NHS Nottingham and Nottinghamshire

Integrated Care Board Meeting Agenda (Open Session)

Thursday 12 September 2024 09:00-11:30

Rushcliffe Arena, Rugby Road, West Bridgford, NG2 7YG

"Every person enjoying their best possible health and wellbeing"

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

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

Our core values:

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

	Item	Presenter	Type *(For Assurance, Decision, Discussion or Information)*	Enc.	Time
	Introductory items				
1.	Welcome, introductions and apologies	Kathy McLean	-	-	09:00
2.	Confirmation of quoracy	Kathy McLean	-	-	-
3.	Declaration and management of interests	Kathy McLean	Information	✓	-
4.	Minutes from the meeting held on: 11 July 2024	Kathy McLean	Decision	✓	-
5.	Action log and matters arising from the meetings held on: 11 July 2024	Kathy McLean	Discussion	✓	-
	Leadership and operating context				
6.	Chair's Report	Kathy McLean	Information	✓	09:05
7.	Chief Executive's Report	Amanda Sullivan	Information	✓	09:15
	Strategy and partnerships				
8.	NHS Nottingham and Nottinghamshire Joint Forward Plan: Delivery Update	Victoria McGregor-Riley	Discussion	✓	09:30
	Delivery and system oversight				
9.	Nottingham and Nottinghamshire Five Year ICS People Plan	Rosa Waddingham/ Philippa Hunt	Assurance	✓	09:50
10.	Quality Report	Rosa Waddingham	Assurance	✓	10:10
11.	Service Delivery Report	Mandy Nagra	Assurance	✓	10:30

	Item	Presenter	Type *(For Assurance, Decision, Discussion or Information)*	Enc.	Time
12.	Finance Report	Marcus Pratt	Assurance	✓	10:50
	Governance				
13.	Committee Highlight Reports: • Strategic Planning and Integration Committee • Quality and People Committee • Finance and Performance Committee	Committee Chairs	Assurance	✓	11:10
	Information items *The following items are for information and will not be individually presented. Questions will be taken by exception.*				
14.	2024/25 Board Work Programme	-	Information	✓	-
15.	NHS Nottingham and Nottinghamshire Integrated Care Board Constitution (October 2024)	-	Information	✓	-
16.	NHS Nottingham and Nottinghamshire Integrated Care Board Governance Handbook (October 2024)	-	Information	✓	-
	Closing items				
17.	Risks identified during the course of the meeting	Kathy McLean	Discussion	-	11:25
18.	Questions from the public relating to items on the agenda	Kathy McLean	-	-	-
19.	Any other business	Kathy McLean	-	-	-
	Meeting close	-	-	-	11:30

Confidential Motion:

The Board will resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1[2] Public Bodies [Admission to Meetings] Act 1960)

2024/25 Schedule of Board Meetings:

Date and time	Venue
14 November 2024, 09:00-12:30	Chappell Meeting Room, Arnold Civic Centre, Arnot Hill Park, Arnold, NG5 6LU
09 January 2025, 09:00-12:30	Rushcliffe Arena, Rugby Road, West Bridgford, NG2 7YG
13 March 2025, 09:00-12:30	Rushcliffe Arena, Rugby Road, West Bridgford, NG2 7YG

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/09/2024
Paper Title:	**Declaration and management of interests**
Paper Reference:	ICB 24 044
Report Author:	Jo Simmonds, Head of Corporate Governance
Report Sponsor:	Lucy Branson, Director of Corporate Affairs
Presenter:	Kathy McLean, Chair

Paper Type:							
For Assurance:		For Decision:		For Discussion:		For Information:	✓

Summary:

As custodians of tax-payers money, Integrated Care Boards (ICBs) are required to implement and demonstrate robust arrangements for the identification and management of conflicts of interest. These arrangements should support good judgement about how any interests should be approached and managed; safeguarding the organisation from any perception of inappropriateness in its decision-making and assuring the public that money is being spent free from undue influence. The ICB's arrangements for the management of conflicts of interests are set out in the organisation's Standards of Business Conduct Policy.

Details of the declared interests for members of the Board are attached at **Appendix A**. An assessment of these interests has been performed against the meeting agenda and the outcome is recorded in the section below on conflicts of interest management.

Members are also reminded of their individual responsibility to highlight any interests not already declared should a conflict (or potential conflict) become apparent in discussions during the meeting. Should any interests arise during the meeting, the ICB's agreed arrangements for managing these are provided for reference at **Appendix B**.

Recommendation(s):

The Board is asked to **note** this item for information.

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

Appendices:
Appendix A: Extract from the ICB's Register of Declared Interests for members of the Board. Appendix B: Managing Conflicts of Interests at Meetings.

Board Assurance Framework:
Not applicable to this report.

Report Previously Received By:
Not applicable to this report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Register of Declared Interests

• As required by section 14Z30 of the NHS Act 2006 (as amended), the ICB has made arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interests.

• This document is extracted from the ICB's full Register of Declared Interests for the purposes of this meeting.

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

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

Name	Current position(s) held in the ICB	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To	Action taken to mitigate risk
ADAMOU, Marios	Non-Executive Director	South West Yorkshire Partnership NHS Foundation Trust	Employed as a Consultant Psychiatrist	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ADAMOU, Marios	Non-Executive Director	Marios Adamou LTD - providing educational and advisory services	Director	✓				01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Marios Adamou Ltd.
ADAMOU, Marios	Non-Executive Director	University of Huddersfield	Visiting Professor			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ADAMOU, Marios	Non-Executive Director	Advance Occupational Healthcare Ltd.	Director	✓				01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Advance Occupational Health Ltd.
BRIGGS, David	Medical Director	British Medical Association	Member		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.

Name	Current position(s) held in the ICB	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To	Action taken to mitigate risk
DADGE, Lucy	Director of Integration	Mid Nottinghamshire and Greater Nottingham Lift Co (public sector)	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Valley Road Surgery	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
DADGE, Lucy	Director of Integration	Nottingham Schools Trust	Chair and Director			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Lilya Lighthouse Education Trust Limited	Trustee		✓			01/12/2023	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	NEMS Community Benefit Services Ltd	Chief Executive	✓				01/10/2024	Present	To be excluded from all commissioning activities and decision making (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by NEMS Community Benefit Services Ltd.
JACKSON, Stephen	Non-Executive Director	Nottingham Business Improvement District (BID) - a business-led,not for profit organisation helping to champion Nottingham.	Non-Executive Chair		✓			01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by BID.
JACKSON, Stephen	Non-Executive Director	Nottingham High School	Governor		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.

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JACKSON, Stephen	Non-Executive Director	Portland College	Governor		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Marketing Nottingham - A not for profit business and the official place marketing organisation for Nottingham City.	Non-Executive Director		✓			01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Marketing Nottingham.
JACKSON, Stephen	Non-Executive Director	Derbyshire Health United CIC - A not for profit community interest company providing a range of health service provisions.	Non-Executive Director	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by DHU CIC).
JACKSON, Stephen	Non-Executive Director	Imperial Business Consulting Ltd - a management consultancy business, based in Leicestershire.	Joint Owner and Chief Executive Officer	✓				01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Imperial Business Consulting Ltd
JACKSON, Stephen	Non-Executive Director	Ravenshead Surgery (Abbey Medical Group)	Registered patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
JACKSON, Stephen	Non-Executive Director	Nottingham City Transport	Spouse is a Non Executive Director				✓	01/11/2023	Present	This interest will be kept under review and specific actions determined as required.

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JACKSON, Stephen	Non-Executive Director	Nottingham Ice Centre	Spouse is a Non Executive Director				✓	01/11/2023	Present	This interest will be kept under review and specific actions determined as required.
LIM, Dr Kelvin	Primary Care Partner Member	NEMS Healthcare Ltd	Shareholder	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangement) relating to services that are currently, or could be, provided by NEMS CBS.
LIM, Dr Kelvin	Primary Care Partner Member	Church Walk Medical Services	Shareholder	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to primary medical services
LIM, Dr Kelvin	Primary Care Partner Member	Eastwood Primary Care Centre	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from
MAJID, Ifti	Mental Health Partner Member	Nottinghamshire Healthcare NHS Foundation Trust	Chief Executive	✓				07/12/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by Nottinghamshire Healthcare NHS Trust
MAJID, Ifti	Mental Health Partner Member	NHS Confederation: BME Leaders Network	Chair		✓			07/12/2022	Present	This interest will be kept under review and specific actions determined as required.

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MAJID, Ifti	Mental Health Partner Member	NHS Confederation: Mental Health Network	Board Member and Trustee		✓			07/12/2022	Present	This interest will be kept under review and specific actions determined as required.
MAJID, Ifti	Mental Health Partner Member	Ellern Mede - provider of high intensity children and young people's eating disorder services	Spouse is Managing Director				✓	07/12/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Ellern Mede.
MAJID, Ifti	Mental Health Partner Member	Knowledge Exchange Group – provider of public sector conferencing	Member of the organisations Advisory Board				✓	01/12/2023	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by the Knowledge Exchange Group Ltd.
MALEY, Caroline	Non-Executive Director	Village Health Group	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
MCLEAN, Kathy	ICB Chair	University Hospitals of Derby and Burton NHS Foundation Trust	Trust Chair	✓				01/07/2022	30/04/2024	This interest will be kept under review and specific actions determined as required.

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MCLEAN, Kathy	ICB Chair	Kathy McLean Limited- Private limited company offering health related advice	Director	✓				01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning
MCLEAN, Kathy	ICB Chair	Barts Health NHS Trust (London)	Non-Executive Director	✓				01/07/2022	30/06/2024	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Barking, Havering and Redbridge University Hospitals NHS Trust	Non-Executive Director	✓				01/09/2022	30/06/2024	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS Employers	Member of the Workforce Policy Board		✓			TBC	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS Employers	Chair of the national negotiation committee for Staff and Associate Specialists on behalf of NHS Employers		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Care Quality Commission (CQC)	Occasional Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	The Public Service Consultants Ltd (Public Sector Consultancy)	Interim Chair	✓				01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by The Public Service Consultants Ltd.

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MCLEAN, Kathy	ICB Chair	NHS Providers Board	Trustee		✓			01/07/2022	01/05/2024	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NEMS Healthcare Ltd	Partner is a shareholder				✓	01/07/2022	11/04/2024	To be excluded from all commissioning decisions (including procurement activities and contract management arrangement) relating to services that are currently, or could be, provided by NEMS CBS.
MCLEAN, Kathy	ICB Chair	Oxehealth Ltd (vision-based patient monitoring and management)	Member of the advisory board	✓				01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Oxehealth Ltd.
MCLEAN, Kathy	ICB Chair	NHS Derby and Derbyshire Integrated Care Board	Chair	✓				01/05/2024	Present	This interest will be kept under review and specific actions determined as required.
PRATT, Marcus	Acting Executive Director of Finance	British Telecom	Shareholder	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ROBINSON, Paul	NHS Trust and NHS Foundation Trust Partner Member	Sherwood Forest Hospitals NHS Foundation Trust	Chief Executive	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangement) relating to services that are currently, or could be, provided by Sherwood Forest Hospitals NHS Foundation Trust.

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SULLIVAN, Amanda	Chief Executive	Hillview Surgery	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
TOWLER, Jon	Non-Executive Director	Sherwood Medical Practice	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
TOWLER, Jon	Non-Executive Director	Major Oak Medical Practice, Edwinstowe	Family members are registered patients				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
TOWLER, Jon	Non-Executive Director	The Conservation Volunteers: a national charity bringing together people to create, improve and care for green spaces.	Chair (Trustee and Director)	✓				01/12/2022	Present	This interest will be kept under review and specific actions determined as required.
TOWLER, Jon	Non-Executive Director	The Conservation Volunteers: a national charity bringing together people to create, improve and care for green spaces.	Fellow director is a senior manager at Everyturn Mental Health				✓	01/12/2022	Present	This interest will be kept under review and specific actions determined as required.
WADDINGHAM, Rosa	Director of Nursing	Care Quality Commission (CQC)	Specialist Advisor (temporary appointment supporting the ICS inspections pilot)		✓			09/10/2023	31/03/2024	This interest will be kept under review and specific actions determined as required.
WADDINGHAM, Rosa	Director of Nursing	NHS Professionals (An NHS staff bank, owned by the Department of Health and Social Care)	Member of the Advisory Board		✓			01/09/2023	Present	This interest will be kept under review and specific actions determined as required.

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WADDINGHAM, Rosa	Director of Nursing	Florence Nightingale Foundation (FNF) (A charity supporting Nurses and Medwives to improve patient care)	Chair of the FNF Members' Advisory Group		✓			01/09/2023	Present	This interest will be kept under review and specific actions determined as required.
WADDINGHAM, Rosa	Director of Nursing	Specsavers	Son is Dispensing Manager at Specsavers, Bingham				✓	01/02/2024	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be provided by Specsavers
WILLIAMS, Melanie	Local Authority Partner Member	Nottinghamshire County Council	Corporate Director for Adult Social Care and Health	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by Nottinghamshire County Council
WILLIAMS, Melanie	Local Authority Partner Member	Orchard Surgery	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.

Name	Current position(s) held in the ICB	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To	Action taken to mitigate risk
The following individuals will be in attendance at the meeting but are not part of the Board's membership:										
BRANSON, Lucy	Director of Corporate Affairs	St George's Medical Practice	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
KING, Daniel	VCSE Alliance Chair	Nottingham Trent University	Employee	✓				06/09/2023	Present	This interest will be kept under review and specific actions determined as required.
HUBBER, Lucy	Director of Public Health, Nottingham City Council	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
MCGREGOR-RILEY, Dr Victoria	Commissioning Delivery Director	Sheffield Teaching Hospitals NHS Foundation Trust	Spouse employed as a consultant surgeon				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCGREGOR-RILEY, Dr Victoria	Commissioning Delivery Director	GP Practice in Bassetlaw	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual
MCGREGOR-RILEY, Dr Victoria	Commissioning Delivery Director	Managers in Partnership	Trade Union Representative (voluntary)			✓		01/09/2022	Present	This interest will be kept under review and specific actions determined as required.
MCGREGOR-RILEY, Dr Victoria	Commissioning Delivery Director	Nottingham University NHS Trust (NUH)	Son employed as a Project Coordinator				✓	04/05/2023	Present	This interest will be kept under review and specific actions determined as required.

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NAGRA, Mandy	Interim System Delivery Director	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
PRINCIPE, Maria	Director of Contracting and Transformation	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
VAN DICHELE, Guy	Local Authority Partner Member - Deputy	United Response National Charity for People with Learning Disabilities	Trustee	✓				15/04/2024	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be provided by United Response National Charity
VAN DICHELE, Guy	Local Authority Partner Member - Deputy	Nottinghamshire County Council	Director	✓				15/04/2024	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by Nottinghamshire County Council

Appendix B

NHS
Nottingham and Nottinghamshire

Managing Conflicts of Interest at Meetings

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

    The above categories are not exhaustive, and each situation must be considered on a case-by-case basis.
4. In advance of any formal meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals.
5. At the beginning of each formal meeting, members and others attending the meeting will be required to declare any interests that relate specifically to a

particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting.

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

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

Integrated Care Board (Open Session)
Unratified minutes of the meeting held on 11/07/2024 09:00-11:50
Rushcliffe Arena, Rugby Road, West Bridgford

Members present:	
Dr Kathy McLean	Chair
Professor Marios Adamou	Non-Executive Director
Dr Dave Briggs	Medical Director
Stephen Jackson	Non-Executive Director
Dr Kelvin Lim	Primary Care Partner Member
Caroline Maley	Non-Executive Director
Marcus Pratt	Acting Director of Finance
Amanda Sullivan	Chief Executive
Jon Towler	Non-Executive Director
Rosa Waddingham	Director of Nursing
In attendance:	
Lucy Branson	Director of Corporate Affairs
Mandy Nagra	Interim Director of Service Delivery (from item ICB 24 034)
Prema Nirgude	Head of Insights and Engagement (for item ICB 24 031)
Maria Principe	Director of Clinical Effectiveness and Transformation (for item ICB 24 029)
Sue Wass	Corporate Governance Officer (minutes)
Apologies:	
Lucy Dadge	Director of Integration
Ifti Majid	NHS Trust/Foundation Trust Partner Member
Paul Robinson	NHS Trust/Foundation Trust Partner Member
Melanie Williams	Local Authority Partner Member

Cumulative Record of Members' Attendance (2023/24)

Name	Possible	Actual	Name	Possible	Actual
Kathy McLean	2	2	Stuart Poynor[1]	1	1
Marios Adamou	2	2	Marcus Pratt[2]	1	1
Dave Briggs	2	2	Paul Robinson	2	1
Lucy Dadge	2	1	Amanda Sullivan	2	2
Stephen Jackson	2	2	Jon Towler	2	2
Kelvin Lim	2	2	Catherine Underwood[1]	1	1
Ifti Majid	2	1	Rosa Waddingham	2	2
Caroline Maley	2	1	Melanie Williams	2	1

1 – Board membership ceased June 2024
2 – Board membership commenced July 2024

Introductory items

ICB 24 022 Welcome, introductions and apologies

The Chair welcomed members to the meeting of the Board. A round of introductions was undertaken and apologies noted as above.

On behalf of the Board, the Chair welcomed Marcus Pratt to his meeting in his capacity as Acting Director of Finance.

ICB 24 023 Confirmation of quoracy

The meeting was confirmed as quorate.

ICB 24 024 Declaration and management of interests

No interests were declared in relation to any item on the agenda.

The Chair reminded members of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.

ICB 24 025 Minutes from the meeting held on: 09 May 2024

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

ICB 24 026 Action log and matters arising from the meeting held on: 09 May 2024

Following a presentation by Nottingham and Nottinghamshire Healthwatch at a previous Board meeting, the Chair noted the positive steps taken to further engage Healthwatch colleagues in supporting the response to any future emerging quality concerns in the local NHS system.

All actions were noted as completed and no other business was raised.

Leadership

ICB 24 027 Chair's Report

Kathy McLean highlighted the following points from her report:

a) Noting the outcome of the General Election, the Chair hoped that health systems would be able to contribute to the recently announced review of the NHS, to be undertaken on behalf of the Government by Professor Lord Darzi. Relationships would be established with newly elected Members of Parliament in Nottingham and Nottinghamshire, and an initial meeting had been diarised to meet with the recently

elected Mayor for the East Midlands to discuss joint priorities for our population's health.

b) A significant challenge for the coming year was to deliver on financial commitments and address the NHS system's underlying financial position. This was an opportunity to deliver more efficient, integrated and higher-quality services.

c) A recent visit to Bassetlaw Hospital, where the two local Primary Care Networks had worked together to stream urgent appointments into hospital, had been very inspiring and a fantastic example of integrated care in practice.

d) Attention was drawn to several governance updates in the report regarding re-appointments, future appointments, annual appraisals, and the conclusion of the ICB's annual Fit and Proper Person Tests for 2023/24.

e) NHS England had approved the ICB's application to vary its Constitution regarding changes to the Board's membership. This was shared with Board members as part of the papers for the meeting for information and would be enacted from 1 October 2024.

The Board **received** the Chair's Report for information.

ICB 24 028 Chief Executive's Report

Amanda Sullivan presented the item and highlighted the following points:

a) Following approval by the Audit and Risk Committee, the ICB's Annual Report and Accounts 2023/24 had been published. It reflected the breadth of the work undertaken by the ICB during the past year and how key statutory duties had been discharged. The ICB would be holding its Annual Public Meeting on 12 September 2024.

b) At its last meeting, Board members agreed to accept NHS England's proposed enforcement undertakings (in connection with NHS England's functions under the National Health Service Act 2006, as amended), with regard to the Nottingham and Nottinghamshire NHS system's financial sustainability, risk of non-compliance with expenditure limits and controls, and significant growth in workforce costs. All NHS partners had committed to bringing the system back to financial balance by March 2026.

c) The ICB would remain in segment three of the NHS Oversight and Assessment Framework following its Quarter Four Review, and it was noted that NHS England would be publishing a revised Oversight and

Assessment Framework for 2024/25 following a period of consultation.

d) It was hoped that talks between the incoming Government and trade unions would be able to end the industrial action that continued to be taken by junior doctors. The latest round of action at the end of June had been well managed by the local system but had impacted on planned care. Planning was also underway for a potential escalation of a dispute between the Government and General Practices, which would have a significant impact on NHS services.

e) Following the recent cyber-attack on the healthcare system in London and the Southeast, additional steps were being put in place to mitigate any future attack. The importance of continuing vigilance and ensuring that individuals' training was up to date was emphasised.

f) Following the recent Channel 4 documentary focusing on the Emergency Department at the Royal Shrewsbury Hospital, NHS England had written to all ICBs and NHS trusts asking every organisation to assure themselves that they were working with their system partners to do all they could to maintain high standards of quality of care within pressurised services.

g) It was pleasing to note that all local NHS organisations had signed up to NHS England's organisational charter for sexual safety in healthcare.

h) The report noted several recent leadership changes within the local authorities and Amanda was looking forward to meeting with the appointees in the coming weeks.

The following points were made in discussion:

i) Members queried whether the ICB was required to assure itself that local NHS trusts had taken appropriate action to assess standards of quality of care, as requested by NHS England's letter. In response, it was noted that there was no formal requirement; however, a review would be undertaken for assurance and reported to the September meeting of the Quality and People Committee, with onward reporting to the Board.

j) When discussing quality standards for care, it was noted that the local system had already put in place a rapid review process for the escalation of local quality concerns and that there had been no escalations over the previous quarter. This was welcomed by members and the Chair noted the value of triangulating intelligence from differing sources, including from Trust Board members.

The Board **received** the Chief Executive's Report for information.

Action: Rosa Waddingham to present to the September meeting of the Quality and People Committee the outcome of a review across NHS system partners to ensure high standards of quality of care within pressurised services.

At this point Maria Principe joined the meeting.

Strategy and partnerships

ICB 24 029 Outcomes Framework

Maria Principe presented the item and highlighted the following points:

a) The report detailed the proposed population outcomes that had been identified to monitor progress with delivery of the Joint Forward Plan. The outcomes covered the four aims of the Integrated Care System (ICS) and were included at appendix one of the report, along with baseline data for each outcome and the current performance and direction of travel.

b) The proposed ambition was for each outcome to return to pre-Covid levels. This represented a challenging ambition, recognising the impact that wider determinants of health had had in the last four years. Using this as an ambition would enable the ICS to use local and more timely data.

c) System partners had been engaged in the development of the proposed outcomes through the Joint Forward Plan Delivery Group, and the outcomes recognised that delivery would be achieved by the collective efforts of all system partners.

d) The Strategic Planning and Integration Committee had endorsed the level of ambition and had suggested several changes to provide greater clarity of the data to partners and the general public, as the dashboard would be published on the website.

The following points were made in discussion:

e) In response to a query regarding who or what determined statistical significance, it was noted that the ICB used a nationally accredited public health model.

f) Members noted the need to manage expectations, as whilst there were substantial plans supporting the delivery of some measures,

there was still considerable work to do on others and transformation plans had yet to be mapped in.

g) Chair of the Strategic Planning and Integration Committee, Jon Towler, asked the Board to note that, as the ICB and ICS outcomes framework were slightly different, the Committee had asked the ICB Team to find a way to integrate them; and it was suggested that a social care section would be one way to do this.

h) Members discussed the benefit of being able to use the data at Primary Care Network level to shape service provision going forward, and it was noted that trusts would also be able to use the data to shape their services.

i) The Board signalled that they wished to be kept up to date with future developments and asked for a regular report to be brought to the Board. It was noted that this would be included within the scheduled Joint Forward Plan updates as part of the Annual Work Programme.

The Board **approved** the proposed outcomes and ambition to be achieved through delivery of the NHS Joint Forward Plan.

At this point Maria Principe left the meeting.

ICB 24 030 Research Strategy

Dr Dave Briggs presented the item and highlighted the following points:

a) The ICS Research Strategy had been developed collaboratively through extensive engagement with a broad range of partners, and a review of relevant local and national strategies. It clearly aligned to the Integrated Care Strategy.

b) There were four pillars of the research strategy: undertaking research to improve the health and care outcomes and reduce the health inequalities of the local population; supporting the workforce to drive and deliver research in a culture where research is everyone's business; maximising the collective capabilities and strengths of the system through collaboration and shared infrastructure; and increasing the implementation of research outcomes that are shown to improve health and care.

c) Nottingham and Nottinghamshire ICS was recognised across the Midlands for its strong history of research activities. The ambition was to become a leading ICS for research and to drive and develop research and increase the implementation of the outcomes of research for the benefit of the population, workforce and system.

d) The next steps included the development of a delivery plan that would measure the progress and impact of the strategy.

e) The Strategic Planning and Integration Committee has reviewed and endorsed the strategy at its May meeting.

The following points were made in discussion:

e) Welcoming the strategy, members queried whether the ICS was working effectively across regional and national boundaries to avoid duplication of effort. It was noted that there were East Midlands and Midlands forums which brought research communities together.

f) In response to a specific query relating to artificial intelligence, it was noted that there were several projects underway, which linked to the Digital Strategy.

g) Members stressed that the delivery plan needed to describe outputs and outcomes to demonstrate how research was improving health services. This would be overseen by the Strategic Planning and Integration Committee.

h) With reference to the fourth pillar of the strategy, the opportunities afforded by local expertise in biotech were noted.

The Board **approved** the Research Strategy.

At this point Prema Nirgude joined the meeting.

ICB 24 031 Working with People and Communities

Prema Nirgude presented the item and highlighted the following points:

a) The Working with People and Communities Annual Report covered the period 1 April 2023 to 31 March 2024 and set out how the ICB had discharged its legal duties regarding public involvement and consultation, and the ways that the ICB had worked with people and communities.

b) The report outlined examples of work being undertaken with the Voluntary and Community Social Enterprise sector and described the work that had taken place to improve the capture of citizen intelligence. It also outlined the ways in which citizen insights had been used to improve services.

c) A key priority going forward would be to demonstrate the impact of working with people and communities by triangulating experiential, evidential and insight knowledge.

The following points were made in discussion:

d) In response to a query on how the value of the Partners' Assembly was assessed, it was noted that it had provided a valuable opportunity to engage a wide audience in the development of the Integrated Care Strategy and Joint Forward Plan.

e) Discussing different sources of intelligence, members noted that citizen intelligence was also drawn from primary care networks, trusts and patient experience teams.

f) Members felt that the report could better detail the positive difference that hearing the citizen's voice had made during the period. It was confirmed that this point had been raised at a recent Strategic Planning and Integration Committee meeting and an action had been taken forward to address this.

g) Members stressed the importance of continuing to seek out the views of people and communities that the ICB was not hearing from. This was noted as already being taken forward by a co-production conversation across the county.

h) The Chair reported that citizen stories would be reinstated at Board meetings from September to illustrate the breadth of the ICB's work.

i) As the subject of a question submitted by a member of the public was pertinent to this discussion, the Chair invited Rosa Waddingham to provide a response. The questioner queried whether the ICB had reneged on its commitment to strategic co-production. In response it was noted that the ICB Strategic Coproduction Group, launched in 2023, had represented a new initiative for the ICB. It had been established to create a Strategy, which had since been developed. Therefore, the role of this group needed to be refreshed to ensure that its aims were clearly linked to the work being conducted at Place level. The membership of the Group would also be widened to ensure diverse voices and people with lived experience were represented.

The Board **noted** the report for assurance.

At this point Prema Nirgude left the meeting.

Delivery and system oversight

ICB 24 032 **Meeting the Public Sector Equality Duty**

Rosa Waddingham presented the item and highlighted the following points:

a) This was the first annual assurance report describing how the organisation was meeting its Public Sector Equality Duty, as described in the Equality Act 2010. It also provided an overview of work undertaken in year regarding the ICB's equality, diversity and inclusion work, which was routinely overseen by the Quality and People Committee.

b) The report provided an update on progress to develop the appropriate infrastructure to monitor equality, diversity and inclusion within the organisation, to assess baseline equality performance, and to implement the ICB's Equality Objectives for 2023-2025.

c) The ICB had self-assessed itself as 'developing' against all the domains within the NHS Equality Delivery System, recognising there was more work to do to develop and improve equality, diversity and inclusion practices.

d) Actions underway to strengthen procedures and to review the ICB's equality objectives were set out within the report.

The following points were made in discussion:

e) Members reflected on the recent Board development session that had focussed on the Race Health Inequalities Maturity Matrix developed by the Nottingham City Place-Based Partnership. The session had been thought-provoking and members were keen to see progress against the ICB's self-assessment in future reports. The Chair confirmed that Board members' annual objectives had been framed around this for 2024/25.

f) Members went on to discuss the relatively high rates of non-disclosure of protected characteristics by ICB staff members and the actions being taken forward through staff networks to encourage increased reporting.

g) Noting the importance of this agenda, the Board confirmed its commitment to delivering positive progress over the coming year, which would be overseen in detail by the Quality and People Committee.

The Board **received** the report for assurance.

ICB 24 033 **Quality Report**

Rosa Waddingham presented the item and highlighted the following points:

a) The report provided a summary of compliance against quality improvements required for 2024/25, and the actions and recovery timeframes for those targets currently off track.

b) A high level of oversight continued to be maintained as Nottinghamshire Healthcare NHS Foundation Trust (NHT) continued to progress a comprehensive and complex programme of improvement work to address identified quality and safety improvements.

c) Nottingham University Hospitals NHS Trust (NUH) remained in a challenged position in the provision of safe and high-quality care in response to regulatory requirements, particularly in the Emergency Department. However positive progress had been made in the maternity improvement programme. The Care Quality Commission had made two unannounced visits and the outcome of their findings was awaited.

d) Sherwood Forest Hospitals NHS Foundation Trust (SFH) had recently received two Prevention of Future Deaths notices and an improvement plan would be overseen by the ICB.

e) Ongoing risks remained around the challenging target for learning disability and autism adult inpatient numbers, and admission avoidance strategies continued to be utilised.

f) Paediatric Audiology Services in Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust remained a focus. An action plan was in place to manage the risk and future service delivery.

g) A focus on quality within the urgent and emergency care pathway remained as a priority focus for the ICB's Quality Team.

The following points were made in discussion:

h) Marios Adamou, Chair of the Quality and People Committee, asked the Board to note that the Committee had continued to take limited assurance from the Quality Oversight Report regarding the effectiveness and the impact of actions taken to improve the quality and safety of services.

i) With regard to the reference in the report to the Nottinghamshire Special Needs and Disabilities Strategy and Nottingham and Nottinghamshire ICS Integrated Joint Commissioning Strategy, Jon Towler asked the Board to note that the Strategic Planning and Integration Committee had recently received both strategies. Although both strategies were robust, in the current financial climate for both the NHS and local authorities, the credibility of the delivery plans that underpinned the strategies needed to be examined closely.

j) In response to a question about whether there were clear exit timelines for those providers in National Oversight Framework segment four, it was noted that there were not.

k) The Chair urged committee chairs to continue to focus on areas of ongoing limited assurance.

The Board **noted** the report.

At this point Mandy Nagra joined the meeting.

ICB 24 034 Service Delivery Report

Mandy Nagra presented the item and highlighted the following points:

a) The report provided a summary of compliance against targets required for 2024/25, and the actions and recovery timeframes for those targets currently off track.

b) There were several areas of improved performance. Improvements had been seen in the four-hour wait performance at NUH, with the Trust achieving local plans in April and May.

c) The position for long waiting elective patients was improving within the system and the forecast was for the elimination of 78 and 65-week waiters by the end of June and September 2024 respectively.

d) Performance in the 28-day Faster Diagnosis Standard continued be strong for both providers. There had also been reductions in the backlog of cancer patients, but this remained a challenging area for NUH, particularly for the Urology tumour site.

e) Mental health out of area placements and early intervention in psychosis performance remained strong.

f) However, the system response to category two ambulance response times continued to be a challenge and there needed to be more flexibility to move patients where there was capacity.

g) Attention would need to be focused on areas such as fragile services and workforce to meet the targets in the operational plan.

The following points were made in discussion:

h) Stephen Jackson, Chair of the Finance and Performance Committee, asked the Board to note that the Committee had taken partial assurance from the improved performance trajectory in several areas.

i) Members queried the continued challenges in urgent and emergency care despite the sustained focus on mitigating actions. It was noted

that having addressed issues around discharge pathways, it had become apparent that there were other challenges that related to cultural, clinical, and leadership behaviours that also needed to be addressed. The Board stressed that the Executive needed to make this a focus of their work in preparation for winter.

j) From a patient quality perspective, members queried plans to reduce the backlog of diagnostic tests and improve two-week GP appointment performance. It was noted that the data in the report had a two-month time lag and both areas were now showing improved performance.

k) Discussing the importance of workforce as an opportunity for both financial and quality improvement for the NHS system, the Board queried plans to ensure the right staffing ratios within the system. It was noted that the People Plan was due to be discussed at the next Board meeting.

The Board **noted** the report.

ICB 24 035 Finance Report

Marcus Pratt presented the item and highlighted the following points:

a) At the end of month two, the system had a deficit position of £38.5 million, representing an adverse variance of £3.7 million from the May 2024 plan.

b) The NHS system had subsequently re-submitted plans on 12 June 2024. This reduced the annual NHS system deficit from £105.8 million to the agreed Revenue Financial Plan Limit of £100.0 million. In addition, NHS system partners had rephased plans, improving the month two position to nil variance.

c) Due to the planned deficit position, a £8.2 million deduction had been made to the capital envelope, and it would be challenging to deliver against the NHS system priorities and requirements in the capital programme.

d) There was considerable risk in the plan, particularly around the delivery of the required efficiency target of £251 million, and tighter control and grip measures and governance arrangements had been put in place to support delivery.

The following points were made in discussion:

e) Stephen Jackson, Chair of the Finance and Performance Committee, asked the Board to note that although there had been good

engagement across the system with the identification of efficiency schemes and examining barriers to delivery, there was low confidence that the measures would achieve the financial plan, which was a major concern. This would be discussed further by the Board in a later session.

The Board **noted** the report.

Governance

ICB 24 036 **Committee Highlight Reports**

The report presented an overview of the work of the Board's committees since its last meeting in May 2024; it aimed to provide assurance that the committees were effectively discharging their delegated duties and included assessments of the levels of assurance the committees had gained from their work during the period.

The Chair noted that updates from committee chairs had already been provided during related discussions under items ICB 24 033, ICB 24 034 and ICB 24 035. Further updates were invited by exception and the following points were raised:

a) Chair of the Strategic Planning and Integration Committee, Jon Towler, asked the Board to note that the Committee had endorsed an approach to commissioning initiatives that would contribute to meeting the ICB's financial challenge. The approach would balance robust decision-making with the flexibility to move at pace.

b) Chair of the Audit and Risk Committee, Caroline Maley, noted that the Committee had overseen the production of the Annual Report and Accounts, and thanked the teams involved for their hard work. This was echoed by the Chair and Chief Executive.

The following points were made in discussion:

c) Noting that the approach to meeting the ICB's financial challenges described by Jon was also being taken to the Nottingham City and Nottinghamshire County Health Scrutiny Committees, members reflected that the City Council in particular was also facing significant financial challenges.

d) Discussing the ICB's robust internal control environment, members commended the ICB's best practice risk management arrangements.

The Board **noted** the reports.

Information items

ICB 24 037 **NHS Nottingham and Nottinghamshire Integrated Care Board Constitution (October 2024)**

This item was received for information.

ICB 24 038 **2024/25 Board Work Programme**

This item was received for information.

Closing items

ICB 24 039 **Risks identified during the course of the meeting**

No new risks were highlighted.

ICB 24 040 **Questions from the public relating to items on the agenda**

In addition to the question answered under item ICB 24 031, one further set of questions had been received from a member of the public prior to the meeting regarding individual patient experience matters. The full set of questions had been shared with all Board members and it was agreed that the ICB's patient experience team would liaise with partner trusts in relation to the specific matters raised and respond to the requestor in due course.

ICB 24 041 **Any other business**

There was no other business and the meeting was closed.

Date and time of next Board meeting held in public: 12 September 2024 at 09:00 (Rushcliffe Arena)

NHS
Nottingham and Nottinghamshire

ACTION LOG from the Integrated Care Board meeting held on 11/07/2024

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
Open – On track	11.07.2024	ICB 24 028: Chief Executive's Report	To present to the September meeting of the Quality and People Committee the outcome of a review across NHS system partners to ensure high standards of quality of care within pressurised services.	Rosa Waddingham	18.09.2024	Scheduled for presentation to the 18 September meeting of the Quality and People Committee. The Board will be updated via the Committee's Highlight Report to the subsequent meeting.

Key:

Closed – Action completed or no longer required	Open – Off track (may not be achieved by expected date of completion)
Open – On track (to be achieved by expected date of completion)	Open – Off track (has not been achieved by expected date of completion)

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/09/2024
Paper Title:	**Chair's Report**
Paper Reference:	ICB 24 047
Report Author:	Dr Kathy McLean, ICB Chair
Report Sponsor:	Dr Kathy McLean, ICB Chair
Presenter:	Dr Kathy McLean, ICB Chair

Paper Type:							
For Assurance:		For Decision:	✓	For Discussion:		For Information:	✓

Summary:

This report outlines my activities and actions in my role as Chair and provides a synopsis of some of the meetings I have attended on behalf of NHS Nottingham and Nottinghamshire Integrated Care Board (ICB).

Recommendation(s):

The Board is asked to:

- **Note** this item for information, in particular the revisions to the ICB's Constitution and the appointments of Jon Towler to the role of Senior Non-Executive member, and of Marcus Pratt, Victoria McGregor-Riley and Maria Principe as Acting Executive Directors of the Board.
- **Approve** the ICB's updated Governance Handbook (as provided at item 16 on the agenda).
- **Approve** the appointment of interim Committee Chairs set out in paragraph 17 of the paper.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	The work of the Chair is focussed on meeting the four core aims.
Tackle inequalities in outcomes, experience, and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:

None.

Board Assurance Framework:

Not applicable for this report.

Report Previously Received By:

Not applicable for this report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Chair's Report

Introduction

1. All members of the Board will have been shocked by the recent riots across the UK following the tragic killings in Southport. Whilst here in Nottingham and Nottinghamshire the disorder was relatively limited, I want to lead the Board in condemning the actions of these far-right agitators and thugs. The NHS belongs to us all and is sustained and enhanced by the wide range of nationalities and ethnicities of those who work in it. I would also like to say thank you to colleagues across the public sector, in particular the police and local authorities who have worked hard to keep us all safe and protected during recent weeks.

2. It is important that the Board affirms once again that we have zero tolerance for racism towards our colleagues and patients. We will wholeheartedly support any colleague who experiences prejudice of any kind, and we have well established routes to raise these concerns. We will also support any colleague across our system who feels unable to provide care for someone due to behaviour that shows discrimination or harassment towards staff.

3. In terms of our external environment, the new Secretary of State for Health and Social Care, Wes Streeting MP, has been setting out his approach to the NHS and I thought it worth noting in particular his positioning of the NHS as an engine of economic growth. The work we are leading as an ICB on the "Fourth Aim" of ICSs to support wider social and economic development will clearly need to become more central to our thinking. It is also clear that delivery by the NHS on its financial commitments is a non-negotiable expectation of the Government and NHS England – we will of course be discussing this later on our agenda.

4. As noted at the July Board meeting, the Secretary of State has also commissioned an independent investigation of the NHS and Professor (Lord) Ara Darzi had been appointed to lead on it. The investigation, which is due to report in September 2024, will:

   - Provide an independent and expert understanding of the current performance of the NHS across England and the challenges facing the healthcare system.
   - Ensure that a new ten-year plan for health focuses on these challenges.
   - Stimulate and support an honest conversation with the public and staff about the level of improvement that is required, what is realistic and by when.

5. Finally in terms of introductory matters, today is the last meeting of the Board for two of our members – Caroline Maley and Lucy Dadge. Caroline leaves the

Board after two years of valuable contributions, particularly through chairing our Audit and Risk Committee. We are sorry Caroline needs to leave for personal reasons but are grateful for the time she has been able to work with us.

6. Lucy Dadge leaves her post of Director of Integration at the end of September. Lucy's unique combination of deep intellect and practical delivery skills will be hugely missed by the ICB and we are lucky that she will continue to contribute to our wider system endeavours through taking up the post of Chief Executive of Nottingham Emergency Medical Services (NEMS). I am certain the Board will join me in wishing both Caroline and Lucy all the best for the future.

Developing our system

7. The Health Service Journal has published an editorial piece I had provided on Integrated Care system (ICS) oversight and regulation. At a time where the operational demands of today need to be balanced against our future plans, I discussed the need also for balanced regulation and oversight, and for clarity on the roles of NHS England and ICBs in this space. To be successful, we must seek to avoid ICBs becoming solely performance managers of providers. Given its importance in improving patient safety and quality, getting system oversight and regulation right will be crucial to enabling the government in achieving its ambitions to devolve, shift to prevention and move care closer to home.

8. Aligned to this was the publication of a report from NHS Providers on regulation, following a survey of trust leaders. The survey was clearly conducted against a backdrop of continuing challenges to performance, finances and care quality, and ongoing industrial action, as well as significant changes to regulation and provider oversight by the Care Quality Commission, NHS England and ICBs. Leaders noted that they have experienced an increased regulatory burden this year, particularly noting a lack of coordination between regulators. Some also questioned whether reporting requirements are realistic or proportionate. Similarly, concerns were raised around whether regulatory activity sufficiently considers the reality of the operating environment. Leaders were much more supportive of the role ICBs played as system partners and conveners than as performance managers. Hopefully, these views will be factored into the clarity we seek on the regulatory space.

9. I have continued my visits around the system and recently met with the clinical leadership team of Collingham Primary Care Network and representatives from Mid-Nottinghamshire Place Based Partnership. We discussed some interesting topics including using data from our System Analytics Intelligence Unit to improve population health management, as well as how family hubs are being utilised to target those communities with lower uptake of children's vaccinations. We had some positive conversations about the Fuller report, the Health Inequalities Innovation Fund and integrated neighbourhood working

developments and I also heard feedback about the pressure people are under in General Practice and some of the other challenges, such as transport for patients accessing appointments and the difficulty of accessing different pathways across area borders.

10. I also had a fantastic visit to the School of Artisan Food in Welbeck, which is part of the Bassetlaw Food Insecurity Network. The school carries out work with General Practices to support GPs, nurses, health visitors and other health providers to talk to patients who may have problems such as eating disorders or metabolic illness and support them to eat well. They also work with schools to ensure that pupils know where food comes from and how it is grown, produced and prepared so they can make healthy, balanced choices for their diet. This is a great example of prevention and supporting social value and also offered me the opportunity to consider improving my own sourdough making skills.

Looking forward

11. Nominations for our second Health and Care Awards for our ICS have now closed and I am delighted by both the number and the quality of entries. I am confident that we will have an excellent awards ceremony on 6 November and look forward to seeing as many Board members as possible there.
12. As I regularly remind the Board, delivering on our financial commitment is a critical priority for us as an organisation and as a system and I look forward, now that we are back from summer breaks, to redoubling our effort on this.

Governance and leadership

13. Following the agreement by NHS England of the ICB's revised Board composition, and the departure of Stuart Poynor and upcoming departure of Lucy Dadge, I am pleased to confirm the following interim appointments to the Board, pending substantive appointments being made:
    a) Marcus Pratt has been appointed as Acting Director of Finance and has been in post since 8 July 2024.
    b) Victoria McGregor-Riley has been appointed as Acting Director of Strategy and System Development. Victoria will commence in post on 1 October 2024.
    c) Maria Principe has been appointed as Acting Director of Delivery and Operations. Maria will commence in post on 1 October 2024.
14. On 26 July 2024, NHS England published an updated model constitution for ICBs, along with updated statutory governance guidance. This has required a number of amendments to our ICB Constitution, which is shared with the Board

for information as part of this pack of papers (see agenda item 15). This revised Constitution will be in place from 1 October 2024.

15. In addition to a number of housekeeping amendments, the following changes have been made:

    a) **Introduction of the role of Senior Non-Executive member** (see section 3.14): This is in line with the governance requirements of NHS trusts and foundation trusts regarding Senior Independent Directors, and the role is required to support the NHS England Regional Director in the appraisal of the ICB Chair and their compliance with the fit and proper person test, and to act as a sounding board for the Chair and, if necessary, to mediate between the Chair and other Board members.

       I am pleased to confirm that I have appointed Jon Towler to the role of Senior Non-Executive member, which Jon will fulfil alongside his Vice-Chair role.

    b) **Introduction of new rules regarding terms of office of the ICB Chair and Non-Executive members** (see paragraphs 3.3.4, 3.3.5, 3.8.5, 3.8.6 and 3.8.7): This is to ensure sufficient flexibility in how the Chair's terms of office are expressed in order to recognise that Interim Chair appointments (approved by the Secretary of State) may be necessary. Also introduced is the requirement for any proposal for the Chair or a Non-Executive member to serve on the Board for longer than six years to be subject to rigorous review to ensure their ongoing independence (to a maximum of nine years in total), which is consistent with the Code of Governance for NHS provider trusts.

    c) **Clarification regarding the legal powers of the Chair and Chief Executive and the roles of the Vice-Chair and Deputy Chief Executive** (see paragraphs 3.13.4 and 3.15.3): This is to confirm the extent to which the powers of the chair and Chief Executive can be discharged in their absence by the Vice-Chair and Deputy Chief Executive.

    d) Removal of all previous clauses that were specific to the establishment of the ICB, and as such, are no longer required.

16. As reported to the last meeting, a review of committee memberships has been completed to reflect the roles and responsibilities introduced by the new Board composition, which will be in place from 1 October 2024. All committee terms of reference have been amended to reflect the outcome of this review and the Board is requested to approve the ICB's updated Governance Handbook, which is shared with the Board as part of this pack of papers (see agenda item 16). This also reflects a number of changes to committee terms of reference as agreed following the 2023/24 committee effectiveness review.

17. In October I will be interviewing for two new Non-Executive members of the Board; this is to fill our newly created role and to appoint a replacement for

Caroline Maley. Prior to these appointments being made and new members joining the Board, it has been necessary to establish some interim arrangements with Non-Executive colleagues to ensure the ongoing effectiveness of the Board's committees. These arrangements, which will commence from 1 October 2024, require Board approval, and can be summarised as follows:

a) Stephen Jackson will become Chair of the Audit and Risk Committee, move to being a member of the Finance and Performance Committee and will also join the membership of the Quality and People Committee.

b) Jon Towler will become Chair of the Finance and Performance Committee.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/09/2024
Paper Title:	**Chief Executive's Report**
Paper Reference:	ICB 24 048
Report Author:	Amanda Sullivan, Chief Executive
Report Sponsor:	Amanda Sullivan, Chief Executive
Presenter:	Amanda Sullivan, Chief Executive

Paper Type:							
For Assurance:		For Decision:		For Discussion:		For Information:	✓

Summary:

This report provides a summary of recent local and national developments and areas of interest for Integrated Care Boards (ICBs) and the wider NHS.

Recommendation(s):

The Board is asked to **note** this item for information.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	This item ensures that the Board is kept informed of organisational, system and national developments that promote achievement of the ICB's core aims.
Tackle inequalities in outcomes, experience, and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:

A: ICB achievements during quarter one, 2024/25.

Board Assurance Framework:

Not applicable.

Report Previously Received By:

Not applicable.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Chief Executive's Report

Zero tolerance of racism in the NHS

1. Following the devastating attacks in Southport last month, the outbreaks of violence in our towns and cities has been deplorable and I echo the remarks in Kathy's report that we must call out racism if we witness it amongst our colleagues or our patients, however difficult or uncomfortable it is.
2. Following conversations with NHS leaders, Amanda Pritchard, NHS England's Chief Executive, has since written to all ICBs and NHS trusts with a commitment to further supporting staff and addressing racist and other discriminatory behaviours. This includes promotion of local staff wellbeing and support networks and guidance on the implementation of policies relating to abuse, violence and racism against staff. The full letter can be found here: https://www.england.nhs.uk/long-read/nhs-response-to-2024-riots/.

Outcome of NHS England's annual assessment of ICB performance 2023/24

3. During July 2024, NHS England completed its annual performance assessment of the ICB against a range of specific objectives set by NHS England and against our statutory duties, alongside an assessment of our wider role within the Integrated Care System.
4. The assessment for 2023/24 has concluded that we have demonstrated effective leadership, with a strong collaborative approach and good engagement with partners and stakeholders. Addressing health inequalities was noted as an area of strength, and the ICB is noted as being recognised nationally as a leader in shared decision-making and Personal Health Budgets. Even though some targets were not achieved for the year, good evidence of collective system working was noted to address elective waiting times and the delivery of cancer care, along with reductions in the backlog of waiting patients towards the end of the financial year.
5. The assessment highlights areas of challenge for the ICB as our financial position and the need for a continued focus on the metrics associated with urgent and emergency care and learning disabilities and autism.
6. The full assessment outcome can be found here: https://notts.icb.nhs.uk/wp-content/uploads/sites/2/2022/04/2023-24-ICB-Annual-Assessment-Letter-Notts-FINAL-v.2.pdf.

Review into mental health services at Nottinghamshire NHS Healthcare Trust

7. Since our last meeting, the Care Quality Commission (CQC) has published its final report into the care and treatment of Valdo Calocane by Nottinghamshire

Healthcare NHS Foundation Trust (NHT). The report clearly indicates a number of areas for improvement for the Trust.

8. NHS England has subsequently responded to the CQC's recommendations and further national guidance has been issued, which includes not discharging people if they do not attend appointments and the sharing of risk assessments with partners and patients' families.

9. The ICB continues support the oversight of improvements needed at NHT, and we continue to work with the Trust to ensure that quality and safety concerns are fully addressed as rapidly as possible. A tailored, intensive support programme is in place with the Trust, focussing on the issues that need to be addressed to achieve rapid and sustainable improvement.

10. The ICB and NHS England Midlands colleagues continue to lead a joint Improvement Oversight and Assurance Group which brings together all relevant parties to ensure that the appropriate support and challenge is offered to NHT during their work to improve services.

Junior doctors' industrial action

11. Following negotiations with the new Government, the two unions representing junior doctors have recommended that their members should consider a deal of an additional 4.05% for the pay year 2023/24 on top of the average 8.8% previously awarded, taking last year's pay uplift to an average of 13.2%. If accepted, this will be backdated to April 2023.

General Practice collective action

12. The British Medical Association's (BMA) General Practice Committee (GPC) is currently in dispute with the government over the imposition of the 2024/25 GP contract. The ballot has concluded, and the taking of collective action has been overwhelmingly supported. Collective action could consist of stopping all non-contractual actions, pausing or delaying data sharing, limiting daily patient contacts, or stopping engagement with other parts of the healthcare system.

13. The ICB has actively engaged with local clinical leaders to understand better the level of local appetite to undertake collective action and the form that it might take.

14. Regional and ICB level primary care and Emergency Preparedness, Resilience and Response (EPRR) teams have developed plans to maintain services during the period of collective action. NHS England has asked for the involvement of wider clinical and leadership input to anticipate and manage changes to service levels in primary care to ensure that potential secondary impacts on emergency care or mental health and community pathways can be

managed effectively. Patients are being asked to continue to access services in the usual way.

ICB achievements quarter one 2024/25

15. Despite the current challenges in our system, I am pleased that we are also making some really positive progress in many areas. Appendix A provides details of several achievements during the first quarter of 2024/25. These include the expansion of Pharmacy First to 97% of our pharmacies to support better access to treatment for seven common conditions; the delivery of one of the best diagnosis dementia rates in the country, supporting patients and carers to access the right support to live well with dementia through early diagnosis; and the launch of a new Insights Hub as a place for all system partners to come together, share insights, and search for information.
16. Going forward, I will present a quarterly update on key achievements to the Board, and I would like to express my thanks to all the teams within our ICB and across the system that are working hard to deliver in these areas.

2024/25 vaccination programmes and winter planning

17. The Government has accepted final advice from the Joint Committee on Vaccination and Immunisation regarding a Covid-19 autumn/winter 2024/25 vaccination programme. The main flu and Covid-19 vaccination campaign will commence on 3 October 2024.
18. The groups to be offered a Covid-19 vaccine in autumn/winter 2024/25 are: residents in a care home for older adults, all adults aged 65 years and over, and persons aged 6 months to 64 years in a clinical risk group. The Government has decided that frontline health and social care workers and staff working in care homes for older adults will continue to be offered Covid-19 vaccination in England. Community pharmacies will be covering a significant number of the vaccinations alongside GP practices in some areas of Nottingham and Nottinghamshire. A mobile service will also be available in areas where there is limited cover for vaccinations, as well as targeting those individuals who have chronic obstructive pulmonary disease (COPD) and/or are frail.
19. The cohorts eligible for the flu programme are: pregnant women, all children aged two or three years on 31 August 2024, primary and secondary school aged children, all children in clinical risk groups aged from six months, those aged 65 years and over, those aged 18 years to under 65 years in clinical risk groups, those in long-stay residential care homes, carers in receipt of carer's allowance, or those who are the main carer of an elderly or disabled person, close contacts of immunocompromised individuals, and frontline workers in a

health and social care setting. All GP practices will be providing the flu vaccination, along with community pharmacies. The school age immunisation service will be visiting all schools and other options to support uptake are currently being considered.

20. In addition, from September, a new vaccine for Respiratory Syncytial Virus will be available to older adults aged 75-79 years old and to pregnant women to protect their babies. This vaccination is received once as opposed to annually. This is a positive step forward for keeping at risk groups well over winter. Nationally, there is a push to vaccinate as many 75–79-year-olds before December, with the aim of completion by 31 August 2025. Within Nottingham and Nottinghamshire maternity services have mobilised to provide the vaccine and GP practices will be covering older adults.

21. The UK Health and Security Agency is monitoring the current outbreak of Clade 1b mpox following detection of the virus in Europe. At this point in time, the Agency is rating the risk to the UK population as low, as most of the eligible group were vaccinated in 2022/23 in response to the last outbreak. However, the Agency has shared with NHS providers several actions to ensure that any cases can be detected, isolated and treated.

22. NHS England has recently circulated updated guidance on the operation of virtual wards, which can also now be referred to as hospital at home services. The guidance provides some analysis of the benefits of virtual wards and best practices, based on their operation over the past few years. It also lists operational and implementation requirements for ICBs for their use, with a focus on frailty, acute respiratory illness, heart failure and children and young people. ICBs are expected to lead on planning, oversight, ensuring the alignment of referral pathways, and ensuring equitable and sustainable service provision and workforce. The full guidance can be found here: https://www.england.nhs.uk/long-read/virtual-wards-operational-framework/.

NHS emergency preparedness, resilience and response (EPRR) exercise programme 2024 to 2030

23. The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could cause large numbers of casualties and affect the health of the community or the delivery of patient care. In a letter to ICBs and NHS trusts, NHS England has confirmed that from October, they will set seven exercise themes for NHS organisations to exercise in turn, and asks that organisations work together to plan, exercise and report on their capabilities within each theme.

24. All NHS organisations will be expected to conduct an exercise on each in turn on a yearly basis. The seven areas are:

    - Casualty and mass casualty.

- Hazardous materials and chemical, biological, radiological and nuclear.
- Business continuity.
- Cyber and digital.
- Infectious disease and pandemics.
- Adverse weather.
- Security, shelter and evacuation.

25. The programme aims to align with current NHS exercise requirements and to use the breadth of NHS organisations in validating, assuring and improving incident response capabilities through shared learning.
26. As a Category One Responder, the ICB has a co-ordinating role within our local system to ensure that core standards are maintained and these exercises will be built into the EPRR annual work programme. This area of work is routinely overseen by the ICB's Audit and Risk Committee.

Future delegation of NHS England functions

27. NHS England has written to ICBs setting out their intention to delegate additional functions to ICBs. These delegations provide the opportunity to enable ICBs to design services and pathways that better meet local priorities and thus improve the health outcomes for local populations.
28. This will be the third delegation of functions to ICBs, following the delegation of pharmacy, optometry and dental services from April 2023 and 59 specialised services from April 2024. This tranche will complete the delegation of specialised commissioned services and will also see the delegation of vaccinations, screening and child health information services and the staff cohort by April 2025.
29. Our ICB will be the East Midlands lead for vaccinations and screening and as with previous delegations, the Strategic Planning and Integration Committee will oversee the necessary preparations for the transfers.

New Hospitals Programme

30. On 29 July 2024, HM Treasury announced that a review would be undertaken of the New Hospitals Programme as part of its wholesale review of Government finances. NHS England is working with the Department of Health and Social Care to conduct the review of projects and decision-making requested by the Secretary of State as soon as possible.
31. I will ensure the Board is updated on the outcome of this review, when available.

Health and Wellbeing Board updates

32. The Nottinghamshire County Health and Wellbeing Board last met on 22 May 2024, as reported to our last Board meeting. We are currently awaiting notification of further meeting dates.
33. The Nottingham City Health and Wellbeing Board last met on 29 May, as reported to our last Board meeting, and will meet again on 25 September 2024.

Recent leadership appointments

34. As noted in my last report, Mel Barrett, has left his post as Chief Executive of Nottingham City Council, and on 5 August the full council meeting approved the appointment of Sajeeda Rose as the Council's new Chief Executive. Sajeeda formerly served as the Council's Corporate Director of Growth and City Development, was Chief Executive of the D2N2 Local Enterprise Partnership, and has recently been instrumental in the establishment of the East Midlands Combined Authority.
35. Nottingham City Council has also recently appointed two new corporate directors. Jill Colbert OBE has been appointed as the new Corporate Director for Children and Education Services, whilst Vicky Murphy will take up the role of Corporate Director for Adult Social Care and Health.
36. Jill will join the Council at the end of September from her current role of Chief Executive of Together for Children, the operating company that delivers all children's services for Sunderland City Council. Within her Chief Executive position, Jill has held the statutory role of Director of Children's Services for Sunderland City Council.
37. Vicky will commence in post during November and joins the Council from her current role as Service Director of Adult Social Care (and Deputy Director of Adult Social Services) at the London Borough of Haringey, managing all social care operations, commissioning and integrated health. As a registered and qualified mental health social worker, Vicky brings over 28 years of experience to her role.
38. On 18 July 2024, the full meeting of Nottinghamshire County Council endorsed Cllr Bethan Eddy as the new Chair of the County's Health and Wellbeing Board. Cllr Eddy will also become a deputy chair of the Nottingham and Nottinghamshire Integrated Care Partnership.
39. At the end of July, Karen Tomlinson's term as Chair of East Midlands Ambulance Services NHS Trust (EMAS) came to an end. I would like to thank Karen for her support and welcome the Trust's new Chair, Jeff Worrall. Jeff has been a Non-Executive Director at EMAS for the past two years and has previously held executive leadership posts at both Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust.

Review into the operational effectiveness of the Care Quality Commission: interim report

40. The Department of Health and Social Care has published an interim report from Dr Penelope Dash, who was asked in May 2024 to undertake a review of the Care Quality Commission (CQC).

41. Emerging findings have found significant failings in the internal workings of the CQC, which have led to a substantial loss of credibility within the health and social care sectors, a deterioration in the ability of CQC to identify poor performance and support a drive to improved quality - and a direct impact on the capacity and capability of both the social care and the healthcare sectors to deliver much needed improvements in care.

42. It makes five recommendations to be progressed at pace:

    - Rapidly improve operational performance.
    - Fix the provider portal and regulatory platform.
    - Rebuild expertise within the organisation and relationships with providers in order to resurrect credibility.
    - Review the Single Assessment Framework to make it fit for purpose.
    - Clarify how ratings are calculated and make the results more transparent particularly where multi-year inspections and ratings have been used.

43. A more substantive report is due to be published in the autumn. For the time being, Dr Dash recommends that the Department of Health and Social Care should enhance its oversight of the CQC and check progress against the interim recommendations of the report. The full review can be found here: https://www.gov.uk/government/publications/review-into-the-operational-effectiveness-of-the-care-quality-commission/

The Hewitt Review, where are we one year on: report by the NHS Confederation

44. The NHS Confederation has reviewed progress in the implementation of proposals from Patricia Hewitt's review of integrated care systems, published just over one year ago.

45. Although progress has been evidenced on some recommendations, the NHS Confederation argues that implementation needs to go further and faster and that short term pressures and a 'short-termist' political climate has impeded progress. Key points include:

    - Although work to define and measure preventative action is progressing, the pace is too slow.

- While there have been attempts to reduce the number of central programmes, guidance and reporting requirements, top-down performance management has increased and is stifling the innovation and change needed to improve care and access to services.
- A national capital strategy, due to be published by the end of 2024, is the response to the issue regarding outdated estate and equipment, however, manifesto pledges by the Government fell short of the funding that NHS leaders estimate is required.

