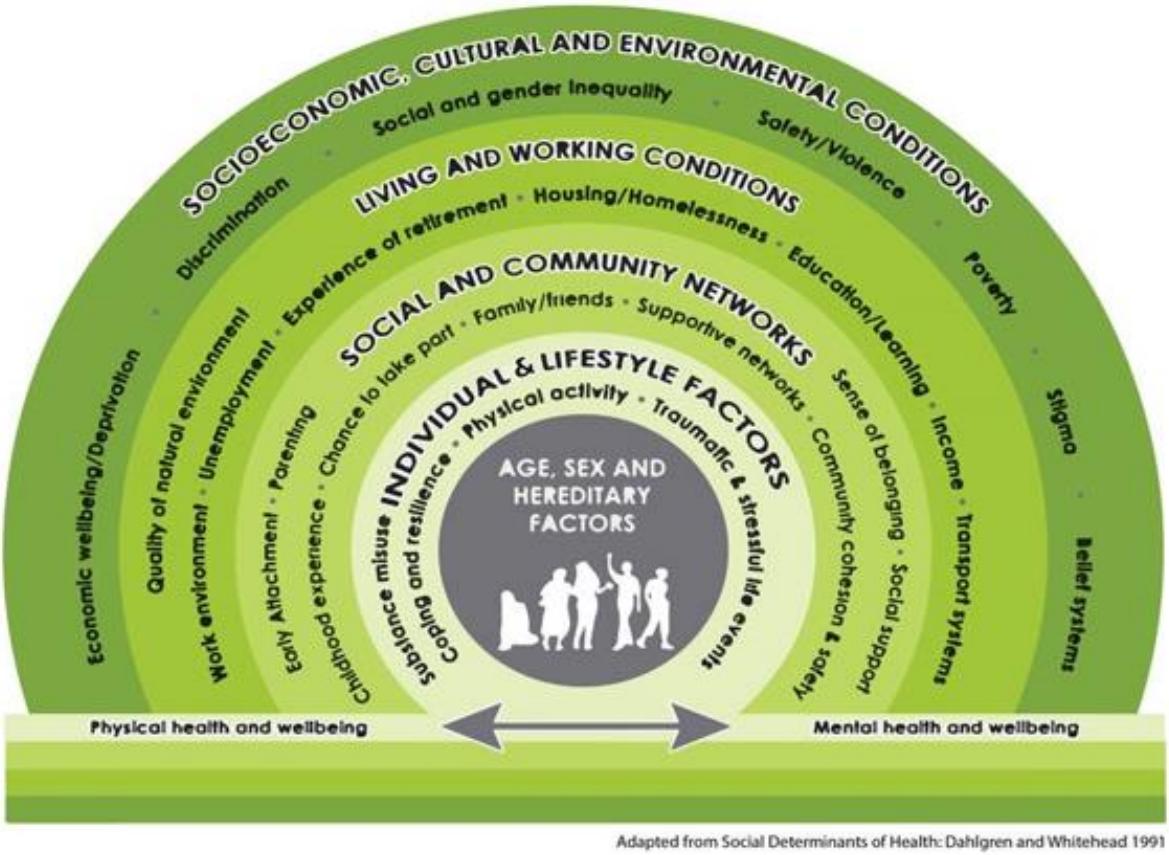
It is not unusual to experience mental health problems, with an estimated **1 in 6 adults suffering from a common mental health problem such as depression or anxiety at any one time** (5). Mental health problems include common mental disorder (such as anxiety and depression), which affects nearly one in four of the population, and mental illnesses such as psychosis, schizophrenia or bipolar disorder, which are less common, affecting 0.5–1% of the population (7).

Mental health problems can be surrounded by prejudice, ignorance and fear. This can result in stigma and discrimination that makes it harder for those with mental health problems to live a normal life.

Mental illness, unlike other health problems tends to start early and persist into and throughout adulthood. It is recognised that about half of all lifetime mental health problems begin during childhood and adolescence (8)(9).

The proportion of people with common mental disorder using mental health treatment has increased. Around one in four aged 16–74 with common mental disorder symptoms was receiving some kind of mental health treatment in 2000 (23.1%) and 2007 (24.4%). By 2014, this had increased to more than one in three (39.4%). This increase is accounted for by IAPT and medication treatments (10).

Figure 3. Influences on mental health and wellbeing



Adapted from Social Determinants of Health: Dahlgren and Whitehead 1991

Influences on mental health

Many factors influence our mental health and may make us more vulnerable to mental health problems. Some of these are based in our genetics and biology, but most influences are at a wider social, community or cultural level.

Figure 3 shows how these influences contribute to mental health across the life course.

Research has shown that work, income, gender, ethnicity, education and socioeconomic position are key influences on mental health (32)

Mental health problems often occur because of trauma in our lives. Our ability to cope may be influenced by factors such as our family, early attachment and presence of supportive networks. Mental health problems can be both caused and influenced by unemployment; debt; poor housing or housing problems; deprivation; domestic violence; discrimination; feeling marginalised within society; loneliness and isolation; and drug and alcohol misuse. The way in which urban areas are planned, designed and built are of major significance to good mental health. Access to high quality housing in safe neighbourhoods, green spaces and strong communities with good transport systems all contribute. Factors such as air pollution, traffic, noise, lack of space, feeling unsafe and insecure, anti-social behaviour and limited options for physical activity impact negatively on mental health. Inequalities in society lead to inequalities in mental health and many of the social influences on mental health can be exacerbated by mental health problems.

Risk factors relating to mental health problems

There are a number of population groups that are at higher risk of experiencing mental health problems (11):

Children and young people	Adults
Children with parents who have mental health or substance misuse problems	People with a history of mental health problems or self-harm
Those who suffer personal abuse and trauma or witness parental domestic violence Children who experience abuse have a 7-fold increased risk of recurrent depression and a near 10-fold increased risk of developing post-traumatic stress disorder as an adult. Where children have experienced abuse there is also an 8-fold increased risk of anxiety and a 9-fold increased risk of suicidal ideation	Homeless people Homeless people have a near to 4-fold increased risk of developing a mental health problem Poor physical health Adults with two or more physical illnesses have a 6-fold increased risk of having mental health problems
Looked after children Looked after children have a 5-fold increased risk of experiencing a childhood mental health problem and between 4- and 5-fold increased risk of a suicide attempt	Offenders and ex-offenders Prisoners experience increased risk of suicide and a 20-fold increased risk of psychosis
Child carers	Adults with a history of violence or abuse
Children and young people excluded from school	Black, Asian and minority ethnic groups, especially young men of Afro-Caribbean origin
Young offenders There is an 18-fold increased risk of mental health problems amongst young offenders and offenders have a 5-fold increased risk of suicide	Lesbian, gay, bisexual, transgender Lesbian, gay, bisexual or transgender adults have a 2-4-fold increased risk of suicide over their lifetime
Teenage parents	Travellers, asylum seekers and refugees
Lesbian, gay, bisexual, transgender	A history of being looked after/adopted
Black, Asian and minority ethnic groups, especially young Asian women	People with learning difficulties
Families living in socio-economic disadvantage There is a 3-fold increased risk of mental health problems for children in families with lower income levels	Isolated older people Citizens living in a cold home or experiencing fuel poverty have a 4-fold increased risk of having depression or anxiety
Adverse childhood experiences Children experiencing 4 or more adverse childhood experiences have more than a 12-fold increased risk of attempted suicide as an adult	Unemployment Unemployed adults have a 5.6-fold increased risk of developing a mental health problem

Research has shown that many mental health problems begin in childhood or early adulthood. The likelihood of diagnosis, of seeking help and how we respond to mental health problems also differ according to factors such as: ethnic background, family history and social/cultural norms (12).

There is evidence that people with long-term physical conditions are two to three times more likely to experience mental health problems than the general population. Much of the evidence relates specifically to disorders such as depression and anxiety, though co-morbidities are also common in dementia, cognitive decline and some other conditions. There is particularly strong evidence for a close association with cardiovascular diseases, diabetes, chronic obstructive pulmonary disease and musculoskeletal disorders (13).

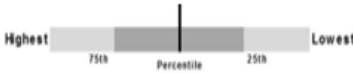
Nottingham City has higher levels than the England average of many of the factors that increase the risk of mental health problems throughout life, such as higher rates of deprivation, greater ethnic diversity; high levels of unemployment, increased youth offending and more looked-after-children.

Overleaf, Figure 4 shows how Nottingham compares to England on a range of indicators that we know are linked with an increased risk of experiencing mental health problems. Nottingham is statistically significantly worse than the England average for nearly all of these measures.

Figure 4: Factors associated with an increased risk of mental health problems – Nottingham City (dates vary)

Key:

- Significantly lower than England average
- Not significantly different from England average
- Significantly higher than England average
- Unable to compare



	Indicator	Local Number	Local Value	Eng Avg	Eng Highest	England Range	Eng Lowest
1	Percentage of people living in 20% most deprived areas in England, 2014	182118	58.0	20.2	60.5		0.0
2	Percentage of children in poverty, under 16 years, 2014	19575	34.3	20.1	39.2		3.1
3	Children subject to a child protection plan with an initial category of abuse, rate per 10,000 aged under 18, 2016	352	53.4	20.8	53.4		2.3
4	Looked after children, rate per 10,000 children under 18, 2015/16	595	90.2	60.3	163.8		21.5
5	First time entrants into the youth justice system 10 to 17 year olds, rate per 100,000, 2016	157	609.3	327.1	739.6		97.5
6	Percentage of 16-18 year olds not in education, employment or training, 2015	580	5.8	4.2	7.9		1.5
7	Hospital admissions for mental health conditions, per 100,000 aged 0-17 years, 2015/16	75	113.8	85.9	179.8		33.8
8	Unemployment 2016	11400	7.6	4.8	9.0		2.3
9	Statutary homeless households, rate per 1,000 households, all ages, 2015/16	597	4.6	2.5	12.5		0.1
10	Admission episodes for mental and behavioural disorders due to use of alcohol condition (narrow) - rate per 100,000 population all ages, 2015/16	454	174.2	80.1	272.7		28.7
11	Long-term health problem or disability - % of population, all ages, 2011	55382	18.1	17.6	25.6		11.2
12	Excess winter deaths index - all ages Aug 2015 / Jul 2016	186	21.3	15.1	27.9		-0.7

Source: Public Health Outcomes Framework Indicators

The relationship between physical and mental health

Physical and mental health are inextricably linked. Physical ill health affects mental health and vice versa. **People living with mental health problems are less likely to have their physical health problems diagnosed and treated, whereas people with physical health problems often have undiagnosed mental health problems** (11).

People with mental health problems experience poor physical health with higher than expected mortality. There are numerous causes of excess mortality amongst people with mental health problems including the adoption of less healthy behaviours and leading less healthy lives owing to a higher prevalence of smoking, alcohol, substance misuse, poor diet, suicide, inactivity and obesity (7). Whilst much of this excess mortality is potentially avoidable, it does not explain it all. Further factors that contribute to excess mortality reported in the Chief Medical Officer of England's report on mental health (7) are summarised below:

Factors that contribute to excess mortality in people with mental health problems

- Health behaviours e.g. smoking, diet, exercise, alcohol and drugs
- Altered help seeking e.g. delayed presentation, reduced treatment adherence, poor uptake of health screening and impaired mental capacity leading to treatment refusal
- 'Diagnostic overshadowing' e.g. failure by health professionals to recognise physical health problems in people with mental heath problems
- Discriminatory policies
- Excess weight and obesity caused by antipsychotic medication
- Social conditions e.g. homelessness, unemployment and poverty
- Suicide and violent victimisation
- Direct physical impacts of mental health problems such as changes to immune function

People with physical health problems, especially chronic diseases, are at increased risk of mental health problems, particularly depression and anxiety. Around 30% of people with a long-term physical health condition also have a mental health problem. This co-morbidity/multi-morbidity is associated with a range of poor outcomes and increased costs (13). Analysis by the Kings Fund (13) indicates that between 12% and 18% of all NHS expenditure on long-term conditions is linked to mental health problems, which if left untreated, can significantly exacerbate physical illness and drive up the costs of health and social care.

The case for prevention and investment

Mental health problems affect the lives of individuals, families, communities and society as a whole. The health and economic costs to an individual with mental health problems can be high. Societal effects include contribution to higher levels of illness, higher crime rates, greater incidence of addiction, poorer work performance/productivity, unemployment, lower educational attainment and lower levels of social cohesion. Mental health problems can result in homelessness, the break-up of families and even self-harm or suicide (14). It is acknowledged that the gap between the employment rate for Nottingham City citizens accessing mental health treatment and the city overall is favourable in Nottingham compared to England and Nottinghamshire and that continued efforts are required to maintain this position. Life expectancy for people experiencing mental health problems is lower on average than for people with good mental health due to a combination of unhealthy behaviours including smoking, drinking alcohol, physical health side effects of medication and barriers to accessing physical healthcare such as stigma (15).

Mental health problems also impact the wider economy, being responsible for more sickness absence than any other illness. **In England, total economic and societal cost of mental health problems exceed £105 billion a year** (16) with the government spending around £19 billion every year within and beyond the health system on dedicated services for people with mental health needs (17). Furthermore, it has been estimated that treating physical problems associated with mental health problems and vice versa is not as effective as it could be and costs more than £11 billion a year (15).

Improvements in mental health can result in direct and indirect savings across health and care budgets such as through reduced use of primary care, mental health and substance misuse/alcohol services. Further to this, improved mental health will result in lower levels of work absence, reduced demand on welfare and benefit support (such as housing and universal credit) and an increase in levels of employment amongst citizens. It has been argued that integrating the care of physical and mental health could both improve health outcomes and save money (15).

Evidence suggests investing in mental health prevention, promotion and early intervention results in savings, and based on even conservative assumptions, many are very low cost and very good value for money

Implementing mental ill health prevention interventions is recommended in the Prevention Concordat for Better Mental Health, which recognises that a shift is needed in the balance of focus from mental health treatment to prevention and promotion. If coupled with a shift in expenditure, this could also generate efficiency gains for commissioners and service providers (18). **Public Health England's modelling work estimates the return on investment for evidence-based interventions varies between £1.26 and £39.11 per £1 spent.** For example, for every £1 invested in school-based social and emotional learning programmes, £5.05 could be realised in costs averted (17).

Mental health inequalities

Understanding and addressing inequality is part of creating a mentally healthier society (19). The distribution of health problems across a population is not even: some groups of people experience more problems with their health than others.

People with a diagnosed serious mental illness are one such group that experiences a marked inequality in life expectancy, dying on average between 15 and 20 years younger than the general population (21). The Public Health Outcomes Framework estimates that people in Nottingham known to mental health services are over 4.5 times more likely to die before the age of 75 years than the general population and that this has consistently been the trend over the last 5 years (PHOF 4.09i).

Deprivation

The pattern of this distribution follows the social gradient: those living in the poorest areas experience more ill health and die younger than those in the richest areas. It is important to note that people from the poorest areas also spend more of their shorter lives living with disabling conditions (20).

Ethnicity

Ethnicity is an important factor in the development and experience of mental health problems. Varying cultural contexts and availability of access to culturally-competent support have a key role in the prevention of mental health problems, their diagnosis, treatment and recovery. In general, people from black, Asian and minority ethnic (BAME) groups living in the UK are more likely to be diagnosed with a mental health problem and, when diagnosed, are more likely to be admitted to hospital and experience a poorer treatment outcome. Furthermore, increased likelihood of disengagement from mental health services can lead to social exclusion, which exacerbates mental health problems. (33)

While BAME groups are considered to be at greater overall risk of mental health problems, considerable variability in prevalence has been found within these groups (35), suggesting a more complex picture. The Adult Psychiatric Morbidity Survey (36) found significant variability by ethnic group in the prevalence of common mental health problems in women but not men. Non-British white women were the least likely to have a common mental health problem (15.6%), followed by white British women (20.9%) and black British women (29.3%). A 2015 review found higher prevalence of psychosis in people from black ethnic minority backgrounds compared with the majority white population when controlling for the effect of socioeconomic status (37).

In 2017, Nottingham City Health and Wellbeing Board published its Health Needs Assessment of the black and minority ethnic populations within Nottingham City. Mental health was one of a number of key themes identified in the assessment. Many of the participants engaged in the assessment felt that mental health problems were common in BAME communities, and that these were exacerbated by cultural bias, experience of stigma and discrimination and challenges in accessing appropriate services. The assessment recommended consideration was given to the following findings:

- BAME communities find it difficult to engage with mental health services for cultural reasons and because they believe the service will not meet their needs.

- BAME communities feel greater investment is required to improve access to culturally appropriate mental health services that have the capacity and resource to prevent and treat mental health problems.

In addition to the two findings listed above, the assessment highlighted a need to raise mental health awareness in BAME groups and drew attention to national research (34) that showed disproportionality in the diagnosis and treatment of people from BAME groups, particularly in crisis situations.

Employment

Inequality in mental health exists between those who are employed and those who are not. Unemployed people are likely to experience poorer mental health than employed people and those with mental health problems are less likely to be in employment. Given that the relationship is bi-directional rather than causal, for some people this can become an insurmountable cycle of unemployment, poor mental health, poverty and deprivation with few opportunities to recover without timely and appropriate intervention.

Carers

The Care Act (2014) defines a carer as any person who provides unpaid care. This might be by looking after partners, other family members and friends who are ill, older or disabled. There are approximately 6.5 million carers in the UK, 13% of whom care for someone with a mental health problem. (40)

Carers are the primary source of support for people with mental health problems. Support often includes:

- Administering medications
- Chaperoning to appointments
- Advocacy
- Providing acceptance, understanding and the encouragement to take steps towards recovery
- Being the driving force that supports change in behaviours that cause harm to mental wellbeing
- Offering advice to practitioners about a patient's behaviour and responses to treatment
- Connecting inpatients to family and the wider community

The act of caring can and often does have a significant impact on people's physical and mental health and wellbeing. The mental health of carers is often neglected, despite known evidence that carers are at increased risk of experiencing mental health problems such as depression and emotional distress (38). The State of Caring report (2018) reported that 72% of carers in the UK suffered mental health problems as a result of caring and 61% said their physical health had been impaired. The people who were most likely to report negative impact on their mental health were those who cared for a disabled child (81%), those with childcare responsibilities for a non-disabled child (80%) and those carers struggling financially (80%) (39).

This strategy supports the Triangle of Care approach. The Triangle of Care (41) is a guide to achieving an alliance between a citizen or patient, practitioner and carer. It sets out six key standards:

1. Carers and the essential role they play are identified at first contact or as soon as possible thereafter
2. Staff are ‘carer aware’ and trained in carer engagement strategies
3. Policy and practice protocols regarding confidentiality and sharing information are in place
4. Defined posts responsible for carers are in place
5. A carer introduction to the service and staff is available, with a relevant range of information across the care pathway
6. A range of carer support services is available

Financial vulnerability

There is a well-documented inverse relationship between socioeconomic status and mental health problems, in that the prevalence of negative health outcomes, including mental health problems, increases as socioeconomic status decreases (42). The Mental Health Foundation proposes that much of the impact of debt on a person’s mental health results from a lack of support, sleep disturbance and feelings of isolation and loneliness (43). Approaches to reducing financial vulnerability and minimising its impact (e.g. through debt first aid, and clearer pathways between health, care and debt / money advice services) play important roles in improving the mental health of citizens.

National strategies and plans

NHS Long Term Plan (2019)

The NHS Long Term Plan sets out a ten-year strategy for the redesign and future-proofing of our health service. The Plan includes the following specific actions around mental health:

- Development of the wider workforce to help address mental health problems;
- Expansion of the community crisis offer;
- Advancement of social prescribing and self-care;
- Improvement of patient control through expansion of the Personal Health Budget for mental health services;
- A focus on children and young people's mental health, including increased funding to expand the community offer and for eating disorder services;
- Implementation of a universal smoking cessation offer for long-term users of specialist mental health services;
- Investment for specialist homelessness NHS mental health support;
- Improvement in access to mental health support for people in work and for those seeking and retaining employment;
- Improvement in access to perinatal mental health care for mothers; and
- A focus on adult mental health services, including increased funding and a new community-based mental health offer.

Prevention Concordat for Better Mental Health (2017)

The Prevention Concordat for Better Mental Health is underpinned by an understanding that taking a prevention-focused approach to improving the public's mental health is shown to make a valuable contribution to achieving a fairer and more equitable society. The Concordat promotes evidence-based planning and commissioning to increase the impact on reducing health inequalities. The sustainability and cost-effectiveness of this approach will be enhanced by the inclusion of action that impacts on the wider determinants of mental health and wellbeing.

The Concordat is intended to provide a focus for cross-sector action to deliver a tangible increase in the adoption of public mental health approaches across:

- local authorities
- the NHS
- public, private and voluntary, community and social enterprise (VCSE) sector organisations
- educational settings
- employers

The Prevention Concordat website provides a range of resources and evidence of cost-effective interventions to aid local areas in planning and commissioning services.

Transforming children and young people's mental health provision: a Green Paper (2017)

This green paper sets out the ambition that children and young people who need help for their mental health are able to get it when they need it. The focus of this paper is on earlier intervention and prevention, especially in and linked to schools and colleges.

The Government is proposing to:

- Create a new mental health workforce of community-based mental health support teams
  - Mental health support teams will be trained staff linked to groups of schools and colleges. They will offer individual and group help to young people with mild to moderate mental health problems including anxiety, low mood and behavioural difficulties.
  - The support teams will work with the designated mental health leads and provide a link with more specialist mental health services. This will mean that schools and colleges will find it much easier to contact and work with mental health services.
- Establish a designated lead for mental health in every school and college
  - oversee the help the school gives to pupils with mental health problems
  - help staff to spot pupils who show signs of having mental health problems
  - offer advice to staff about mental health
  - refer children to specialist services if needed
- A new 4-week waiting time for NHS children and young people's mental health services to be piloted in some areas
- Set up a new national partnership to improve mental health services for young people aged 16 to 25. The partnership will start by deciding which areas to focus on. This might be student mental health, looking at how universities, colleges, local authorities and health services work together.
- Improve understanding of mental health
  - Including a better understanding of how social media affects the health of children and young people
  - Carry out research into what is the best way to support families
  - Research and produce guidance on how mental health problems can be prevented

Five Year Forward View for Mental Health (2016)

The Five Year Forward View for Mental Health (FYFVMH) builds on the NHS Five Year Forward View plans for how to ensure the NHS is sustainable in relation to mental health and transform mental health services. The FYFVMH sets out an extensive number of recommendations and specifically identifies three priority actions for the NHS by 2020/21:

- A 7 day NHS – right care, right time, right quality;
- An integrated mental and physical health approach; and
- Promoting good mental health and preventing poor mental health.

The strategy directs local areas to develop effective mental health prevention plans and use the best data available to commission the right mix of services to meet local needs. Plans should focus on public mental health, including promoting good mental health, addressing the wider social determinants of mental health problems, local approaches to challenging stigma, and targeting at risk groups with proven interventions (such as NICE guidelines).

In order to develop an integrated approach across the local system, engagement is required not solely by the NHS but from local authorities, healthcare, social care, public health, housing, criminal justice, voluntary sector and service user involvement.

Future in Mind (2015)

This report by the Children and Young People's Mental Health Taskforce identifies actions that transform the design and delivery of mental health services for children and young people. Emphasis is placed on: better understanding of mental health and reduced mental health stigma that affects young people; substantial changes to how care is accessed and delivered; increased access to and use of clinically effective support and interventions including parenting support to strengthen attachment between parent and child; better care and support to the most vulnerable and developing the workforce through better understanding of mental health and the support available to children and young people.

A Local Transformation Plan is in place, aligned to the integrated care system footprint as a means to implementing the recommendations in Future in Mind across Nottingham and Nottinghamshire.

The 10 actions proposed by the Government that would lead to substantial change by 2020 are:

1. Improved public awareness and understanding, where people think and feel differently about mental health problems for children and young people where there is less fear and where stigma and discrimination are tackled.
2. Children and young people having timely access to clinically effective mental health support when they need it.
3. A step change in how care is delivered moving away from a system defined in terms of the services organisations provide (the 'tiered' model) towards one built around the needs of children, young people and their families.
4. Increased use of evidence-based treatments with services rigorously focused on outcomes.
5. Making mental health support more visible and easily accessible for children and young people.
6. Improved care for children and young people in crisis so they are treated in the right place at the right time and as close to home as possible.
7. Improving access for parents to evidence-based programmes of intervention and support to strengthen attachment between parent and child; avoiding early trauma, building resilience and improving behaviour.
8. A better offer for the most vulnerable children and young people, making it easier for them to access the support that they need when, and where they need it.
9. Improved transparency and accountability across the whole system, to drive further improvements in outcomes.

Professionals who work with children and young people are trained in child development and mental health and understand what can be done to provide help and support for those who need it.

Mental Health Crisis Care Concordat (2014)

The vision of the concordat is that the signatory agencies work together to deliver high quality responses when people of all ages experiencing mental health problems require urgent help at a time of crisis, as well as to work together to prevent crisis through intervening at an earlier stage.

The Concordat is a shared agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental health crisis need help: in policy making and spending decisions, in anticipating and preventing mental health crises wherever possible, and in making sure effective emergency response systems

operate in localities when a crisis does occur. The Concordat is arranged around:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crises

This Concordat expects that, in every locality in England, local partnerships of health, criminal justice and local authority agencies will agree and commit to local Mental Health Crisis Declarations. Nottinghamshire (City and County jointly) has a signed Declaration in place since December 2014 and has a current action plan detailing priorities for 2017-19.

The National Strategy for Suicide Prevention in England (2012)

This strategy sets out a national cross-government approach to reducing the rate of suicide and improving support available to those bereaved by suicide. The strategy identified six areas for action in order to achieve an overall reduction in the rate of suicide. These included:

1. Reducing the risk of suicide amongst groups of people in the population that are known to be at greater risk of suicide
2. Tailoring approaches to improve the mental health of certain groups in the population such as people from BME groups, pregnant women (perinatal mental health), children and young people, those that misuse substances and the unemployed (this is not an exhaustive list)
3. Reducing access to the means of suicide such as reducing the means by which the public can access the rail network
4. Providing better information and support to those bereaved or affected by suicide
5. Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Supporting research, data collection and monitoring

Following on from the national strategy, the most recent Third Suicide Progress report (2017) establishes the need to continue to deliver on these six areas for action, whilst also accentuating the need to:

- challenge stigma around mental health and suicide; and
- include a greater focus and improved response to those that self-harm (as it identifies self-harm as the single biggest indicator that someone is at risk of suicide).

No Health without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages (2011)

This national strategy for mental health underlined the equal importance of mental and physical health (parity of esteem), the need to focus on prevention, to intervene early and encourage partnership working to improve mental wellbeing across the population in order to achieve the following outcomes:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm

- Fewer people will experience stigma and discrimination

Summary of key themes from national strategies

Whilst each of these national strategies warrants full consideration at local level in its own right, there are some essential elements that we want to focus our energies on in Nottingham City to further our overall strategic aim.

Reducing mental health stigma and enabling greater awareness of mental health

This is universal with a specific focus on reducing prejudice and discrimination experienced by black, Asian and minority ethnic populations. Work around addressing stigma will be carried out through our Time to Change programme and through developing mental health awareness and understanding in the workforce. Work surrounding suicide prevention and self-harm reduction will play an important role.