46. The full report can be found here: https://www.nhsconfed.org/long-reads/hewitt-review-where-are-we-one-year.

Realising the potential of integrated care systems: report by The King's Fund

47. Two years on from the creation of integrated care systems, the King's Fund has recently published a report on the extent to which whole system solutions to workforce challenges are being used.
48. The report found that although there were signs that progress was being made, transformative work was taking place at a pace slower than expected and the King's Fund found that there was widespread concern that systems may not achieve their full potential unless more is done to create an environment conducive to success. The full report can be found here: https://www.kingsfund.org.uk/insight-and-analysis/reports/integrated-care-systems.

Appendix A: **ICB Achievements Quarter One, 2024/25**

1. Hosted the third meeting of the ICS Partners Assembly for 200 delegates, which provided insights from professionals, voluntary organisations and the public to support the ongoing development of the Integrated Care Strategy, NHS Joint Forward Plan and system transformation programmes.
2. Launched a new Insight Hub as a place for all system partners to come together, share insights, and search for information.
3. Across Nottingham and Nottinghamshire, 215 pharmacies (97.2%) are now signed up to Pharmacy First. This is supporting our communities to get better access to treatment for seven common conditions including urinary tract infection (in women aged 16-64 years), sinusitis (aged 12 years and over) and sore throats.
4. Nottingham and Nottinghamshire ICS continues to deliver one of the best Dementia Diagnosis Rates in the country. The Dementia Diagnosis Rate is a measure of those diagnosed with Dementia compared with the expected Dementia prevalence. An early diagnosis helps patients and carers to access the right support to live well with Dementia.
5. A programme of Dementia engagement took place in May to understand experiences of the Dementia pathway, including what has worked well and what could be improved. 174 people responded to the engagement survey and findings will help shape the local Dementia strategy and future service provision.
6. Three Dementia Specialist Admiral Nurses have been piloted in Primary Care Networks across Nottingham and Nottinghamshire. The pilot has improved the care and support available for those living with Dementia enabling patients and carers to live well at home and reduce pressure on General Practice and secondary care services. Carer quote *“The difference has been amazing for both my husband and me. Just spurring people on for us and putting our struggles over to doctors and clinics has established contact and given us lots of options. We are now aware of what things are out there to help us and given us someone we know to be able to contact for future help. Until meeting this Admiral Nurse, we were really struggling. No one seemed to get back to us if we contacted them and we felt as though no one was listening to us.”*
7. Focused work has been undertaken with Nottinghamshire Healthcare Trust and system partners to increase access to the perinatal mental health service. This work has ensured our residents are supported to access specialist mental health provision when pregnant and/or postpartum. Work has focussed on understanding barriers and inequity in access. This analysis has led to adapted service delivery, to address barriers to access.

8. Two successful Musculoskeletal (MSK) Community Well-being sessions were held in Mid-Nottinghamshire in the spring. These provided a holistic approach to personalised care and support for patients on current waiting lists. Over 280 patients attended and were invited to have a ‘What Matters to Me’ conversation; system partners participated offering tailored advice and support. Evaluation is under way, which will inform the future approach across the ICS. Further details of the event can be found here - Partnership-events-aim-to-improve-health-outcomes-for-hospital-patients.

9. Bassetlaw Place-Based Partnership has developed ‘Peace of Mind’, a waiting well initiative, in response to increased waiting times for children and young people mental health services across Bassetlaw. 12 months of co-production has produced a toolkit of 29 pages of information, engaging activities and links to videos that can be used by all young people as a way of supporting positive mental health and wellbeing and preventing illness. The toolkit was created by children and young people, for children and young people, to ensure that the content is relevant and appealing to target cohorts.

10. Newgate Primary Care Network ran a drop in Saturday morning cervical screening event for their local Polish community in response to low cervical screening uptake figures. A translator supported the event. Twenty patients attended (40% of this small sample had some degree of abnormality) 13% were referred directly to colposcopy following abnormal cellular findings. 31% had High Risk HPV so plan to recall in a year. 56% had negative results. Patients reported a community feeling in the waiting room and not having to book and being able to drop in was positively received.

11. Bassetlaw Place-Based Partnership planned and delivered the sixth annual Move More in May campaign, a month-long community-wide initiative aimed at supporting local people of all sizes, abilities, and ages to incorporate more movement into their daily lives. Total steps achieved in the campaign – 51,196,318. As a result of the campaign ten new Community Health and Wellbeing Champions have been recruited and are undertaking training.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/09/2024
Paper Title:	**NHS Nottingham and Nottinghamshire Joint Forward Plan: Delivery Update**
Paper Reference:	ICB 24 049
Report Author:	Joanna Cooper, Assistant Director of Strategy Sarah Fleming, Programme Director System Delivery and Development
Executive Lead:	Lucy Dadge, Director of Integration
Presenter:	Victoria McGregor-Riley, Commissioning Delivery Director

Paper Type:							
For Assurance:	✓	For Decision:		For Discussion:		For Information:	

Summary:

The NHS Joint Forward Plan (JFP) was refreshed for 2024/25 and signed off by the Board on 9 May 2024.

At its meeting on 11 July 2024, the Board agreed a set of outcomes and associated ambition that will be achieved by delivery of the JFP. Outcomes will be presented to the Board on an annual basis.

This paper presents the first bi-annual progress update on delivery of the key milestones with a focus on the areas of:

- Prevention: reducing physical and mental illness and disease prevalence; and
- Timely access and early diagnosis for cancer and elective care.

Overall, delivery of the milestones for the focus areas within the JFP is progressing. A key risk to delivery is the current operating and financial context which necessarily requires a focus and reduces capacity for transformational change.

The JFP Delivery Group oversees delivery of the outcomes across all workstreams as well as the strategic direction for transformation including the role of Place Based Partnerships and Provider Collaboratives. The group will support the ongoing development of the JFP including increasing the specificity of deliverables and clarity over responsibility for delivery.

Recommendation(s):

Board is asked to **note** progress and **discuss** the risks associated with delivery of the NHS Joint Forward Plan.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	The JFP sets out a transformed approach to system working based on the key strategic principles of prevention, equity and integration. These principles inform the key programmes/interventions that are expected to drive improved outcomes for the population through a better understanding of local population need,

How does this paper support	the ICB's core aims to:
	the development of locally sensitive support and services, and through greater collaboration between NHS partners as well as wider system partners.
Tackle inequalities in outcomes, experience and access	The Plan describes the NHS approach to ensuring that local population need is understood, and that support and service provision is tailored to this need.
Enhance productivity and value for money	Key drivers for productivity and value for money are described in the JFP, along with the contribution each programme / initiative will make.
Help the NHS support broader social and economic development	The approach to social economic development is set out the in the JFP.

Appendices:

Appendix A: JFP Delivery Plan Progress Update

Board Assurance Framework:

This paper provides assurance in relation to the management of the following ICB strategic risk(s):

- Risk 1: Timely and equitable access – Failure to ensure timely and equitable access to urgent and emergency care, elective and cancer care and mental health services.
- Risk 5: Health inequalities and outcomes – Failure to identify and/or deliver service transformation to address health inequalities and improve outcomes.
- Risk 10: Culture and leadership – Failure to orchestrate positive system culture and leadership to drive effective partnership working.

Report Previously Received By:

Reports have been provided to the previous meetings of the Board and the Strategic Planning and Integration Committee.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

NHS Nottingham and Nottinghamshire Joint Forward Plan: Delivery Update

Background

1. The Joint Forward Plan (JFP) has been reviewed and refreshed as part of an integrated approach to planning, incorporating the five-year JFP, three-year financial opportunities and 2024/25 operational planning.
2. A set of outcomes was confirmed by the Board on 11 July 2024, with an agreed ambition of returning to pre-pandemic outcomes, recognising the impact of the pandemic on operational delivery of key access targets and the associated influence on outcomes.

Delivery and oversight arrangements

3. A JFP Delivery Group has been established to focus on the delivery of outcomes across all workstreams, focusing on collective ownership of oversight and delivery.
4. The JFP Delivery Group brings together programme leads from the ICB, NHS organisations, the Provider Collaborative and Place Based Partnerships to consider interdependencies between programmes of work and to provide a mechanism for ongoing assurance throughout the year on delivery of the JFP. The focus is two-fold:
    a. Delivery of milestones: understanding progress with planned milestones from Programme Boards and understanding the risks for other programmes due to delays in implementation.
    b. Delivery of outcomes: monitoring the impact of the JFP on population outcomes.
5. The JFP Delivery Group is also progressing the development of a Target Operating Model for the Integrated Care System (ICS). This will define how the JFP will be delivered through neighbourhood, place, and system working.
6. The JFP Delivery Group meets quarterly to provide leadership and oversight of delivery of the Plan.

Implementation of the Joint Forward Plan

7. The JFP Delivery Group has developed a Delivery Plan Progress Update (Appendix A) to provide the Board with assurance on key areas of delivery for the four clinical priority areas:

a. Prevention: we will reduce physical and mental illness and disease prevalence.
b. Proactive management of long-term conditions and frailty to support early identification and avoid unnecessary escalation.
c. Improve navigation and flow to reduce emergency pressures in physical and mental health settings.
d. Timely access and early diagnosis for cancer and elective care.

8. A delivery confidence rating is provided against each of the key delivery areas.

9. The report presents a deep dive into prevention and timely access and early diagnosis. Key areas to note include:

a. Almost 17% of the ICB's population is diagnosed with some form of cardiovascular disease (CVD). Hypertension is one of the most important risk factors for CVD and case finding approaches have been put in place to identify people with suspected hypertension for early appropriate management. Since September 2022, hypertension diagnosis across the ICS has increased by 10.4% (August 2024) with over 17,800 new cases diagnosed. Numerous approaches are being taken to maximise case finding. For example, in Nottingham West Primary Care Network, a Cardiology Pharmacy Team was established working across the 12 GP practices. The team reviewed more than 3,250 patient records and achieved a 25% hypertension diagnosis rate. This freed up 3,103 appointments in General Practice. A similar project was undertaken in Mid Nottinghamshire targeting the 20% most deprived areas. The service found 980 new cases of hypertension in eight months.

b. Integrated Neighbourhood Working continues to develop through Place Based Partnerships (PBPs) focusing on local and system priorities. A Best Years Hub has been established in Newark and Sherwood to provide support to people over 65 years living with a long-term health condition. Support includes educational groups, activities, and befriending to reduce social isolation and support people to manage their health and wellbeing. Referrals have been received from care homes and District Councils, as well as self-referrals. The hubs were launched in June with 70 people attending in the first month experiencing seated exercise classes, craft, gardening, and other support and activities.

c. Asthma prevalence in the ICB is 10% of the population, with a prevalence of 5.8% for people who are prescribed asthma-related drugs. Children aged zero to 14 are at significantly higher risk of asthma emergency admissions than adults. Inhaler technique in children can be poor, with evidence showing that the health care team and care givers should advise on the proper use at every opportunity to ensure effective medication delivery. Targeted education sessions for healthcare, education and social care professionals, as well as families, children, and young people have

been established to increase understanding of good asthma care and management for children and young people. Projects are being initiated to bring diagnosis rates in line with expected prevalence through a community diagnostic centre model.

10. A deep dive for proactive care and navigation and flow will be presented to Board in March 2025.

Joint Forward Plan outcomes

11. In 2023/24, the first year of the JFP, monitoring was focused on understanding progress with key milestones. The focus is now on understanding the impact of deliverables against population outcomes.
12. The System Analytics Intelligence Unit is finalising an Outcomes Framework to ensure a common view of JFP outcomes, quality, and performance across the ICS.
13. The JFP Delivery Group will consider progress with delivery of the outcomes on a quarterly basis.
14. The approach to monitoring the JFP will continue to evolve to provide a greater level of clarity over the impact delivery of milestones has on progress with the outcomes.
15. The Board will receive an update on outcomes annually.

Risks and issues

16. The JFP is the way in which health system partners come together to deliver improved population health outcomes, and care as close to home as possible. This requires a joint and sustained focus of all system partners on the same issues, understanding interdependencies, and evidencing new ways of working.
17. Health partners have worked together to build this culture through the development of the JFP and are now moving into the monitoring of impact on population outcomes.
18. Given the complexity of the financial and operating environment for NHS partners (including General Practice collective action), there is a need to accelerate transformation to maximise the opportunities to improve population health and wellbeing. The challenging environment may have a short-term impact on progress with improving outcomes.
19. The need to achieve financial sustainability across the NHS means that there will be changes to currently commissioned services that may impact future delivery of the plan. This will be assessed by the JFP Delivery Group. A system

Equality, Quality and Impact Assessment is progressing which will support this assessment.

Next steps

20. The JFP Delivery Group will continue to provide leadership to the delivery of the plan and ensure that there is clarity over the deliverables and the outcomes they will achieve.
21. Work will continue to shape the Target Operating Model for the ICS to define how the JFP will be delivered through neighbourhood, place, and system working.
22. As the system matures with the Provider Collaborative developing, the ongoing evolution of PBPs and Primary Care Networks, and the ICB redefining its operating model, there will be a need for greater clarity of the overarching Target Operating Model for the ICS.
23. This will include clarity over how we ensure all parts of the system work together. The JFP Delivery Group will be key in agreeing with partners our future Target Operating Model.
24. The Group will further refine the deliverables to ensure there is specificity for all milestones with clarity over the responsibility for delivery. This will ensure the opportunity for working through provider collaboration arrangements and PBPs is recognised.
25. The Board will receive an update on outcomes on 13 March 2025.
26. Complementary to this, further work is taking place to confirm a set of outcomes for the Integrated Care Strategy. Bi-annual reporting on outcomes and delivery of the 14 priorities will be presented to the Integrated Care Partnership at its meeting on 28 October 2024.

Appendix A

Nottingham and Nottinghamshire

Joint Forward Plan Progress Update

September 2024

Nottingham and Nottinghamshire

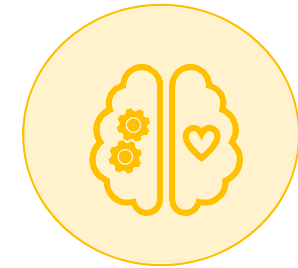
Delivering the right care at the right time

JFP focus areas

Prevention: we will reduce physical and mental illness and disease prevalence

Proactive management of long-term conditions and frailty to support early identification and avoid unnecessary escalation

Improve **navigation and flow** to reduce emergency pressures in physical and mental health settings



Timely access and early diagnosis for cancer and elective care

Progress summary

Nottingham and Nottinghamshire

- Overall, delivery of the focus areas within the Joint Forward Plan remains on track.
- Key deliverables that have been identified as off track with recovery plans in place are:
  - Development of targeted case finding specifically focused on population health needs across Places and system priorities, for example, frailty, severe multiple disadvantage, obesity.
  - Based on identified local and system priorities, Place Based Partnerships will develop integrated neighbourhood teams to curb demand growth, focusing on keeping people out of hospital wherever possible.
  - System-wide approach to personalised care planning across all sectors (acute, community and primary) and roll-out personalised care, optimise integrated care pathway and referrals.
  - Increase immunisation and screening uptake for ‘at risk’ groups.
  - Maximise productivity and make best use of workforce, for example, shared workforce plans, staff digital passports and Making Every Contact Count.
  - Embedded integrated neighbourhood team working across community teams. Prioritise those cohorts/pathway development where data indicates there is greatest opportunity for impact at both Place and system level, for example, frailty, respiratory, hypertension, Cardiovascular disease (CVD).
  - Frailty same-day emergency care (SDEC) and expanding our SDEC offer across hospitals ensuring direct access for all professionals and implementing new data requirements.
  - Virtual wards fully established and meeting target activity levels. Integrated care pathways with social care established for specific cohorts.
  - Develop a co-located urgent treatment centre at QMC to reduce demand on Accident & Emergency.
  - Deliver medically safe for transfer plan target and develop trajectory for years 2 to 5.
  - Transform our Pathway 2 and 3 offer to improve patient flow for patients who are medically safe for transfer and reduce length of stay in Pathway 2 beds.
  - Develop an urgent care coordination hub (UCCH) which will act as a single point of access for health professionals.
  - Continued support to eliminate waits of over 65 weeks for elective care.
- There are some areas where resource / capacity has been identified as a risk e.g. transformation of integrated neighbourhood working and embedding of Making Every Contact Count.
- There is a need for further financial analysis to maximise opportunities in planned care.
- Deep dives of two priorities are included in this report:
  - Priority 1: Prevention: reduce physical and mental illness and disease prevalence
  - Priority 4: Timely access and early diagnosis for cancer and elective care.

Rushcliffe Arena, 09:00-12/09/24

Priority 01 Prevention: reduce physical and mental illness and disease prevalence.

Outcomes	Increase in life expectancy Increase in multi-morbidity free life expectancy Reduction in average number of years spent in poor health Improve early cancer diagnosis	Reduction in avoidable premature mortality Stabilise obesity in Year 6 children Increase in the proportion of people reporting high satisfaction with the services they receive Increase the number of people who have the support to self-care and self-manage and improve their health and wellbeing

Key Deliverables	Delivery Confidence	Progress Update September 2024	Recovery Actions / Mitigations / Issues / Risks
Development of targeted case finding specifically focused on population health needs across Places and system priorities, for example, frailty, severe multiple disadvantage, obesity.	**Amber**	• Cardiovascular disease (CVD) hypertension case finding and management progressing with Core20+5 Accelerator programme and quality improvement approach to hypertension case finding aligned. • Using System Analytics Intelligence Unit (SAIU) analysis and recommendations, Integrated Neighbourhood Teams (INTs) are prioritising hypertension case finding and management for neighbourhoods most at risk. • Successful bid awarded through NHS England (NHSE) to expand the optometry hypertension case finding pilot in Mid Nottinghamshire. • Development of a Children and Young People's (CYP) data dashboard underway with initial area of focus being on Special Educational Needs and Disabilities (SEND) to be published in August 2024.	• Optometry pilot system planning terminated due to uncertainty around General Practice (GP) collective action.
Based on identified local and system priorities, Place Based Partnerships will develop integrated neighbourhood teams to curb demand growth, focusing on keeping people out of hospital wherever possible.	**Amber**	• Community transformation programmes are being embedded following learning and a Place Based Partnership (PBP) approach to integrated neighbourhood working (INW) is being rolled out. • PBPs received funding for INW developments which supports a targeted approach to improve the co-ordination of services, provide person-centred care and to address the wider determinants of health and wellbeing. Currently in 11 priority neighbourhoods/Primary Care Networks (PCNs) in the County. City PBP progressing INW in 2 PCNs with ambition to embed across all PCNs by March 2026. • Improving CYP vaccination and immunisation rates. CYP remains a priority with targeted work.	• City progressing INW without dedicated resource. • 2024/25 Delivery Plans are in place across all neighbourhoods/PCNs and PBPs have established appropriate governance structure to ensure work remains on track.
System-wide approach to personalised care planning across all sectors (acute, community and primary).	**Amber**	• Engagement will be undertaken through INW where frailty is a key programme of work. • Healthy Weight Management programme for CYP is funded to support personalised care and bespoke packages of care where core intervention does not meet the child's need. • The "You know Your mind" service is embedded in the County for children in care and care leavers. • Embedding of the localised Social Prescribing offer continues including continuation funding for Green Social Prescribing.	• Effective Care and Support planning requires increased level of training. Opportunities are being discussed. • SAIU considering future data capture/reporting requirements. • Work to ensure ownership within the System Transformation programmes is required to further personalisation being everyone's business.
Implement structured education programmes	**Green**	• CYP services commissioned holistically alongside public health, social care and education to provide training to all professionals working with children. • Continued promotion of face to face and virtual diabetes structured education programmes to healthcare professionals and patients (Diabetes Education & Self-Management Service, DESMOND and Dose Adjustment for Normal Eating, DAFNE). • Health care professional sessions delivered – footcare, 4 diabetes in young people sessions planned for September/October. 4 Chronic Kidney Disease (CKD) sessions planned for October.	• Working with providers of patient education programmes to understand uptake and impact. • Collaborative working continues across providers to ensure good update to training and education programmes.

Priority 01 Prevention: reduce physical and mental illness and disease prevalence. Annual Deep Dive

Tobacco dependency

- NHS services in place for inpatient, maternity and mental health as part of the Nottingham and Nottinghamshire Alliance and Vision for Tobacco Control.
- Between June 23 and July 24, 1,471 people were referred for support to stop smoking via maternity pathways at NUH, SFH and Doncaster and Bassetlaw Teaching Hospitals (DBTH).
- ICB Smoking At Time Of Delivery (SATOD) rate decreased by 1.3% from 22/23 to 23/24, the sharpest decrease in 10 years of reporting.
- In July 24, SFHT recorded their lowest SATOD rate of 6.8% from highs of 15% reported previously.
- NHS services integrating with local authority commissioned services and working with Public Health to take a targeted approach.

Severe Mental Illness Health Checks (SMI)

- Annual health checks are increasing. In 2023/24 6,137 people received a complete core physical health check equating to 72% of the GP SMI register and 21% more patients than in 2022/23. This resulted in 5-8% more patients being identified for weight management, lifestyle interventions for high blood pressure, and for high cholesterol.
- 98% of General Practices have signed up to the Local Enhanced Service for 2024-26 to deliver health checks and follow up interventions.
- A pilot is taking place in Nottingham City for a peer support offer to increase access to physical health interventions identified e.g. lifestyle interventions and cancer screenings.

Cancer

- Continuing to expand access to community lung health checks.
- Early stages of developing East Midlands Cancer Alliance Advancing Cancer Equity (ACE) Programme. The programme aims to explore, define, address and narrow inequalities in access, outcomes and experience. The programme will comprise of 5 key improvement delivery components.
- Women's health hub focused on screening with a focus on addressing the barriers experienced by women and girls.

Maternity

- Work and development of programmes continues to be supported by the maternity equity strategy.
- CardMedic implemented in Nottingham University Hospitals and Sherwood Forest Hospital. CardMedic is a healthcare translation app that provides on-demand access to clinically interpreted interactions in almost 50 languages, as well as formats such as EasyRead and sign language. Nottingham University Hospital has appointed a community engagement matron. Key priorities include interpreting services; cultural competency training; engagement with local BAME community groups; workforce diversity; antenatal forums in different languages.
- Preterm Birth Clinics: Midwifery Leads in post at Sherwood Forest Hospital and Nottingham University Hospitals and progressing optimisation work.
- Refreshed Maternity and Neonatal Voices Partnership Model recruited to e.g. Engagement Leads in post at both Sherwood Forest Hospital and Nottingham University Hospitals – increased capacity to reaching out service users and staff. Evaluation being scoped.

Long Term Conditions

Respiratory

- Targeted work to increase uptake of vaccines.
- Lung health check programme screening for respiratory disease in areas of highest prevalence and deprivation.
- In-patient smoking cessation services targeting respiratory wards.
- Increasing access to spirometry and targeting specific groups to be supported by Integrated Neighbourhood Teams. Successful bid to increase spirometry testing in targeted groups. Increasing access to Pulmonary Rehab.

Cardiovascular disease: hypertension case finding and management

- Progressing with Core20PLUS5 Accelerator programme and quality improvement approach to hypertension case finding.
- Since September 2022, hypertension diagnosis across the ICS has increased by 10.4% (August 2024) with over 17,800 new cases diagnosed. System Analytics Intelligence Unit (SAIU) analysis and recommendations, Integrated Neighbourhood Teams prioritising hypertension case finding and management for neighbourhoods most at risk
- Successful bid to expand the optometry hypertension case finding pilot. Focus will be on Mid-Nottinghamshire and Nottingham City.

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Priority 01 Prevention: reduce physical and mental illness and disease prevalence. Annual Deep Dive

Tackling Health Inequalities: our Core20PLUS5 approach Children and Young People including Special educational needs and disabilities. Continuation of priorities in Children and Young People Core20Plus5, with a focus on the nationally identified 5 areas of priority and on locally identified ”Plus” populations.

National priorities

Asthma: Increase system understanding of good asthma care and management through targeted education sessions for healthcare professionals, education and social care professionals and families, children and young people. Projects initiated to bring diagnosis rates in line with expected prevalence and provide clinical oversight to Children and Young People with this condition where risk factors are identified, through a community diagnostic centre model.

Epilepsy: understanding in disparities of epilepsy data, working with colleagues from the Children's Integrated Commissioning Hub (CICH) to understand how mental health support can be provided to Children and Young People with epilepsy. Focus on epilepsy nurse specialist workforce and aligning this with areas of national priority.

Diabetes: close loop continuous glucose monitoring (CGM) roll out.

Oral Health: oral health promotion ongoing through local authority. An oral health needs assessment has been completed to help shape future delivery.

Infant Mental Health: 0-5 – Infant mental health system mapping work underway. This includes maternal and paternal mental health, parent-infant relationships, and the mental health of infants and young children. A review of key evidence, parent and carer feedback and gaps or inequalities in access will follow (Q4 24/25).

Local priorities

Special educational needs and disabilities (SEND)

- Joint oversight and accountability by the NHS and local authorities for children and young people with SEND and their families with reporting into the ICS Children and Young Peoples Board. Contractual arrangements have been implemented for providers to report on SEND activity. A data dashboard is under development and due to be published in August 2024. Partner organisations within the ICS are working collaboratively to meet the needs of this population through population needs-led and efficient commissioning.

Children in Care and Care Leavers

- Nottingham City continuing to pilot mental health provision in Leaving Care Team. Equivalent provision is being mobilised in county in Q2 23/24. The equivalent provision is being mobilised in the Leaving Care Team in the county.
- Sustaining personal budgets (You Know your Mind) for looked after children within the county and city.
- Nottinghamshire County Council Joint Strategic Needs Assessment for Children in Care and Care Leavers is due to be presented to the Health and Wellbeing Board in September 2024 for ratification. Actions for improvement will be overseen by Partnership Board.
- Children in Care Nursing Team have implemented a transformation plan to ensure equity of practice for children and young people originating from Nottingham and Nottinghamshire and those placed in-area. A levels of needs framework is also in development to ensure right care at the right time.
- The system average waiting time for Children in Care's Initial Health Assessments are reducing.

Youth Justice

- Joint Commissioning opportunity for Youth Justice Health between the councils, ICB and Office of the Police and Crime Commissioner is progressing (Q3 24/25).
- Youth Justice Nursing Team service delivery changes to ensure equitable practice across the city and county are progressing (Q3 24/25).

Priority 01 Prevention: reduce physical and mental illness and disease prevalence. Annual Deep Dive

Health Inequalities Investment Fund

The ICB remains committed to the implementation and evaluation of schemes identified in 23/24 along with a new process being identified for 24/25 and in preparation for 25/26 onwards.

Nine schemes across three areas of health inequalities are being supported:

- **Community:** Integrated Neighbourhood Teams is developing in all four Places (Nottingham City are progressing without additional funding), this includes targeted work to support frailty and long-term conditions e.g. community hypertension case finding and management/cardiovascular disease (CVD) case finding.
- **Best Start in Life**: Children and Young People immunisations and vaccinations in Nottingham City, Family Mentor Programme and Children and Young People Healthy Weight Management Programme.
- **Inclusion Health**: Severe Multiple Disadvantage programmes in Nottingham City and Nottinghamshire County.

Through the Integrated Care Strategy and Joint Forward Plan, the focus will remain on how best to target resources in line with the commitment to equity.

Best Years Hub

The Best Years Hubs launched in June 2024 in both Newark and Sherwood. The hubs provide residents over the age of 65 living with a long-term health condition in Newark and Sherwood, with educational groups, weekly activities, one-to-one befriending to help improve wellbeing and reduce social isolation and Advanced Care Planning. The hubs are delivered and supported by an integrated team of professionals and volunteers working across health, social care, local authority, community, and voluntary sectors.

The first month of the Newark Hub at Cleveland Square proved to be so successful that we are already looking to open other hubs!

"I am really glad that I was told about the Best Years centre, the staff and volunteers are so kind to me and it's nice to have something to look forward to every week. My volunteer driver Jackie is absolutely lovely she takes me every week and I am so grateful that I am getting out a bit more now. I think it's marvellous they are taking us on a trip something a lot of us at this group would not be able to do on our own- I thank everyone of them."

With the support of Diabetes UK and Abbott, Ashfield South PCN were able to offer a free and comprehensive Diabetes Health check to the residents of Kirkby in Ashfield and the surrounding areas.

Residents were able have their BMI confirmed according to their height and weight, have their blood pressure checked, and undergo a finger-prick blood test to confirm their blood glucose and cholesterol levels. The specialist Abbott machines were able to produce results from the blood tests in just 7 minutes and therefore residents were able to receive their results instantly and left with their results recorded on a record card.

Diabetes UK, NDPP (Diabetes Prevention) and DESMOND (Diabetes Education & Self-management Service) were also on site to help inform residents about Diabetes, answer any questions, and to help signpost to services which may benefit them.

In addition, local leisure centre provider, Everyone Active, was on site offering free trial sessions as well as information on how to access their exercise referral schemes, to help residents become more active.

Targeting and Promotion

To promote the event, local practices sent text message invites to patients who would most benefit from the service. These included those:

- Aged 30-60, with a BMI > 30.
- Who did not already have a Diabetes diagnosis.
- Who had not had a Hba1c test within the last 6 months.
- Who lived within our District's "priority place", Coxmore Estates (Abbey Ward).

In addition, we sought the support of colleagues from within our INT (Integrated Neighbourhood Team) including:

- Ashfield District Council
- Ashfield Voluntary Action
- Everyone Active

We even had a shout out from our Local MP on social media!

On the day

We were blessed with good weather and had a great turn out to the event. Thanks to NHS Property Services we were able to provide seating to residents waiting and had fans in the consultation rooms to keep the blood test machines (and our staff) nice and cool. We had a steady flow of visitors throughout the day thanks to the promotional work undertaken before the event as well as some leaflet promotions within the town centre and at local businesses on the day.

Our PCN team of Nurses, General Practice Assistants and a Pharmacist worked tirelessly throughout the day, and we had some great feedback from residents who were extremely grateful of the services. Whilst most attendees were local, we did have some visitors from further afield across Mid-Notts and beyond!

In total we were able to test 77 people as well as bring awareness of the risks of Diabetes, how to prevent or manage the condition, and to promote a healthy diet and active lifestyle.

It was a fantastic event, and we thank everyone involved in making the day a success.

Priority 02	Proactive management of long-term conditions and frailty to support early identification and avoid unnecessary escalation.

Outcomes	Increase in life expectancy Increase in multi-morbidity free life expectancy	Reduction in average number of years spent in poor health Reduction in avoidable premature mortality

Key Deliverables	Delivery Confidence	Progress Update September 2024	Recovery Actions / Mitigations / Issues / Risks
Develop Place-Based Partnership (PBP) focus on tackling the quality of care in frailty that would be supported by the whole system and its partners. Identify the frailty cohort of focus based on data which indicates where resources are being over utilised and where care could be provided more appropriately.	**Green**	• PBP plans aligned to system-wide approach to Frailty. • Workflows used by Care Navigators in eHealthScope have been updated to reflect requirements for multi-disciplinary teams (MDTs). New workflows developed for frailty and long-term conditions (LTCs). • Engagement will be undertaken through INW/ local design teams where frailty is a key programme of work. • Local design teams across all 4 PBPs are focussing on the greatest areas of need including CVD and long-term conditions.	• New model for care navigation requires sign off and approval of investment. This is on track. • Workflows require agreement for technical development. This is on track.
Reinvigorate the Practice Pack model at a Practice, Primary Care Network (PCN) and Place.	**Green**	• Practice / PCN and PBP high level dashboard available on SAIU Portal. • Primary Care Performance and Delivery Group reviewing outliers and determining next steps.	• The refreshed Practice Pack approach will rely on General Practices to access information via the SAIU portal and undertaking their own analysis.
Frailty same-day emergency care embedded.	**Amber**	• External audit assessment has been completed on the system discharge arrangements. The final report presented to the Discharge Governance Steering Group and Urgent and Emergency Care Programme Board. • Implementation of Discharge Recovery Action Plan focusing on immediate actions to reduce the no criteria to reside (NCTR) / medically safe for transfer (MSFT) numbers.	
Asthma diagnosis tools embedded within primary care for children and young people.	**Completed**	• System-wide education programme for upskilling professionals in asthma identification and care embedded in primary care, Emergency Department, community services and schools. • System deep dive to understand local population and prioritise areas of focus for improvement of asthma undertaken in 2022 and currently being updated.	
Increase immunisation and screening uptake for 'at risk' groups.	**Amber**	• Efforts continue to increase vaccination rates. • Actions are being taken to support PCNs to reach out. Increased clinics in NG7, targeting in schools and of older people. • Local Authorities are working with PBPs on increasing health checks. • PBPs have implemented INTs which will include a focus on immunisation and screening.	• Transient population in Nottingham City. • Capacity and funding required to carry out extensive outreach. • Sherwood Forest Hospitals capacity to do maternal vaccinations escalated as a risk.

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Priority 02	Proactive management of long-term conditions and frailty to support early identification and avoid unnecessary escalation.

Outcomes	Increase in life expectancy Increase in multi-morbidity free life expectancy	Reduction in average number of years spent in poor health Reduction in avoidable premature mortality

Key Deliverables	Delivery Confidence	Progress Update September 2024	Recovery Actions / Mitigations / Issues / Risks
Deliver Primary Care Strategy and integrated approach to Long Term Conditions Management with a focus on the top five health conditions for the population.	**Green**	• Primary Care Strategy Delivery Group established. Community Pharmacy chapter drafted and under consultation. Plans for developing a Dental and Ophthalmology Strategy working group to support the creations of the relevant chapters. Outcomes and metrics for the strategy are being developed as the chapters are established to ensure monitoring of delivery can be reported. • Actions aligned to Prevention, Identification and management of Long-Term Conditions (LTC)/Frailty are being implemented and are aligned to the system wide transformation priority.	• There may be delivery risks associated with uncertainty around General Practice (GP) collective action. Work ongoing to understand impact of any collective action.
Continued identification of physical health issues in people with a serious mental illness thorough physical health checks to ensure proactive management in this group who do not routinely access physical health services.	**Green**	• Local data for the rolling 12 months to July 2024 shows 5,795 patients have had a complete core check, which is 64.3% of the Severe Mental Illness (SMI) register. National Q1 data will be reported in August 2024. • Communications for primary care, health improvement workers and other stakeholders continue to raise awareness of checks, signpost to training opportunities, guidance on engaging patients and making reasonable adjustments. • Peer Support Workers and existing Health Improvement Workers continue to support with delivery of the checks, alongside primary care delivery. • SMI Local Enhanced Service extension approved 2024-26, 98% of practices signed up. This supports delivery of an enhanced health check and referral into follow up interventions.	• PCN Test and Learn pilots during Q1-Q3 to include approaches to targeting patients who have not had any checks, under-represented populations and those with partial checks • Recruit the final x2 Health Improvement Workers for City by Q3.

Priority 03	Improve navigation and flow to reduce emergency pressures in physical and mental health settings.	
Outcomes	Increase in life expectancy Increase in multi-morbidity free life expectancy Reduction in average number of years spent in poor health Reduction in avoidable premature mortality	Increase in the proportion of people reporting high satisfaction with the services they receive Reduction in Hospital Emergency admissions to hospital (Length of Stay 1+ bed-days) Reduction in Hospital Emergency admissions for COPD, Cancer, CVD, Falls, Alcohol (including same-day discharges)

Deliverables	Delivery Confidence	Progress Update September 2024	Recovery Actions / Mitigations / Issues / Risks
Embedded integrated neighbourhood team working across community teams. Prioritise those cohorts/pathway development where data indicates there is greatest opportunity for impact at both Place and system level, for example, frailty, respiratory, hypertension, Cardiovascular disease (CVD).	**Amber**	• Key areas of focus for initiatives to be undertaken across our community landscape (2024-2026) will be frailty prevention, early identification and ongoing management.	Robust programme management arrangements are in place to oversee this approach.
Further develop social prescribing model across all Places/care navigation across primary care, aligned with Make Every Contact Count approach.	**Green**	• A multi-level, consistent 'Make Every Contact Count' (MECC) training offer will be co-designed with the Health and Social Care workforce. • An extended MECC and wider prevention training offer will support the workforce to facilitate better conversations about health behaviours and the building blocks of health. • A new social prescribing mental health model is being developed which will focus therapeutic interventions building on existing mental health community provision. • A new care navigation model is in development whereby workflows developed are aligned to addressing Frailty and Long-Term Conditions.	
Virtual wards fully established and meeting target activity levels. Integrated care pathways with social care established for specific cohorts	**Amber**	• Providers are developing a new system wide model that will deliver improved performance and efficiencies in 24/25. Implementation expected to commence in Q3. • 276 beds against an NHSE submitted plan of 204 beds. 69% occupancy (snapshot @ 20th June) against an NHSE target of 80%. • Focus for 24/25 will be on community led respiratory and frailty.	There is a risk that any reduction in financial investment may impact on the capacity that can be delivered in 24/25. Providers are working together to mitigate the risk and a proposal is expected in Q2.
Develop a co-located urgent treatment centre at QMC to reduce demand on Accident & Emergency.	**Amber**	• Co-located designated Urgent Treatment Centre is being developed at Queens Medical Centre with a phased implementation plan and go live date of April 2025. • Phase 1 went live in July 2024 – launching a new expanded inclusion criteria with an aim of increasing the number of patients streamed to the 'UTC'	There is a risk that the financial investment required means that a fully compliant designated UTC may not be delivered by April 2025. Providers are working to mitigate the risk and a proposal is expected in Q2.
Deliver medically safe for transfer plan target and develop trajectory for years 2 to 5.	**Amber**	• Significant improvements seen in medically safe for transfer (MSFT), no criteria to reside (NCTR), and long length of stay (LLOS) at both trusts. In May, NCTR was the lowest since September 2023 and MSFT lowest since November 2021. LLOS was lowest since October 2021. • Improvements in discharge levels seen at Nottingham University Hospitals over previous months, significant reduction in patients waiting for Pathway 2. Averaging over 300 discharges per day.	There is a risk that if investment in P1 and P2 is reduced there will be an impact on the progress made with MSFT delays. Providers are working together on mitigations and proposals are expected in Q2/3.

Rushcliffe Arena, 09:00-12/09/24

Priority 03	Improve navigation and flow to reduce emergency pressures in physical and mental health settings.	
Outcomes	Increase in life expectancy Increase in multi-morbidity free life expectancy Reduction in average number of years spent in poor health Reduction in avoidable premature mortality	Increase in the proportion of people reporting high satisfaction with the services they receive Reduction in Hospital Emergency admissions to hospital (Length of Stay 1+ bed-days) Reduction in Hospital Emergency admissions for COPD, Cancer, CVD, Falls, Alcohol (including same-day discharges)

Deliverables	Delivery Confidence	Progress Update September 2024	Recovery Actions / Mitigations / Issues / Risks
Expand our same-day emergency care (SDEC) offer across hospitals ensuring direct access for all professionals and implementing new data requirements.	**Amber**	• During 2024 SDEC pathways and services will continue to expand at both NUH and SFHFT. Surgical SDEC is now live at SFHFT, with medical SDEC expanding at NUH through the multi-specialty SDEC development on A Floor. Phase 5 of the multi-specialty SDEC A floor project is expected to go live in October. • Specialty referral Policy was signed off by acutes trusts and UEC board which will open up access to specialties for all competent trained clinicians in the Nottinghamshire system rather than designated clinical groups.	
Transform our Pathway 2 and 3 offer to improve patient flow for patients who are medically safe for transfer and reduce length of stay in Pathway 2 beds.	**Amber**	• A meeting has been held with SFHFT and NHT re community bed provision in Mid Nottinghamshire as part the new P2 model and offer. • Aiming for new model ahead of winter 24/25.	Risk that a P2 model is not agreed before winter due to complexities around contracting of beds. Proposal going to Chief Operating Officers (COOs) in Q2 for support to mitigate.
Develop an urgent care coordination hub (UCCH) which will act as a single point of access for health professionals.	**Amber**	• Average of 290 calls transferred to the UCCH per week, of which, 61% of calls are managed without an emergency response. • Percentage of urgent community response (UCR) increased to 84% of calls resulting in a response (was 50% visit rate prior to UCCH) – more efficient use of resources. Funding has been sourced to continue this initiative. Expansion of this service is being explored to further reduce activity sent to ED e.g. from care homes etc. • Further development of the service during the 'perfect fortnight' including referrals from ambulance crews and improving onwards referral to UCR.	Risk that the service cannot be expanded any further due to the lack of additional investment available. NEMS are investigating any efficiencies that can be made.

Priority 04	Timely access and early diagnosis for cancer and elective care.

Outcomes		
Outcomes	Increase in life expectancy Increase in multi-morbidity free life expectancy Reduction in average number of years spent in poor health Improve Early Cancer diagnosis	Reduction in avoidable premature mortality Increase in the proportion of people reporting high satisfaction with the services they receive Reduction in Hospital Emergency admissions to hospital Reduction in Hospital Emergency admissions for Cancer

Deliverables	Delivery Confidence	Progress Update September 2024	Recovery Actions / Mitigations / Issues / Risks
Continued support to eliminate waits of over 65 weeks for elective care.	**Amber**	• At week ending 23 June 2024 there were 647 patients against a plan of 338. Forecast remains to achieve zero by September, particular focus on Ears, Nose and Throat (ENT).	• Plans in place and assurance sought for at risk specialties.
Elective hubs and clinical diagnostic centres established (Newark, City, Mansfield).	**Green**	• Elective Hub (City Campus); Main construction works for phase 2 begun in June 2024. However further delays are expected to affect the planned completion of March 2025. • Elective hub (Newark). The operating theatre opened as planned and has operational since 6th November. The "Getting it Right First Time" (GIRFT) regional team visited the hub on 23rd May 24. Working towards a hub accreditation review in Spring 2025.	• Ongoing as plan.
Expansion of targeted lung health check, (TLHC) breast cancer screening, community prostate clinics and community liver surveillance programmes.	**Green**	• Targeted Lung Health Check (TLHC) expansion plans continue to be implemented with next phase in Sherwood from July 24. Phase 2 starts in Hucknall, Calverton and Arnold in April. • TLHC recently located in Nottingham City Centre to provide open access service to severe multiple disadvantage (SMD) population. 16 people were identified as at risk and supported to attend. • Overall, 200 cancers now diagnosed across the programme with 65% early diagnosis rate (compared to 30% for symptomatic patients). Significant levels of non-cancer diagnosis - Respiratory, heart and liver disease.	• Ongoing as plan.
Identify the top 5 specialities with the longest waits for CYP elective care. Differentiating waits and preoperative care for children and young people where development is disproportionately affected compared to adults.	**Green**	• Diagnostic productivity programme focussing on MRI and Audiology utilisation improvement, impact from July. • System partners working together around Echocardiography, MRI and Audiology. • In Audiology, clinic changes will be introduced for school ages children from end of July, which will double capacity. Patient Initiated Follow Up (PIFU) has been introduced for Paediatric Audiology. Additional Audiology clinics run by insourcing provider at weekends. Review underway to maximise efficiency of scheduling and booking rules. • CYP elective wait data is regularly reported against and reviewed.	
Roll-out personalised care, optimise integrated care pathway and referrals. Maximise productivity and make best use of workforce, for example, shared workforce plans, staff digital passports and Making Every Contact Count.	**Amber**	• Work continues with Digital Notts to develop the enhanced eMeet and Greet programme to support early health screening and elective recovery. • Opportunities identified through the newly published NHSE Missed Appointments Toolkit with speciality teams who experience high Did Not Attend (DNA) rates to refine action plans. • A review of the referral optimisation outcomes is underway, and work will continue to focus on reducing unwarranted variation across the patient pathway and link to the GIRFT productivity programmes. Revised Gynaecology guidelines are being reviewed by primary care and self-care guidelines for patients to compliment the referral guidelines are being drafted.	• Focus continues via the Getting it Right First Time (GIRFT) Programme Board and reported to the Planned Care Transformation Board. Plans aligned with digital team. There is a need for further financial analysis to maximise opportunities.

Priority 04 | Timely access and early diagnosis for cancer and elective care. Annual Deep Dive.

Cancer
Position Overview:

- **62-day backlog** – NUH is delivering against the revised improvement trajectory: 272 v 284 @2/7/2024. There has been recent progress in reducing the 62-day backlog, with reductions over the past few weeks. Urology remains the largest backlog at 122 patients. The trust is working to achieve the fair shares target of 233 patients by September. The SFH Cancer backlog remains under the fair shares.
- **Faster Diagnosis Standard** – Consistently achieving target. May performance was 79.9% for SFH and 79.6% for NUH. June forecasts are to similar levels.
- **31-day** – May performance was 85.7% for SFH against a plan of 87% and 93.1% for NUH against a plan of 90.6%. Both providers forecast to achieve operational plans in June
- **62-day** – NUH and SFH exceeded operational plans in April. Provisional May data is below operational plans but is subject to validation. NUH forecast to achieve plan in June of 60.8% and SFH forecasting 66.3% in June which is below their plan of 70%. SFH forecasting plan achievement in August.

Areas of focus to improve performance in the short and medium term

- Jubilee theatres at NUH opened in March 24 – additional capacity for Lower Gastrointestinal (LGI), Lung, Urology and Gynaecology.
- Mutual aid opportunities in Gynaecology being explored by NUH (proposed – 7 patients, 1 colposcopy per list) ongoing actions to identify how SFH staff member can provide additional support due to Human Resources (HR) and accreditation requirement issues. The service are reaching out to Leicester and Ilkeston too to explore further mutual aid opportunities.
- Industrial Action Update - all specialties have very limited impact on cancer pathways as capacity maintained or shifted to accommodate where changes have had to be made.
- A range of specialty actions are taking place around Pathology, Radiology Skin, Urology and others funded via East Midlands Cancer Alliance (EMCA) Quick Win Funding.
- Enhanced Faecal Immunochemical Testing (FIT) protocol to be implemented in LGI at NUH to triage patients from Cancer Patient Tracking List (PTL) to Routine waiting list.
- Cancer Tele-dermatology service implemented at SFH and to be extended to Newark. NUH piloting service in Q2.

Transformation

- Targeted Lung Health Check (TLHC) expansion plans continue to be implemented with next phase in Sherwood Mid Nottinghamshire from July 24. Phase 2 starts in Hucknall, Calverton and Arnold in April 25. TLHC recently located in Nottingham City Centre to provide open access service to severe multiple disadvantage (SMD) population, through joint working with Framework and local Charities. Of the first 13 scanned, 2 cancers diagnosed.
- Overall, 200 cancers now diagnosed across the programme with 65% early diagnosis rate (compared to 30% for symptomatic patients). Significant levels of non-cancer diagnosis - Respiratory, heart and liver disease.

Priority 04 — Timely access and early diagnosis for cancer and elective care. Annual Deep Dive.

Elective Care
Position Overview:

- **104 week wait (ww)** – delivered zero for end of June 2024 at NUH and SFH.
- **78 ww** – delivered zero for end of June 2024 at NUH and SFH.
- **65 ww** – At week ending 23.6.24 there were 647 patients against a plan of 338 (NUH 529 against plan of 220, SFH 118 against plan of 118). Forecast remains to achieve zero by September, particular focus is at NUH for Ears, Nose and Throat (ENT).
- **52 ww** – Behind the provider system plan with 4,942 patients against a plan of 4,620 patients (NUH 3,759 against 3,390 plan, SFH 1,183 against 1,230 plan).
- **Incomplete Referral to Treatment (RTT)** – Latest position at 26.6.24 is 127,412 patients against a provider plan of 120,743.

Areas of focus to improve performance in the short and medium term

- System work is progressing to reduce waits across a number of pathways by Trusts working together and reviewing capacity from a combined perspective.
- SFH are adopting the digital solution used at NUH (DrDr) to increase pace on validation from mid-July. This is positive progress and an example of 'adapt and adopt'.
- Milestone plans are being finalised to improve outpatient and theatre productivity.
- NUH has revamped and relaunched the outpatient improvement programme under the Productivity Workstream of the financial sustainability programme.
- Productivity opportunities will continue to be scoped in detail and shared across providers; where there is a similar opportunity, joint working may be appropriate, and learning will be shared.
- The existing groups for Musculoskeletal (MSK) and Eye Health are clinically led and will encompass wider transformation and milestone plans will be agreed.
- The System Analytical & Information Unit (SAIU) are working with trust Business Information (BI) teams to confirm datasets, benchmarking information, and key metrics to inform and identify financial opportunities.

Outpatient transformation

- Work continues with Digital Notts to develop the enhanced eMeet and Greet programme to support early health screening and elective recovery.
- Opportunities identified through the newly published NHS England Missed Appointments Toolkit with speciality teams who experience high Did Not Attend (DNA) rates to refine action plans.
- A review of the referral optimisation outcomes is underway, and work will continue to focus on reducing unwarranted variation across the patient pathway and link to the Getting it Right First Time (GIRFT) productivity programmes. Revised Gynaecology guidelines are being reviewed by primary care and self-care guidelines for patients to compliment the referral guidelines are being drafted.
- Elective Hub (City Campus); Main construction works for phase 2 begun in June 2024. However further delays are expected to affect the planned completion of March 2025. Further details on mitigation plans and revised timelines are expected week commencing 17th June 24.
- Elective hub (Newark). The operating theatre opened as planned and has operational since 6th November, with full sign off in place from the beginning of January allowing full range of procedures suitable for Newark. The GIRFT regional team visited the hub on 23rd May 24 and shared a report which summarises the discussions and outline of the opportunities and recommendations for SFH to take forward. These include working towards a hub accreditation review in Spring 2025.

Priority 04 | Timely access and early diagnosis for cancer and elective care. Annual Deep Dive.

Diagnostics
Position Overview:

- SFH were above their local trajectory in May with 72.6% against a 72.0% plan. NUH were below plan with 66.8% against 69.3%.
- At SFH, seven modalities were achieving 85% ambition in May, with two achieving 85% at NUH.
- **Reduction in both waiting list volume and backlogs from April to May 2024.** The May 2024 waiting list volume was 29,363 patients across NUH and SFH, this is a slight decrease on the 29,483 waiting at the end of April 2024. The backlog volume is 8,843 patients which a reduction of 520 compared to the 9,363 at the end of April 2024.
- **Diagnostic tests delivered in May were above planned levels by 1579 (4.7%),** with 35,475 Diagnostic tests delivered (for tests included in the operational plan). This level was above the April volume by 1,608 tests.
- Echocardiography activity at SFH has increased substantially since implementing the recovery plan. An additional 375 tests were delivered in May 2024 compared to the same period of 2023 (36% growth).
- In May, Computed Tomography (CT) and Echocardiography (Echo) achieved the planned 6-week performance at NUH, with Audiology and Gastroscopy achieving at SFH.
- Challenged specialities include Echo at SFH, MRI and Audiology at NUH. Audiology has increased demand and clinical staff vacancies. Demand control measures in place to limit referrals to Nottingham City and South Nottinghamshire Place until performance is improved and stable.

Areas of focus to improve performance in the short and medium term

- CT performance in May much improved at NUH linked to CT 7 opening- 6 weeks earlier than expected. Backlog reduction already evident, opportunity now to accelerate performance improvement for CT.
- PA supported diagnostic productivity programme at NUH focussing on Magnetic Resonance Imaging (MRI) and Audiology utilisation improvement, impact from July.
- System partners working together around Echocardiography, MRI and Audiology.
- A range of actions have been implemented for Echo at SFH to increase activity and reduce the backlog volume, which include additional weekend working, insourcing at Mansfield and Newark Hospitals and deep dive into booking processes. The trust have secured additional graduate trainee posts including running an internal graduate trainee programme. Four graduates completed internal programme and have been retained at SFH. 5th trainee recruited and commenced training in September.
- Good progress with iRefer roll out at both trusts, ensuring appropriateness of GP referral.
- In Audiology, clinic changes will be introduced for school ages children from end of July, which will double capacity. Changes will also be made around the adult clinic rota from August to reduce clinic time from 60 to 45 minutes. Patient Initiated Follow Up (PIFU) has been introduced for Paediatric Audiology. Additional Audiology clinics run by insourcing provider at weekends. PA consultancy reviewing scheduling and booking rules to maximise efficiency.

CDC planning for 2025/26

- Mansfield Community Hospital Community Diagnostic Centre (CDC) approved by the National Team. CDC accelerator activity underway at Mansfield and Newark sites – MRI, Echo, ultrasound, Phlebotomy.
- Nottingham City CDC is due to open in Autumn 2025 and will deliver an additional 50,000 diagnostic tests during 25/26 across 10 modalities. This will increase to around 108,000 tests in 2026/27.

Key

Nottingham and Nottinghamshire

	Delivery Confidence
Blue	Delivery complete / delivery complete for 2024/25
Red	Off track to deliver in 2024/25 (major) e.g. • High impact on direct patient care • High negative impact on addressing health inequalities • High impact on provider / partner resilience in one or more sectors • High impact with likely adverse publicity / reputational damage / loss of regulator confidence • High effort. Significant capacity/contractual issues. • High-cost impact, adverse financial impact on the system control total
Amber	Off track to deliver in 2024/25 (minor) e.g. • Medium impact on patient care limited to scope of contract • Medium negative impact on addressing health inequalities • Medium impact on specific provider / partner • Medium impact with likely adverse publicity / reputational damage / reduction in regulator confidence • Medium effort. Some capacity/contractual issues. • Medium cost impact, adverse financial impact on the system control total
Green	On track to deliver in 2024/25 e.g. • Minimal or no impact on direct patient care • Minimal or no negative impact on health inequalities • Minimal or no impact on provider / partners • Minimal or no impact on reputation • Minimal or no issues with delivery • No or low-cost impact, impact over limited geographical area

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/09/2024
Paper Title:	**Nottingham and Nottinghamshire Five Year ICS People Plan**
Paper Reference:	ICB 24 050
Report Author:	Philippa Hunt, Chief People Officer
Executive Lead:	Rosa Waddingham, Director of Nursing
Presenter:	Philippa Hunt, Chief People Officer

Paper Type:							
For Assurance:		For Decision:	✓	For Discussion:		For Information:	

Summary:

The ICB is responsible for developing robust arrangements with partners to support 'one workforce' by leading system development and implementation of the ICS People Plan.

Predecessor organisations to the ICB had a People Strategy, a People Plan 2019-2024 and a People Board that provided oversight and assurance. The ICS People Plan described in this paper builds from this early work and incorporates the various additional national people and planning requirements.

The ICB's Quality and People Committee will continue to provide assurance to the Board relating to the implementation and effectiveness of the ICS People Plan.

Recommendation(s):

The Board is asked to **approve** the ICS People Plan in support of the strategic direction set out in the ICS Strategy and Joint Forward Plan.

How does this paper support	**the ICB's core aims to:**
Improve outcomes in population health and healthcare	This paper describes the process for the ICS people plan – without the correct number of people working with the required skills it will not be possible to improve population health outcomes.
Tackle inequalities in outcomes, experience, and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:

Appendix A – Delivery Plan 2024/25
Appendix B – Governance Arrangements

Board Assurance Framework:

This paper provides assurance in relation to the management of the following ICB strategic risk(s):

Board Assurance Framework:

- Risk 6: Sustainable workforce – Failure to utilise the system workforce effectively and ensure a sustainable workforce for the future.
- Risk 10: Culture and leadership – Failure to orchestrate positive system culture and leadership to drive effective partnership working.

Report Previously Received By:

The Quality and People Committee oversee the development of the People Plan.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Nottingham and Nottinghamshire Five Year ICS People Plan

Introduction and context

1. The ICS People Plan has evolved from, and been informed by, previous approaches, and is linked to the efficiencies and transformation priorities for the system. The Plan is the result of more than 12 months' work to bring together the various elements of both people planning and workforce planning priorities and to fully engage and consult with stakeholders. It stays true to the Integrated Care Strategy and NHS Long Term Plan whilst taking account of social and economic changes to the environment and the impact on staff.
2. Development of the ICS People Plan has been informed by all system partners, the ICS Reference Group, and through development sessions with Board members and NHS provider Chief People Officers. Whilst the initial approach is focussed on NHS people requirements outlined in our Joint Forward Plan, over time all system partners will contribute to the evolution and delivery of the ICS People Plan, which will be driven by service transformation requirements.
3. The ICS People Plan is driven by the NHS People Promise and the ten outcomes-based functions[1] that we must deliver:
   a) Supporting the health and wellbeing of all staff
   b) Growing the workforce for the future and enabling adequate workforce supply
   c) Supporting inclusion and belonging for all, and creating a great experience for staff
   d) Valuing and supporting leadership at all levels, and lifelong learning
   e) Leading workforce transformation and new ways of working
   f) Educating, training, and developing people, and managing talent
   g) Driving and supporting broader social and economic development:
   h) Transforming people services and supporting the people profession
   i) Leading coordinated workforce planning using analysis and intelligence
   j) Supporting system design and development
4. The ICS People Plan is distinct from the workforce plan, which is financially driven, links to the pay bill and is part of the annual operational planning process. However, the ICS workforce plan will be driven by the transformation approach outlined in the ICS People Plan and our Joint Forward Plan workforce

[1] Building strong integrated care systems everywhere: guidance on the ICS people functions, Version 1, August 2021 NHSE

summary, which outlines current challenges, future ambitions and sets a trajectory for the next five years.

ICS People Plan ambitions

5. The ICS People Plan has four key ambitions.
   a) **A healthy and well workforce**. Achieved by looking after the health and wellbeing of all our people.
   b) **A fully inclusive and representative workforce**. Achieved by ensuring our people belong and feel included, recruiting and supporting career development for the less well represented people living and working in the ICS and ensuring all our people have a voice that is listened to, heard, and acted upon.
   c) **A right sized, talented, well skilled, educated and trained, affordable workforce**. Achieved by ensuring our people want to remain in the ICS and having a triangulated workforce, demand and affordability with an agreed establishment and skills profile.
   d) **A transformed workforce, delivering health and care priorities in new ways and or at different locations**. Achieved by working with priority programs to develop their people and workforce deliverables and ensuring our people feel supported to work different.
6. The priorities for each of these ambitions have been developed with three lenses.
   a) **Manging todays ICS workforce**: Looking after our people; Ensuring our people belong and feel included; Ensuring our people want to remain; Our people feel supported to work differently.
   b) **Making tomorrow better**: Making our ICS a better place to work; Ensuring a compassionate and inclusive environment; Planning a skilled and affordable workforce; Flexible and adaptable workforce.
   c) **Developing a future right sized, right skilled workforce across health and care**: Ensuing our people are healthy and well; Engaged, representative and included; Right sized and affordable; Abled to deliver excellent care.
7. The People Plan has been summarised into a shared single set of ambitions (Table 1), which is reflected in the ICS organisations' people plans. As such, the combined delivery of their plans (which are specific to their own organisational context), will demonstrate delivery of the ICS People Plan ambitions and priorities.

Rushcliffe Arena, 09:00-12/09/24

Table 1 – The Nottingham and Nottinghamshire ICS People Plan

People Plan Ambitions	A healthy and well workforce	A fully inclusive and representative workforce	A right sized, talented, well skilled, educated and trained, affordable workforce	A transformed workforce, delivering priorities in new ways and or at different locations
Managing today's ICS workforce	**Enabling** – flexible working **Improving** – staff wellbeing **Improving** – placement quality and student experience **Supporting** – all NHS orgs sign sexual safety charter	**Enabling** – Career conversation **Focusing** – on six High Impact Areas **Developing** – the Freedom to Speak Up Network, **Training** – in Dyslexia Support **Enabling** – career progression for BAME colleagues **Training** – for allyship inc. active bystander	**Delivering** – an ICS retention strategy **Reducing** – agency and bank usage **Increasing** – placement capacity **Agreeing** – an ICS Collaborative Bank **Supporting** – ease of movement in the system, harmonisation of policies, mandatory training	**Delivering** – staff passporting **Making** – training portable **Delivering** – E Rostering **Delivering** – E job planning **Developing** – new roles to make services more resilient. **Supporting** – priority programs to develop their workforce deliverables
Making tomorrow's ICS workforce better	People working and learning in the ICS feel safe and supported in their physical and mental health and wellbeing, and are therefore better able to provide high-quality, compassionate care to patients.	Leaders at every level live the behaviours and values set out in the People Promise. Valuing and supporting life-long learning and leadership at all levels.	The system is retaining, recruiting and, where required, growing its workforce to meet current demand and activity. Education and training plans and opportunities are aligned and including to enable new ways of working and support personalised career journeys.	Service redesign is focused on enabling staff to embrace new ways of working and the use of technology and wider innovation. Transformation is planned to meet population health needs, drive efficiency and value for money.