Preventing mental illness

Preventing mental health problems from arising in the first place and intervening swiftly when problems start to arise can lead to improved quality of life for individuals as well as fewer people requiring specialist services, thereby reducing cost in the longer term. This approach requires concerted planning and allocation of resources. Where resources can be allocated, they should be used in an equitable way in order to reduce health inequalities.

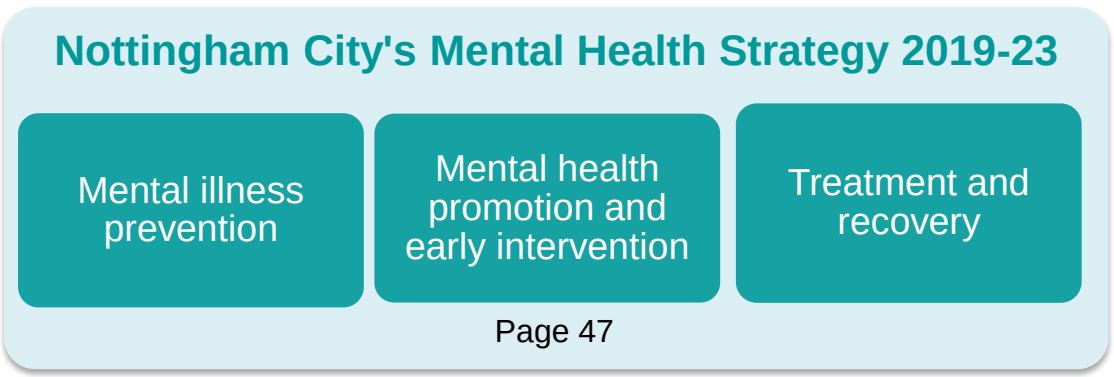
Improve awareness and access to mental health services

All age access will be improved with clear consideration being given to certain groups including those who are unemployed, black, Asian and minority ethnic populations, children and pregnant women. The right support should be available earlier to avoid people being passed from one service to another and people reaching a crisis. Support for children and young people's mental health will become more visible and available universally via schools. Improving access to evidence-based treatments such as Improving Access to Psychological Therapies and Early Intervention in Psychosis should continue to be a local priority.

Integrated care

To date, emphasis has been placed on the integration of mental and physical health by addressing the physical health needs of patients experiencing mental health problems. As we move forward, a greater emphasis will need to be placed on the mental health of people with physical long-term conditions, the integration of mental health services within acute hospitals and the integration of primary and secondary care, especially with improved access to patient record systems and the sharing of information to improve patient care and treatment.

The Strategy's alignment to the wider strategic context



A shared vision for mental health

The national and local context

The following information highlights the impact various aspects of mental health have on society, highlighting the scale of the problem and the need to prioritise resources to address mental health.

One in four adults experience at least one **diagnosable mental health problem** in any given year (22).

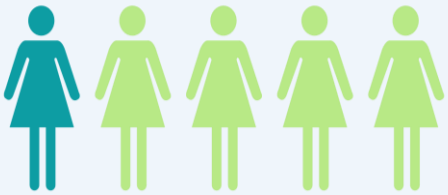
In Nottingham this would be **64,539 adults****

10% of children aged 5 - 16 have **significant mental health problems** (23)

This would be **4,243 children** In Nottingham**

50% of long-term mental health problems emerge by the age of **14**;

75% by the age of **18** (9)



A fifth of women under 24 years of age report 'ever' **having self-harmed** (10)

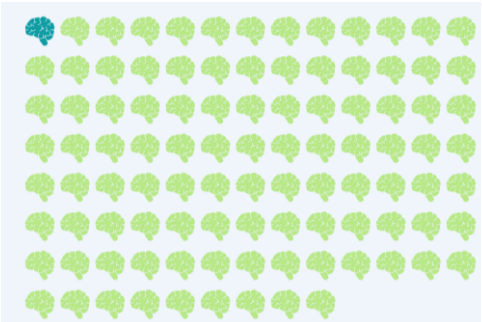
In Nottingham this would be **12,407 women****

1 in 10 new mothers experience **postnatal depression** (5)

In Nottingham this would be **431 new mothers****

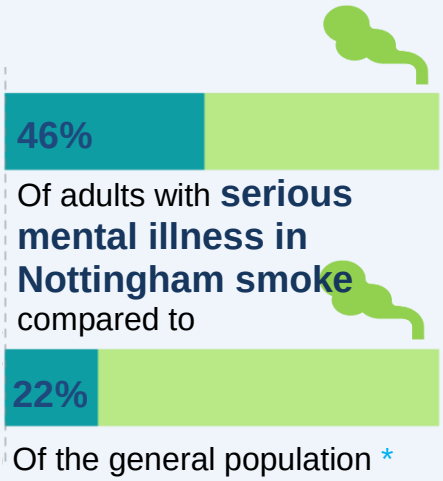
Around **25%** of mental health patients who die by suicide have a **major physical illness** (24).

Approximately **50%** of people who have died by suicide have a **history of self-harm**



About 1 in 100 people in the population have a **serious mental illness** (5).

In Nottingham this would be **3,253 people****



90% of all prisoners are estimated to have a **diagnosable mental health problem** (22).

This would be **954 of** Nottingham **inmates*****

Source: * PHE Local Tobacco Profile **ONS mid-2016 population estimates ***Department of Justice http://www.justice.gov.uk/contacts/prison-finder/nottingham

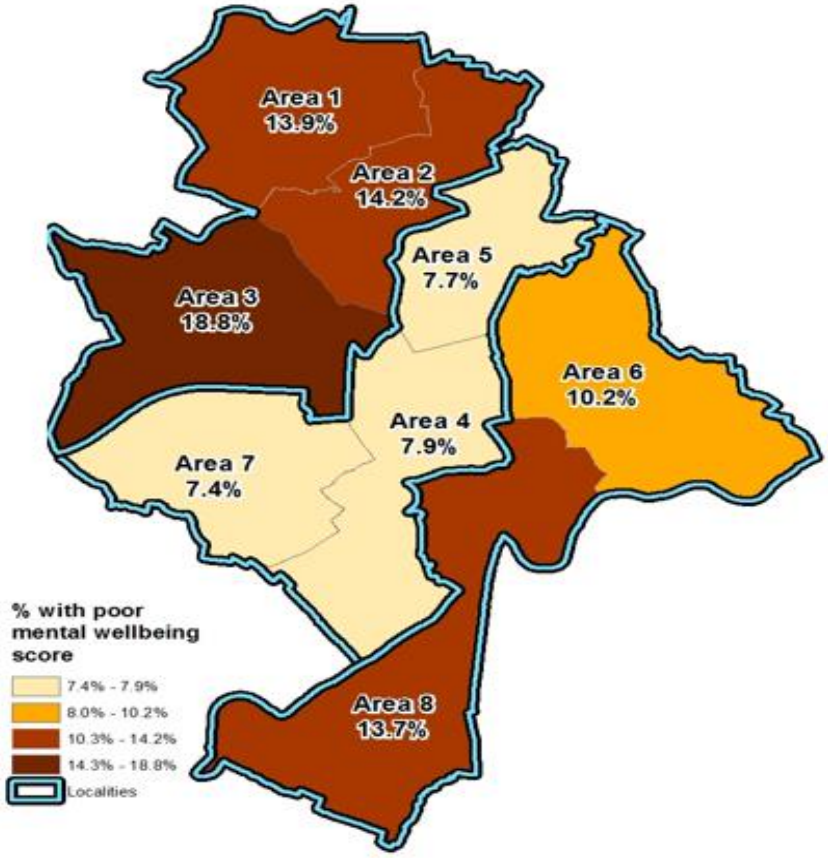
Nottingham context

Mental Wellbeing

Mental wellbeing in adults is measured in Nottingham by the annual citizens' survey using the Warwick Edinburgh Mental Wellbeing Scale (25) with approximately 2,000 people taking part. We do not know how well this reflects the mental wellbeing of citizens who do not take part in the survey, but the measure itself is a good indicator for those who do take part. A higher score on a range from 14-70 indicates better mental wellbeing. In 2017, the average mental wellbeing score for Nottingham City was 52.4, slightly higher than that of England 49.9 (26).

There is a need for caution in the interpretation of results broken down to populations smaller than Nottingham City. However, results suggest the need to improve mental wellbeing in the following groups that tend to have lower mental wellbeing scores: unemployed people, those otherwise not in paid work, those with a disability or long-term illness and people living in social rented housing. The areas of Nottingham that tend to report lower average mental wellbeing scores are Aspley, Bilborough, Leen Valley (Area 3 average score 49.7), Basford and Bestwood (Area 2 average score 50.8). With Area 3 having the highest proportion of respondents (18.8%) reporting a poor mental wellbeing score (Figure 5). The proportion of people reporting an above average mental wellbeing score (greater than 60) in 2017 was 21% of those surveyed, which is a reduction from 25% in the 2016 survey.

Figure 5: Percentage of Nottingham Citizen Survey respondents reporting a poor mental wellbeing score (2017)



Common and serious mental health problems

It is possible to estimate the numbers of people experiencing mental health problems based on national surveys. Figures 5a, 5b, 6a and 6b provide a visual representation of the range of mental health problems likely to be experienced by the population of Nottingham at any one time.

Due to the high levels of multiple risk factors experienced by the Nottingham population, together with a younger, more deprived and ethnically diverse community, these estimates should be treated with some caution and are likely to underestimate the true level of mental health problems in Nottingham.

For further information on the mental health needs of Nottingham City, see the following joint strategic needs assessment chapters:

- Adult mental health (2016)
- Mental wellbeing (2016)
- Suicide (2018)
- Emotional and mental health needs of children and young people (2015)
- Carers (2017)

Figures 6a and 6b highlight that, **based on national estimates, there are over 110,000 males and females aged 16+ years experiencing a range of mental health problems living in Nottingham**. Overall, more women than men have a lived experience of these problems. It is important to note that not all of these people will be known to or in receipt of mental health services. However, this profile provides an indication of the level of mental health need that exists in Nottingham in any given year.

Figures 7a and 7b illustrate, **based on national prevalence rates, there are over 5,000 boys and girls aged 5-16 years who experience mental health problems** including anxiety, depression and conduct disorders such as defiance, aggression and anti-social behaviour. Children experiencing such problems are more likely to have poorer outcomes and are more likely to experience mental health problems in adulthood. A limitation of this estimate is that the underlying national prevalence data is nearly 15 years old and rates of mental health problems amongst children may have changed.

Figure 6a. Estimate of mental health problems amongst **males** aged 16+ in Nottingham based on national prevalence

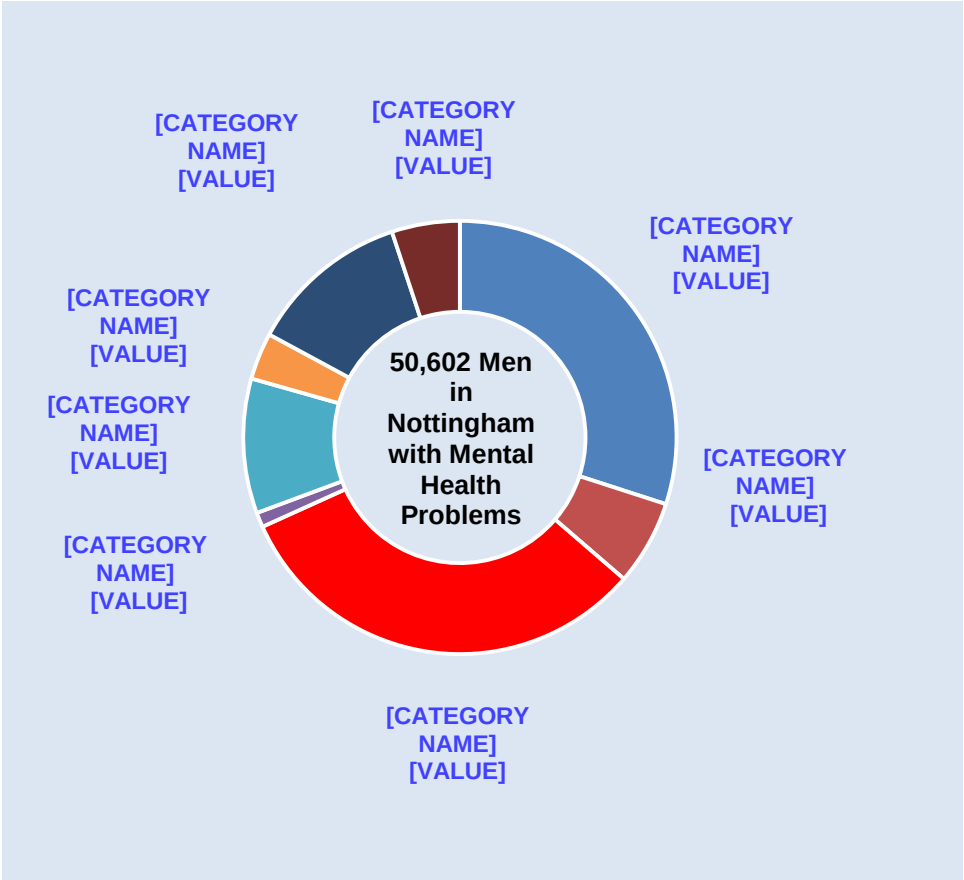
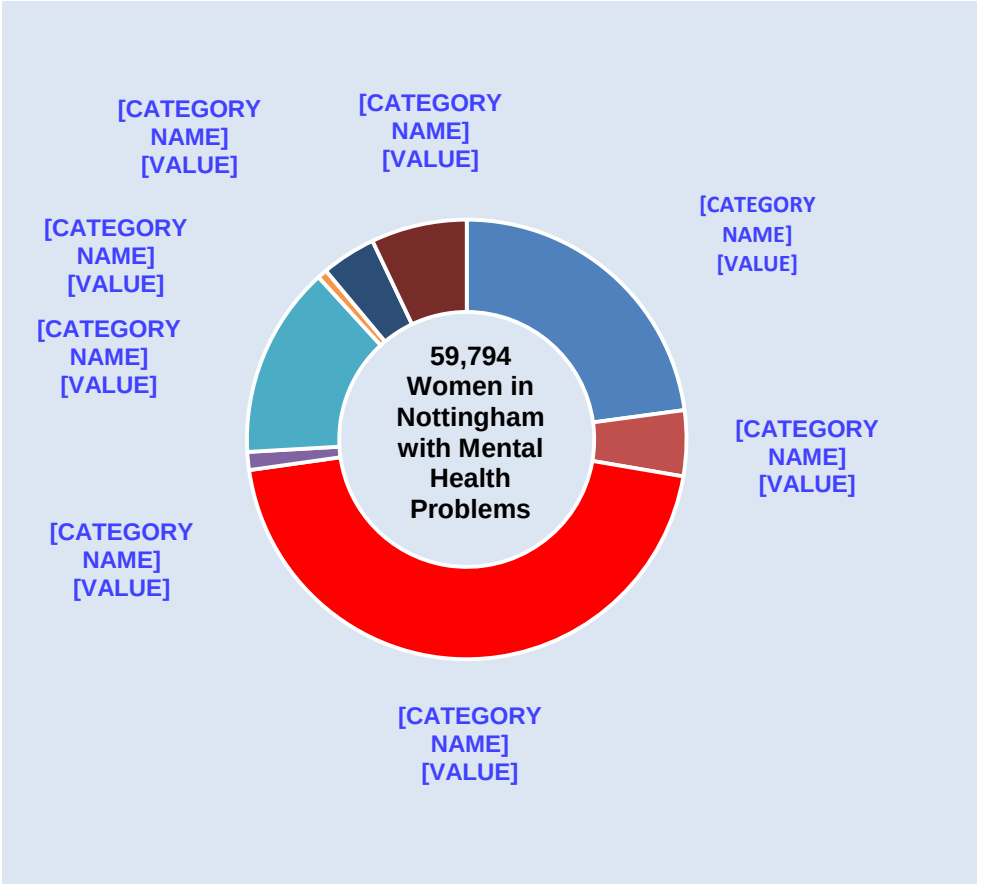


Figure 6b. Estimate of mental health problems amongst **females** aged 16+ in Nottingham based on national prevalence



Source: APMS (2014) and ONS mid-year population estimate (2016)

Figure 7a. Estimate of mental health problems amongst **boys aged 5-16 years** in Nottingham based on national prevalence

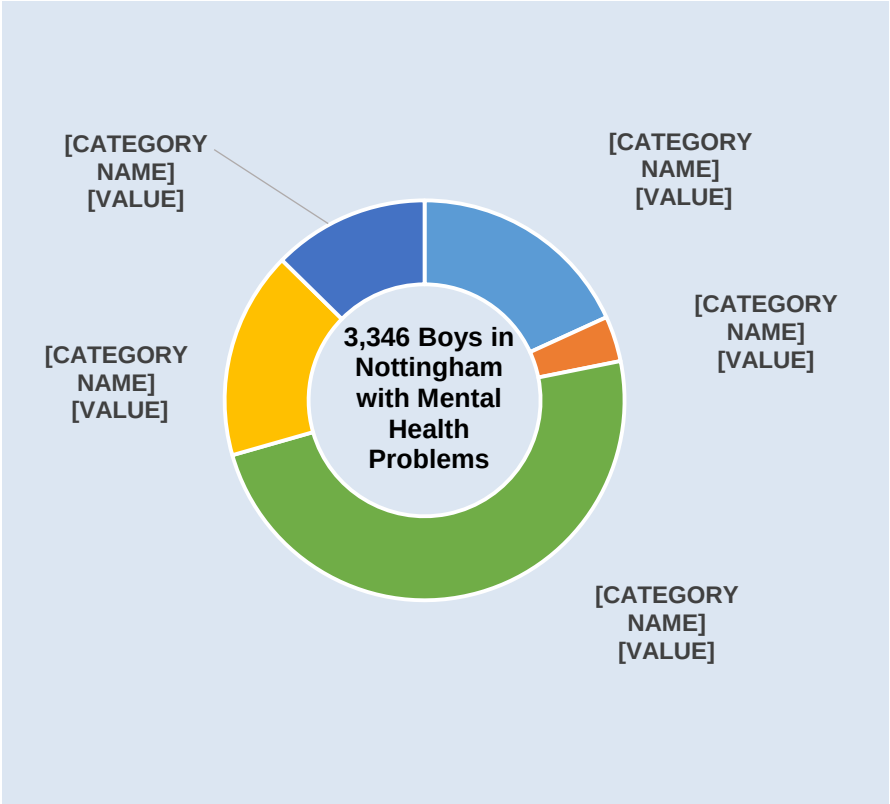
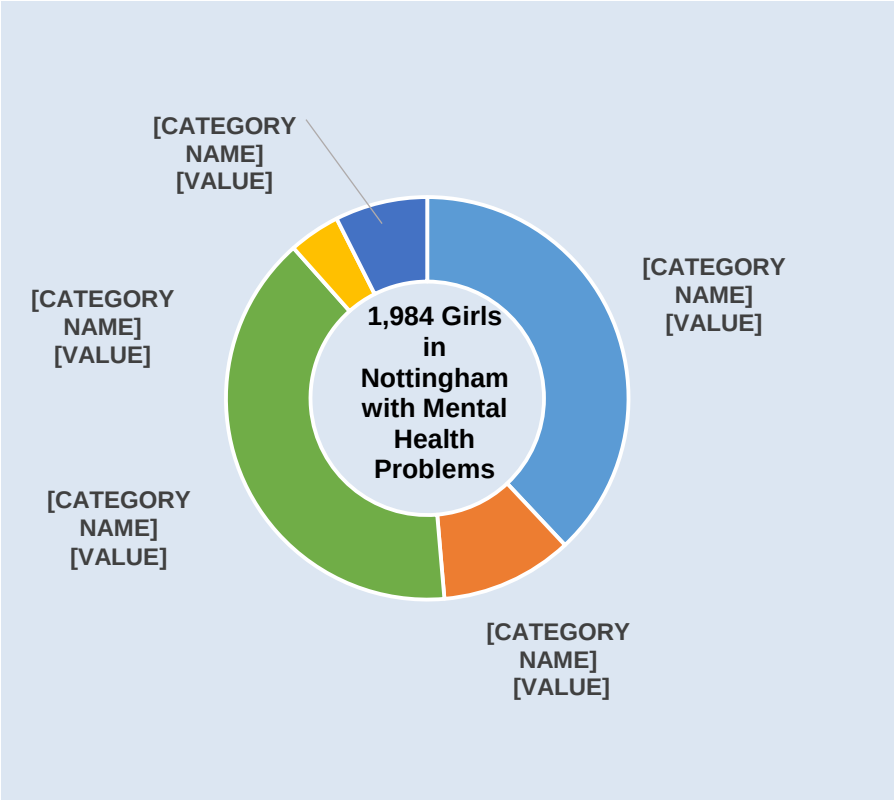


Figure 7b. Estimate of mental health problems amongst **girls aged 5-16 years** in Nottingham based on national prevalence



Source: Mental Health of Children and Young People in Great Britain (2004) and ONS mid-year population estimate (2016)

Resources and budgets

The full picture of spend on mental health services is not straightforward, in part because services are commissioned by different organisations. Also, because provision of universal services includes work to support good mental health in ways that mean specific funding cannot easily be disaggregated. Mental health treatment and support is primarily paid for by Nottingham City Council (children and adult social care), Clinical Commissioning Groups (primary and secondary mental health services) and NHS England (specialist inpatient mental health services and services in secure settings, such as prisons). However, the contribution of education, employers, community and voluntary sectors is acknowledged.

In 2016/17, Nottingham City Council spent £10 million, along with a further £4 million from the Nottingham City Clinical Commissioning Group, on adults with a primary support reason of mental health. This investment included the provision of a range of services, such as residential and nursing homes, care support and enablement, day care and direct payments. The cost has risen from the previous year and is likely to continue to rise due in part to an ageing population and people living longer with more ill health, greater complexity of needs and more disabling conditions (multi-morbidity).

In 2018/19, Nottingham City Clinical Commissioning Group invested £45 million on the provision of mental health services across primary care (Improving Access to Psychological Therapies and services in the community) and secondary care mental health services delivered by Nottinghamshire Healthcare NHS Trust, including community mental health teams, specialist mental health services and inpatient services.

The Local Transformation Plan identifies the spend on children's emotional and mental health for 2016/17 by each commissioning body, including:

- NHS England spent £2 million on inpatient provision including acute care, eating disorders, paediatric intensive care unit, low secure provision and Child and Adolescent Mental Health Service Learning Disability beds;
- Nottingham City Clinical Commissioning Group spent £3.7 million on community emotional and mental health provision; and
- Nottingham City Council spent just under £1 million on community emotional and mental health provision, including looked after children.

There is currently a risk within the health and social care system as a whole, whereby one organisation disinvests in an aspect of mental health service provision only for an increase in pressure to arise elsewhere. This is associated with a potential increase in cost to another part of the system essentially serving the same group of people in the population.

One option to mitigate the risk is to pool budgets across the health and social care system and to plan care in a more integrated way thus establishing a culture of collaboration and incorporating prevention as a central element (27). Nottingham City partners are currently working together through the Health and Wellbeing Board to realise this ambition. Integration beyond the Nottingham City boundary is in development under the All-age Integrated Mental Health and Social Care Strategy 2018.

Nottingham's strategy for mental health planning and investment

Learning from our previous strategy

This strategy builds on the previous mental health strategy for Nottingham City which covered the period 2014-2017. However, the current economic climate provides an opportunity to ensure that this refreshed strategy meets national and local strategic mental health priorities.

A strategy evaluation was conducted to inform future priorities and lessons that could be learnt. There were a number of areas where outcomes showed an improved trend over the strategy period. For example:

- Advancements in Improving Access to Psychological Therapies in terms of access, referral and completion
- An increase in the GP population with recorded depression and severe mental illness
- An increase in the percentage of mental health patients with comprehensive care plans
- An improved recovery rate for depression

Notwithstanding this progress, a number of areas require further focus and improvement. The gap in employment between those with mental health problems and the overall population has increased, as has the life expectancy gap. Those with mental health problems experience higher morbidity and mortality than those without. Admissions to hospital for mental health problems in children under 18 have also increased.

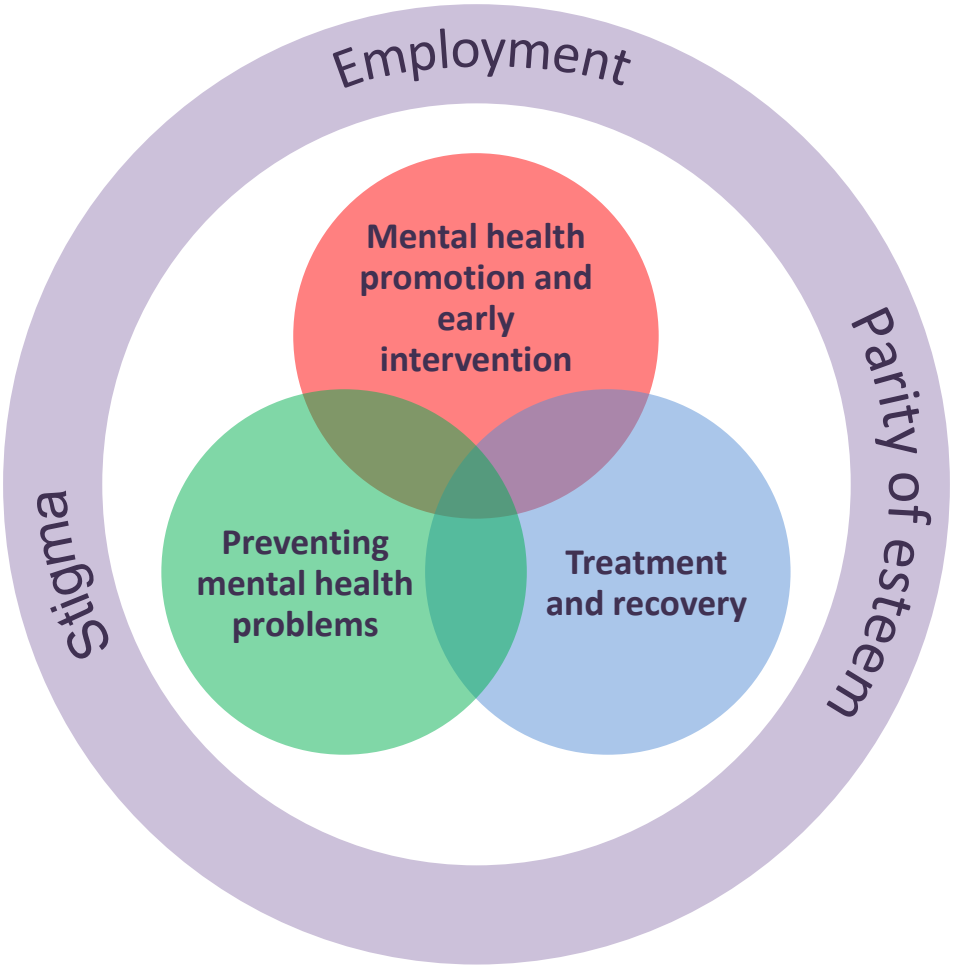
The gaps identified have informed our future strategic direction. The development of this strategy, its outcome measures and priorities include a clear need to continue focus on physical health and parity of esteem, early identification and recovery.