People Plan Ambitions	A healthy and well workforce	A fully inclusive and representative workforce	A right sized, talented, well skilled, educated and trained, affordable workforce	A transformed workforce, delivering priorities in new ways and or at different locations
A future ICS workforce	Patients and service users describe their experience as being individually focused, appropriate to their needs, timely and delivered with a high degree of compassion.	Leaders create a sense of individual worth, recognition and belonging within their team, organisation, and system. Leaders encourage every individual to have a voice and the flexibility to fully apply their skills and knowledge.	The workforce is representative of the population served. There are the right number of staff who are engaged with the right skills at the right time and able to work in the most appropriate location. Opportunities for education and training are available to the employed, volunteers and carers.	Service redesigned around the patient/service user, a consistent application of system wide quality improvement approach (IMPACT). Improved population health outcomes typically associated with ‘learning systems’ are achieved.

Underpinning Principles:

- Driving and supporting broader social and economic development
- Leading coordinated workforce planning using analysis and intelligence.
- Supporting system design and development
- Transforming people services and supporting the people profession

Development of workforce plans

8. The ICS transformation areas include the development and delivery of a strategic workforce plan, but also provide the building blocks for the development of a workforce plan driven by transformation objectives rather than financial envelopes. There are nine transformation areas identified: workforce, frailty, urgent and emergency care transformation, value-based commissioning, digital transformation, community transformation including primary care, elective pathway redesign, end of life/hospice care, and the development of the Provider Collaborative.

9. Each of these areas will work to develop a clear plan of a future state of delivery, and as a result workforce requirements as the shape. Given the design of these programmes this will include a range of health, care, community, and other partners across the system footprint. Each programme will be supported to develop and design their workforce ambitions by people leads from across the system.

10. An ICS People Planning Framework for transformation programmes has been developed to ensure consistency of approach in line with the principles of the ICS People Plan.

11. The People Planning Framework also ensures that these plans are aligned around the four standard workforce objectives detailed in NHS people plans.

    a) **Digital technology as an enabler to flexibility and resourcing**: on a systems footprint not an organisational one – coordinated implementation of workforce digital technology e.g. ESR, e-rostering and e-job planning.

    b) **Work across transformation priorities to have clear workforce strategies and plan**: including all system partners within a programme/pathway – matrix working will be key to understanding dependencies and opportunities across programs.

    c) **Move to a 'one workforce approach'**: recognising that the future workforce will want to have flexible rewarding careers within a system that recognises and develops talent and is representative of the population of Nottingham and Nottinghamshire. Recognising that this vanguard work is being lead and supported within the provider collaborative.

    d) **Development of a flexible contingent system workforce**: supported by workforce policies, practices and procedures that are simplified, standardised across the system, and use technology to automate transactional activity (wherever possible). The Provider Collaborative will lead (and expand to partner organisations) this work. The financial pressures caused by workforce availability will be reduced by the development of a flexible contingent system workforce.

12. This approach is underpinned by the ICS 'system first' approach, acknowledging this may result in differential benefits for organisations, yet the People Plan and developing workforce plan will ensure an overall benefit for the ICS.
13. The ICS People Planning Framework will ensure that as the transformation programs develop their workforce strategies and plans consistently and form the basis for the development of a transformation, rather than finance driven workforce plan across the ICS.

Delivery

14. A road map for delivery to the end of this financial year, 'managing delivery today' summarising the granular plans has been produced and is provided at Appendix A.
15. Governance arrangements to oversee the delivery of this plan have been developed, as illustrated at Appendix B.
16. A further delivery plan encompassing the transformation programme drivers will be developed and shared by December 2024.

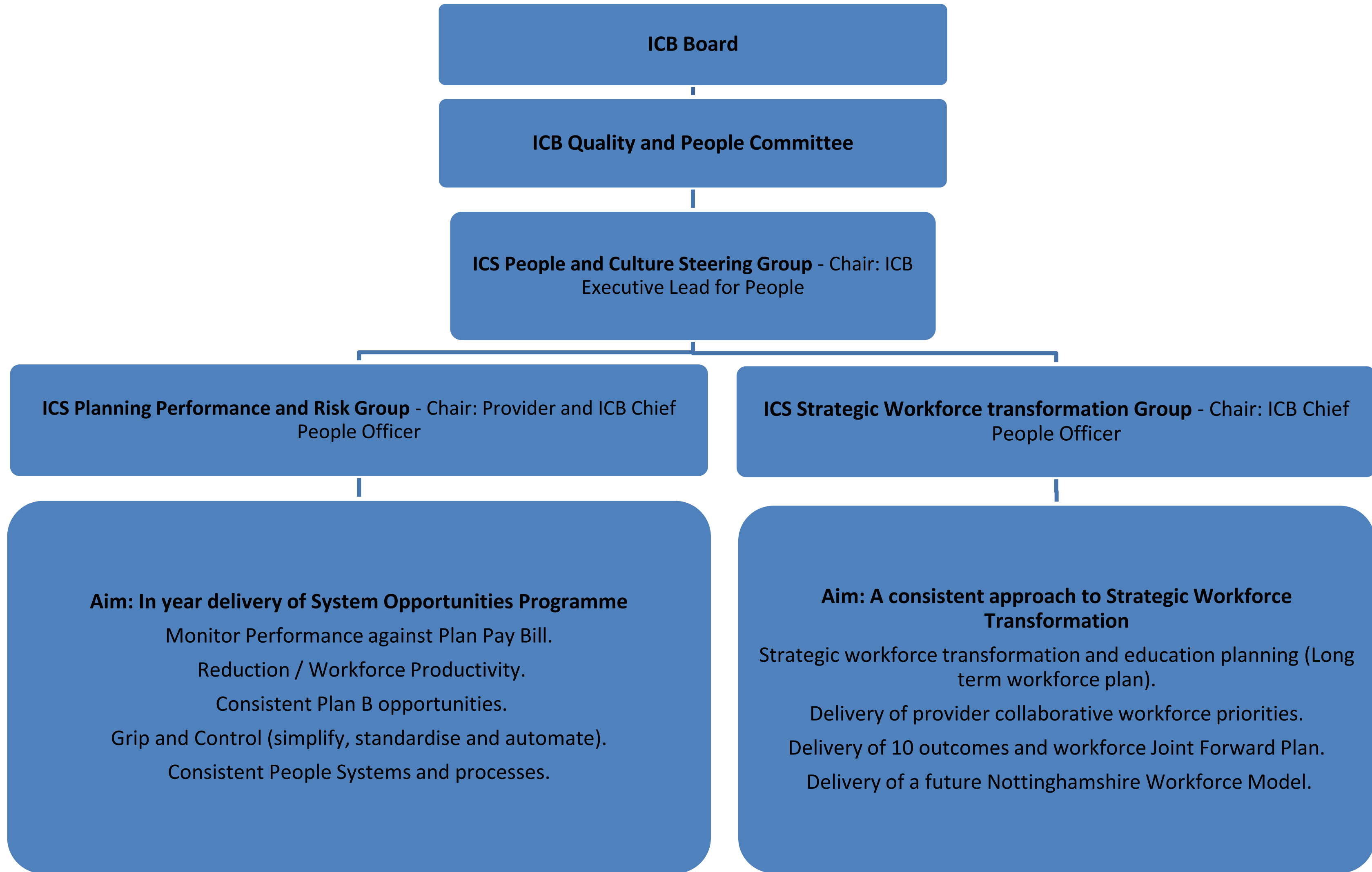
Appendix A: Delivery Plan 2024/25 (supported by partner organisation People Plans)

	September to December 2024	January to March 2025
Development of a flexible contingent system workforce	• Provider collaborative to lead work ongoing extension/development of the current work.	• Identification of further reductions in temporary staffing costs and further use of collaborative approaches • Scope the development of flexible contingent workforce models
Work across transformation priorities to have clear workforce strategies - including all system partners within a programme pathway	• Establish the ICS Strategic Workforce Transformation Group. • Confirm with NHS England the required workforce growth for delivery of the long-term workforce plan. • Initiate process with System Analytics and Intelligence Unit for the population health data to drive demand. • Work across all providers and social care to map the existing and future workforce. • Implement training to raise skills and knowledge relating to workforce planning (6 steps process) across programmes. • Map workforce elements of each programme to understanding timing and resource required. • Establish education subgroup. • Establish a process to be informed of commissioning intentions (new and decommissioning) to support a Workforce Impact Assessment. • Active review and horizon scanning of national and regional funding. • Develop networks to ensure shared good practice to promote innovation and creativity. • Ensure updates relating to the People Plan are communicated.	• Establish a process for mapping demand to existing skill mix and available workforce. • As part of the annual planning enhance collaboration and triangulation of demand affordability and workforce • Develop metrics for workforce supply working with NHS England and higher education institutions. • With NHS England and higher education institutions, and in line with the long-term workforce plan establish future needs and start developing Nottingham and Nottinghamshire integrated education approach.
Move to a one workforce approach	• Ongoing and an extension of the efficiencies work to ensure workforce growth is in line with programme plans.	• Commence work to 'right size' the workforce across transformation priorities to have clear workforce strategies - including all system partners withing a programme pathway taking account of priority programmes and available funding. • Scope a recruitment hub for the ICS
Digital technology as an enabler to flexibility and resourcing on a systems footprint	• Work with programmes to establish digital future needs.	• Create digital workforce plans for programmes ensuring cross dependencies are mapped.

Rushcliffe Arena, 09:00-12/09/24

Rushcliffe Arena, 09:00-12/09/24

Appendix B: Governance Arrangements



NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/09/2024
Paper Title:	**Quality Report**
Paper Reference:	ICB 24 051
Report Author:	Nursing and Quality Business Management Unit
Executive Lead:	Rosa Waddingham, Director of Nursing
Presenter:	Rosa Waddingham, Director of Nursing

Paper Type:							
For Assurance:	✓	For Decision:		For Discussion:		For Information:	

Summary:

The report provides updates on quality and safety matters relating to the following NHS trusts for which the ICB has responsibility, based on the NHS Oversight Framework (NOF):

- Nottinghamshire Healthcare NHS Foundation Trust
- Nottingham University Hospitals NHS Trust
- Sherwood Forest Hospitals NHS Foundation Trust

The report also includes exception reporting for areas of enhanced quality oversight, as per the ICB's escalation framework (included for information at Appendix 1):

- Nottingham CityCare Partnership CIC
- Urgent and Emergency Care
- Maternity
- Special Educational Needs and Disabilities
- Looked After Children

The report should be read in conjunction with the full Integrated Performance Report, which is provided for Board members separately.

Recommendation(s):

The Committee is asked to **receive** this report for assurance.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	Provides an overview of quality and performance within the system which supports the view of outcomes relating to population and healthcare.
Tackle inequalities in outcomes, experience and access	Quality oversight provided by the paper is central to understanding the impact on outcomes, experiences and access.
Enhance productivity and value for money	Quality reporting takes account of obligations in terms of social value and the related quality of service current performance.
Help the NHS support broader social and economic development	The mitigations and quality assurance within the report support social and economic development principles.

Appendices:

Appendix 1: Escalation Framework

Board Assurance Framework:

This paper provides assurance in relation to the management of the following ICB strategic risk(s):

- Risk 1: Timely and equitable access – Failure to ensure timely and equitable access to urgent and emergency care, elective and cancer care and mental health services.
- Risk 4: Quality improvement – Failure to systematically improve the quality of healthcare services.

Report Previously Received By:

Quality delivery has been reported through the Quality and People Committee.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Quality Report

Nottinghamshire Healthcare NHS Foundation Trust – NHS Oversight Framework Segment Four (NOF 4)

Risk

1. Nottinghamshire Healthcare NHS Foundation Trust (NHT) continues to respond to address identified quality and safety improvements and continues to focus on progressing a comprehensive complex programme of improvement work.

Mitigation

2. The Improvement Oversight and Assurance Group receives updates on the Section 48 review recommendations, phase one of the Integrated Improvement Plan (IIP) and oversight of the 'safe now' process.
3. Additional mitigations:
   a) Nottingham and Nottinghamshire Integrated Care Board (ICB) presence at formal NHT internal quality oversight and assurance meetings.
   b) The monthly NHT led Care Quality Commission Oversight Group continues to report progress against open actions.
   c) A weekly 'safe now' process to oversee risk, immediate improvement actions, and appropriate escalation to executives has been established.
   d) Recruitment to a dedicated ICB Quality Manager mental health post has been successful with an anticipated start date in quarter three.

Assurance

4. Assurance remains limited, both in terms of the overall progress made to date and in terms of the Trust's capacity to sustain and build on improvements.
5. The 'safe now' safety huddles and associated outputs were well received at the Improvement Oversight and Assurance Group. This work has required significant support and focus from the ICB to achieve momentum.
6. The remaining part of the Section 48 review relating to the care of Valdo Calocane has been published and an overview of plans and progress in relation to all elements of this will be presented at the September meeting of the Quality and People Committee.

Nottingham University Hospitals NHS Trust – NHS Oversight Framework Segment Four (NOF 4)

Risk

7. Nottingham University Hospitals NHS Trust (NUH) remains in a challenged position in providing safe and high-quality care in response to regulatory requirements.

Mitigation

8. Weekly discussions continue between senior leadership colleagues within the ICB, NUH and the East Midlands Ambulance Service NHS Trust (EMAS), focusing on emerging quality concerns relating to handover delays.
9. NUH colleagues continue to engage with ICB Quality colleagues in regular assurance meetings and supporting quality insight visits across the urgent and emergency care pathway.

Assurance

10. Assurance is limited, in view of the complexity and persistently high-risk score. Engagement and focus from the Trust remains good and they are active participants in key system quality and improvement groups.
11. The CQC visited Trust maternity services in an unannounced inspection in June and feedback is awaited.
12. The Trust has scheduled a series of insight visits. These started July and have ICB input. There will be a focussed quality visit into the Emergency Department as part of the winter planning and preparation.

Sherwood Forest Hospitals NHS Foundation Trust – NHS Oversight Framework Segment Two (NOF 2)

Risk

13. There is a risk that effective oversight across multiple ongoing improvement activities will be diminished in the absence of a continuous improvement strategy.

Mitigation

14. Sepsis and escalation of the deteriorating patient remains a key focus for Trust wide improvements.
15. The ICB has continued to support oversight of the improvement actions. Regular insight visits have commenced with a review of the paediatric emergency pathway during June 2024.
16. The Trust has been identified as ‘early adopters’ of Martha’s Rule, which is a structured approach to obtain information relating to a patient's condition

directly from patients and their families, and a multidisciplinary working group has been established.

Assurance

17. Assurance is adequate. Sherwood Forest Hospitals NHS Foundation Trust (SFH) remains at NOF2, which reflects the national definition, allowing for some areas of targeted support to address specific identified issues.

Horizon Scanning

18. Further prevention of future death notices from the Coroner's Office are anticipated following two maternity inquests.

Nottingham CityCare Partnership CIC – Enhanced Oversight

Risk

19. There is a risk to patient safety and quality of care across services arising from concerns that have led to CityCare being escalated to enhanced oversight, through the system quality group and ICB oversight mechanisms.
20. Caseload capping has been implemented in Community Nursing and Integrated Care Home and Home Care, and patient safety concerns have been raised as a result.

Mitigation

21. A Contract Performance Notice was issued at the beginning of June in respect of the caseload capping and the approach to this has been discussed at executive level. The caseload capping has been scaled back in response to safety concerns, and the ICB Quality team is actively supporting an associated caseload review.
22. The quality concerns escalated during quarter one are under formal review using the ICS/National Quality Board framework. Regular meetings are planned and 'indicators of success' have been shared with CityCare colleagues to support discussions.

Assurance

23. CityCare has additional nursing leadership and continues to work with the ICB on the addressing quality and contract performance concerns. Progress is being made.

Learning Disability and Autism (LDA) – Enhanced Oversight

Risk

24. Ongoing risks remain around adult inpatient numbers, and concern that inpatient numbers will increase as the year goes on. We continue to lack

progress in discharging six individuals from non-secure settings who are clinically ready but there are delays in procurement of community placements.

25. Reduction in unplanned care beds by two has meant a reduced ability to support people in an enhanced crisis bed within the community.

26. We continue to be challenged in relation to discharging long stay patients into the community. Five year plus patients continue to be an area of focus nationally and regionally and there is a risk that the margin between target and trajectory will widen as the year progresses.

Mitigation

27. Inclusion in the system oversight arrangements on a weekly basis has supported escalations and whilst slow, progress is being made.

28. To support with the lack of unplanned care beds local authority commissioners are updating the commissioning plan and will work with the market to develop provision.

Assurance

29. Several issues are impacting on performance, including inability to commission alternatives to admissions (enhanced respite, unplanned care), local authority frameworks to secure community placements, and overall patient flow. A robust process has been developed to attempt to resolve these issues through the governance of the programme and to escalate to the LDA Executive Board for early resolution.

Urgent and Emergency Care – Enhanced Oversight

Risk

30. Quality and patient safety concerns remain as a result of delays and extended waits for patients on the urgent and emergency care pathway. Whilst NUH remains under significant scrutiny due to performance issues, there is wider impact felt by system partners including SFH, community services and NEMS.

Mitigation

31. The Urgent and Emergency Care Board and the ICS System Quality Group are proactively collaborating to monitor these risks and any emerging issues. The Urgent and Emergency Care Board retains oversight of performance, quality and safety across the pathway.

32. The Getting It Right First Time (GIRFT) team continue to meet NUH on a monthly basis to review progress against their clinical recommendations following the visit in March 2024 and subsequent visit to the City Hospital in April 2024.

33. Recognition that the work described to mitigate across both SFH and NUH shows some improvement in quarter four and quarter one performance, there are still significant risks to sustained delivery.

Assurance

34. There is partial to limited assurance. Performance scrutiny is intense, and work is ongoing to bring quality and safety priorities into focus.
35. A letter from NHS England has been published in the summer requiring action to maintain focus on quality of care and experience in pressurised services, specifically alternative pathways for frail older people and maximising in-hospital flow. The system response to this has been developed and assured through the Urgent and Emergency Care Board and the NHS system Quality Group.

Maternity – Enhanced Oversight

Risk

36. Continued focus remains on key areas of partial assurance in relation to maternity, especially given learning from regulatory visits, internal reviews and coronial cases.
37. We continue to focus on ensuring safe, person-centred equitable care, but recognise that across the system more work is needed, especially to ensure that our services are completely accessible for all our citizens.

Mitigation

38. Both SFH and NUH continue to work towards full Saving Babies Lives Care Bundle Version Three compliance.
39. A joint focus on our equity plans across the Local Maternity and Neonatal System (LMNS) is in place, this is supported by a refocussed and strengthened maternity voices partnership.
40. An independent maternity senior advocate is in place to actively support families who have experienced issues with their care.

Assurance

41. The LMNS programme has partial assurance and remains in enhanced oversight. There is evidence of sustained commitment to mandated quality and safety improvement programmes and active workstreams across all pillars.
42. The LMNS executive board is considering how it ensures more independent oversight of progress against its key objectives.

Special Educational Needs and Disabilities – Enhanced Oversight

Risk

43. Due to system capacity, financial challenges, and complexity of medical conditions and health needs, quality of provision and experiences for children and young people with Special Educational Needs and Disabilities (SEND) in Nottingham and Nottinghamshire may deteriorate further.
44. There is a significant increase in the numbers of National first tier tribunal appeals for 'extended appeals' being raised against the ICB health provision commissioned within children and young people's Education, Health and Care Plans.

Mitigation

45. Both Nottingham and Nottinghamshire SEND Partnership Assurance Improvement Groups are working collaboratively with partners across the system and Nottinghamshire SEND Partnership continues to deliver on the Priority Action Plan to deliver improvements, to respond to challenges and risks identified across the system.

Assurance

46. Nottinghamshire SEND Partnership is subjected to regular stocktake and deep dive monitoring events, as part of the improvement programme requirements. The feedback from the last deep dive provided recommendations for areas of improvement and the local area partnership agreed actions and ownership for delivery.
47. There is an independently chaired improvement board for the Nottinghamshire County SEND partnership who are assured about the progress being made against priority actions within the SEND local area improvement plan.
48. The SEND data dashboard and improved collection of data across children and young people's services contributes to improved oversight and monitoring of progress and future arrangements.

Looked After Children – Enhanced Oversight

Risk

49. Overall, delays for Initial Health Assessments and Review Health Assessments continues.

Mitigation

50. Both Nottingham City and Nottingham County have safeguarding arrangements in place oversee detailed plans and progress in relation to Initial Health Assessments and Review Health Assessments to ensure progress.

51. Focus continues both on in area, and out of area provision and children placed from other local authorities.

Assurance

52. Overall waiting times for Initial Health Assessments have improved.

53. NUH has updated internal escalation pathways and is reviewing whole community paediatric demand and capacity/clinic capacity.

Appendix 1. Escalation Framework

The ICS developed an Escalation Framework, to provide structure and consistency across all areas of oversight for escalation of concern through the governance routes of the system, and which then feed into the formal governance of the ICB. The framework has been created based upon work undertaken through the quality route building upon previous National Quality Board (NQB) guidance.

Monitoring level	Routine	Further Information Required	Enhanced	Escalated Risk
What does this mean?	No specific areas of concern identified	Potential for concern. Key milestones not achieved. More information required to determine level of risk	Delivery or quality concerns identified.	Serious specific risk to delivery or quality identified, including where there is a need to act rapidly to protect patients or staff.
What action should be taken?	Actions to be taken by relevant operational oversight group	Agree route to follow up to gain necessary information to assess risk and agree who will lead.	Agree actions and schedule for discussion at each Operational oversight Group until concerns resolved.	Trigger escalation single subject review /deep dive / risk summit.

NHS
Nottingham and
Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/09/2024
Paper Title:	**Service Delivery Report**
Paper Reference:	ICB 24 052
Report Author:	Sarah Bray, Associate Director of Performance and Assurance Rob Taylor, Deputy Director of Performance and Assurance
Report Sponsor:	Marcus Pratt, Acting Director of Finance
Presenter:	Mandy Nagra, Interim Director of Service Delivery

Paper Type:							
For Assurance:	✓	For Decision:		For Discussion:		For Information:	

Summary:

The purpose of this report is to present progress against compliance and commitment targets as required for 2024/25. The report describes the key drivers behind performance and actions being taken to address areas of concern in all service delivery performance areas. This report should be read in conjunction with the full Integrated Performance Report, which is provided for Board members separately.

Despite steady improvements being made across four-hour accident and emergency performance and ambulance handovers, performance is still not at a level that our patients should expect, therefore Nottingham and Nottinghamshire moved into Tier 2 NHS England oversight arrangements for urgent and emergency care during August, which ensures direct oversight and support from NHS England. This supported improvement is to drive a stepped sustainable increase in performance ahead of winter.

The system has reported improvements in the four-hour wait performance, with Nottingham University Hospitals NHS Trust (NUH) achieving local plans in April to July. Sherwood Forest Hospitals NHS Foundation Trust (SFH) is below their local plans; however, these were an ambitious increase to 76% from the start of the year. An area of focus for both urgent care systems is on minor injuries and illness services and delivery of sustainable performance at all sites, as well as focus at NUH on achieving consistent performance above 98% within four hours for Eye Casualty.

Ambulance turnaround times have continued to improve through July and into August, but further work is required to deliver consistency in performance at the Queens Medical Centre. Ambulance handover performance continues to be strong at SFH, despite the increased demand they have been receiving.

Diagnostic six week waits continue to deliver below planned improvement levels and have high levels of patients waiting. Improvements are being made across some of the areas of concern, however this is not at the pace expected. As such NHS England has undertaken a supportive visit with the system to identify additional areas of support and improvements and pathway reviews. Additional funding has also been made available for additional capacity to support improvements across specific modalities.

Delivery of zero patients waiting 65 weeks or more is challenging for the system. The position is significantly above the planned level with 626 patients forecast to be waiting 65

Summary:

weeks or more at the end of August against a plan of 103. This places significant risk against the aim of eliminating 65 week waits by the end of September within the system. The volume of long waiters in Ear Nose and Throat at NUH is the largest challenge with the trust exploring opportunities around insourcing, outsourcing and taking a range of other actions to increase throughput.

Performance in the 28-day Faster Diagnosis Standard continues to benchmark well for both providers. Reductions have been made in the 62-day backlog for NUH, with the Trust forecasting achievement of the fair shares standard during September. Performance against the national 62-day standard also continues to improve however there are capacity challenges within the head and neck service which will be explored in detail at the System Oversight Group in early September.

Inappropriate Out of Area placements has been an area of focus for the system, as the position continued to increase through to the end of 2023/24. Local reporting indicates significant improvement being made over recent weeks, reducing from 52 patients on 14/04/24 to 22 patients at 27/08/24 which is behind the recovery trajectory of 11 patients.

Community waiting lists is an increasing area of focus as part of the move to ensure equity and transparency of waits across all areas of healthcare. There is growth forecast in the volume of children and young people waiting more than 52 weeks in community providers for speech and language therapy. This issue is addressed with the provider through the System Oversight Group, as well as routine contract meetings.

Recommendation(s):

The Board is asked to **receive** the report for assurance regarding the progress against service delivery plans and targets.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	Provides an overview of the performance of services, including timely access, which will impact upon the outcomes in population health
Tackle inequalities in outcomes, experience and access	Provides information relating to performance viewed across health inequality population cohorts
Enhance productivity and value for money	Provides information in relation to productivity and volumes of activity being undertaken across the system
Help the NHS support broader social and economic development	Addressing long waits, ensuring patients with high clinical needs are seen quickly and supporting patients to 'wait well' while tackling long waits, will support patients to return to work where possible.

Appendices:

None.

Board Assurance Framework:

This paper provides assurance in relation to the management of the following ICB strategic risk(s):

- Risk 1: Timely and equitable access – Failure to ensure timely and equitable access to urgent and emergency care, elective and cancer care and mental health services.

Board Assurance Framework:

- Risk 2: Primary care – Failure to reduce unwarranted variation and improve access to primary medical services and pharmacy, optometry and dental (PODs) services.
- Risk 4: Quality improvement – Failure to systematically improve the quality of healthcare services.

Report Previously Received By:

The report elements have been previously reported to the Finance and Performance Committee and discussed through the System Oversight Group (A) Delivery.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Rushcliffe Arena, 09:00-12/09/24

Service Delivery Report

Key performance metric summary

1. The table below provides a summary of the key performance indicators for urgent care, planned care, mental health, primary care and community services. The table includes the latest monthly position against the plan as well as the plan for March 2025. The plan for March 2025 is included to enable current performance to be viewed alongside the year end ambition.

Programme Area	Key Metric	Metric Basis	Latest data Period	Plan	Actual	Variance	Plan Mar-25	SPC Variation	ICB Ranking	IPR Page No.
Urgent Care	Total A&E Attendances	Provider	Jul-24	34,860	36,190	1,330	35,574	Common Cause		50
Urgent Care	A&E 4hr % Performance (All types)	Provider	Jul-24	71.2%	70.0%	-1.2%	78.0%	SC Improving High	38/42	52
Urgent Care	A&E 12 Hour Waits	Provider	Jul-24	0	477	477	0	SC Improving Low		52
Urgent Care	Hospital Handover Delays >60 mins	Provider	Jul-24	0	781	781	0	SC Improving Low		51
Urgent Care	Ambulance Total Hours Lost	Provider	Jul-24	2,178	2,045	-133	0	SC Improving Low		51
Urgent Care	No. Patients utilising Virtual Ward	Population	Jul-24	209	276	67	236	SC Improving High	17/42	53
Urgent Care	Length of Stay > 21 days	Provider	Jul-24	400	358	-42	430	Common Cause		
Planned Care	104 Week Waiters	Provider	Jun-24	0	0	0	0		1/42	
Planned Care	78 Week Waiters	Provider	Jun-24	0	0	0	0	SC Improving Low	1/42	
Planned Care	65 Week Waiters	Provider	Jun-24	330	635	305	0	SC Improving Low	16/42	56
Planned Care	62 Day Backlog	Provider	Jul-24	339	313	-26	344	SC Improving Low	13/42	59
Planned Care	Cancer 28 Day Faster Diagnosis	Provider	Jun-24	78.0%	79.9%	1.9%	78.1%	Common Cause	8/42	59
Planned Care	Diagnostics 6 week %	Provider	Jun-24	71.4%	70.0%	-1.4%	84.1%	SC Improving High	34/42	60
Mental Health	Inappropriate OAPs at the end of the period	Population	Jun-24	31	40	9	0	SC Concerning High	36/42	63
Mental Health	NHS TT - Completing Treatment	Population	Jun-24	3,774	1,400	-2,374	15,097	Common Cause		62
Mental Health	NHS TT >90Days 1st & 2nd Treatment	Population	Jun-24	10.0%	59.8%	49.8%	10.0%	SC Concerning High		62
Mental Health	SMI Health Checks	Population	Jul-24	4,100	5,795	1,695	4,371	SC Improving High	27/42	64
Mental Health	CYP Eating Disorders - Urgent	Population	Mar-24	95.0%	88.0%	-7.0%	95.0%	Common Cause	11/42	65
Mental Health	CYP Eating Disorders - Routine	Population	May-24	95.0%	80.0%	-15.0%	95.0%	Common Cause	22/42	65
Primary Care	Primary Care - GP Appointments	Population	Jun-24	577,993	596,802	18,809	713,967	Common Cause		
Primary Care	Primary Care - % book 2 Weeks	Population	Jun-24	81.0%	80.6%	-0.4%	90.0%	SC Concerning Low	41/42	68
Community	52ww Community WL - Adult	Provider	Jun-24	89	92	3	65	SC Concerning High	9/42	69
Community	52ww Community WL - CYP	Provider	Jun-24	60	18	-42	118	SC Concerning High	5/42	69

To note:
Statistical Process Control (SPC) is an analytical technique that plots data over time. It enables variation that occurs naturally (Common Cause Variation) to be separated from variation that is statistically significant and therefore not due to random chance (Special Cause Variation), which is abbreviated to SC in the table above. The metrics below have been plotted in SPC charts, with the output summarised into the Statistical Process Control column. Special Cause statements indicate where there has been significant movement over the last 6 data points and provide an indication of whether the trend is improving or deteriorating. Common cause variation indicates no material movement away from the mean level.

Service delivery updates

2. The following paragraphs provide a description of the latest performance for urgent care, planned care, mental health, primary care and community services

Urgent care

3. During August the system was moved into Tier 2 support for urgent and emergency care by NHS England. This will mean additional support and reviews, which will be provided by NHS England, and also fortnightly oversight meetings with NHS England. In addition, the system has been identified as one of the areas for early implementation of the 45-minute ambulance handover approach which has been developed in the London system.

4. **Four hour waits**: In July, the system achieved 70% performance for four hour waits against a plan of 71.2%. NUH achieved 68.8% against a plan of 67%, with SFH delivering 71.7% against a plan of 76%.

5. NUH had four consecutive months of achieving the operational plan target for all accident and emergency attendance types (1,2 and 3), from April through to July. However, challenges remain on type 1 attendances which remain below the plan. (Note that a Type 1 department is a major emergency department that provides a consultant-led 24-hour service with full facilities for resuscitating patients, for example patients in cardiac arrest. Type 1 departments account for most attendances. Type 2 departments are consultant-led facilities but for specific conditions, for example, eye conditions or dental problems. Type 3 departments treat minor injuries and illnesses.)

6. NUH is continuing to try and evaluate the effectiveness of the actions implemented to identify those with the most significant impact and have re-established daily 4-hour meetings and a focused piece of work is being carried out around Eye Casualty, as a recent dip in performance has impacted on the overall 4-hour performance. Improvements have been seen in 12-hour performance and now the Trust is working towards 2-hour non-admitted breaches becoming zero tolerance.

7. **Virtual wards**: Latest published data for July shows an improved position for virtual wards at 276 beds, which is above the plan of 209 beds. The ICB places 17 of 42 nationally with 21.7 beds per 100,000 registered population (aggregate England position is 19.6 per 100,000). The occupancy level increased from 69.2% in June to 76.1% in July. The operational plan includes a target of 236 beds by March 2025.

8. **Discharge**: Improvements in discharge levels that were reported previously have been maintained at NUH, which average over 300 per day. The July position for patients that have been deemed as not meeting the necessary criteria to reside in the hospital and eligible for discharge was 273 patients

against a plan of 315 patients. At NHS system-level there is a System Discharge Board in place to enable focus on addressing these issues, which has seen performance achieve plan for the last three months.

9. In July 2024, there were 2,055 discharge delays over 30 minutes, of which 781 were above 60 minutes. Of the 60-minute delays, 774 were at NUH and seven were at SFH.

10. **Ambulance handovers**: There were 2,474 hours lost through ambulances waiting to handover patients to hospitals in Nottinghamshire in July in excess of the 30 minutes expected (15 mins pre and 15 mins post-handover time), this significantly limits the capacity of EMAS to respond to calls within a timely manner.

11. The handover clock starts when the ambulance wheels stop in the patient offloading bay and the 'Red at hospital' button is pressed on the Mobile Data Terminal. Where a patient is handed over directly from the conveying crew to hospital staff, the operational handover clock stop is when clinical handover has been fully completed and the patient has been physically transferred onto hospital apparatus. Handover times exceeding the 30 minutes are aggregated to generate the total number of lost hours from handovers.

12. In July 2024, NUH reported 1,788 lost hours from handover delays – this is the second highest reported figure of the 27 reporting hospitals in the Midlands. NUH has now had seven consecutive months of improvement, including an improvement of 1,154 since the April 2024 position. The reported lost hours account for over 13% of the total EMAS reported lost hours for July (13,294). However, this is an improvement on the June position.

Planned care

13. **78 week waits**: In June, there were 0 patients waiting 78 weeks or more across the two acute providers at the end of the month. The latest data states that by the end of August there was one 78-week waiter at SFH and 0 at NUH.

14. **65 week waits**: There were 635 patients over 65 weeks at the end of June (526 at NUH, 109 at SFH) against a plan of 330. The most recent unvalidated data indicates that NUH did not achieve the August plan. SFHT were also above their August plan position with 100 patients against a plan of 50.

15. NUH is working to identify mitigations for approximately 280 Ear Nose and Throat patients who are at risk of waiting over 65 weeks at the end of September, which highlights that there are significant risks to eliminating 65 week waits by the end of September. Despite being above plan at the end of August, SFH has forecast to achieve zero 65-week waiters by the end of September, however, are also working through specific patients at risk for the end of September position.

16. **52 week waits**: There were 4,853 patients waiting over 52 weeks at the end of June against a plan of 4,620. The most recent unvalidated data indicates that NUH and SFH are slightly behind their August plans. NUH has 3,441 patients against a 3,100 plan and SFH have 1094 patients compared to plan of 840.
17. **62-day cancer performance**: Continued improvements are seen for the 62-day backlog of cancer patients for NUH. The backlog hit the trajectory for weekending 23/08/24 with 245 against a 246 trajectory. The ambition remains to achieve the fair shares target of 233 during September. SFH continue to be under their fair shares position with a two week wait backlog of 66 against a standard of 111 patients.
18. **62-day** performance continues to improve. NUH included a seasonal reduction in the plan for August, and the current forecast of 76.9% is comfortably above the plan of 60.15%. SFH has a lower forecast at 61%, but this is a pessimistic scenario, which is likely to improve following validation as occurred in previous months. The Head and Neck service is a challenge within the system, with low percentage of patients seen within seven days at SFH. A detailed discussion at NHS system level is scheduled in early September.
19. **Diagnostics**: The total volume of patients waiting more than six weeks reduced between April and June by 476 patients. However, the backlog remains above planned levels at 8,896 against a plan of 7,056 patients. Echocardiography, MRI and Audiology are key drivers of the position due to having a high volume of patients waiting over six weeks at system level.
20. More recent data highlights that both providers were below their diagnostic operational plans in July. NUH had 68.9% of patients seen within six weeks against a plan of 70.2%. SFH had 69.7% against a plan of 75.1%. However, improvements are being seen around MRI, CT, and DEXA scans, and Echocardiography.
21. Echocardiography at SFH continues to be very challenging. The July waiting list was 3,615 patients, of which 2,249 were waiting beyond six weeks. Increased activity levels have been delivered by the Trust, which were 231 tests (16%) higher than June 2024 and 627 (61%) tests above the level delivered in June 2023. The recovery plan is based on increased activity delivery via activity delivery at Community Diagnostic Centre sites, additional over time sessions by existing staff and further insourcing. The plan at SFH for 2024/25 is to achieve 80% of patients seen within six weeks by March 2025.
22. CT performance in June at NUH had improved compared to the previous month and was above trajectory. The position for June was 81.4% of 3,670 patients waiting over six weeks against a target of 72.5%. The service expects to remain ahead of trajectory.
23. There is significant variation in the volume of patients waiting, and waiting times by modality, within the system. Detailed review of performance is undertaken at

the System Oversight Group, which includes tracking of the position against the recovery trajectories.

Mental health

24. As a programme, mental health performs well, with improvements being made across many service areas, and achievements being acknowledged by NHS England for dementia diagnosis.

25. **Talking Therapies**: NHS Talking Therapies delivered against the improvement trajectory for first to second wait in June (60% v 70% plan) and are forecasting to deliver 45% in July against a plan of 65%. The improvement plan is to return to 10% by December. Treatment numbers (three-month) rolling access performance remains under target, numbers entering treatment in May 2024 were 6,810 which is below previous months volumes. The service continues to achieve and exceed the six week (98.7%) and 18 week (100%) waiting time standards. Patients waiting over 90 days between first and second treatments continues to reduce and is currently 61 days with a median of 48 days. The total number of patients waiting over 90 days has halved since the beginning of June 2024. The Reliable Recovery target for 2024/25 is 48% and reported performance in June was 47.6% based on national data. The year-to-date position of 49.3% is above target and provisional data for July shows performance below target at 46.9% but this may change with validation. Weekly improvement meetings are being held with the provider, with a weekly improvement trajectory being developed and agreed.

26. **Children and Young People Eating Disorders**: The routine referrals are not achieving the 95% compliance; however patient volumes are small and therefore have a significant impact on the overall level of compliance. The root cause for underperformance is patient choice and the need for a Consultant Psychiatrist to attend a clinical emergency. A ‘deep dive’ is being undertaken to understand how to mitigate likelihood of these exceptions. Recovery trajectories are being developed for 2024/25.

27. **Out of Area Placements**: Local data as at 27/08/2024 indicates there were 22 Out of Area placements against an operational plan of 31. The operational plan delivers zero by the end of March 2025. There has been an increase in male bed demand over the last two months which has been challenging, however steps are in place to increase discharges allowing further repatriation of patients. For any patients admitted to an out of area bed (inappropriate or appropriate) there is an out of area case manager who works to repatriate the patients. Nationally there are limited beds available.

Primary care and community services

28. **General Practice**: The volume of Total GP Appointments in June was 3.2% above the planned level. 80.6% of appointments were offered within two weeks in June 2024, which is below the operational plan of 81%.

29. A monthly Primary Care Performance and Delivery Group has been established that monitors delivery against all primary care performance metrics, identifying specific areas of concern and practices that may need specific support for improvement. Engagement work is being undertaken with specific GP Practices, where it has been identified that there is a coding issue with how 14-day appointments are being captured, there is high confidence that as this is corrected, the system will report delivery against the 85% expected position.

30. **Community**: The plan for the volume of 52-week targets for children and young people waiting for community services for 2024/25 details material increases from 60 patients by the end of quarter one to 118 by quarter four. In June, there were 18 patients waiting over 52 weeks. All the patients are waiting for Speech and Language Therapy Services.

31. Demand and Capacity work is being undertaken on the Community Speech and Language service (SLT), which will inform the improvement plan. Similar analysis has previously been undertaken on the Autism pathway. The third element of SLT is 'Complex SLT' which is performing adequately at present. Therefore, key demand pressures are seen at Community SLT and Autism SLT. Additional recovery action plans are also in place for Podiatry and Paediatric Diabetes, which are monitored through contract meetings.

32. In June, there were 92 Adults waiting more than 52 weeks for community services in Nottinghamshire. Of these 49 of these patients are waiting for Continence/Colostomy services. The next largest group were 27 patients waiting for podiatry or podiatric surgery.

NHS Oversight Framework

33. As of 29 August 2024, our NHS system performs well across many metrics and is in the inter quartile range for most metrics, with some areas performing in the upper quartile. The areas of lowest performance are:

    a) Accident and Emergency 4 Hours

    b) Out of Area Placements

    c) Diagnostic Waits (6 weeks)

    d) GP Appointments (14 days)

34. There is a quarterly responsibility for the ICB to provide assessment recommendations for local providers to inform and support the formal assessments undertaken by NHS England as part of their regulatory

responsibilities. The output of the national assessments has been received from NHS England, which has finalised the assessments as follows for Quarter One, 2024/25:

a) ICB – National Oversight Framework (NOF) Assessment Level 3 (no change).

b) NUH – NOF Assessment Level 4 – this now relates to finance. Oversight of improvements for quality and maternity continues jointly with NHS England. (no change).

c) NHT – NOF Assessment Level 4– this has deteriorated from NOF 3 due to the significant quality challenges facing the organisation.

d) SFHT – NOF Assessment Level 2 (no change).

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/09/2024
Paper Title:	**Finance Report**
Paper Reference:	ICB 24 053
Report Author:	Clare Hopewell, Assistant Director of System Finance Ian Livsey, Deputy Director of Financer Ben Taylor, PMO Operations Manager
Report Sponsor:	Marcus Pratt, Acting Director of Finance
Presenter:	Marcus Pratt, Acting Director of Finance

Paper Type:							
For Assurance:	✓	For Decision:		For Discussion:		For Information:	

Summary:

This Finance Report focuses on the financial position of the ICB and the NHS system at the end of month four; the report draws out the key messages for the Board.

NHS system:

The system is £2 million year to date adverse to plan at month four; however, remains on forecast to deliver the year end plan of £100 million deficit. £3.9 million of the adverse variance relates to industrial action impacts and is reported in line with NHS England guidance. Continuing healthcare (CHC) and prescribing pressures are £4.5 million adverse to plan and efficiencies across the system £11 million ahead of plan. The actual deficit at month four is £70.1 million and reflects the way that planned efficiencies are profiled to deliver later in the financial year. Efficiency delivery is £11 million ahead of plan at month four with £54.5 million delivered to date. The planned efficiency forecast is to deliver £257 million savings, £2.6 million is unidentified at month end close.

ICB:

The ICB is continuing to forecast to deliver the planned £17.8 million deficit. The year-to-date position is also on plan at £5.9 million deficit. Key forecast overspending areas at this stage of the year include continuing healthcare (CHC) costs at £7.7 million, prescribing costs at £6.0 million and acute independent sector costs at £2.5 million forecast overspend. Offsetting these overspends is a forecast underspend in reserves representing the mitigating non-recurrent solutions. The ICB financial plan for 2024/25 requires the delivery of £68.5 million of efficiencies. Year to date actual delivery is £21.6 million (31.5% of the required target). Opportunities continue to be scoped to identify additional savings to support the ICB position and wider system efficiency challenges. The latest risk adjusted year end forecast against the £68.5 million target is estimated to be £54.1 million (78.9%), an increase of £3 million since last reported. Intensive work continues to mitigate delivery challenges to increase delivery confidence.

Recommendation(s):

The Board is asked to **receive** the report for assurance.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	Provides assurance on the effective use of financial resources and delivery of the financial plan, which is fully aligned to improving outcomes in population health
Tackle inequalities in outcomes, experience and access	Provides assurance on the effective use of financial resources and delivery of the financial plan, which is fully aligned to tackling inequalities
Enhance productivity and value for money	Provides direct assurance on the effective use of financial resources
Help the NHS support broader social and economic development	Provides assurance on the effective use of financial resources and delivery of the financial plan, which is aligned to broader social and economic development

Appendices:
None.

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 3: Financial sustainability – Failure to achieve financial sustainability across the system.

Report Previously Received By:
The Finance and Performance Committee has previously considered the report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Finance Report

NHS system key messages

Indicator Measure	Year to Date Plan	Year to Date Actuals	Year to Date Variance	Plan/ Ceiling/ Envelope	Forecast Outturn	Variance	RAG Year to Date	RAG Forecast Outturn
Financial Sustainability (Variance from breakeven)	-68.1	-70.1	**-2.0**	-100.0	-100.0	**0.0**	Red	Green
Pay Spend	-631.1	-630.0	**1.1**	-1847.5	-1842.1	**5.3**	Green	Green
Agency Spend vs Plan	-17.4	-17.0	**0.4**	-52.4	-54.4	**-2.0**	Green	Red
Agency Spend vs Ceiling		-17.0		-63.5	-54.4	**9.1**		Green
Whole Time Equivalent (Provider) - 24/25 plan as at 31.03.25	34,456	34,091	**-365**				Green	
Financial Efficiency vs Plan	43.5	54.5	**11.0**	257.0	257.0	**0.0**	Green	Green
Recurrent Efficiencies	31.5	39.1	**7.6**	201.5	195.0	**-6.5**	Green	Red
Achievement of Mental Health Investment Standard		72.4		217.8	217.8	**0.0**		Green
Capital Spend vs System Envelope	25.8	16.2	**-9.6**	91.5	91.5	**0.0**	Red	Green
Elective Recovery Fund Performance	119%	118%	**-1%**	120%	120%	**0%**	Red	Green

1. The NHS system has a reported a £70.1 million deficit at month four, which is £2 million adverse to plan against the June plans submitted.
2. The system forecast remains in line with June plans (£100 million deficit).
3. £3.9 million of the adverse variance relates to industrial action impacts and is reported in line with NHS England guidance. Continuing healthcare (CHC) and prescribing pressures are £4.5 million adverse to plan and efficiencies across the system are £11 million ahead of plan.
4. The actual deficit at month four is £70.1 million and reflects the way that planned efficiencies are profiled to deliver later in the financial year.

By Organisation £000	Year to date Plan	Year to date Actuals	Year to date Variance	In-month Plan	In-month Actuals	In month Variance	Total full Year Plan	Forecast Outturn	Variance
Nottingham University Hospitals	-33.4	-36.5	-3.1	-4.6	-5.8	-1.3	-51.6	-51.6	0.0
Sherwood Forest Hospitals	-11.4	-12.3	-0.9	-1.0	-1.4	-0.3	-14.0	-14.0	0.0
Nottinghamshire Healthcare	-17.4	-15.3	2.1	-4.4	-2.4	2.0	-16.5	-16.5	0.0
Nottingham and Nottinghamshire ICB	-5.9	-5.9	0.0	-1.5	-1.5	0.0	-17.8	-17.8	0.0
TOTAL	**-68.1**	**-70.1**	**-2.0**	**-11.5**	**-11.1**	**0.4**	**-100.0**	**-100.0**	**0.0**

5. **Debt**: £46.4 million will be added to the NHS system’s cumulative debt, which will need to be repaid in future years.

6. **Workforce**: Staff costs are £1.1 million underspent across the NHS system at month four with whole time equivalents (WTEs) being 365 WTEs lower than plan. Agency spend is £17 million, which is £0.4 million under the year-to-date plan. Agency plans are £11.2 million below the agency cap and across the NHS system 2.7% of the total pay bill.

7. **Efficiencies**: The year-to-date position includes £54.5 million of efficiency. All organisations within the NHS system continue to work up financial recovery plans, as the risk on the delivery of the efficiency plan target of £257 million remains high.

8. **Investigation and Intervention Process**: The Nottingham and Nottinghamshire ICS is one of nine NHS systems nationally that has been required to commission a delivery partner to support delivery of the 2024/25 financial plan. The ICB has engaged P.A Consulting to undertake this work. Phase one of this process has focussed on stress-testing plans to identify and quantify the key risks to delivery. Working with NHS system partners, the investigation phase has identified further opportunities and high impact interventions to accelerate and support delivery of the financial plan.

9. **Financial Risk**: In addition to efficiency delivery, there are also risks around growth and price increases relating to CHC and risks around pay awards, inflationary pressures and potential ongoing industrial actions.

10. **Governance and Oversight**: The NHS system has enhanced its efficiency governance and oversight arrangements. All organisations have financial sustainability boards/groups with senior ICB attendance. This feeds into the NHS System Financial Recovery Group, which scrutinises and oversees the efficiency and finance position weekly.

11. **Capital Envelope**: The NHS system submitted a capital envelope plan of £80.3 million, which included a deduction of £8.2 million from the initial capital

envelope allocation of £88.5 million. The reduction in capital available being one of the implications of the NHS system having a deficit financial plan.

12. This will have a real impact on the NHS system being able to utilise capital monies to support the capital schemes already expected to be delivered in 2024/25 and will require close monitoring and prioritisation by the NHS system Provider Collaborative to ensure delivery within the revised envelope.

13. The system has also been allocated an additional £11.2 million to support the impact of IFRS16 with external bodies. With that addition, the total capital envelope to £91.5 million. Spend year-to-date against the revised NHS system capital envelope of £91.5 million is £16.2 million, and against the total Capital Departmental Expenditure Limit Plan of £199.2 million, is £33.2 million.

ICB key messages

Key financial Performance Indicator	Target	Year to Date	Forecast
Deliver Planned Surplus/Deficit	£17.8 million deficit full year	£5.9 million deficit (on plan)	£17.8 million deficit
Deliver Income and Expenditure Breakeven	Breakeven	£5.9 million deficit	£17.8 million deficit
Achieve Mental health Investment Standard	Spend in Full	On target	On target
Deliver Better Payment Practice Code Targets	›95% all categories	›95% all categories	›95% all categories
Do not Exceed Capital Allocation	Spend ‹£2.02 million	On target	On target
Do not exceed Running Cost Allowance (RCA)	Running Cost spend <£19.2 million	On target	On target
Deliver Efficiency Target	Deliver £68.5 million	On target	On target

14. The ICB is continuing to forecast to deliver the planned £17.8 million deficit. The year-to-date position is also on plan at £5.9 million deficit.

15. Key forecast overspending areas include CHC costs, prescribing costs and acute independent sector costs. Offsetting these overspends is a forecast underspend in delegated services (GP contracts: pharmacy, optometry and dental (PODs) services) alongside offsetting adjustments in reserves that represent mitigating non recurrent solutions.

16. The overall efficiency target of £68.5 million is currently forecast to be delivered in full. That target has now been allocated to programme areas and the full year forecast position is based on agreed savings schemes delivering in full. Risk of non-delivery is captured within the ICB's risks and mitigations log. As previously reported, the savings and efficiency governance process that support the delivery of the efficiency target is fully in operation.

17. A number of risks exist in delivering the reported position. Delivery of the efficiency target being the key risk (£24 million). In addition, there are risks on price and activity growth in spend lines associated with continuing healthcare

services, prescribing and estates inflation (£18 million). At this stage there are mitigations to cover off these risks to give a neutral net risk position.

18. The ICB has utilised £1,010 million or 34.2% of its 2024/25 of its cash draw down requirement of £2,950 million. This compares to an expected utilisation of 33.3%. The cash balance held as of 31 July was £0.616 million compared to a maximum target balance of £2.91 million.

19. Better Payment Practice Code (BPPC). The ICB met all its BPPC targets of paying at least 95% by value and volume of invoices within 30 days for the end of the reporting period.

20. The ICB capital programme of £2.0 million is currently forecast to be spent in full.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/09/2024
Paper Title:	**Committee Highlight Reports**
Paper Reference:	ICB 24 054
Report Author:	Committee Secretariat
Report Sponsor:	ICB Committee Chairs
Presenter:	ICB Committee Chairs

Paper Type:							
For Assurance:	✓	For Decision:		For Discussion:		For Information:	

Summary:

This report presents an overview of the work of the Board's committees since the last Board meeting in July 2024. The report aims to provide assurance that the committees are effectively discharging their delegated duties and to highlight key messages for the Board's attention. The report includes the committees' assessments of the levels of assurance they have gained from the items received and any actions instigated to address any areas where low levels of assurance have been provided.

Also included is a summary of the high-level operational risks currently being oversighted by the committees. All committees of the ICB Board have a responsibility to oversee risks relating to their remit and ensure that robust and timely management actions are being taken in mitigation. As such, all committee meetings have risk as a standing agenda item.

Recommendation(s):

The Board is asked to **receive** the report for assurance.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	The Board's committee structure has been designed to provide assurance to the Board that statutory duties and responsibilities in line with the core aims are being effectively discharged.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:

A: Highlight Report from the Strategic Planning and Integration Committee
B: Highlight Report from the Quality and People Committee
C: Highlight Report from the Finance and Performance Committee
D: Current high-level operational risks being oversighted by the Board's committees

Board Assurance Framework:
The Board's committees scrutinise assurances in relation to the strategic risks for which they are the 'lead' committee and escalate levels of assurance to the Board via this consolidated highlight report.

Levels of assurance:	
Full Assurance	The report provides clear evidence that: • Desired outcomes are being achieved; and/or • Required levels of compliance with duties is in place; and/or • Robust controls are in place, which are being consistently applied. Highly unlikely that the achievement of strategic objectives and system priorities will be impaired. No action is required.
Adequate Assurance	The report demonstrates that: • Desired outcomes are either being achieved or on track to be achieved; and/or • Required levels of compliance with duties will be achieved; and/or • There are minor weaknesses in control and risks identified can be managed effectively. Unlikely that the achievement of strategic objectives and system priorities will be impaired. Minor remedial and/or developmental action is required.
Partial Assurance	The report highlights that: • Achievement of some outcomes are off-track or mechanisms for monitoring achievement in some areas have yet to be established/fully embedded; and/or • Compliance with duties will only be partially achieved; and/or • There are some moderate weaknesses that present risks requiring management. Possible that the achievement of strategic objectives and system priorities will be impaired. Some moderate remedial and/or developmental action is required.
Limited Assurance	The report highlights that: • Achievement of outcomes will not be achieved or are significantly off-track for achievement; and/or • Compliance with duties will not be achieved; and/or • There are significant material weaknesses in control and/or material risks requiring management. Achievement of strategic objectives and system priorities will be impaired. Immediate and fundamental remedial and/or developmental action is required.

Report Previously Received By:
Not applicable.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Appendix A: Strategic Planning and Integration Committee Highlight Report

Meeting Dates:	05 September 2024
Committee Chair:	Jon Towler, Non-Executive Director

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
NHS Nottingham and Nottinghamshire Joint Forward Plan (JFP): assurance of delivery	The Committee received the first bi-annual progress update on delivery of the key milestones, with a focus on the areas of prevention and timely access and early diagnosis for cancer and elective care. Whilst delivery of the milestones for the focus areas was progressing, the need to achieve financial sustainability across the NHS meant that there would be changes to currently commissioned services that may impact future delivery of the plan. Work would be taken forward at pace to determine which deliverables must continue and which could be re-scheduled in preparation for the 2025/26 JFP refresh. The JFP Delivery Group would continue to provide leadership to the delivery of the plan to ensure that there was clarity over the deliverables and the outcomes they would achieve, and to shape the Target Operating Model for the System to define how the JFP would be delivered through neighbourhood, place, and system working. Members applied a partial assurance rating as there was not yet a clear link between the delivery of the key milestones and improved outcomes.	**Partial**	**Not applicable**

Matters of interest:

The Committee also received and discussed:

a) A progress update on the mobilisation, implementation, and evaluation of the 2023/24 Health Inequalities and Innovation Fund (HIIF) schemes, and the process for the 2025/26 HIIF, which would be in line with financial planning. Members supported the prioritisation of an independent evaluation of the 2025/26 HIIF schemes to support decision making around the potential continuation of schemes.

b) An update on the response to General Practice collective action. The impact of collective action would continue to be monitored and assessed daily to ensure a timely response, with developed contingency plans being invoked if required.

c) The East Midlands Fertility Policy Review Case for Change and supported the proposed next stage of the process, which would be to move to pre-engagement, once the five East Midlands ICBs had agreed to proceed.

d) The Interpretation and Document Translation Service Review. The service review would be considered by the Board in September 2024, along with feedback from the Committee.

e) A comprehensive update on the risks relating to the Committee's remit (attached for the Board's information at Appendix D)

f) The Log of Investment, Disinvestment, Procurement and Contract Award Decisions (Healthcare) 2024/25, which provided a summary of all such decisions made during the year to date.

Appendix B: Quality and People Committee Highlight Report

Meeting Dates:	17 July 2024
Committee Chair:	Marios Adamou, Non-Executive Director

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. Quality Oversight Report	The focus of discussion was related to Nottinghamshire Healthcare NHS Foundation Trust (NHT) given the imminent publication of the Section 48 investigation report. Members were satisfied that progress and improvement were evident, although were fully aware of the scale of challenges to be addressed. Members were informed that following the Care Quality Commission (CQC) inspection of maternity services at Nottingham University Hospitals NHS Trust (NUH), several concerns had been raised, particularly in relation to staffing and skill mix. A system roundtable meeting would be set up during August 2024 to look at the support requirements of the long term improvement programme for maternity services. The ongoing discussions with Nottingham CityCare related to the quality and delivery of services was also spotlighted by members. Members were pleased to hear that CityCare's engagement with the ICB had improved. Members specifically requested that future reports provide clarity with regard to changes that had taken place since the last report to enable tracking of tangible evidence of delivery.	**Limited**	**Limited** *Awarded at the meeting held on 19 June 2024.*
2. Primary Medical Services Quality Report	This scheduled report was well received by members who found that it provided the necessary level of detail and evidence to reach a level of	**Adequate**	**Adequate**

Item	Summary	Level of assurance	Previous level of assurance
	assurance. It was suggested that further reports would benefit from explicit links to the Primary Care Strategy. Two emerging areas of risk and challenge were highlighted as the potential for General Practice industrial action and the requirement for Primary Care to implement the Patient Safety Incident Response Framework (PSIRF). The timeline for the latter was currently unknown and guidance from NHS England (NHSE) was awaited.		*Awarded at the meeting held in January 2024.*
9. Delivery of 2024/25 Workforce Plan (Month two)	Members raised significant concern regarding the content and quality of the report and as such, were not assured in respect of delivery of the workforce plan. Whilst verbal assurances were provided across a number of areas, it was agreed that the feedback from members would be implemented to ensure that the routine report met the Committee's requirements.	**Limited**	**Partial** *Awarded at the June 2024 meeting.*

Other considerations:

Decisions made:
a) Approved the updated Safeguarding Policy. The policy included the required updates resulting from 'Working Together to Safeguarding Children 2023' and included a new control record and updated Equality Impact Assessment. b) Approved the updated Complaints and Enquiries policy. The update had incorporated recommendations from the recent internal audit review. c) Approved the ICB Corroborative Statement to be inserted into Quality Accounts for: Nottingham CityCare, Primary Integrated Community Services (PICS) and Woodthorpe Hospital. d) Endorsed the process for undertaking Equality and Quality Impact Assessments in support of the financial recovery plan. Members were assured by the very comprehensive process described and had confidence that the process would enable comprehensive assessments of the impact of proposed service changes.

Information Items and Matters of interest:
The Committee also: a) Reviewed identified risks relating to its areas of responsibility. The number of risks remained high, at 51, with 19 of those risks graded as high risks. An action was agreed for risk mitigations to be reviewed to ensure they included the necessary level of detail. The risks are provided for the Board's information at Appendix D.