Nottingham's model

A report by the Chief Medical Officer for England (2013) states that central government departments, Public Health England, NHS England and others should consider adopting the World Health Organisation's framework approach. The report also strongly recommends local authorities, the NHS and clinical commissioning groups structure their funding and interventions in mental health using this framework.

Our mental health strategy builds on the World Health Organisation's framework, reflecting that actions may overlap across all three domains and the cross-cutting themes. The Nottingham City model (Figure 7) suggests that, in order to have a real impact on the mental health of our population, activity is required across all domains. **It is not enough to focus on treatment without prevention, whilst improving early intervention will not succeed without the availability of suitable treatment** (7).

Figure 8. Conceptual model of Nottingham's framework for the prevention of mental health problems, mental health promotion, treatment and recovery, derived from the World Health Organisation Public Mental Health Framework and the CMO 2013 model.



Preventing mental health problems

The prevention of mental health problems is concerned with the causes of disease and can be defined as:

> ***Mental disorder prevention aims to reduce the incidence, prevalence and***

recurrence of mental disorders, the time spent with symptoms and the risk conditions for mental illness, preventing or delaying recurrences and also decreasing the impact of illness in the affected person, their family and society. (7)

Preventive public mental health interventions should begin before and during childhood, as we know that half of all mental health problems develop before the age of 14 and three quarters develop by the age 25 (28). Further efforts to prevent mental health problems must continue into adulthood as part of a life course approach.

The focus for the **prevention** of mental health problems in Nottingham City will:

- Ensure comprehensive perinatal and infant mental health pathways are commissioned and delivered.
- Ensure all children, young people and families have easy access to timely, evidenced-based treatment of emotional/mental health difficulties. This should include educating other professionals to offer lower level and preventative emotional wellbeing support, whilst ensuring children and young people gain access to more specialist mental health treatments where required.
- Provide support to build resilience amongst Nottingham City's citizens most at risk from the impacts of social exclusion.
- Improve housing standards for Nottingham City citizens in private and rented accommodation.
- Promote self-help and ensure resources and signposting are available to help Nottingham City citizens improve and maintain their own mental health and wellbeing.
- Ensure that a strategic, needs-led training offer for mental health is available to organisations including suicide prevention, mental health first aid and trauma-informed practice.
- Develop a making every contact count prevention model that includes an emphasis on mental health.
- Adopt a mental health in all policies approach to emphasise mental health and wellbeing through all local public policy developments and not solely through healthcare policy.
- Become a signature to the Government's Prevention Concordat for Better Mental Health consensus statement.

Mental health promotion and early intervention

Mental health promotion is concerned with the determinants of mental health and can be defined as:

> ***"Mental health promotion activities imply the creation of individual, social and environmental conditions that enable optimal psychological and psychophysiological development. Such initiatives involve individuals in the process of achieving positive mental health, enhancing quality of life and narrowing the gap in health expectancy between countries and groups. It is an enabling process done by, with and for the people."*** (7)

The focus for mental health **promotion and early intervention** in Nottingham City will:

- Establish clear and consistent universal messages to help citizens understand how best to look after their mental health.
- Work towards becoming a trauma-informed health, care and education system. Identify citizens at risk of worse mental health through identification and appropriate interactions with citizens that are at risk of and experience trauma.
- Enable children and adults with, or at risk of, mental health problems to access the appropriate level of support as and when they need it.
- Enable children and adults with, or at risk of, mental health problems to lead healthier lifestyles through increased levels of physical activity, improved nutrition, reduced weight, reduced alcohol consumption and stopping smoking.
- Ensure the Improving Access to Psychological Therapies programme is expanded in response to local need in adults, children and high-risk groups, including people accessing substance misuse treatment and people with long-term conditions.
- Expand the primary mental health care offer to include social prescribing, debt advice, peer support and system navigation.
- Work with NHS England and the criminal justice system (including the Youth Offending Service) to better identify and support those who have or are at risk of mental health problems.
- Intervene earlier through improved information sharing at an organisational level and on an individual care basis.
- Promote greater integration of case management systems to improve decision-making and wider adoption of the single care record.

Treatment and recovery

Whilst approximately three quarters of individuals with physical disorders receive treatment, only about a quarter of people with mental health disorders do so. Furthermore, **people with mental illness die up to 15–20 years earlier on average than people without mental illness** (7).

Enabling individuals to recover from and avoid further mental health problems through effective, timely and appropriate high quality treatment is the third component of this strategy.

The focus for **treatment and recovery** in Nottingham City will:

- Ensure universal and targeted Child and Adolescent Mental Health Services are appropriate for local need.
- Reduce out-of-area placements in mental health services for adults in acute inpatient care.
- Ensure an appropriate response is available for people with multiple complex needs (mental health, substance misuse, homelessness and offending).
- Utilise trauma-informed approaches consistently across health and social care settings and the wider workforce.
- Ensure crisis support for children, young people and adults is available, effective and timely.
- Ensure all those identified as at risk of self-harm have safety plans.
- Ensure follow-up support is appropriate for those transitioning between settings including inpatient mental health, prison and the wider criminal justice system (including the Youth Offending Service), university and children's care.
- Establish integrated working between mental health and social care in order to provide high quality joined up planned care.
- Use relevant research and evidence to improve mental health outcomes. This will include research into improving the mental health outcomes of Nottingham's lesbian, gay, bisexual and transgender populations undertaken in 2019 by the University of Leicester and the University of Brighton.

Cross-cutting themes

In addition to the above three domains, the Nottingham City model incorporates three further cross-cutting themes: employment, parity of esteem and reducing stigma. These three themes require concerted attention in order to improve overall mental health across the City. There is local evidence (29) that some of Nottingham City's population, including the black, Asian and minority ethnic populations, experience mental ill health disproportionately as well as experiencing stigma and discrimination, lower levels of employment and negative experiences of accessing healthcare. As with other risk factors, where any individual or group of people experience multiple factors, over time these result in a greater negative impact upon mental health and wellbeing.

Employment

Unemployment is associated with an increased risk of mortality and morbidity, including poor mental health, suicide and health-damaging behaviours (30). Mental health problems can be considered as both a risk factor for 'worklessness' and an outcome of it. As such, **mental health problems are a leading cause of sickness absence in the UK, with over 15 million days lost (11.5% of total days lost)** due to stress, depression and anxiety in 2016, an increase of more than 24% since 2009. Furthermore, individuals can become trapped in a cycle whereby mental health problems can create and maintain 'worklessness', which then worsens mental health (7).

The focus for **employment** in Nottingham City will:

- Enable those with, or at risk of, mental health problems to secure and maintain employment.
- Establish financial resilience as a component of good quality care for people experiencing mental health problems.
- Develop a strategic approach to improving the mental health of people in employment so that they remain employed. This might include the widespread adoption of reasonable adjustments.
- Provide support to navigate benefits and universal credit, especially for those with debt and financial issues.
- Take action to improve the mental health and wellbeing of our workforce and, in doing so, provide an example of good practice to other local employers.

Parity of esteem

The term 'parity of esteem' was introduced in 2011 in the Government's mental health strategy 'No Health without Mental Health'. It refers to the equal status of mental and physical health. **Parity of esteem seeks to ensure that all health and social care services view and treat mental and physical health problems equally**. Services and health workers have traditionally focused on one aspect or the other, which can lead to gaps in addressing health needs.

People with physical health problems, especially chronic diseases, are at increased risk of mental health problems, particularly depression and anxiety. Around 30% of people with a long-term physical health condition also have a mental health problem (13).

The focus for **parity of esteem** in Nottingham City will:

- Enable those with serious mental health problems to lead healthier lives and ensure those with long-term physical health conditions have their mental health needs addressed.
- Support the implementation of smokefree settings at Nottinghamshire Healthcare NHS Foundation Trust and Nottingham University Hospitals NHS Trust.
- Develop a strategic approach to a mental health training offer for front-line staff to understand mental health problems and mental health stigma.
- Establish a greater emphasis on mental health across universal health and care services, including provision of training for staff about emotional development, trauma-informed approaches and mental health (accompanied by access to consultation and advice from clinical specialists where required).

Reducing stigma

Stigma against people with mental health problems can have a substantial public health impact and can be defined as:

> ***…an attribute that is deeply discrediting and that reduces the bearer from a whole and usual person to a tainted, discounted one.*** (31)

Stigma and discrimination against people with mental health problems can have a substantial impact which can further inequalities: including poor access to mental and physical healthcare; reduced life expectancy; exclusion from higher education and employment; increased risk of contact with the criminal justice system; victimisation; poverty and homelessness (7).

The 2014 Adult Psychiatric Morbidity Survey of Mental Health showed that a fifth of people seek help from family, friends and neighbours following an attempted suicide. Therefore, reducing stigma in local communities is important to reducing barriers to people seeking help (24).

In 2018, Nottingham became the East Midlands Time to Change hub. The intention is to become a city where people talk openly about mental health problems in the same way as physical health issues, without fear of stigma or discrimination. Time to Change is a growing social movement aimed at changing how we all think and act about mental health. Too many people with mental health problems are made to feel isolated, worthless and ashamed. Our plans for the hub will be co-produced with people who have a lived experience, focusing on men, the workplace and the African-Caribbean community.

The focus for **reducing stigma** in Nottingham City will:

- Raise awareness of mental health stigma and discrimination via the Time to Change programme, ensuring actions are embedded and sustained.
- Reduce the level of stigma experienced by citizens, including: those with learning disability; those in black, Asian and minority ethnic groups; older people; the homeless; offenders; those affected by trauma; those affected by substance misuse and lesbian, gay, bisexual and transgender people.
- Develop mental health champions within the statutory and non-statutory workforce.
- Develop and support public-facing campaigns that raise awareness of mental health problems and challenge stigma.

Our aim will be achieved through these actions relating to our three key areas:

- Preventing mental health problem
- Mental health promotion and early intervention
- Treatment and recovery

As well as our three crosscutting themes:

- Employment
- Mental health stigma
- Parity of esteem

Progress towards our aim will be monitored through the existing mechanisms for mental health reporting, including the Nottingham City Health and Wellbeing Board, the Mental Health Partnership Board and the Clinical Commissioning Group Governing Body.

References

1. WHO. Mental Health a state of wellbeing [Internet]. 2014 [cited 2018 Mar 2]. Available from: http://www.who.int/features/factfiles/mental_health/en/

2. NHS Digital. Mortality rate three times as high among mental health service users than in general population [Internet]. 2012. Available from: http://content.digital.nhs.uk/article/2543/Mortality-rate-three-times-as-high-among-mental-health-service-users-than-in-general-population

3. Cooper R, Boyko C, Codinhoto R. Mental Capital and Wellbeing : Making the most of ourselves in Mental Capital and Wellbeing : Making the most of ourselves in the 21st century. Foresight [Internet]. 2008;1–22. Available from: http://www.bis.gov.uk/assets/bispartners/foresight/docs/mental-capital/learning_through_life.pdf

4. Mental Health Strategic Partnership. Building resilient communities: Making every contact count for public mental health. 2013;(August):1–49. Available from: http://mentalhealth.org.uk/content/assets/PDF/publications/building-resilient-communities.pdf

5. HM Government. No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages. Policy. 2012;1–103.

6. NHS Choices. Psychosis [Internet]. Available from: https://www.nhs.uk/conditions/psychosis/

7. Dame P, Davies SC. Annual Report of the Chief Medical Officer 2013 Public Mental Health Priorities: Investing in the Evidence. [cited 2018 Jan 31]; Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413196/CMO_web_doc.pdf

8. Kessler RC, Angermeyer M, Anthony JC, DE Graaf R, Demyttenaere K, Gasquet I, et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. [Internet]. Vol. 6, World psychiatry : official journal of the World Psychiatric Association (WPA). 2007. p. 168–76. Available from: http://www.ncbi.nlm.nih.gov/pubmed/18188442%5Cnhttp://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=PMC2174588

9. Jones PB. Adult mental health disorders and their age at onset. Br J Psychiatry [Internet]. 2013;202:s5–10. Available from: https://pdfs.semanticscholar.org/7d75/ef8f4f93f3cb42e427895e8a876bb2860212.pdf

10. McManus S, Bebbington P, Jenkins R BT (eds. . (2016). Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS. 2016; Available from: https://digital.nhs.uk/catalogue/PUB21748

11. DH. Confident Communities , Brighter Futures. A framework for developing wellbeing. 2010;

12. MHF. Health inequalities manifesto 2018. 2018;1–22.

13. Naylor C, Parsonage M, McDaid D, Knapp M, Fossey M, Galea A. Long-term conditions and mental health: The cost of co-morbidities [Internet]. The King's Fund and Centre for Mental Health. 2012. p. 1–32. Available from:

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf

14. Panel JC. Public Mental Health Services. 2013;(July):1–58.

15. Naylor C, Das P, Ross S, Honeyman M, Thompson J, Gilburt H. Bringing together physical and mental health A new frontier for integrated care. 2016 [cited 2018 Jan 31]; Available from: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Bringing-together-Kings-Fund-March-2016_1.pdf

16. Foley T. Bridging the Gap : The financial case for a reasonable rebalancing of health and care resources. 2013;(October):1–31.

17. Mcdaid D, Park A-L, Knapp M, Ali N, Appleby L, Belsman L, et al. Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Ill-Health Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Ill- Health Commissioning Co. 2017; Available from: www.gov.uk/phe%0Awww.facebook.com/PublicHealthEngland

18. Knapp, M.; McDaid, D.; Parsonage M. Mental Health Promotion and Prevention: The Economic Case. UK Dep Heal [Internet]. 2011;(January):48. Available from: http://www.lse.ac.uk/businessAndConsultancy/LSEEnterprise/pdf/PSSRUfeb2011.pdf

19. Mental Health Foundation. Better Mental Health For All: A public health approach to mental health improvment. 2016;65.

20. The Marmot review. The Marmot review: Fair society, healthy lives. 2010;1–242. Available from: http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf

21. Laursen TM, Nordentoft M, Mortensen PB. Excess Early Mortality in Schizophrenia. Annu Rev Clin Psychol [Internet]. 2014;10(1):425–48. Available from: http://www.annualreviews.org/doi/10.1146/annurev-clinpsy-032813-153657

22. CentreForMentalHealth(forNHS). 13 The five year forward view for mental health. Ment Heal Taskforce. 2016;(February):82.

23. Public Health England. The mental health of children and young people in England. 2016;(December):1–33.

24. Department of Health. Preventing suicide in England : Third progress report of the outcomes strategy to save lives. 2017;(January).

25. NHS Health Scotland. Measuring Mental Wellbeing Warwick Edinburgh Mental Wellbeing Scale [Internet]. Available from: http://www.healthscotland.scot/tools-and-resources/wemwbs

26. Morris S, Earl C, Neave A. Health Survey for England 2016 Well-being and mental health Health Survey for England 2016: Well-being and mental health. Heal Surv Engl [Internet]. 2017;(December):1–20. Available from: http://healthsurvey.hscic.gov.uk/media/63763/HSE2016-Adult-wel-bei.pdf

27. NHS Confederation. What the NHS needs to see from the social care green paper [Internet]. 2018. Available from: http://www.nhsconfed.org/-/media/Confederation/Files/Publications/Social-care-green-paper-briefing-WEB.pdf

28. Kessler R et. 2005 Lifetime prevalence and age-of-onset distributions of DSM-IV

disorders.pdf. 2005.

29. Burton, J Hadid, D and Denness H. Health Needs Assessment of the Black and Minority Ethnic populations within Nottingham City. 2017.

30. Public Health England. The importance of health and work [Internet]. 2017. Available from: https://www.gov.uk/government/publications/health-and-work-infographics/the-importance-of-health-and-work

31. Goffman E. Stigma: notes on the management of spoiled identity. Simon & Schuster; 1963.

32. CSDH. Closing the gap in a generation [Internet]. Closing the gap in a generation. Health Equity Through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health. 2008. p. 246. Available from: http://www.bvsde.paho.org/bvsacd/cd68/Marmot.pdf%5Cnpapers2://publication/uuid/E1779459-4655-4721-8531-CF82E8D47409

33. Mental Health Foundation. Black, Asian and minority ethnic (BAME) communities. 2019. Available from: https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities

34. Mind (2013). Mental health crisis care: commissioning excellence for Black and minority ethnic groups. A briefing for Clinical Commissioning Groups, March 2013.

35. Mental Health Foundation (2016) Fundamental Facts About Mental Health.

36. NHS Digital (2014) Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England

37. Qassem, T., Bebbington, P., Spiers, N., McManus, S., Jenkins, R., & Dean, S. (2015). Prevalence of psychosis in black ethnic minorities in Britain: Analysis based on three national surveys. Social Psychiatry and Psychiatric Epidemiology, 50(7), 1057–1064.

38. Mental Health Foundation (2016) Mental health statistics: carers.

39. Carers UK (2018) State of caring 2018.

40. Carers UK (2015) Facts about carers.

41. Carers Trust (2013) The Triangle of Care. Carers Included: A Guide to Best Practice in Mental Health Care in England. Second Edition. London.

42. Royal Society for Public Health (2018). Life on Debt Row. London.

43. Mental Health Foundation. Debt and mental health. 2019. Available from: https://www.mentalhealth.org.uk/a-to-z/d/debt-and-mental-health

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HEALTH AND WELLBEING BOARD

24 July 2019

	Report for Information
Title:	Clinical and Community Services Strategy
Lead Board Member(s):	
Author and contact details for further information:	Lewis Etoria Head of Communications and Engagement Nottingham and Nottinghamshire ICS and CCG Lewis.etoria@nhs.net
Brief summary:	This paper summarises the work of the Clinical and Community Services Strategy. The strategy provides a framework for the future model of clinical and community health and wellbeing services across Nottingham and Nottinghamshire and will drive the work to develop services in terms of what will be delivered where. A draft of the strategy has been developed and is provided with this paper. A presentation summarising the strategy will be provided.

Recommendation to the Health and Wellbeing Board:

The Health and Wellbeing Board is asked to:

a) Review the content of the strategy and receive the summary presentation and provide feedback on the strategy and its likely impact

Contribution to Joint Health and Wellbeing Strategy:	
Health and Wellbeing Strategy aims and outcomes	**Summary of contribution to the Strategy**
Aim: To increase healthy life expectancy in Nottingham and make us one of the healthiest big cities	The Clinical and Community Services Strategy aims to contribute to increasing healthy life expectancy and reducing health inequalities by establishing a new model of care for healthcare services that focuses on prevention and early intervention. The strategy has a clear focus on people and places rather than services and organisations. It will drive service reviews that aim to design care around people and communities. One of the key principles underpinning the
Aim: To reduce inequalities in health by targeting the neighbourhoods with the lowest levels of healthy life expectancy	
Outcome 1: Children and adults in Nottingham adopt and maintain healthy lifestyles	
Outcome 2: Children and adults in Nottingham will have positive mental wellbeing and those with long-term mental health problems will have good physical health	

Outcome 3: There will be a healthy culture in Nottingham in which citizens are supported and empowered to live healthy lives and manage ill health well	strategy is that mental health and wellbeing will be considered alongside physical health and wellbeing.
Outcome 4: Nottingham's environment will be sustainable – supporting and enabling its citizens to have good health and 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 strategy sets out a number of clinical design principles that will underpin the service reviews that it drives. One of these is that mental health and well-being will be considered alongside physical health and wellbeing.

Background papers: *Documents which disclose important facts or matters on which the decision has been based and have been relied on to a material extent in preparing the decision. This does not include any published works e.g. previous Board reports or any exempt documents.*	

Clinical and Community Services Strategy

Briefing Paper

Purpose and background

This paper summarises the work of the Clinical and Community Services Strategy. The strategy provides a framework for the future model of clinical and community health and wellbeing services across Nottingham and Nottinghamshire and will drive the work to develop services in terms of what will be delivered where.

The Clinical and Community Services Strategy has been developed based on robust evidence and citizen engagement. The ongoing work to review services in line with the model set out in the strategy has citizen involvement embedded within its approach.

A draft of the strategy has been developed and is provided with this paper.

Case for change

The Clinical and Community Services Strategy has been developed in response to a number of challenges facing the health and care system in Nottingham and Nottinghamshire. These challenges form our case for change.

Improving health and wellbeing
Depending on where you live, overall life expectancy and healthy life expectancy can vary significantly across Nottingham and Nottinghamshire. Addressing these health inequalities is a key objective of the Integrated Care System (ICS). Our clinical and community services need to take account of the wider determinants of health to have an impact in this area.

Transforming the quality of care
Our citizens have told us that they want easier access to services and greater control over their own health and wellbeing. This means transforming the way that services are delivered, for example making greater use of technology to improve access.

Clinical sustainability
The current healthcare system is clinically unsustainable. Our services cannot keep pace with the increases in demand. This means that we need to transform how and where services are delivered and move to a more proactive model of care that focuses on prevention and early intervention.

Workforce
To improve health and wellbeing and transform our healthcare system we need to have people with the right skills and expertise in the right locations. As with other healthcare systems, we face a number of challenges in recruiting and retaining the

staff we need. The ICS People and Culture Strategy sets out how we will recruit and retain the staff we need to provide the right services across the system.

Sustainable finances
The healthcare system faces a significant financial gap, which is projected to increase if we do not change how we deliver services. Much of the cost increases in the system are driven by increases in demand. A transformed health and care model needs to focus on prevention and early intervention to reduce demand to be financially sustainable.

Our clinical model

Our Clinical and Community Services Strategy sets out six principles that define our clinical model. These principles have been developed over a series of clinically led workshops. They are informed by what our citizens have told us over recent years across a range of engagement activities. Our clinical design principles underpin all of the work that this strategy will drive.

Our clinical design principles

- Principle 1 - Care and support will be provided as close to home as is both clinically effective and most appropriate for the patient, whilst promoting equality of access
- Principle 2 - Prevention and early intervention will maximise the health of the population at every level and be supported through a system commitment to 'make every contact count'
- Principle 3 - Mental health and well-being will be considered alongside physical health and wellbeing
- Principle 4 - The model will require a high level of engagement and collaboration both across the various levels of the ICS and with neighbouring ICSs
- Principle 5 - The models of care to be developed will be based on evidence and best practice, will ensure that pathways are aligned and will avoid un-necessary duplication.
- Principle 6 - They will be designed in partnership with local people and will operate across the whole healthcare system to deliver consistent outcomes for patients through standardised models of care except where variation is clinically justified.

Our clinical model is based around a life continuum, which recognises that people need different types of support at different times in their lives. Our life continuum includes a progression of care needs.

Progression of care needs

- Staying healthy
- Living well
- Care in a crisis

- Managing illness
- End of life

Our model is summarised in the diagram at Appendix 1.

Given the challenges and expectations of the people of Nottingham and Nottinghamshire we are being ambitious in our proposed changes. There are some things that we will not change. These are our fixed reference points to support service and capital planning. They are set around core areas of urgent access and interdependency of services in those locations. While many services not on this list will not change location, their future planning will be undertaken by reference to these fixed points through the service review process and engaging with patients and the public.

Agreed fixed points of delivery

- **Kingsmill Hospital** - Accident & Emergency for all patients and antenatal and postnatal obstetrician led services
- **QMC Nottingham** - Accident & Emergency for all patients; Major Trauma & associated services; Antenatal and Postnatal Obstetrician led services; Neonatal Intensive Care; Nottingham Children's Hospital
- **Newark Hospital** - Designated range of Commissioner Requested Services which includes high volume/low complexity elective care and diagnostics plus Urgent Care services
- **Rampton Hospital** - High secure mental health facilities
- **Wells Road Centre Nottingham** - Low secure adult mental health facilities
- **LIFT and PFI facilities** - All the LIFT and PFI healthcare facilities will be effectively used.

Delivering our new model of care

Our Clinical and Community Services Strategy is underpinned by other work being progressed across the system.

Informatics and technology strategy
Maximising use of technology will be essential to delivering our new model of care. Our Informatics and Technology Strategy prioritises work to develop an integrated shared care record. Without better use of information across the system we cannot make the shift to a more proactive and prevention based model of care.

Estates
Our Estates Strategy, with the service reviews being driven by the Clinical and Community Services Strategy, will help guide decisions about where services will be located.

Workforce

The ICS has developed a People and Culture Strategy that sets out how we will review the workforce needs of a transformed system.

Demand and capacity modelling
Our Clinical and Community Services Strategy will seek to reduce demand on services and shift activity from acute hospital settings to a community setting. It may also result in the relocation of services as a consequence of service reviews, which will require closer consideration of impact and potentially public consultation. To support these decisions there is a need to develop a system wide approach to demand and capacity modelling – analysis to understand how to meet the health needs of the population.

Next phase of strategy development

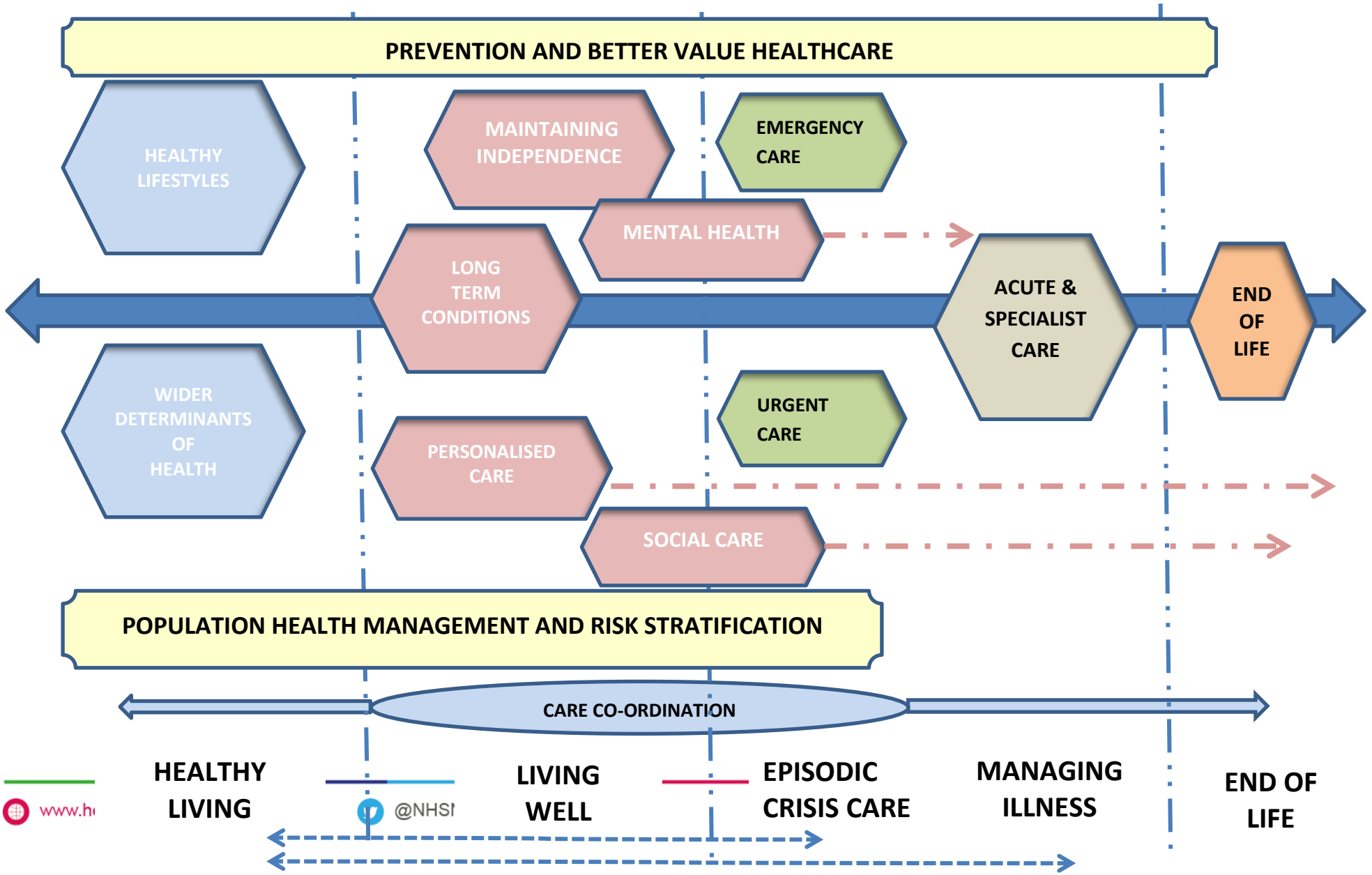
Driven by the clinical model developed within this draft strategy, we are currently undertaking a range of service reviews. While a minimum of 20 service reviews have been identified, the following have been prioritised and are underway.

- Cardio vascular disease – stroke
- Respiratory – COPD and asthma
- Frailty
- Children and young people
- Colorectal services
- Maternity and neonates.

Each of the above service reviews is underpinned by our clinical design principles and is driven by clinical and patient input. Each review includes has patient engagement embedded across its approach and involves clinicians, health professionals and patients in developing end-to-end care pathways.

Integrated Care System
Nottingham & Nottinghamshire

Appendix 1



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ACUTE, COMMUNITY AND PRIMARY CARE SERVICES

CLINICAL & COMMUNITY SERVICES STRATEGY

DRAFT

Contents

1. EXECUTIVE SUMMARY

In Nottinghamshire we have made great progress in improving people's health and wellbeing. Today, we can treat diseases and conditions we once thought untreatable: cancer survival rates, for instance, have increased dramatically in just twenty years.

However, with great improvements come new challenges. While we now live longer, for many these additional years are not lived in good health. The growing prevalence of long-term health conditions, for instance, places new strains on our health and care services. There is inequality evident in both the location of challenges and in access to services. In some areas, it is easier to access a GP than in others, or to find things to do to keep you active and fit.

As the challenges our health and care system faces change, so must our services. In this endeavour, we start with a simple goal: to ensure everyone in Nottinghamshire has the best possible health and wellbeing they can. This means more people able to live full and independent lives in their homes, more care provided for them near those homes, better local access to health and care services, and a greater focus on the prevention of illnesses, not just their treatment.

Our vision for the ICS is ambitious.

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

The Need for an ICS Clinical & Community Strategy

The NHS Long Term Plan is clear that to meet the challenges that face the NHS it will increasingly need to be:

- More joined up and coordinated in its care
- More proactive in the services it provides
- More differentiated in its support offer to its individuals.

Explicit within this is the recognition that some of the service changes necessary may not be in the interests of individual organisations but are required to maximise what can be achieved for the individual patient and the whole system.

Nottingham and Nottinghamshire has the benefit of long established relationships and partnerships and these are the basis on which our new models of care and clinical strategy are being developed.

The Strategy Development Process

This Strategy has been developed through an open and inclusive process which weaves together the expertise of both clinicians and care experts with citizens in determining the future shape of services across the system.

This Clinical and Community Services Strategy does not sit in isolation, it is an integral part of the components that will be necessary to make our new system function effectively and deliver the desired outcomes.

The strategy provides the framework for future service model development and to help understand what services will be delivered where.

The Case for Change

We have made great strides in improving the health and care that our population receive, but to continue to improve outcomes and stay within the funding allocated by the Government we recognise we need a major transformation programme which will require all sectors – NHS, social care, local authority, private and voluntary to work collaboratively with our citizens to radically redesign the way we deliver our services.

Delivering the NHS Five Year Forward View Triple Aims is a major driver of our case for change. The Triple Aims are;

Improving Health & Well-being

There are currently 1.1m people in the Nottingham and Nottinghamshire ICS which is set to increase by 3% by 2024 and by 10% by 2039.

Depending on where you live in Nottingham and Nottingham, people have different overall life expectancy and healthy life expectancy (i.e., the number of years a person lives in 'good health'). This variation is significant and is a key outcome that the ICS wishes to make improvements in to close the gap.

Deprivation and socio-economic factors are key drivers of this inequity - unemployment, lower qualifications and less healthy lifestyle choices (healthy eating, smoking, overweight/obesity, low physical exercise) consistently result in poorer health and wellbeing outcomes.

Transforming the Quality of Care

Our citizens want to be able to receive services in a very different way to that which their parents and grandparents did. They have told us they want easier access to services closer to home, increased use of technology, such as options of web based consultations and other ways that enable them to take greater control of their health and well-being whilst still being able to see a doctor face-to-face when it's really needed.

Clinical Sustainability

The current healthcare system is clinically unsustainable driven by demand pressures, insufficient levels of out of hospital services and staff shortages.

From an activity perspective all modes of service delivery have increased year on year such that A&E attendances have seen a 4% increase in the last 3 years with a 17% increase in those aged 70+. Inpatient episodes have also increased by 7% over the last 3 years.

Circulatory disease (including stroke, coronary heart disease), Cancers and Respiratory diseases currently account for 60% of the diseases that cause the gap in life expectancy between the most and least deprived areas in Nottinghamshire and these are set to rise. Evidence has confirmed that these diseases can be prevented by improving lifestyle choices.

The pressures on our current services are unsustainable and require a significant

transformation in not only how and where services are delivered, but also how we shift to a more proactive model of care that focuses on preventing the population developing the disease burden in the first place.

Workforce Challenges

Workforce is a key driver for change within our system. We employ a wide range of talented and dedicated staff across our services who provide excellent care and support to our populations.

However, it is becoming increasingly difficult to recruit staff with the right skills and expertise in the right locations as there are national shortages of staff entering training places or wanting to join these professions. We know that measures such as trying to recruit more staff or increasing wages alone are not going to solve this issue so we need to consider different options of how we recruit and retain the necessary workforce.

We face a number of challenges across our ICS in relation to workforce related issues. These include aspects such as high sickness and turnover rates; high reliance on agency staff and high vacancy rates. Our local estimates indicate that based on current demand trajectories we will have a shortage of at least 1500 clinical staff over the next five years. This is exacerbated by a reduced supply of graduates and an ageing workforce with a significant number of staff reaching retirement age.

Our People and Culture strategy outlines a range of initiatives and actions that need to be taken for us to address this significant workforce challenge. These are aligned to four strategic workforce objectives;

1. Recruitment & retention supporting our current workforce;
2. Supporting and retaining our students;
3. Developing and supporting new roles;
4. Preparing the workforce for new ways of working.

Sustainable Finances

The ICS currently spends £3.2bn annually on health and care services and for a number of years has been spending more money than it receives from the Government. Without change, the situation will get worse.

Key challenges are growth in activity/demand (health and social care), provider pay pressures and non-delivery of efficiency programmes.

The system faces a gap of £159.6m in 2019/20 representing 4.9% of the total system resources – this gap is expected to increase to in excess of £500m by 2023/24 for NHS services alone if we do not change the way in which we design services and work with our populations to improve their health and well-being to prevent them entering ill-health in the first place.

To a large extent these cost increases are driven by projected increases in demand for healthcare services. If there was no projected increase in demand for services the financial gap would actually narrow to £50m due to the funding increases expected.

Current services are not set up to enable our staff to work as efficiently or as effectively as they could or to deliver as much health care as could be provided if services were better organised. It is therefore imperative that we drive forward our transformational change in order that we will be able to deliver services and meet the needs of our local populations within the available resources.

We can only spend the money that the Government has allocated to us – to do otherwise is unfair on other areas and other parts of the public sector. But this isn't simply about reducing spend – by doing things differently, we can change the way that we deliver services that mean people get treatment when it is needed and are supported to stay well whilst spending less money.

Developing the Clinical Model

We have held a series of clinically led workshops in which over 200 clinicians and health and care professionals from a wide range of disciplines and all parts of our system were represented and developed the following set of design principles have been agreed with the Programme Board to build on the vision and system challenges;

- Principle 1 – Care and support will be provided as close to home as is both clinically effective and most appropriate for the patient, whilst promoting equality of access
- Principle 2 – Prevention and early intervention will maximise the health of the population at every level and be supported through a system commitment to 'make every contact count'
- Principle 3 – Mental health and well-being will be considered alongside physical health and wellbeing
- Principle 4 – The model will require a high level of engagement and collaboration both across the various levels of the ICS and with neighbouring ICSs
- Principle 5 – The models of care to be developed will be based on evidence and best practice, will ensure that pathways are aligned and will avoid un-necessary duplication.
- Principle 6 – They will be designed in partnership with local people and will operate across the whole healthcare system to deliver consistent outcomes for patients through standardised models of care except where variation is clinically justified.

The Clinical Model Framework

Our aspiration is that we want people to live healthy and fulfilling lives. However, we also recognise that at times throughout their life, people will become unwell and that they will need different services at different points in their lives.

Our clinical model is based around a life continuum – recognising that people will move both up and down the continuum in terms of the support and intervention that they need. This model is supported by some key cross cutting aspects such as population health management and 100% risk stratification, prevention being everybody's responsibility and a focus on personalisation and self-care.

A recognised progression of care needs has therefore been utilised within the development of this clinical and care strategy. These include;

- **Staying Healthy**
  - Primary Prevention & Education
  - Wider determinants of health
- **Living well**
  - Primary & secondary prevention
  - Maternity and Children's Services
  - Universal Personalised care
  - Living with a Long-term health or care need (including mental ill health)
- **Care in a Crisis**
  - Care that is needed on an emergency or same day/ urgent basis
- **Managing Illness**
  - Planned acute or specialist care (including cancer care) and support with the aim to return back to living well.
- **End of Life**
  - Patient centred with joint decision making

Delivering Our New Models of Care

To support this clinical model there is an ongoing process of clinically and professionally led service reviews. These reviews are utilising a systemic approach to consider where and how we currently deliver services and compare these against benchmarking data, national and international models of best practice and ongoing developments in technology and infrastructure. This will enable us to determine;

- Size and configuration of future estate
- Shared and inter-connected IT systems
- Skills, configuration and requirements for our future workforce models

Our system is developing across 3 levels of collaboration;

- Primary Care Networks (PCNs) consisting of integrated health and care teams linking with wider local authority housing and community services across neighbourhood localities
- Integrated Care Providers (ICPs) facilitating the integrated provision and delivery of outcomes for the population. Three ICPs have been agreed - Mid Notts, South Notts and Nottingham City
- Integrated Care System (ICS) for the whole of Nottingham and Nottinghamshire

Conclusion

This Clinical and Community Services Strategy starts to define what needs to be delivered and to some extent, where and when that care needs to be delivered in our future vision. This will continue to be developed further during the next stage of the strategy development. However, its success is dependent on the 3 levels of our system continuing to collaborate, develop and mature into effective commissioning and integrated delivery structures. We have a compelling need for change, driven by the changing needs of our local population, financial and workforce drivers and by the need to ensure we are consistently offering the best evidence based services for all of our citizens.

2. INTRODUCTION

The Need for an ICS Clinical Strategy

The NHS Long Term Plan is clear that to meet the challenges that face the NHS it will increasingly need to be:

- More joined up and coordinated in its care
- More proactive in the services it provides
- More differentiated in its support offer to its individuals.

At the heart of this approach is working as an integrated health and care system to achieve the best outcomes for our citizens. Explicit within this is the recognition that some of the service changes necessary may not be in the interests of individual organisations but are required to maximise what can be achieved for the individual patient and the whole system.

As such, the vision for the ICS is to deliver sustainable joined up, quality health and social care and broader community services that maximise the health and well-being of the people of Nottingham and Nottinghamshire.

Each individual partner in the Integrated Care System (ICS) has their own Service Strategies in relation to the delivery of their core services. This ICS Clinical and Community Services Strategy provides a long term (five year plus) overarching vision for our health and care delivery system and provides a strategic direction and framework for which future service development and reconfiguration will be considered against.

Nottingham and Nottinghamshire has the benefit of long established relationships and partnerships and these are the basis on which our new models of care and clinical strategy are being developed.

A separate, but inter-related mental health strategy has also been developed across the ICS. There are inevitably a considerable number of overlapping and integrated outcomes and actions that need to be taken to deliver the holistic needs of our population. Therefore, the ICS Board will ensure that there are single, integrated implementation plans where appropriate.

The Strategy Development Process

This Strategy has been developed through an open and inclusive process which weaves together the expertise of both clinicians and care experts with citizens in determining the future shape of services across the system.

This Clinical Services Strategy does not sit in isolation, it is an integral part of the components that will be necessary to make our new system function effectively and deliver the desired outcomes. The strategy provides the framework for future service model development and to help understand what services will be delivered where.

This will be informed by a greater understanding of the needs of our population through Population Health Management data.

Stakeholder Engagement

As part of the development process there has been a wide range of stakeholder engagement events and opportunities for input. These include;

- 3 design workshops including over 200 local clinicians, care professionals and system leaders from across statutory, voluntary, and commissioning organisations
- Technology and Innovation workshop with 35 experts from a range of fields
- The third strategy design workshop included citizen representatives and a number of citizens groups from across the system have also been engaged in the production of the strategy
- Citizens are now involved in each of our service reviews (see section 7) through attendance at workshops and through specific focus groups for the different areas of care. Voluntary sector organisations are also involved in each of the reviews. The numbers of citizens involved in the work will grow as the service reviews are extended.

The System level Outcomes Framework

This Clinical and Community Services Strategy has been developed alongside other key workstreams across the ICS. The need to align the strategy with the emerging system-level Outcomes Framework is essential. The ICS Board recently confirmed that the ICS Outcomes Framework is being based on the triple aims (improved health and wellbeing, transformed quality of care, and sustainable finances) whilst increasing healthy life expectancy remains the overarching system outcome.

The purpose of the Framework is to provide a clear view of our success as an ICS in improving the health, wellbeing and independence of our citizens and transforming the way the health and care system operates. The Framework sets out short, medium and long term outcomes the whole ICS will work together to achieve based on eight ambitions. These remain in draft but are currently outlined as follows;

Outcome Ambitions
Our people live longer, healthier lives
Our children have a good start in life
Our people and families are resilient and have good health and wellbeing
Our people enjoy healthy and independent ageing for longer, at home or in their community
Our people have equitable access to the right care at the right time in the right place
Our services meet the needs of our people in a positive way
Our system is in financial balance and achieves maximum benefit against investment
Our system has a sustainable infrastructure

This Clinical and Community Services Strategy focuses on what future services will look like to deliver this outcomes framework over the long term.

3. THE CASE FOR CHANGE

The populations of Nottingham and Nottinghamshire's require health and care services that are of the highest quality and delivered as locally as possible. Our citizens have told us that they want to be supported to take more responsibility for their own health and that if they become ill they want to be cared for at home where-ever possible with a proactive support system wrapping services around them.

We have made great strides in improving the health and care that our population receive, but to continue to improve outcomes and stay within the funding allocated by the Government we recognise we need a major transformation programme which will require all sectors – NHS, social care, local authority, private and voluntary to work collaboratively with our citizens to radically redesign the way we deliver our services.

There are a number of reasons why our services need to be radically re-focused to ensure we can maximise the health and well-being of our population and deliver the triple aims identified in the Five Year Forward View and the NHS Long Term Plan. These include improving health and well-being, transforming the quality of care and delivering sustainable finances.

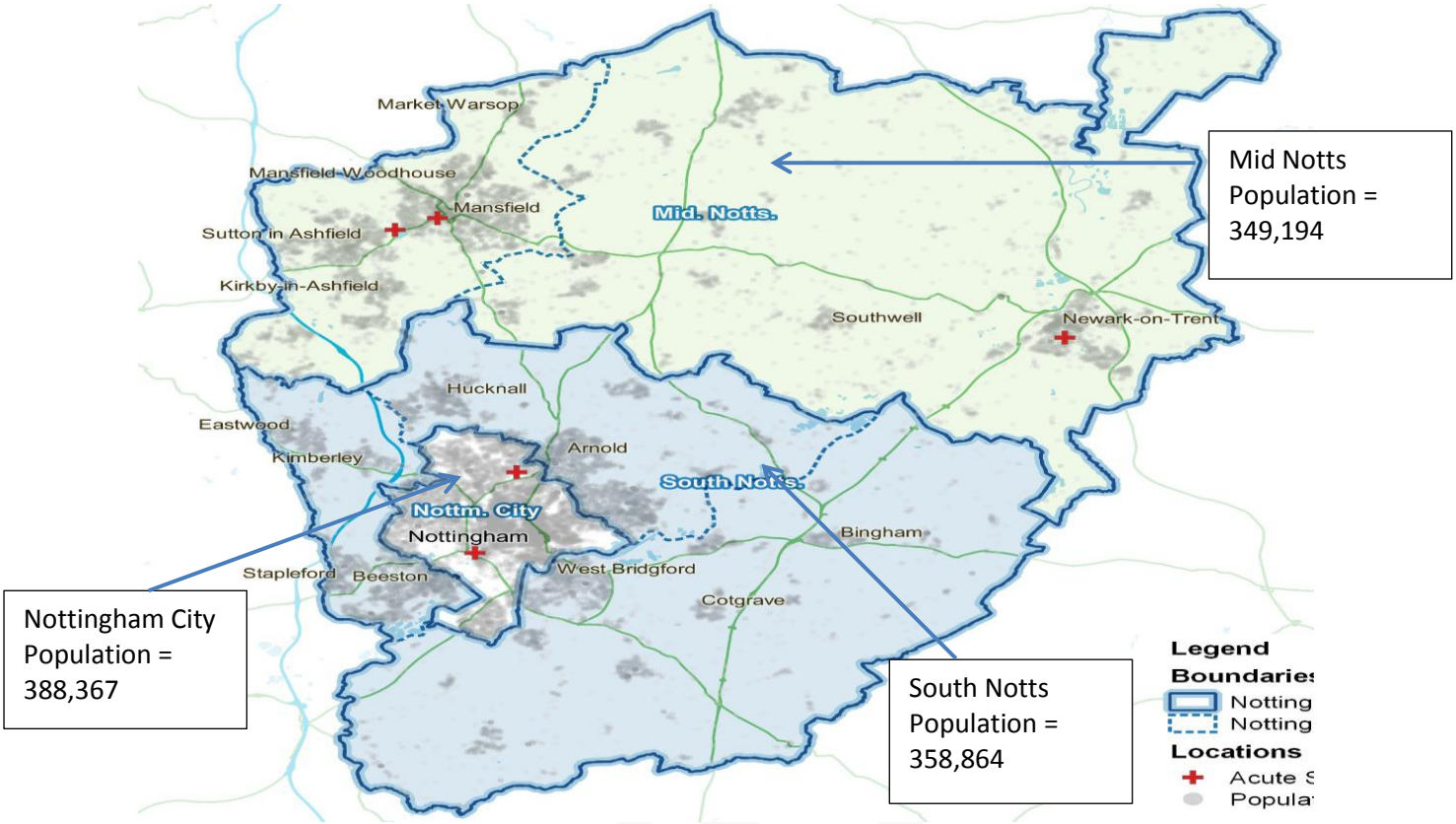
Improving Health & Well-being

There are currently 1.1m people in the Nottingham and Nottinghamshire ICS which is set to increase by 3% by 2024 and by 10% by 2039.

The age profile of our populations in Mid Notts and South Notts are relatively similar to that of the England average, whilst our Nottingham City population has a smaller proportion of those aged 50+ and a higher proportion of younger people even when we discount for its large student population. People are also living far longer with 13% of the ICS population currently aged 70+ which is set to rise to 18% by 2039.

Deprivation is a strong driver of illness and poor levels of health. Our ICS has large variations in the levels of deprivation, for example Nottingham City and Mansfield and Ashfield are some of the most deprived districts in England compared to Rushcliffe which at 318th is one of the least deprived in the country.

Deprivation and socio-economic factors significantly affect a person's life expectancy. Nottingham City and Mansfield & Ashfield are affected by higher unemployment, lower qualifications and less healthy lifestyle choices (healthy eating, smoking, overweight/obesity, low physical exercise) resulting in poorer health and wellbeing outcomes. Across the ICS we have a differential pattern in overall life expectancy with male life expectancy ranging between 77yrs – 80.7yrs and females ranging between 81.1yrs - 83.4yrs.



The healthy life expectancy i.e. the number of years a person lives in 'good health' also shows a pattern of inequity – a male in Nottingham City lives 57 years in good health compared to a male in the rest of Nottinghamshire who lives 62.5 years. The patter is similar for females with 53.3 years compared to 61.6 years.

Around 20% of our lives are spent in poor health, and evidence suggests that the past gains in life expectancy may be becoming harder to achieve. We are now living with more complex illnesses for longer. This trend is set to continue as the proportion of those aged 65 and over with four or more diseases is set to double by 2035, with around a third of these people having a mental health problem.

Therefore improving healthy life expectancy is essential to creating a sustainable system and securing this improvement requires change in every part of the system.

Childhood obesity is a further key indicator of the impact our lifestyle choices have on the health of our population. It is associated with a higher chance of premature death and disability in adulthood. Overweight and obese children are more likely to stay obese into adulthood and to develop long term health (LTC) conditions such as diabetes and cardiovascular diseases at a younger age.

At the age of 4-5yrs Nottingham City children are already significantly less likely to be a healthy weight than those in Nottinghamshire and the rest of England. By age 10-11yrs the gap has grown further with only 57.8% of Nottingham City children being a healthy weight compared to 64.3% in England.

Transforming the Quality of Care

Changing Public Expectations

We have a growing population with increasingly complex care needs that are placing different demands on the health and care services. However, they also want to be able to receive services in a very different way to that which their parents and grandparents did. Our citizens tell us they want easier access to services closer to home, increased use of technology, such as options of web based consultations and other ways that enable them to take greater control of their health and well-being whilst still being able to see a doctor face-to-face when it's really needed.

Many of our health facilities were established over 50 years ago to meet a very different health need. Our health and care services need to adapt and change to provide high quality care for people at home or in the community (where clinically appropriate) and to ensure everyone can benefit from modern day medicine and technological advances.

Clinical Sustainability

The current healthcare system is clinically unsustainable driven by demand pressures, insufficient levels of out of hospital services and staff shortages.

From an activity perspective we have seen:

- **Outpatient appointments** have increased by 15% in the last 3 years (17/18 vs 14/15) with a 20% increase in age 70+ Outpatient appointments.
- **A&E attendances** have seen a 4% increase in the last 3 years (17/18 vs 14/15) with a 17% increase in age 70+ A&E attendances in last 3 years.
- **Inpatient episodes** have increased by 7% over the last 3 years but we have seen a corresponding decrease in bed days by 9% and an increase in daycase activity of 10%. There has been a 17% increase in inpatient episodes in those aged 75+.

Currently 13% of the ICS population is aged 70+ and this population accounts for;

- 20% A&E attendances,
- 27% outpatient appointments,
- 31% of emergency inpatients,
- 33% of elective and 33% of daycases

Circulatory disease (including stroke, coronary heart disease), Cancers and Respiratory diseases currently account for 60% of the diseases that cause the gap in life expectancy between the most and least deprived areas in Nottinghamshire and these are set to rise. For example over the next 20 years Stroke will increase to 84%, respiratory diseases to 101% and Cancer to 179%.

Evidence has confirmed that these diseases can be prevented by improving lifestyle choices. For example;

- 9 out of 10 strokes are caused by risk factors that can be modified
- 40 - 45% of Cancers are caused by risk factors that can be modified

Current data suggests that we still have significant areas of unhealthy lifestyle choices as demonstrated below;

Smoking	• Mansfield & Ashfield > 1 in 5 people • Rushcliffe 1 in 12 people
Exercised for 30 mins for 12 out of 28 days	• Nottingham City/ Mansfield and Ashfield - 1 in 3 people • Rushcliffe - 1 in 2 people

With the population growing, ageing and spending a higher proportion of time in poor health, there will be an ever increasing need for carers. Informal carers need more support, they are 2.5 times more likely to experience psychological distress than non-carers; working carers are two to three times more likely to suffer poor health than those without caregiving responsibilities. Dementia carers particularly struggle and dementia is due to increase 86% in the next 10 years.

The pressures on our current services are unsustainable and require a significant transformation in not only how and where services are delivered, but also how we shift to a more proactive model of care that focuses on preventing the population developing the disease burden in the first place.

Clinical sustainability also requires us to review and consider how and where we deliver services from. Treatments are becoming increasingly specialised offering the potential to improve quality of care further by enabling access to the latest treatments and techniques. However, this does require more specialised services to be based around larger centres. This will enable specialist staff to build their skills and capabilities, and to ensure all patients have access to specialist skills and equipment.

Workforce Challenges

Workforce is a key driver for change within our system. It is becoming increasingly difficult to recruit staff with the right skills and expertise in the right locations as there are national shortages of staff entering training places or wanting to join these professions. We know that measures such as trying to recruit more staff or increasing wages alone are not going to solve this issue so we need to consider different options of how we recruit and retain the necessary workforce.

The ICS has developed a 10 year People and Culture strategy which will fully articulate the challenge and put forward some of the mitigations in terms of recruiting and retaining high quality staff to deliver the care needs of our population. We employ a wide range of talented and dedicated staff across our system who provide excellent care and services to our populations. The profile of staff is as follows;

- 35,436 Full time equivalent members of staff are employed across the Nottinghamshire system
- 18,318 of our staff are based in our hospitals
- 11,949 of our staff are based within a community setting
- 2,171 of our staff are based out of hospital but work system wide
- 2,965 of our staff are based out of the ICS

We face a number of challenges across our ICS in relation to workforce related issues. These include aspects such as;

- We have a system wide reliance on agency staff which is both a financial issue and a clinical risk. The three NHS providers in Nottinghamshire spent approximately £40m on agency staff in 2018/19.
- There is a requirement in the GP Forward View and the Mental Health Forward View to increase the numbers of staff in these areas, e.g. 77 more GPs by 2020, 30 Children & Young People MH workers, and 23 Mental Health crisis workers
- Sickness absence is higher than the national NHS average
- Vacancy rates higher than the national NHS average (12.1% vs 9.1%) and we have a high turnover rate at 11.4%
- Nursing vacancy rates are also extremely high – 18.9%, which equates to a vacancy figure of 1,412 FTE.

Our local estimates indicate that based on current demand trajectories we will have a shortage of at least 1500 clinical staff over the next five years. This is exacerbated by a reduced supply of graduates and an ageing workforce with a significant number of staff reaching retirement age.

Some of the key staffing impacts on the delivery of our strategy include a shortage of General Practitioners (77 FTE short by 2020) along with a general shortage of primary care based staff. Certain hospital based specialities including Health Care of the Elderly, Stroke, Paediatrics, Emergency Medicine and Radiology are all struggling to meet the growing demand.

Additionally, there are 2000 (9%) social care/ residential care vacancies with turnover in Nottingham in line with the England average for this sector of 30.1%.

Our People and Culture strategy outlines a range of initiatives and actions that need to be taken forward for us to address this significant workforce challenge. These are aligned to four strategic workforce objectives;

1. Recruitment & retention supporting our current workforce;
2. Supporting and retaining our students;
3. Developing and supporting new roles;
4. Preparing the workforce for new ways of working.