Appendix C: Finance and Performance Committee Highlight Report

Meeting Dates:	31 July 2024
Committee Chair:	Stephen Jackson, Non-Executive Director

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. 2024/25 System and ICB Finance Report (M3)	At month three, the system reported a deficit of £59 million, which was £2.4 million adverse to the year-to-date plan. Members were reminded that the system had agreed to a £100 million deficit Revenue Financial Plan Limit with NHSE, with the expectation that this would be supported by a matching non-recurrent allocation, provided costs remained within the plan. Delivery of efficiency savings were £4.1 million ahead of plan by month three, with £33 million in efficiencies achieved. The forecast for the year remained at £257 million. The system risk assessment for the 2024/25 forecast showed a potential gross deficit of £124.2 million against the plan, with a net deficit of £24.9 million after mitigation, representing a £19 million reduction in net risk from the month two position. The ICB continued to forecast delivery of its planned £17.8 million deficit. The year-to-date position was on plan at a £4.4 million deficit. The ICB forecasted areas of overspend remained in continuing healthcare costs, prescribing costs, and acute independent sector costs. These were partially offset by a forecasted underspend in reserves. Members noted with concern that it was assumed that further costs and impact related to industrial action would need to be absorbed locally.	**Partial**	**Limited** *Awarded at the meetings between March and June 2024.*

Item	Summary	Level of assurance	Previous level of assurance
	Additional concern related to the potential cost pressure had been identified following the recent announcement of a 5.5% pay award for NHS staff. The partial assurance rating recognised the progress to date but remaining caution around full year delivery.		
2. Delivery of the 2024/25 financial plan	Following a request by the Board, the report had been provided to enable members to offer a view on assurance regarding the credibility of efficiency plans to deliver the £100 million deficit for 2024/25. A system approach had been taken to develop plans to bridge the gap in unidentified efficiencies and address the shortfall in delivery confidence of plans. At this point in time, comprehensive plans had been developed by the ICB, NUH and Sherwood Forest Hospitals NHS Foundation Trust (SFH). The NHT plan had addressed the efficiencies gap but further work was required around risks to delivery of their plans. At month three, efficiency plans remained ahead of plan with £33 million delivered against the £28.9 million target. However, plans were profiled towards the tail end of the financial year. Month three delivery represented 13% of the annual target after 25% of the year. Members were pleased to see the progress made to date; the risk adjusted figure had reduced from £100 million to £85 million but it was recognised that there remained significant work to do. The approach had enabled system partners to think more collaboratively in respect of matters such as vacancy controls, service review and decommissioning plans. There was a commitment for organisations to work together in additional areas such as, consistency of approach to subsidised staff meals and car parking income, reviewing high cost, low volume services	**Partial**	**Not applicable**

Item	Summary	Level of assurance	Previous level of assurance
	for the potential for consolidation, seeking a collaborative solution to direct access pathology and identifying areas for back-office collaboration. Members were assured that progress had been made but on the basis of current plans and evidence of delivery, the Committee could not provide the Board with an assurance level higher than partial.		
3. Operational Plan 2024/25 Delivery (M3) and Service Delivery report	In July 2024, members received reports highlighting areas of improvement and challenges. Improvement in performance was noted, and confidence in the achievement of quarter two plans. Significant progress was reported with regard to Cancer performance, waiting lists and mental health out of area placements. The position regarding Urgent and Emergency Care (UEC) was showing sustained improvement at NUH, following a fourth consecutive month delivered to plan. SFH had reported periods of good performance in respect of UEC, but reaching this on a sustained level was proving challenging. Ambulance handovers had also improved although remained unstable at times. Members welcomed the report, acknowledging the improvements and recognising the areas requiring continued focus, notably ambulance handovers and some areas of performance at SFH. The overall assurance rating remained at partial, reflecting the sustained improvements and increased confidence in plans to improve performance further.	**Partial**	**Partial** *Awarded at the June 2024 meeting.*
4. Digital, Data and Technology Strategy Report	Members were assured about the progress in implementing the Digital, Data, and Technology strategy. Significant advancements were reported across the four active NHS digital priorities. Both priority one (public-facing digital services) and priority two	**Adequate**	**Adequate** *Awarded at the February*

Item	Summary	Level of assurance	Previous level of assurance
	(digital and social inclusion) were rated green, while priority three (frontline digitisation) and priority four (interoperability) received an amber rating. There was also an emphasis on strategy development and enhancing programme governance. The team continued to successfully secure additional funding and worked closely with the ICB finance team to support the financial recovery programme. However, a risk persisted regarding Nottingham City Council's readiness to share social care data with the Notts Care Record (NCR). The NCR aims to integrate records across clinical and social care settings. Despite programme funding being allocated, several issues remain unresolved. The risk is being escalated, and the Programme Team is collaborating with Nottingham City Council to address the outstanding actions.		*2024 meeting.*

Other considerations:

Decisions made:
a) Members **endorsed** the final draft ICS Infrastructure Strategy ahead of submission to NHSE and presentation to the Board in September 2024, noting that further work would focus on the new requirement to submit a capital workbook.
Matters of interest:
a) The Operational Risk Register included 16 risks, with seven rated as high risks. The risks are provided for the Board's information at Appendix D.

Appendix D: Current high-level operational risks being oversighted by the Board's committees

Risk Ref.	Risk Description	Current Score	Responsible Committee
ORR084	If organisations within the Nottingham and Nottinghamshire system are unable to access IT systems, they may not be able to conduct core business as usual functions. This may result in patients not receiving timely diagnosis or treatment due to necessary equipment not functioning or patient records being unavailable.	**High** 20 (I4 x L5)	Audit and Risk Committee
ORR090	If the Nottingham and Nottinghamshire system does not have sufficient system partner 'buy in' and capacity to engage with and deliver transformation schemes alongside business-as-usual delivery it may not be possible to progress the system, primary care and ICB digital transformation agenda.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR195 (NEW)	If NHS Nottingham and Nottinghamshire ICB is unable to identify and implement sustainable recurrent financial efficiency solutions, at pace, there is a risk the ICB's underlying position (UDL) will continue to worsen with impact to the ability to deliver within the ICB's financial resources.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR196 (NEW)	If the Nottingham/shire NHS system, as a collective, does not meet its agreed 2024/25 year-end financial position, there is a risk to the extent to which the system will be able to create financial 'headroom' to invest in services. This may lead to reputational issues and increasing levels of regional and national intervention by NHS England.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR197 (NEW)	If the Nottingham/shire NHS system, as a collective is unable to identify and implement sustainable recurrent financial efficiency solutions, at pace, there is a risk the collective underlying position (UDL) will continue to worsen, which may significantly impact Nottingham/shire's ability to become a financially sustainable system.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR210 (NEW)	As a result of ongoing operational and financial pressures, there is a risk to further deterioration in staff health, wellbeing and morale. This may impact on staff productivity and lead to staff feeling disconnected or disengaged with the ICB. This may, in turn, result in further increases to levels of sickness and vacancies within the organisation.	**High** 16 (I4 x L4)	Human Resources Executive Steering Group
ORR191	If Nottinghamshire Healthcare NHS Foundation Trust (NHCT) do not have the capability to make the required quality improvements identified as a result of current quality, staffing and performance concerns and exacerbated by regional and national reviews, there is a	**High** 20 (I4 x L5)	Quality and People Committee

Risk Ref.	Risk Description	Current Score	Responsible Committee
	risk the quality of services provided may not meet optimal care standards. This may lead to potential risk of harm and poor health outcomes to the population of Nottingham/shire.		
ORR024	If Nottingham University Hospitals NHS Trust (NUH) do not have the capacity to make improvements in a timely manner (following CQC visits), the quality of services provided may not meet optimal care standards resulting in poor patient experience and adverse health outcomes for the population of Nottingham/shire.	**High** 16 (I4 x L4)	Quality and People Committee
ORR061	If demand outstrips the system's capacity to promptly treat cancer, people may wait longer for treatment, which may lead to poor patient outcomes and experience. This risk is further exacerbated by industrial action.	**High** 16 (I4 x L4)	Quality and People Committee
ORR077	If current challenges in the health and social care system continue there is a risk of sustained levels of significant workforce pressures which may lead to sickness, exhaustion, 'burn out' and inability to maintain psychological safety of workforce.	**High** 16 (I4 x L4)	Quality and People Committee
ORR083	If discharges from learning disability and autism inpatient settings are delayed due to lack of available capacity in community-based settings, patients may stay in inpatient settings longer than necessary. This may lead to poor patient experience and adverse health outcomes for the population of Nottingham/shire.	**High** 16 (I4 x L4)	Quality and People Committee
ORR092	If the system is unable to provide timely diagnostics, due to increased demand and/or capacity constraints, this may adversely impact patient health outcomes.	**High** 16 (I4 x L4)	Quality and People Committee
ORR101	If pressures on elective activity persist, due to capacity constraints and non-elective demand, there is a significant risk that planned care waiting times will increase further. This may in turn present a risk of patient deterioration and deconditioning (physical or cognitive functions), leading to increased levels of morbidity and mortality. This risk is further exacerbated by industrial action.	**High** 16 (I4 x L4)	Quality and People Committee
ORR170	If insufficient availability of mental health inpatient beds continues, there is a risk that individuals may face delayed or inadequate treatment or be transferred for care in an 'out of area' setting, which may result in increased distress, potential harm to themselves or others, or a higher likelihood of crisis situations.	**High** 16 (I4 x L4)	Quality and People Committee
ORR171	If capacity issues continue, there is a risk of not being able to facilitate timely discharge of individuals requiring ongoing mental health support once their medical or physical issues	**High** 16 (I4 x L4)	Quality and People Committee

Risk Ref.	Risk Description	Current Score	Responsible Committee
	have resolved, which may lead to delays in discharge, potentially exacerbating current challenges across the urgent and emergency care pathway.		
ORR177	If system workforce planning remains short-term, due to operational and financial challenges, there is risk that it may not address medium to longer term strategic education and planning needs. This may lead to issues with initial workforce supply and ineffective use of workforce. This risk is exacerbated by challenges experienced in getting system data into a single place to support ICS workforce planning and projections.	**High** 16 (I4 x L4)	Quality and People Committee
ORR179 (NEW)	If there are insufficient funding allocations and/or uncertainties regarding reimbursement rates, the imposition of the 2024/25 GP Contract may impact the financial sustainability of GP practices. This may increase the likelihood of contracts being 'handed back' and non-delivery of local enhanced services, potentially presenting a risk to access and health outcomes for the local population.	**High** 16 (I4 x L4)	Quality and People Committee
ORR199 (NEW)	If GPs participate in collective action, there may be a risk to primary care and community pharmacy service delivery. This may lead to the potential for harm to citizens in terms of management of chronic conditions and urgent medical concerns. Furthermore, this may lead to Increased activity at other providers with the potential for wider patient safety impacts.	**High** 16 (I4 x L4)	Quality and People Committee
ORR023	If Nottingham University Hospitals NHS Trust (NUH) do not have the capability to make improvements in a timely manner following CQC recommendations, the quality of maternity services provided may not meet optimal care standards resulting in poor patient experience and adverse health outcomes for the population of Nottingham/shire.	**High** 15 (I5 x L3)	Quality and People Committee
ORR208 (NEW)	If the quality of maternity services does not improve, services provided may not meet optimal care standards. This may result in potential risk of harm (i.e. physical and psychological) and poor patient experience for women, birthing people, their babies, and families.	**High** 15 (I5 x L3)	Quality and People Committee
ORR155	If the transformation of urgent and emergency care services is not prioritised and delivered, there is a risk that limited health and social care resources may not be used most efficiently. This may lead to an inability to meet demand: today and in the future.	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee
ORR159 (NEW)	If General Practices, Primary Care Networks and the ICB do not have appropriate capacity, capability and resources to deliver the actions identified in the ICS Primary Care Strategy and Primary Care Access Recovery Plan (PCARP) this may result in an inability	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee

Risk Ref.	Risk Description	Current Score	Responsible Committee
	for these approaches to be delivered. This may in turn impact on the ability to meet the needs of our population.		
ORR182 (NEW)	If the imposition of the 2024/25 GP Contract and associated GP collective action impacts on partnership working, there may be a risk to primary care engagement which may impact on collaboration with ICS strategic and transformation programmes.	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee
ORR192	If resources at Nottinghamshire Healthcare NHS Foundation Trust (NHCT) are primarily focused on addressing immediate quality, staffing and performance concerns, there is risk that there may not be sufficient capacity or 'headspace' to deliver mental health and community service transformation. This may result in future population needs not being made and/or anticipated efficiencies not materialising.	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee

NHS Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/09/2024
Paper Title:	**Board Annual Work Programme 2024/25**
Paper Reference:	ICB 24 055
Report Author:	Lucy Branson, Director of Corporate Affairs
Executive Lead:	-
Presenter:	-

Paper Type:							
For Assurance:		For Decision:		For Discussion:		For Information:	✓

Summary:
The purpose of this item is to provide the Board's Annual Work Programme 2024/25 for Member's information at each meeting.

Recommendation(s):
The Board is asked to **note** this item for information.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	The ICB's governance arrangements ensure appropriate oversight and decision-making with regard to achievement of the core aims.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:
Appendix A – Annual Work Programme 2024/25 Appendix B – Purpose and content of agenda items

Board Assurance Framework:
Not applicable.

Report Previously Received By:
Not applicable.

Are there any conflicts of interest requiring management?
No

Is this item confidential?
No

Appendix A

2024/25 Board Work Programme

"Every person enjoying their best possible health and wellbeing"

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

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

Our core values:

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

Agenda item (See Annex 1 for purpose and content)	09 May	11 Jul	12 Sep	14 Nov	09 Jan	13 Mar	Link to BAF	Notes
Introductory items	✓	✓	✓	✓	✓	✓	Not applicable	See note 1
Leadership and operating context								
Chair's Report	✓	✓	✓	✓	✓	✓	Strategic risk 10	See note 2
Chief Executive's Report	✓	✓	✓	✓	✓	✓	Strategic risk 9 and 10	See note 3
Strategy and partnerships								
Joint Forward Plan and Outcomes Framework	✓	✓	✓	-	-	✓	Strategic risk 1, 2, 3, 4, 5	See note 4
Joint Capital Resource Use Plan	✓	-	-	-	-	✓	Strategic risk 3 and 8	See note 5

Agenda item (See Annex 1 for purpose and content)	09 May	11 Jul	12 Sep	14 Nov	09 Jan	13 Mar	Link to BAF	Notes
VCSE Alliance Report	✓	-	-	✓	-	-	Strategic risk 9	See note 6
Research Strategy	-	✓	-	-	-	-	Strategic risk 5	See note 7
Infrastructure Strategy	-	✓	-	-	✓	-	Risk 8	See note 8
Working with People and Communities	-	✓	-	-	-		Risk 4, 5 and 9	See note 9
Strategic Commissioning Report	-	-	✓	-	-	-	Strategic risk 1, 2 and 5	See note 10
Clinical and Care Professional Leadership	-	-	-	✓	-	-	Strategic risk 6, 9 and 10	See note 11
HealthWatch Report	-	-	-	-	✓	-	Risk 4, 5 and 9	See note 12
2025/26 Operational and Financial Plan	-	-	-	-	-	✓	Strategic risk 1, 2, 3, 4, 5	See note 13
2025/26 Opening Budgets	-	-	-	-	-	✓	Risk 3	See note 14
NHS England Delegations	-	-	-	-	-	✓	Strategic risk 9	See note 15
Provider Collaborative	-	-	-	✓	-	-	Strategic risk 1, 6, 10	See note 28
Delivery and system oversight								
Health Inequalities Statement	✓	-	-	-	-	-	Strategic risk 1, 2, 4 and 5	See note 16
Meeting the Public Sector Equality Duty	-	✓	-	-	-	-	Strategic risk 1, 2, 4, 5 and 6	See note 17
People Plan	-	-	✓	-	-	-	Risk 6	See note 18
Digital, Data and Technology Strategy	-	-	-	-	✓	-	Risk 7	See note 19
Green Plan	-	-	-	-	✓	-	Risk 8	See note 20
Quality Report	✓	✓	✓	✓	✓	✓	Risk 4	See note 21
Service Delivery Report	✓	✓	✓	✓	✓	✓	Risk 1 and 2	See note 22
Delivery plan for recovering access to primary care	✓	-	-	✓	-	-	Risk 2	See note 23
Finance Report	✓	✓	✓	✓	✓	✓	Risk 3	See note 24
Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity	-	-	-	✓	-	-	Risk 9	See note 29
Governance								

Agenda item (See Annex 1 for purpose and content)	09 May	11 Jul	12 Sep	14 Nov	09 Jan	13 Mar	Link to BAF	Notes
Committee Highlight Reports	✓	✓	✓	✓	✓	✓	All risks	See note 25
Board Assurance Framework	✓	-	-	✓	-	-	Not applicable	See note 26
Closing items	✓	✓	✓	✓	✓	✓	Not applicable	See note 27

Board Seminars and Development Sessions, and ICS Reference Group Meetings:

Topic	11 Apr	30 May	13 Jun	16 Sep	10 Oct	12 Dec	16 Dec	13 Feb	17 Mar
Development Session: • 2024/25 priorities and strategic risks • Governance self-assessments • Race health inequalities maturity matrix • Development of place-based partnerships	✓	-	-	-	-	-	-	-	-
ICS Reference Group: • 2024/25 operational and financial commitments • ICS People Plan	-	✓	-	-	-	-	-	-	-
Board Seminar: • ICS People Plan • Development of the provider collaborative	-	-	✓	-	-	-	-	-	-
ICS Reference Group: • Health inequalities and proactive care System risk management and risk appetite	-	-	-	✓	-	-	-	-	-
Board Seminar: • Mental health • Primary care (primary medical services and pharmacy, optometry and dental services)	-	-	-	-	✓	-	-	-	-

Topic	11 Apr	30 May	13 Jun	16 Sep	10 Oct	12 Dec	16 Dec	13 Feb	17 Mar
Board Seminar: • Population health management approach to frailty • Working with people and communities	-	-	-	-	-	✓	-	-	-
ICS Reference Group: • Planning for 2025/26 (operational and joint forward plans)	-	-	-	-	-	-	✓	-	-
Development Session: • Board effectiveness/ maturity	-	-	-	-	-	-	-	✓	-
ICS Reference Group: • Social and economic development • Research	-	-	-	-	-	-	-	-	✓

Annex 1: Purpose and content of agenda items

No.	Agenda item	Purpose
1.	**Introductory items**	This section of the meeting will include: • A copy of members' registered interests for consideration and agreement of how any real or perceived conflicts of interest are required to be managed. • The previous meeting's minutes for agreement (and any matters arising). • The Board's Action Log for review.
2.	**Chair's Report**	To present a summary briefing for Board members of the Chair's reflections, actions and activities since the previous Board meeting. As appropriate, this will include updates on key governance developments, and on an annual basis this will present the Board's Annual Work Programme and include a review of the skills, knowledge and experience of Board members (when taken together) to ensure the Board can effectively carry out its functions.
3.	**Chief Executive's Report**	To present a summary briefing on recent local and national developments and areas of interest for Integrated Care Boards (ICBs) and the wider Integrated Care System (ICS), along with key updates from system partners, including the Integrated Care Partnership, Health and Wellbeing Boards and the East Midlands Joint Committee. On a quarterly basis, the reports will include the latest segmentation ratings under the NHS Outcomes Framework. The report will include key updates regarding the ICB's workforce on a periodic basis, including NHS staff survey results, freedom to speak up, equality performance and wider workforce indicators. As appropriate, the report may also include specific items requiring approval or for noting by Board members.
4.	**Joint Forward Plan and Outcomes Framework**	**May 2024** – To present the ICB's Joint Forward Plan for 2024/25 for approval (prepared with partner NHS trusts and NHS foundation trusts) setting out how the ICB will exercise its functions over the next five years. A draft Strategic Outcomes Framework will also be presented for review. **July 2024** – To present the final proposed Strategic Outcomes Framework for approval (action from May meeting). **September 2024** – To present a mid-year strategic delivery update on the key areas that provide the greatest opportunity to improve population health and achieve the ICS principles of principles of integration, equity and prevention, as defined within the Joint Forward Plan. The final Strategic Outcomes Framework will also be presented. **March 2025** – To present a strategic delivery report for 2024/25, which will consider the steps the ICB has taken to implement the Joint Local Health and Wellbeing Strategies. The annual refresh of the Joint Forward Plan for 2025/26 will also be presented for approval. Development and delivery of the plan will be overseen by the Strategic Planning and Integration Committee. The Director of Integration is the executive lead for strategic planning.
5.	**Joint Capital Resource Use Plan**	To present the Joint Capital Resource Use Plan for approval (prepared with partner NHS trusts and NHS foundation trusts). Development and delivery of the plan will be overseen by the Finance and Performance Committee (delivery reports for the Board included in the routine Finance Reports – see 24 below). The Director of Finance is the executive lead for capital planning.

No.	Agenda item	Purpose
6.	VCSE Alliance Report	**May 2024** – To receive a report summarising the work of the Nottingham and Nottinghamshire VCSE Alliance. **November 2024** – To receive a brief update on the areas identified for further focus (action from May meeting).
7.	Research Strategy	To present the ICS Research Strategy for approval. This will include a summary of the key achievements in this area since the ICB's establishment. Development and delivery of the strategy will be overseen by the Strategic Planning and Integration Committee. A further strategic delivery update will be scheduled for the Board in 2025/26. The Medical Director is the executive lead for research.
8.	Infrastructure Strategy	To present the ten-year ICS Infrastructure Strategy for approval. **July 2024** – item deferred, now scheduled to be received at the September Board meeting. Development and delivery of the strategy will be overseen by the Finance and Performance Committee. A further strategic delivery update will be scheduled for the Board in 2025/26. The Director of Finance is the executive lead for estates.
9.	Working with People and Communities	To present an annual report on the ICB's arrangements for working with people and communities. This will be reviewed by the Strategic Planning and Integration Committee prior to presentation to Board. The Chief Executive is the executive lead for working with people and communities.
10.	Strategic Commissioning Report	To present relevant updates to the Board regarding developments and decisions across the ICB's commissioning portfolio, including commissioning functions delegated by NHS England to the ICB. The Strategic Planning and Integration Committee will oversee the ICB's strategic commissioning responsibilities during the year. The Director of Integration is the executive lead for commissioning.
11.	Clinical and Care Professional Leadership	To present a report on the clinical and care professional leadership arrangements established across the Integrated Care System. The Medical Director is the executive lead for clinical and care professional leadership.
12.	HealthWatch Report	To receive a report summarising the work of HealthWatch Nottingham and Nottinghamshire.
13.	2025/26 Operational and Financial Plan	To present the ICB's operational and financial plans for 2025/26 for approval. Development of the plans will be overseen by the Finance and Performance Committee. Delivery of the 2024/25 plans will be overseen by the Finance and Performance Committee and the Quality and People Committee (delivery reports for the Board included in the routine Quality, Service Delivery and Finance Reports – see 21, 22 and 24 below). The Director of Finance is the executive lead for operational planning and finance.
14.	2025/26 Opening Budget	To present the ICB's 2025/26 opening budget for approval. This will be reviewed by the Finance and Performance Committee prior to presentation to Board. The Director of Finance is the executive lead for finance.

No.	Agenda item	Purpose
15.	NHS England Delegations	To present a strategic update in relation to NHS England's ongoing programme of delegating commissioning functions. This will include approval of associated governance arrangements, as appropriate. The Strategic Planning and Integration Committee will oversee developments in-year, including pre-delegation assessments and due diligence. The Chief Executive is the executive lead for the delegation programme.
16.	Statement on Health Inequalities	To present an annual statement on health inequalities. This will be reviewed by the Finance and Performance Committee prior to presentation to Board. The Medical Director is the executive lead for health inequalities.
17.	Meeting the Public Sector Equality Duty	To present an annual report on the ICB's arrangements for meeting the Public Sector Equality Duty. This will be reviewed by the Quality and People Committee prior to presentation to Board. The Director of Nursing is the executive lead for equality, diversity and inclusion.
18.	People Plan	To present a strategic update on the delivery of the ICS People Plan. The Quality and People Committee will oversight in-year delivery. The Director of Nursing is the executive lead for people and culture.
19.	Digital, Data and Technology Strategy	To present a strategic update on the delivery of the ICS Digital, Data and Technology Strategy. The Finance and Performance Committee will oversight in-year delivery. The Medical Director is the executive lead for digital and data.
20.	Green Plan	To present a strategic update on the delivery of the ICS Green Plan. The Finance and Performance Committee will oversight in-year delivery. The Director of Finance is the executive lead for environmental sustainability.
21.	Quality Report	To present quality oversight reports, including performance against key quality targets. This will be reviewed by the Quality and People Committee prior to presentation to the Board. The Director of Nursing is the executive lead for quality.
22.	Service Delivery Report	To present performance against the key operational service delivery targets. This will be reviewed by the Finance and Performance Committee prior to presentation to the Board. The Director of Finance and Director is the executive lead for performance management.
23.	Delivery Plan for Recovering Access to Primary Care	To present progress updates against the primary care access recovery plan, including a plan refresh in line with 2024/25 planning guidance. The November paper will also include an update on progress in delivering the ICB's Primary Care Strategy. The Strategic Planning and Integration Committee will oversight in-year delivery. The Medical Director and Director of Integration are the executive leads for primary care.
24.	Finance Report	To present the ICB and wider NHS system financial position, covering revenue and capital, and including delivery updates against financial efficiency plans. This will be reviewed by the Finance and Performance Committee prior to presentation to the Board. The Director of Finance is the executive lead for finance.
25.	Highlight Reports from the Finance and Performance	To present an overview of the work of the Board's committees to provide assurance that the committees are effectively discharging their delegated duties

No.	Agenda item	Purpose
	Committee, Quality and People Committee, Strategic Planning and Integration Committee, Audit and Risk Committee, Remuneration Committee	and to highlight key messages for the Board's attention. This includes the committees' assessments of the levels of assurance they have gained from the items received and the actions instigated to address any areas where low levels of assurance have been provided. Also included is a summary of the high-level operational risks currently being oversighted by the committees.
26.	**Board Assurance Framework**	To present themed-year and year-end positions of the Board Assurance Framework. This will include annual approval of the ICB's strategic risks. The Audit and Risk Committee will oversee the strategic risks during the year via focussed updates from each executive director. The Director of Nursing is the executive lead for risk management.
27.	**Closing items**	This section of the agenda at each meeting will be used to share items that are for information only, which will not be individually presented, although questions may be taken by exception at the discretion of the Chair. These will include routine sharing of the Board's Work Programme. The following items will also be shared during the year: • 2024/25 Internal Audit Plan • Senior Information Risk Owner (SIRO) Annual Report • Emergency Accountable Officer (EAO) Annual Report • Learning from the Lives and Deaths of People with Learning Disabilities and Autism (LeDeR) Annual Report This section of the meeting will also include the following verbal items: • Risks identified during the course of the meeting • Questions from the public relating to items on the agenda • Any other business
28.	**Provider Collaborative**	To provide an update on the progress made by the Provider Collaborative
29.	**Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity**	To provide assurance on the completion of the annual assurance process for 2024/25.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/09/2024
Paper Title:	**ICB Constitution**
Paper Reference:	ICB 24 056
Report Author:	Lucy Branson, Director of Corporate Affairs
Executive Lead:	-
Presenter:	-

Paper Type:							
For Assurance:		For Decision:		For Discussion:		For Information:	✓

Summary:
As referenced in paragraph 14 of the Chair's Report on this agenda.

Recommendation(s):
The Board is asked to **note** this item.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	The ICB's governance arrangements ensure appropriate oversight and decision-making with regard to achievement of the core aims.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:
None.

Board Assurance Framework:
Not applicable.

Report Previously Received By:
Not applicable.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

NHS Nottingham and Nottinghamshire Integrated Care Board

CONSTITUTION

Version	Effective Date	Changes
1.0	1 July 2022	First version constitution on establishment of the ICB.
1.1	10 November 2022	Housekeeping amendments to 1.4.7(f), 3.2.4, 3.2.7, 7.1.1 and Appendix 1, as directed by NHS England.
1.2	1 October 2024	To reflect an increase in the number of Ordinary Members of the Board; one further non-executive member and one further executive member. Changes to 2.2.2(a), 2.2.2(b), 2.2.3(f), 2.2.3(j), 2.2.3(k) and 3.8.1, 3.12, 3.12.1, 3.12.3 and 7.3.1.
1.3	1 October 2024	To incorporate amendments to 2.2.3(f), 3.1.1(b), 3.3.4, 3.8.5, 3.8.6, 4.6.8(a), 4.6.8(b), 7.2.7, 3.13.4, 3.15.3 and Appendix 1, addition of 3.3.5, 3.13.2, 3.14 and removal of previous 1.5.2 and 3.17, as directed by NHS England. In addition to a number of housekeeping amendments, the changes introduce the role of Senior Non-Executive member, and new rules regarding terms of office of the Chair and Non-Executive members and the maximum number of years able to be served. The amendments also provide clarification regarding the legal powers of the Chair and Chief Executive and the roles of the Vice-Chair and Deputy Chief Executive, and remove previous clauses related to the establishment of the ICB.

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1. Introduction

1.1 Background/ Foreword

1.1.1 NHS England has set out the following as the four core purposes of Integrated Care Systems:

(a) Improve outcomes in population health and healthcare.

(b) Tackle inequalities in outcomes, experience and access.

(c) Enhance productivity and value for money.

(d) Help the NHS support broader social and economic development.

1.1.2 The Integrated Care Board will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

(a) Improving the health of children and young people.

(b) Supporting people to stay well and independent.

(c) Acting sooner to help those with preventable conditions.

(d) Supporting those with long-term conditions or mental health issues.

(e) Caring for those with multiple needs as populations age.

(f) Getting the best from collective resources so people get care as quickly as possible.

1.1.3 In Nottingham and Nottinghamshire, the Integrated Care Partnership will form the 'guiding mind' for the Integrated Care System in creating an integrated care strategy that will set out how the assessed needs of its area are to be met by the Integrated Care Board, NHS England and relevant local authorities. The Integrated Care Board will pay due regard to this integrated care strategy when exercising its functions.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS Nottingham and Nottinghamshire Integrated Care Board (referred to in this constitution as "**the ICB**").

1.3 Area covered by the Integrated Care Board

1.3.1 The area covered by the ICB (referred to in this constitution as "**the ICB Area**") is coterminous with the District of Ashfield, District of Bassetlaw, Borough of Broxtowe, Borough of Gedling, District of Mansfield, District of Newark and Sherwood, City of Nottingham and Borough of Rushcliffe.

1.4 Statutory framework

1.4.1 The ICB is established by order made by NHS England under powers in the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 ("**the 2006 Act**").

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its constitution (section 14Z29 of the 2006 Act). This constitution is published on the ICB's website at www.notts.icb.nhs.uk.

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both duties and powers. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

(a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act).

(b) Exercising its functions effectively, efficiently, and economically (section 14Z33 of the 2006 Act).

(c) Duties in relation children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014).

(d) Adult safeguarding and carers (the Care Act 2014).

(e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35 of the 2006 Act).

(f) Information law (for instance, data protection laws, such as the UK General Data Protection Regulation, the Data Protection Act 2018, and the Freedom of Information Act 2000).

(g) Provisions of the Civil Contingencies Act 2004.

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:

(a) Section 14Z34 of the 2006 Act (improvement in quality of services).

(b) Section 14Z35 of the 2006 Act (reducing inequalities).

(c) Section 14Z38 of the 2006 Act (obtaining appropriate advice).

(d) Section 14Z40 of the 2006 Act (promoting research).

(e) Section 14Z43 of the 2006 Act (having regard to the wider effect of decisions).

(f) Section 14Z45 of the 2006 Act (public involvement and consultation).

(g) Sections 223GB to 223N of the 2006 Act (financial duties).

(h) Section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61 of the 2006 Act).

1.5 Status of this constitution

1.5.1 The ICB was established on 1 July 2022 by The Integrated Care Boards (Establishment) Order 2022, which made provision for its constitution by reference to this document.

1.5.2 Changes to this constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this constitution may be varied in accordance with the procedure set out in this paragraph. The constitution can only be varied in two circumstances:

(a) Where the ICB applies to NHS England in accordance with NHS England’s published procedure and that application is approved.

(b) Where NHS England varies the constitution of its own initiative (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the constitution is as follows:

(a) The Chair or Chief Executive may periodically propose amendments to this constitution.

(b) All proposed amendments shall be considered and endorsed by the Board of the ICB in line with its procedures for making decisions (as set out in the ICB's Standing Orders), prior to an application being made to NHS England to vary the constitution.

(c) Proposed amendments to this constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related documents

1.7.1 This constitution is also supported by a number of documents, which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to this constitution and form part of it for the purpose of the provisions set out at 1.6 of this constitution and the ICB's legal duty to have a constitution:

(a) **Standing Orders** – which set out the arrangements and procedures to be used for meetings and the processes to appoint the ICB committees.

1.7.3 The following do not form part of this constitution but are required to be published:

(a) **Scheme of Reservation and Delegation (SoRD)** – sets out those decisions that are reserved to the Board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with this constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

(b) **Functions and Decisions Map** – a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decisions Map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

(c) **Standing Financial Instructions** – which set out the arrangements for managing the ICB's financial affairs.

(d) **Governance Handbook** – this brings together all the ICB's governance documents, so it is easy for interested people to navigate. It includes (but is not limited to):

   (i) The above documents (a) to (c).

   (ii) Terms of reference for all committees and sub-committees of the Board that exercise ICB functions.

   (iii) Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to one or more other body (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body); or to a joint committee of the ICB and one or more of those organisations in accordance with section 65Z6 of the 2006 Act.

   (iv) Terms of reference of any joint committee of the ICB and one or more other body (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

   (v) The up-to-date list of eligible providers of primary medical services as referenced at 3.6.2 of this constitution.

(e) **Key policy documents** – which should also be included in the Governance Handbook or linked to it – including (but not limited to):

   (i) Standards of Business Conduct Policy, which incorporates the ICB's policy and procedures for the identification and management of conflicts of interest.

   (ii) Policy for public involvement and engagement.

2. Composition of the Board of the ICB

2.1 Background

2.1.1 This part of the constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in part 3 of this constitution.

2.1.2 Further information about the individuals who fulfil these roles can be found on the ICB's website at www.notts.icb.nhs.uk.

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this constitution as **"the Board"** and members of the ICB referred to as **"Board Members"**) consists of a Chair, a Chief Executive, and at least three Ordinary Members.

2.1.4 The membership of the ICB (the Board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions.

2.1.5 NHS England Policy requires the ICB to appoint the following additional Ordinary Members: three executive members, namely a Director of Finance, a Medical Director, and a Director of Nursing; and at least two non-executive members.

2.1.6 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as **"Partner Members"**) are nominated by the following, and appointed in accordance with the procedures set out in part 3 of this constitution:

(a) NHS trusts and NHS foundation trusts who provide services within the ICB Area and are of a prescribed description.

(b) The primary medical services (general practice) providers within the ICB Area and are of a prescribed description.

(c) The local authorities which are responsible for providing social care and whose areas coincide with or include the whole or any part of the ICB Area.

While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the Board, they are not to act as delegates of those sectors.

2.2 Board membership

2.2.1 The ICB has five Partner Members:

(a) Two from the NHS trusts and NHS foundation trusts who provide services within the ICB Area.

(b) One from the primary medical services (general practice) providers within the ICB Area.

(c) Two from the local authorities that provide social care and whose areas coincide with the ICB Area.

2.2.2 The ICB has also appointed the following further Ordinary Members to the Board (which are in addition to those set out at 2.1.5 and 2.1.6 of this constitution):

(a) Three non-executive members.

(b) Two executive members, namely a Director of Strategy and System Development and a Director of Delivery and Operations.

2.2.3 The Board is therefore composed of the following members:

(a) Chair.

(b) Chief Executive.

(c) Two Partner Members – NHS trusts and NHS foundation trusts.

(d) One Partner Member – providers of primary medical services.

(e) Two Partner Members – local authorities.

(f) Five Non-Executive members (from which Vice-Chair and Senior Non-Executive member appointments will be made in accordance with 3.13 and 3.14 of this constitution).

(g) Director of Finance.

(h) Medical Director.

(i) Director of Nursing.

(j) Director of Strategy and System Development.

(k) Director of Delivery and Operations.

2.2.4 The Chair will exercise their function to approve the appointment of the Ordinary Members with a view to ensuring that at least one of the Ordinary Members will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

2.2.5 The Board will keep under review the skills, knowledge, and experience that it considers necessary for members of the Board to possess (when taken together) in order for the Board to effectively carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.3 Regular participants and observers at meetings of the Board

2.3.1 The Board may invite specified individuals to be Participants or Observers at its meetings to inform its decision-making and the discharge of its functions as it sees fit.

2.3.2 Participants will receive advanced copies of the notice, agenda and papers for Board meetings. They may be invited to attend any or all of the Board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting, but may not vote.

2.3.3 Observers will receive advanced copies of the notice, agenda and papers for Board meetings. They may be invited to attend any or all of the Board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.

2.3.4 Participants and/or observers may be asked to leave the meeting by the Chair in the event that the Board passes a resolution to exclude the public as per the Standing Orders.

3. Appointments process for the Board

3.1 Eligibility criteria for Board membership

3.1.1 Each member of the ICB must:

(a) Comply with the criteria of the Fit and Proper Person Test.

(b) Be committed to upholding the Seven Principles of Public Life (known as the Nolan Principles).

(c) Fulfil the requirements relating to experience, knowledge, skills, and attributes set out in the relevant role specification.

3.2 Disqualification criteria for Board membership

3.2.1 A Member of Parliament.

3.2.2 A person whose appointment as a Board member ("the candidate") is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted:

(a) In the United Kingdom of any offence.

(b) Outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any health service body.

3.2.6 A person whose term of appointment as the chair, a member, a director, or a governor of a health service body, has been terminated on the grounds:

(a) That it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office.

(b) That the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings.

(c) That the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest.

(d) Of misbehaviour, misconduct, or failure to carry out the person's duties.

3.2.7 A Health Care Professional or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practice or any alleged fraud, the final outcome of which was:

(a) The person's suspension from a register held by the regulatory body, where that suspension has not been terminated.

(b) The person's erasure from such a register, where the person has not been restored to the register.

(c) A decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded.

(d) A decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

(a) A disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002.

(b) An order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under:

(a) Section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities).

(b) Section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State for Health and Social Care.

3.3.2 In addition to the criteria specified at 3.1 of this constitution, this member must fulfil the following additional eligibility criteria:

(a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

(a) They hold a role in another health or care organisation within the ICB Area.

(b) Any of the disqualification criteria set out at 3.2 of this constitution apply.

(c) They are an employee of the ICB, or a person seconded to the ICB.

3.3.4 Except as provided for at 3.3.5 of this constitution, the normal term of office for the Chair will be three years and the total time able to be served is a maximum of nine years in total. Re-appointments that take individuals beyond six years in office will be subject to rigorous review to ensure continuing independence.

3.3.5 Normal terms of office may be varied, based on the ICB's requirements at the time of appointment.

3.4 Chief Executive

3.4.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England

3.4.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.

3.4.3 Further to the criteria specified at 3.1 of this constitution, the Chief Executive must fulfil the following additional eligibility criteria:

(a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

3.4.4 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

(b) Subject to the provisions set out at 3.4.3(a) of this constitution, they hold any other employment or executive role.

3.5 Partner Member – NHS trusts and NHS foundation trusts

3.5.1 These Partner Members are jointly nominated by the NHS trusts and NHS foundation trusts which provide services for the purposes of the health service within the ICB Area and meet the Forward Plan Condition or (if the Forward Plan Condition is not met) the Level of Services Provided Condition, as prescribed in regulations:

(a) Sherwood Forest Hospitals NHS Foundation Trust.

(b) Nottingham University Hospitals NHS Trust.

(c) Nottinghamshire Healthcare NHS Foundation Trust.

(d) East Midlands Ambulance Services NHS Trust.

(e) Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.

3.5.2 These members must fulfil the eligibility criteria set out at 3.1 of this constitution and the following additional eligibility criteria:

(a) Be the Chief Executive or relevant Executive Director of one of the NHS trusts or NHS foundation trusts within the ICB Area.

(b) One member must be able to bring an informed view of hospital, urgent and emergency care services.

(c) The other member must have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

3.5.3 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

(b) They are an employee of the ICB, or a person seconded to the ICB.

3.5.4 These members will be appointed by the Chief Executive, subject to the approval of the Chair.

3.5.5 The appointment process will be as follows for each of these Partner Member roles:

(a) **Joint nomination:** When a vacancy arises, each eligible organisation listed at 3.5.1 of this constitution will be invited to nominate an individual who meets the required criteria for the role (as set out at 3.5.2 and 3.5.3 of this constitution). Eligible organisations may choose to nominate an individual from their own organisation or from another eligible organisation listed at 3.5.1 of this constitution. There is no requirement for every eligible organisation to nominate an individual.

All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, specifying a date for responses to be provided. The list will be adopted on the specified date and taken forward to step (b) below if the eligible organisations have expressly confirmed the list or provided no response.

Should no individuals be nominated, or if a majority of the eligible organisations do not agree the list, then the nomination process will be re-run until sufficient nominations are received and/or agreement is reached.

(b) **Assessment, selection and appointment:** The agreed list of jointly nominated individuals will be considered by a panel convened by the Chief Executive. The panel will assess the suitability of the nominees against the requirements of the role as set out at 3.5.2 and 3.5.3 of this constitution. If there is more than one suitable nominee, then the panel will select the most suitable for appointment. Should no individual be eligible for appointment following assessment, then the nomination process at 3.5.5(a) of this constitution will be repeated.

(c) **Approval:** The individual identified as most suitable for appointment will then be subject to approval by the Chair before taking up their role on the Board.

3.5.6 Except as provided for at 3.5.8 of this constitution, the normal term of office for these Partner Members will be two years.

3.5.7 There is no limit to the number of terms of office that can be served by an individual, whether consecutively or otherwise; however, no individual will have the right to be automatically reappointed, as the appointment process set out at 3.5.5 of this constitution will be followed at the end of each term of office.

3.5.8 Normal terms of office may be varied at the discretion of the Chair, based on the ICB’s requirements at the time of appointment and to facilitate Board continuity.

3.6 Partner Member – providers of primary medical services

3.6.1 This Partner Member is jointly nominated by the providers of primary medical services for the purposes of the health service within the ICB Area and that are primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility. The list of relevant providers of primary medical services for this purpose is published as part of the ICB's Governance Handbook. The list will be kept up to date but does not form part of this constitution.

3.6.2 This member must fulfil the eligibility criteria set out at 3.1 of this constitution and the following additional eligibility criteria:

(a) Be a registered medical practitioner, performing primary medical services for one of the providers set out at 3.6.1 of this constitution.

3.6.3 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

(b) They are an employee of the ICB, or a person seconded to the ICB.

3.6.4 This member will be appointed by the Chief Executive, subject to the approval of the Chair.

3.6.5 The appointment process will be as follows:

(a) **Joint nomination:** When a vacancy arises, individuals that meet the required criteria for this role (as set out at 3.6.2 and 3.6.3 of this constitution) may nominate themselves for this role. All self-nominations must be seconded by at least one of the eligible organisations described at 3.6.1. There is no requirement for every eligible organisation to nominate an individual.

All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, specifying a date for responses to be provided. The list will be adopted on the specified date and taken forward to step (b) below if the eligible organisations have expressly confirmed the list or provided no response.

Should no individuals be nominated, or if a majority of the eligible organisations do not agree the list, then the nomination process will be re-run until sufficient nominations are received and/or agreement is reached.

(b) **Assessment, selection and appointment:** The agreed list of jointly nominated individuals will be considered by a panel convened by the Chief Executive. The panel will assess the suitability of the nominees

against the requirements of the role as set out at 3.6.2 and 3.6.3 of this constitution. If there is more than one suitable nominee, then the panel will select the most suitable for appointment. Should no individual be eligible for appointment following assessment, then the nomination process at 3.6.5(a) of this constitution will be repeated.

(c) **Approval:** The individual identified as most suitable for appointment will then be subject to approval by the Chair before taking up their role on the Board.

3.6.6 Except as provided for at 3.6.8 of this constitution, the normal term of office for this Partner Member will be three years.

3.6.7 There is no limit to the number of terms of office that can be served by an individual, whether consecutively or otherwise; however, no individual will have the right to be automatically reappointed, as the appointment process set out at 3.6.5 of this constitution will be followed at the end of each term of office.

3.6.8 Normal terms of office may be varied at the discretion of the Chair, based on the ICB's requirements at the time of appointment and to facilitate Board continuity.

3.7 Partner Members – local authorities

3.7.1 These Partner Members are jointly nominated by the local authorities whose areas coincide with, or include the whole or any part of, the ICB Area. Those local authorities are:

(a) Nottingham City Council.

(b) Nottinghamshire County Council.

3.7.2 This member will fulfil the eligibility criteria set out at 3.1 of this constitution and the following additional eligibility criteria:

(a) Be the Chief Executive or hold a relevant executive level role of one of the bodies listed at 3.7.1 of this constitution or be a member of one of these bodies if deemed most appropriate.

(b) One member must be able to bring a perspective of the social care needs and health and wellbeing characteristics of people and communities living in an urban city area.

(c) The other member must be able to bring a perspective of the social care needs and health and wellbeing characteristics of people and communities living in market towns and rural areas.

3.7.3 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

(b) They are an employee of the ICB, or a person seconded to the ICB.

3.7.4 These members will be appointed by the Chief Executive, subject to the approval of the Chair.

3.7.5 The appointment process will be as follows for each of these Partner Member roles:

(a) **Joint nomination:** When a vacancy arises, each eligible organisation listed at 3.7.1 of this constitution will be invited to nominate an individual who meets the required criteria for the role (as set out at 3.7.2 and 3.7.3 of this constitution). Eligible organisations may choose to nominate an individual from their own organisation or from another eligible organisation listed at 3.7.1 of this constitution. There is no requirement for every eligible organisation to nominate an individual.

The eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, specifying a date for responses to be provided. The list will be adopted on the specified date and taken forward to step (b) below if the eligible organisations have expressly confirmed the list or provided no response.

Should no individuals be nominated, or if the eligible organisations do not agree the list, then the nomination process will be re-run until sufficient nominations are received and/or agreement is reached.

(b) **Assessment, selection and appointment:** The agreed list of jointly nominated individuals will be considered by a panel convened by the Chief Executive. The panel will assess the suitability of the nominees against the requirements of the role as set out at 3.7.2 and 3.7.3 of this constitution. If there is more than one suitable nominee, then the panel will select the most suitable for appointment. Should no individual be eligible for appointment following assessment, then the nomination process at 3.7.5(a) of this constitution will be repeated.

(c) **Approval:** The individual identified as most suitable for appointment will then be subject to approval by the Chair before taking up their role on the Board.

3.7.6 Except as provided for at 3.7.8 of this constitution, the normal term of office for these Partner Members will be three years.

3.7.7 There is no limit to the number of terms of office that can be served by an individual, whether consecutively or otherwise; however, no individual will have the right to be automatically reappointed, as the appointment process

set out at 3.7.5 of this constitution will be followed at the end of each term of office.

3.7.8 Normal terms of office may be varied at the discretion of the Chair, based on the ICB's requirements at the time of appointment and to facilitate Board continuity.

3.8 Non-Executive members

3.8.1 The ICB will appoint five Non-Executive members.

3.8.2 These members will be appointed and approved by the Chair.

3.8.3 These members will fulfil the eligibility criteria set out at 3.1 and the following additional eligibility criteria:

(a) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit and Risk Committee.

(b) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee.

(c) Have a connection to the ICB Area.

3.8.4 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

(b) They hold a position or office in another health or care organisation that provides services within the ICB Area.

(c) They are an employee of the ICB, or a person seconded to the ICB.

3.8.5 Except as provided for at 3.8.7 of this constitution, the normal term of office for a Non-Executive member will be three years and the total time able to be served is a maximum of nine years in total.

3.8.6 The Chair may approve the re-appointment of an individual to the role of Non-Executive member for further terms of office up to the maximum number of years able to be served, subject to demonstration of continuing competence through a satisfactory annual performance appraisal. Re-appointments that take individuals beyond six years in office will be subject to rigorous review to ensure continuing independence. No individual will have the right to be automatically re-appointed.

3.8.7 Normal terms of office may be varied at the discretion of the Chair, based on the ICB's requirements at the time of appointment and to facilitate Board continuity.

3.9 Director of Finance

3.9.1 This member will fulfil the eligibility criteria set out at 3.1 of this constitution and the following additional eligibility criteria:

(a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

(b) Be a qualified accountant with full professional membership.

3.9.2 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

3.9.3 This member will be appointed by the Chief Executive, subject to the approval of the Chair.

3.10 Medical Director

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 of this constitution and the following additional eligibility criteria:

(a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

(b) Be a registered medical practitioner.

3.10.2 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

3.10.3 This member will be appointed by the Chief Executive, subject to the approval of the Chair.

3.11 Director of Nursing

3.11.1 This member will fulfil the eligibility criteria set out at 3.1 of this constitution and the following additional eligibility criteria:

(a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

(b) Be a registered nurse.

3.11.2 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

3.11.3 This member will be appointed by the Chief Executive, subject to the approval of the Chair.

3.12 Director of Strategy and System Development and Director of Delivery and Operations

3.12.1 These members will fulfil the eligibility criteria set out at 3.1 of this constitution and the following additional eligibility criteria:

(a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

3.12.2 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

3.12.3 These members will be appointed by the Chief Executive, subject to the approval of the Chair.

3.13 Vice-Chair

3.13.1 Subject to paragraphs 3.13.2 and 3.13.3 of this constitution, the Chair will appoint a Non-Executive member as Vice-Chair. Any such appointment will be for a period not exceeding the remainder of the individual's term as a Non-Executive member, as specified on appointment.

3.13.2 No individual shall hold the position of Chair of the Audit and Risk Committee and Vice-Chair at the same time.

3.13.3 Any Non-Executive member appointed as Vice-Chair may resign at any time from the office of Vice-Chair by giving notice in writing to the Chair. In the event of a resignation, the Chair may appoint another Non-Executive member as Vice-Chair in accordance with the provisions set out at 3.13.1 of this constitution.

3.13.4 Where the Chair has ceased to hold office, or where they are unable to perform their duties as Chair owing to illness or any other cause, the Vice-Chair shall act as Chair until a new Chair or interim Chair is appointed or the existing Chair resumes their duties, as the case may be. References to the Chair in this constitution and the ICB's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation shall, so long as there is no Chair or interim Chair able to perform those duties, be taken to include references to the Vice-Chair. However, the Vice-Chair shall not be permitted to carry out any functions which legislation specifically confers on a Chair, in particular the functions of a Chair under Schedule 1B of the 2006 Act.

3.14 Senior Non-Executive member

3.14.1 Subject to paragraph 3.14.2 of this constitution, the Chair will appoint a Non-Executive member as Senior Non-Executive member. The Senior Non-Executive member position may be held by any of the Non-Executive members, including the Vice-Chair and the Chair of the Audit and Risk Committee. Any such appointment will be for a period not exceeding the remainder of the individual's term as a Non-Executive member, as specified on appointment.

3.14.2 Any Non-Executive member appointed as Senior Non-Executive member may resign at any time from the office of Senior Non-Executive member by giving notice in writing to the Chair. In the event of a resignation, the Chair may appoint another Non-Executive member as Senior Non-Executive member in accordance with the provisions set out at 3.14.1 of this constitution.

3.15 Deputy Chief Executive

3.15.1 Subject to paragraph 3.15.2 of this constitution, the Chief Executive will appoint an Executive Director as Deputy Chief Executive subject to approval of the Chair.

3.15.2 Any Executive Director appointed as Deputy Chief Executive may resign at any time from the office of Deputy Chief Executive by giving notice in writing to the Chief Executive and Chair. In the event of a resignation, the Chief Executive may appoint another Executive Director as Deputy Chief Executive in accordance with the provisions of paragraph 3.15.1 of this constitution.

3.15.3 Where the Chief Executive has ceased to be employed, or where they are unable to perform their duties as Chief Executive owing to illness or any other cause, the Deputy Chief Executive shall act as Chief Executive until a new Chief Executive or interim Chief Executive is appointed or the existing Chief Executive resumes their duties, as the case may be. References to the Chief Executive in this constitution and the ICB's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation shall, so long as there is no Chief Executive or interim Chief Executive able to perform those duties, be taken to include references to the Deputy Chief Executive. However, the Deputy Chief Executive shall not be permitted to carry out any functions which legislation specifically confers on a Chief Executive.

3.16 Board members: removal from office

3.16.1 Arrangements for the removal from office of Board Members is subject to the relevant terms of appointment and application of the relevant ICB policies and procedures.

3.16.2 With the exception of the Chair, Board Members shall be removed from office if any of the following occurs:

(a) They no longer fulfil the requirements of their role or become ineligible for their role as set out in this constitution, regulations or guidance.

(b) They fail to attend three consecutive Board meetings (except under extenuating circumstances, such as illness).

(c) They fail to uphold the Seven Principles of Public Life (known as the Nolan Principles) or have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; and seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise.

(d) They are subject to disciplinary proceedings by a regulator or professional body.

3.16.3 Board Members may be suspended pending the outcome of an investigation into whether any of the matters set out at 3.16.2 of this constitution apply.

3.16.4 Executive Directors (including the Chief Executive) will cease to be Board Members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

3.16.5 The Chair of the ICB may only be removed by NHS England, subject to the approval of the Secretary of State for Health and Social Care.

3.16.6 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

(a) Terminate the appointment of the ICB's Chief Executive.

(b) Direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.17 Board members: terms of appointment

3.17.1 With the exception of the Chair and Non-Executive members, arrangements for remuneration and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published on the ICB's website and any guidance issued by NHS England or other relevant body. Remuneration for the Chair will be set by NHS England. Remuneration for Non-Executive members will be set by a Non-Executive Director Remuneration Panel. The Non-Executive Director Remuneration Panel will operate under terms of reference agreed by the Board and published in the ICB's Governance Handbook.

3.17.2 With the exception of the Chair and Non-Executive members, other terms of appointment will be determined by the Remuneration Committee.

3.17.3 Terms of appointment of the Chair will be determined by NHS England. Terms of appointment of the Non-Executive members will be determined by the Non-Executive Director Remuneration Panel.

4. Arrangements for exercising functions

4.1 Good governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England.

4.1.2 The ICB has a Standards of Business Conduct Policy, which sets out the standards and public service values that members of the Board and its committees must follow whilst undertaking ICB business. The Standards of Business Conduct Policy is published on the ICB's website.

4.2 General

4.2.1 The ICB will:

(a) Comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations.

(b) Comply with directions issued by the Secretary of State for Health and Social Care.

(c) Comply with directions issued by NHS England.

(d) Have regard to statutory guidance including that issued by NHS England.

(e) Take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England.

(f) Respond to reports and recommendations made by local Healthwatch organisations within the ICB Area.

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with the requirements set out at 4.2.1(a) to 4.2.1(f) of this constitution, documenting them as necessary in this constitution, its Governance Handbook and other relevant policies and procedures as appropriate.

4.3 Authority to act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

(a) Any of its Board Members or employees.

(b) A committee or sub-committee of the Board.

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other body (another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other prescribed body), subject to regulations. Other ICBs, NHS England, NHS trusts and NHS foundation trusts may also arrange for their functions to be exercised by or jointly with the ICB, subject to regulations. Where the ICB and any one or more other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6 of the 2006 Act). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5, section 65Z6, or section 75 of the 2006 Act, the Board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a Scheme of Reservation and Delegation (SoRD), which is published in full on the ICB's website at www.notts.icb.nhs.uk.

4.4.2 Only the Board may agree the SoRD and any amendments to the SoRD may only be approved by the Board on the recommendation of the Chair or Chief Executive.

4.4.3 The SoRD sets out:

(a) Those functions that are reserved to the Board.

(b) Those functions that have been delegated to individuals or to committees and sub-committees.

(c) Those functions delegated to, or by, one or more other body, or to be exercised jointly with one or more other body, under sections 65Z5, 65Z6 and 75 of the 2006 Act.

4.4.4 The ICB remains accountable for all its functions, including those that it has delegated. All those with delegated authority are accountable to the Board for the exercise of their delegated functions.

4.5 Functions and Decisions Map

4.5.1 The ICB has prepared a Functions and Decisions Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decisions Map is published on the ICB's website at www.notts.icb.nhs.uk.

4.5.3 The map includes:

(a) Key functions reserved to the Board of the ICB.

(b) Commissioning functions delegated to committees and individuals.

(c) Commissioning functions delegated under sections 65Z5 and 65Z6 of the 2006 Act to be exercised by, or jointly with any one or more body (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body.

(d) Functions delegated to the ICB (for example, from NHS England).

4.6 Committees and sub-committees

4.6.1 The Board may appoint committees and arrange for its functions to be exercised by such committees. Committees may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees, if empowered to do so by the Board.

4.6.2 All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the Board, or by the relevant parent committee in the case of sub-committees. All terms of reference are published in the ICB's Governance Handbook.

4.6.4 The Board remains accountable for all functions, including those that it has delegated to committees and sub-committees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub-committees that fulfil delegated functions of the ICB, will be required to:

(a) Report regularly to the Board (or parent committee in the case of sub-committees) to provide assurance that they are effectively discharging delegated responsibilities.

(b) Review their effectiveness on at least an annual basis.

4.6.5 Any committee or sub-committee established in accordance with the provisions set out at 4.6 of this constitution may consist of or include persons who are not Board Members or employees.

4.6.6 All individuals appointed as members of committees and sub-committees that exercise ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the individual's involvement with the private healthcare sector or otherwise.

4.6.7 All members of committees and sub-committees are required to act in accordance with this constitution, including the ICB's Standing Orders, as well as the ICB's Standing Financial Instructions and any other relevant ICB policies.

4.6.8 The following committees will be maintained:

(a) **Audit and Risk Committee:** This committee is accountable to the Board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The Audit and Risk Committee will be chaired by a Non-Executive member. The Chair of the ICB cannot chair or be a member of the Audit and Risk Committee. The Vice-Chair cannot chair the Audit and Risk Committee.

(b) **Remuneration Committee:** This committee is accountable to the Board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB. The Remuneration Committee will be chaired by a Non-Executive member. The Chair of the ICB cannot be chair of the Remuneration Committee but can be a member. The Chair of Audit and Risk Committee cannot chair or be a member of the Remuneration Committee.

4.6.9 The Board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 of this constitution, the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other body as defined by the 2006 Act (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body), subject to regulations.

4.7.2 All delegations made under these arrangements are set out in the ICB's Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the 2006 Act will be set out in a delegation agreement which defines the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation agreements made under this provision will be reserved to the Board.

4.7.4 The Board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation agreements, summaries of which will be published in the ICB's Governance Handbook.

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5. Procedures for making decisions

5.1 Standing Orders

5.1.1 The ICB has agreed a set of Standing Orders which describe the processes that are employed to undertake its business. They include procedures for:

(a) Conducting the business of the ICB.

(b) The procedures to be followed during meetings.

(c) The process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in terms of reference which have been agreed by the Board.

5.1.3 A full copy of the Standing Orders is included in Appendix 2 and form part of this constitution.

5.2 Standing Financial Instructions

5.2.1 The ICB has agreed a set of Standing Financial Instructions (SFIs), which set out the arrangements for managing the ICB's financial affairs (associated delegated limits of financial authority are set out in the Scheme of Reservation and Delegation).

5.2.2 A copy of the SFIs is published on the ICB's website at www.notts.icb.nhs.uk.

6. Arrangements for conflicts of interest management and standards of business conduct

6.1 Conflicts of interests

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has an agreed policy and procedures for the identification and management of conflicts of interest; these are incorporated within the ICB's Standards of Business Conduct Policy, which published on the ICB's website at www.notts.icb.nhs.uk.

6.1.3 All Board, committee and sub-committee members, and employees of the ICB, will comply with the ICB's policy and procedures on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this constitution and the ICB's policy and procedures for the identification and management of conflicts of interest.

6.1.6 The Board will appoint a Conflicts of Interest Guardian from its non-executive members to further strengthen scrutiny and transparency of ICB's decision-making processes. In collaboration with the ICB's governance lead, their role is to:

(a) Act as a conduit for anyone with concerns relating to conflicts of interest.

(b) Be a safe point of contact for employees or workers of the ICB to raise concerns in relation to conflicts of interest.

(c) Support the rigorous application of the principles and policies for managing conflicts of interest.

(d) Provide independent advice and judgment where there is any doubt about how to apply conflicts of interest policies and principles in individual situations.

(e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions, the ICB will abide by the following principles for managing conflicts of interest to ensure they are handled with integrity and probity, in an open and transparent way:

(a) Conducting business appropriately: decision-making will be geared towards always meeting the statutory duties of the ICB; ensuring that needs assessments, engagement and consultation mechanisms, commissioning strategies and provider selection procedures are robust and based on expert professional advice.

(b) Being proactive, not reactive: seeking to identify and minimise the risk of conflicts of interest at the earliest possible opportunity, for instance by:

(i) Considering potential conflicts of interest when appointing individuals to the Board or other decision-making committees; clearly distinguishing between those individuals who should be involved in formal decision taking, and those whose input informs decisions.

(ii) Ensuring individuals receive proper induction and training so that they understand their obligations to declare their interests.

(iii) Establishing and maintaining the register of interests and agreeing in advance how a range of possible situations and scenarios will be handled, rather than waiting until they arise.

(c) Assuming that individuals will seek to act ethically and professionally: ensuring there are prompts and checks to identify when conflicts occur, supporting individuals to exclude themselves appropriately from decision-making.

(d) Being balanced and proportionate: identifying and managing conflicts, preserving the spirit of collective decision-making wherever possible, and not expecting to eliminate conflicts completely.

(e) Transparency and sound record keeping: clearly documenting the rationale for decision-making so that an audit trail of actions taken is evident and able to withstand scrutiny.

(f) Creating an environment and culture where individuals feel supported and confident in declaring relevant information and raising concerns.

6.3 Declaring and registering interests

6.3.1 The ICB maintains a register of the interests of:

(a) Board Members.

(b) Members of the Board's committees and sub-committees.

(c) Its employees.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act, the register of interests is published on the ICB's website at www.notts.icb.nhs.uk.

6.3.3 All relevant persons as per 6.1.3 and 6.1.5 of this constitution must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the register as per 6.3.1 of this constitution.

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

6.3.7 Interests (including offers/receipt of gifts and hospitality) of decision-making staff will remain on the published register for a minimum of six months. In addition, the ICB will retain a record of historic interests (including offers/receipt of gifts and hospitality) for a minimum of six years after the date on which they expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the relevant ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of business conduct

6.4.1 Board Members, members of the Board's committees and sub-committees and employees will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should:

(a) Act in good faith and in the interests of the ICB.

(b) Follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles).

(c) Comply with the ICB Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct Policy.

7. Arrangements for ensuring accountability and transparency

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.

7.2 Meetings and publications

7.2.1 The ICB will comply with the Public Bodies (Admission to Meetings) Act 1960, as set out at Standing Order 4.11, including admission to meetings held in public and publication of associated papers and minutes.

7.2.2 Annual accounts will be externally audited and published.

7.2.3 A clear complaints process will be published.

7.2.4 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.2.5 Information will be provided to NHS England as required.

7.2.6 This constitution and the ICB's Governance Handbook will be published as well as other key documents, including but not limited to:

(a) All ICB policies, including those relating to conflicts of interest.

(b) Registers of interests.

7.2.7 The ICB will publish a plan, produced with partner NHS trusts and NHS foundation trusts, at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years (the "Joint Forward Plan"). The plan will:

(a) Describe the health services for which the ICB proposes to make arrangements in the exercise of its functions.

(b) Explain how the ICB proposes to discharge its duties under:

(i) Sections 14Z34 to 14Z45 of the 2006 Act (general duties of integrated care boards).

(ii) Sections 223GB and 223N of the 2006 Act (financial duties).

(c) Set out any steps that the ICB proposes to take to implement the joint local health and wellbeing strategies to which it is required to have regard under Section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

(d) Set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25.

(e) Set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults).

7.3 Scrutiny and decision making

7.3.1 Six Non-Executive members will be appointed to the Board (including the Chair) and all Board and committee and sub-committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

7.3.2 Healthcare services will be arranged in a transparent way, and decisions around which organisations provide services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.3.3 The ICB will take all reasonable steps to comply with local authority health overview and scrutiny requirements.

7.4 Annual report

7.4.1 The ICB will publish an annual report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular:

(a) Explain how the ICB has discharged its duties under sections 14Z34 to 14Z45 and 14Z49 of the 2006 Act (general duties of integrated care boards).

(b) Review the extent to which the ICB has exercised its functions in accordance with its plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan) of the 2006 Act.

(c) Review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised).

(d) Review any steps the ICB has taken to implement any joint local health and wellbeing strategies to which it is required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

(e) Include a statement of the amount of expenditure incurred by the ICB during the financial year in relation to mental health and a calculation of the proportion of the expenditure incurred by the ICB during the financial year that relates to mental health. An explanation of the statement and calculation must be provided.

8. Arrangements for determining the terms and conditions of employees

8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines, and appoint staff on such terms and conditions as it determines.

8.1.2 The Board has established a Remuneration Committee which is chaired by a Non-Executive member other than the Chair or Audit and Risk Committee Chair.

8.1.3 The membership of the Remuneration Committee is determined by the Board. No employees may be a member of the Remuneration Committee, but the Board ensures that the Remuneration Committee has access to appropriate advice by:

(a) Expert human resources advisors attending meetings to support the Remuneration Committee in discharging its responsibilities.

8.1.4 The Board may appoint independent members or advisers to the Remuneration Committee who are not members of the Board.

8.1.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the Board are published in the Governance Handbook.

8.1.6 The duties of the Remuneration Committee include:

(a) Setting the remuneration, allowances and other terms of appointment for members of the Board, except for the Chair and non-executive members.

(b) Setting any allowances for members of committees or sub-committees of the Board, who are not members of the Board.

8.1.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9. Arrangements for public involvement

9.1.1 In line with section 14Z45(2) of the 2006 Act, the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

(a) The planning of the commissioning arrangements by the ICB.

(b) The development and consideration of proposals by the ICB for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them.

(c) Decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act, the ICB and its partner NHS trusts and NHS foundation trusts will make appropriate arrangements to consult with the ICB's population when preparing or revising their joint five-year plan. Public consultation will be completed in accordance with the ICB's policy for public involvement and engagement.

9.1.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities:

(a) Putting the voices of people and communities at the centre of decision-making and governance.

(b) Starting engagement early when developing plans, feeding back to people and communities how engagement has influenced activities and decisions.

(c) Understanding the needs, experience and aspirations of people and communities for health and care, using engagement to find out if change is having the desired effect.

(d) Building relationships with excluded groups – especially those affected by inequalities.

(e) Working with Healthwatch and the voluntary, community and social enterprise sector as key partners.

(f) Providing clear and accessible public information about vision, plans and progress to build understanding and trust.

(g) Using community development approaches that empower people and communities, making connections to social action.

(h) Using co-production, insight and engagement to achieve accountable health and care services.

(i) Co-producing and redesigning services and tackling system priorities in partnership with people and communities.

(j) Learning from what works and building on the assets of all health and care partners – networks, relationships, activity in local places.

9.1.4 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

9.1.5 These arrangements include:

(a) The creation, implementation and evaluation of a system-wide strategy for engaging with people and communities, to be reviewed at least every three years.

(b) The establishment of a Citizen Intelligence Advisory Group to ensure the Board is supported in discharging the duties set out in 9.1.1.

(c) Having a Board approved policy for public involvement and engagement, which will require the ICB to:

(i) Be clear about who is being engaged, the possible options, the engagement process, what is being proposed and the scope to influence.

(ii) Ensure that engagement takes place in a suitable timeframe to allow decisions to be genuinely influenced by feedback received.

(iii) Adapt engagement activities and methods to meet the specific needs of different patient groups and communities.

(iv) Keep the burden of engagement to a minimum to retain continued buy-in to the process by people and communities.

(v) Ensure that responses to engagement exercises are carefully analysed with clear feedback provided to participants, which set out the decision made and the influence the results of the engagement exercise had on the final decision.

Appendix 1: Definitions of terms used in this constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
ICB Board	Members of the ICB.
ICB Area	The geographical area that the ICB has responsibility for, as defined at 1.3 of this constitution.
Committee	A committee created and appointed by the ICB Board.
Sub-Committee	A committee created and appointed by and reporting to a committee.
Forward Plan Condition	The 'Forward Plan Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Level of Services Provided Condition	The 'Level of Services Provided Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Integrated Care Partnership	The statutory joint committee for the ICB Area established by the ICB and each responsible upper tier local authority whose area coincides with or falls wholly or partly within the ICB Area.
Ordinary Member	The Board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the Board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 of this constitution, having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB Area and are of a prescribed description. • The primary medical services (general practice) providers within the ICB Area and are of a prescribed description.

	• The local authorities which are responsible for providing social care and whose area coincides with or includes the whole or any part of the ICB Area.
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
Health Care Professional	An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

Appendix 2: Standing Orders

1. Introduction

1.1.1 These Standing Orders have been drawn up to regulate the proceedings of NHS Nottingham and Nottinghamshire Integrated Care Board ("**the ICB**") so that the ICB can fulfil its obligations as set out largely in the National Health Service Act 2006 ("**the 2006 Act**"), as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022. They form part of the ICB's Constitution.

1.1.2 These Standing Orders should be read alongside the ICB's constitution, Standing Financial Instructions and Scheme of Reservation and Delegation, which together describe the ICB's governance framework.

1.1.3 These Standing Orders set out the:

(a) Arrangements for conducting the business of the ICB.

(b) Procedures to be followed during meetings of the Board of the ICB ("**the Board**") and its committees and sub-committees.

2. Amendment and review

2.1.1 These Standing Orders are effective from the date the ICB is established.

2.1.2 These Standing Orders will be reviewed on an annual basis or sooner if required.

2.1.3 Amendments to these Standing Orders will be made in line with the procedure set out at section 1.6 of the ICB's constitution.

2.1.4 All changes to these Standing Orders will require an application to NHS England for variation to the ICB constitution and will not be implemented until the constitution has been approved.

3. Interpretation, application, and compliance

3.1.1 Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB's constitution and as per the definitions in Appendix 1.

3.1.2 These Standing Orders apply to all meetings of the Board, including its committees and sub-committees unless otherwise stated. All references to Board are inclusive of committees and sub-committees unless otherwise stated.

3.1.3 All members of the Board, members of committees and sub-committees and all employees should be aware of these Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.1.4 In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the ICB's governance lead, will provide a settled view which shall be final.

3.1.5 All members of the Board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible. If the Chief Executive is responsible for the non-compliance, then this should instead be reported to the ICB's lead for governance.

3.1.6 If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification and the Audit and Risk Committee for review.

4. Meetings of the Board

4.1 Calling meetings

4.1.1 Meetings of the Board shall be held at regular intervals at such times and places as the Board may determine. The Board will normally meet no less than six times per year. Terms of reference for committees and sub-committees will specify the required frequency of meetings.

4.1.2 In normal circumstances, each member of the Board will be given not less than one month's notice in writing of any meeting to be held. However:

(a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.

(b) Members of the Board may request the Chair to convene a meeting by notice in writing signed by not less than one third of the Board Members, specifying the matters they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Board Members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the Board, specifying the matters to be considered at the meeting.

(c) In emergency situations, the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

(d) A failure to give notice in accordance with the above requirements shall not invalidate a decision otherwise taken in accordance with these Standing Orders.

4.1.3 In accordance with Public Bodies (Admission to Meetings) Act 1960, a public notice of the time and place of meetings open to the public, and how to access the meetings, all be given by posting it at the offices of the ICB and electronically on the ICB's website at least three clear days before the meeting, or if the meeting is convened at shorter notice, then at the time it is convened.

4.2 Chair of a meeting

4.2.1 The Chair of the ICB shall preside over meetings of the Board.

4.2.2 If the Chair is absent or is disqualified from participating by reason of a conflict of interests, then the Vice Chair will preside. If both the Chair and Vice Chair are absent or disqualified from participating, then a Non-Executive member of the Board (other than the Chair of the Audit and Risk Committee) shall be chosen by the members present, or by a majority of them, and shall preside.

4.2.3 The Board will appoint a Chair to all committees that it has established. Chairs of sub-committees will be appointed by the relevant parent committee. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3 Agenda, supporting papers and business to be transacted

4.3.1 The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2 Except where the emergency provisions apply (as provided for in Standing Order 4.1.2(c)), the agenda and supporting papers will be circulated to all members of the Board at least five calendar days before the meeting.

4.3.3 Agendas and papers for meetings open to the public will be published electronically in advance of the meetings on the ICB's website at www.notts.icb.nhs.uk.

4.4 Petitions

4.4.1 Where a valid petition has been received by the ICB, it shall be included as an item for the agenda of the next meeting of the Board in accordance with the process set out within the ICB's Governance Handbook.

4.5 Nominated deputies

4.5.1 With the permission of the Chair, the Executive Directors and Partner Members of the Board may nominate a deputy to attend a meeting of the Board that they are unable to attend. Deputies may speak, but not vote, on their behalf, and will not count towards the quorum unless Standing Order 4.7.2(c) applies.

4.5.2 Any nomination of a deputy must be made in writing to the Chair in advance of the meeting, confirming that the individual nominated to deputise fulfils the requirements of the role and is not disqualified. Ad-hoc deputy arrangements are not permitted. The decision of the Chair (or in their absence, the person presiding over the meeting) regarding authorisation of nominated deputies is final.

4.5.3 Terms of reference for committees and sub-committees will specify the extent to which nominated deputies are allowed.

4.6 Virtual meetings

4.6.1 The Board may meet virtually using telephone, video and other electronic means when necessary. Where a virtual meeting is convened, the usual process for meetings of the Board will apply, including those relating to the quorum (as set out in Standing Order 4.7) and those relating to meetings being open to the public and representatives of the press (as set out in Standing Order 4.11).

4.6.2 Virtual attendance at in-person meetings will be permitted at the discretion of the Chair.

4.7 Quorum

4.7.1 The quorum for meetings of the Board will be five members, including:

(a) The Chair of the meeting and one further Non-Executive Director.

(b) The Chief Executive or the Director of Finance.

(c) The Medical Director or the Director of Nursing.

(d) One Partner Member.

4.7.2 For the sake of clarity:

(a) No person can act in more than one capacity when determining the quorum.

(b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interests, shall no longer count towards the quorum.

(c) An officer in attendance for an Executive Director in accordance with Standing Order 4.5.1 may only count towards the quorum if they have formal acting up status.

(d) A failure to comply with the above requirements as to quorum shall not invalidate a decision otherwise taken in accordance with these Standing Orders.

4.7.3 For all committees and sub-committees, the details of the quorum for these meetings and the status of any nominated deputies are set out in the appropriate terms of reference.

4.8 Vacancies and defects in appointments

4.8.1 The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.

4.9 Decision making

4.9.1 The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate. Where helpful, the Board may draw on third party support such as peer review or mediation by NHS England.

4.9.2 Generally, it is expected that decisions of the Board will be reached by consensus. Should this not be possible, then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

(a) All members of the Board who are present at the meeting will be eligible to cast one vote each.

(b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.

(c) For the sake of clarity, any participants or observers at the meeting (in accordance with section 2.3 of the ICB's constitution) will not have voting rights.

(d) A resolution will be passed if more votes are cast for the resolution than against it.

(e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.

(f) No resolution will be passed if it is unanimously opposed by all the Executive Directors present or by all the Non-Executive Directors present.

(g) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

4.9.3 Decision-making arrangements for committees and sub-committees will be set out within the appropriate terms of reference.

Emergency powers for urgent decisions

4.9.4 In the case of urgent decisions and extraordinary circumstances, every attempt will be made for the Board to meet virtually. Where this is not possible Standing Orders 4.9.5 and 4.9.6 will apply.

4.9.5 The powers which are reserved or delegated to the Board, may for an urgent decision be exercised by the Chair and Chief Executive subject to every effort having made to consult with as many members of the Board as possible in the given circumstances.

4.9.6 The exercise of such powers by the Chair and Chief Executive will be reported to the next formal meeting of the Board for formal ratification and to the Audit and Risk Committee for review of the reasonableness of the decision to use emergency powers.

4.9.7 Decision-making arrangements set out within committee and sub-committee terms of reference will specify the extent to which urgent decisions can be taken in extraordinary circumstances.

4.10 Minutes

4.10.1 The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4 Where providing a record of a meeting open to the public, the minutes shall be made available to the public.

4.11 Admission of public and representatives of the press

4.11.1 In accordance with the Public Bodies (Admission to Meetings) Act 1960, meetings of the Board, and meetings of committees that are comprised entirely of Board Members or at which all Board Members are present, at which public functions are exercised, will be open to the public. There is no requirement for meetings of the Remuneration Committee or the Audit and Risk Committee to be open to the public.

4.11.2 The Board may resolve to exclude the public and representatives of the press from a meeting, or part of a meeting, where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960, as amended or succeeded from time to time.

4.11.3 The Chair (or in their absence, the person presiding over the meeting) shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press, such as to ensure that the Board’s business can be conducted without interruption or disruption.

4.11.4 As permitted by section 1(8) of the Public Bodies (Admissions to Meetings) Act 1960 (as amended from time to time), the public and representatives of the press may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5 Matters to be dealt with at a meeting following the exclusion of the public and representatives of the press shall be confidential to the members of the Board.

4.11.6 Members of the Board and any regular participants or employees of the ICB in attendance will not reveal or disclose the contents of papers or minutes marked as ‘confidential’ or ‘private’ outside of the Board, without the express permission of the Board. This prohibition will apply equally to the content of any discussion during the Board meeting that may take place on such papers or minutes.

5. Suspension of Standing Orders

5.1.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended at any meeting of the Board by the Chair (or the person presiding over the meeting), provided that a majority of members present, including at least one executive member and one non-executive member, are in favour of suspension.

5.1.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.1.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit and Risk Committee for review of the reasonableness of the decision to suspend Standing Orders.

6. Execution of documents

6.1 Custody of seal, sealing of documents and register of sealings

6.1.1 The ICB will have a common seal for executing certain documents, as required by legislation.

6.1.2 The seal will be kept by the ICB's lead for governance in a secure place.

6.1.3 The seal swill be affixed in the presence of two officers of the ICB, to include either the Chief Executive or the Director of Finance, and shall be attested by them.

6.1.4 An entry of every sealing will be made and numbered consecutively in a register provided for that purpose.

6.1.5 A report of all sealings will be made to the Board, or a committee nominated by the Board, at least annually.

6.2 Execution of a document by signature

6.2.1 Where any document will be a necessary step in legal proceedings on behalf of the ICB, it will, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any other executive member of the Board.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/09/2024
Paper Title:	**ICB Governance Handbook**
Paper Reference:	ICB 24 057
Report Author:	Lucy Branson, Director of Corporate Affairs
Executive Lead:	-
Presenter:	-

Paper Type:							
For Assurance:		For Decision:		For Discussion:		For Information:	✓

Summary:
As referenced in paragraph 16 of the Chair's Report on this agenda.

Recommendation(s):
The Board is asked to **note** this item.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	The ICB's governance arrangements ensure appropriate oversight and decision-making with regard to achievement of the core aims.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:
None.

Board Assurance Framework:
Not applicable.

Report Previously Received By:
Not applicable.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Governance Handbook

Version	Effective Date	Changes
1.0	1 July 2022	First version Governance Handbook on establishment of the ICB.
1.1	10 November 2022	Transfer of duties regarding research and patient and public engagement from the Quality and People Committee to the Strategic Planning and Integration Committee.
1.2	1 April 2023	Minor amendments to committee terms of reference, Scheme of Reservation and Delegation and Standards of Business Conduct Policy, following a stock-take of governance arrangements 100-days post-establishment.
1.3	1 June 2023	Minor amendments to Executive portfolios following publication of NHS England guidance in relation to *Executive lead roles within integrated care boards*.
1.4	24 July 2023 and 3 August 2023	Dis-establishment of Human Resources Sub-committee and Primary Medical Services Contracting Sub-Committee.
1.5	11 January 2024 and 16 January 2024	Amendments to committee terms of reference, Scheme of Reservation and Delegation, Standing Financial Instructions and Standards of Business Conduct Policy to address requirements of the NHS Provider Selection Regime.
1.7	1 October 2024	Amendments to committee memberships (and associated quorums) to reflect the new Board composition and revised executive portfolios. Additional duties and change in name for Remuneration and Human Resources Committee, and increased meeting frequency.

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1. Introduction

1.1 Establishment of the ICB and its Constitution

1.1.1 NHS Nottingham and Nottinghamshire Integrated Care Board ("the ICB") was established by NHS England on 1 July 2022 by The Integrated Care Boards (Establishment) Order 2022.

1.1.2 The ICB has a **Constitution** that sets out the statutory framework that the ICB operates within and its arrangements for demonstrating accountability and transparency. It also sets out the ICB's Board membership and associated appointment processes, arrangements for exercising the ICB's functions and procedures for making decisions. Provisions for conflicts of interest management and required standards of business conduct are also included.

1.1.3 The ICB also has a set of **Standing Orders**, which form part of the Constitution and set out the:

(a) Arrangements and procedures for meetings of the Board

(b) Processes to appoint committees and sub-committees of the Board.

1.2 Governance Handbook

1.2.1 This Governance Handbook, which sits alongside the ICB's Constitution, brings together the following key documents:

(a) **Terms of Reference** – for all committees and sub-committees of the Board that exercise ICB functions and make decisions.

(b) **Standing Financial Instructions** – which set out the arrangements for managing the ICB's financial affairs.

(c) **Scheme of Reservation and Delegation** – which sets out functions that are reserved to the Board, functions that have been delegated to an individual or to committees and sub-committees, and functions delegated to another body or bodies or to be exercised jointly with another body or bodies.

1.2.2 This Governance Handbook also includes further information in support of the ICB's governance arrangements, including:

(a) A summary of the Board's role and responsibilities, along with details of Executive Director portfolios.

(b) An up-to-date list of eligible providers of primary medical services as referenced at 3.6.2 of the ICB's Constitution.

(c) Guidance for Board and committee members on the required etiquette for meetings.

(d) Guidance for members of the public in relation to the ICB's meetings that are held in public, including how members of the public can ask questions of the Board.

(e) The procedure for the consideration of petitions received by the ICB.

1.2.3 The ICB has developed a **Functions and Decisions Map**, which is a high-level structural chart that sets out where key decisions are taken or where functions are delegated to different parts of the Integrated Care System – it aims to be an easy-to-read version of the ICB's Scheme of Reservation and Delegation, designed to present the ICB's governance arrangements in a simple way. The ICB's Functions and Decisions Map is published in full on the ICB's website at www.notts.icb.nhs.uk.

1.2.4 The ICB has a suite of key policy documents, covering different aspects of its corporate and commissioning responsibilities. This includes its **Standards of Business Conduct Policy** (which incorporates the ICB's policy and procedures for the identification and management of conflicts of interest) and its **Policy for Public Involvement and Engagement**. All ICB policies are published in full on the ICB's website at www.notts.icb.nhs.uk.

1.3 Review and amendment of the Governance Handbook

1.3.1 To ensure that this Governance Handbook remains up-to-date and relevant, the ICB's Director of Corporate Affairs will ensure that it is reviewed on an ongoing basis and at least annually to ensure it continues to support effective governance and decision-making.

1.3.2 The Board will approve all amendments to the Governance Handbook.

2. The Board – Roles and Responsibilities

The ICB is governed by a unitary Board, which means all Board members are collectively and corporately accountable for organisational performance.

Non-Executive members of the Board – provide an independent view on the running of the organisation, bringing purposeful, constructive scrutiny and challenge to Board and committee discussions.

Executive members of the Board – manage the day-to-day responsibilities of the organisation.

Partner members of the Board – bring knowledge and a perspective from their relevant sectors to the work of the Board; these cover mental health, hospital, urgent and emergency care services, primary and community care, and social care.

The Board is responsible for:

a) Ensuring the ICB plays its role in achieving the four aims of the Integrated Care System:

   i) Improve outcomes in population health and healthcare.

   ii) Tackle inequalities in outcomes, experience and access.

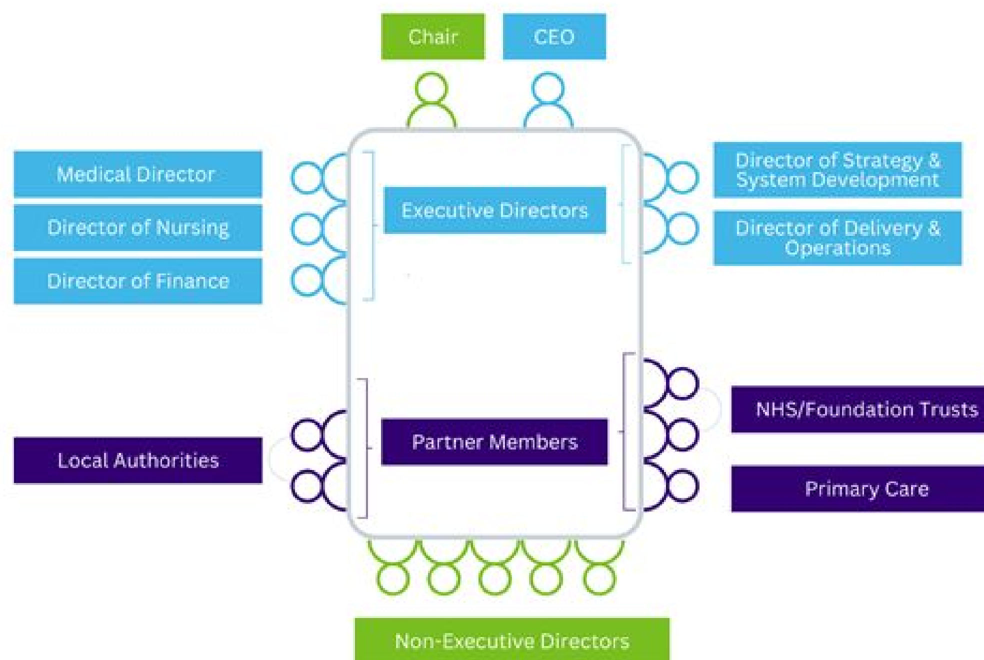
   iii) Enhance productivity and value for money.

   iv) Help the NHS support broader social and economic development.

b) Formulating a plan for the organisation.

c) Holding the organisation to account for the delivery of the plan; by being accountable for ensuring the organisation operates effectively and with openness, transparency and candour and by seeking assurance that systems of control are robust and reliable and that statutory duties are being met.

d) Shaping a healthy culture for the organisation and the system through its interaction with system partners.



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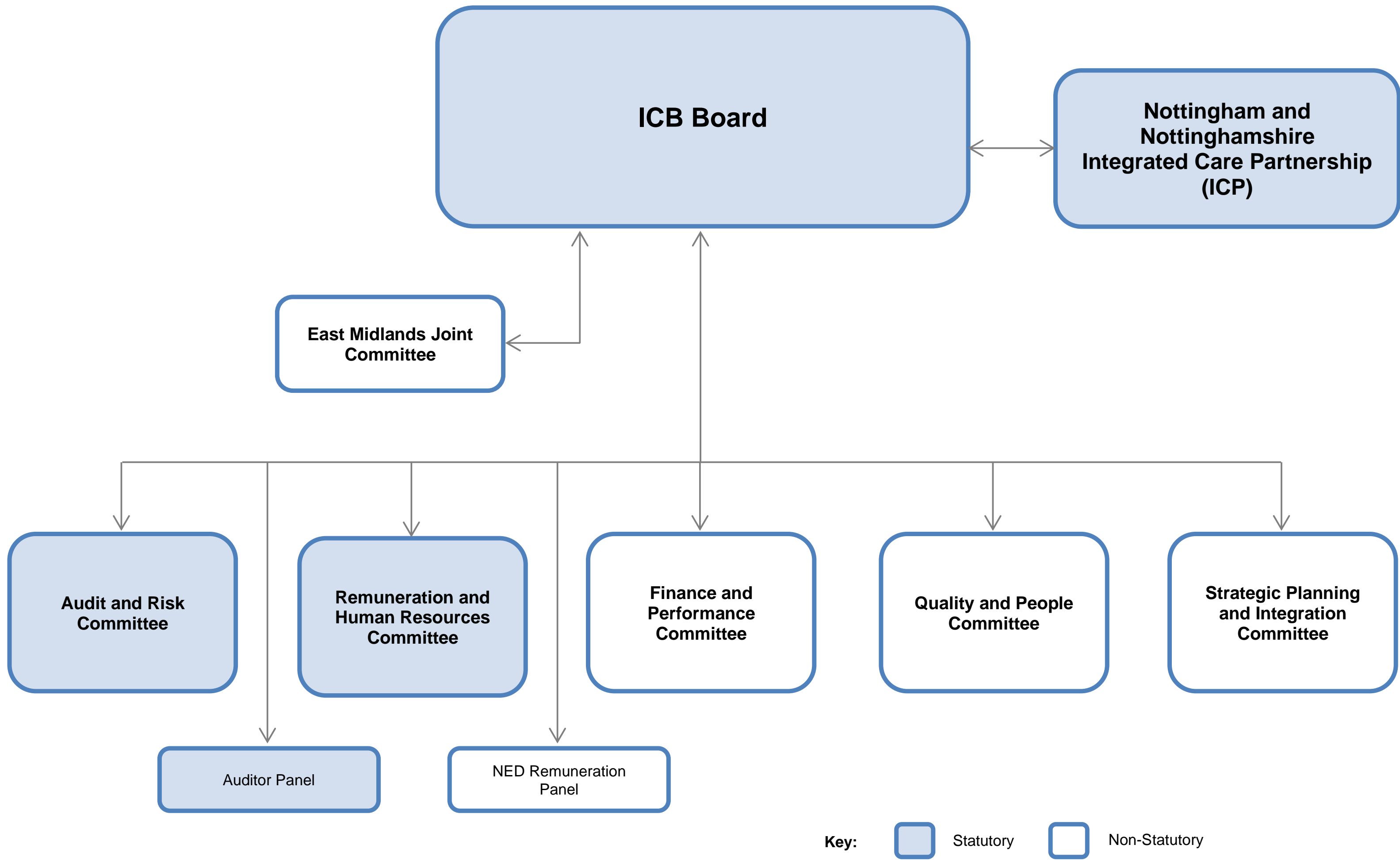
3. Executive Director Portfolios

Executive Director	Portfolio of responsibilities	
Chief Executive	• ICB Accountable Officer	• Communications and engagement
Director of Finance	• Financial planning and stewardship and resource allocation (including new payment mechanisms and risk sharing arrangements) • Capital planning • Operational planning • Contracting • Efficiency and productivity	• Provider/ system financial recovery and oversight • Programme Management Office • Estates • Environmental sustainability • Audit and counter fraud arrangements • Procurement and provider selection
Medical Director	• Health inequalities • Preventative care and long-term conditions management • Clinical prioritisation and transformation • Population health management and system intelligence • Data, digital and technology	• Medicines management • Clinical and care professional leadership and engagement • Research, evidence and evaluation • Innovation • Senior Information Risk Owner (SIRO)
Director of Nursing	• Quality oversight and assurance, quality improvement and infection, prevention and control • Safeguarding (all-age), including looked after children and care leavers • Children and young people with special educational needs and disabilities (SEND) • Learning disability and autism (all age) • Down syndrome (all age)	• Individual funding requests • Continuing healthcare and personalisation • People and culture (including ICB human resources and organisational development) • Equality, diversity and inclusion • Corporate affairs (including corporate governance, risk and assurance, and information governance) • Caldicott Guardian

Rushcliffe Arena, 09:00-12/09/24

Executive Director	Portfolio of responsibilities	
Director of Strategy and System Development	• Integrated care strategy and strategic planning (ICB five-year plan) • Integration of health, social care and health-related services • Development and oversight of Joint Forward Plan delivery • Strategic business case development (PCBCs, DMBCs)	• Reconfiguration • Commissioning policy development • Provider collaboration • Joint commissioning • ICB collaboration • JSNAs (with local authorities) • System operating model development
Director of Delivery and Operations	• Performance and system oversight • Provider oversight and ratings • System transformation programme delivery • System / provider performance and delivery oversight • Delivery of operational standards and the operational plan • EPRR and Accountable Emergency Officer (AEO) • System Control Centre and urgent and emergency care resilience	• Service design, transformation and commissioning (including NHS England delegated functions): – Urgent and emergency care – Planned care, cancer and diagnostics services, and palliative care – Mental health services – Community services – Maternity and neonatal services – Services for children and young people (aged 0 to 25) – Primary care services (medical, dental, ophthalmic, pharmaceutical) and Primary Care Networks – Provider collaborative plan delivery

4. ICB Board and Committee Structure



5. Audit and Risk Committee – Terms of Reference

<table>
<tr><td>1. Purpose</td><td>The Audit and Risk Committee ("the Committee") exists to:
a) Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the ICB's activities that supports the achievement of the organisation's objectives.
b) Provide the Board with an independent and objective view of the ICB's financial systems, financial information and compliance with the laws, regulations and directions governing the ICB in as far as they relate to finance.
c) Scrutinise every instance of non-compliance with the ICB's Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions and monitor compliance with the ICB's Standards of Business Conduct Policy.
d) Approve the ICB's Annual Report and Accounts.
The Committee is also responsible for overseeing the ICB's compliance with the regulatory requirements for information governance (including data protection and cyber security), health and safety and emergency preparedness. The Committee will also monitor progress against the ICB's overarching policy work programme.</td></tr>
<tr><td>2. Status</td><td>The Committee is established in accordance with the National Health Service Act 2006 (as amended by the Health and Care Act 2022) and the ICB's Constitution. It is a statutory committee of, and accountable to, the Board.
The Board has authorised the Committee to:
a) Investigate any activity within its terms of reference.
b) Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.
c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.
d) Create sub-committees or task and finish groups to take forward specific programmes of work as considered necessary by the Committee's membership. The Committee shall determine the membership and terms of reference of any such sub-committees or task and finish group. Any sub-committee or task and finish group established may consist of, or include, persons who are not Board members or ICB employees.</td></tr>
<tr><td>3. Duties</td><td><u>Integrated governance, risk management and internal control</u></td></tr>
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	The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the ICB's activities, which supports the achievement of its objectives. The Committee will: a) Review the adequacy and effectiveness of the ICB's risk management arrangements and all risk and control related disclosure statements (including the annual governance statement) together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances. b) Review the adequacy and effectiveness of the underlying assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements. This will include reviewing the outcome of the annual effectiveness assessment of all committees prior to consideration by the Board. c) Review of all instances of non-compliance with Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation. d) Review the reasonableness of the use of emergency powers for urgent decisions by the Chair of the ICB and Chief Executive on behalf of the Board and all instances where Standing Orders have been suspended. e) Review the reasonableness of the use of emergency powers for urgent decisions on behalf of the Strategic Planning and Integration Committee and Finance and Performance Committee. f) Approve and monitor compliance with standards of business conduct policies and any related reporting and self-certifications. g) Scrutinise compliance with legislative and regulatory requirements relating to information governance (including data protection and cyber security) and the extent to which associated systems and processes are effective and embedded within the ICB. h) Monitor progress against the ICB's overarching Policy Work Programme. In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from Executives and managers, as appropriate. The Committee will use the Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

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Internal audit
The Committee will approve arrangements for the provision of internal audit services.
The Committee will ensure that there is an effective internal audit function established by management that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, ICB Chief Executive, ICB Chair and the Board. This will be achieved by:
i) Considering the provision of the internal audit service and the costs involved; ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
j) Reviewing and approving of the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the ICB (as identified in the Board Assurance Framework).
k) Considering the major findings of internal audit work (and management’s response) and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.
l) Monitoring the effectiveness of internal audit and completing an annual review.
External audit
The Committee will review the work and findings of the external auditors and consider the implications and management’s responses to their work. This will be achieved by:
m) Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.
n) Discussing with the external auditors their local evaluation of audit risks and assessment of the organisation and the impact on the audit fee.
o) Reviewing all external audit reports, including the report to those charged with governance and any work undertaken outside of the audit plan, together with the appropriateness of management responses.
The Committee will also ensure a cost-efficient external audit service.
Counter fraud
The Committee will approve arrangements for the provision of counter fraud, bribery and corruption services.
The Committee will satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority’s
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	standards and will review the outcomes of work in these areas. This will be achieved by: p) Reviewing, approving and monitoring counter fraud work plans; receiving regular updates on counter fraud activity and monitoring the implementation of action plans. q) Ensuring that the counter fraud service submits an Annual Report, outlining key work undertaken during each financial year and progress in achieving the requirements of the Government Functional Standard 13 for counter fraud. The Committee will refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Authority. *Financial reporting and stewardship* r) The Committee will monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance. s) The Committee will ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided. t) The Committee will scrutinise the outcome of the annual review of the Standing Financial Instructions, recommending any amendments to the Board for approval. u) The Committee will: i) Be notified of any new bank accounts or changes to existing bank accounts, and any arrangements made with the ICB's bankers for accounts to be overdrawn. ii) Approve the use of procurement or other card services by the ICB, including the types of card services that should be allowed, the types of transactions that should be permitted, the individuals who should be issued with a card, and the overall credit and individual transaction limits to be associated with each card. iii) Monitor the actual use of card services against authorised uses. iv) Review all instances where provider representations have been received in relation to procurement and contract award decisions for healthcare services. v) Review all instances where competitive tendering requirements have been waived for non-healthcare services. vi) Review the extent to which debt is being managed effectively. vii) Scrutinise any retrospective approvals to commit revenue expenditure.

	viii) Review all losses and special payments (including special severance payments). *Annual report and accounts* v) The Committee will review and approve the annual report and accounts, focusing particularly on: i) The wording in the annual governance statement and other disclosures. ii) Changes in, and compliance with, accounting policies, practices and estimation techniques. iii) Unadjusted mis-statements in the financial statements. iv) Significant judgements in preparation of the financial statements. v) Significant adjustments resulting from the audit. vi) Letters of representation. vii) Explanations for significant variances. *Information governance* w) The Committee will scrutinise compliance with legislative and regulatory requirements relating to information governance and the extent to which associated systems and processes are effective and embedded within the ICB. This will include oversight of the ICB's performance against the Data Security and Protection Toolkit (DSPT) standards. *Other regulatory and mandatory requirements* The Committee will also ensure the adequacy and effectiveness of the ICB's arrangements in relation to: x) The role of the ICB in respect of emergencies; overseeing the organisation's compliance against the requirements of the Civil Contingencies Act (2004) (CCA), the NHSE Emergency Preparedness, Resilience and Response (EPRR) Framework and any other mandated guidance pertaining to EPRR and business continuity. y) The statutory and mandatory requirements for health, safety, security and fire. z) The development and embedment of robust incident management processes, including ensuring that any 'lessons learnt' are routinely identified and appropriate actions are implemented to avoid reoccurrence. aa) The Committee will also review and approve policies specific to the Committee's remit. bb) Monitor the quality of data that informs the work of the Committee; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.

<table>
<tr><td>4. Membership</td><td>The Committee’s membership will be comprised of three Non-Executive Directors of the Board. Between them, the members will possess knowledge, skills and experience in accounting, risk management, internal, external audit; and technical or specialist issues pertinent to the ICB’s business.
The Chair of the ICB cannot be a member of the Committee.
Attendees
The following will be routine attendees at the Committee’s meetings:
a) Executive Director of Finance (or a suitable deputy, as appropriate)
b) Director of Corporate Affairs (or a suitable deputy, as appropriate)
c) Internal Audit
d) External Audit
Other officers may be invited to attend meetings when the Committee is discussing areas of risk or operation that fall within their areas of responsibility. This will include:
e) The Chief Executive being invited to attend, at least annually, to discuss with the Committee the process for assurance that supports the annual governance statement.
f) The Local Counter Fraud Specialist being invited to attend at least twice per year.
The Chair of the ICB will also be invited to attend one meeting each year to gain further assurance regarding the effectiveness of the ICB’s governance arrangements.</td></tr>
<tr><td>5. Chair and deputy</td><td>The Board will appoint a Non-Executive Director who has qualifications, expertise or experience to enable them to lead on finance and audit matters to be Chair of the Committee. The Vice-Chair of the ICB cannot be Chair of the Committee.
In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Committee’s membership will be nominated to deputise for that meeting.</td></tr>
<tr><td>6. Quorum</td><td>The Committee will be quorate with a minimum of two members present.
If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.
If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.</td></tr>
</table>

7. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. If a consensus agreement cannot be reached, then the item will be escalated to the Board for a decision.
8. Meeting arrangements	The Committee will meet no less than six times per year at appropriate times in the reporting and audit cycle. The Head of Internal Audit and representatives from external audit have a right of direct access to the Chair of the Committee and may request a meeting if they consider that one is necessary. The Committee will meet privately with the internal and external auditors at least once during the year. Meetings of the Committee, other than those regularly scheduled above, shall be summoned by the secretary to the Committee at the request of the Chair. The Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Committee will apply, including those relating to the quorum (as set out in section 6 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Committee to be open to the public. Secretariat support will be provided to the Committee to ensure the day-to-day work of the Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Committee. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
9. Minutes of meetings	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Committee at the following meeting.
10. Conflicts of interest management	In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the

	existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Committee will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
11. Reporting responsibilities and review of effectiveness	The Committee will provide assurance to the Board that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, by: a) Providing an assurance report to the Board following each of the Committee's meetings; summarising the items discussed, decisions made and any specific areas of concern that warrant immediate Board attention; and b) Providing an annual report to the Board, summarising how the Committee has discharged its duties across the year, key achievements and any identified areas of required committee development. This report will be informed by the Committee's annual review of its effectiveness. Any items of specific concern, or which require Board approval, will be the subject of a separate report.
12. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Issue Date:	Status:	Version:	Review Date:
1 October 2024	Approved	1.3	31 March 2025

6. Auditor Panel – Terms of Reference

1. Purpose and duties	The Auditor Panel (“the Panel”) exists to advise the Board on the selection and appointment of the organisation’s external auditor. This includes: a) Agreeing and overseeing a robust process for selecting the external auditors in line with the organisation’s normal procurement rules. b) Making a recommendation to the Board as to who should be appointed. c) Ensuring that any conflicts of interest are dealt with effectively. d) Advising the Board on the maintenance of an independent relationship with the appointed external auditor. e) Advising the Board (if asked) on whether or not any proposal from the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable. f) Agreeing the ICB’s position regarding the purchase of non-audit services from the appointed external auditor g) Advising the Board on any decision about the removal or resignation of the external auditor. The Panel will monitor the quality of data that informs its work; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
2. Status	The Panel has been established by the Board in accordance with The Local Audit and Accountability Act 2014 (the Act). The Board has authorised the Panel to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Panel. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.
3. Membership	The Panel’s membership will be comprised of three Non-Executive Directors of the Board. *Attendees* Senior Managers may be invited to attend meetings of the Panel to support the Panel in discharging its responsibilities.

4. Chair and deputy	The Board will appoint a Non-Executive Director who has qualifications, expertise or experience to enable them to lead on finance and audit matters to be Chair of the Panel. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Panel's membership will be nominated to deputise for that meeting.
5. Quorum	The Panel will be quorate with a minimum of two members present. If any Panel member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
6. Decision-making arrangements	Panel members will seek to reach decisions by consensus where possible. If a consensus agreement cannot be reached, then the item will be escalated to the Board for a decision.
7. Meeting arrangements	The Panel shall agree the frequency and timing of meetings needed to allow it to discharge its responsibilities. The Panel may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Panel will apply, including those relating to the quorum (as set out in section 5 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Panel to be open to the public. Secretariat support will be provided to the Panel. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Panel. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
8. Minutes of meetings and reporting responsibilities	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Panel (this may be performed virtually due to the timings between meetings). The Panel will report in writing to the Board following each of its meetings in the form of a report from the Chair of the Panel.

9. Conflicts of interest management	In advance of any meeting of the Panel, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Panel will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Panel's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Panel's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
10. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time in order to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Issue Date:	**Status:**	**Version:**	**Review Date:**
1 July 2022	Approved	1.0	31 March 2025

7. Remuneration and Human Resources Committee – Terms of Reference

1. Purpose	The main purpose of the Remuneration and Human Resources Committee ("the Committee") is to exercise the ICB's functions as set out in paragraphs 18 to 20 of Schedule 1B to the NHS Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022). The remit of the Committee excludes the remuneration, fees, allowances and other terms of appointment for the Chair of the ICB and for the non-executive members of the Board. These will be set by NHS England and the NED Remuneration Panel, respectively.
2. Status	The Committee is established in accordance with the National Health Service Act 2006 (as amended by the Health and Care Act 2022) and the ICB's Constitution. It is a statutory committee of, and accountable to, the Board. The Board has authorised the Committee to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary. d) Create sub-committees or task and finish groups to take forward specific duties or programmes of work as considered necessary by the Committee's membership. The Committee shall determine the membership and terms of reference of any such sub-committees or task and finish group. Any sub-committee or task and finish group established may consist of or include persons who are not Board members or ICB employees.
3. Duties	a) Determine the remuneration, fees, allowances and other terms of appointment for Executive Directors and all other Very Senior Manager (VSM) appointments (substantive and fixed term). Remuneration proposals will be guided by the relevant national pay frameworks, ensuring that Very Senior Managers are fairly rewarded for their individual contribution to the organisation, whilst ensuring proper regard to the organisation's circumstances and performance. b) Scrutinise and approve the ICB's VSM structure, ensuring clarity of roles in line with the organisation's purpose and functions and affordability.

	c) Advise on recruitment and selection plans for all VSM roles to ensure integrity, rigour and fairness in the appointment process. d) Determine any allowances to be paid to Board, committee and sub-committee members who are not employees (excluding Non-Executive Directors). e) Determine the remuneration, fees, allowances and other terms of appointment for any individuals engaged on a contract for service. f) Scrutinise and approve all proposed exit payments, ensuring that appropriate ICB policies and national guidance have been followed, and seeking HM Treasury pre-approval if required (which will be required for any proposed special severance payments). g) Oversee compliance with the requirements set out in the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, as necessary. h) Oversee arrangements for human resources management for all staff employed by the ICB. i) Monitor the quality of data that informs the work of the Committee; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
4. Membership	The Committee's membership will be comprised of four Non-Executive Directors of the Board, which includes the Chair of the ICB. The Chair of the Audit and Risk Committee cannot be a member of the Committee. *Attendees* Senior Managers may be invited to attend meetings of the Committee to support the Committee in discharging its responsibilities (providing their own remuneration is not being discussed). This will include expert human resources advisors.
5. Chair and deputy	The Board will appoint a Non-Executive Director to be Chair of the Committee. The Chair of the ICB cannot be Chair of the Committee. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Committee's membership will be nominated to deputise for that meeting.
6. Quorum	The Committee will be quorate with a minimum of two members present. If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

<table>
<tr><td></td><td>If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.</td></tr>
<tr><td>7. Decision-making arrangements</td><td>Committee members will seek to reach decisions by consensus where possible. Should this not be possible, then a vote of the Committee members will be required, the process for which will be, as follows:
a) All members of the Committee who are present at the meeting will be eligible to cast one vote each. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.
b) A decision will be passed if more votes are cast for it than against it.
c) Casting vote – If an equal number of votes are cast for and against a resolution, then the Chair of the Committee will have a casting vote.
Should a vote be taken, the outcome of the vote, and any dissenting views, will be recorded in the minutes of the meeting.
The Committee will take proper account of National Agreements, for example Agenda for Change and relevant guidance issued by the Government, the Department of Health and Social Care and NHS England in reaching its determinations.</td></tr>
<tr><td>8. Meeting arrangements</td><td>The Committee will meet on a quarterly basis.
The Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Committee will apply, including those relating to the quorum (as set out in section 6 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair.
There is no requirement for meetings of the Committee to be open to the public.
Secretariat support will be provided to the Committee to ensure the day-to-day work of the Committee is proceeding satisfactorily.
Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Committee.
Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair.
Agendas will be agreed with the Chair prior to the meeting.</td></tr>
<tr><td>9. Minutes of meetings and reporting responsibilities</td><td>Minutes will be taken at all meetings and presented according to the corporate style.</td></tr>
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	The minutes will be ratified by agreement of the Committee (this may be performed virtually due to the timings between meetings). The Committee will report in writing to the Board at least annually in the form of a report from the Chair of the Committee.
10. Conflicts of interest management	In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Committee will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
11. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis, but may be amended at any time in order to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Issue Date:	**Status:**	**Version:**	**Review Date:**
1 October 2024	Approved	1.1	31 March 2025

8. NED Remuneration Panel – Terms of Reference

1. Purpose and duties	The Non-Executive Director (NED) Remuneration Panel ("the Panel") exists to set the remuneration, fees, allowances and other terms of appointment for the non-executive members of the Board. The remit of the Panel excludes the remuneration, fees, allowances and other terms of appointment for the Chair of the ICB, which will be set by NHS England. The Panel will monitor the quality of data that informs its work; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
2. Status	The Panel has been established by the Board in accordance with the ICB's constitution. The Board has authorised the Panel to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Panel. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.
3. Membership	The Panel's membership will be comprised of the Chair of the ICB, a non-remunerated Partner Member of the Board and the Director of Corporate Affairs. *Attendees* Senior Managers may be invited to attend meetings of the Panel to support the Panel in discharging its responsibilities. This will include expert human resources advisors.
4. Chair and deputy	The Chair of the ICB will be Chair of the Panel. Should the Chair of the ICB be unable to attend all or part of the meeting, then a further non-remunerated Partner Member will be invited to join the Panel's membership and one of the non-remunerated Partner Members will be nominated to deputise for that meeting.
5. Quorum	The Panel will be quorate with a minimum of two members present. If any member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
6. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. Should this not be possible, then a vote of the

<table>
<tr><td></td><td>Panel members will be required, the process for which will be, as follows:
a) All members of the Panel who are present at the meeting will be eligible to cast one vote each. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.
b) A decision will be passed if more votes are cast for it than against it.
c) Casting vote – If an equal number of votes are cast for and against a resolution, then the Chair of the Panel will have a casting vote.
Should a vote be taken, the outcome of the vote, and any dissenting views, will be recorded in the minutes of the meeting.
The Panel will take proper account of relevant guidance issued by the Government, the Department of Health and Social Care and NHS England in reaching its determinations.</td></tr>
<tr><td>7. Meeting arrangements</td><td>The Panel shall agree the frequency and timing of meetings needed to allow it to discharge its responsibilities.
The Panel may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Panel will apply, including those relating to the quorum (as set out in section 5 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair.
There is no requirement for meetings of the Panel to be open to the public.
Secretariat support will be provided to the Panel to ensure its work is proceeding satisfactorily.
Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Panel.
Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair.
Agendas will be agreed with the Chair prior to the meeting.</td></tr>
<tr><td>8. Minutes of meetings and reporting responsibilities</td><td>Minutes will be taken at all meetings and presented according to the corporate style.
The minutes will be ratified by agreement of the Panel (this may be performed virtually due to the timings between meetings).
The Panel will report in writing to the Board following each of its meetings in the form of a report from the Chair of the Panel.</td></tr>
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9. Conflicts of interest management	In advance of any meeting of the Panel, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Panel will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
10. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis, but may be amended at any time in order to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Issue Date:	Status:	Version:	Review Date:
1 April 2023	Approved	1.1	31 March 2025

9. Finance and Performance Committee – Terms of Reference

1. Purpose	The Finance and Performance Committee ("the Committee") exists to: a) Scrutinise arrangements for ensuring the delivery of the ICB's statutory financial duties in line with sections 223GB to 223N of the NHS Act 2006 (as amended by the Health and Care Act 2022). b) Oversee the ICB's performance management framework, including scrutiny of actions to: i) Tackle heath inequalities and deliver improved health outcomes; and ii) Address shortfalls in performance against national and local health targets and performance standards. The Committee is also responsible for scrutinising the ICB's arrangements and delivery in relation to operational planning, estates, environmental sustainability (including statutory duties as to climate change) and data and digital, ensuring continuous improvements in performance and outcomes. The Committee also oversights non-healthcare contracts. The remit of the Committee incorporates the relevant requirements set out within the Delegation Agreement between NHS England and the ICB (Primary Medical Services), insofar as they relate to finance, performance and estates.
2. Status	The Committee is established in accordance with the National Health Service Act 2006 (as amended by the Health and Care Act 2022) and the ICB's constitution. It is a committee of, and accountable to, the Board. The Board has authorised the Committee to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary. d) Create sub-committees or task and finish groups to take forward specific duties or programmes of work as considered necessary by the Committee's membership. The Committee shall determine the membership and terms of reference of any such sub-committees or task and finish group. Any sub-committee or task and finish group established may consist of or include persons who are not Board members or ICB employees.

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<td>3. Duties</td>
<td>
a) Oversee the development of robust joint financial plans with the ICB's partner NHS trusts and NHS foundation trusts and recommend these for approval by the Board; ensuring that plans clearly demonstrate the use of resources to improve outcomes and tackle health inequalities. This will include:
i) A plan to meet statutory financial duties, for inclusion within the joint five-year forward plan (the system financial strategy).
ii) A joint capital resource use plan.
b) Ensure the ICB's annual budgets are prepared within the limits of available funds and recommend these for approval by the Board.
c) Review and scrutinise delivery of the joint financial plans and the ICB's in-year budgetary position, ensuring that:
i) Required efficiencies are identified and delivered, including opportunities at system level where the scale of partners together and the ability to work across organisations can be leveraged.
ii) Robust action plans are developed in response to any material breaches.
iii) Monies designated for integration are used for that purpose.
iv) The ICB's expenditure in each financial year does not exceed the aggregate of any sums received within that financial year.
v) Local capital and revenue resource use for each financial year does not exceed the limits specified by NHS England.
vi) Any joint financial objectives set by NHS England for the ICB and its partner NHS trusts and NHS foundation trusts are achieved.
d) Oversee arrangements for robust prioritisation of future capital resource use and the development of capital funding bids.
e) Oversee a system-based approach to preparing the annual operational plan, ensuring alignment with national priorities and recommending this for approval by the Board.
f) Oversee the ICB's performance management framework, including scrutiny of identified improvement plans to address shortfalls in performance against national and local health targets and performance standards.
g) Review and scrutinise the ICB's performance against measures put in place to reduce inequalities between persons with respect to their ability to access health services,
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	and between patients with respect to the outcomes achieved for them by the provision of health services. h) Examine performance at system, organisation and place levels, focussing in detail on specific issues where performance is showing deterioration, or where there are issues of concern. Any areas of deteriorating performance that could compromise health outcomes or quality of service will be referred to the Quality and People Committee for scrutiny of potential harm and appropriate interventions. i) Scrutinise the extent to which system transformational change programmes are driving improvements in performance. j) Oversee the development of the ICS Digital and Data Strategy in line with the seven success measures within the 'What Good Looks Like' framework and recommend this for approval by the Board; ensuring the strategy is underpinned by a sustainable financial plan and scrutinising delivery against the approved plan. k) Ensure compliance to digital and data sharing standards across the system. l) Oversee the development of the ICS Green Plan in line with national guidance and targets and recommend this for approval by the Board; subsequently scrutinising net zero progress against the approved plan and overseeing an annual update to the plan considering: i) Progress made and the ability to increase or accelerate agreed actions ii) New initiatives generated by staff or partner organisations iii) Advancements in technology and other enablers iv) Likely increase in ambition and breadth of national carbon reduction initiatives and targets. m) Oversee the development of a system-wide estates strategy and recommend this for approval by the Board; subsequently scrutinising its delivery. n) Approve the ICB's estates plan for the GP practices within its area and scrutinise arrangements for ensuring that the GP practice premises estate is properly managed and maintained. o) Make decisions in relation to the Premises Costs Directions Functions (in relation to General Medical Services), in line with any associated guidance issued by the Secretary of State for Health and Care or NHS England. p) Approve ICB headquarters estate and lease arrangements.

	q) Make decisions on resource allocations, procurement approaches and contract awards for non-healthcare services, in line with the Scheme of Reservation and Delegation (this excludes the appointment of the ICB's external auditor, which is completed in line with legislation by an Auditor Panel, convened for this purpose). r) Review and approve policies specific to the Committee's remit. s) Oversee the identification and management of risks relating to the Committee's remit. t) Monitor the quality of data that informs the work of the Committee; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
4. Membership	The Committee will have eight members, comprised as follows: a) Three Non-Executive Directors of the Board. b) Executive Director of Finance c) Executive Director of Delivery and Operations d) Executive Director of Nursing e) Senior leadership representative of the Medical Directorate f) Senior leadership representative of the Strategy and System Development Directorate *Attendees* The Committee may invite a range of Senior Managers to attend meetings to support the Committee in discharging its responsibilities. The Chair of the ICB will also be invited to attend one meeting each year to gain further assurance regarding the effectiveness of the ICB's governance arrangements.
5. Chair and deputy	The Board will appoint a Non-Executive Director to be Chair of the Committee. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Committee's non-executive membership will be nominated to deputise for that meeting.
6. Quorum	The Committee will be quorate with a minimum of five members, to include at least one Non-Executive Director and one Executive Director. To ensure that the quorum can be maintained, the Executive members of the Committee are able nominate a suitable deputy to attend a meeting of the Committee that they are unable to attend to speak and vote on their behalf. Committee members are responsible for fully briefing their nominated deputies and for informing the secretariat so that the quorum can be maintained.

	If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
7. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. Should this not be possible, then a vote of the Committee members will be required, the process for which will be, as follows: a) All members of the Committee who are present at the meeting will be eligible to cast one vote each. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote. b) A decision will be passed if more votes are cast for it than against it. c) Casting vote – If an equal number of votes are cast for and against a resolution, then the Chair of the Committee will have a casting vote. Should a vote be taken, the outcome of the vote, and any dissenting views, will be recorded in the minutes of the meeting. On occasion, the Committee may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between the scheduled meetings of the Committee and in relation to which a decision must be made prior to the next scheduled meeting. The powers which are delegated to the Committee, may for an urgent decision be exercised by the Chair of the Committee and the Director of Finance, subject to every effort having been made to consult with as many members of the Committee as possible in the given circumstances. The exercise of such powers by the Chair of the Committee and the Director of Finance will be reported to the next formal meeting of the Committee for formal ratification and to the Audit and Risk Committee for review of the reasonableness of the decision to use emergency powers.
8. Meeting arrangements	Meetings of the Committee will be scheduled on a monthly basis and the Committee will meet no less than ten times per year. Meetings of the Committee, other than those regularly scheduled above, shall be summoned by the secretary to the Committee at the request of the Chair. The Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Committee will apply, including

	those relating to the quorum (as set out in section 6 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Committee to be open to the public. Secretariat support will be provided to the Committee to ensure the day-to-day work of the Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Committee. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
9. Minutes of meetings	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Committee at the following meeting.
10. Conflicts of interest management	In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Committee will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee’s decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee’s decision-

	making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
11. Reporting responsibilities and review of committee effectiveness	The Committee will provide assurance to the Board that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, by: a) Providing an assurance report to the Board following each of the Committee's meetings; summarising the items discussed, decisions made and any specific areas of concern that warrant immediate Board attention. b) Providing an annual report to the Board, summarising how the Committee has discharged its duties across the year, key achievements and any identified areas of required committee development. This report will be informed by the Committee's annual review of its effectiveness. Any items of specific concern, or which require Board approval, will be the subject of a separate report.
12. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time in order to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Issue Date:	Status:	Version:	Review Date:
1 October 2024	Approved	1.2	31 March 2025

10. Quality and People Committee – Terms of Reference

1. Purpose	The Quality and People Committee ("the Committee") exists to ensure that the ICB is: a) Meeting its statutory requirements with regard to continuous quality improvements and enabling a single understanding of and shared commitment to quality care across the system that is safe, effective, equitable, and that provides a personalised experience and improved outcomes. b) Developing robust arrangements with partners to support 'one workforce' by leading system development and implementation of the ICS People Plan. The Committee also scrutinises the robustness of safeguarding, medicines management and compliance with equality legislation (including the Public Sector Equality Duty). The remit of the Committee incorporates the relevant requirements set out within the Delegation Agreement between NHS England and the ICB (Primary Medical Services), insofar as they relate to quality and people.
2. Status	The Committee is established in accordance with the National Health Service Act 2006 (as amended by the Health and Care Act 2022) and the ICB's constitution. It is a committee of, and accountable to, the Board. The Board has authorised the Committee to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary. d) Create sub-committees or task and finish groups to take forward specific duties or programmes of work as considered necessary by the Committee's membership. The Committee shall determine the membership and terms of reference of any such sub-committees or task and finish group. Any sub-committee or task and finish group established may consist of or include persons who are not Board members or ICB employees.
3. Duties	a) Oversee the development of the ICB's quality strategy and shared quality improvement priorities and plans, ensuring these have collective system ownership and are reflective of local quality challenges, focused on reducing inequalities in the quality of care.

	b) Scrutinise the effectiveness and sustained delivery of the quality strategy, improvement priorities and plans. c) Scrutinise arrangements in place to work with partners to support system quality management, combining quality planning, quality assurance and control, and quality improvement, ensuring system structures operate effectively with timely action being taken to address areas of concern. d) Scrutinise arrangements for ensuring that personalised care becomes 'business as usual' across the health and care system, ensuring delivery of national and local requirements. e) Scrutinise arrangements for safeguarding vulnerable adults and children in line with the ICB's statutory responsibilities. f) Ensure that the ICB's arrangements include effective and transparent mechanisms with regard to co-production, learning and improvement. This will include learning from incidents, never events and complaints. g) Scrutinise arrangements for ensuring the safe and effective management of medicines. h) Scrutinise arrangement for meeting the ICB's equality duties. This will include overseeing the development and implementation of equality improvement plans and the delivery of associated equality objectives. i) Oversee and scrutinise arrangements for the design, implementation and effectiveness of the ICS People Plan, which will include: i) Ensuring partners are aligned across the ICS to develop and support the 'one workforce', including through closer collaboration across the health and care sector, and with local government, the voluntary and community sector and volunteers. ii) Scrutinising delivery of local strategic and operational people priorities. iii) Reviewing action being taken to protect the health and wellbeing of people working within the ICS footprint. iv) Monitoring leadership development, talent management and succession planning approaches in order to drive the culture, behaviours and outcomes needed for people working in the system and the local population. v) Overseeing plans to develop – and where required, grow – the 'one workforce' to meet future need, through new ways of working, technology and wider innovation to meet population health needs and to create flexible and rewarding career pathways for those working in the system.

	vi) Ensuring collaboration across system partners to support local social and economic growth and a vibrant local labour market. j) Review and approve policies specific to the Committee's remit. k) Oversee the identification and management of risks relating to the Committee's remit. l) Monitor the quality of data that informs the work of the Committee; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
4. Membership	The Committee will have nine members, comprised as follows: a) Three Non-Executive Directors of the Board b) Primary Care Partner Member of the Board c) Executive Director of Nursing d) Executive Medical Director e) Executive Director of Delivery and Operations f) Senior leadership representative of the Strategy and System Development Directorate g) Senior leadership representative of the Finance Directorate *Attendees* The Committee may invite a range of Senior Managers to attend meetings to support the Committee in discharging its responsibilities. The Chair of the ICB will also be invited to attend one meeting each year to gain further assurance regarding the effectiveness of the ICB's governance arrangements.
5. Chair and deputy	The Board will appoint a Non-Executive Director to be Chair of the Committee. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Committee's non-executive membership will be nominated to deputise for that meeting.
6. Quorum	The Committee will be quorate with a minimum of five members, to include one Non-Executive Director and one Executive Director. To ensure that the quorum can be maintained, the Executive members of the Committee are able nominate a suitable deputy to attend a meeting of the Committee that they are unable to attend to speak and vote on their behalf. Committee members are responsible for fully briefing their nominated deputies and for informing the secretariat so that the quorum can be maintained. If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the

	agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
7. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. Should this not be possible, then a vote of the Committee members will be required, the process for which will be, as follows: a) All members of the Committee who are present at the meeting will be eligible to cast one vote each. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote. b) A decision will be passed if more votes are cast for it than against it. c) Casting vote – If an equal number of votes are cast for and against a resolution, then the Chair of the Committee will have a casting vote. Should a vote be taken, the outcome of the vote, and any dissenting views, will be recorded in the minutes of the meeting.
8. Meeting arrangements	Meetings of the Committee will be scheduled on a monthly basis and the Committee will meet no less than ten times per year. Meetings of the Committee, other than those regularly scheduled above, shall be summoned by the secretary to the Committee at the request of the Chair. The Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Committee will apply, including those relating to the quorum (as set out in section 6 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Committee to be open to the public. Secretariat support will be provided to the Committee to ensure the day-to-day work of the Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Committee. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.