Staff engagement is a key enabler to delivery of both our People and Culture strategy and to this Clinical and Community Services Strategy. It is essential that we listen and respond to our workforce to shape the delivery of our priorities. Evidence tells us that an engaged and committed workforce leads to improved patient outcomes and increased staff satisfaction which will assist with recruitment and retention challenges.

Developing our Clinical and Community Services Strategy will also identify where we will deliver services differently and how we can use enablers such as technological advances to mitigate some of the workforce challenges. We need to ensure that staff are empowered to work at the top of their licence and that we maximise their valuable contribution by developing new and

innovative roles where appropriate to ensure we continue to focus on high quality patient outcomes.

Additionally, we recognise that the current roles and workforce structures are not fit for purpose. We need to develop a flexible workforce that is not constrained by organisational or professional boundaries. In order to achieve this we will need to link with education providers and review the approach to training our future workforce to focus on the skills we need rather than the roles themselves.

Sustainable Finances

The ICS currently spends £3.2bn annually on health and care services and for a number of years has been spending more money than it receives. Without change, the situation will get worse. In 2018/19 the financial position of the system deteriorated, with a forecast in-year deficit of £87 million, this is £19 million worse than the position agreed with national NHS leaders. Key challenges are growth in activity/demand (health and social care), provider pay pressures and non-delivery of efficiency programmes.

The system faces a gap of £159.6m in 2019/20 representing 4.9% of the total system resources – this gap is expected to increase to in excess of £500m by 2023/24 for NHS services alone if we do not change the way in which we design services and work with our populations to improve their health and well-being to prevent them entering ill-health in the first place.

The improved NHS Long Term Plan funding settlement will result in system resources increasing by circa 20% over the next five years but this will not keep pace with cost increases which are projected at 35% for the same period if we don't do anything differently. To a large extent these cost increases are driven by projected increases in demand for healthcare services. If there was no projected increase in demand for services the financial gap would actually narrow to £50m due to the funding increases expected.

The NHS is implementing a new financial framework for providers and commissioners and it is expected that in future years we will move away from control totals and sustainability funding. However, for 2019/20 control totals remain in place, for individual organisations and ICSs.

Current services are not set up to enable our staff to work as efficiently or as effectively as they could or to deliver as much health care as could be provided if services were better organised. It is therefore imperative that we drive forward our transformational change in order that we will be able to deliver services and meet the needs of our local populations within the available resources.

These features of the financial position of the ICS show that while it is unrealistic to expect no increase in demand for services, improving the health of the population with better prevention, earlier intervention and more developed self-care, is at least as important to a sustainable healthcare system as the improving the efficiency of service provision.

National Drivers

There are a range of national policy drivers that we remain committed to as a wider system that this strategy has taken account of. In particular:

- The Five Year Forward View and the refreshed guidance in February 2018 reaffirmed national priorities and set out five challenges for the NHS and care system to respond to.
- General Practice Forward View in April 2016 which was supplemented by Investment and Evolution; a five year framework for GP Contract reform to implement *The NHS Long Term Plan*
- Prevention is Better than Cure – Our vision to help you live well for longer - Department of Health & Social Care (Nov 2018)
- Universal personalised care: Implementing the comprehensive model – NHSE (Jan 2019)
- Our understanding of the implications of the imminent 'Green Paper' on Social care

Local Drivers - Fixed Points in the System

Given the challenges and expectations of the people of Nottingham and Nottinghamshire we are being ambitious in our proposed changes. But there are some things that we are not proposing to change in order to create a small number of fixed reference points to support service and capital planning. These are set around core areas of urgent access and interdependency of services in those locations. These have been confirmed as;

Agreed Fixed Points of Delivery	
Kingsmill Hospital	Accident & Emergency for all patients; and Antenatal and postnatal obstetrician led services;
QMC Nottingham	Accident & Emergency for all patients; Major Trauma & associated services; Antenatal and postnatal obstetrician led services; Neonatal Intensive Care; Nottingham Children's Hospital;
Newark Hospital	Designated range of Commissioner Requested Services which includes high volume/low complexity elective care and diagnostics plus Urgent Care services
Rampton Hospital	High secure mental health facilities
Wells Road Centre Nottingham	Low secure adult mental health facilities
LIFT and PFI Facilities	All the LIFT and PFI healthcare facilities will be effectively used

These fixed points are important as they set the foundations to construct where future service provision will be delivered from across the system. They will be used to build other services around and enable the focus to be on how these are maintained in the future rather than whether they are required. While many services not on this list will not change location, their future planning will be undertaken by reference to these fixed points through the service review process and engaging with patients and the public (Section 7).

Estates & Infrastructure

A further key constraint and opportunity is the quality of the estate and infrastructure of current service provision. There is £168m of backlog maintenance required across the key NHS provider organisations much of it critical for ongoing service delivery.

The healthcare estate infrastructure in the ICS costs circa £172m p/a of which £78m p/a is Private Finance (PFI) or LIFT payments.

It is also the case that there is significant opportunity to better use estate capacity in the system either through effective reuse or disposal. Some areas for improvement include;

- 33% of the acute hospital estate is used for non-clinical purposes and 2.55% of the estate is unoccupied
- Across the health community there are 316 healthcare buildings including 115 owned by GPs
- The ICS has been set a land disposal target for Nottinghamshire of £12.2m to support the reinvestment in modern facilities

It is therefore essential that the future clinical services models enable

- Improved use of our quality estate, especially PFI and LIFT building where we are tied into a long term contractual commitment
- Reduction in the acute service estate footprint, currently envisaged to be predominantly at the City Hospital campus, to enable investment in better quality estate both on that site and elsewhere
- Use the estate more effectively for the whole health and care system looking beyond traditional organisational boundaries.

Conclusion

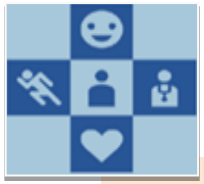
We have a compelling need for change, driven by the changing needs of our local population and by the need to ensure we are consistently offering the best evidence based services for all of our citizens.

We are faced with a current health and care system that has a number of challenges ranging from an inability to recruit and retain the key skills and personnel that we require to deliver care and rising costs that mean that our current services are costing more than the income we receive.

These issues are very real and we need to address them in a way that will improve outcomes for individuals, our communities as well as all of our staff working across the system.

Figure 1 overleaf provides a summary of how the development of the Clinical and Community Services strategy will support the ICS to deliver the NHS Long Term Plan 'Triple Aims';

DRIVING CHANGE ACROSS THE ICS 'TRIPLE AIMS'



Improved Health and Wellbeing

- The clinical and community services strategy will support people to live longer, healthier lives
- Our children will have a good start in life
- Reduce avoidable admissions and managing conditions amenable to healthcare
- Reducing outcomes gap so that our populations enjoy healthier and independent ageing for longer
- Improving workplace health and reducing long term unemployment

Transforming Care and Quality

- Shifting from a reactive hospital based treatment model to pro-active approaches of prevention and early intervention
- Variation in primary care access and outcomes will be reduced
- Inconsistent clinical pathways and outcomes removed
- Improve self-care and management
- Developing new models of care in priority pathways
- Our populations will have equitable access to the right care at the right time in the right place

Sustainable Finances

- Nottinghamshire currently spends £3.2bn on health and social care services
- Health and Care system faces a **£156.9m Do Nothing gap** in 2019/20 representing 4.9% of system resources
- Projected gap of **£500m for NHS alone** by 2023/24
- System resources expected to increase by 20% over next five years but this will be outstripped by cost increases of 35% if we don't do anything different
- New Clinical Service Models will be a key contributor to bridging this gap alongside increasing efficiency and reducing waste

NB – Figures currently exclude Nottingham City Council

4. OUR SHARED VISION

Our Vision

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

The aim of our strategy is to support the system to achieve this by shifting the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention, delivered in people's homes or in community locations where this is appropriate.

By working in partnership across our different providers of care and all our sectors of care – acute, community, general practice, local authorities and wider community services including voluntary and private providers, we aim to ensure our citizen's experience is less fragmented and is integrated via a single patient held, patient record.

This requires a high level of trust both at an organisational level and individual clinician level to enable the necessary culture change that will support positive risk taking to become the norm.

The NHS Long Term Plan articulated the gap around delivery of the 'triple aims' and identified five major practical changes necessary to achieve closure of these gaps. The ICS has undertaken a process to align our system priorities to the Long Term Plan and confirmed five priorities that must be delivered. This strategy will make a step change in supporting the delivery of these priorities which include;

- Redesign the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting
- Improve the care of people with single and multiple long term conditions through greater proactive management and self-management to reduce crises
- Re-shape and transform services and other interventions so they better respond to the mental health and care needs of our population
- Reduce waste and improve efficiency and value across the system (including estates)
- More action on and improvements in the upstream prevention of avoidable illness and its exacerbations.

5. APPROACH TO STRATEGY DEVELOPMENT

Our clinical strategy fully recognises that we cannot continue with the current 'illness' models of healthcare that the NHS has traditionally delivered.

Tangible benefits can be achieved if we fully embrace the opportunities provided by utilising population health management data to risk stratify the population. This will allow us to identify who is most at risk of developing preventable conditions or whose health may deteriorate and then identifying the 'what and where' health and care services will be delivered to pro-actively target those most at risk.

The Clinical Design Principles

Through engagement at the workshop events the following set of design principles have been agreed with the CSS Programme Board to build on the vision and system challenges;

- Principle 1 – Care and support will be provided as close to home as is both clinically effective and most appropriate for the patient, whilst promoting equality of access
- Principle 2 – Prevention and early intervention will maximise the health of the population at every level and be supported through a system commitment to 'make every contact count'
- Principle 3 – Mental health and well-being will be considered alongside physical health and wellbeing
- Principle 4 – The model will require a high level of engagement and collaboration both across the various levels of the ICS and with neighbouring ICSs
- Principle 5 – The models of care to be developed will be based on evidence and best practice, will ensure that pathways are aligned and will avoid un-necessary duplication.
- Principle 6 – They will be designed in partnership with local people and will operate across the whole healthcare system to deliver consistent outcomes for patients through standardised models of care except where variation is clinically justified.

Public Engagement

Nottingham and Nottinghamshire have a long history of service transformation and throughout each of these programmes of work there have been numerous consultation and engagement events with patients, carers and the public. These were then supplemented by public engagement at the outset and during the development of the Strategic Transformation Partnership work.

The output from this wide range of engagement events has created an overwhelming case for change in terms of the way that health and care services have been traditionally delivered across Nottingham and Nottinghamshire and have been the foundation of the case for change for the Clinical and Community Services Strategy.

The Clinical Services Strategy Programme Board acknowledged that this work remains valid and demonstrates a strong consensus as to what the public would like to see from our clinical and community services. The following key factors from the feedback were considered during the strategy development;

- Joined up health and care to enable a seamless approach for the individual
- Prevention and self-care are essential components
- Less reliance and demand on acute hospitals – and ultimately smaller facilities
- Strengthened and integrated primary and community care services with new models of care able to meet the needs of individuals in their own homes where ever possible
- Evidence based planning and streamlining to reduce inefficiency and unwarranted clinical variation

The Clinical Model Framework

Our aspiration is that we want people to live healthy and fulfilling lives. However, we also recognise that at times throughout their life, people will become unwell and that they will need different services at different points in their lives.

It is also acknowledged that people will move both up and down the continuum in terms of the support and intervention that they need. For example, an individual's life may suddenly be impacted by a significant trauma that has life changing consequences or a family may have a child born with extremely complex health and care needs that will stay with them throughout their lives. Others may have complex needs that following intervention allow them to live independently with support from their GP or community team.

A recognised progression of care needs has therefore been utilised within the development of this clinical strategy. These include;

- **Staying Healthy**
  - Primary Prevention & Education
  - Wider determinants of health
- **Living well**
  - Primary & secondary prevention
  - Maternity and Children's Services
  - Universal Personalised care
  - Living with a Long-term health or care need including mental ill health
- **Care in a Crisis**
  - Care that is needed on an emergency or same day/ urgent basis
- **Managing Illness**
  - Planned acute or specialist care (including cancer care) and support with the aim to return back to living well.
- **End of Life**
  - Patient centred with joint decision making

Using this consistent approach across our service reviews will enable the aggregate changes and impact to be determined for;

- Size and configuration of future estate

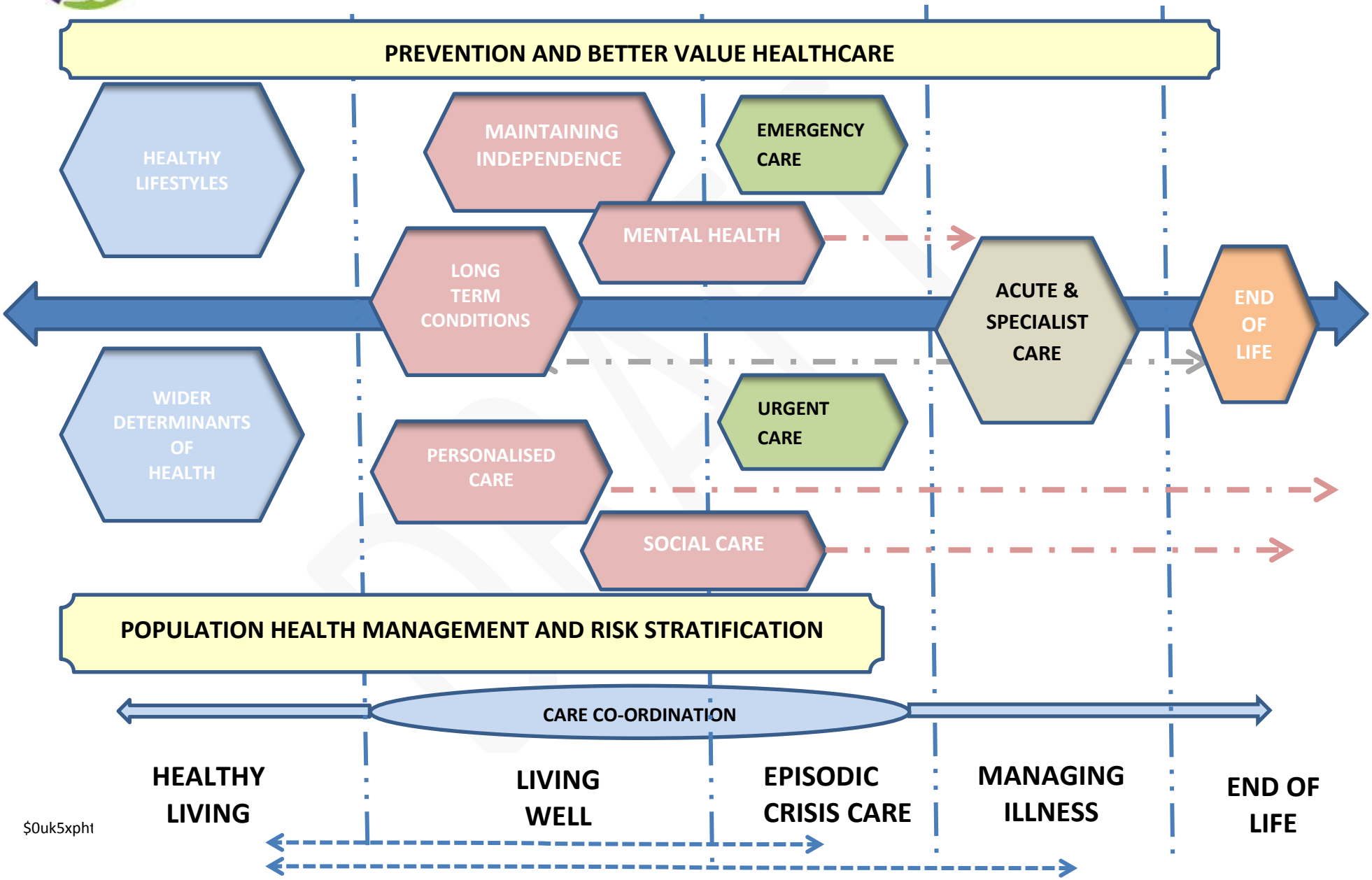
- Shared and inter-connected IT systems
- Skills, configuration and requirements for our future workforce models
- Ongoing organisational development and culture changes

Overleaf provides a schematic representation of our approach to developing the Clinical and Community Services Strategy whilst the next section explores the dimensions of care for the high level clinical model in more depth.

The schematic demonstrates that some aspects of our care model are needed throughout a person's life, for example we would see that there are opportunities for prevention and promotion of maximising the value from our health services pertain to all parts of our continuum whilst in other aspects, people will move through various stages for example, they may be in need of support in an emergency but then return back to healthy living.

Integrated Care System
Nottingham & Nottinghamshire

Nottingham City Council | Nottinghamshire County Council | NHS



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HEALTHY LIVING

WHY PREVENTION & EDUCATION?

Prevention is about helping people stay healthy, happy and independent for as long as possible. This means reducing the chances of problems arising in the first place and, when they do, supporting people to manage them as effectively as possible. Prevention activities are key to keeping people independent and well at home and to avoid the escalation of needs that can result in crisis interventions. Prevention is important at all ages throughout life.

Around 20% of our lives are spent in poor health, and evidence suggests that the past gains in life expectancy may be becoming harder to achieve. We are now living with more complex illnesses for longer. This trend is set to continue as the proportion of those aged 65 and over with four or more diseases is set to double by 2035, with around a third of these people having a mental health problem.

The case for change has clearly identified that we can make a positive difference in our population's health if we focus on prevention as well as educating and supporting our populations to choose healthier lifestyle choices. In Nottingham and Nottinghamshire, the leading risks attributable to years of life lost due to premature mortality are tobacco, alcohol, dietary risks and high blood pressure.

It is estimated that currently only 3-5% of health spending is on public health activities, yet population health initiatives when evaluated usually have a far greater return on investment for every £1 spent.

For example, we know that 9 out of 10 strokes are caused by behaviours that could be modified. A key health intervention that would support this change is the NHS Health Check Programme. However, only 44% of those people who were invited to participate across our ICS during 2013-2018 for a coronary vascular disease check actually attended.

The case for change articulated the growing problem relating to LTCs resulting from obesity, especially obesity arising in childhood.

Obese children and adolescents suffer from both short-term and long-term health consequences. The most significant health consequences often do not become apparent until adulthood and these include cardiovascular diseases (mainly heart disease and stroke); diabetes; musculoskeletal disorders, especially osteoarthritis; and certain types of cancer (endometrial, breast and colon).

It is estimated around 50% of GP appointments, 64% of outpatient appointments, and 70% of hospital bed days are due to preventable ill health. Overall 40% of the burden on health services in England may be avoidable through preventable action.

The evidence around smoking cessation is overwhelming. The World Health Organisation has clearly outlined the health benefits of quitting smoking. Within 2-12 weeks of quitting, circulation improves and

lung function increases and within a year coronary heart disease is about half that of a smoker and within 5 years stroke risk has reduced to half that of a smoker.

Across Nottingham and Nottinghamshire, the move towards a smoke free generation would annually save lives (c. 1,823 early deaths are due to smoking), reduce hospital admissions for smoking related and directly attributable conditions (c.10,992), reduce health inequalities and provide societal cost savings of £153m.

Another key area is the impact of alcohol on a wide range of conditions such as cancer, cardiovascular and alcohol related injuries. Alcohol related hospital admissions account for 1.1million admissions a year nationally.

The benefits that can be achieved from a focused reduction on preventable conditions such as tobacco and alcohol are significant. As such, a key part of our Clinical and Community Services Strategy will be that prevention and maximising future health is something that all partners are responsible for and will be considered throughout every stage of our clinical model.

As a system, we have a responsibility to make the environment and culture within which people live, work and play more supportive of enabling good health. We need to incentivise people to want to lead an active lifestyle and to have the knowledge, skills and confidence to take full control of their lives and making healthy choices as easy as possible.

We need open conversations at a population and individual level on how the health and social care system works jointly with the public to collectively support health and well-being. One such mechanism will be health promotion activities and a wide range of media need to be utilised to maximise public awareness and uptake. Technology will play an important and evolving role in preventative activity as well as a focus on factors such as housing and air pollution.

There is a growing body of evidence that health and care interventions are only able to address 10% of overall health benefit in terms of access to care and it is only by addressing the wider determinants of health that a real step change can be made in people's lives.

We need to;-

- Ensure prevention activity is considered for all ages and takes a conception to grave approach that enables us to 'make every contact count' (MECC)
- Systematically tackle Nottingham and Nottinghamshire leading risks factors which impact on premature mortality - namely tobacco, dietary risks including obesity, alcohol, lack of exercise and high blood pressure
- Prevent or delay long term health and social care needs by identifying early risk factors that could impact on people's independence, health and well-being
- See a systematic culture change – moving to a system that takes a longer-term view and thinks about prevention rather than simply treatment
- Establish virtual clinics to access information, advice and guidance to prevent ill-health
- Establish links with education providers to pro-actively support children and their families to have the best start in life
- Ensure housing plans for the future support all communities that can meet the needs of people with all age disabilities and an ageing population
- Increase social prescribing for leisure activities to increase levels of physical activity at all ages

Key Outcomes

- A narrowing in the life expectancy gap and the healthy life years gap across our populations
- The overall demand for services is reduced as a result of work on prevention and the wider determinants of health
- In the longer term see a significant reduction in premature death from the main attributable risk factors

- Prevention activities are pro-actively and systematically funded and a longer-term view is taken to return on investment.
- Risk factors are identified and addressed at an earlier stage
- The interventions applied will be universal in their reach, but targeted according to need.
- An increasing number of people are supported in their own homes and local communities for longer

LIVING WELL

We want to increase the amount of years that people live in good health. To do this we need to support people to have a good start in life and then enabling them to live independent, fulfilling lives where they feel able to reach their full potential. This is a key outcome that the ICS wants to achieve.

We know that the number of people living with multi-morbidity prevalence will rise dramatically across our population over the coming years. The numbers of people with 4+ diseases will more than double in the next 20 years and this is significantly increasing the complexity of those people who do need health and care support.

Our current system is overly reliant on beds and care isn't provided in the right place. Our data suggests that in point prevalence studies, during the study period in 2017 50% of the patients in a hospital bed at Nottingham University Hospital could have been cared for more appropriately in a different setting and then when we reviewed CityCare beds in 2018 we found 60% of patients could have been cared for elsewhere.

In 2017/18, 335 elderly people aged over 65 were admitted to care homes in Nottingham (887/1,000 pop = 12th highest nationally out of 152 Local Authorities), and 987 in Nottinghamshire County (590/1,000 pop = 78th).

The evidence base for Personalised Care continues to grow – current statistics suggest that people who are confident to manage their health conditions (that is, people with higher levels of activation) have 18% fewer GP contacts and 38% fewer emergency admissions than people with the least confidence.

It is estimated that if we can provide greater proactive management and increase self-care activities then there is the opportunity to reduce our spend on Long Term Condition management by £12m in 2019/20 across the ICS. This would be achieved by reducing demand on acute hospital care and through re-investment of potential savings allow additional services to be developed in community based supporting infrastructure.

Community pharmacies could play a significant role in supporting people to live well and reduce the need for urgent assistance. Expansion of services such as supervision of medication compliance, medicines support including adjustments and prescribing support along with wider offers such as advice on minor ailments has shown that there are significant benefits to the NHS of cost efficiencies worth £1.1 billion and avoided treatment costs worth £242 million. In addition patients report time savings in reduced travel time and saved GP appointments.

Understanding the changing needs of our population and local communities is essential and will be informed by the use of population health management data. This work brings together health and social care factors and uses predictive analysis to help target interventions on a personalised basis.

MATERNITY, CHILDREN & FAMILIES

There has been a focus on transforming maternity care across our ICS for some time and we now need to increase the pace and focus on delivery.

We know that there is still a great deal to do to ensure that our children and their families have a great start in life. For example, we have high proportion of mothers who smoke at the time of delivery (14.7% compared to England average at 10.8%) and in addition there is a high still birth rate in Mansfield and Ashfield (5.1%) and in Nottingham City (5.2%) compared to the national average at (4.3%). With the right targeted interventions we can make a dramatic improvement in this area.

Maternity and family health will take a preconception-to-adulthood approach with the focus on 'teams around the family' operating largely through a community hub-based model, working to avoid cycles of poor health outcomes. This approach will work to deliver the best start in life and make the best use of all contacts to prevent poor health outcomes for the whole family.

Families will have a care navigator through their Primary Care Network who will pro-actively help to access the right support at the right time in the right place. This single point of contact is vital for providing a family with consistency throughout the early years.

Most services will operate best from a community hub where specialists can be co-located, rather than in the home, although home visiting will be an option where appropriate for the patient.

This pathway will be supported by consultant-led maternity services operating from the ICS' two acute trusts. Birth setting will be determined by patient choice, and the option of home birth (where clinically appropriate) will be presented alongside other options.

Due to the breadth of the reviews for both Maternity and Children & Young People further pathway work is ongoing in the next phase of service reviews and it has been agreed that the two aspects will initially be separated to enable a detailed understanding of the emerging models of care and challenges for each element of service provision.

PERSONALISED CARE

Personalised care will mean that our citizens have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual preferences. Personalised care is central to our new service models. Working through the Primary Care Networks we will ensure that people have more options, better support, and properly joined-up care at the right time in the optimal care setting.

Less than half of people in Nottinghamshire with a long term condition have had a conversation with a primary care Health Care Professional to discuss what is important to them, and a third don't have an agreed care plan.

This shift in focus therefore represents a new relationship between people, professionals and the health and care system. It provides a positive change in power and decision making that enables people to feel informed, have a voice, be heard and be connected to each other and their communities.

MANAGING LONG TERM (LTC) CONDITIONS

People with long term health and care needs want to live as normally and independently as they can. Despite the diversity of the range of conditions in terms of diagnosis and disease, people with a LTC progress through the same stages of intervention as other conditions.

An ever increasing proportion of the population are living with a multiple range of health and care needs. Whilst traditionally we may assume that this is isolated to older people, this is not the case. Older adults (65+) with functional needs i.e. Frailty are a major user of care services and have increasing risk of hospitalisation, increased length of stay and ultimately increased risk of needing long term care. However, there is an increasing proportion of children, young people and adults living with multiple long term conditions who require access to multiple services and specialities.

An individual's care needs will be met in the most appropriate place that their level of acuity dictates, but where-ever possible the default will be to provide holistic support services into a person's home.

Personalised health and care plans will be in place for every person who has a LTC and will be fully co-produced recognising that the patient and their carers are often experts in their own condition and care needs.

Loneliness and social isolation are often associated with those with complex health care needs. 11% of people over 75 report feeling isolation and 21% report feeling lonely. Strategies that enable people to be socially engaged, remain in employment where appropriate and continue with activities that give their life meaning also need to be integral within our clinical and community models.

A key component of our Clinical and Community Strategy therefore needs to be a radical redesign of our approach to drive a proactive approach focusing on wellness and 'what matters to me' rather than an illness model of 'what is wrong with me'.

MENTAL HEALTH

An increasing number of people are now living with both physical LTCs such as respiratory or heart disease and mental health LTC's such as dementia and alzheimers. We need to clearly align our work in managing complex health needs with those contained with the mental health strategy to ensure system wide, integrated interventions that meet the needs of the whole person.

SOCIAL CARE

County, City and District Councils provide a wide range of community support to people, including preventative, housing, leisure and social care services. They are therefore integral to achieving the objectives of the ICS and key partners across the system.