9. Minutes of meetings	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Committee at the following meeting.
10. Conflicts of interest management	In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Committee will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
11. Reporting responsibilities and review of committee effectiveness	The Committee will provide assurance to the Board that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, by: a) Providing an assurance report to the Board following each of the Committee's meetings; summarising the items discussed, decisions made and any specific areas of concern that warrant immediate Board attention. b) Providing an annual report to the Board, summarising how the Committee has discharged its duties across the year, key achievements and any identified areas of required committee

	development. This report will be informed by the Committee's annual review of its effectiveness. Any items of specific concern, or which require Board approval, will be the subject of a separate report.
12. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time in order to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Issue Date:	**Status:**	**Version:**	**Review Date:**
1 October 2024	Approved	1.3	31 March 2025

11. Strategic Planning and Integration Committee – Terms of Reference

<table>
<tr><td>1. Purpose</td><td>The Strategic Planning and Integration Committee (“the Committee”) exists to exercise the ICB’s duties and powers to commission certain health services, as set out in sections 3 and 3A of the NHS Act 2006 (as amended by the Health and Care Act 2022), other than those explicitly delegated elsewhere. See schedule 1 attached to these terms of reference for further details of the relevant health services.

The remit of the Committee also incorporates the relevant requirements set out within the Delegation Agreement between NHS England and the ICB (Primary Medical Services), insofar as they relate to the planning, design and commissioning of primary medical services.

In exercising these functions, the Committee will make strategic commissioning decisions in order to further the four aims of the ICS to: improve outcomes in population health and healthcare; tackle inequalities in outcomes, experience and access; enhance productivity and value for money; and help the NHS support broader social and economic development.

When making decisions, the Committee will actively promote system development in line with the principles of subsidiarity and collaboration, and compliance with the general duties of ICBs as set out in sections 14Z32 to 14Z45 of the NHS Act 2006 (as amended), public sector equality duties, social value duties, the rules set out in NHS Provider Selection Regime. See schedule 1 attached to these terms of reference for further details of the general duties.

The Committee will also oversee:
a) Arrangements for developing the ICB’s Joint Forward Plan.
b) Ongoing system developments, including development of proposals for onward approval by the Board regarding the delegation of functions to be exercised by, or jointly with partners, within a place or at scale, in line with secondary legislation and statutory guidance issued by NHS England.
c) Development of applications to NHS England for further delegated functions.</td></tr>
<tr><td>2. Status</td><td>The Committee is established in accordance with the National Health Service Act 2006 (as amended) and the ICB’s Constitution. It is a committee of, and accountable to, the Board.

The Board has authorised the Committee to:
a) Investigate any activity within its terms of reference.</td></tr>
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	b) Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary. d) Create sub-committees or task and finish groups to take forward specific duties or programmes of work as considered necessary by the Committee's membership. The Committee shall determine the membership and terms of reference of any such sub-committees or task and finish group. Any sub-committee or task and finish group established may consist of or include persons who are not Board members or ICB employees. Individuals appointed as members of any sub-committee or task and finish group that is established to exercise the ICB's commissioning functions will be subject to approval by the ICB Chair (in line with the membership approval requirements set out in section 4 of these terms of reference).
3. Duties	a) Oversee the development of the ICB's Joint Forward Plan, ensuring it is prepared with the ICB's partner NHS trusts and NHS foundation trusts in line with any directions or guidance issued by NHS England, and recommending this for approval by the Board. b) Steer the development of strategic commissioning proposals in order to ensure that integrated services are in place to deliver the ICS Outcomes Framework and the ambitions and shared priorities set out in the Integrated Care Strategy, Joint Local Health and Wellbeing Strategies, and the ICB's Joint Forward Plan. Strategic commissioning proposals will facilitate the transformation of services to tackle complex challenges, including: i) Improving the health of children and young people. ii) Supporting people to stay well and independent. iii) Acting sooner to help those with preventable conditions. iv) Supporting those with long-term conditions or mental health issues. v) Caring for those with multiple needs as populations age. vi) Getting the best from collective resources so people get care as quickly as possible. c) Ensure the ICB's statutory duties and regulatory assurance roles in considering proposals for service change and reconfiguration are effectively discharged.

	d) Make resource allocation decisions (regarding investment and disinvestment business cases in line with the financial limits set out within the Scheme of Reservation and Delegation). When making decisions, the Committee will consider strategic alignment, impact on health inequalities, clinical effectiveness, anticipated health benefit/ health gain, cost effectiveness and affordability. e) Make decisions in relation to the award of healthcare contracts (in line with the financial limits set out within the Scheme of Reservation and Delegation), ensuring compliance with the NHS Provider Selection Regime. f) Oversee arrangements for the commissioning of primary medical services and for primary medical services contract management, including: i) The design of any enhanced services and local incentive schemes. ii) Urgent care services for out of area registered patients. iii) Establishing any new primary medical services providers in the area, in line with plans regarding the primary medical services provider landscape. g) Review and scrutinise regular updates regarding ongoing system development, including those relating to primary care networks, place-based partnerships, provider collaboratives, and joint and delegated commissioning arrangements. h) Scrutinise arrangements for public involvement and consultation in line with the ICB's statutory responsibilities. This will include: i) Overseeing the development and delivery of the ICB's public involvement and engagement strategy, ensuring the diversity of the population is effectively considered, including those who experience the greatest health inequalities. ii) Reviewing and scrutinising how people's voices and experiences across providers and partners are co-ordinated and heard. i) Scrutinise arrangements for ensuring the promotion of research as an essential function for continual improvement in health, well-being, high quality care and reducing health inequalities j) Oversee the development of proposals for ICB functions to be exercised by or jointly with any one or more other body (another ICB, an NHS trust, an NHS foundation trust, NHS England, a local authority, combined authority or any other prescribed body) under sections 65Z5 of the NHS Act 2006 (as amended) and recommend these for approval by the

	Board. Arrangements may involve the functions in question to be exercised by a joint committee and for the establishment of a pooled fund to fund those functions (under section 65Z6 of the 2006 Act). k) Oversee the development of proposals for the ICB to enter into partnership arrangements with one or more local authority under section 75 of the NHS Act 2006 (as amended) and recommend these for approval by the Board. These partnership arrangements will relate to the exercise of NHS functions and health-related functions, where the partnership arrangement is likely to lead to an improvement in the way these functions are exercised. Partnership arrangements may also include the establishment of a pooled fund made up of contributions from each partner. l) Review and scrutinise the impact of delegation agreements and partnership arrangements, ensuring they are delivering better outcomes, addressing health inequalities, sustaining joined-up, efficient and effective services and enhancing productivity. m) Oversee evaluation of the return on investment of funded healthcare services in terms of reduced health inequalities and improved health outcomes. n) Review an annual report on the work of the Individual Funding Request Panel. o) Review an annual report on the work of the Mental Health and Learning Disability Specialist Treatment/Funding Panel. This will include review and approval of the Panel's terms of reference on an annual basis. p) Review and approve policies specific to the Committee's remit and in line with the ICB's Scheme of Reservation and Delegation. q) Oversee the identification and management of risks relating to the Committee's remit. r) Monitor the quality of data that informs the work of the Committee; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
4. Membership	The Committee will have 12 members, comprised as follows: a) Three Non-Executive Directors of the Board b) Chief Executive c) Executive Director of Strategy and System Development d) Executive Medical Director e) Senior leadership representative of the Delivery and Operations Directorate f) Senior leadership representative of the Finance Directorate

<table>
<tr><td></td><td>g) Senior leadership representative of the Nursing and Quality Directorate
h) Director of Communications and Engagement
i) Health and social care commissioning representative from Nottingham City Council
j) Health and social care commissioning representative from Nottinghamshire County Council
All individuals appointed as members of the Committee are required to be approved by the Chair of the ICB due to the Committee's role in exercising the ICB's commissioning functions. The Chair of the ICB will not approve an individual to be a member of the Committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the individual's involvement with the private healthcare sector or otherwise.

Attendees
A representative from Healthwatch Nottingham and Nottinghamshire will have a standing invitation to attend meetings of the Committee.
The Committee may also invite a range of Senior Managers to attend meetings to support the Committee in discharging its responsibilities.
The Chair of the ICB will also be invited to attend one meeting each year to gain further assurance regarding the effectiveness of the ICB's governance arrangements.</td></tr>
<tr><td>5. Chair and deputy</td><td>The Board will appoint a Non-Executive Director to be Chair of the Committee.
In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Committee's non-executive membership will be nominated to deputise for that meeting. In such circumstances, care will be taken to ensure that the Audit and Risk Committee Chair's role of Conflicts of Interest Guardian is not compromised.</td></tr>
<tr><td>6. Quorum</td><td>The Committee will be quorate with a minimum of six members, to include one Non-Executive Director and one Executive Director.
To ensure that the quorum can be maintained, the Executive members of the Committee are able nominate a suitable deputy to attend a meeting of the Committee that they are unable to attend to speak and vote on their behalf. In line with the requirement for the Chair of the ICB to approve all individuals appointed as members of the Committee, all deputies must be nominated and approved by the Chair of the ICB in advance of the meeting. Committee members are responsible for fully briefing their nominated deputies</td></tr>
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<tr><td></td><td>and for informing the secretariat so that the quorum can be maintained. Ad hoc deputy arrangements are not permitted.
If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.
If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
For the sake of clarity, no person can act in more than one capacity when determining the quorum.</td></tr>
<tr><td>7. Decision-making arrangements</td><td>Committee members will seek to reach decisions by consensus where possible. Should this not be possible, then a vote of the Committee members will be required, the process for which will be, as follows:
a) All members of the Committee who are present at the meeting will be eligible to cast one vote each. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.
b) A decision will be passed if more votes are cast for it than against it.
c) Casting vote – If an equal number of votes are cast for and against a resolution, then the Chair of the Committee will have a casting vote.
Should a vote be taken, the outcome of the vote, and any dissenting views, will be recorded in the minutes of the meeting.
On occasion, the Committee may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between the scheduled meetings of the Committee and in relation to which a decision must be made prior to the next scheduled meeting.
The powers which are delegated to the Committee, may for an urgent decision be exercised by the Chair of the Committee and the Chief Executive subject to every effort having been made to consult with as many members of the Committee as possible in the given circumstances.
The exercise of such powers by the Chair of the Committee and the Chief Executive will be reported to the next formal meeting of the Committee for formal ratification and to the Audit and Risk Committee for review of the reasonableness of the decision to use emergency powers.</td></tr>
<tr><td>8. Meeting arrangements</td><td>Meetings of the Committee will be scheduled on a monthly basis and the Committee will meet, as a minimum, on a bi-monthly basis.</td></tr>
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	Meetings of the Committee, other than those regularly scheduled above, shall be summoned by the secretary to the Committee at the request of the Chair. The Committee may meet virtually using telephone, video and other electronic means when necessary. Where a virtual meeting is convened, the usual process for meetings of the Committee will apply, including those relating to the quorum (as set out in section 6 of these terms of reference) and those relating to meetings being open to the public and representatives of the press (as set out in section 9 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. Secretariat support will be provided to the Committee to ensure the day-to-day work of the Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Committee. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
9. Minutes of meetings	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Committee at the following meeting.
10. Conflicts of interest management	In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Committee (or person presiding over the meeting) will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be

	seen as detrimental to the Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
11. Reporting responsibilities and review of committee effectiveness	The Committee will provide assurance to the Board that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, by: a) Providing an assurance report to the Board following each of the Committee's meetings; summarising the items discussed, decisions made and any specific areas of concern that warrant immediate Board attention. b) Providing an annual report to the Board, summarising how the Committee has discharged its duties across the year, key achievements and any identified areas of required committee development. This report will be informed by the Committee's annual review of its effectiveness. Any items of specific concern, or which require Board approval, will be the subject of a separate report.
12. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Issue Date:	**Status:**	**Version:**	**Review Date:**
1 October 2024	Approved	1.4	31 March 2025

Schedule 1

Duties of Integrated Care Boards (ICBs) to commission certain health services	**Power of Integrated Care Boards to commission certain services**
ICBs must arrange for the provision of the following to such extent as it considers necessary to meet the reasonable requirements of the people for whom it has responsibility: a) Hospital accommodation. b) Other accommodation for the purpose of any service provided under the NHS Act 2006 (as amended). c) Medical services other than primary medical services. d) Dental services other than primary dental services. e) Ophthalmic services other than primary ophthalmic services. f) Nursing and ambulance services. g) Such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as the ICB considers are appropriate as part of the health service. h) Such other services or facilities for palliative care as the ICB considers are appropriate as part of the health service. i) Such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as the ICB considers are appropriate as part of the health service. j) Such other services or facilities as are required for the diagnosis and treatment of illness. *Note: ICBs' duties to arrange for the provision of services or facilities does not apply to the extent that NHS England has a duty to arrange for their provision, or another ICB has a duty to arrange for their provision.*	ICBs may arrange for the provision of such services or facilities as it considers appropriate for the purposes of the health service that relate to securing improvement: a) In the physical and mental health of the people for whom it has responsibility. b) In the prevention, diagnosis and treatment of illness in those people. *Note: ICBs may not arrange for the provision of a service or facility if NHS England has a duty to arrange for its provision.* **General duties of Integrated Care Boards** a) Duty to promote NHS Constitution (section 14Z32) b) Duty as to effectiveness, efficiency and economy (section 14Z33) c) Duty as to improvement in quality of services (section 14Z34) d) Duties as to reducing inequalities (section 14Z35) e) Duty to promote involvement of each patient (section 14Z36) f) Duty as to patient choice (section 14Z37) g) Duty to obtain appropriate advice (section 14Z38) h) Duty to promote innovation (section 14Z39) i) Duty in respect of research (section 14Z40) j) Duty to promote education and training (section 14Z41) k) Duty to promote integration (section 14Z42) l) Duty to have regard to wider effect of decisions (section 14Z43) m) Duties as to climate change (section 14Z44) n) Public involvement and consultation by ICBs (section 14Z45)

12. List of primary medical services providers

The following provides an up-to-date list of the eligible providers of primary medical services within the ICB Area for the purpose of nominating the Primary Care Partner Member of the Board, as referenced at 3.6.2 of the ICB's constitution.

No.	Practice Code	Practice Name	Postcode
1.	C84065	Abbey Medical Centre	NG9 2QP
2.	C84037	Abbey Medical Group	NG21 0RB
3.	C84679	Acorn Medical Practice	NG18 1QA
4.	C84067	Ashfield House Surgery	NG17 9JB
5.	C84091	Aspley Medical Centre	NG8 5RU
6.	C84693	Bakersfield Medical Centre	NG3 7EJ
7.	Y05369	Balderton Primary Care Centre	NG24 3HJ
8.	C84009	Barnby Gate Surgery	NG24 1QD
9.	C84101	Bawtry And Blyth Medical	DN10 6RQ
10.	C84017	Belvoir Health Group	NG13 8FD
11.	Y06356	Bilborough Medical Centre	NG8 4PN
12.	C84123	Bilsthorpe Surgery	NG22 8QB
13.	C84112	Bramcote Surgery	NG9 3HF
14.	C84092	Bridgeway Practice	NG2 2JG
15.	C84077	Brierley Park Medical Centre	NG17 2NF
16.	Y06792	Broad Oak Medical Practice	NG8 6LN
17.	C84605	Castle Healthcare Practice	NG2 7SD
18.	C84120	Chilwell Valley and Meadows Practice	NG9 6DX
19.	C84034	Churchfields Medical Practice	NG6 0HD
20.	C84020	Churchside Medical Practice	NG18 1QB
21.	C84046	Clifton Medical Practice	NG11 8EW
22.	C84045	Collingham Medical Centre	NG23 7LB
23.	C84035	Crown House Surgery	DN22 7XF
24.	C84066	Daybrook Medical Practice	NG5 6HP
25.	C84044	Deer Park Family Medical Practice	NG8 2GR
26.	C84039	Derby Road Health Centre	NG7 2DW
27.	C84025	East Bridgford Medical Centre	NG13 8NY

No.	Practice Code	Practice Name	Postcode
28.	C84032	Eastwood Primary Care Centre	NG16 3BS
29.	C84011	Elmswood Surgery	NG5 4AD
30.	C84105	Fairfields Practice	NG7 5HY
31.	C84074	Family Medical Centre (Kirkby)	NG17 7BG
32.	C84018	Family Medical Centre (Sood)	NG3 2FW
33.	C84036	Forest Medical	NG19 6AB
34.	C84019	Fountain Medical Centre	NG24 1QH
35.	C84667	Giltbrook Surgery	NG16 2GE
36.	Y03124	Grange Farm Medical Centre	NG8 4HQ
37.	C84063	Greendale Primary Care Centre	NG3 7DQ
38.	C84676	Greenfields Medical Centre (Yvs Rao)	NG7 6ER
39.	C84624	Hama Medical Centre	NG16 2NB
40.	C84629	Health Care Complex, Kirkby	NG17 7BG
41.	C84705	Hickings Lane Medical Centre	NG9 8PN
42.	C84055	Highcroft Surgery	NG5 7BQ
43.	C84691	High Green Practice (Khan)	NG7 5HY
44.	C84656	Hill View Surgery	NG21 0JP
45.	C84660	Hounsfield Surgery	NG23 6PX
46.	C84078	Hucknall Road Medical Centre	NG5 1NA
47.	C84654	Jacksdale Medical Centre	NG16 5JW
48.	C84081	John Ryle Medical Practice	NG11 8EW
49.	C84704	JRB Healthcare (Beechdale Surgery)	NG8 3LF
50.	C84613	Jubilee Park Medical Partnership	NG4 3DQ
51.	C84013	Kingfisher Family Practice	DN22 7XF
52.	C84061	King's Medical Centre	NG17 1AT
53.	Y05690	Kirkby Community Primary Care Centre	NG17 7AE
54.	C84076	Kirkby Health Centre	NG17 7LG
55.	C84001	Larwood Surgery	S81 0HH
56.	C84043	Leen View Surgery	NG6 8QJ
57.	C84694	Lime Tree Surgery	NG8 6AB
58.	C84029	Lombard Medical Centre	NG24 4XG

No.	Practice Code	Practice Name	Postcode
59.	C84140	Lowmoor Road Surgery	NG17 7BG
60.	C84113	Major Oak Medical Practice	NG21 9QS
61.	C84144	Meadows Health Centre (Larner)	NG2 2JG
62.	C84658	Meden Medical Services	NG20 0BP
63.	C84116	Melbourne Park Medical Centre	NG8 5HL
64.	C84021	Middleton Lodge Practice	NG22 9SZ
65.	C84106	Mill View Surgery	NG18 5PF
66.	C84090	Musters Medical Practice	NG2 7SD
67.	C84024	Newgate Medical Group	S80 1HP
68.	C84131	Newthorpe Medical Practice	NG16 3HU
69.	C84692	North Leverton Surgery	DN22 0AB
70.	C84095	Oakenhall Medical Practice	NG15 7UA
71.	C84016	Oakwood Surgery	NG19 8BL
72.	C84051	Orchard Medical Practice	NG18 5GG
73.	C82040	Orchard Surgery	DE74 2EL
74.	C84064	Parkside Medical Centre	NG6 8QJ
75.	Y02847	Parliament Street Medical Centre	NG1 6LD
76.	C84115	Plains View Surgery	NG3 5LB
77.	C84057	Pleasley Surgery	NG19 7PE
78.	C84084	Radcliffe-On-Trent Health Centre	NG12 2GD
79.	C84117	Radford Medical Practice (Kaur)	NG7 3GW
80.	C84087	Rainworth Health Centre	NG21 0AD
81.	C84129	Rise Park Surgery	NG5 5EB
82.	C84060	Rivergreen Medical Centre	NG11 8AD
83.	C84094	Riverside Health Centre	DN22 6FB
84.	C84069	Roundwood Surgery	NG18 1QQ
85.	C84637	Sandy Lane Surgery	NG18 2LT
86.	C84042	Saxon Cross Surgery	NG9 8DA
87.	C84142	Selston Surgery	NG16 6BT
88.	C84682	Sherrington Park Medical Practice	NG5 2EJ
89.	C84059	Sherwood Medical Partnership	NG19 0FW

No.	Practice Code	Practice Name	Postcode
90.	C84628	Sherwood Rise Medical Centre	NG7 7AD
91.	Y05622	Southglade Medical Practice	NG5 5GU
92.	C84049	Southwell Medical Centre	NG25 0AL
93.	C84004	St Albans Medical Centre	NG6 8AQ
94.	C84086	St Georges Medical Practice	NG2 7PG
95.	C84136	St Luke's Surgery	NG7 3GW
96.	C84026	Stenhouse Medical Centre	NG5 7BP
97.	C84714	Sunrise Medical Practice	NG11 8NS
98.	C84695	The Alice Medical Centre	NG5 5HW
99.	C84047	The Calverton Practice	NG14 6FP
100.	C84103	The Forest Practice	NG7 5HY
101.	C84703	The Gamston Medical Centre	NG2 6PS
102.	C84646	The Ivy Medical Group	NG14 5BG
103.	C84107	The Linden Medical Group	NG9 8DB
104.	C84080	The Manor Surgery	NG9 1GA
105.	C84151	The Medical Centre (Irfan)	NG7 7DS
106.	C84030	The Oaks Medical Centre	NG9 2NY
107.	Y00026	The Om Surgery	NG15 7JP
108.	C84028	The Ruddington Medical Centre	NG11 6HD
109.	C84023	The University of Nottingham Health Service	NG7 2QW
110.	C84072	The Wellspring Surgery	NG3 3GG
111.	C84683	The Windmill Practice	NG2 4PJ
112.	C84053	Torkard Hill Medical Centre	NG15 6DY
113.	C84010	Trentside Medical Group	NG4 2FN
114.	C84619	Tudor House Medical Practice	NG5 3HU
115.	C84008	Tuxford Medical Centre	NG22 0HT
116.	C84150	Unity Surgery	NG3 6EU
117.	C84085	Victoria And Mapperley Practice	NG1 3LW
118.	C84005	Village Health Group	LE12 6JG
119.	C84664	Welbeck Surgery	NG5 2JJ
120.	C84621	West Bridgford Medical Centre	NG2 7PX

No.	Practice Code	Practice Name	Postcode
121.	C84696	West Oak Surgery	NG3 6EW
122.	C84033	Westdale Lane Surgery	NG4 3JA
123.	Y05346	Westwood Primary Care Centre	S80 2TR
124.	Y06443	Whyburn Medical Practice	NG15 7JE
125.	C84012	Willowbrook Medical Practice	NG17 1ES
126.	C84122	Wollaton Park Medical Centre	NG8 1FG
127.	C84014	Woodlands Medical Practice	NG17 1JW

13. Meeting etiquette for Board and committee members

Introduction

As a publicly funded organisation, NHS Nottingham and Nottinghamshire Integrated Care Board has a duty to set and maintain the highest standards of conduct and integrity and this should be demonstrated through the appropriate behaviours of members and attendees (hereafter referred to as 'individuals') of our Board, committees and sub-committees.

This meeting etiquette sets out the behaviours expected at formal meetings; regardless of whether the meeting is in open or closed session or held in person or virtually.

Prior to meetings

Attendance at meetings should be prioritised in diaries; however, if individuals are sending apologies, they must inform the Committee Secretary of this as soon as possible and (where terms of reference permit) arrange for a deputy to attend in their place. Individuals are responsible for ensuring their deputy is well-briefed and able to contribute effectively at the meeting.

Individuals should make sure they are fully prepared for the meeting by:

(a) Being clear as to the purpose of the meeting and the role they play at the meeting (this is particularly important for individuals deputising for absent members).

(b) Reading the agenda and papers; being clear on the purpose of items being presented (e.g. any decisions requested) and considering any questions/points that they may wish to raise.

(c) Advising the Committee Secretary of any conflicts, or potential conflicts of interest, in relation to the agenda (if these have not been identified already).

(d) Arriving at the meeting, or joining online if being held virtually, in plenty of time. This will allow the meeting to start promptly (for example, enabling individuals time to resolve any connectivity issues).

(e) Informing the Chair if they need to leave during the meeting (however, this should be avoided if possible).

(f) For virtual meetings, ensuring that they have the corporate background on, particularly if the meeting is in open session. Positioning themselves so that they are close to the camera, so that their face fills most of the screen and can be clearly seen by anyone watching and making sure (as far as possible) that they/the meeting will not be disturbed by other members of their household.

(g) Ensuring that they have everything they need for the meeting, such as a drink, pen and paper etc. and by ensuring that their device is fully charged or that they are quickly able to connect to a power source if needed.

During meetings

During meetings, individuals should:

(a) Stay fully engaged and dedicate their attention to the purpose of the meeting, refraining from performing other duties that will distract them (or could appear to distract them), for example, by responding to emails.

(b) For virtual meetings, ensure that their video function is on throughout the duration of the meeting so that other members/attendees can always see you. Individuals should also ensure that their microphone is always muted (unless they are speaking) to reduce background noise interference and to minimise the risks of people speaking over one another.

(c) Turn off their mobile phone/electronic communications device. When an electronic device must be kept on, it should be turned to silent/vibrate and individuals should excuse themselves from the meeting if they need to answer an urgent call. Excusing themselves means leaving the room if the meeting is in person or temporarily turning their camera off if the meeting is virtual. During their absence, individuals will not be included in the meeting quorum.

(d) Raise their hand to indicate that they wish to speak. For virtual meetings, this can be done by pressing the ‘Raise Hand’ button (or equivalent) in the virtual meeting application. In both cases, individuals are required to wait until the Chair states that they may speak to avoid interrupting a fellow Board/committee member. When invited to speak, individuals should do so clearly, concisely and at a volume that all attendees can hear (especially the minute-taker).

(e) Refrain from private conversations with other members, even if this is considered relevant to the meeting discussion (in which case, it should be raised as described above). This also applies during virtual meetings, where the ‘Chat’ function can be considered the equivalent of talking directly/privately with other members. This can be distracting and comments made in this way will not be recorded in the meeting minutes. As such, this function should only be used when individuals need to speak directly to the Chair or Committee Secretary (e.g. if they need to leave the meeting).

(f) Listen attentively and respectfully to others and be constructive and professional when providing critique and/or challenge.

(g) Speak up if they disagree. Silence will be taken by the Chair as their agreement/approval and the members in attendance have collective responsibility of any decisions made or actions agreed.

14. Board meetings: Guidance for members of the public

Introduction

NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) is committed to openness and transparency and conducts as much of its business as possible in meetings that are open to members of the public.

A meeting in public is where members of the public can attend to observe a formal meeting. However, observers are not permitted to join in the discussion. These are different from public meetings, which are open forums to allow members of the public to ask questions and discuss issues, usually on a specific topic.

How do I find out about meetings?

Meeting dates, times and venues, which can be subject to change, are published on the ICB's website: www.notts.icb.nhs.uk.

Meeting agendas and supporting papers are available on the website five calendar days before each meeting.

Can members of the public ask questions during the meeting?

To assist in the management of the agenda and meeting, individuals are requested to submit written questions to the Board's email address nnicb-nn.ics@nhs.net at least 48 hours before the meeting. However, the Chair will also accept questions on the day provided that they are pertinent to items on the agenda. The Chair reserves the right to decide whether to accept the question.

Where possible, a response will be given to questions at the meeting, however if the matter is complex or requires the consideration of further information, a written response to questions will be provided within ten working days. If the number of questions raised exceeds the time allocated, questions will be taken on a first come, first served basis and any remaining questions subsequently addressed in writing.

We will not be able to discuss questions if:

(a) They do not relate to an item on the agenda;

(b) They relate to individual patient care or the performance of individual staff members; or

(c) They relate to issues which are the subject of current confidential discussions, legal action or any other matter not related to the roles and responsibilities of the ICB.

The Chair reserves the right to move the meeting on if they judge that no further progress is likely to result from further discussion or questioning, or to ensure that the meeting can be conducted on time.

Any questions submitted may be treated as a request under the Freedom of Information Act 2000 and treated accordingly.

Attendance at meetings

If you have any particular needs with regards to access or assistance, such as wheelchair access or an induction loop please contact nnicb-nn.ics@nhs.net and we will do our best to assist you. Please be aware that you will need to sign-in at the venue reception upon arrival, for fire safety and security reasons. A member of staff will escort everyone to the meeting room. Unfortunately, if members of the public arrive after the meeting has already started it may not be possible for them to join the meeting.

We are always interested to know who is attending our meetings and would like to encourage a wide range of organisations and individuals. To help us with this, we will ask you to sign a register when you arrive for the meeting.

At the end of meeting, all members of the public will also be escorted back to the main entrance by a member of staff.

Please note that the use of mobile phones or other electronic devices during the meeting will not be permitted if their use is deemed disruptive to the meeting. This is for the benefit of all present.

Identifying Board members

The Chair will ask members to introduce themselves at the beginning of each meeting. A name plate for each member will also be displayed on the table to help you see who is speaking during the meeting.

Discussions at meetings

The members will have been provided with copies of the agenda and papers at the same time as they are published on the website and will therefore have had the opportunity to consider the papers prior to the meeting. The Board will consider the items on the agenda in turn and each paper includes a summary cover sheet, which makes recommendations for the meeting to consider. For some items there may be a presentation whereas for others this may not be necessary. The members may not actively discuss each item in detail; this does not mean that the item has not received careful consideration but means that the members have no further questions on the matter and do not wish to challenge the recommendation(s). A formal vote will not be taken if there is a consensus on a suggested course of action.

Minutes

A record of the issues discussed and decisions taken at the meeting will be set out in the minutes, which members will be asked to approve as a correct record at its next meeting. Please note that the minutes will not be a verbatim record of everything that was discussed at the meeting.

Public order

The Chair may at any time require the public or individual members of the public or media to leave the meeting or may adjourn the meeting to a private location if they consider that those present are disrupting the proper conduct of the meeting or the business of the Board.

Will all discussion be held in open session?

The following criteria are applied in considering whether matters should be dealt with on a confidential basis.

- Material relating to a named individual;
- Information relating to contract negotiations;
- Commercially sensitive information;
- Information which may have long term legal implications or contain legal advice which, if revealed may prejudice the ICB's position;
- Other sensitive information, which, if widely available, would detrimentally affect the standing of the ICB; and
- Exceptionally, information which by reason of its nature, the ICB is satisfied should be dealt with on a confidential basis.

15. Procedure for the consideration of petitions

Criteria for Acceptance

(a) Petitions may be received in paper or electronic format (e.g. email, web based or social media).

(b) Petitions should include a statement, which should include:

- The organisation to which the petition is being addressed
- The proposition which is being promoted by the petition
- The timeframe over which the petition has been collected

(c) The name and address of the petition organiser, who must be resident within the Nottingham and Nottinghamshire ICB Area, should be provided on the first page of the petition.

(d) The following information about each petitioner should be included:

- Name
- Postcode
- Signature (in the case of a written petition)
- Email address (in the case of an electronic petition)

Acceptance

(e) An acknowledgement of receipt of the petition will be provided to the lead petitioner within five working days of receipt, with a clear explanation about what will happen next.

(f) Once received, the Chief Executive or nominated representative will ensure that the petition receives appropriate and proportionate consideration and that a response is made in writing.

(g) Where a petition, with significant support (with a minimum of 1,000 signatures) has been received by the ICB, the Chief Executive shall consult with the Chair as to whether the petition should be included as a specific item for the agenda and consideration at the next meeting of the Board to agree any appropriate actions.

(h) The following issues will be taken into account when considering a petition:

- If a petition is raised about a perceived lack of or missing service, influence will be afforded to the most cogent ideas and arguments, based upon clinical effectiveness, quality, patient safety, clinical and cost effectiveness and not necessarily to the views of the most numerous stakeholders.

- The petition's concerns will be assessed in relation to the rationale and constraints behind it. For example, a petition that proposes a realistic alternative option will normally be given greater weight than a petition that simply opposes an option that has been put forward for valid reasons.
- The petition's concerns will also be assessed in relation to the impact on other populations if these demands were accepted. This assessment could take into account views expressed in other petitions (which may conflict).

(i) The organiser of the petition will receive correspondence from the ICB, in the form of an outcome letter describing how the issues raised have or will influence the decisions of the ICB, within 40 working days of receipt of the petition.

Criteria for Non-Acceptance

(j) Petitions will not be considered if they are repeated, vexatious or if they concern issues which are outside the ICB's remit. Petitions will also not be considered if the information contained is confidential, libellous, false, defamatory or offensive.

(k) A petition will be considered as a repeat petition if:

- It covers the same or substantially similar subject matter to another petition received within the previous six months;
- It is presented by the same or similar individuals or groups as another petition received within the previous six months.

(l) A petition will be considered as a vexatious petition if:

- It focuses on individual grievances
- It focuses on the actions or decisions of an individual and not the organisation

(m) A petition will be considered as outside the ICB's' remit if:

- It focuses on a matter relevant to another organisation
- It requests information available via Freedom of Information legislation
- Its aim is to correspond on personal issue(s) with an individual(s)
- Signatories are not based in the UK

(n) A petition will be considered as confidential, libellous, false or defamatory if:

- It contains information which may be protected by an injunction or court order

- It contains material which is potentially confidential, commercially sensitive, or which may cause personal distress or loss

(o) A petition will be considered as offensive if:

- It contains language that may cause offence, is provocative or extreme in its views

(p) Where a petition does not meet the criteria for acceptance, then the ICB will respond in writing within 20 working days to advise that the petition has been rejected. The reason for rejection will be given clearly and explicitly.

Annex A: Standing Financial Instructions

The ICB's Standing Financial Instructions are published in full on the ICB's website at www.notts.icb.nhs.uk.

Annex B: Scheme of Reservation and Delegation

The ICB's Scheme of Reservation and Delegation is published in full on the ICB's website at www.notts.icb.nhs.uk.

Annex C: Nottingham and Nottinghamshire Integrated Care Partnership

Section 116ZA of the Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Care Act 2022), requires Integrated Care Boards (ICBs) and upper tier Local Authorities to establish Integrated Care Partnerships (ICPs) as equal partners. In Nottingham and Nottinghamshire, an ICP has been established as a joint committee of Nottingham City Council, Nottinghamshire County Council and NHS Nottingham and Nottinghamshire ICB.

The primary role of the ICP is to lead on creating an Integrated Care Strategy and Outcomes Framework to reduce health inequalities and improve health and care outcomes and experiences for the Nottingham and Nottinghamshire population. In doing so, the ICP acts as the 'guiding mind' of the local health and care system, providing a forum for NHS leaders and Local Authorities to come together with important stakeholders from across the wider system and communities.

More information about the ICP is available here: https://healthandcarenotts.co.uk/about-us/our-integrated-care-partnership/. This includes the ICP's terms of reference, membership details, and meeting dates and papers.

Nottingham and Nottinghamshire

Rushcliffe Arena, 09:00-12/09/24

Nottingham & Nottinghamshire Integrated Care Board

Integrated Performance Report

Reporting Month: June 2024 / July 2024

Board Month: September 2024

NHS Nottingham and Nottinghamshire

Integrated Performance Report September 2024 – Report Contents

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1. Introduction

This report presents progress against the key performance targets, across quality, service delivery, finance and workforce, and to note key developments and actions being taken to address performance issues. Where appropriate, information is provided for total Nottingham and Nottinghamshire population, and total provider responsibilities for those providers geographically located within Nottinghamshire, Sherwood Forest Hospitals (Acute), Nottingham University Hospitals (Acute) and Nottinghamshire Healthcare NHS Trust (Mental Health). The indicators included in the Board Integrated Performance Report (IPR) are reviewed annually and are based on the system operational plan for 2023/24, compliance and commitment targets, and any additional key local and national measures.

The intention is that each ICS Oversight Group, which is led by an ICB Executive Lead, will propose a level of assurance following the discussion of the reported metrics based upon the ICS Assurance Escalation Framework (page 95) which will support the escalation of issues to the ICB Board.

Service Delivery and workforce areas have adopted a reporting approach using Statistical Process Control (SPC) charts, further detail relating to SPC is included on page 78 of the report for reference to aid the review of the performance report tables included in the report. The aim of the SPC charts is to provide richer information relating to whether a service is improving or deteriorating based on trend (variation icons) and the likelihood of the system plan or target being met (assurance icons).

The system is experiencing pressures to delivery across all areas of the ICS Aims, with patients experiencing longer waits than acceptable across urgent care, cancer and elective pathways, Learning Disability and Autism patients remaining in inpatient care settings and Mental Health patients being placed in out of area beds

The full detail of the performance measures which the ICB is required to deliver, are provided across a series of functional score cards on pages 4 –12. These provide an overview of the areas which are and are not delivering as planned. The SPC icons provide an indication of the improvement or deterioration in the position (variation) as well as an indication of whether the current process or performance levels will achieve the required level in future (assurance).

Exception reports by functional area, detailing the areas of concern, actions being taken to address the current issues, and assurance as to whether these actions will impact upon and improve the position, are provided on pages 13 – 107.

NHS Nottingham and Nottinghamshire

Quality Scorecard

Quality Scorecard	Latest Period	Plan	Actual	Variance	Section
Learning Disability & Autism					
LD&A Inpatients Rate Adults – ICB	Jun-24	14	16	+2	Section 01
LD&A Inpatients Rate Adults – NHSE	Jun-24	28	27	-1	
LD&A Inpatients Rate CYP – NHSE	Jun-24	3	0	-3	
LD&A Annual Health Checks	Jun- 24	857	949	+92	
Maternity					
No. stillbirths per 1000 total births	Dec 23		2.2	1.3	Section 02
No. neonatal deaths per 1000 live births	Dec 23		2.24	0.11	
Infection Prevention Control Hospital Acquired Infections ICB (52R+02Q) (based on 2023-24 targets as 2024-25 not issued to date)					
MRSA	May 24	0	0	0	Section 10
C-Diff	May 24	22	27	-5	
Ecoli BSI	May 24	72	91	-19	
Klebsiella BSI	May 24	21	24	-3	
Pseudomonas BSI	May 24	6	9	-3	

Quality Scorecard	Latest Period	Plan	Actual	Variance	Section
Vaccinations					
MMR second dose at 5 years	Sep 23	95%	82%	-13%	Section 06
COVID Vaccination Booster dose	Jan 24		54.4%		
Seasonal Flu Vaccination	Mar 24		57.4%		

NHS Nottingham and Nottinghamshire

3a. Service Delivery Scorecard - Streamline Urgent Care and Flow

Population

Pre-Hospital Flow Volumes

Name	Latest Period	Plan	Actual	Variance	V	A
EMAS Calls - ICB Population	Jul-24	-	23721	-		
111 Calls Answered - ICB Population	Mar-24	-	35235	-		

Pre-Hospital - Alternatives to ED

Name	Latest Period	Plan	Actual	Variance	V	A
Urgent Care Response (UCR) - ICB Population	-	-	-	-		
UCR Response % - ICB Population	-	-	-	-		

Front Door - Flow Volumes

Name	Latest Period	Plan	Actual	Variance	V	A
Ambulance Conveyances to ED (Vol)	Jul-24	-	7597	-		
Ambulance Conveyances to ED (%)	Jul-24	-	46.3%	-		
Total A&E Attendances - ICB Population	Jul-24	-	41737	-		

In-Hospital Flow

Name	Latest Period	Plan	Actual	Variance	V	A
Total NEL admissions - ICB Population	Jun-24	-	11739	-		
NEL Conversion Rate from ED Atds - %	-	-	-	-		
SDEC % of Total Admissions - ICB Population	-	-	-	-		
% Bed Occupancy - ICB Population	-	-	-	-		

Flow out of Hospital

Name	Latest Period	Plan	Actual	Variance	V	A
Number of MSFT > 24 Hours	-	-	-	-		
No Criteria to Reside	-	-	-	-		
Length of Stay > 21 days	-	-	-	-		
Pthy 0 - Discharges Home	Jul-24	8590	12457	✓ 3867		
Pthy 1 - Disch home w/ hlth and/or social care	Jul-24	1106	991	✗ -115		
No. Patients utilising Virtual Ward	Jul-24	209	276	✓ 67		

Provider

Pre-Hospital Flow Volumes

Name	Latest Period	Plan	Actual	Variance	V	A
EMAS Calls - ICB Provider	-	-	-	-		
111 Calls Answered - ICB Provider	-	-	-	-		

Pre-Hospital - Alternatives to ED

Name	Latest Period	Plan	Actual	Variance	V	A
Urgent Care Response (UCR) - ICB Provider	-	-	-	-		
UCR Response % - ICB Provider	-	-	-	-		

Front Door - Flow Volumes

Name	Latest Period	Plan	Actual	Variance	V	A
Ambulance Conveyances to ED (Vol)	-	-	-	-		
Ambulance Conveyances to ED (%)	-	-	-	-		
Total A&E Attendances - ICB Provider	Jul-24	34860	36190	✗ 1330		

In-Hospital Flow

Name	Latest Period	Plan	Actual	Variance	V	A
Total NEL admissions - ICB Provider	Jun-24	11350	12083	✗ 733		
NEL Conversion Rate from ED Atds - %	Jun-24	-	33.9%	-		
SDEC % of Total Admissions - ICB Provider	Jul-24	33.0%	36.0%	✓ 3.0%		
% Bed Occupancy - ICB Provider	May-24	95.2%	92.7%	✓ -2.5%		

Flow out of Hospital

Name	Latest Period	Plan	Actual	Variance	V	A
Number of MSFT > 24 Hours	Jul-24	-	176	-		
No Criteria to Reside	Jul-24	315	273	✓ -42		
Length of Stay > 21 days	Jul-24	400	358	✓ -42		
Pthy 0 - Discharges Home	-	-	-	-		
Pthy 1 - Disch home w/ hlth and/or social care	-	-	-	-		
No. Patients utilising Virtual Ward	Jul-24	-	243	-		

3a. Service Delivery Scorecard - Urgent Care Compliance

EMAS Performance Compliance

Population

Name	Latest Period	Plan	Actual	Variance		V	A
Ambulance (mean) resp time Cat 1 (Notts)	Jul-24	00:07:00	00:08:20	✗	00:01:20		
Ambulance (mean) resp time Cat 2 (Notts)	Jul-24	00:27:30	00:35:10	✗	00:07:40		
% Cat 2 waits below 40 minutes (Notts)	Jul-24	90.0%	57.7%	✗	-32.3%		
Ambulance resp time Cat 3 - 90th Centile *	Jul-24	02:00:00	06:42:36	✗	04:42:36		
Ambulance resp time Cat 4 - 90th Centile *	Jul-24	03:00:00	06:39:56	✗	03:39:56		

Provider

Name	Latest Period	Plan	Actual	Variance	V	A
Ambulance (mean) resp time Cat 1 (Notts)	-	-	-	-		
Ambulance (mean) resp time Cat 2 (Notts)	-	-	-	-		
% Cat 2 waits below 40 minutes (Notts)	-	-	-	-		
Ambulance resp time Cat 3 - 90th Centile *	-	-	-	-		
Ambulance resp time Cat 4 - 90th Centile *	-	-	-	-		

Acute Performance Compliance

Population

Name	Latest Period	Plan	Actual	Variance		V	A
Hospital Handover Delays > 30 Minutes	Jul-24	-	2531		-		
Hospital Handover Delays > 60 minutes	Jul-24	-	951		-		
Ambulance Total Hours Lost	Jul-24	2322	2474	✗	152		
A&E 4hr % Perf (All)	-	-	-		-		
12 Hour Breaches ED	-	-	-		-		
12 Hour Breaches as % ED Atds	-	-	-		-		

Provider

Name	Latest Period	Plan	Actual	Variance		V	A
Hospital Handover Delays > 30 Minutes	Jul-24	-	2055		-		
Hospital Handover Delays > 60 minutes	Jul-24	0	781	✗	781		
Ambulance Total Hours Lost	Jul-24	2178	2045	✓	-133		
A&E 4hr % Perf (All)	Jul-24	71.2%	70.0%	✗	-1.2%		
12 Hour Breaches ED	Jul-24	0	477	✗	477		
12 Hour Breaches as % ED Atds	Jul-24	2.0%	7.0%	✗	5.0%		

3b. Service Delivery Scorecard - Planned Care Recovery (1)

NHS
Nottingham and Nottinghamshire

Population

Elective Recovery - Total Waiting List & Long Waits

Name	Latest Period	Plan	Actual	Variance	V	A
Total Waiting List Size	Jun-24	125666	130352	✗ 4686		
Incomplete RTT pathways >52 Wks	Jun-24	4659	5088	✗ 429		
Incomplete RTT pathways >65 Wks	Jun-24	338	669	✗ 331		
Incomplete RTT pathways >78 Wks	Jun-24	0	6	✗ 6		

Elective Recovery - Activity

Name	Latest Period	Plan	Actual	Variance	V	A
Total Referrals	Mar-24	-	24952	-		
Total Ordinary Electives	Jun-24	1907	2213	✓ 306		
Total Daycases	Jun-24	13200	14310	✓ 1110		
Total Outpatients 1st (Spec Acute)	Jun-24	25647	29373	✓ 3726		
Total Outpatients FUp (Spec Acute)	Jun-24	46885	63231	✓ 16346		
Total Diagnostic Activity (Key 15)	Jun-24	-	40464	-		

Elective Recovery - Productivity & Transformation

Name	Latest Period	Plan	Actual	Variance	V	A
Total Outpatients - Virtual(%)	Jun-24	25.0%	19.3%	✗ -5.7%		
Patient Initiated Fups (%)	-	-	-	-		
Advice and Guidance (% of 1st OP)	May-24	-	34	-		
Completed Adm RTT Pathways	Jun-24	5322	5237	✗ -85		
Completed Non-Adm RTT Pathways	Jun-24	25440	21401	✗ -4039		

Provider

Elective Recovery - Total Waiting List & Long Waits

Name	Latest Period	Plan	Actual	Variance	V	A
Total Waiting List Size	Jun-24	120743	122395	✗ 1652		
Incomplete RTT pathways >52 Wks	Jun-24	4620	4853	✗ 233		
Incomplete RTT pathways >65 Wks	Jun-24	330	635	✗ 305		
Incomplete RTT pathways >78 Wks	Jun-24	0	0	✓ 0		

Elective Recovery - Activity

Name	Latest Period	Plan	Actual	Variance	V	A
Total Referrals	Mar-24	-	22095	-		
Total Ordinary Electives	Jun-24	2630	2180	✗ -450		
Total Daycases	Jun-24	15854	13467	✗ -2387		
Total Outpatients 1st (Spec Acute)	Jun-24	30582	26300	✗ -4282		
Total Outpatients FUp (Spec Acute)	Jun-24	38550	60583	✓ 22033		
Total Diagnostic Activity (Key 15)	-	-	-	-		

Elective Recovery - Productivity & Transformation

Name	Latest Period	Plan	Actual	Variance	V	A
Total Outpatients - Virtual(%)	Jun-24	25.0%	17.9%	✗ -7.1%		
Patient Initiated Fups (%)	Jun-24	5.0%	5.5%	✓ 0.5%		
Advice and Guidance (% of 1st OP)	May-24	-	21	-		
Completed Adm RTT Pathways	Jun-24	4657	4354	✗ -303		
Completed Non-Adm RTT Pathways	Jun-24	23466	19168	✗ -4298		

Note: Population activity actuals include delegated specialised activity, however plans submitted did not include the delegated activity

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3b. Service Delivery Scorecard - Planned Care Recovery (2)

NHS
Nottingham and Nottinghamshire

Diagnostic Recovery

Population: Name	Latest Period	Plan	Actual	Variance	V	A	Provider: Name	Latest Period	Plan	Actual	Variance	V	A
Total Diagnostic Activity	Jun-24	39052	38995	-57			Total Diagnostic Activity	Jun-24	35480	34160	-1320		
Diagnostic Waiting List	Jun-24	26436	31344	4908			Diagnostic Waiting List	Jun-24	24665	29643	4978		
Diagnostic Backlog	Jun-24	7326	8896	1570			Diagnostic Backlog	Jun-24	7056	8896	1840		
Diagnostics +6 Wks	Jun-24	72.3%	71.6%	-0.7%			Diagnostics +6 Wks	Jun-24	71.4%	70.0%	-1.4%		

Cancer Recovery

Population: Name	Latest Period	Plan	Actual	Variance	V	A	Provider: Name	Latest Period	Plan	Actual	Variance	V	A
Cancer 2ww %	-	-	-	-			Cancer 2ww %	Apr-24	93.0%	77.1%	-15.9%		
Cancer - Faster Diag Std 28 Days	Jun-24	78.0%	80.0%	2.0%			Cancer - Faster Diag Std 28 Days	Jun-24	78.0%	79.9%	1.9%		
Cancer - No. 1st Definitive Treatments	Jun-24	-	1071	-			Cancer - No. 1st Definitive Treatments	Jun-24	-	1138	-		
Cancer - No.receiving 1st Trt <31 days %	Jun-24	96.0%	92.3%	-3.7%			Cancer - No.receiving 1st Trt <31 days %	Jun-24	96.0%	91.8%	-4.2%		
Cancer - No. patients waiting <62 days %	Jun-24	63.1%	67.5%	4.3%			Cancer - No. patients waiting <62 days %	Jun-24	63.1%	66.4%	3.2%		
Cancer - 62 day backlog	-	-	-	-			Cancer - 62 day backlog	Jul-24	339	313	-26		

NHS Nottingham and Nottinghamshire

3c. Service Delivery - Mental Health Scorecard

Population

Mental Health - Talking Therapies (Previously IAPT)

Name	Latest Period	Plan	Actual	Variance	V	A
Talking Therapies - Referrals	Jun-24	-	2580	-		
Talking Therapies- 1st Treatment <6 Weeks	Jun-24	75.0%	98.6%	✓ 23.6%		
Talking Therapies- 1st Treatment <18 Weeks	Jun-24	95.0%	100.0%	✓ 5.0%		
Talking Therapies - Entering Treatment (3mth)	Jun-24	-	6520	-		
Talking Therapies- >90 Days 1st & 2nd Treatment	Jun-24	10.0%	59.8%	✗ 49.8%		
Talking Therapies- Recovery Rate (3mth Rolling)	Jun-24	50.0%	50.5%	✓ 0.5%		

Mental Health - Adult Mental Health

Name	Latest Period	Plan	Actual	Variance	V	A
Adult MH IP Discharges - % Fup 72 hours	Mar-24	80.0%	64.0%	✗ -16.0%		
Inappropriate OAP Bed days	Mar-24	0	1325	✗ 1325		
Rate per 100,000 Older Adult MH LOS > 90 Days	Mar-24	8	12	✗ 4		
SMI Health Checks	Jul-24	4100	5795	✓ 1695		
Access SMI +2 Contacts Community MH Services	Jun-24	14550	15445	✓ 895		
Dementia Diagnosis	Jun-24	70.3%	70.5%	✓ 0.2%		

Mental Health - Access

Name	Latest Period	Plan	Actual	Variance	V	A
Perinatal Access % (12 month rolling)	Apr-24	-	9.6%	-		
Perinatal Access - Volume	Jun-24	1305	1205	✗ -100		
Individual Placement Support	Mar-24	1126	1440	✓ 314		
Early Intervention in Psychosis (EIP)	Mar-24	60.0%	87.0%	✓ 27.0%		

Mental Health - Children & Young People

Name	Latest Period	Plan	Actual	Variance	V	A
CYP - New Referrals	Feb-24	-	1845	-		
CYP Eating Disorders - Routine Ref Perf (Qtr)	Mar-24	95.0%	80.0%	✗ -15.0%		
CYP Eating Disorders - Urgent Ref Perf (Qtr)	Mar-24	95.0%	88.0%	✗ -7.0%		
CYP Access (1+ Contact) (12 Mth Rolling)	Jun-24	19820	20190	✓ 370		

3d. Service Delivery – Primary & Community Scorecard

NHS
Nottingham and Nottinghamshire

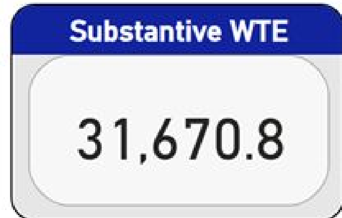
Population							
Primary Care and Community Recovery							
Name	Latest Period	Plan	Actual	Variance		V	A
Total Appointments	Jun-24	577993	596802	✓	18809		
% Face to Face Appointments	Jun-24	-	68.6%		-		
% Same Day Appointments	May-24	-	42.5%		-		
% Pts able to book within 2 Weeks	Jun-24	81.0%	80.6%	✗	-0.4%		
Number of NHS App Registrations	Jul-24	60.0%	55.7%	✗	-4.3%		
Community Waiting List (0-17 years)	Jun-24	-	3907		-		
Community Waiting List (18+ years)	Jun-24	-	8744		-		

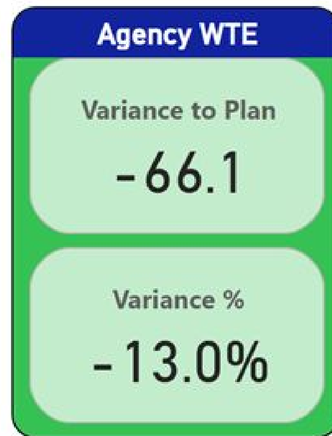
4 - ICB Finance Scorecard

Indicator Measure	YTD Variance £m's			YE FOT Variance £m's			RAG	
	Plan	Actuals	Variance	Plan/ Ceiling/ Envelope	FOT	Variance	YTD	FOT
Financial Sustainability (Variance from b/e)	-68.1	-70.1	-2.0	-100.0	-100.0	0.0		
Pay Spend	-631.1	-630.0	1.1	-1847.5	-1842.1	5.3		
Agency Spend vs Plan	-17.4	-17.0	0.4	-52.4	-54.4	-2.0		
Agency Spend Vs Ceiling		-17.0		-63.5	-54.4	9.1		
WTE (Provider) - 24/25 plan as at 31.03.25	34,456	34,091	-365					
Financial Efficiency Vs Plan	43.5	54.5	11.0	257.0	257.0	0.0		
Recurrent Efficiencies	31.5	39.1	7.6	201.5	195.0	-6.5		
Achievement of MHIS		72.4		217.8	217.8	0.0		
Capital Spend Vs System Env (inc IFRS16)	25.8	16.2	-9.6	91.5	91.5	0.0		
ERF Performance (inc system A&G)	119%	118%	-1%	120%	120%	0%		

- The system has reported a £70.1m deficit at month 4, which is £2.0m adverse to plan against the submitted June plans. The position includes £54.5m of efficiency.
- Staff costs are £1.1m underspend across the system at month 4 with WTEs being 365 WTEs lower than plan.
- Agency spend is £17m which is £0.4m under the July year-to-date plan. (Agency plans are £11.2m below the agency cap and across the system 2.8% of the total pay bill).
- Spend to date against the system capital envelope is £16.2m.
- ERF estimated performance year-to-date across the system is 118% against a 119% year-to-date plan.

Total ICS Provider Workforce - All Metrics





Data Source - Provider Workforce Returns and KPI returns

Nottingham and Nottinghamshire

Quality Integrated Performance Report

June 2024 and Quarter 1 2024/2025

National Oversight Framework (NOF)

01 - NOF 4 Nottingham University Hospital NHS Trust

02 - NOF 4 Nottinghamshire Healthcare NHS Foundation Trust

03 - NOF 2 Sherwood Forest Hospital NHS Foundation Trust

Enhanced Oversight

04 - Nottingham CityCare

05 - Learning Disability & Autism

06 - Maternity

07 - Special Educational Needs and Disabilities

08 - Looked After Children

09 - Children & Young People

10 - Vaccinations

11 - Infection Prevention & Control

Routine Oversight

12 - Patient Safety

13 - Universal Personalised Care

14 - Co-Production

15 - Adult & Children Safeguarding

16 - Care Homes and Home Care

17 - Medicine Optimisation

18 - Personal Health Budgets

19 - Continuing Healthcare

20 - Patient Experience

People Capacity/Availability

Nottingham and Nottinghamshire

Statutory duties outlined below will be included in the Quality Integrated Performance Report Quarterly;

- **Routine Oversight -** Care Homes and Home Care
- **Routine Oversight -** Medicine Optimisation
- **Routine Oversight -** Personal Health Budgets
- **Routine Oversight -** Continuing Healthcare
- **Routine Oversight -** Patient Experience

2024/25 Quarter	Presented at Quality and People Committee
Quarter 1	17 July 2024
Quarter 2	11 November 2024
Quarter 3	10 February 2025
Quarter 4	TBC April 2025

NHS
Nottingham and Nottinghamshire

National Oversight Framework (NOF)

Nottingham and Nottinghamshire Trusts

- 01 - NOF 4 Nottingham University Hospital NHS Trust
- 02 - NOF 4 Nottinghamshire Healthcare NHS Foundation Trust
- 03 - NOF 2 Sherwood Forest Hospitals NHS Foundation Trust

	Segment description		Scale and nature of support needs
	ICB	Trust	
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver on the statutory and wider responsibilities of an ICB are well developed	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place based and overall ICB priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	On a development journey, but demonstrate many of the characteristics of an effective ICB Plans that have the support of system partners are in place to address areas of challenge	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Flexible support delivered through peer support, clinical networks, the NHS England universal support offer (e.g. GIRFT, Right Care, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the six oversight themes Significant gaps in the capability and capacity required to deliver on the statutory and wider responsibilities of an ICB	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts)	Bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required (see Annex A)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

01. Nottingham University Hospitals Trust (NUHT)

Reporting Period:
01 June 24 – 30 June 24

Nottingham University Hospitals Trust (NUHT)

National Oversight Framework 4

Rationale for oversight level: NUHT will remain in NHS OF 4, with exit now anticipated for consideration in 2025/26 due to financial concerns. CQC overall 'Requires Improvement' with 'inadequate' rating for 'well led' (reported September 2021) and 'inadequate' for Maternity services in December 2020. Significant financial challenge are the key drivers for the NOF 4 rating.