Social care provides information and advice, short term reablement and long term support to enable the promotion of independence and well-being and to ensure that people understand the choices about how and where their ongoing care needs might be best met.

Both the City and County Council partners in the ICS have their own adult social care strategies and transformation programmes and this clinical and community services strategy fully acknowledges the essential interface between this strategy and those developed with a focus on the provision of social care.

We Need to;-

- Ensure a single health and care record is available that is ultimately held by the patient and shared across all organisations
- Ensure an empowering, patient centred culture is in place that enables the conversations to be around 'what matters to me as a person'
- Change the skills of our workforce with a continued focus on multi-skilled practitioners able to deliver first line interventions with knowledge of when to refer to specialised staff
- Support the community and voluntary sector to further extend its impact on outcomes through initiatives such as ending social isolation and self-care hubs
- Link with the Population Health Management work to ensure 100% of the population can be risk stratified by each PCN to proactively case manage those at risk of exacerbating LTC's and losing independence and wellbeing
- Ensure that care co-ordination is implemented in a standardised manner across all our PCNs to deliver clear support and sign-posting initially focusing on those with multiple co-morbidities
- Review the benefits to be achieved from telehealth and remote monitoring technologies in accordance with the Assistive Technologies Strategy
- Confirm our approach to developing a single point of access (SPA) model across both an ICS or if more appropriate in each ICP footprint and

whether this is to be multi-agency and how it aligns with the Integrated Urgent Care roll out
- Ensure systematic medication reviews for all people with multiple co-morbidities
- Complete the Better Births maternity review and implement the recommendations across our system
- Develop our community hub model for maternity and family health services
- Use assessment tools such as the Patient Activation Measure to build knowledge, skills and confidence with the person to self-manage and provide personalised solutions that meaningful to the individual
- Use person centred conversations to understand where adjustments to the individual's lifestyle could impact on their health, wellbeing and independence

Key Outcomes

- We will be systematically using readily accessible population level data to support segmentation and risk stratification.
- A narrowing in the life expectancy gap and the healthy life years gap across our populations
- Social Prescribers are in every Primary Care Network and are able to appropriately direct patients to a wide range of resources across their local community
- Local Community Pharmacies will be a key first point of contact with appropriate local and national payment mechanisms in place to support this
- Increased numbers of people have a single care co-ordinator to support them navigate and sign-post them to appropriate services
- Increased proportion of people are able to access Personal Health Budgets
- Those accessing services reporting:
  - Feeling more empowered to manage their condition and are able to access the right additional support when required
  - Receiving integrated, wrap around locally delivered care and support to meet their physical and mental health needs
- Ensure we have outcome measures in place that measure the whole system of care for people with complex needs
- A reduction in the number of people entering long term residential or nursing home care

CARE IN A CRISIS

At different times in an individual's life they may require access to crisis care to manage a sudden onset of illness or a traumatic event. Our current models of managing these episodes are often predicated on patients themselves deciding whether their need is urgent or indeed an emergency or can be managed in a routine way through their GP.

As a system we are facing a number of operational challenges in terms of achieving the required levels of service delivery for A&E. This includes the 4 hour performance target. For example, NUH has consistently underperformed with an average of 64.4% achieved in March 2019, but Sherwood Forest has also seen deteriorating performance at 91.7% in Q4. Ambulance response times across our ICS are also longer than the required standards in all categories of response.

At least 8,500 (11.6%) of emergency admissions per year are for COPD, stroke, heart failure, asthma, diabetes, heart attacks, angina and hypertension – many of which we have already identified are preventable conditions. Over 75s make up less than 10% of the ICS population, but account for a 1/3rd of emergency admissions and a half of emergency bed days. Two thirds of emergency inpatient beds are occupied by the over 65s (c. 1,000 beds/day).

Spending time in hospital when it could be avoided can be detrimental to a persons' overall health - 35% of 70-year-old patients experience functional decline during hospital admission in comparison with their pre-illness baseline; for people over 90 this increases to 65% therefore we should do everything possible to ensure we avoid any un-necessary hospital admissions or delays in to a person's discharge.

It is estimated that there is a significant financial saving opportunity if we could radically redesign the urgent and emergency care system with an opportunity potential of circa £14m across the ICS in 2019/20.

The individual's perception of an emergency or urgent need may at times be somewhat different from the clinical opinion. This disconnect may be due to a lack of knowledge, fear and anxiety or simply a desire for the convenience of getting their need met in a convenient and immediate manner.

Therefore, a focus for the clinical strategy is in defining urgent, same day care in a way that is relevant to society and setting clear parameters for what a patient can consistently expect from different settings and how they will meet their individual needs.

This will clarify for citizens what they should expect from emergency and urgent care settings as well as the different range of access to General Practice services both in and out of hours.

Emergency Care

Emergency care is defined as being required immediately or within 4 hours of the injury or symptom commencement.

Access to the emergency department will be triaged via the emergency ambulance or single front door to ensure people are directed to the appropriate level of service provision.

Ambulance services are at the heart of the urgent and emergency care system and we need to ensure that our paramedics and ambulance crews have the skills and resources to enable more care to be delivered at home or settings outside of hospital, whilst at the same time working to reduce delays in hospital handovers. We will increasingly support ambulance decision making with technology and appropriate algorithms to support the correct management and care for a patient.

Urgent Care

Urgent care is defined as being required within a 4 - 24 hour period after the commencement of symptoms or diagnosis.

The model of urgent care is still to be fully determined and will need to link into the developing Urgent Treatment Centres and to the Primary Care Networks. The latter will have a key role to play in meeting the urgent/same day demand elements of the clinical model for those who have primary health care needs.

The developing PCNs will ensure that 100% of practices are covered by extended hours access at evenings and weekends seven days a week and will support the delivery of a combined access offer including the *NHS App* and on-line booking options.

In addition, PCNs will continue to develop innovative solutions to increase 'streaming' of patients so that they are able to offer convenient same day urgent appointments whilst preserving continuity of care for patients with more complex long-term conditions.

Models to actively support people whose conditions are exacerbating to prevent a hospital admission are well developed in parts of the ICS. Our Clinical and Community Services Strategy assumes that models such as 'Call for Care' will be available routinely for all of our population. This will enable the emergency ambulance service and both in-hours and out-of-hours General Practice to access a dedicated team to provide urgent, home based assessment and intervention within 2-4 hours. This will enable people to safely stay in their own homes and prevent a hospital admission.

We will aim for a consistent model of Emergency and Urgent care access across all parts of the ICS that is clearly communicated and understood by the public. Our aim is that this will encourage appropriate usage of Emergency Department, Urgent Treatment Centres, General Practice and wider primary care services rather than the ongoing high levels of usage at hospital based emergency services.

We need to;-

- Confirm our overall approach for accessing urgent levels of care to ensure appropriate signposting and consistency of offer to local alternatives such as Community Pharmacy
- Develop a clear and coherent long term communication campaign in conjunction with the public to support ongoing behaviour change and align the public and clinicians expectations over service offers
- Provide a web based, trustworthy source of localised information regarding self-help, advice and sign-posting
- Provide a single point of telephone access via NHS111 and the Clinical Assessment Service (CAS) that will intelligently triage all requests for care and signpost patients to the right point of care, including the capacity to make GP appointments in line with the requirements of the new GP Contract.
- Develop the offer from each of our PCNs to enable appropriate on the day access balanced with the ability to preserve continuity of care
- Develop a consistent model for a community hub and determine the locations for these across the ICS
- Ensure a model that meets the key components of 'Call for Care' is available in all areas of Nottingham and Nottinghamshire
- Ensure alignment of this model with the approach to support people who experience a mental health crisis

Key Outcomes

- Seamless integration across acute, community, primary and local authority crisis services. This could include co-location of a broad range of services within single sites or locality hubs to provide a 'one stop shop' approach. These should include physical, mental health, housing and social care and where appropriate wider community and voluntary sector services.
- A standardised, consistent emergency and urgent care offer across all the whole of the ICS
- Reduced demand on the hospital emergency department and the ambulance service
- The public reporting increased confidence in being able to access emergency department alternatives in the wider community
- Delivery of the ED performance targets and an improved outcome and experience of care for those who need to use crisis services
- Parity of service offer whether the crisis is related to a mental health or physical health care need

MANAGING ILLNESS

There is an expectation that most people at some point in their lives will require support to manage an episode of illness. Again, the aim here is to agree with the person what it is they want to achieve and provide specific support and intervention that meets those needs and enables them to return back to living a healthy and fulfilling life.

We recognise that our previous systems and processes have created services that are confusing and inequitable across our whole ICS. Nationally it's been estimated that up to 50% of patients attending General Practice have conditions that may not need a GP and could be treated by less qualified staff.

Previous work across the ICS has demonstrated that most of the elective or planned care activity currently takes place in hospitals resulting in people travelling to a main hospital site for care that could equally be delivered closer to home. Phase 2 of outpatient transformation work has the potential to release £5.6m of costs in 2019/20 if we develop different models of delivering planned care services.

We are not consistently delivering the required performance targets and some of these contacts are not always valuable e.g. Procedures of Limited Clinical Value (PLCV) and some outpatient appointments.

Our Clinical and Community Services Strategy and the ongoing service reviews will therefore focus on the fundamental principle to reduce variation and drive standardisation in outcomes for the whole population. This will require common pathways across primary, secondary and tertiary care and with social care to ensure there is consistency in entry and exit points when people find themselves needing care and support to manage episodes of illness.

Planned Care

Planned care is defined as care that is non-urgent, for which the patient receives a pre-arranged appointment and is either a self-referral or via a clinical referral.

A key principle in reviewing our planned care services is to ensure we reduce variation and drive standardisation where appropriate in order to reduce duplication and improve equity of service delivery and outcomes.

Considerable work has already been undertaken across the ICS to improve the pathways of planned care, from developing standard referral guidelines in a number of specialities to redesigning some clinical pathways such as Musculo-Skeletal services (MSK) and gynaecology.

The Clinical and Community Services Strategy development is therefore working alongside these ongoing programmes of work and assumes that as we move forward all pathway reviews for planned care will take on a whole patient journey perspective and cover all aspects of care from referral to discharge with ongoing care in a person's place of residence where appropriate.

A key assumption of the clinical and community strategy is that increasingly a

greater proportion of planned care will take place in a community setting. This will include the delivery of first and follow-up outpatient appointments on both a face-to-face basis and via the use of telephone or video technology.

It also assumes that the level of surgical intervention will decrease for an increasing proportion of patients who, through being full chose not to have an active surgical intervention but are managed through alternative means such as ongoing physiotherapy and support.

Perioperative care will increasingly take place out of hospital settings, in community locations, utilising a range of near patient diagnostics and outreach services supported by technology.

The utilisation of designated planned care facilities will support the system to enable consistent delivery of planned care, irrelevant of pressures on emergency services.

ACUTE AND SPECIALIST CARE

Although care at home is the preferable option wherever possible, the model accepts that home may not at times to be able to provide the level of support, expertise or environment required. Hospital beds will be provided where these are the appropriate option agreed by the patient and care team.

We will build on the national direction of travel towards the centralisation of specialised services being provided in larger centres where this is appropriate to do so and it is based on associated improved clinical outcomes and the development of network models of delivery.

Nottingham and Nottinghamshire has a significant range of specialised services provided in both physical and mental health care and we will concentrate our expertise on developing these services and being at the forefront of innovation.

Specialist care can also extend to our expertise in specialised diagnostic areas (e.g. PET CT, Medical Genetics) and we will continue to work with key partners locally and nationally to ensure that the citizens of Nottingham and Nottinghamshire have appropriate and timely access to the latest technologies.

Cancer Care

Prevention of cancer is equally as important as the diagnosis and treatment and we recognise the importance of national screening programmes and maximising uptake into these via Primary Care Networks and communication campaigns at both a national and local level. To date our ICS screening rates for bowel, breast and cervical cancer across Nottinghamshire are all above the national average rates although they are below the national average in the Nottingham City population.

We have a good track record of achieving the targets for seeing people within 14 days if they are referred for a suspected cancer and 5,600 people were newly diagnosed with cancer in 2016/17 which is roughly in line with the national incidence rate. However, we have difficulties in meeting

the 62 day wait standards and are failing to meet the surgical treatment of cancer within 31 days.

Diagnosing cancer will continue to take place in acute hospital settings for the foreseeable future, but it's anticipated over the life of this strategy that this will shift increasingly into community-based settings as technological advances support different diagnostic approaches. Referral processes will be a combination of GP direct access and patient self-referral if clear and obvious cancer symptoms are present.

We envisage that an increasing number of treatments will be undertaken closer to home through mobile chemotherapy and immunotherapy services. Treatment should be supported by an MDT, attached to a Primary Care Network and will be the key mechanism to link the patient with other support e.g. mental health outside of the defined cancer treatment.

Post-discharge care will increasingly shift to community or home settings, delivered either in primary care or by an expanded community cancer workforce who are able to undertake better assessment of need and reduce the requirement for crisis management.

We need to:-

- Ensure we develop standard referral guidelines and planned care pathways that reduce variation and improve equity of outcomes for our population
- Ensure specialist care and cancer service developments deliver the appropriate models of centralisation and ensure outreach services are in place
- Continue to scope the required community infrastructure and capacity to support the shift to out of hospital models of community care

Key Outcomes

- Consistency of offer and delivery at all levels of care
- Timely access to care in the right location with reduced delays in transfers of care
- Care co-ordinated across defined pathways underpinned by integrated technology and health care record.
- Improved outcomes in early diagnosis and cancer survival rates

END OF LIFE

End of life care is the part of palliative care which follows from the diagnosis of a terminal illness where cure is no longer possible and the patient is entering the process of dying.

There is increasing acknowledgement of the growing palliative and end of life care needs for people with non-cancer diagnosis, and our emerging new care models around End of Life Care support the growing national policy direction.

End of life care national statistics indicate that currently;

- 1% of the population dies each year in the UK
- Only 25% of deaths are from cancer
- 46.9% die in hospital and 46% in their usual place of residence
  70% of people do not die where they choose

Increasingly people are using a Preferred Priorities for Care document to write down what their wishes and preferences are during the last year or months of their life. It includes their individual views on what is important to them and where they would like to die.

Across our ICS 48.8% of deaths occur in hospital compared to the national average. There is also a differential across our system with 53.1% in Nottingham City compared to 44.4% in Rushcliffe.

The term 'end of life care' is used by different people to mean different things, since this phase could vary between months, weeks, days or hours in the context of different disease trajectories. This Clinical and Community Services Strategy assumes that End of Life services will be based on the needs of the individual rather than a predetermined period of time. It is however anticipated that it will include people who are likely to die within the next 12 months who have;

- Advanced, progressive, incurable conditions
- General frailty and co-existing conditions that mean they are expected to die within12 months
- Existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- Life-threatening acute conditions caused by sudden catastrophic events

Palliative care is an approach that improves the quality of life of patients and their families through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other problems, physical, psychological and spiritual. It is based on the following palliative care principles:

- A focus on quality of life which includes good symptom control
- A whole person approach which takes into account the person and those that matter to them
- Respect for patient autonomy and choice
- Emphasis on open and sensitive communication

Our system has already undertaken considerable work in the Mid Nottinghamshire locality to develop an integrated service specification around a 'community hub' model of care to enable patients to be cared for as close to home as possible. These will be fully aligned with the ongoing clinical strategy work.

When end of life decisions are required, the lead clinical role should come from the Primary Care Network Multi-Disciplinary Team (MDT) regardless of clinical setting. This may be supported by living wills which can be shared with clinicians as required.

Specialist palliative care will be available to support the MDT team for those people with more complex palliative care needs. Specialist palliative care is provided by specially trained multi-professionals and can be accessed in any care setting. Advice regarding symptoms and medications, or a wider discussion of the patient's current situation including the appropriate provision of in-patient, community, day care or hospice and out-patient services is a key feature of the emerging model.

The specialist team is complemented by chaplaincy, therapists and psychology services working alongside a wider team of nursing staff to deliver the care required across the different aspects of the service.

We need to;-

- Ensure conversations regarding end of life are based around the wishes of the person and those that matter to them and that these are clearly documented and shared across the MDT
- Ensure Primary Care is able to take a lead role in managing the end of life needs of their local population
- Develop partnership working across the system (PCNs and Specialist Palliative Care teams) to ensure the appropriate support is available to enable people to die at their preferred location
- Ensure end of life care is appropriately developed for all people who are dying, and extends beyond those dying from cancer
- Extend the use of enhanced summary care records and the use of a portal so that people's end of life wishes are readily available for all service providers irrelevant of care setting

Key Outcomes

- An increase in the number of people dying in their preferred location
- An increase in the number of families and carers reporting feeling supported and aware of where to seek help and support in times of crisis
- An increase in the number of people with a living will that clearly outlines their wishes that has been shared with their clinical teams

6. DELIVERING OUR NEW MODELS OF CARE

In order to ensure that our delivery models develop in a coherent and systematic approach our system is developing across 3 levels of collaboration;

- Primary Care Networks (PCNs) consisting of integrated health and care teams linking with wider local authority housing and community services across neighbourhood localities
- Integrated Care Providers (ICPs) facilitating the integrated provision and delivery of outcomes for the population. Three ICPs have been agreed - Mid Notts, South Notts and Nottingham City
- Integrated Care System (ICS) for the whole of Nottingham and Nottinghamshire

The Clinical and Community Services Strategy starts to define what needs to be delivered and to some extent, where and when that care needs to be delivered in our future vision.

This will continue to be developed further during the next stage of the strategy development. However, its success is to some extent entirely dependent on the 3 levels of the system continuing to collaborate, develop and mature into effective commissioning and integrated delivery structures.

Integrated Place Based Care

The notion of 'place' and 'neighbourhoods' have become increasingly important in health and care policy. Alongside the development of this clinical services strategy there has been a significant amount of work to develop the vision and model for delivery at a place level in our ICPs and at a neighbourhood level in our PCNs.

Primary Care Networks

General Practice accounts for nine out of ten patient contacts within the NHS and plays a crucial role in providing urgent care, coordinating and providing chronic disease management, health promotion and early intervention and in supporting people to manage their own care.

PCNs will work together with other local health and care providers around natural local communities to provided coordinated care through the development of integrated neighbourhood teams. 'Primary Care' is defined as first line services such as; general practice, community services, mental health, voluntary sector and social care etc.

The PCNs will utilise Population Health Management (PHM) intelligence and 100% population risk stratification to proactively identify and co-ordinate the care management of their neighbourhood population.

Our aim that PCNs will work collaboratively to focus on prevention and personalised care, supporting patients to make informed decisions about their care and look after their own health by connecting them with the full range of statutory and voluntary services. To achieve this we aim to have a

core consistent "community hub" offer across the ICS so that the range of services is understood by professionals and public alike. This will increase confidence in access of these services and over time enable ongoing reductions in hospital based provision.

The new models of care will incorporate the provision for local pharmacies to provide consistent low acuity urgent care services dealing with minor conditions and accurately signposting people with higher levels of need to the appropriate services.

The ability for pharmacies to support the self-care agenda should not be underestimated as part of both the management of long-term conditions and for those with an urgent care need.

Integrated Care Partnerships

Our three ICPs will undertake integrated provision and coordination of care, holding a clear contract value for what the providers are commissioned to deliver. This may result in ultimately moving towards capitated budgets in accordance with national policy intentions.

Our ICPs are an aggregation of the relevant Primary Care Networks (PCNs) and all other services that support health and wellbeing within their defined place. They will observe the overriding principle of equity of access to universal and targeted services to address health and wellbeing.

They will collaborate with other ICPs in the ICS to ensure consistency of entry and exit points for patients using the services of providers who are partners with more than one ICP.

Integrated Care System

The ICS is a collaboration of equal partners working to system wide objectives. The ICS is responsible for ensuring that appropriate strategies are in place to invest our resources in what we know works and to ensure culture change through removing blocks to integrated care.

The aim of the ICS is to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age.

The ICS will work through the three ICPs and PCNs to ensure a comprehensive health and care offer is equitably available to all of our citizens. This strategy clearly articulates the need to blur the organisational boundaries between all sectors of health and care provision. This will inevitably require strong organisational leadership and a balance of the necessary trade-offs that will be required to support the transition periods as we move from the old to the new models of care with associated activity, income and workforce consequences.

Page 17 outlines the agreed facilities that will be significant for service provision into the future and our ICS will be working collaboratively with the main service providers and through the ICPs to ensure that patients who require hospital based care can access this swiftly and safely. When a person's medical care requirements have been met then their discharge or

transfer of care to the PCN teams needs to be smooth and seamless.

The following schematic demonstrates our vision of working at system, place and neighbourhood population levels detailing what should happen where in order to ensure the right activities for the right population levels.

This strategy provides a framework and agreed direction against which future service reviews will be undertaken. The aggregate impacts of the ongoing service reviews will provide key requirements for the future development of other supporting areas in the ICS including;-

Informatics and Technology Strategy

The delivery of an integrated shared care record cannot be under-emphasised if our strategic intent is to be met. We have made significant progress in system inter-operability and development of the Care Centric Portal but the aspirations around the development of a single health and care record need to be clarified and remain a system priority.

Estates Strategy

This strategy and the output of the ongoing service reviews will be essential in guiding decisions about where individual services are located and the consequential investment in estates and infrastructure that is required.

The system has already outlined a number of estate priorities in terms of acute services infrastructure and the outputs from the ongoing service reviews will clearly identify the associated community infrastructure necessary.

Workforce Strategy

The ICS has developed a People and Culture strategy. There is an urgent need to continue to review the range of skills needed and develop different types of roles that will enable us to have workforce that is agile and fit for the future.

Where necessary, consolidation of workforce and integration of provision will allow specialists to offer more effective support within a single setting and then provide a hub and spoke model to other locations to ensure economies of scale, maximise expertise and improve outcomes.

Hospital based activity will reduce in the new models of care and the specialist workforce necessary to support our acute hospitals will increasingly support outreach models of care to support generalist care in the community.

Demand & Capacity Modelling

Shifts in activity from acute hospital settings to a community facing delivery models are fully anticipated as a consequence of this clinical and community strategy. It is also anticipated that there may be some relocation of services as a consequence of the service reviews that will require closer consideration and potentially public consultation.

There is a clear need for a system wide demand and capacity modelling approach to enable us to better understand the size and volume of activities that will take place in each sector as a consequence of the new pathways of care and service models. The current approach of each organisation modelling individual elements of impact is not sustainable and needs to be fully reviewed.

7. NEXT PHASE OF STRATEGY DEVELOPMENT

New models of care, workforce and commissioning must reflect whole patient journeys and providers within our ICS have already recognised that they will need to adapt, integrate and collaborate to accommodate this approach.

Our clinical models distinguish between the imperative of developing sustainable services designed around entire patient journeys which cross organisational boundaries and at this stage we have not assessed the impact on individual providers who will play a part in delivering care for part of those journeys.

The development of this Clinical and Community Services Strategy has not been undertaken in isolation. There are already a number of well-established groups exploring new service models for certain patient cohorts and taking forward evidence based care across the system. A number of these were explored as part of the first phase of workshops for the clinical strategy and these have not been duplicated, but we will complement and learn from each other as the systematic reviews move forward.

There is a need to ensure continual alignment with various other plans and system wide initiatives including the ICS Five Year Strategic Plan, the mental health strategy delivery plan and the implementation of the Urgent Treatment Centre requirements.

ONGOING SERVICE REVIEWS

This Clinical and Community Services Strategy is only one component of the whole system review that is required. We are also taking forward a systematic review process of our 'end to end' pathways of care – from a patient first noticing they have a symptom or need through diagnosis, treatment and discharge to the management of ongoing care needs or end of life care.

This is an extensive system wide piece of work which will ultimately take place across a minimum of 20 services. The CSS Programme Board have reviewed these services against a range of quantitative and qualitative criteria and agreed the prioritisation of six services reviews which have all now commenced. These include;

- Cardio Vascular Disease – Stroke
- Respiratory – COPD and Asthma
- Frailty
- Children and Young People
- Colorectal Services
- Maternity and Neonates

These reviews will enable the long term ICS programme of change to be developed to deliver these New Care Models and to inform what the future requirements are for estate and workforce in particular but also technology.

8. CONCLUSION

The Clinical and Community Services Strategy starts to define what needs to be delivered and to some extent, where and when that care needs to be delivered in our future vision.

This will continue to be developed further during the next stage of the strategy development. However, its success is to some extent entirely dependent on the three levels of our system continuing to collaborate, develop and mature into effective commissioning and integrated delivery structures.

Fundamental within our new service models is the principle that more care will be delivered closer to people's homes rather than in a central hospital based location. Prevention and population health management will drive a pro-active model of care that will target interventions and reduce the overall burden of ill-health.

In order for this to be achieved there needs to be a significant review of the infrastructure that is currently available to enable this shift in focus to take place.

Whilst providing convenient services close to home is important, patient choice and 'what matters to me' is equally as important as clinical expertise in terms of assessment of need. However, both the timeliness of the response and the level of care required will be the key determining factors in deciding upon the location that care is delivered.

We have a compelling need for change, driven by the changing needs of our local population, financial and workforce drivers and by the need to ensure we are consistently offering the best evidence based services for all of our citizens.

Taking forward the key recommendations in this clinical and community services strategy will offer the system a strategic framework within which it can aim to achieve its aspirations and vision for improving the health and well-being of the population of Nottingham and Nottinghamshire.

DOCUMENT CONTROL

Document Review

Date	Version	Reviewer	Role	Status
7/4/19	V1.0	Angela Potter	Programme Director	Initial drafting
10/4/19	v.1.3	AP/DH		Addition of comments from DH
23/4/19	V1.6	AP		Re-presentation following feedback from TT
26/4/19	V1.7	AP/DH		Ongoing review
21/5/19	V1.8	AP		Working Draft - updates following comments from members of CSS Board and Design Group
31/5/19	V1.9	AP		Working draft – updates from Alex Ball
04/06/19	V2.0	DH		Final Draft for ICS Board

Document Approval

Date	Version	Reviewer	Role	Status
26/4/19	V1.7	Clinical Strategy Board	Programme Board	Working Draft
21/5/19	V1.8	Sub-group	CSS	Working Draft

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HEALTH AND WELLBEING BOARD

DAY MONTH YEAR

	Report for Information
Title:	**Update on the Proposed merger of Nottingham City and Nottinghamshire CCG**
Lead Board Member(s):	
Author and contact details for further information:	Sarah Carter Executive Director – Transition Operations, HR and Organisational Development Nottingham and Nottinghamshire CCGs Sarah.Carter21@nhs.net
Brief summary:	In April 2019, following many years of ever-closer collaboration and integration, each of the six Clinical Commissioning Groups Governing Bodies formally agreed in principle the proposal to merge and create a single, strategic commissioning organisation for Nottingham and Nottinghamshire. During May and June the CCG undertook a stakeholder consultation with GP member practices, Healthwatch, local authorities and other key stakeholders, which has confirmed widespread support for a full merger. In July 2019, at our first joint Governing Board meeting 'in common', leaders approved the decision to submit a merger application to NHS England. The application is in accordance with CCG governance arrangements, and reflects a vote undertaken with member GP practices in June 2019 where 86% of those GPs who voted expressed support for a full merger. The draft application for the proposed merger is now to be submitted to NHS England. If successful the new single CCG organisation would become operational on 1 April 2020 and would be known as 'NHS Nottingham and Nottinghamshire Clinical Commissioning Group', in line with the regulations in The National Health Service (Clinical Commissioning Groups) Regulations 2012 (3) to (6).

Recommendation to the Health and Wellbeing Board:

The Health and Wellbeing Board is asked to:

a) Note the update following the stakeholder consultation on the proposed merger of the six CCGs
b) Review the final draft findings and feedback on the stakeholder consultation

Contribution to Joint Health and Wellbeing Strategy:	
Health and Wellbeing Strategy aims and outcomes	**Summary of contribution to the Strategy**
Aim: To increase healthy life expectancy in Nottingham and make us one of the healthiest big cities	Fundamental changes to our system architecture are an enabler for commissioning care and transformation in more joined-up ways, working across organisational boundaries and thinking less in terms of where care is delivered and more on the outcomes it is delivering, therefore providing the best care possible for the people of Nottingham and Nottinghamshire.
Aim: To reduce inequalities in health by targeting the neighbourhoods with the lowest levels of healthy life expectancy	
Outcome 1: Children and adults in Nottingham adopt and maintain healthy lifestyles	
Outcome 2: Children and adults in Nottingham will have positive mental wellbeing and those with long-term mental health problems will have good physical health	
Outcome 3: There will be a healthy culture in Nottingham in which citizens are supported and empowered to live healthy lives and manage ill health well	
Outcome 4: Nottingham's environment will be sustainable – supporting and enabling its citizens to have good health and 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

Background papers: *Documents which disclose important facts or matters on which the decision has been based and have been relied on to a material extent in preparing the decision. This does not include any published works e.g. previous Board reports or any exempt documents.*	- Paper 1 – Consultation Findings Report on the engagement and consultation with stakeholders on the proposed merger - Paper 2 – Response to the findings of the stakeholder consultation (Final draft)

NOTE: Once you have completed this report front sheet, upload the main report as a separate document via the 'Add Document' button. If you have appendices you can either include them at the end of the report or upload as separate documents. When uploading the main report and any appendices remember to include the title. Guidance on completing this front sheet and writing the main report is available from the Constitutional Services Team.

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Response to Consultation Feedback

PLEASE NOTE: Whilst this document is largely complete, this version remains a working draft which is still being developed and written. There may be some gaps (identified with placeholders) and further editing to be undertaken. It is being shared at this stage to seek further comment and input.

Contents

Background

This report responds to the consultation held during May and June 2019 on future Commissioning arrangements across Nottingham and Nottinghamshire. In that consultation two options were proposed: 1) to merge the six CCG organisations and create a single, strategic commissioner; and 2) to make no change, i.e. for the six CCG organisations to stay as they are with no further structural change.

Led by the six CCGs across Nottingham and Nottinghamshire, the consultation attracted a total of 192 responses from stakeholders such as GP members, local authorities, Healthwatch, healthcare providers, local residents and patient groups. The responses to the consultation have been summarised by an independent external consultant and this document should be read alongside that report.

Summary of Consultation Responses

Overall, there was strong support for the proposal with 68% of respondents indicating that they were in favour of the merger to create a single strategic commissioner. In addition, only 16% of respondents were in favour of there being no change to the current commissioning arrangements. This is therefore a clear and strong indication of support for the proposal.

Reasons for Supporting the Proposal

Within the strong indication of support for the proposed merger to create a single strategic commissioner, a number of common themes underpinning that support emerged. The top five themes were;

1. Efficiency – respondents were attracted to the potential in the new organisation to reduce duplication and improve efficiencies with a more coordinated approach. The removal of the need to run six separate statutory organisations with associated administrative burden was also part of this strong positive feedback.
2. Financial – it was clear from many responses that interested parties saw the proposed merger and creation of a strategic commissioner as a way to unlock cost savings and other financial efficiencies.
3. Consistency – given the population size of the proposed single commissioning organisation, respondents felt that the proposed merged organisation was strongly positioned to standardise and ensure consistency of patient access across the whole of Nottingham and Nottinghamshire.
4. Collaboration – similarly, a single organisation was seen to be ideally positioned to act as a strong, collaborative partner with the Integrated Care System and other system partners. This feedback included the ability to more easily share clinical information where appropriate.
5. Front Line – finally in these top themes, respondents were attracted to the idea that a single merged organisation would be able to align clinical resources to the front line to more directly serve patients.

Supporting Actions

These strong indications of support from respondents to the consultation give confidence that the merger is the right approach to take. However in order to deliver on the underlying rationale that respondents used to indicate their support for the proposed merger, the following supporting actions are proposed to be put in place. It should be noted that these actions are already part of the merger programme plan and benefits realisation plan which can be viewed as part of the merger application process.

- Complete the CCG staff restructure to deliver an integrated and streamlined management approach to the work of the merged organisation and also unlock the savings represented by removing back-office duplication.
- Roll out a complete Organisational Design process including an enhanced employee benefit offer, a leadership development programme, refreshed vision and values – all to support the alignment of the single CCG's staff to a clear set of strategic priorities and operating model.
- Reap the benefits of the merged organisation by streamlining the financial reporting required and the controls in place – unlocking internal resource to focus on financial support to strategic commissioning and reducing external costs on (eg) Audit.
- Along with the considerable reduction in leadership and management time attending duplicated governance meetings, the creation of a single strategic commissioner will enable a stronger voice for commissioning in system level conversations with other ICS partners. This opportunity must be grasped.
- There is already a proposed approach to clinical involvement at all levels within the Nottingham and Nottinghamshire system – ensuring the voice of General Practice is heard through commissioning decisions. This proposal will need to be taken forward, including ensuring that the potential for reduction in the burden on clinical time is unlocked.

Concerns Expressed by Respondents

Whilst there was an overwhelming level of support for the merger, there were also, within the limited number of respondents not supportive of the proposal, a number of concerns that will need to be addressed. These concerns have been grouped into five themes;

1. Local Focus – risk of losing i) focus on specific needs of localities and populations ii) patient and clinical engagement iii) local expertise and knowledge of local population needs. The local voice of patients and groups could be marginalised and the ability to address health inequalities could be affected as a result.
2. Information – respondents said they needed more information before being able to give their opinions on a merger and/or noting the unknowns relating to emergent NHS arrangements, i.e. ICS, ICPs and PCNs. Some respondents asked for evidence to support proposals and/or clarity on how the 20% cost savings will be achieved.
3. Loss of Services – risk of potential loss of local services, particularly in rural areas, with funding diverted to support more deprived areas and other populations elsewhere.
4. Size – a single organisation could be too large and unwieldy, with less accountability to local populations. It could also be harder to engage with, including geographically.
5. Satisfied – respondents are happy with present arrangements and do not wish to see any change.

It should be noted that only concerns expressed by more than five (5) respondents are included in the above themes – so other concerns expressed had very limited currency amongst the respondents.

Mitigating Actions

Despite the overall strong level of support for the proposed merger, those views against the merger represent important feedback that needs to be considered carefully. The following mitigating actions are proposed against each of the five themes.

Local Focus

i. As a single commissioning organisation we would ensure that we are able to work more consistently and make our resources go further while delivering fair and equitable outcomes for patients, however this would not be at the cost of addressing local healthcare priorities. The new system architecture which incorporates Primary Care Networks at a locality level, and Integrated Care Providers at a Place levels, and our approach to clinical leadership and engagement being embedded at every footprint of the system architecture will ensure effective connection and balance in our approach to specific and local focus on needs, and active engagement in commissioning decisions. We would also look to ensure that some dedicated CCG roles are specifically allocated to work on certain geographic localities to ensure that local needs are well represented. In addition to this, the move to a strategic commissioner across the larger geography does not preclude the ability to prioritise investment in healthcare services according to local population needs in local areas.

ii. Ensuring ongoing clinical leadership and involvement in commissioning activities remains an absolute priority for us. Clinical time is valuable, and with a national shortage of clinicians to provide patient care it is essential that clinical resources are used wisely. Our proposals aim to free-up clinicians to support the development and delivery of care services, instead of being tied up in CCG administration or duplicated activity. The existing Clinical Chairs for the CCGs have worked together to agree a set of proposals for how clinicians will be at the heart of the future proposed arrangements. These include the following elements;

a. Clinicians will have key roles to play in Primary Care Networks and Integrated Care Providers. Working at neighbourhood and wider 'place' levels, these new networks and alliances will assume responsibility from the existing CCGs for the development of pathways and many other clinically-led initiatives. At a local level, clinicians will therefore be able to have the greatest impact on improving the quality of care and services for the populations they serve. Each Primary Care Network has an appointed Clinical Director to support this commitment.

b. Regardless of what our future organisational arrangements look like, we remain committed to engaging and involving our key stakeholders in our commissioning activities.

c. As happens now, the Governing Body of a single CCG would include patient representatives (lay members) and clinical leads including a GP Clinical Chair, other GPs, a nurse and a secondary care doctor. We would also continue to strengthen and build upon our arrangements for involving and engaging local people, clinicians, CCG staff, partners and others in our everyday activity, which include patient participation groups, patient and public engagement committees, lay member representation and other events and activities.

iii. Primary Care Networks will bring together local expertise from across the system and the community to work on understanding local population needs. PCNs will be fundamental in ensuring that individual places health care needs are understood and met through appropriate methods for that community. PCNs are under development and it is now a good time to get involved. To find out more about PCNs visit: https:// www.england.nhs.uk/wp- content/ uploads/2019/06/designing-integrated-care-systems-in-england.pdf

Information

i. It is right to observe that much of the work going on across England to create Integrated Care Systems (and Strategic Commissioning organisations as part of that) is being developed as it is being delivered. This ambiguity is one of the challenges that system leaders in Nottingham and Nottinghamshire have to deal with as one of the first wave 'accelerator' systems.

ii. Through national publications such as the NHS Long Term Plan (January 2019), the Implementation Framework for the Long Term Plan (June 2019) and the various supporting documents, including the document referenced in the above section, more and more clarity is emerging on the future commissioning arrangements for England. We will continue to ensure that patients and members of the public are keep informed about these changes, including through the new Patient and Public Engagement Committees that are included in the "merger-ready" governance structure already in place. Keeping the public informed about these national changes and ensuring that they are able to be involved in their development is a critical activity for the proposed merged organisation – details of this can be seen in the Communications and Engagement Strategy which will be available as part of the merger application process.

iii. Collectively, all six CCGs have developed plans to reduce expenditure in accordance with the nationally mandated 20% reduction in management costs by 2020/21. This is the CCG contribution to the overall £700m national administrative savings requirement for commissioners and providers by 2023/24. To ensure that full, recurrent savings can be made from the beginning of 2020/21, CCGs are asked to ensure that they are planning for and taking actions to achieve these reductions during 2019/20. One of the benefits of working on a larger scale is that we have more control over where the money goes. By taking away perverse incentives in healthcare we will save millions across Nottingham and Nottinghamshire. But at the same time we need to cut our CCG operating costs by 20%.

iv. The CCGs running costs allowance will reduce by £2.4m to £19.7m by 2021.The largest element of running costs is pay to staff, clinicians and independent lay members. This element accounts for 80% of the total running cost spend. The other 20% covers everything else and includes estate costs, IMT, corporate costs such as audit fees, legal and professional services, stationery and office costs.

v. Delivery against the running cost reduction requirement will be delivered through reduction of duplication, reduced workforce costs and driving efficiency through reduction of non-pay running costs. More detailed information will be available by October 2019 when the impacts of plans are known. This efficiency will not be delivered through reduction in clinical commissioning spend.

vi. How and on what the CCGs spend money on will continue to be subject to scrutiny from various parties. We will still be clinically led by our GPs and the new Governing Body and will continue to have Lay Members. Regulators will need to be assured that our plans continue to address the needs of all our patients, across the previous CCG areas. Our independent auditors scrutinise the CCG and give a public assessment as to the how we operate against "value for money" criteria.

Loss of Services

i. The new Primary Care Networks and Integrated Care Providers will take on our existing responsibility to develop personalised care services which meet the needs at neighbourhood level. The work of the PCNs will directly inform the commissioning plans and activities of the CCG.

ii. The new arrangements for one single CCG taking strategic decisions across the whole area and smaller PCNs at local level will directly lend themselves to having an even closer local focus, whilst at the same time enabling more effective commissioning of services across the entire geography.

iii. By supporting and working with these networks we have an opportunity to strengthen our existing approach to commissioning for specific populations and communities across Nottingham and Nottinghamshire.

iv. As a single clinical commissioning group our duty to promote the involvement of patients and carers in decisions which relate to their care or treatment would remain. As one CCG we would still be required to ensure that we work with our stakeholders and involve people in any service change. As we potentially move into one organisation we would retain the two locality based Patient and Public Engagement Committees.

v. Our commissioning plans are scrutinised by regulators and our partners in Health Scrutiny Committees at the local councils to ensure they are aligned to areas of priority and need.

vi. Each of the current CCGs have been given details of their financial allocation of resources for the next five years. The allocations process uses a statistical formula to make geographic distribution fair and objective, so that it more clearly reflects local healthcare need and helps to reduce health inequalities. Although the financial allocations would be combined for a single CCG the organisation will be able to make spending decisions in line with the needs of the local populations.

Size

i. There are pros and cons to whatever size organisation we choose. We believe the proposed merged CCG will provide the advantages of scale with a focus on local relationships working to population needs.

ii. We believe if we stay as we are, we would not be maximising our opportunity to commission healthcare services that ensure the best possible health and wellbeing for the population we serve within the available resources. We would be using public money to fund avoidable duplication of administrative services, tying up clinical time that could be freed up to focus on front-line services and healthcare improvements.

iii. At the same time as merging into one strategic commissioning organisation we are also breaking down the organisation into smaller neighbourhood units with the introduction of Primary Care Networks and ICPs. This will offer the best elements of both a strategic and local approach.

iv. As outlined in the Communications and Engagement Strategy for the proposed merged organisation, there will be a variety of ways for patients and the public to get involved in the shaping of health services – including both commissioning and system transformation activities – at all levels of the population from their local GP practice's Patient Participation Group up to the 1m+ Nottingham and Nottinghamshire level – and all stages in-between.

Satisfied

i. Whilst the current commissioning arrangements have served the people of Nottingham and Nottinghamshire well since 2013, the political and external context for the NHS in England has changed significantly since then. The NHS Long Term Plan sets clear expectations for the next generation of commissioning organisations. These include typically having a single commissioner within each healthcare system and one set of commissioning decisions. Staying as we are would not directly align with the national direction for the NHS.

ii. In order to maximise the voice of strategic commissioning within the Nottingham and Nottinghamshire ICS, there needs to be one single commissioning organisation operating on a system-wide basis, with more tactical commissioning activities taking place at the ICP (Place) and PCN (Neighbourhood) levels.

iii. Furthermore, whilst we have made some financial savings by implementing joint arrangements across our CCGs, given the reductions in management cost budget allocations, we need to find ways to unlock further savings. Each current CCG is a separate legal entity and it costs significantly more to service all six organisations than it would a single body. If we continue to run multiple CCGs the costs incurred on back-office activities will be much higher than having one streamlined organisation.

Summary

It is clear that the overwhelming majority of respondents to the stakeholder consultation are in favour of the proposed merger of the six CCGs in Nottingham and Nottinghamshire to create a single, strategic commissioner operating across the whole system.

However, this was not a unanimous position and so it is important that the minority views of respondents are carefully considered and taken into account going forward.

The five themes identified and the mitigating actions laid out above are important considerations as system leaders and the CCG's leadership team consider the next steps with the proposed merger. The actions described above will be monitored throughout the next stages of the merger application process, during mobilisation and when as part of the ongoing evaluation of benefit realisation of the creation of a new organisation.

Nottingham City Council

Statutory Officers Report for Health and Wellbeing Board

Corporate Director of Children's Services

July 2019

Corporate Director for Children and Adults

After 7 years at Nottingham City Council, I have finally succumbed to pressure from family to retire. The recruitment campaign for your new Corporate Director is well underway. However, I am not going anywhere soon so this is not my goodbye message and I have committed to staying until the end of November 2019 by which time hopefully my replacement will be in post.

City exceeds national average for pupils at Good and Outstanding schools

The percentage of pupils in Nottingham going to 'Good' or 'Outstanding' schools is now above the England average – 86% in Nottingham compared to 85% nationally – as well as above the East Midlands average of 80%.

This is thanks to excellent progress being made across Nottingham schools, most recently the fantastic improvements made at Both Cantrell Primary in Bulwell and Seely Primary in Sherwood, which were previously rated as 'requiring improvement' – but new inspections have seen them reach the 'Good' standard set by Ofsted, the education inspectorate.

Both schools have been supported by the Nottingham Schools Trust. These new statistics are fantastic news – not only for the schools but also for the city as a whole.

Read more here: [http://www.mynottinghamnews.co.uk/double-celebration-as-city-exceeds-national-average-for-pupils-attending-good-and-outstanding-schools/]

Nottingham City Early Years PVI Providers

Following the fantastic news about our Good and Outstanding Schools, the Early Years team are pleased to report that at this moment in time the amount of inspected Ofsted Registered PVI Early Years Providers (day care nurseries and pre-schools) who have a good or outstanding grade stands at 98%. The most recent Ofsted Statistical release reports a national figure of 97%. We are delighted to share this news and proud of the support the sector provides for the city's children and their families.

Two new schools for Nottingham

On Friday 14th June, the Government announced that Nottingham is to gain two brand new schools.

As part of a programme to increase school spaces where they are needed most, two local academy trusts have put in successful bids to the Department for Education – one for a primary school and another for a secondary school.

The primary school bid was submitted by Greenwood Academies Trust, for a 420-place school with a 60-place nursery in the Waterside area, which is currently being developed as Nottingham's newest neighbourhood. The City Council included a school

among the features it wants to see in the area, and Greenwood has worked with the council to develop its proposals.
The Trust has a strong record of excellence in providing both primary and secondary education for city children and young people and is signed up to the council's inclusion model to prevent exclusions.

The secondary school bid was submitted by the Archway Academy Trust (Bluecoat) which has also worked with the City Council to identify needs and site options to ensure best access for pupils across the city. Archway have a successful track record of providing good and outstanding secondary education in the city and a commitment to inclusive education.

The new schools will build on the City Council's long-term school expansion strategy which has seen £42m of investment since 2009 to provide 5,000 additional primary places once all year groups are full by 2022. The council has worked hard to ensure the city continues to have the right number of places for the right number of children.

New adoption arrangements for children in care

Our new Regional Adoption Agency for the East Midlands officially launched on 03 April 2019 to offer children in care the stability and security they need to achieve their potential.

Incorporating Derbyshire County Council, Derby City Council, Nottinghamshire County Council and Nottingham City Council. The Regional Adoption Agency (RAA) will work collaboratively across the East Midlands to encourage more people to become adopters, which in turn leads to markedly improving the life chances of children in care.

A key aim of the RAA is to encourage more people who express an interest in adoption to attend information events and hear from people who have already gone through the process.

You can find out more on the new website www.adoptioneastmidlands.org.uk

LGA Peer Review – Early Years Social Mobility, Speech and Language

The Local Government Association have been commissioned by the Department for Education to deliver 30 Early Years Social Mobility, Speech and language Peer Challenges over the coming year.

On 14 December 2017, the Department for Education (DfE) launched *Unlocking Talent, Fulfilling Potential: a plan for improving social mobility through education*. Ambition 1 in the plan is to close the word gap in the early years.

The Government has committed £8.5m to spread best practice on improving early language outcomes. A new programme of peer challenge and support for local authorities is central to this offer.

The peer team visit the Council for four days. During this time the challenge team will talk to a cross-section of senior officers and frontline staff, elected members, partners and observe early years practice. The team will feed back their observations and recommendations/findings from all the elements of the peer review at the end of the site

visit and a report will be produced. This will highlight the strengths of the Council and areas they might need to consider along with some recommendations.

Further information can be found on the LGA website https://www.local.gov.uk/early-years-social-mobility-peer-review-programme

Nottingham City's Peer Challenge has been scheduled for 15-18 October 2019

Alison Michalska
Corporate Director for Children and Adults
(July 2019)

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NOTTINGHAM CITY COUNCIL

HEALTH AND WELLBEING BOARD

MINUTES of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 29 May 2019 from 2.03 pm - 4.09 pm

Membership

Present	Absent
Councillor Eunice Campbell-Clark (Chair)	Councillor Leslie Ayoola
Hugh Porter (Vice Chair)	Dr Marcus Bicknell
Councillor Cheryl Barnard	Sarah Collis
Andrea Brown	Samantha Travis
Alison Challenger	Hazel Johnson
Alison Michalska	Jane Todd
Catherine Underwood	Alison Wynne
Councillor Sam Webster	
Councillor Adele Williams	
Tim Guyler	

Colleagues, partners and others in attendance:

Lyn Bacon	-	Nottingham Citycare Partnership
Matthew Healey	-	Nottinghamshire Police
Leslie McDonald	-	Nottingham Third Sector Health and Wellbeing Provider Forum
Kate Morris	-	Governance Officer

1 CHANGE IN MEMBERSHIP

RESOLVED to note the following membership changes:

Current Member	Organisation	New member
Councillor Sam Webster	Nottingham City Council	Councillor Eunice Campbell-Clark
Councillor David Mellen	Nottingham City Council	Councillor Adele Williams
Vacancy	Nottingham City Council	Councillor Leslie Ayoola
Superintendent Ted Antill	Nottinghamshire Police	Superintendent Matthew Healey
Tracey Taylor	Nottingham University Trusts	Alison Wynne
Hazel Buchanan	Greater Nottingham Clinical Commissioning Group	Andrea Brown

2 APOLOGIES FOR ABSENCE

Councillor Leslie Ayoola – Nottingham City Council

Dr Marcus Bicknell – CCG
Jane Todd – Nottingham CVS
Alison Wynne – NUH Trust

3 DECLARATIONS OF INTERESTS

None.

4 OBESITY

David Johns, Acting Consultant in Public Health, introduced the themed discussion on Obesity. He gave the Board an overview of Obesity in Nottingham City, which has increased in recent years, outlining the correlation between high levels of deprivation and high levels of obesity in children in Nottingham. David emphasised the need for a whole system approach, incorporating partner organisations and stakeholders in order to tackle the issue.

Caroline Keenan, Insight specialist for Public Health presented the Board with information on the new adult weight management services available in Nottingham. She highlighted the following points:

(a) There are 4 tiers of weight management provision for adults, the first 2, health promotion & primary care and lifestyle interventions are primarily the responsibility of the local authority. The third and fourth tiers, including specialist weight management services and bariatric services are traditionally the responsibility of health care trusts.

(b) Nottingham City Council currently offers two interventions, Slimming World weight management on referral and Ladle, a digital weight management course.

(c) Eligibility for referral to Slimming World is based on BMI, includes 12 weekly classes and is available across the city at various different times of the day. Priority groups include:
- People with learning disabilities
- People with mental health problems
- Pregnant women
- People of African, Caribbean or South Asian descent; and
- Men.

Mark Fulford, Facilities Manager (Catering) for Nottingham University Hospitals detailed to the Board work ongoing within the Trust to improve the food offering for staff visitors and patients. He highlighted the following points:

(d) There are 4 trust wide standards which all catering outlets are subject to:
- A ban of price promotions on sugary drinks and foods high in fat, sugar or salt.
- A ban on advertising sugary drinks and foods high in fat, sugar or salt on NHS premises.
- A ban on sugary drinks and foods high in fat, sugar or salt from check out areas
- Ensuring that healthy options are available at any point, including those staff working night shifts.

(e) Other standards introduced ensure that at least 75% of prepacked sandwiches and other savoury prepacked meals contain 400kcal or less per serving, and do not exceed more than 5g saturated fat per 100g and that 80 % of confectionary and sweets do not exceed 250kcal;

(f) Going forward there are a number of initiatives taking place to continue to theme of healthy eating within NUH trust. A fruit a veg stall will be introduced onto the City and QMC Campus'. There will be continued work with retail partners to deliver the standards set out above and checks and audits to ensure that the maintained.

Gemma Poulter, Head of Integration – Adult Social Care and Amanda Chambers, Getting Active Strategic Lead introduced information to the Board on the Sport England local delivery pilot aimed at reducing physical inactivity.

Gemma presented the story of a citizen who had a long term condition which had led to her becoming increasingly inactive. She detailed her meeting with a community activator, who spoke to the citizen and her partner about what they wanted to achieve, supported the citizen to access the leisure centre and swimming facilities. The outcome for the citizen was not just becoming more active, but increased their confidence, increased their feeling of belonging to the community, increased motivation for healthier eating, and improved the relationship with her partner.

After presenting the case study, the following information about the programme was highlighted to the Board:

(g) The aim of the pilot is to make being active easy, integrate physical activity into the community and co-ordinate work of partners and organisations who are working towards making physical activity the norm for people who live in our communities;

(h) It is recognised that how active someone is, is influenced by a range of different factors around them that are beyond the limits of their own motivation and the control of any single service, club or programme. The pilot is exploring with local communities how these factors can be tackled to increase activity;

(i) The most significant benefits can be seen in citizens who move from being inactive (no physical activity, light intensity activity or activity limited to up to 30 minutes a week) to being fairly active.

(j) Outcomes for citizens engaging in physical activity are not limited to health benefits, they also report better mental wellbeing, increased feeling of community integration, and improved interpersonal relationships;

Penny Poyser, Chair of the Nottingham Good Food Partnership (NGFP) introduced the partnership to the Board and outlined some of the work the Partnership is doing in Nottingham to promote healthy and sustainable food. She highlighted the following points:

(k) In 2018 Nottingham Good Food Partnership became a member of the Sustainable Food Cities Network, a network of over 60 members working towards developing best practice in all aspects of sustainable food;

(l) In 2018 NGFP ran two new programmes in Sneinton focussed on providing children with healthy food and fun activities during the school holidays. This included a healthy eating and play programme over a number of sessions to reach low income families to help alleviate the issue of holiday hunger;

(m) 108 young children and 50 parents were fed at a cost of £0.31 per head. The meals provided were nutritiously dense vegan meals including home made baked beans and beetroot falafels. Surplus food was distributed to participant to take home.

(n) The partnership also hosted the city's first healthy food festival for children called Veg Power which attracted over 400 children and their parents.

(o) The festival had a number of creative activities available, home baking ideas, a pop up allotment, and food from a diverse range of cultures. Feedback from parents was that children tried foods they would normally refuse at home.

(p) Future projects include the Family Veg Power Festival on 4 August 2019 in Sneinton Plaza and Square and more work on holiday hunger.

Following discussion and comments from the Board, the following points were made:

(q) There is a piece of work currently looking at the provision already in place across the sectors, and collating information on where there is need for services. This information will feed in to work to ensure a responsive system is in place.

(r) A focus on work with faith groups and the culturally diverse community groups across Nottingham is helping to raise awareness.

(s) Workforce education is essential and work at NCC continues and healthy eating options have been introduced at the food outlets at Loxley house. This not only raise awareness for staff but prompts frontline staff to engage with service users around healthy eating;

(t) The introduction of planning legislation to create exclusion zones for fast food outlets around schools has recently been turned down at a central government level, further work is being done at a local level to attempt to restrict expose around schools;

(u) A 10% reduction in childhood obesity is abmitous but the Board questioned whether there should be a target to reduce obesity in adults too.