Current Position

- The Trust is challenged to provide safe and high-quality care in response to regulatory requirements due to sustained operational pressures exacerbated by financial constraints and workforce issues including resource, culture and staff wellbeing.
- The operational pressures in the Emergency Department (ED) remains persistent with patients regularly receiving care in spaces such as corridors and the middle of the majors unit or cared for in any available spaces on wards including end of bay areas.
- Despite persistent crowding, there has been sustained incremental improvement in ambulance handover times and length of stay in the department in recent months. ED have also reported a sustained decrease in pressure ulcers acquired in the department.
- The Getting It Right First Time (GIRFT) team have made some recommendations to reduce length of ED stay and ambulance handover waits, and a plan is being developed to action these.
- The GIRFT team meet NUHT monthly to review progress and date following their visit in March 2024
- Transition to the Patient Safety Incident Response Framework (PSIRF) occurred on target and the PSIRF implementation Steering Group was stood down in June. Work will now be fed into the Patient Safety Group.
- Publication of IR(ME)R report following inspection on 5 June 2024. Summary of findings showed many areas of good practice, with evidence of extensive ongoing programme of clinical audit. Scope for improvement surrounding how the service managed version-controlled documents, the service did not have a study of risk of accidental or unintended exposures from radiotherapeutic procedures. Despite this much of the information CQC expected to see was contained in other procedures. Action plan to be submitted in 6 weeks.
- An unannounced maternity CQC visit took place on 18/19 June. Initial feedback reported that staff were fantastic with largely positive feedback from women & birthing people. There were some areas of significant concern around staffing, 'fresh eyes', fridge temperatures, listening to women & families, IPC and learning from incidents. A draft report is awaited.
- Notification of potential for issue of a section 31 in relation to Maternity (20.6.24) in the main linked to concerns around staffing. Trust have responded to the requests for info and follow up information has also been provided. Response from CQC awaited.
- Whilst engagement is positive and improvements evident, significant support systems are still required with ICB, NHS England and CQC partners as active participants. Were the Trust to move into NOF 3, enhanced support from the ICB will continue to be required for some time.
- The quality oversight focus is now moving towards improvement activities and plans into 'business as usual' and supporting this transition as a foundation for the future. NUHT colleagues are committed to this approach and engaged with system activities including System Quality Group; Patient Safety Incident Response Framework (PSIRF) implementation; and the Local Maternity and Neonatal System (LMNS).

Actions Being Taken & Next Steps

- ICB Quality colleagues meeting in person with Deputy Chief Nurse for Operations fortnightly with a focus on ED pressures, handover delays and boarding on wards
- Arrangements are being made for ICB regular insight visits in ED to meet with patients and staff
- The ICB have been invited to participate in a new round of internal '15 Steps' visits to NUHT wards beginning in July.
- The development of the system quality dashboard will support the introduction of the quality metrics into the UEC pathway

Risks & Escalations (Risk ORR024)

- **(Risk ORR024).** Whilst there have been improvements in the oversight areas of leadership and maternity, significant financial challenge remains. There is evidence of sustained attention to alleviating pressure in the Urgent and Emergency Care (UEC) pathway and considerable assurance in relation to the continued improvement around maternity services.
- **Never Event** discussed at Incident Oversight Group on 11th June – wrong site injection of local anaesthetic, patient suffered no/low harm

Content Author: Penny Cole | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

02. Nottinghamshire Healthcare Foundation Trust (NHCFT)

Reporting Period:
01 June 24 – 31 June 24

Nottinghamshire Healthcare Foundation Trust (NHCFT)

National Oversight Framework 4

Rationale for oversight level: Quality and Governance concerns. Risks to delivery of safe services.

Current Position

- National Oversight Framework segment 4 rating, quality, safety and financial concerns.
- NNICB risk ORRR191 - without the capability to make the required quality improvements there is a risk that the quality of services provided may not meet optimal care standards. This may lead to potential risk of harm and poor health outcomes.
- 80 open CQC actions to include, 48 Must Do, 29 Should Do, and 3 enforcement actions.
- Secretary of State ordered section 48 review and recommendations.
- Quality and safety improvement actions in adult in-patient AMH and MHSOP settings.
- Quality and safety improvement actions in community mental health and crisis teams.
- Safe now assurance process
- Trust wide Integrated Improvement Plan – Phase 1 and 2.
- Awaiting publication of remaining part of the section 48 review (the care of VC), expected publication in Q2.

Actions Being Taken & Next Steps

- NNICB and NHSE led Monthly Improvement Oversight Assurance Group (IOAG) overseeing section 48 review recommendations and progress of actions, Rampton Hospital relicensing and financial recovery. This includes oversight of the safe now process.
- Monthly NHCFT led Integrated Improvement Portfolio Board, NNICB presence. Support from regional recovery team to develop the improvement plan and associated metrics.
- Monthly NHCFT led CQC oversight group to oversee progress of CQC actions, address barriers, escalate concern.
- A NHCFT led Trust wide homicide review has been undertaken. A detailed report and learning will be shared with NHSE. This will include the specific action plan aligned to learning from the separate VC homicide review.
- Monthly Rapid Improvement boards established in In-patient settings (AMH/MHSOP) and community mental health and crisis response teams. Progress against actions for improvement are reported to at the rapid improvement board.
- Weekly safe now process established to oversee data aligned to quality and safety metrics, these enable a prompt response such as increased support to frontline staff to manage and support restrictive practice, physical healthcare deterioration etc.
- NNICB presence at NHCFT internal quality, safety oversight arrangements – QOG/SIRG

Risks & Escalations (Risk ORR191)

- Continued adverse media potentially affecting the Trusts' reputation.
- Cluster of medium to high-risk PFD report coronial cases to be heard in July 2024.
- Continued harm to patients as evidenced via weekly Incident Review Group meeting – attended by NNICB and provides opportunity for discussion, confirm and challenge using PSIRF methodology.

Content Author: Penny Cole | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

03. Sherwood Forest Hospitals NHS Foundation Trust

Reporting Period:
01 June 24 – 30 June 24

Sherwood Forest Hospitals NHS Foundation Trust (SFHFT)

National Oversight Framework 2

Rationale for oversight level: Ongoing support within the improvement activities underway. Assurance of insight not always evident at Trust meetings attended by NNICB, confirm and challenge usually welcomed.

Current Position

- The Trust continues to see high demand through the UEC pathway this includes the provision of system support via EMAS diverts where possible.
- Full capacity plan initiated during June in response to high demand for urgent and emergency care.
- A multidivisional emergency department improvement plan continues attended by the NNICB quality team. Improvements and changes to estate slow due to process and publicly funded building status.
- Review of workplace and improvement culture in isolated areas continues to support ongoing improvement works. Update due July 2024.
- PSIRF and the oversight process continues to be developed with alignment and consistency of reporting being a focus for improvement. Updates to the reporting system include the option of recording overcrowding themes within the Datix platform.
- Successful recruitment of two newly qualified paediatric nurses due to commence in September 2024 and January 2025 to support expansion of workforce for improvement works. There are developing plans for these posts to become rotational to support and develop a wide skill set.

Actions Being Taken & Next Steps

- Insight visits planned for the first week of July to include Mansfield Community and Newark Hospital.
- Kings Mill site insight visits into Paediatric areas following the pathway and workstreams of the ongoing emergency department quality improvement plans. Positive feedback from staff. Challenges noted regarding the estate and utilisation. Plans to improve the offer for patients and parents through feedback.
- Approach made to support planning for potential CQC inspections through unannounced insight visits.
- NNICB have supported with interviews for the new paediatric Matron post.

Risks & Escalations

- Maternity Inquest listed for first week of July 2024, high risk of Prevention of Future Death notice. PFD witness Director of Midwifery, there are several witnesses having separate legal representation at the hearing. There remains a risk of adverse media attention to this case.
- Continuous Quality Improvement Strategy not yet approved

NHS
Nottingham and Nottinghamshire

Enhanced Oversight

What does this mean? What is the assessment of risks relating to delivery / quality

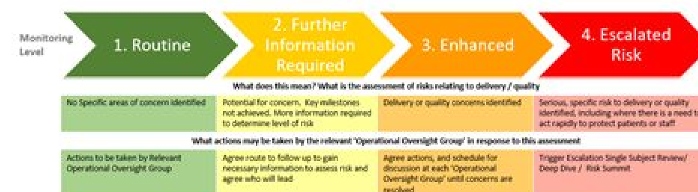
Delivery or quality concerns identified

What actions may be taken by the relevant ‘Operational Oversight Group’ in response to this assessment

Agree actions, and schedule for discussion at each ‘Operational Oversight Group’ until concerns are resolved

Quality Areas of Enhanced Oversight

- 04 - Nottingham CityCare
- 05 - Learning Disability & Autism (including Oliver McGowan Mandatory Training)
- 06 - Maternity
- 07 - Special Educational Needs and Disabilities
- 08 - Looked After Children
- 09 - Children & Young People
- 10 - Vaccinations
- 11 - Infection Prevention Control



Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

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04. Nottingham CityCare

Reporting Period:
01 June 24 – 30 June 24

Nottingham CityCare

National Quality Board and ICB Framework - Enhanced

Rationale for oversight level: Quality and safety concerns raised with ICB Quality team through a variety of sources. In line with normal processes, triangulation of these concerns against the data and intelligence was undertaken resulting in two areas of **Escalated Risk** and six areas of **Enhanced Risk.**

Current Position

1.0 Escalated Risk:

1.1 Management of incidents

Report from CityCare's June Quality and Safety meeting shows number of open Patient Safety Incidents (PSI) has reduced significantly. CityCare transitioned from Datix to InPhase for incident reporting and are working through some initial problems around access.

1.2 Quality insight:

Gaps remain in quality and safety reporting to the ICB. CityCare have advised data will be sent week commencing 24 June 2024.

2.0 Enhanced Risk:

2.1 Harm free care/Patient Safety

May performance reports shows number of waits over 10 weeks has reduced in several services. Gap in Mental Health expertise within senior team still cited barrier to recruiting mental health staff, links made with NHT for support with clinical supervision. .

2.2 Risk Management

Governance meetings are improving but risk registers and their review are not visible to the ICB.

2.3 Performance

Higher activity than planned cited in all CityCare services apart from MOSAIC and Homeless Health. Vacancies and sickness within small teams impacting performance. Paediatric continence and Dietetics, and CHC particularly affected.

2.4 Workforce

High use of agency staff continues despite caseload capping. Clarity is needed about whether predominant use is to cover vacancies or to meet higher demand. Children's Dietetics service is particularly fragile due to vacancies in senior staffing. Agency staff covering gaps, but clinical leadership required.

2.5 Culture and Leadership

Interim PSIRF lead continues Learning Response methodology and is supporting CityCare Leads to complete a Patient Safety Incident Investigation (PSII) into a Pressure Ulcer. Monitoring required to ensure progress is sustained when interim lead leaves.

2.6 Governance and Oversight

Clearer Governance processes described for PSIRF, links established between Operational and Quality oversight. Now InPhase is in place monitoring required to ensure oversight processes embed and are effective.

3.0 Caseload Capping

The caseloads of Community Nursing and Integrated Care Home Service (ICHS) remain capped, although reverted to stage one of the plan following safety concerns for those discharged from acute services. Initial review of themes from caseload reviews suggest work is required to improve discharge planning. ICB has served a Contract Performance Notice (CPN) to CityCare regarding the caseload capping, NNICB quality colleagues are supporting the joint discussions in response to this.

Actions Being Taken & Next Steps

- Monthly Quality Review meeting suggested in line with enhanced status, for six months initially. TOR and exit/transition criteria have been drafted for review.
- ICB Quality Team are building links with the Deputy Operational Directors and Assistant Clinical directors within the care Groups to help gain further oversight.
- ICB Quality Team and CityCare continue to meet to review themes from caseload reviews, prioritisation and quality surveillance.
- CityCare to reconsider the EQIAs to include wider impact of caseload capping and relevant mitigations.to include wider impact on system and vulnerable people

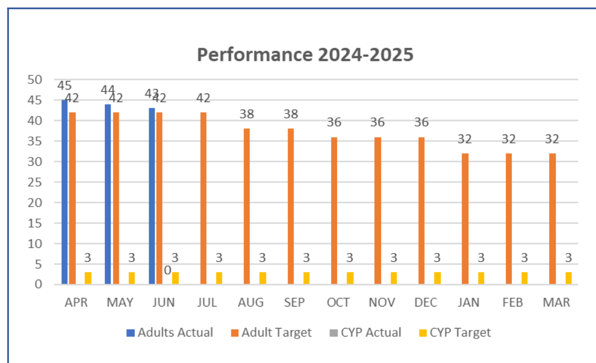
Risks & Escalations (Risk ORR115)

- As a result of current quality, staffing and performance concerns at Nottingham CityCare, there is a risk that required short-term improvements may not be promptly addressed, leading to a potential risk of harm and poor health outcomes to the population of Nottingham City **(ORR189)**
- If resources at Nottingham CityCare are primarily focused on addressing immediate quality and performance concerns, there is a risk that there may not be sufficient capacity or 'headspace' to deliver community service transformation programmes. This may result in future population needs not being met and/or anticipated efficiencies not materialising **(ORR190)**

05. Learning Disability & Autism

Reporting Period:
01 June 24 – 30 June 24

Learning Disability and Autism (LD&A)

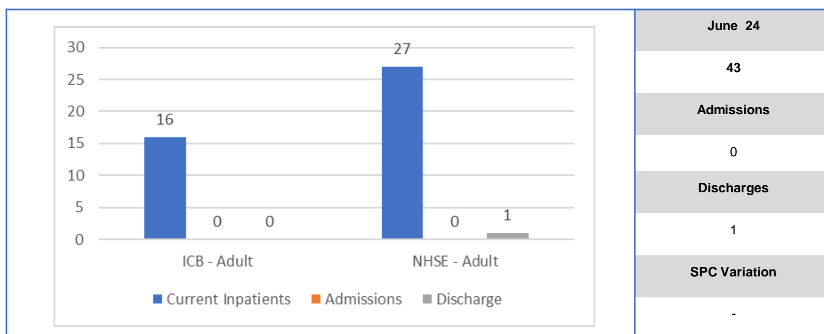


Learning Disability and Autism (LD&A) Inpatient

Data Cut-Off Date: 30/06/2024

Explanatory Note/Insight Analysis and Assurance:
Adult Inpatient Trajectories: Our current adult inpatient number stands at 43 our planned trajectory is 42. . There have been no admissions in June continuing to show the systems strong performance in preventing avoidable admissions from the community. There has been 1 adult inpatient discharge in June from a secure eating Disorder Unit.
Children & Young People Inpatient Trajectories: We continue to perform strongly in meeting the NHSE trajectory and currently we have 0 CYP in inpatient settings. We have had 1 CYP discharge back to their family home in the month of June.

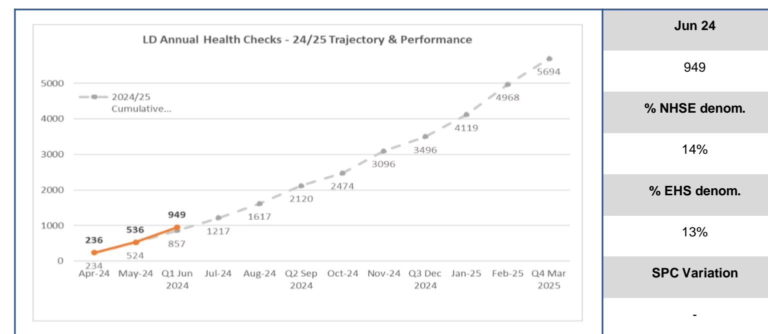
Learning Disability and Autism (LD&A)
Adult Inpatient Movements



June 24
43
Admissions
0
Discharges
1
SPC Variation
-

Data Cut-Off Date: 31/05/2024

Learning Disability Annual Health Checks



Jun 24
949
% NHSE denom.
14%
% EHS denom.
13%
SPC Variation
-

Data Cut-off Date: 27/06/2024

Explanatory Notes/Insight Analysis and Assurance: As at 27 June 24, **949 Annual heath checks have been completed** putting performance against this year's denominator set by NHSE at the start of the year (based on the September 23 all age QOF GP LD Register) at 14**% and 13%** against the GP LD register on E-healthscope (14 years and over).

Content Author: Rhonda Christian | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

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05. Learning Disability & Autism

Reporting Period:
01 June 24 – 30 June 24

Learning Disability and Autism (LDA)

System Quality Group Oversight – Enhanced

Rationale for oversight level: Focus remains on adult inpatient performance with monthly NHS England system performance meetings in place.

Current Position

There remains a focus on inpatient performance following the NHSE June performance meeting it was agreed that these should move to quarterly oversight, next meeting schedule for September 2024. There is to be a development day for the ICS LDA Partnership Executive Board. The focus will be to clearly define the responsibilities, priorities and membership of the board.

Inpatient performance

Adult Inpatient Trajectories: Our current adult inpatient number stands at 43. We have had 0 admissions throughout June and 1 NHSE discharge. The system is currently actively supporting 78 individuals on the DSR who are RAG rated Red, Amber or Green. Despite this pressure the system so far has been successful in supporting individuals/families/carers and social care providers to deliver effective support systems within the community. This continues to be reflected within our admission figures and we can report that we haven't had any admissions to inpatient settings for adults during the month of June.

Children & Young People Inpatient Trajectories: We continue to perform strongly in meeting the trajectory set by NHSE (3). Currently we have 0 CYP in inpatient settings. We have had 1 CYP discharged back to their family home in the month of June.

Learning disability Annual Health Checks: As at 27 June 24, 949 Annual heath checks have been completed putting performance against this year's denominator set by NHSE at the start of the year (based on the September 23 all age QOF GP LD Register) at 14% and 13% against the GP LD register on E-healthscope (14 years and over). 90% of AHCs are recorded to have a Health Action Plan (HAP) in place, with 25 people recorded to have declined a HAP which equates to a decline rate of 0.3% against the total LD register on E-Healthscope. 203 health checks (17%) have been completed for those people who didn't receive one in the previous year, known as the priority cohort. The Impact and Investment Fund (IIF) continues to incentivise practices during 2024/25 to complete a Health Action Plan and record the individual's ethnicity as part of the health check.

Actions Being Taken & Next Steps

Monthly Summit meetings are in place with system leadership across health and social care to support pace of change in conjunction with national support by NDTi and action plans linked to LGA review. Workstream action plans have been refreshed to reflect the recommendations from the reviews and are being taken to the July Executive Partnership Board for approval and oversight.

CETR Oversight panels continue to address and unblock any barriers to discharge. Monthly Joint clinical meetings between IMPACT Provider Collaborative and the ICB have been set up to address patients who are not progressing within secure settings. ICB LDA Quality Leads to attend IMPACT monthly clinical meetings to support with discharge planning.

ICS wide gaps/issues and barriers to developing models and services to be escalated through programme governance and to the Exec Board.

Risks & Escalations

- Delays with neurodevelopmental assessments continue to impact on CYP and adults not receiving support , in response an improvement action plan continues to be monitored monthly through the neurodevelopmental assessment steering group, with oversight from the Operational Delivery.
- We have six individuals who are currently in hospital due to a lack of community placements and another 4 who lack a clear clinical pathway within low & medium secure settings.
- Our adult inpatient target stands at 43 one above trajectory. If we had discharged the six people that are waiting for a community placement, we would be above trajectory by 5. The lack of progress on discharges for those that are ready is impacting on the systems performance.

05. Learning Disability & Autism – Oliver McGowan Mandatory Training

Reporting Period:
01 June 24 – 30 June 24

Nottingham and Nottinghamshire

Oliver McGowan Mandatory Training for Learning Disabilities and Autism (OMMT)

System Quality Group Oversight – Enhanced

Rationale for oversight level: The OMMT pilot will run until the end of September 2024 to enable full testing of the system infrastructure. The planned end-of-pilot evaluation in October 2024 will inform the scaling up and delivery of OMMT to the rest of the system. There is recognised risk to delivery of training to relevant staff because of operational pressures, the complexity of the training model and the restrictions on the number of staff who can attend each training session, across health and social care organisations.

Current Position

Enabling infrastructure:

- The OMMT Steering Group has been expanded to include representatives from all key partner organisations.
- The LDA Board has provided oversight to the pilot. From October 2024, oversight will move to the People and Culture Steering Group in preparation for scaling up and moving to BAU.

Developing infrastructure and sufficient trainer capacity by 2024/25:

- With the help of two lead trainers, our first Tier 1 and Tier 2 trio have been trained. Accreditation for the Tier 1 trio is being sought from NHSE. This is needed before delivery can start – expected by mid to end July 2024. The first Tier 2 session was delivered on 28 June 2024. We are aiming to have 3 x Tier 1 trios and 3 x Tier 2 trios trained by the end of September 2024. Training delivery will begin in July.
- Recruitment of more experts by lived experience (EBLEs) as co-trainers continues – currently working with 9 experts. This will enable the development of trios. Contracts are in place with two local self-advocacy groups – these groups will help to recruit and support EBLE co-trainers – and links with other self-advocacy groups are being explored.
- Options for increasing, training and supporting more facilitator trainers (in addition to the two lead trainers) is being explored.
- External Tier 1 sessions will continue to be bought in as we continue to develop our system resource.
- We are exploring buying in external Tier 2 sessions to be delivered between September and November.
- The ICB is completing a training needs analysis for its staff to include OMMT in its corporate assurance processes.
- CQC regulated providers are seeking to comply with legislation by providing training for their staff. Limited training capacity will impact on their ability to comply, particularly in social care as funding KPIs relate to NHS staff.

Actions Being Taken & Next Steps

- The Oliver McGowan programme team is constantly exploring all options for delivery, including purchasing sessions from external providers, while system infrastructure to deliver the training ourselves is being developed.
- The focus is on delivering training to all health staff. At least 20% of sessions will be made available to social care staff during the pilot phase (as agreed with NHSE).
- NHSE was updated on our progress and position in April. Quarterly updates are planned.

Risks & Escalations

- There are challenges to releasing staff to complete the 90-minute e-learning package and the further interactive sessions to complete the training. Co-operation from partners will be needed to ensure that appropriate staff are identified and released to maximise training capacity. Most clinical staff will need Tier 2 training, and this is delivered face-to-face over one day. Primary care staff will need to complete this training, conversations with the Local Medical Council (LMC) are planned.
- Training venues for up to 30 staff will be needed from each organisation, free of charge, for delivery of the face-to-face Tier 2 training. This is an NHS England requirement and presenting a challenge to providers.
- Organisational administrators will need to be trained on the ICS booking system and start to manage bookings and reports for their own staff.
- Funding received is for NHS workforce but the ICS is adopting a system approach. The ICB have received information that funding for social care will be provided but the amount and timeline is unknown. This makes future planning for social care roll out challenging.
- Key Performance Indicators (KPIs) have not been met for 2023/24 due to delays in the recruitment of lead trainers and national shortages of OMMT 'train the trainer' training.
- KPIs for 2024/25 are higher than for 2023/24. The focus is on developing infrastructure and sustainable capacity for delivery of the training, as well as to make best endeavours to train >30% of eligible NHS staff (estimated at 9,840 staff) in Tier 1 and >30% of NHS staff eligible for Tier 2 (estimated at 22,960).
- Exact numbers of staff in the ICS needing Tier 1 and Tier 2 are still being determined.
- Training capacity for 2024/25 and beyond is being is being determined.

Content Author: Rhonda Christian | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

Rushcliffe Arena, 09:00-12/09/24

06. Maternity

Reporting Period:
01 June 24 – 30 June 24

Local Maternity & Neonatal System (LMNS)

Saving Babies Lives Care Bundle Version Three – compliance update.

Intervention Elements	Description	NUH Element Progress Status (LMNS Validated)	NUH % of Interventions fully implemented	SFH Element Progress Status (LMNS Validated)	SFH % of Interventions fully implemented
Element 1	Smoking in pregnancy	Partially Implemented	50%	Partially Implemented	60%
Element 2	Fetal growth restriction	Fully Implemented	100%	Fully Implemented	100%
Element 3	Reduced fetal movements	Fully Implemented	100%	Partially Implemented	50%
Element 4	Fetal monitoring in labour	Partially Implemented	60%	Fully Implemented	100%
Element 5	Preterm birth	Partially Implemented	81%	Partially Implemented	85%
Element 6	Diabetes	Partially Implemented	67%	Partially Implemented	83%
All elements	TOTAL	Partially Implemented	80%	Partially Implemented	86%

Both Sherwood Forest Hospital NHS Foundation Trust (SFHFT) and Nottingham University NHT Trust (NUHT) continue to work towards full compliance with SBLCBv3.

Both have recently completed their fourth submission of evidence. A full Local Maternity and Neonatal System (LMNS) review of the evidence has taken place, and a quarterly review meeting is due to be held imminently with both trusts.

Some fluctuation remains in audit compliance levels. Compliance levels for April 2024 can be seen above, with a slight decrease in compliance due to audits with small denominators and numerators.

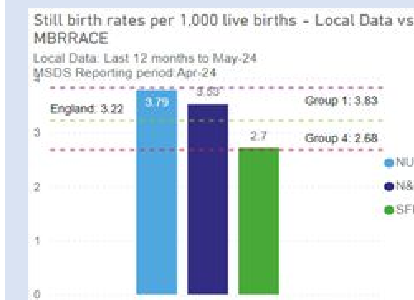
LMNS Quality & Outcomes Dashboard – July 2024 (May data).

- There was 1 **still birth** reported at SFHFT in May 2024, when comparing with respective peers, SFHFT rate is 2.7 per 1000 live births, compared with G4 average of 2.68.

- There were no **neonatal deaths** reported at SFHFT in May 2024, When comparing with G4 peers, SFHFT are marginally higher (1.1 vs 1.05 per 1000 live births).

- There were four **stillbirths** at NUHT in May 2024, when comparing with their respective peers, NUHT are marginally better than the G1 comparator average (3.79 vs 3.83 per 1000 live births).

- There were no **neonatal deaths** reported at NUHT in May 2024. When comparing with group 1 peers, NUHT are marginally hight (2.8 vs 2.73 per 1000 live births).



Stillbirths - as a system, NNICB are higher than the UK average by 0.31 per thousand births.

NND – NNICB is greater than the England average by 0.49 per thousand births

06. Maternity

Reporting Period:
01 June 24 – 30 June 24

Local Maternity & Neonatal System (LMNS)

System Quality Group Oversight – Enhanced

Rationale for oversight level: NUH maternity remains under external scrutiny with active involvement with the Maternity Safety Support Programme and the Ockenden investigation ongoing. Improvements noted in governance, engagement and some clinical outcomes although not yet consistently embedded.

Current Position

- Preterm Birth Clinic Midwifery Leads in post at both NUH and SFH – target Go Live March 2025 (enhanced at NUH, new service at SFH).
- Perinatal Pelvic Health – Service User with lived experience recruited to support co-production of service development to March 2025. Service Change Review Group endorsed to progress on June 20th.
- The LMNS PMO have been working with system partners to agree a system approach to MNVP requirements of (Maternity Incentive Scheme) MIS year 6 (Safety action 7).
- The LMNS PMO are developing an overview of all LMNS funded projects completed and the impact the projects have made to update the SPI committee in August/September.
- Tongue Tie project has been stood down following LMNS Transformation Board on June 13th – There is no formal pathway at NUH for assessment and division of tongue tie – 6x Paediatric clinic appointments available every four weeks. NUH priority is achieving BFI accreditation.

Perinatal Quality Surveillance workstream

The PQSG risk/RAID log has been updated to reflect the current risks within Maternity Quality & Safety. These include the development of the LMNS Quality and Outcomes dashboard, the transition to PSIRF and compliance with MIS year 6.

Development of the LMNS Quality and Outcomes dashboard continues in collaboration with SAIU, monthly updates are provided through the LMNS Dashboard Subgroup to include a monthly update of safety & mortality data and dashboard development update

There was an unannounced CQC visit at NUH on 18th and 19th June 2024. Initial feedback reported that staff were fantastic with largely positive feedback from women & birthing people.
There were some areas of significant concern around staffing in relation to a skills mix heavily reliant on band 5s and staff not being able to take breaks, 'fresh eyes', fridge temperatures. Listening to women & families, IPC and learning from incidents. A draft report is awaited.

Actions Being Taken & Next Steps

- Added MNVP resource and capacity will enable increased engagement with our local, diverse and most vulnerable populations. Our MVP and NVP Leads will be included as quorate members of key assurance and safety champion meetings at both trusts in line with MIS year 6 requirements. In addition, the MNVP will meet quarterly with Maternity & Neonatal colleagues in 'trust catch ups' to share and triangulate service user voice, improvement planning, and impact being made.
- Phase one of the LMNS Quality and Outcomes dashboard is expected to be published by the end of July 2024

Risks & Escalations

- Due to issues with developing data sets to demonstrate impact requirements against the LMNS transformation funding, system interoperability and data sharing; there is a risk the system may not be able to tangibly measure patient outcomes and impact of transformation commissioning, to demonstrate results, value and performance. This adversely impacts on priority setting, decision-making and result in resources being used ineffectively.
- Limited availability of Newborn Life Support (NLS) courses at NUH to enable meeting MIS standard for neonatal nursing and maternity – paper going to maternity oversight committee.

Content Author: Sarah Pemberton | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

07. Special Educational Needs and Disabilities

Reporting Period:
01 June 24 – 30 June 24

Special Educational Needs & Disabilities (SEND)

System Quality Group Oversight – Enhanced

Rationale for oversight level: Due to system capacity, financial challenges, and complexity of medical conditions and health needs, quality of provision and experiences for CYP with SEND in Nottingham and Nottinghamshire may deteriorate further.

Current Position

- Both Nottingham and Nottinghamshire SEND Partnership Assurance Improvement Groups (PAIG) are working collaboratively with partners across the system and Nottinghamshire local area SEND partnership continue to deliver on the Priority Action Plan (PAP) to deliver improvements, to respond to challenges and risks identified across the system.
- Nottingham City and Nottinghamshire SEND partnerships have submitted a Self-Evaluation Framework (SEF), as part of the East Midlands regional Peer Challenge programme, participation is required for the local area partners responsible for meeting the needs of CYP with SEND and this will take place on the 16th October 2024..
- SEND Joint Commissioning Strategy has been produced and seeking endorsement through system governance routes from ICB and LAs in early July 2024.
- Nottinghamshire County SEND Partnership have finalised the local area outcome-based SEND Strategy and will be ready for publication August 2024.
- Nottinghamshire SEND Partnership participated in a further monitoring Stocktake with DFE and NHSE regional advisors, awaiting formal feedback.
- A proposed CYP Data Dashboard structure has been developed and shared with system partnerships for feedback led by the ICB Senior Children's Analyst in readiness for the first iteration for end of July 2024
- Contracts for CCYPS (NHFT) are being amended to include SEND KPI
- Impact measures agreed for both LA PAIG datasets.
- Speech and Language Communication Needs (SLCN)early identification, early intervention training for Specialist Education colleagues due to commence September 2024. Drop-in sessions advice line due to start July 2024, to offer accessible assistance and guidance to individuals, their families, and caregivers supporting early identification of SLCN and targeted early intervention strategies.
- Independent consultant working work with local provider to review the autism pathway which includes speech, language and communication needs pathway
- ICB CYP Transformation and Maternity commissioning team have successfully recruited a new Head of CYP & Maternity Commissioning start date to be agreed. Capacity remains an issue in this team to drive improvements for SEND arrangements
- Discussions to increase capacity, within the DCO for SEND team, has been haltered due to vacancy freeze. A formal request to recruit a fulltime band 6 position (to replace the existing 0.8 wte band 7 post, following a resignation) has been made, a job matching request made once approved a formal request to panel to recruit to vacancy will be made.
- A decision on Designated Medical Officers requirements for the ICB remains. Costing request has been made via the ICB finance team, who have liaised with the trusts and advised there appears to be no costings available for the Designated Medial Officer for SEND roles, within any of our NHS trusts and therefore querying whether ICB fund these positions.
- **Tribunals 'Extended Appeals' raised against the ICB; 21 OPEN – Nottinghamshire have received a Judicial Review health therapies requested to support.**

Actions Being Taken & Next Steps

- Recovery plan to be explored with community paediatric providers to ensure able to deliver on statutory requirements for EHCP. CYP commissioners to follow up.
- Contracts for wider NHS providers require to be amended to include SEND KPI
- Timeframe for delivery of the planned system approach, to meet the needs of CYP with complex physical health needs in education settings, to be confirmed with Browne Jacobson, provider comissioned to support the integrated system approach.
- Review of the Tribunal 'extended appeal' co-ordination and management required to ensure monitoring and learning for ICB commissioning and quality teams.
- Continuation of work to support joint commissioning arrangements for identified gaps in provision.
- Planning of workforce development for SEND leadership across the system .

Risks & Escalations

- Risks are highlighted on the Operational Risk Register ORR129 with actions and clear mitigations detailed.
- Nottingham City LA current position, increases risk in being able to demonstrate accountability and oversight across the system, should an inspection take place in the autumn 2024.
- Nottinghamshire SEND improvement risk register holds the specific programme risks.
- Capacity and resource for the DCO for SEND team and the CYP commissioning and transformation team will impact on ability to support the partnership across the system to deliver on SEND requirements; operationally and strategically from July 2024 until approved arrangements in place and recruitment can be implemented.
- A significant increase in '' Extended Appeal' being raised against ICB and limited ownership, awareness and understanding of the monitoring and management of tribunals across the ICB quality and commissioning teams, to enable and inform learning for future commissioning requirements or improvements, opening ICB to vulnerability.

08. Looked After Children

Reporting Period:
01 June 24 – 30 June 24

Looked After Children (LAC)

System Quality Group Oversight – Enhanced

Rationale for oversight level: Overall there remain delays for IHA and RHA timeliness, there has been an improvement in waiting times comparative to 2022/23. The work to improve statutory compliance and ensure health providers deliver timely assessments will remain a prioritised work stream for 2024/25. There are no updates as Q1 2024/25 data not due

Current Position

IHA summary - 2023 - 2024

	DBHT				SFHT				NUH			
Total No. (+ %)	Q1*	Q2	Q3	Q4	Q1*	Q2*	Q3	Q4	Q1*	Q2	Q3	Q4
Total IHA referrals received	15	23	13	10	59	47	45	48	121	140	128	61
IHA referrals received from local authorities within 5 days *(correctly consented and within timeframe)*	6= 40%	11= 48%	4= 31%	6= 60	-	-	4= 9%	7= 15%	11= 11%	12= 9%	13= 10%	4= 7%
IHA completed and sent within 20 days of correct consent *(excluding exemptions*	10= 91%	2= 15%	4= 100%	3= 43%	15= 30%	5= 14%	18= 75%	16= 47%	4= 4%	19= 14%	7= 5.5%	7= 11.5%
waited times *(IHA completed)* ***In weeks***	**-**	**5-6**	**2-3**	**3-4**	**3-4**	**4-5**	**3-4**	**3-4**	**10+**	**10+**	**9-10**	**3-4**

NHT	**RHA 2023 - 2024**				
Numbers of RHA and %	**Q1**	**Q2**	**Q3**	**Q4**	**Average**
6 monthly RHA delivered on time	**46=57.5%**	**33= 63.5%**	**50 = 82%**	**52=76.5%**	**70%**
Annual RHA delivered on time	**56 =61%**	**76 =60%**	**68=60%**	**82 =55%**	**59%**
Total RHA delivered	129 =75%	145 = 81%	152 = 87%	161 =74%	79%
Total RHA delivered on time	102 = 59%	109 = 61%	118 = 67%	134= 61.5%	62%

Risks & Escalations

There are no new risks however the existing risk for Initial Health Assessments (IHAs) and Repeat Health Assessments (RHAs) have been separated so there remain two Looked After Children (LAC) risks on the risk register to reflect this.

Actions Being Taken & Next Steps

- The IHA 2023/24 summary demonstrates that timely referrals into health providers remain a challenge and overall compliance is still below expected threshold. New KPI metrics will deliver standardised and detailed data for 2024/25 (please note that IHA data has merged the previous KPI and updated KPI metrics).
- There has been improved IHA waiting times, particularly in NUHT where waiting times were over 10 weeks in 2022/23.
- IHA recovery work continues across the system and health data is now triangulated with the local authorities and a system IHA action plan has been developed.
- RHA compliance has improved comparative to 2022/23. Capacity and demand work is being concluded with NHCFT.

Rushcliffe Arena, 09:00-12/09/24

09. Children and Young People

Reporting Period:
01 June 24 – 30 June 24

Children & Young People

System Quality Group Oversight – Enhanced

Rationale for oversight level: Long term under investment in children's health and social care, the Covid-19 pandemic and its aftermath, and the enduring cost-of-living crisis have all combined to create a crisis that means children growing up with disadvantage are increasingly more likely to experience ill health (King's Fund 2024). N&N ICB has no clear routes for CYP Governance which risks significant gaps, potential duplication of services and unclear information sharing and decision-making routes.

Current Position

- Transition information shared as part of benchmarking exercise has been limited, which implies that ICB commissioning arrangements are not compliant with NICE Quality Standard QS140, updated 2023 .
- There has been joint financial agreement between ICB, County YJB, City YJB and OPCC.
- Paediatric Audiology Services in DBTH continue in serious incident response, overseen by NHSE. 5 year cohort review continue. The IT system issues are now said to be resolved and services have been resumed, although waiting numbers and times have increased further. There is also an NNICB Task and Finish Group, initiated by Director for Transformation, to understand the position around contracting and commissioning. Although there are regular meetings, progress has been slow.
- There continue to be Children and Young People (CYP) presenting with complex behavioural, mental health and autism related needs where there is no clear route for provision or pathways for care. Two of the acute trusts have made the decision not to admit where there is no health need, leading to some prolonged stays in ED for some CYP.
- Whistleblowing received from NHFT Provider Collaborative around concerns at Hopewood Hospital.
- There was a delay in a young person accessing medical care following an ingestion self-harm episode
- There are challenges in assuring quality of home care provision for CYP with Continuing Care funding

Actions Being Taken & Next Steps

- N&N Transition Network discussion planned for HoNCYP, SEND Improvement Manager and Deputy Head of Commissioning for CYP to discuss. NUH are planning to update their work and will include HoNCYP.
- CYP Commissioner for Youth Justice is progressing action to implement services now that funding is agreed.
- 5 year cohort review has commenced and after reviewing 23% of the records, 25 (21%) children have been identified for recall. The numbers of NNICB CYP is not yet clear. Plan for completion of the review is 26th July 2024. Service mitigations remain in place for current and future CYP following NHSE clinical visit. . Meetings held fortnightly for progress and oversight.
- Cases continue to be escalated. Business case for the (D2)N2 workforce model has been delayed but continues to be progressed via ICB and NHCT routes to achieve decision making on finance and support for the proposal. SFH are developing a SOP for CYP who are dysregulated or in crisis to ensure internal processes for multi-agency working are enacted prior to escalation. There will be a round table learning event following prolonged ED attendance at DBTH.
- Awaiting updated actions from NHCT-The Provider Collaborative are leading, as commissioners of the service.
- Local investigation into the service involved is underway and ICB wide advice shared on clinical management
- Task and finish group work is in progress with the Home Care Home Care Quality Team to understand the gaps and to implement improvements

Risks & Escalations

- There are two risks on the corporate risk register ORR 005 and ORR 128.
- Risk ORR 128 is strategic as local actions would not resolve it due to national issues. There is high financial risk to manage care provision outside of current commissioned services to meet the high level, individual needs of specific CYP and a high risk to health and wellbeing and safeguarding for Children and Young People (CYP) who are managed in inappropriate settings
- CYP Audiology services in DBTH is in incident response, overseen by NHSE, with a look back on records over 5 years. Harm has been identified. NNICB T&F Groups in place.

10. Vaccinations

Reporting Period:
01 June 24 – 30 June 24

Vaccinations

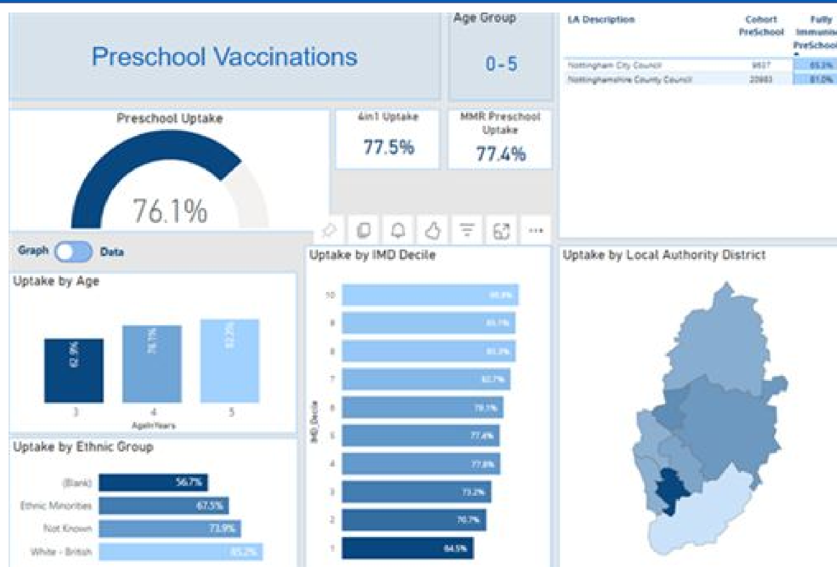
System Quality Group Oversight – Enhanced

Rationale for oversight level: The risk of measles has reduced with no further new confirmed cases. The last confirmed case was 7th June. There have also been no further probable cases identified. The rates of Pertussis has dropped considerably across Nottingham and Nottinghamshire with 5 probably cases and 1 confirmed case. Efforts continue to increase vaccination rates. Consideration should be given as to whether to reduce from enhanced level of oversight.

Current Position

MMR

The number of cases has dropped but actions continue to increase uptake for vaccinations. The data presents the overall uptake and indicates the difference In uptake between City and County.



Pertussis

Source: Pertussis immunisation in pregnancy: vaccine coverage (England) - GOV.UK (www.gov.uk)

The 4 in 1 vaccine provided in preschool Vaccination includes whooping cough.

Pertussis uptake in pregnancy:

	2020/21	2021/22	2022/23	2023/24
Nottingham & Nottinghamshire	72%	67%	66%	66%
National	68%	65%	61%	58%

Actions Being Taken & Next Steps

- MMR
- Increasing PCN Clinics in NG7
- Targeting schools in NG7. Also targeting older age group by calling families.
- Increasing outreach including through Family Nurse Partnership
- Comms – public and primary care
- Nxt step – clinics across other PBPs, NUH opportune vaccines
- Pertussis
- Working with SFH to ensure contracted capacity is in place for maternal vaccines
- NUH outreach
- Targeted comms

Risks & Escalations

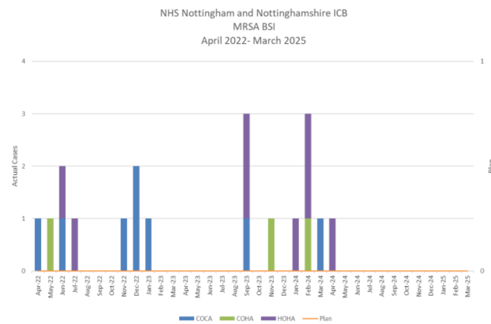
- Transient population in Nottingham City
- Capacity and funding required to carry out extensive outreach
- SFHFT capacity to do maternal vaccinations

11. Infection Prevention & Control

Reporting Period:
01 June 24 – 30 June 24

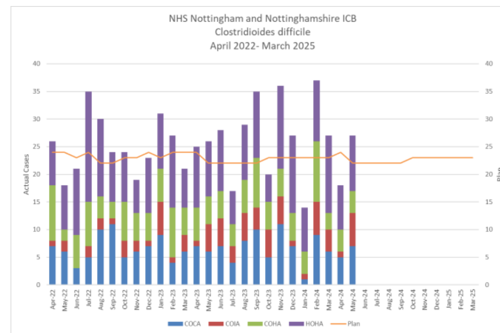
Infection Prevention and Control

HCAI Data 22-25 – MRSA Bloodstream Infections



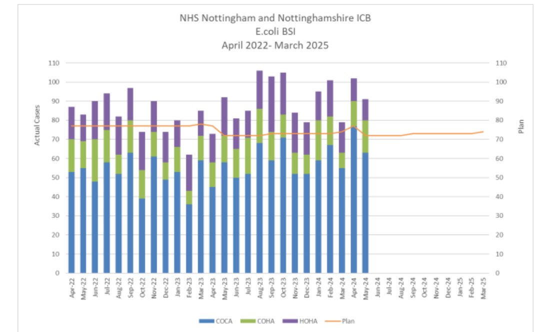
Data Cut-Off Date: 31/05/2024

HCAI Data 22-25 – C.difficile Infections



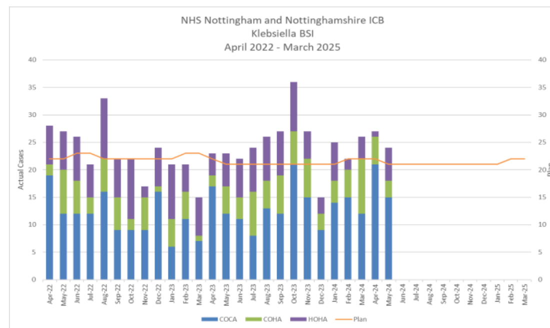
Data Cut-Off Date: 31/05/2024

HCAI Data 22-25 – E.coli Bloodstream Infections



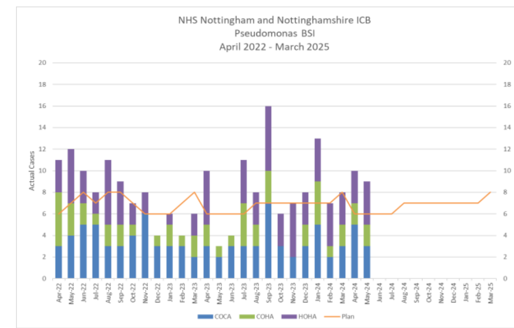
Data Cut-Off Date: 31/05/2024

HCAI Data 22-25 – Klebsiella Bloodstream Infections



Data Cut-Off Date: 31/05/2024

HCAI Data 22-25 – Pseudomonas Bloodstream Infections



Data Cut-Off Date: 31/05/2024

Content Author: Sally Bird | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

11. Infection Prevention & Control

Reporting Period:
01 June 24 – 30 June 24

Infection Prevention and Control

System Quality Group Oversight – Enhanced

Rationale for oversight level: Healthcare Associated Infection (HCAI) targets anticipated to remain the same 2024/25, these will be difficult to achieve. The sustained pressure on health and social care services continues to impact on HCAI. Measures taken to improve 'flow' in secondary care increase the risk of HCAI acquisition. Whilst progress continues with deep cleaning in secondary care these actions alone are unable to improve overall HCAI performance. The increase in patient acuity; aging population; limited access to primary care appointments; surgery delays; increase in antimicrobial resistance and antimicrobial prescribing; deprivation and poor self-care all increase the risk of acquiring HCAI and remain a constant pressure.

Current Position

- Limited improvement since last reporting. New HCAI thresholds 2024-25 are still to be issued but are not expected to change. These will be hard to achieve in the current climate.
- Access to lateral flow tests from local pharmacies remains problematic for care homes suspected COVID outbreaks. There has been a slight increase in COVID outbreaks this month.
- NUHT have reported a slight increase in hospital onset healthcare associated (HOHA) *C. difficile* cases since the reporting protocol changed. They are over plan but are 1 case lower than reported over the same period last year. SFHT remain under plan for *C. difficile*
- The ICB remains over plan for Gram-negative bloodstream infections (BSI) in May (69% of E.coli BSI are community onset community associated).
- Operational pressures at NUHT continue to impact with corridor-care and boarding of patients on ward areas in use to ease flow. SFHT are going '1 over ' on wards with no additional overnight stays. Overcrowding continues to impact on IPC measures as both acute trusts continue to have significant pressures on bed occupancy. Focus remains on IPC training compliance at NUHT,SFHFT and NHCFT which needs to improve and oversight of cleaning programmes
- Limited progress has been made with HCAI data analysis support. SAIU have no capacity, Public Health are looking at data sources and coding, UKHSA are collating case data, rates and trends.
- HCAI clinical reviews in place to identify areas for improvement and learning, when identified this is shared at system meetings. SFHT completing rapid reviews on all cases and are engaging with joint reviews of those in receipt of shared care.
- New suppliers have been sourced for hand hygiene products to replace Gojo, restrictions to supplies remain but this is to support with consistent supplies.
- The laboratory reporting software (WinPath) is to be updated at NUHT/SFHT. There are concerns that this could severely impact the ability to generate infection 'alert lists'.
- SFHT are in the process of recruiting to the IPC Development fixed term post. Only one post was filled.

System position May 2024

***C.difficile* infections**
- NUHT breached provisional month plan 13/ 8 (9 HOHA)
- ICB over month plan 27/22

MRSA BSI
- No cases

***E.coli* BSI**
- ICB breached month plan 91/72 (69% COCA), NUHT breached month plan 21/22

***Pseudomonas* BSI**
- CB breached month plan 9/6 , NUHT breached month plan 5/4, SFHT breached month 1/0

***Klebsiella* BSI**
- ICB breached month plan 24/21 (63% COCA), SFHT breached month plan 2/1

Actions Being Taken & Next Steps

- Previous IPC reported actions continue, with further focus on improving IPC training, fit testing and blood culture taking (NUHT).
- Pharmacy hub alerted to issues re access to LFT, comms have been issued but the issue has not been resolved.
- NUHT and SFHFT continue to report improvements in 'deep cleaning' despite high occupancy levels.
- Provider Board assurance frameworks and action trackers in use to highlight gaps and monitor improvement actions.
- Continued action taken to improve IPC audit performance, particularly in areas of high occupancy/overcrowding. IPC measures in place to support improved compliance in areas with long waits (ED).
- Public Health and UKHSA both supporting with analysis of E.coli BSI data locally to further understand the factors driving the increase.
- The aim is to use the data to determine next steps
- Individual case reviews continue for healthcare associated cases. Joint work has started to review complex shared care cases SFHT.
- Trusts have mitigation plans in place, supplies remain adequate and new dispensers are being fitted.
- Changes to the WinPath software have been added to Trust risk logs and mitigations considered. Assurance is still outstanding particularly for SFHT where compatibility issues with other software are still a concern. The upgrade has now been postponed to Sept (from July) to allow time to test software
- System IPC operational and strategic groups remained focused on reducing avoidable HCAI, IPC leads engage with regional work.
- SFHT are looking to extend the IPC Development post to a year rather than re advertising the post as NHSE funding needs to be allocated.

Risks & Escalations

- Limited improvement since last month reporting.
- New annual HCAI 2024-25 targets have not been issued but are unlikely to change, this will make them difficult to achieve in the current climate.
- ICB high case numbers Gram-negative BSI against plan.
- Potential risk of gap in reporting of community infections and case reporting at SFHT post WinPath software upgrade if software testing does not fix compatibility issues.

NHS Nottingham and Nottinghamshire

Routine

What does this mean? What is the assessment of risks relating to delivery / quality

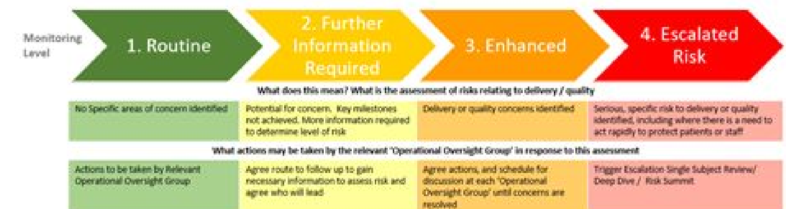
No Specific areas of concern identified

What actions may be taken by the relevant 'Operational Oversight Group' in response to this assessment

Actions to be taken by Relevant Operational Oversight Group

Quality Areas of Routine Oversight

- 12 - Patient Safety
- 13 - Universal Personalised Care
- 14 - Co-Production
- 15 - Adult & Children Safeguarding
- 16 - Care Homes and Home Care
- 17 - Medicine Optimisation
- 18 - Personal Health Budgets
- 19 - Continuing Healthcare
- 20 - Patient Experience



12. Patient Safety

Reporting Period:
01 June 24 – 30 June 24

Patient Safety

System Quality Group Oversight – Routine

Rationale for oversight level:
- PSIRF now transitioned across the system with oversight processes for Yr1 in place.
- System patient safety strategy in development with actions on track.

Current Position

Patient Safety Specialists
Nottingham & Nottinghamshire patient safety update presentation to the regional patient safety network included three focus areas:
- Insight – an overview of the system priorities and demographics; approach to dashboard development; focus on benchmarking exercise and patient safety insight visits.
- Involvement – ICB facilitated 'After Action Reviews' and proactive safety planning with partners in relation to newly commissioned Termination of Pregnancy (TOP) services
- Improvement – Overview of the system patient safety priorities and links to ICS strategy; examples of system improvement groups and projects (tissue viability; falls prevention)

The presentation was well received with follow up meetings requested from some regional colleagues to share learning and insights.

Delegate pack finalised for Patient Safety Specialist Network meeting on 10 July; highlight report template included to support a facilitated discussion of risks, achievements and challenges including where system support could add value. Evaluation form also developed to support planning for future events.

ICB Patient Safety Specialists making good progress with the national Patient Safety Syllabus Levels 3 & 4 (essential to role).

PSIRF
360 Assurance audit in planning stages; terms of reference to be finalised with draft version focusing on PSIRF oversight arrangements.

Patient Safety Partners – job description and person specification developed with support from ICB patient engagement lead. System approach explored with providers but feedback indicates they would prefer a provider-based approach. System involvement planned with pastoral and networking support.

Links with other programmes
System quality framework is in development, to include quality improvement activities. The system quality dashboard is instrumental to patient safety and quality discussions – there are Patient Safety Specialists involved in these workstreams and alignment is planned via PQAIG.

Actions Being Taken & Next Steps

- Await outputs of the Patient Safety Network in July to inform development of strategy and future planning.
- Evidence repository established via Business Management Team to support 360 Assurance PSIRF audit.
- Agree and commence PSP recruitment (substantive vs bank vs expenses only)

Risks & Escalations

System learning from deaths arrangements not fully established – scheduled for discussion at Patient Safety Network meeting

Content Author: Penny Cole | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

13. Universal Personalised Care

Reporting Period:
01 June 24 – 30 June 24

Universal Personalised Care

System Quality Group Oversight – Routine

Rationale for oversight level: Personalisation continues to work towards embedding personalisation across the system.

Current Position

Social Prescribing:

- **LMNS** – Induction and Training Resources, and Outcome measures presented to the LMNS Social Prescribing Working Group - Agreed MNVP to Coproduce with birthing parents the most appropriate outcomes measures tool.
- **Social Prescribing** is led within PCN's and via Placed based partnerships – the delivery and developments, mapping the needs, challenges, and priorities are shared and overseen via the quarterly Social Prescribing Strategic Developments Group.
- **Social Prescribing Data and Digital Interoperability** Task & Finish group set up (in response the 360 Assurance Audit)
- **Green Social Prescribing 1-year extension**, the MoU agreement and funding from DEFRA and NHSE is due July - the expectation is to ensure the funding is processed via the ICB and to flow directly as a one-off payment to Nottingham Community Voluntary Services (NCVS) as the lead organisation of the programme. A contract variation will be required

Communications:
Dr Rebecca Barker's column on Personalised Care was published in the Worksop Guardian, Mid Notts Chad, and Hucknall Dispatch.

Workforce Development:
23 Personalised Care Ambassadors have signed up and the first Community of Practice meeting was held in June. The Personalised Care Workforce Charter and Commitments are complete, pending senior leadership sign off. Shared decision training remains available with a current total of 16 people trained.

My Life Choices Co-production Group:
Approved their Common Purpose and developing a referral form for project input and their membership continues to grow.

Projects and Feedback:

- The "About Me" project received positive feedback at a Nottinghamshire Healthcare Trust meeting. The Nottinghamshire ABL Tier 3 Family Weight Management project is complete, engaging 14 families.
- A "Personalised Care" tab is live on System One F12 templates, with Social Prescribing Link Workers in Ashfield North PCN ready to use the "About Me" feature.
- Progress on digitalising the "About Me" feature, with support from Digital Notts and integration with the NHS Notts Care Record.

Actions Being Taken & Next Steps

- **Personalised Care Governance:** The governance structure has been aligned to meet the new requirements of the programme. A development day for the Strategic Operational group is to be held in July.
- There is a review of the UPC and Social Prescribing delivery work plans for 2024/25,

Risks & Escalations

- **Personalised Care and weight management:**
- The projects have experienced delays in implementing the agreed evidence-based outcome measures.
- Project manager leaving team in July so capacity and resources reduced, and work plan will be reviewed.

14. Co-Production

Reporting Period:
01 June 24 – 30 June 24

Co-Production

System Quality Group Oversight – Routine

Rationale for oversight level: Delivery continues with a focus on the development of the Coproduction Network and supporting infrastructure.

Current Position

- **Strategy requirement – the development of the Coproduction Network**. This is an ongoing key focus for the team for the rest of the year. The objectives of the network remain as :
  - Connectivity: a. Building relationships- helping colleagues and people identify and contact others who work in coproduction across the system, this is directly informed by the relationships built and maintained by the team.
    b. Connecting people who want to coproduce to coproduction opportunities.
    c. Avoiding duplication and sharing best practice.

Scoping it taking place to evolve this offer from a database held by the coproduction team to something universally accessible and to expand the offer of promoting and connecting people to coproduction – currently this is done via the regular new coproduction newsletter.

- **Coproduction Toolkit** – The Toolkit will be reviewed during quarter 2 , with a review of the resources and educational material. This will include a review of the presentation of the information available on the ICB website and intranet. A key priority for the toolkit will be the lived experience resources section, with content for lived experience people created by people with lived experience, initial contact has been made with groups and people who may be able to deliver this aspect.
- **Coproduction newsletter** – a special edition to promote National Coproduction Week 2024 was created and circulated in June. This is in addition to the regular bi-monthly edition. Feedback on the newsletter continues to be positive. The Newsletter is used to promote coproduction activities available for people to join and each edition is themed on a relevant coproduction value.
- **Strategic Coproduction Group re-set** – a series of three public Listening Events are being planned to take place during July and August and potentially September. These events will be in person; one in the North, one in the South, and one online. The listening events is a response to some challenge on approach to the previous group and the aim is to listen to and capture ideas and opinions about strategic coproduction and to inform the direction the ICB takes with the re-set group. This will be a key priority for the team.
- **National Coproduction Week 2024** – this has been a significant focus for the team during June. Taking place during the 1-5 July 2024, the Team have again curated several events for people to attend based on the national theme #what'smissing. This includes Lunch and Learn sessions with speakers - Top Tips for Involving Children & Young People and Top Tips for Engaging with Refugees & Asylum Seekers. The events have been heavily promoted and people are attending from different system partner organisations, However, uptake from ICB staff has been low. A celebration of coproduction document is being produced to showcase some of the coproduction work taking place across the system. The Big Coproduction Conversation again this year seeks to ask survey questions to contribute to a baseline assessment of people's attitudes to coproduction and needs in order to work in a coproduced way.
- **Shared System Coproduction Resource group** – this is a coproduction team led, fully coproduced system piece of work with people with lived experience and system partners. The aim of the work is to produce a system wide coproduction resource which identifies the conditions needed for coproduction to grow – with the aim of standardising the approach and encourage consistency across all partners.

Actions Being Taken & Next Steps

- Coproduction Week 2024 (July)
- Ongoing development of the Coproduction infrastructure for the Network and technology required.
- Preparation for the Coproduction Strategy review.
- Preparing for the reset of Strategic Coproduction Group with a series of listening events planned for July and August 2024.

Risks & Escalations

- Low uptake from ICB staff of the Coproduction Week 2024 events, even with heavy promotion- would be good to get support from managers to encourage staff to attend.

Content Author: Rhonda Christian | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

Rushcliffe Arena, 09:00-12/09/24

15. Adult & Children Safeguarding

Reporting Period:
01 June 24 – 30 June 24

Adult & Children Safeguarding

System Quality Group Oversight – Routine

Rationale for oversight level: All major statutory duties for the ICB and system partners are being met. Where concerns have been raised around specific issues, the ICS Safeguarding Public Protection and Assurance Group are monitoring and actioning these issues effectively.

Current Position

- Safeguarding Level 4 & 5 training now booked with Bond Salon and will take place in September 24 – places have been offered out to safeguarding leads across the partnership.
- Safeguarding Executive Leadership training now secured from Browne Jacobson – to be arranged for Q.3 with a focus on CYP 16 & 17 year olds
- Right Care Right Person workstreams now in progress with ICB representation.
- NHSE DHR review audits now in place.
- The Safeguarding Children team are contributing to a multiagency cross partnership audit relating to sec 47 strategy discussions which is statutory function as a safeguarding partner (WTSC 2023)
- One child safeguarding rapid review has been completed and the panel have concluded a LCSPR is required. The report has been submitted to the National Panel and a response is anticipated shortly.
- A previous rapid review which identified further partnership learning under a Child Safeguarding Practice process has identified an Independent reviewer has been completed. The report has been reviewed at the Safeguarding Partnership Child Safeguarding Practice Review sub-group and will be discussed at the Strategic leadership group
- MASH heath (County) continue to be part of the multiagency redesign with an extended period of testing . This commenced on 12.6.24 and revisions are now in progress with an extended rollout to test the systems being planned form mid-July. Continuing work to engage the ICS Health providers to integrate them more robustly into the work plan continues.
- Work has commenced with the health providers to progress the next development of the national Child Protection Information system (CPIS) project which is to be extended across service areas with information who are subject to child protection plans and children in care. Currently a plan reviewing the IT systems to support the project is progressing and liaison with our local authorities. NHSE national team will advise further with a plan of roll-out once the testing sites have completed further testing.
- Primary Care Safeguarding undertaking aa dip-test audit of the communications to GP's relating to notifications for Initial Child Protection Conferences across the system as there had been raised some concerns that GP's were again not receiving invites and subsequently unable to contribute information and receive ongoing information

Actions Being Taken & Next Steps

- GP leads sessions now planned for delivery in Q4 with adult safeguarding focus, delayed from Q3 due to competing priorities.
- MARAC review pilot being rolled out Q3 across Nottingham City. Discussions with new DA lead in County commencing to try and encourage adoption of new process across County.
- LDA/CHC workshop arranged for Q2 to upskill colleagues in application of MCA, DoLs and COP process.
- Commenced Domestic Abuse needs assessment in Primary Care to inform future needs to improve outcomes.
- Undertaking MCA audit across Primary care as second phase of MCA needs assessment..
- Task and finish group in progress for CP-IS
- Primary care team conducting dip-test audit to advise of concern raised and work with Local Authorities a plan of action to mitigate findings if required.