RESOLVED to:

(1) Commit to the Nottingham City Council objective of reducing childhood obesity by 10% by 2023

(2) Encourage conversations with citizen on moving and eating for good health and, where appropriate, refer citizens to one of the weight management services available in Nottingham City

(3) Support exploration of a new, systems approach to eating and moving for good health in Nottingham City; and

(4) Sign-up to the Physical Activity and Nutrition Declaration, which has previously been endorsed by the Health and Wellbeing Board.

5 HEALTH AND WELLBEING STRATEGY ANNUAL UPDATE

Uzmah Bhatti, Insight Specialist (Public Health) Strategy and Resources introduced the Annual update report 2019 on the Joint Health and Wellbeing Strategy 2016-2020 providing the Board with an update on strategic developments. She bought the following points to the attention of the Board:

(a) The strategy is divided into 5 areas, an overarching aim to increase healthy life expectancy in Nottingham and 4 outcomes which are then further broken down into different indicators:

- Healthy lifestyles
- Mental wellbeing
- Healthy culture
- Healthy environment

(b) Healthy life expectancy in Nottingham is lower than comparators for both men and women. This figure has not changed for men but has shown a downward trend women since targets were set;

(c) When targets were set, there were significant differences between neighbourhoods in Nottingham with people in the most socio-economically deprived wards experiencing poorer health earlier than those in less deprived wards. Further ward level data is not available to analyse whether there has been a greater impact at ward level.

(d) The Healthy Lifestyle Outcome indicators updates include the following key points:

- Although rates of sexually transmitted infection remains high in Nottingham, there has been no statistically significant increase since baseline. Actions are being taken to address challenges around rising demand and higher needs in groups such as young people.

- There has been significant progress and the conception rate amongst girls age 15-17 has decreased approximately 15% since baseline. Further system-wide actions are being identified to sustain this downward trend.

- Alcohol related hospital remain unchanged and are higher than comparators. A number of work streams are in progress to reduce this number, including funding bids for an Alcohol Hub in emergency departments and for accommodation to help “street drinkers”.

- Targets around reducing smoking amongst adults have been achieved. Persistent and vulnerable smokers are now to focus of a new smoking cessation service.

- Obesity is an ongoing national issue. This has been discussed at length in minutes 4.

(e) Service related targets for mental health have been achieved. In addition to this, Time to Change hub has over achieved on targets. Activity target at people with serious mental illness, BME people and construction workers is being progressed. A refreshed strategy is currently out for consultation

(f) Healthy Culture targets around askLION and reablement have been met and exceeded. However, targets around hospital discharge and financial resilience have been more challenging. Actions are being taken to address these.

(g) Good progress has been made in the Healthy Environment Outcome. Air quality has been improved and EMAS has reduced their carbon footprint. There is still work to do around reducing the number of households in fuel poverty and excess winter deaths as is the case across most of the core cities; Policy restricting hot food outlets near secondary schools has had to be removed due to challenges. Transport improvement continues with various initiatives funded by external sources.

During questions and comments from the Board the following further points were highlighted:

(h) There has been some really positive work coming from the strategy. It is due to be refreshed and the Board will work towards setting further robust and focused challenges in order to benefit the citizens of Nottingham;

(i) The Board agreed that partnership working continued to be essential to progressing work towards the strategy targets including the co-ordination of funding where appropriate;

RESOLVED to:

(1) Note the contents of the report;

(2) Consider what actions members can take together to support delivery of the Strategy in its final year; and

(3) Support the development of a refresh of this strategy;

6 PRIMARY CARE NETWORKS

Andrea Brown, Associate Director of Joint Commissioning and Planning for Greater Nottingham Clinical Commissioning Group introduced the report on Primary Care Networks (PCN's) to the Board setting out the development of PCN's. The following information was highlighted:

(a) Since Nottingham and Nottinghamshire became one of the first wave of Integrated Care Systems in 2018 Nottingham City CCG and the other 5 CCG's within Nottingham and Nottinghamshire have been working towards aligning teams and functions;

(b) The PCN's will focus on service delivery with responsibility for planning and funding of services remaining with the commissioner;

(c) A PCN will be a group of practices working together with a range of local providers across primary care, community services, social care and the voluntary sector and it will offer more personalised coordinated health care;

(d) PCN's broadly fit with the Nottingham City Council Ward Boundaries and have a similar configuration as the Care Delivery Groups previously established;

(e) The CCG's aim is to form a single CCG as the strategic commissioning organisation within the Nottingham and Nottinghamshire ICS, which will work alongside a number of other changes to NHS services outlined in the NHS Long Term Plan;

(f) A consultation process is currently taking place on this merger and input from Board members would be welcomed;

RESOLVED to:

(1) Help raise awareness of the plans for the Primary Care Networks and the different levels of the ICS in order to build a consistent and shared understanding of how the system will work together to improve health and care in Nottingham City; and

(2) Consider the role that partners could play in the development and implementation of the PCNs.

7 IMPACT OF THE COMMISSIONING REVIEWS 2018/19

Christine Oliver, Head of Commissioning, introduced the report updating the Board on the progress to date on the Commissioning reviews for Nottingham City Council and the joint priorities for NCC and Nottingham City CCG for 2018-19. The following points were highlighted during discussion:

(a) A new inpatient contract was tendered resulted in a new in patient detoxification contract being awarded. A new contract is due to commence a the beginning of July 2019.

(b) Work around Homelessness continues with a number of new contracts introduced at the beginning of 2018/19 and a new service model implemented. These services include those aimed at reducing the risk of homelessness and a greater number of households at risk of homelessness have been supported into accommodation that is more appropriate. Further work continues;

(c) Following the review of Domestic and Sexual Violence Services additional funding was secured which has allowed additional provision including 24hour domestic helpline, a male IDVA service and 3 specialist domestic violence refuge provision;

(d) Many of the joint reviews are still being undertaken and will continue into 2019/20. This includes reviews of Mental Health services where there is currently a lot of pressure;

(e) The Transforming Care Programme is an ambitions and complex programme. The joint review is taking place closely with NHS England;

RESOLVED to note the progress made in relation to last year's Strategic Commissioning Priorities

8 COMMISSIONING INTENTIONS 2019/20

Christine Oliver, Head of Commissioning, updated the Board on the Commissioning Intentions for 2019/20. She set out the intentions of Nottingham City Council (NCC) and the Joint intentions of Nottingham City Council and Nottingham City Clinical Commissioning Group (CCG) which will form the basis of the work programme for both organisations. She highlighted the following information contained within the report:

(a) Although there is work occurring around mental health services a clear pathway for services is yet to be established . Catherine Underwood, Hugh Porter and John Brewin will take this work forward and align it to the Integrated Care Partnership for the city. This includes transformation of CAMHS services and the development of an integrated Mental Health Accommodation Pathway;

(b) A new homecare model is in place which forms part of the Adult Social Care Better Lives Better outcomes agenda;

(c) The Better Care Fund and improved Better Care Fund supporting integration of provision between Health and Social Care continues to focus on Delayed Transfers of Care from hospital to the community;

RESOLVED to note the main areas of activity identified within the Commissioning Plans.

9 BOARD MEMBER UPDATES

Board member updates were noted.

10 MINUTES

The minutes of the meeting held on 27 March 2019 were confirmed as a true record and were signed by the Chair.

11 FORWARD PLAN

RESOLVED to note the forward plan

12 ACTION LOG

The Chair asked that all members review the action plan and provide updates on outstanding actions.

13 MINUTES OF THE HEALTH AND WELLBEING BOARD COMMISSIONING SUB COMMITTEE HELD ON 27 MARCH 2019 (DRAFT)

RESOLVED to note the draft minutes of the Health and Wellbeing Board Commissioning Sub Committee held on 27 March 2019.

14 NEW JOINT STRATEGIC NEEDS ASSESSMENT CHAPTERS - DEMOGRAPHY AND PREGNANCY

RESOLVED to note the new Joint Strategic Needs Assessment Chapters Demography and Pregnancy.

15 QUESTIONS FROM THE PUBLIC

None.

16 FUTURE MEETING DATES

RESOLVED to meet on the following Tuesdays:

24 July 2019
25 September 2019
27 November 2019
29 January 2020
25 March 2020

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Health and Wellbeing Board Forward Plan 2019/20

Submissions for the Forward Plan should be made at the earliest opportunity through Kate Morris, Nottingham City Council Constitutional Services Team Kate.morris2@nottinghamcity.gov.uk

Date of meeting	Agenda Item	Lead
September 2019 (25/09/2019)	**Themed Discussion – Winter Preparedness**	Shade Agboola / Caroline Nolan
	Joint Health and Wellbeing Board Strategy 2020 onwards	Uzmah Bhatti
	ICP Update	Ian Curryer / Hugh Porter
November 2019 (27/11/2019)	**Themed Discussion – Social Prescribing**	
	Primary Care Networks - Update	
January 2020 (29/01/2020)	**Themed Discussion – 1st Draft of Health and Wellbeing Strategy 2020 onwards**	Uzmah Bhatti
March 2020 (25/03/2020)	**Themed Discussion – Sign off and Launch of Health and Wellbeing Strategy 2020 onwards**	Uzmah Bhatti
	Violence Prevention	Alison Challenger

NB: In addition to the items listed above, all ordinary Health and Wellbeing Board meeting agendas will normally include the following items:

- Minutes of the last meeting
- Board Forward Plan
- Board Member Updates
- New Joint Strategic Needs Assessment (JSNA) Chapters
- Minutes of any HWB Commissioning Sub Committee meetings that have taken place since the previous meeting
- Citizen questions

Suggested items to be scheduled:

- Children's health and wellbeing
- Domestic and sexual violence services
- Delayed Transfers of Care

- Joint CCG/ NCC update on the NHS Long Term Plan
- Health in all policies policy
- Air Quality

Health and Wellbeing Board Action Log

Meeting and Issue	Agreed Actions	Updates received on progress
28 November 2018 Reducing Alcohol Harm	All Board Members were asked to: • Sign the Alcohol Declaration • Identify alcohol champions within their organisation • Consider how to embed Identification and Brief Advice (IBA) in their organisation	CCG has signed the declaration, appointed an alcohol champion and is working towards embedding IBA in their organisation. NCC confirmed declaration signed, alcohol Champion appointed and IBA embedded as part of HiAP work. NUH Signed. Consultant medical champion identified. [Dr Steve Ryder] Screening for alcohol introduced in all in-patients at NUH. IBA training by area given and being delivered. ED-bid for prevention hub in ED successful which will also embed screening and IBA in ED
28 November 2018 Autism	All Board Members were asked to: • support engagement on the themes within the Autism Strategic Framework within their organisation • identify autism champions within their organisation	CCG has appointed an autism champion NUH Autism awareness and autism champion training delivered (approx. 250 staff). Training was funded by NUH charity and this funding has ended and training concluded. Awaiting outcome of national consultation to inform next steps for future training. Autism champion identified (Giles Matsell, Head of Equality and Diversity)
30 January 2019 Mental Health	All Board Members were asked to consider: • signing the Time to Change Employer Pledge to demonstrate their commitment to changing how people think and act about mental health in the workplace and ensuring employees with mental health problems are supported	CCG has signed the Time to Change Employer Pledge and are reviewing the opportunity to train staff on Mental Health First Aid. NUH have established a Mental Health Shared Governance Council. This group has agreed that the pledge should be signed and have provisionally registered to obtain the information to do this.

Meeting and Issue	Agreed Actions	Updates received on progress
	• identifying mental health champions within their organisation • ensuring that their workforce has access to mental health training • how their organisation could take the impact of past traumatic experiences on mental health into account when reviewing its working practices and supporting its workforce The Mental Health Sub Group was asked to review the issues raised during the discussion and bring back proposals for actions that Board Members can take to make a difference to improving mental health a future Board meeting.	Work is underway to determine our approach to identify, train and support mental health champions within the organisation. This approach will need to be embedded appropriately as part of our wider organisational response and strategy to mental health. Various training is available to all staff (and training for managers) including stress awareness and mindfulness. Training is continually monitored and reviewed.
27 March 2019 Smoking in Nottingham City	All Board Members were asked to: <u>Smoking in Pregnancy</u> • Support the LoveBump Campaign across their organisations • Support the achievement of the Council Plan commitment to reduce smoking rates of pregnant women at the time of delivery • Ensure the NHS long term plan commitment to provide pregnant women and their partners with a new NHS stop smoking pathway including support, is designed alongside non-NHS funded services	<u>CCG</u> has confirmed completion of 1-6 - The majority of the actions are supported through the approach taken across the system, including through the ICS prevention workstream. The CCG are considering staff policies and the opportunity to introduce vaping. <u>NUH Smoking in Pregnancy</u> The smokefree team at NUH is providing a regular training session at the maternity / maternity support worker forums. Materials relating to Love Bump have been disseminated to midwives. <u>Smoking Cessation</u> The Smokefree advisers based at NUH routinely offer information to smokers about how to access the stop smoking service in the community.

Meeting and Issue	Agreed Actions	Updates received on progress
	Smoking Cessation • To create awareness about smoking cessation service (Stub-it) • Encourage citizens who smoke to seek support via their GP's especially if they are in one of the target groups for the service • Support referral of patients who are smokers in target groups to the new service Implementation of the NICE guidance supporting cessation in secondary care (PH48) • Support continued implementation of PH48 in NUH • Review current policies and ensure that provision is made for staff, patients, and families who wish to vape on site • Support staff in the delivery of brief advice through completion of the "very Brief Advice Training Module" by the National Centre for Smoking Cessation Training (NCSCT) Vaping and E-cigarettes • Review current smoking cessation policies in organisations • Consider expanding current policy to include recognition that e-cigarettes are 95% less harmful than cigarettes • Support staff, patients, and clients who	Implementation of the NICE guidance supporting cessation in secondary care (PH48) NUH now have a smokefree lead in post since April whose role is to support the continued implementation of ph48 across NUH. The current smokefree policy is under review and agreement has been established from the management board that staff, patients and visitors can vape on site. Funding is also being sought to support NUH staff wishing to quit smoking to access Stop smoking medications. A training pathway for VBA for staff across NUH is currently being developed. Vaping and E-cigarettes Current policy is being updated and will include recognition that e-cigarettes are 95% less harmful than cigarettes.

Meeting and Issue	Agreed Actions	Updates received on progress
	wish to vape by considering the provision of dedicated vaping locations/areas on site	
29th May 2019 Obesity	• Commit to the Nottingham City Council objective of reducing childhood obesity by 10% by 2023 • Encourage conversations with citizens on moving and eating for good health and, where appropriate, refer citizens to one of the weight management services available in Nottingham City • Support exploration of a new, systems approach to eating and moving for good health in Nottingham City; and • Sign-up to the Physical Activity and Nutrition Declaration, which has previously been endorsed by the Health and Wellbeing Board.	

NOTTINGHAM CITY COUNCIL

HEALTH AND WELLBEING BOARD COMMISSIONING SUB COMMITTEE

MINUTES of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 29 May 2019 from 4.09 pm - 4.37 pm

Membership

Present	**Absent**
Andrea Brown	Katy Ball
Councillor Eunice Campbell-Clark	
Hugh Porter	
Christine Oliver	

Colleagues, partners and others in attendance:

Clare Gilbert - Commissioning Lead for Adults
Bobby Lowen - Commissioning Lead
Kate Morris - Governance Officer

1 MEMBERSHIP UPDATE

RESOLVED to note the following membership changes

- **Councillor Eunice Campbell-Clark, Portfolio Holder for Health, HR and Equalities replaces Councillor Sam Webster.**
- **Andrea Brown, Associate Director of Joint Commissioning and Planning, replaces Michelle Tilling.**

2 APOLOGIES FOR ABSENCE

Katy Ball – Christine Oliver attending as Substitute

3 DECLARATIONS OF INTERESTS

None

4 MINUTES

The minutes of the meeting on 27 Mar 2019 were confirmed as a true record and were signed by the Chair.

5 NOTTINGHAM CITY BETTER CARE FUND GOVERNANCE ARRANGEMENTS 2019/20

Clare Gilbert, Commissioning Lead for Adults, introduced the report on the Nottingham City Better Care Fund Governance Arrangements 2019/20. She informed the Sub-Committee that the governance document was signed off at the Better Care Fund Delivery Group on March 2019. The document outlines the following:

- Confirmation of internal and joint BCF governance arrangements
- BCF Delivery group meeting frequency, attendees roles and responsibility
- A refresh of the risk management process; and
- Details of BCF representatives at other forums where BCF metrics are reviewed and discussed.

The sub-committee commented that by using named individuals in the governance document it was immediately out of date and that a better approach would be to reference job titles with an addendum that is kept up to date as people move roles.

RESOLVED to note the Nottingham BCF Governance document, signed off by the BCF delivery group on 14 March 2019

6 BETTER CARE FUND QUARTER 4 PERFORMANCE REPORT

Clare Gilbert, Commissioning Lead for Adults, introduced the Better Care Fund and Improved Better Care Fund Quarterly Performance reports to the Sub-Committee

She informed the sub-committee that both the rate of permanent admission to residential care, and the proportion of older people who were still at home 91 days after discharge targets were on track. However, the reduction in non-elective admissions is not on target and data was not available to assess progress on the Delayed Transfers of Care (delayed days) target.

Further work is ongoing to assess the spike in non-elective admissions, in particular paediatric non-elective admissions.

The Sub-Committee agreed that there has been learning that will be useful to reflect on when new ways of working are devised.

RESOLVED to:

(1) Note performance in relation to the Better Care Fund performance metrics for Q4 18/19;

(2) Note performance in relation to the improved Better Care Fund (iBCF) reporting requirements for Q4 18/19;

(3) Note the quarterly return, which was submitted to NHS England on 08/05/2019 and authorised by Councillor Sam Webster.

JSNA Chapter - Air Quality and Health 2019

Topic information	
Topic title	*Air Quality and Health*
Topic owner	*Shade Agboola, Consultant in Public Health*
Topic author(s)	*Richard Taylor (Environmental Health Officer), Environmental Health and Safer Housing Service, Community Protection*
Topic endorsed by	*Health Protection Strategy Group*
Current version	*June 2019*
Replaces version	*May 2015*
Linked JSNA topics	Cardiovascular Disease (2016), Chronic Obstructive Pulmonary Disease (2016), Dementia (2018), Excess Winter Deaths (2015), Life Expectancy and Healthy Life Expectancy (2018), Physical Activity (2016), Smoking and Tobacco Control (2015).

Executive summary

Introduction

Air pollution is the top environmental risk to human health. In the UK it is ranked as the fourth greatest threat to public health after cancer, heart disease and obesity, and is a contributory factor to heart disease and some types of cancer.

Human-made air pollution comes from a range of different sources including agriculture, industrial, commercial and domestic activities, and transport. Emissions from road traffic are one of the largest contributors to ambient air pollution in urban areas.

Long-term exposure to air pollution, at the levels experienced in many urban centres in the UK, including Nottingham, causes respiratory and cardiovascular disease and lung cancer. It has also has been linked to other cancers. In children, air pollution reduces lung development and function and can lead to the development of asthma.

Short-term exposure to elevated levels of air pollution leads to a worsening of symptoms for those with existing asthma, respiratory or cardiovascular diseases, and can trigger acute events such as asthma and heart attacks in vulnerable individuals.

In Nottingham in 2016, it is estimated that **181** adult deaths were brought forward due to the health impacts of **air pollution** (comprising PM_{10}, $PM_{2.5}$, NO_2 and other pollutant species).

The impact of air pollution on health is modifiable, and there are cost-effective, achievable local collective and personal actions that reduce personal exposure to, and emissions of, air pollution, and improve health and air quality. These include active travel (walking and cycling), travelling using public transport and ultra-low emission vehicles, and increased energy efficiency (coupled with appropriate ventilation) in buildings and homes. These actions also produce benefits across local priorities, including increasing physical activity, achieving and maintaining healthy weight, reduction in hospital admissions due to excess cold, respiratory, cardiovascular and obesity problems, reduced CO_2 emissions (a key driver of climate change), and reduce the generation of secondary pollutants that also effect health, and have other adverse impacts on the natural environment.

Unmet needs and gaps

The national Public Health Outcomes Framework (PHOF) datasets show that in Nottingham in 2016 approximately **146** deaths (6.3%) of all adult mortality was attributable to long-term exposure to human-made particulate air pollution. It is estimated that in Nottingham in 2016 ambient concentrations of nitrogen dioxide (NO_2) contributed to **35** additional deaths, i.e. **181** adult deaths were attributable to the combination of $PM_{2.5}$, NO_2 and other air pollutants.

It was predicted that by the end of 2019 concentrations of NO_2 in Nottingham's air will be below the annual mean National Air Quality Objectives (NAQOs), and EU limit value. However, despite meeting the NAQO for PM_{10}, concentrations of particulate matter (PM_{10} and $PM_{2.5}$) currently exceed, and are likely to continue to exceed, the World Health Organization's guidelines. Furthermore, the WHO have advised there is no 'safe' concentration for particulate matter in ambient air.

There is increasing evidence that indoor air pollution significantly affects health, and contributes to the development of respiratory conditions that are then further exacerbated by ambient/outdoor air pollution and indoor air pollution e.g. asthma.

The government's Clean Air Strategy 2019 considers both outdoor and indoor air pollution and how reducing emissions, pollutant concentrations and exposure, both outside and inside buildings and homes, can protect and improve health.

The National Institute for Clinical Excellence is preparing guidance (for publication late 2019) for local authorities and health organisations on how to improve citizen health by reducing outdoor and indoor air pollution, and exposure to it.

Gaps include:

- Organisational and public awareness and understanding of the range of air pollutants, wide range of sources, and their effects on health.
- Comprehensive demographic/geographic air pollution-health impact information for Nottingham's citizens.

- Air quality monitoring data of sufficiently high temporal and spatial resolution to inform studies into local health impacts and distribution and thus the need for additional air quality monitoring to inform the studies.
- Cost-benefit analysis tools that holistically (and therefore more fully) identify and consider the fullest range of economic, environmental and health impacts of air pollution (including CO_2, knock-on effects of climate change and the predicted likely consequent environmental change impacts on health and infrastructure).
- Organisational application of approaches and mechanisms that most effectively achieve behavioural change. (Inform, promote, model, enable and reinforce choices and decisions that reduce emissions and exposure).
- Resources/funding to sustain a co-ordinated holistic behavioural change programmes and multi-media messages.

Recommendations for consideration by commissioners

- Continue to include in the Health and Wellbeing Strategy an action plan to raise awareness of the impacts of air pollution and the need to improve air quality, and a summary of the actions citizens and businesses can take to reduce emissions and personal exposure,
- Support the development and roll-out of a communication strategy and awareness raising events to provide key messages on air pollution (outdoor and indoor), emission and exposure reduction to the public and businesses (e.g. information in GP surgeries),
- Support the development and use of comprehensive cost-benefit analysis tools to better quantify the impact of air pollution and mitigation measures on health and healthcare costs in Nottingham and Nottinghamshire,
- Support the collection of air pollution/health impact geo-spatial data for Nottingham to inform local and national air pollution-health studies, and enable targeted action if appropriate.

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JSNA Chapter – Smoking and Tobacco Control

Topic information	
Topic title	Smoking and Tobacco Control
Topic owner	Shade Agboola, Consultant in Public Health
Topic author(s)	Isabel Allsop and Claire Novak
Topic endorsed by	Strategic Tobacco Control Group
Current version	June 2019
Replaces version	July 2015
Linked JSNA topics	Cancer (2016) Cardiovascular disease (2016) Chronic obstructive pulmonary disease (2016) Adult mental health (2016) Pregnancy (2019)

Executive summary

Introduction

Smoking remains the single largest preventable cause of early death in the UK and worldwide. Half of all lifelong smokers will die prematurely, usually about 10 years younger than non-smokers. The main causes of death from smoking are heart disease and strokes, lung cancer and chronic obstructive pulmonary disease (COPD).

For every smoking related death, another ten smokers will be living with a smoking related disease. Smoking affects every organ and every cell of the body, causing conditions ranging from diabetes, tuberculosis, sudden infant death syndrome, osteoporosis, impotence and reduced fertility. A third of all cancers and over 90% of lung cancers are directly caused by smoking. Action on Smoking and Health (ASH), a public health charity campaigning to reduce the harm caused by tobacco, produce a series of 'at a glance' factsheets.

This chapter will focus on changes since the 2015 chapter. Smoking in pregnancy is considered in the Pregnancy JSNA chapter.

Unmet needs and gaps

Smoking cessation services

- Stub it! smoking cessation service is being delivered at present from only city centre locations. This means that citizens who are disabled or have poor mobility may not be able to access the service.

- The service is still fairly new and is currently dealing with a backlog of clients, resulting in long waiting times
- In secondary care, ward based advisors are providing smoking cessation support to smokers admitted into secondary care. This supports them to achieve temporary abstinence. Following discharge, reports from advisors suggest that follow-up by community based services is patchy and inconsistent, resulting in many smokers relapsing
- The current smoking cessation service does not have provision for children who might need support to stop smoking
- Current evidence on e-cigarettes suggest that they are far less harmful than smoking and should be used as part of harm reduction or quitting smoking. Public perception has lagged behind the evidence with many people believing that they are just as harmful as cigarettes. Encouraging people who cannot quit to switch to e-cigarettes would be a productive harm reduction strategy
- Strategies to target inpatients in hospitals is evidence based, yet staff have often not received training in the delivery of Very Brief Advice, limiting the success of this strategy

Equality and deprivation

- Deprived areas within the City continue to have smoking rates that are significantly higher than the national average which continues to widen the inequalities gap
- Illicit tobacco prevalence remains high in deprived areas of the city which undercuts the effects of tobacco control legislation and contributes to crime

Environmental exposures

- Second hand smoke remains a significant concern with a quarter of deprived homes allowing smoking inside. There is currently no targeted work in these areas to tackle children's exposure to second hand smoke
- PH48 implementation in hospitals can be intermittent with patients and visitors continuing to smoke on hospital grounds, exposing other patients to second hand smoke
- Shisha lounges remain prevalent in Nottingham City, despite smokefree legislation, putting the customers and employees of the shisha lounges at risk
- There is a lack of information on the harms of social smoking in the 16-24 year old age group

Recommendations for consideration by commissioners

Recommendation	Responsibility		
	Local Authority	Service Providers	CCG/CCP
Ensure that all hospital staff are trained in Very Brief Advice		Secondary care education administrators	
More stringent implementation of PH48 in secondary care, addressing QMC main entrance and City hospital gates	x	Secondary care	
Making Every Contact count in GP practice, dentistry, opticians	x	Various health care delivery	

etc., using Very Brief Advice		providers	
Give consideration to smokers with reduced mobility in order to address access to smoking cessation services	x		
Provide fast tracking to community smoking cessation services for smokers who have quit in hospital, allowing the continuation of treatment in the community at a reasonable time	x	x	x
Include a question in the Citizens Survey to assess the approximate percentage of homes which allow smoking inside and expose children to second hand smoking	x		
Continue to expand the scope of smokefree areas	x		
Consider a public awareness campaign to encourage smokers to switch to e-cigarettes	x		
Continue to review the compliance to smokefree legislation of shisha lounges and issue notices accordingly	X Environmental Health		
Improve education in schools, colleges and universities as to the harms of shisha smoking, especially in areas with a high proportion of Asian ethnic minorities		x	
Continue to target those trading in illicit tobacco	X Trading Standards and Nottinghamshire Police		
Promote e-cigarettes as the treatment of choice for smoking cessation	X	X	X

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