Risks & Escalations

- Requests from partners for additional funds to carry out statutory reviews. City SAB currently considering a proposal from the City Partnership board to release additional funds for SAB – as budget held jointly currently.
- Escalation relating to completion of required Court of Protection documentation and MCA assessments by Mid/north Notts CHC teams. Risk Assessed as High.

16. Quarter 1 Care Homes & Home Care

Reporting Period:
01 April 24 – 30 June 24 (Quarter 1)

Care Homes & Home Care

System Quality Group Oversight – Routine

Rationale for assurance level: City and County both have sufficiency capacity in both care homes and home care to support flow and demand from hospitals and community. There are gaps in the market in some areas due to reducing bed numbers and contractual sanctions, Mid-Notts has been impacted with their nursing bed provision reducing substantially over the last year. There continues to be robust oversight of the market in terms of financial viability, with evidence of an increase in quality concerns in the market due to reduced investment in the environment. Market sustainability is a concern for the County, not only in respect of available provision but also in the management of closures and the impact on front line teams, the development of the new PIT team will support pro-active and re-active provider failure once all posts are recruited.

Current Position

- The County are experiencing an increase in suspended services – There has been an increase in the number of Ageing Well care homes which have been issued with a default notice, many with subsequent suspension of placements. This equates to more than 5% of the services across Nottinghamshire.
- The County have had one urgent home closure since the last report. Ryland Care Home (Residential) was closing due to quality and financial concerns, but the provider declared their company had gone into liquidation, therefore meaning urgent closure. Staff at the service continued to work to support people knowing they would not get paid.
- Ageing Well sufficiency & quality in Mansfield remains a significant issue – a further suspension of a Mansfield service has resulted in limited nursing bed stock in this district. There are currently only 7% of nursing vacancies available in the Mansfield district (28th June). However, mitigations include 13% of nursing bed availability in North Ashfield and 6% availability in Newark
- Observing an increase in the number of quality & safety concerns likely to be linked to financial issues in a small number of services, including reduction in staff, poor environment and essential equipment missing – potential risk of provider failure in a small number of services, which is being monitored..
- The County's Ageing well framework is live, the 4th round of the framework has now closed with evaluation being underway. The majority of care homes not currently on the framework have applied during this 4th round.
- The work of the Quality Improvement Manager is being focused where needed to make the most impact on improvement
- The County's Living Well Care Homes continues to have a high number of services with contractual sanctions in place
- The Home Care market across Nottingham and Nottinghamshire remains stable with no sufficiency concerns.
- Whilst home care remains stable there is an increasing risk with international recruitment and licence suspensions that could impact on capacity.

Actions Being Taken & Next Steps

- On-going dialogue with the home care market for gaps in capacity and where demand ensuring flow to fill gaps including preparing for winter pressure
- Working closely with Notts Care Association (NCA)
- Oversight of capacity in the home care market (County)
- Implementation of a brokerage service (County) details to be confirmed but initial plans to target over 65 placements
- On-going market oversight monitoring risks
- Market engagement (meetings online/in person and events)
- Weekly bulletin
- Commissioners working with mid-notts providers regarding the reduced nursing provision.
- A mapping exercise with providers is currently being undertaken to understand the level of nursing provision in County/City (e.g complex nursing/dementia)
- County to develop a new team called the Provider Improvement Team to pro-actively and re-actively support the market (temporary for 18 months).

Risks & Escalations

- Demand for home care not meeting available capacity
- Financial viability (unused bed capacity, home care capacity and cost of living impacts)
- Overseas worker recruitment – risks associated with numbers of licences and staff and also the changes to the VISA process. With the increase in licences being suspnded there is also the risk to business continuity for people receiving services and also for displaced staff. The teams are linked into the regional and national support for international recruitment.
- Market sustainability is an issue for parts of the County following a number of care home closures. This has impacted mid-Notts (particularly Mansfield) with a reduced number of nursing beds.

Content Author: Nicola Ryan | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

Rushcliffe Arena, 09:00-12/09/24

17. Quarter 1 Medicine Optimisation

Reporting Period:
01 April 24 – 30 June 24 (Quarter 1)

Medicine Optimisation

Current Position

- Medicines Safety Officer work programme for 2024/25 reviewed due to ICB MO team workforce capacity issues
- Ongoing support and partnership working with Local Authorities on safeguarding incidents related to medication and care home closure
- Ongoing support to GP practices and ICB commissioned organisations in relation to incident investigation where medicines are involved.
- Ongoing monitoring of anti-microbial prescribing to benchmark and identify prescribing outliers.
- Promotion of AMR through presentation at South Notts PLT events in May and East Of England webinar in April 24. Both events well received.
- Safe Management of Controlled Drugs Annual Report 2023/24 - development underway.
- Medication Safety Officer Report for 2023/24- development underway
- Review of Patient Group Directions (PGDs) for NHS commissioned services through private providers initiated .
- Quarterly reporting template developed for contracted services to report back and provide assurance to the ICB about the processes they have in place to ensure safe, legal and effective use and prescribing of medicines.
- Facilitation of ICS wide process for Directions to Administer to ensure robust, safer medicines administration
- Polypharmacy – system wide scoping for delivery of work programme under the National Medicines Optimisation Opportunities choices.
- Business case for change in provision of wound care products for community nursing in Bassetlaw, to align with the rest of NNICB and improve equity and support more timely patient care
- Scoping commissioning Continence Prescription Service for Mid Notts and Bassetlaw, to align with the rest of NNICB and improve equity and support timelier, specialist patient care.
- Co-production of the ICS Medicines Optimisation Strategy. Engaging with a wide range of stakeholders- workshop event held in May 24.
- Development of the financial efficiencies programme for prescribing, and review of ICB efficiency projects overall, ensuring that prescribing quality and safety is robust and maintained.
- Medicines Optimisation- Quality and Safety in Social Care Annual report for 23/24 presented to QPC June 24.
- Support to recruitment of ICB Community Pharmacy Primary Care and ICS Pharmacy Faculty roles.
- Support and promotion of patient safety specialist role - stakeholder visits undertaken May 24
- Promotion of Medicines Optimisation strategic objectives at ICB open house event – June 24.

Actions Being Taken & Next Steps

- Care Home and Home Care visits being undertaken by Medicines Optimisation Technician staff to promote and ensure the safe management of medicines in social care establishments
- Support offered to those GP practices where Controlled Drug prescribing is an outlier
- Ongoing support to GP practices and ICB commissioned organisations in relation to incident investigation where medicines are involved.
- Medicines Safety work streams support linked to antimicrobial prescribing and drugs in pregnancy eg valproate and topiramate.
- Safeguarding's continue to be supported, with common themes identified and lessons learnt shared
- Medicines Safety and Antimicrobial prescribing included as part of GP practice prescribing visits currently being undertaken across all GP practices
- Stakeholder meetings for implementation of Sodium Valproate NatPSA alert ongoing plus establishment of primary care stakeholder group.
- ICB PGD policy currently being updated to ensure commissioned providers follow a transparent review process.
- Ongoing medicines optimisation support to local LeDeR process and input to regional team.
- Process for Medicines Optimisation Team being developed to review reports back from contracted services and follow up as needed
- Assurance and reporting framework for medicines optimisation developed. Reporting to QPC and System Quality Group will be aligned with this framework. . Paper to Quality and People Committee (QPC) in July to describe this was deferred so will resubmit.
- Reporting to ICS Collaborative Clinical and Care Leadership and Transformation Group about system polypharmacy work
- Place based meetings to inform production of the ICS Medicines Optimisation Strategy

Risks & Escalations

- Workforce capacity of ICB Medicines Optimisation team in particular within Pharmacy interface team and Bassetlaw place. Large number of clinical guidelines requiring review.
- Lack of engagement from specialists to support guideline review
- Lack of engagement from some Primary Care Networks/Place areas due to competing priorities.
- Clarity on ICB position re current and future shared care arrangements required.

Content Author: Coral Osborn | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

18. Quarter 1 Personal Health Budgets

Reporting Period:
01 April 24 – 30 June 24 (Quarter 1)

Personal Health Budgets

System Quality Group Assurance – Routine

Rationale for assurance level: The ICB achieved 7169 PHBs, which is 82% towards the overall NHS England Personal Health Budget (PHB) target for 2023/24.

Current Position

- Completed Q4 PHB Direct Payment Financial auditing
- Completed Q4 PHB financial monitoring direct payment alert audit – On going monthly review on actions completed
- Personal Health Budget (PHB) quality framework – ICB Self assessment completed
- Health inequalities and obesity Personal Health Budget (PHB) projects – to date:
  - 107 PHB referrals received
  - 7 PHB's closed
  - 87 PHB's completed
  - 14 PHB's currently open

Actions Being Taken & Next Steps

- Quarter 1 PHB data will be requested at the end of June 24 - NHSE have not set any PHB targets for 2024/25 but as an ICB we will continue to collate PHB figures.
- Personal Health Budget (PHB) quality framework – Prioritise and planning stage
- Complete Quarter 1 PHB panel submission and care and support plan quality assurance audit and report
- Complete Quarter 1 PHB direct payment financial monitoring

Risks & Escalations

- Currently the ICB only offer Therapy Personal Health Budgets (PHBs) within Bassetlaw Place. The therapy Personal Health Budgets (PHBs) are offered to people who have a long term condition and are processed by the Bassetlaw Complex case manager. The Personal Health Budgets (PHBs) are funded via the Long Term Conditions core budget and are short term Personal Health Budgets (PHBs) to support health outcomes. Individuals who are not living within Bassetlaw place are currently unable to access the same offer.

18. Quarter 1 Personal Health Budgets

Reporting Period:
01 April 24 – 30 June 24 (Quarter 1)

Personal Health Budgets

System Quality Group Assurance – Routine

Rationale for assurance level: The ICB achieved 7169 PHBs, which is 82% towards the overall NHS England Personal Health Budget (PHB) target for 2023/24.

Additional Information - Taken from the End of Year Summary Report

'Legal right to have' PHBs – Continuing Healthcare, Children's Continuing Care and Wheelchair Services:
There are 3 main areas which the ICB must provide a personal health budget or a personal wheelchair budget under the 'legal right to have'. They all make up the highest numbers of the PHB data. All three require an individual to be eligible before a PHB can be provided and for this reason we cannot increase these numbers each quarter as we will always be limited by eligibility.

Additional PHB's offers which are all outside of the 'legal right to have':
NHS carers breaks - managed by the ICB's Carers break Service. They do not collate any figures from Bassetlaw place. Numbers dropped by 52% in Q3 compared to Q1.
Know your Mind - manage their own PHB offer. They have had a reduction in their overall referrals for PHB's quarter on quarter. They also do not have a 100% approval for these referrals.
Neuro Therapy PHB's - managed by the Neuro case manager. These PHB's are currently only offered within Bassetlaw place so growth in numbers will not be high as is evidenced with the 0% increase. If there were more capacity within the ICB PHB team, then we could expand the offer across the remaining areas of Nottingham and Nottinghamshire.

Additional PHB projects:
- Autism and Learning Disability Key Working Service - manage their own PHB offer. The PHB numbers have been low, on average 2 per quarter.
- Health inequalities and Obesity - 6 projects funded by NHSE funding to pilot PHB's for individuals who were clinically obese and facing health inequalities. These projects were quite slow to get started and were being managed by external teams and not directly managed by the ICB. The ICB were there to provide PHB training to the external teams, oversee the financial elements of the project, receive referrals for a PHB and set up the payment on for or on behalf of the individual. Referrals only began coming into the ICB in Q3 2023/24
- Mental health – Personality Disorder Service - ICB mental health funded PHB pilot project. Delay in recruiting officer to post and induction. PHB's only started in Q4 23/24.
- Hospital Discharge PHB's - The ICB started offering these PHB's to help support an earlier discharge from hospital. No further funding was allocated for these PHB's and we stopped offering them in Q2 but used the remaining of the funding into Q3.

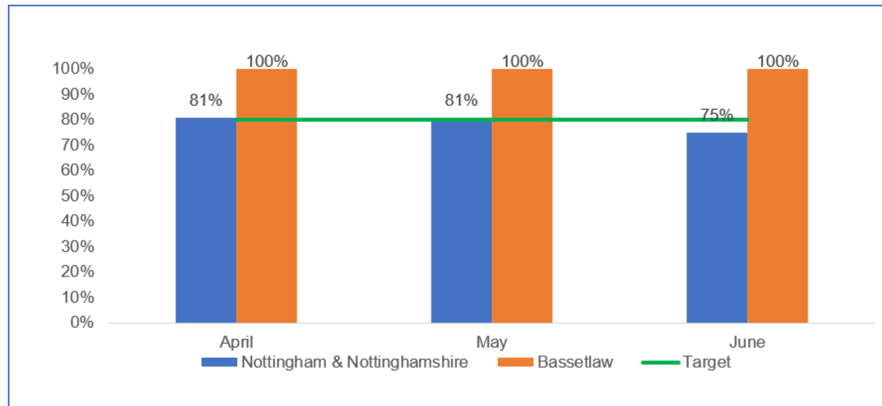
Actions to be taken:
- Although NHSE have not announced any specific PHB targets for 2024/25 we will continue to monitor and report on the numbers of new PHB's across Nottingham and Nottinghamshire on a quarterly basis.
- The ICB PHB team will continue to support the project officer for the Mental Health Personality PHB pilot with the aim of increasing the numbers of new PHB offered. We will also support in the evaluation of the pilot.
- The ICB PHB team will support the Neuro Case Manager in expanding the Neuro therapy PHB's across the rest of Nottingham and Nottinghamshire.
- The ICB PHB team will work with the Carers Breaks team to begin to include Bassetlaw NHS carer break PHB's in the reporting.
- The ICB PHB team will continue to work with other ICB teams or external teams who wish to offer PHB's within their service.

19. Quarter 1 Continuing Healthcare

Reporting Period:
01 April 24 – 30 June 24 (Quarter 1)

Continuing Healthcare

Eligibility decisions made within 28 days from receipt of Checklist



Data Cut-Off Date: 30/06/2024

Explanatory Note/Insight Analysis and Assurance: the ICB has not consistently met the target of 80% of eligibility decisions made within 28 days from receipt of checklist target in quarter 1.

Eligibility decisions exceeding 12 weeks

Quarter 1	April	May	June
Nottingham and Nottinghamshire	0	0	0
Bassetlaw	0	0	0

Data Cut-Off Date: 30/06/2024

Explanatory Note/Insight Analysis and Assurance: the ICB has met the target of zero eligibility decisions exceeding 12 weeks throughout quarter 1.

Content Author: Sally Dore | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

19. Quarter 1 Continuing Healthcare

Reporting Period:
01 April 24 – 30 June 24 (Quarter 1)

Continuing Healthcare

System Quality Group Assurance – Routine

Rationale for assurance level: Targets met in April and May. Not met in June but ICB aware of reasons and this is being managed with the CHC delivery service.

Current Position

Continuing Healthcare (CHC) data for the following performance indicators is collected monthly and reported to NHS England quarterly:
The ICB met both performance indicators in the first 2 months of quarter 1 but did not meet the 28 day target in June.

- Percentage of Continuing Healthcare (CHC) eligibility decisions made within 28 days of receipt of referral – the target is 80%. This target was missed in June 2024. This is mainly due to the CHC service in the south focussing on overdue fast track reviews but also there were delays in securing social workers to attend MDTs.
- Number of Continuing Healthcare (CHC) eligibility decisions outstanding 12 weeks or more from the date of receipt of the referral – target is ZERO. This target was met.

The Mid Notts locality overdue reviews for people in receipt of CHC and joint funded packages by a third party organisation commissioned by the ICB, was scheduled for completion by May 2024. These hav enow all been concluded. The outcomes of some joint funded reviews where ICB funding has been reduced or removed have been disputed by the County Council. Regular weekly meetings between the ICB and the Councils are taking place to conclude these – all disputed cases should be concluded by 4th July 2024.

A policy for healthcare contributions to care packages has been approved by SPI Committee. The Councils are not in agreement with it. However, work has commenced to review all the joint funded cases to ensure any funding is in line with the new policy. Agency staff have been recruited for 3 months to undertake this work. Any disagreements with the Council are being discussed at the weekly meetings.

Work continues to align CHC across the ICB with the preferred option for future configuration due to be considered by executives in July 2024.

A challenging savings and efficiencies target has been set for CHC and work continues to develop and implement the plans for achieving this. This includes detailed work on Children and Young People to understand the high expenditure on care packages and in particular to develop a funding model for looked after children made eligible for CC.

Actions Being Taken & Next Steps

- Monitor the 28 day target over the coming months whilst the CHC service focusses on overdue fast track reviews, and continue to have zero cases waiting over 12 weeks for a decision.
- Continue the work to review joint funded cases to ensure health contributions are in line with the new policy.
- Proposals for CHC delivery across the ICB to be reviewed by executives so the detailed work to implement changes can begin in 2024 for implementation in Q1-Q2 2025-26.
- Continue to develop savings and efficiencies plans to mee the target – implement those plans already in place.
- Recruitment of a Lead Children's Nurse to implement plans for savings and efficiencies.

Risks & Escalations

- Staffing Challenges – there continues to be vacancies and long term sick absences within the ICB central team and the Continuing Healthcare (CHC) operational teams.
- Disputes with the Councils regarding the outcomes of some of the joint funded reviews where the ICB has enacted financial reductions.
- Reaching an agreement with both Local Authorities regarding the joint funding process.
- Children's Continuing care continues to be a high spend area with demand from Councils for contributions to looked after children with challenging behaviour and/or psychological and emotional needs.

Content Author: Sally Dore | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

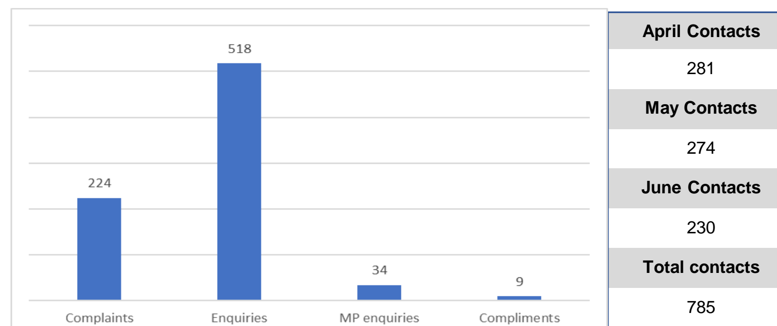
19. Quarter 1 Patient Experience

Reporting Period:
01 April 24 – 30 June 24 (Quarter 1)

Nottingham and Nottinghamshire

Patient Experience

Quarter 1 All Contacts Received

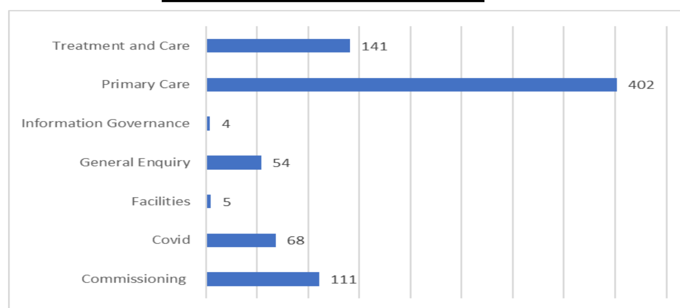


April Contacts
281
May Contacts
274
June Contacts
230
Total contacts
785

Data Cut-Off Date: 30/06/2024

Explanatory Note/Insight Analysis and Assurance: All contacts logged and responded to appropriately

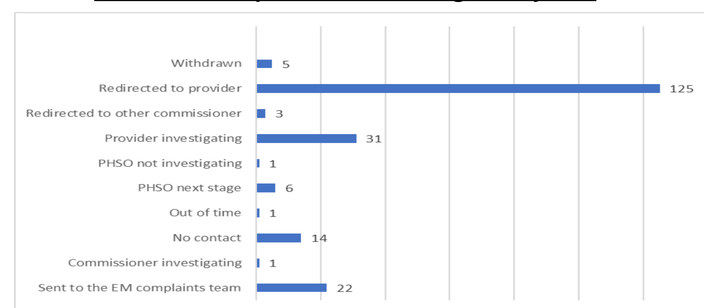
Quarter 1 All Contact Themes



Data Cut-Off Date: 30/06/2024

Explanatory Note/Insight Analysis and Assurance: The database has appropriate categories to log contacts received

Quarter 1 Complaints Not Investigated by PET



Data Cut-Off Date: 30/06/2024

Explanatory Note/Insight Analysis and Assurance: Complaints not for Patient Experience Team (PET) investigation and closed appropriately

Content Author: Sally Dore | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

19. Quarter 1 Patient Experience

Reporting Period:
01 April 24 – 30 June 24 (Quarter 1)

Patient Experience

System Quality Group Assurance – Routine

Rationale for assurance level: The NHS Complaint Regulations state that 100% of complaints received must be acknowledged within three working days – 99.5% compliance has been achieved during the reporting period with one complaint taking four days due to team capacity. 10 complaints received and closed in Q1 by the Patient Experience Team (PET) were responded to within the complaint response timescale.

Current Position

- The ICB has a statutory requirement to manage complaints in accordance with the Local Authority Social Services and NHS Complaints Regulations 2009.
- The ICB is required to acknowledge receipt of a complaint within three working days in a written format which does include email. In addition, the ICB is required to set a timescale for response with the complainant and, if this timescale is not able to be met, to advise the complainant of a new response date. The ICB timescales are 25, 40 and 65 working days.
- The team handled 785 contacts during the reporting period – a decrease of 114 contacts from Q4.
  - 224 complaints (94 fewer than Q4)
  - 518 enquiries (78 fewer than Q4)
  - 34 Member of Parliament (MP) enquiries (one fewer than Q4)
  - 9 compliments (1 more than Q4)
- 37 the 224 complaints received were agreed for investigation by the ICB; 15 complaints were for the PET to handle and 22 GP, Pharmacy, Optometry and Dentistry (POD) complaints were for the East Midlands (EM) Complaints team to handle. 1 PHSO complaint about same sex IVF funding was received; the PHSO decided not to investigate further.
- 5 complaints received in Q1 are still under investigation by the PET.
- 10 complaints handled by the PET were received and closed during Q1 with the following outcomes:
- 7 complaints resolved locally by PET (these did not go through the NHS complaints process; the complainants' wanted these recording as complaints but they were not appropriate for formal acknowledgement and investigation and complainant was satisfied with local resolution as an outcome); these were about children's ADHD services, CHC funding, delayed referral by GP, lack of access to NHS dentist and IVF policy/funding.
- Two complaints not upheld – one CHC, one IVF policy.
- One complaint partially upheld – retrospective review of CHC from solicitors. No specific lessons learned but apology given for periods of unassessed care and delay in initially agreeing to a retrospective review.

Actions Being Taken & Next Steps

- On 1 April 2024, NHSE delegated Specialised Commissioning to the ICB. From information provided, the complaints and enquiries function will come into the PET in April 2025
- The 2023/34 PET annual report was presented at Q&P Committee on 17 April 2024
- The Complaints and Enquiries policy has been updated as per the 360 Assurance complaints audit action. 360 Assurance has approved the updates
- The complaints leaflet and PET webpage has been updated as per the 360 Assurance complaints audit action
- The remaining audit actions are in progress according to the timescales
- Monthly maternity contacts report and GP/POD contacts report
- Monthly and quarterly 'deep dive' reports of PET activity, themes, trends and lessons learnt
- Complaint outcomes from complaints received in previous quarters will continue to be reported within each new IPR quarter
- Quarterly GP contacts report for the Primary Care Committee
- Monthly meetings with the East Midlands (EM) Complaints team `

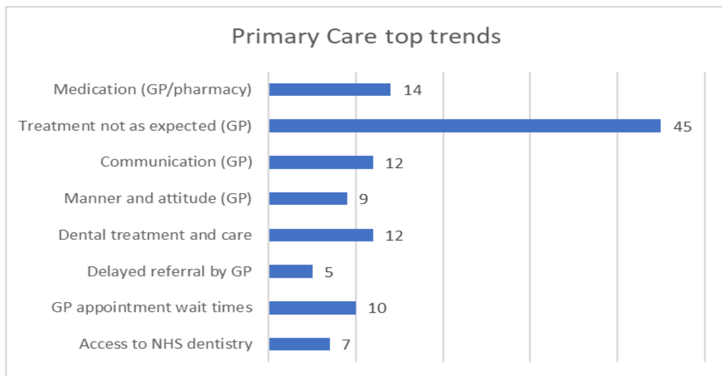
Risks & Escalations

- The unreasonable and persistent contact from one patient has escalated since Q4 and since 11 April 2024, the PET (along with ICB CHC teams and the ICS generic mailbox) has received 25 email contacts but no telephone contact. The 'no contact' decision continues to be adhered to. The issues raised remain the same as first raised in 2022.
- One complaint received in Q3 2022 is still under investigation. This is a complex complaint and has involved significant work and time on the part of the complaint handler. AGCSU confirmed on 01/07/2024 that a resolution meeting will take place before the end of July.

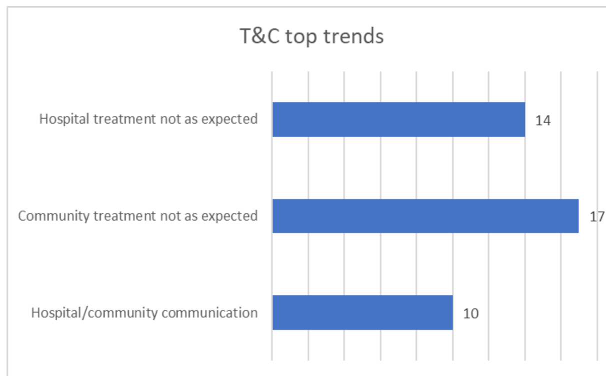
19. Quarter 1 Patient Experience

Reporting Period:
01 April 24 – 30 June 24 (Quarter 1)

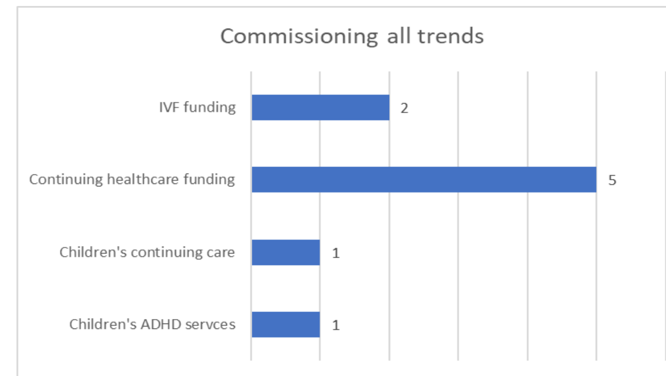
Patient Experience – Complaint Trends and Lessons Learned



Primary Care continues to be the main theme for complaints with 150 complaints received in Q1. The graph above shows the top 8 trends this quarter. This is reported in more detail in the Primary Care quarterly report.



Treatment and Care (acute, mental health, community services) received 63 complaints in Q1. The graph above shows the top 3 trends this quarter.



Continuing healthcare funding is the most common trend. IVF funding for same sex couples is also a recurrent trend for enquiries and MP enquiries received.

Complaints closed in Q1

20 complaints in total were closed in Q1. This includes the 10 complaints received in Q1 and mentioned in slide 35.
One complaint received in Q3 and five complaints received in Q4 were closed in Q1 with the outcome of 'resolved locally by PET'. Four of these complaints were closed within the timescale with one taking 66 days and one taking 109 days due to complexity and time taken to gain information to respond.

The four complaints received in previous quarters had outcomes as below:
Not upheld – two (received in Q4)
Partially upheld – one (received in Q4)
Upheld - one (received in Q3)
Three of these complaints were closed within the set timescale with one taking 72 days due to complexity/time taken to receive information needed to respond.

Lessons Learned and Actions from complaints (no system learning this quarter)

- NUH has improved communication between relatives and patients to improve management of appointments for neurodiverse patients to improve delays by ensuring that staff have good care plans and knowledge of patient needs in advance of appointments. (partially upheld complaint Q4)
- The ICB agreed to reimburse care home fees incurred between April 2013 and September 2015 following legal advice (locally resolved complaint (Q3)
- CityCare has shared the complaint about an inaccurate CASP with their CHC team for learning and has requested that staff are more robust in their quality assurance process (upheld complaint Q3)
- The ICB agreed to pay care home fees. Fees had previously been confirmed at a higher rate without formal approval. Issues need prompt escalation; a prompt clinical opinion is needed; face to face meetings to be implemented to build relationships; emails to be responded to more quickly. Extra staffing is being sought to support this (locally resolved complaint Q3)
- The ICB agreed to pay overdue invoices from 2019 for a care home. The CHC team will review and implement processes to improve communication and look at what happened to the original emails (locally resolved complaint Q1)
- Delay in complainant receiving fast track PA funding that was agreed by CityCare and paid by family. Delay was due to CityCare needing to do retrospective work to confirm and agree the complex package of care. The ICB made payment once CityCare had notified payment was required (locally resolved complaint Q4)

Content Author: Sally Dore | **Exec Lead: Rosa Waddingham** | **System Oversight: System Quality Group** | **ICB Committee: Quality & People Committee**

Nottingham and Nottinghamshire

Service Delivery Performance

ICS Aim 1: To improve outcomes in population health and healthcare

ICS Aim 2: To tackle inequalities in outcomes, experience and access

- 7.1 – Service Delivery SPC Matrix
- 7.2 - Urgent Care Pathways
- 7.3 – Elective Care Recovery
- 7.4 – Mental Health Recovery
- 7.5 – Primary and Community Care Recovery
- 7.6 – Provider Level Overview

7.1 - ICB Service Delivery Metrics Insights – Reporting Period August 2024

NHS Nottingham and Nottinghamshire

August 2024	Assurance: Pass	Assurance: Hit & Miss	Assurance: Falling Below
Variation: Special Cause - Improvement	SDEC % of Total Admissions (Prov) P0 - Discharges Home (Pop) Outpatient FUps (Pop & Prov) Talking Therapies < 6 Weeks SMI Health Checks	No Criteria to Reside (Prov) Ambulance Hours Lost (Pop & Prov) Ordinary Electives (Pop) Daycases (Pop) Outpatient 1st (Pop & Prov) PIFU (Prov) RTT Admitted (Pop) Diag Backlog (Pop) Diag +6Wks (Pop & Prov) Cancer 62 Day Backlog (Prov) Adult SMI +2 Contacts Community Dementia Diagnosis Individual Placement Support	P1 Discharges Home H&SC (Pop) Patients Using Virtual Wards (Pop) Hospital Handover Delays > 60 mins A&E 4hr % (Prov) 12 Hour Breaches Actual (Prov) Total Waiting List (Pop & Prov) 65 Week Waits (Pop & Prov) 78 Week Waits (Pop & Prov) Ordinary Electives (Prov) Daycases (Prov) Diag Activity (Pop) Diag Backlog (Prov) Cancer 1st <31 days % (Pop & Prov) Perinatal Access Volume CYP Access (1+ Contact) NHS App Registrations
Variation: Common Cause - Random	Talking Therapies < 18 Weeks Early Intervention Psychosis	A&E Attendances (Prov) % Bed Occupancy (Prov) Length of Stay >21 days (Prov) Ambulance Response Cat 2 (Pop) Ambulance Response Cat 4 (pop) 12 Hour Breaches % Ed Atts (Prov) 52 Week Waits (Pop & Prov) RTT Admitted (Prov) RTT Non-Admitted (Pop & Prov) Cancer FDS (Pop & Prov) Cancer 62 Day % (Pop & Prov) Talking Therapies Recovery Rate Older Adult MH >90 day LOS CYP Eating Disorders - Urgent Total Appointments	Ambulance Response Cat 1 (Pop) % Cat 2 waits below 40 minutes (Pop) Ambulance Response Cat 3 (Pop) Total Outpatients - Virtual (Pop) Diag Activity (Prov) Cancer 2ww % (Prov) CYP Eating Disorders - Routine
Variation: Special Cause - Concern		NEL Admissions (Prov) Diag Waiting List (Pop & Prov) Adult MH - 72 Hour Follow Ups % Patients able to book in 2wks (Pop)	Total Outpatients - Virtual (Prov) Talking Therapies > 90 days 1st & 2nd Inappropriate OAP Bed Days

Items for escalation based on the indicators Falling short of the target and showing Special Cause for concern are as follows:

Outpatients
- Total Outpatients - Virtual (Prov) - Page 58

Mental Health
- Talking Therapies > 90 days 1st & 2nd - Page 62
- Inappropriate OAP Bed Days - Page 63

***Areas which continue to improve** however are still unlikely to achieve the plan set in the near future*

***Areas which are not significantly changing or having periods of sustained improvement** AND which continue to fail to deliver to planned levels, e.g. 4 hour ED, cancer backlogs. These areas may be deteriorating or improving, however have not had a sustained change for 6 periods to trigger a special cause 'low' or 'high' alert as yet, e.g. cancer 62 day backlog, 12 hour breaches*

The Matrix supports the identification of areas of risk and concern, as well as areas of improvement, across the range of service delivery requirements.
For example, the orange bottom right box consolidates all of the areas which have deteriorating performance levels and are unlikely to achieve the required positions based on current performance levels. These, and other areas of deterioration, or areas expected to falling below requirements have been included as exception reports.

Rushcliffe Arena, 09:00-12/09/24

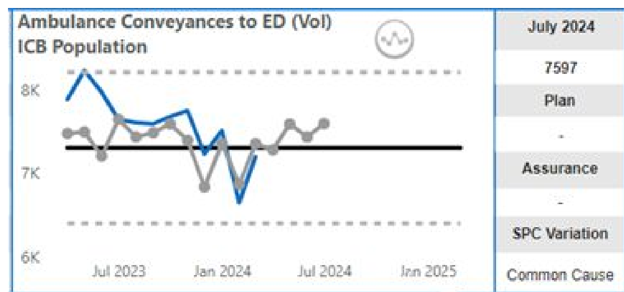
7.2 Service Delivery Urgent Care Performance

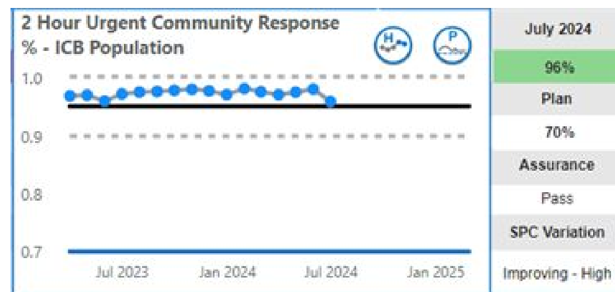
7.2.1 – Exception Report: Pre-Hospital Flow
7.2.2 – Exception Report : Front Door & In-Hospital Flow
7.2.3 – Exception Report : Ambulance Handovers
7.2.4 - Exception Report : A&E Four Hour Wait
7.2.5 - Exception Report : Flow Out of Hospital
7.2.6 - Exception Report : Ambulance Performance

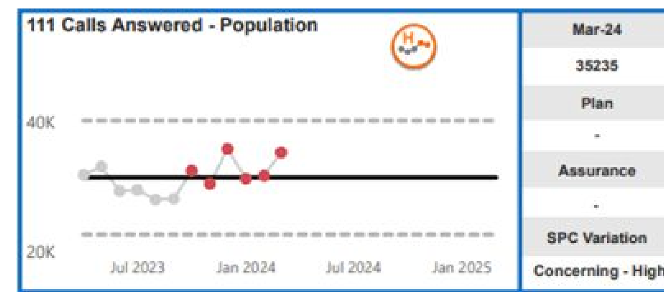
7.2.1 - Streamline Urgent Care – Exception Report: Pre-Hospital Flow

NHS
Nottingham and Nottinghamshire

Oversight Level	Routine







EMAS - In July 2024, there were 23,721 calls within Nottinghamshire for ambulance services, which is an increase of 4.75% compared to the volume in July 2023 (22,620). Call volumes increased by 3.88% from June to July 2024 (22,818 to 23,721 calls). Over time, the proportion that are closed without dispatching an ambulance (Hear and Treat) has increased. These formed 19.6% of the total in July 2024 compared to 11.8% in July 2023. 'See and Treat' (treatment carried out at patient's location) formed 26.8% of the total (July 23=31.3%) and 'See and Convey' (arrival at scene followed by ambulance conveyance to a healthcare facility) were 53.6% of the total (July 23=56.9%). The Nottinghamshire proportions are in line with the EMAS position for these three metrics. Additional demand has been seen at SFH and work is being undertaken with EMAS and ICB around criteria to identify the drivers of the growth.

111 - In March 2024, 35,235 calls were answered by the 111 service for Nottingham and Nottinghamshire, which compares to 31,705 in February 2024 and 19,492 in March 2023. Currently issues with obtaining more recent 111 data due to changes in publishing. Update expected before next IPR.

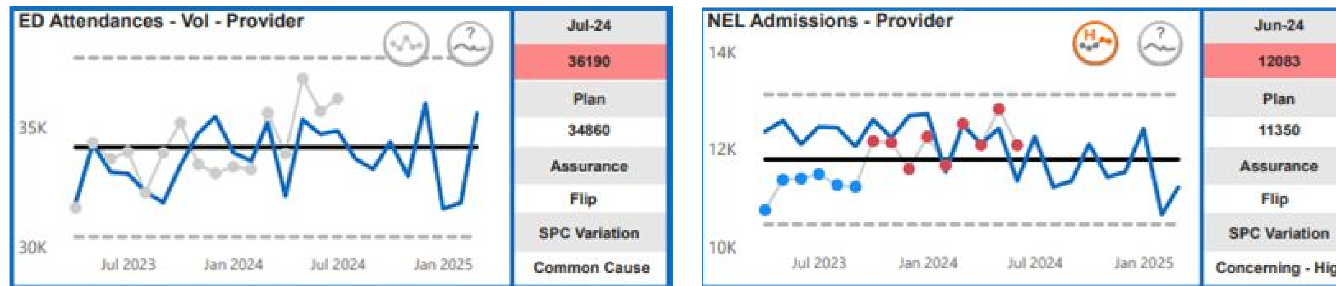
UCR - All integrated care systems must ensure urgent community response (UCR) services are available to all people within their homes or usual place of residence, including care homes, which can help to prevent avoidable hospital admissions. The ICB performance remains above the 70% standard for patients being seen within 2 hrs. In July, performance was 96% of 1,031 calls responded to within 2 hours. The UCR service has consistently exceeded the minimum standard of reaching 70% of two-hour crisis response demand within two hours, achieving an average of 98%. This is the highest in the Midlands and exceeding the national average of 84%. Work is being carried out on expansion of referral routes to UCR through Urgent Care Co-ordination Hub. Discussions continue on the future single UCR service offer across the ICS.

Content Author: Rob Taylor	ICB Programme Lead: Gemma Whysall	Executive Lead: Mandy Nagra	System Oversight Group: A - Delivery	ICB Committee: Finance & Performance Committee

7.2.2 - Streamline Urgent Care – Exception Report : Front Door & In-Hospital Flow

NHS Nottingham and Nottinghamshire

Oversight Level	Further Information Required



Position

A&E and Non-elective activity plans (ICB Provider) –There were 18,754 A&E attendances at NUH in July 2024, which was an increase from the previous month by 82 attendances. This is marginally higher than the planned level by 1.46% or 273 attendances. Note that these volumes exclude any patients that attend the London Road Urgent Treatment Centre.

At SFH, there were 17,436 attendances in July 2024, which was 6.25% or 1,057 attendances above the planned volume. This is 10.35% higher than July 2023 and is having a direct impact on the ability of SFHT to deliver to their 4-hour trajectory.

In June, Non-elective (NEL) admissions were 6.25% or 733 admissions above plan. Admissions into NUH were 569 admissions over plan or 7.2%, admissions to SFH were 4.28% above the planned level (164 admissions).

Actions

NUH continuing to try and evaluate the effectiveness of the actions implemented to identify those with the most significant impact. A flow coordinator is to be placed in UTU to focus on pathways. Co-located UTC transfer of 25 patients to NEMS, following its start in July, August and September will see an increase in patient movement with the second phase set to go live in October.

NUH will be moving to NerveCentre for ED on 24th September and are subsequently planning on moving to NerveCentre for IP and OP by November 2025. A whole module has been created for SDEC, which will be implemented following go live of the ED module in Autumn. This will enable Same Day Emergency Care (SDEC) to be accurately and routinely reported at NUH.
SFH have improved Rota management focus and senior support for some agency cover is supporting due to challenges covering shifts. Work being carried out around patients identifying primary care as reason for ED attend, aiming to capture practice information to target additional actions.

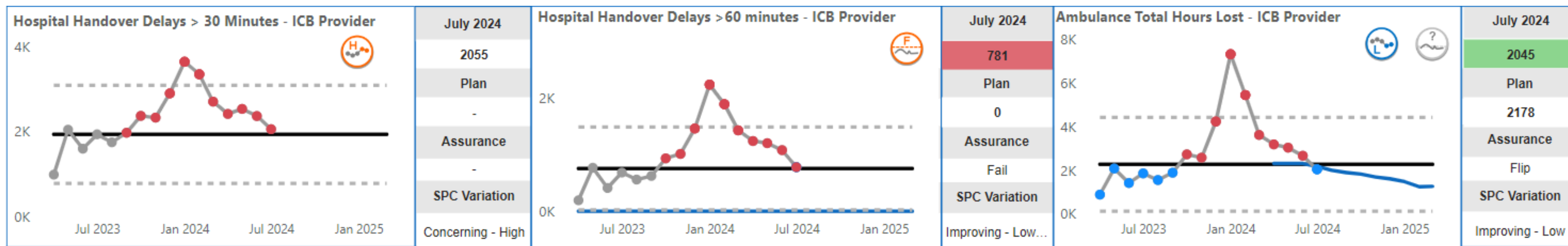
Additional analysis has been undertaken to determine drivers of SFHT demand increase to identify mitigating actions, meeting with EMAS to reset system boundaries, UCR activity discussions are being undertaken to ensure maximum utilisation, a new approach will be tested with EMAS and Care Homes in August.

Content Author: Rob Taylor	ICB Programme Lead: Gemma Whysall	Executive Lead: Mandy Nagra	System Oversight Group: A - Delivery	ICB Committee: Finance & Performance Committee

7.2.3 - Streamline Urgent Care – Ambulance Handovers

NHS Nottingham and Nottinghamshire

Oversight Level | **Escalated Risk**



Position

In July 2024, there were 2,055 delays over 30 minutes, of which 781 were above 60 minutes. Of the 60-minute delays, 774 were at NUH and 7 were at SFH. There were 2,045 hours lost through ambulances waiting to handover patients to hospitals in Nottinghamshire in June in excess of the 30 minutes expected (15 mins pre and 15 mins post-handover time), this significantly limits the capacity of EMAS to respond to calls within a timely manner. The handover clock starts when the ambulance wheels stop in the patient offloading bay and the 'Red at hospital' button is pressed on the Mobile Data Terminal. Where a patient is handed over directly from the conveying crew to hospital staff, the operational handover clock stop is when clinical handover has been fully completed and the patient has been physically transferred onto hospital apparatus. Handover times exceeding the 30 minutes are aggregated to generate the total number of lost hours from handovers.

In July 2024, QMC reported 1,788 lost hours from handover delays – this is the second highest reported figure of the 27 reporting hospitals in the Midlands. QMC have now had seven consecutive months of improvement, including an improvement of 1,154 since the April 2024 position. This July position is approximately 1,037 hours lower than Leicester Royal Infirmary who reported the highest position. QMC's reported lost hours account for over 13% of the total EMAS reported lost hours for July (13,294). However, this is an improvement on the June position where QMC lost hours made up over 18% total. By comparison, KMH place 14/27 and Nottingham City place 12/27 within the region. As a County, Nottinghamshire reported 2,474 lost hours, this includes Doncaster & Bassetlaw Hospitals (428 lost hours), SFH (147), NUH (1,899). This was the third highest volume within the region, 1,208 hours below Lincolnshire and accounting for over 18% of total EMAS reported lost hours (22% in June).

Actions

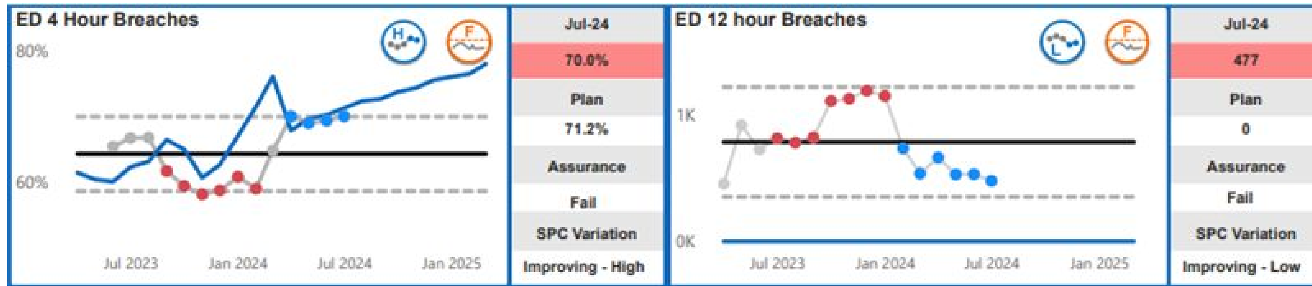
Monthly pre-handover lost hours improvement trajectories have been calculated as part of the Cat 2 Handover plan within the contract, and this will provide the basis for routine improvement monitoring. Post-handover hours lost improvement trajectory is being developed. NUH and EMAS have identified actions to be undertaken to address 'pin' process, CEO discussions are being undertaken to understand what more can be done. "Maintaining 30 minutes ambulance handover SOP" is being developed with EMAS looking into benchmarking analysis around 30 min handovers. EMAS in discussions with NUH about case reviews of patient handovers to ensure most efficient processes in place. 45-minute handover meetings with EMAS also started at NUH. Plan for pilot to commence on 6th September, with Exec meeting this week to discuss.

Content Author: Rob Taylor	ICB Programme Lead: Gemma Whysall	Executive Lead: Mandy Nagra	System Oversight Group: A - Delivery	ICB Committee: Finance & Performance Committee

NHS Nottingham and Nottinghamshire

7.2.4 - Streamline Urgent Care – A&E Four Hour Wait

Oversight Level | Escalated Risk



Position

In July, the system achieved 70% performance for 4-hour waits against a plan of 71.2%. NUH achieved 68.7% against a plan of 67.0%, with SFH delivering 71.6% against a plan of 76.0%. NUH have had four consecutive months of achieving the operational plan target for all A&E attendance types (1,2 and 3). However, challenges remain on type 1 attendance performance. Note that a Type 1 department is a major emergency department that provides a consultant-led 24-hour service with full facilities for resuscitating patients, for example patients in cardiac arrest. The Type 1 majors four-hour performance is significantly influenced by ambulatory majors and have long waits to be seen. The volume of patients waiting 12 hours from arrival increased in June from May and challenges remain with the pace at which patients move through the Majors department. 4-hour performance is ahead of plan but work being carried out with focus on non-admitted patients as this should deliver further improvements. System performed at 7% for July against 2% target for 12-hour breaches as percentage of ED attendances, a decline in performance since June (6.3%).

SFH have had fluctuating A&E performance associated with high demand and challenges with senior clinicians staffing. Achieving high performance is a challenge where ambulance arrivals exceed 100 per day and attendance significantly above plan.

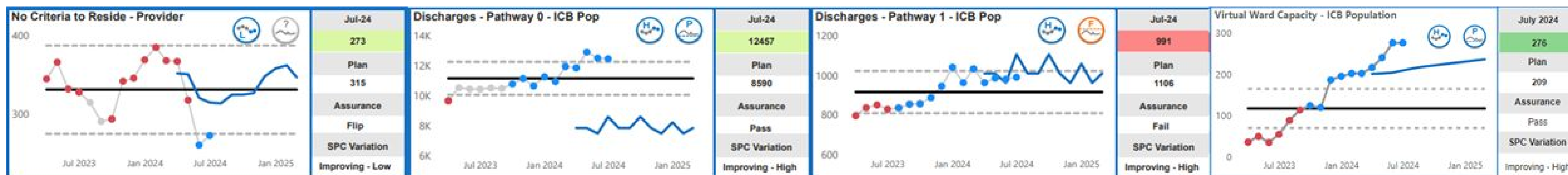
Actions

NUH have clear plans which identify actions and timescales and have re-established daily 4-hour meetings. Review taking place around sustainability options due to challenges with staff sickness levels. They have segmented pathways to identify the component parts which require intervention and have related clear data driven actions. Cultural change is progressing with four-hour target, but to culturally embed it will take time after many years of non-delivery and the trial of new targets. The Trust have also developed an ED crowding metric to track flow, which will be tracked internally and at system level via the weekly SOG A meeting. Working towards 12-hour non-admitted breaches becoming zero tolerance – currently averaging around 18 per day. Themes identified include senior decision making and planning, long waits to be seen and diagnostic delays. Actions include use of SDEC for undifferentiated patients, re-direction to UTC and implementation of new injuries rota on 9th September. NUH also undertaking analysis around LLOS.
SFH will link with NHSE to benchmark their workforce and understand whether it is the right size to meet the demand and understand if there are methods adopted by other providers to mitigate staffing gaps. Routine ICB & provider CEO and COO meetings at both Providers taking place to retain focus on UEC improvement plan and actions

7.2.5 - Streamline Urgent Care – Exception Report : Flow Out of Hospital

NHS Nottingham and Nottinghamshire

Oversight Level	Enhanced Oversight



The volume of pathway 0 (Simple) discharges remains significantly above the planned level with 12,457 discharges in July against a plan of 8,590. Pathway 1 discharges fell below planned volumes with 991 against a plan of 1,106 discharges in July.

There have been significant improvements in discharge levels seen at NUH. There have been an average of over 300 discharges per day (all pathways) for each month in 2024/25 at NUH. SFH have averaged over 140 discharges per day since May. Note that pathway 1 discharges are where the patient is able to return home with support from health and social care. Pathway 0 discharges require no input from health or social care.

There has been a small increase in position for the volume of patients that have No Criteria To Reside (NCTR) within NUH and SFH. This has moved from 318 in May, down to 261 in June and back up to 273 in July. This position is below plan of 315 patients and is the second lowest volume of NCTR patients since August 2022, after June 2024. Discussions continue regarding improvements to discharge readiness through discharge lounges and into pathways, as well as effective utilisation of virtual ward capacity.

LLoS position for July (358) declined from June (328) but remained below the plan of 400. NUH achieved 252 vs 290 plan, this was the first increase in LLoS in 6 months. SFH 106 vs 110 plan, the first increase in 3 months.

For July, the ICS reported no change in Virtual Ward bed capacity, however, this remains at 276 against a plan of 209, and with increased occupancy of 76.1% (April – 69.9%). NHSE expectations are that wards and systems will reach 80% utilisation of actual capacity. Latest published data for July shows the ICB places 17th of 42 nationally with 21.7 beds per 100,000 registered population (Aggregate England position is 19.6 per 100,000). The occupancy level increased from 69.2% in June to 76.1% in July. The operational plan includes a plan of 236 beds by March 2025.

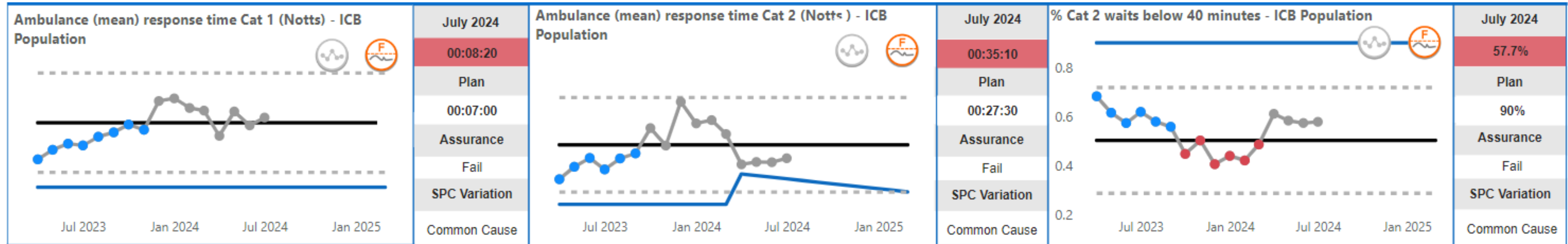
Content Author: Rob Taylor	ICB Programme Lead: Gemma Whysall	Executive Lead: Mandy Nagra	System Oversight Group: A - Delivery	ICB Committee: Finance & Performance Committee

Rushcliffe Arena, 09:00-12/09/24

7.2.5 - Streamline Urgent Care – Exception Report : Ambulance Performance

Nottingham and Nottinghamshire

Oversight Level | Escalated Risk



Ambulance Response Times: Category 1 and 2 response times remain higher than target. (Category 1 : immediate response is required due to a life-threatening condition, such as cardiac or respiratory arrest. Category 2 : serious conditions, such as a stroke or chest pain which may require rapid assessment and/or urgent transport).

Category 1, Category 2 and Cat 2< 40 Mins metric have failure alerts, which signify that achievement of the standard is unlikely without a significant intervention. The average response time for category 2 calls in July was 35:10 mins against a plan time of 27:30 mins. A drop in performance of 01:29 minutes from June. The Category 2 performance level is a significant challenge for the system at over 35 minutes against a plan of 27:30 minutes. Performance of this standard is linked to ambulance handover times. Extended handover waits reduce the capacity that EMAS has available to respond to calls in a timely manner.

Weekly meetings between senior operational leads from EMAS, BDGH, NUH, SFH and the Urgent Care Resilience team continue to take place with main-focus of improving ambulance handover performance. Weekly Ambulance Turnaround Time (ATT) meetings taking place at NUH with focus on reducing lost handover hours, early discharge lounge movement set at 10pt by 10am at QMC and 8pts by 10am at City Campus, flow out of ED including by freeing up acute inpatient beds including optimal use of escalation capacity and discharge lounge and improved TTO process. Discussions with EMAS around Cat 2 performance taking place with EMAS.

7.3 Service Delivery Elective Care Performance

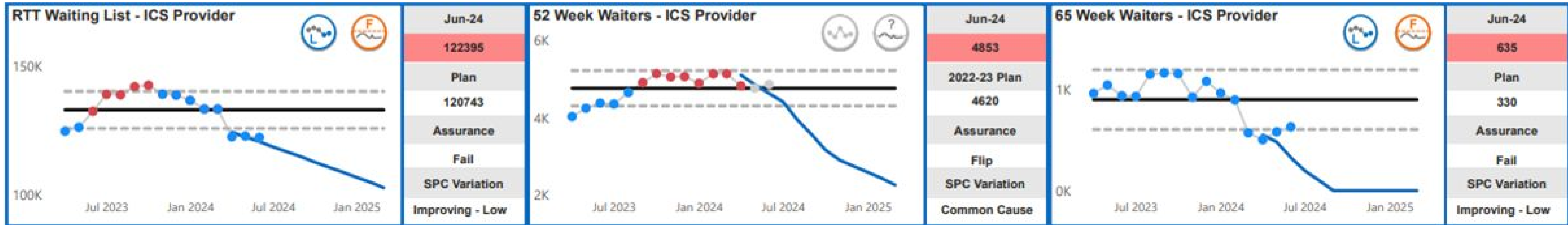
7.3.1 – Elective Waits Exception Report
7.3.2 – Elective Activity Exception Report
7.3.3 – Productivity and Transformation Exception Report
7.3.4 – Cancer Exception Report
7.3.5 – Diagnostics Exception Report

Rushcliffe Arena, 09:00-12/09/24

7.3.1 - Planned Care – Elective Waits

Oversight Level Enhanced Oversight

NHS
Nottingham and Nottinghamshire



Position

In June, there were no patients waiting 78 weeks or more across the two providers. More recent data indicates that there were two 78-week waiters within the system at the end of July, which were at SFH in Cardiology. There were 635 patients over 65 weeks at the end of June (526 at NUH, 109 at SFH) against a plan of 330.

Unvalidated data presented at SOG A indicates that SFH achieved the July plan with 77 patients against a plan of 80 patients. However, NUH did not achieve their July plan (460 patients above trajectory – ENT challenges are the main cause). There were 4,853 patients waiting over 52 weeks at the end of June against a plan of 4,620 which is 233 patients behind trajectory. More recent unvalidated data presented at SOG indicates that NUH are behind their July plan (3,676 patients v 3,200 plan) with SFHT ahead of July position (1,121 patients v 1,205 plan).

Actions

ENT at NUH is the most significant challenge around delivery of zero 65-week waiters. Within ENT, Paediatrics, Head and Neck, Rhinology and Laryngology are on track to achieve a maximum wait of 65 weeks by September. Otology is the highest risk cohort of patients. Medinet is being utilised by the Trust to the maximum level, which is 4 outpatient clinics, and 4 theatre lists per week. Outpatient sessions have been substituted for theatre sessions, which will deliver a further 6 clock stops per week from the 19th August onwards. Text validation of the waiting list has been completed for admitted and non-admitted, Adults and Paediatrics. PA consultancy are supporting oversight of theatre scheduling. Insourcing opportunities are being explored with multiple providers.

SFH have risks in ENT and Cardiology around achieving zero 65-week waiters at the end of September. In ENT, the trust are utilising weekend and evening lists to reduce backlogs. A locum consultant due to start in early September to start to support reduction in consultant only ENT procedures in theatre.

Forecast

SFH are on track to eliminate 65ww by September. NUH plan to achieve 65 weeks in all specialities except ENT by end of September. Current plans for ENT to clear by 2nd December, and zero for December end of month. However, the trust are exploring actions to expedite delivery of a maximum wait of 65 weeks.

7.3.2 - Planned Care – Elective Activity

NHS
Nottingham and Nottinghamshire

Metric Name	June Only				April to June			
	Plan	Actual	Variance	% Variance	Plan	Actual	Variance	% Variance
Elective Ordinary - ICS Provider	**2,630**	**2,180**	**-450**	**-17.1%**	**8,136**	**6,861**	**-1,275**	**-15.7%**
Elective Ordinary - NUH	2,235	1,799	-436	-19.5%	6,933	5,686	-1,247	-18.0%
Elective Ordinary - SFH	395	381	-14	-3.5%	1,203	1,175	-28	-2.3%
Op Plan Diagnostic Activity - ICS Provider	**35,480**	**34,160**	**-1,320**	**-3.7%**	**104,342**	**103,502**	**-840**	**-0.8%**
Op Plan Diagnostic Activity - NUH	20,898	19,817	-1,081	-5.2%	62,826	60,567	-2,259	-3.6%
Op Plan Diagnostic Activity - SFH	14,582	14,343	-239	-1.6%	41,516	42,935	1,419	3.4%
Total Day Cases - ICS Provider	**15,854**	**13,467**	**-2,387**	**-15.1%**	**49,018**	**41,617**	**-7,401**	**-15.1%**
Total Day Cases - NUH	12,037	9,889	-2,148	-17.8%	37,696	30,954	-6,742	-17.9%
Total Day Cases - SFH	3,817	3,578	-239	-6.3%	11,322	10,663	-659	-5.8%
Total Outpatients 1st (Spec Acute) - ICS Provider	**30,582**	**26,300**	**-4,282**	**-14.0%**	**94,204**	**79,792**	**-14,412**	**-15.3%**
Total Outpatients 1st (Spec Acute) - NUH	19,560	14,933	-4,627	-23.7%	62,154	45,454	-16,700	-26.9%
Total Outpatients 1st (Spec Acute) - SFH	11,022	11,367	345	3.1%	32,050	34,338	2,288	7.1%
Total Outpatients FUp (Spec Acute) - ICS Provider	**59,857**	**60,583**	**726**	**1.2%**	**183,653**	**187,654**	**4,001**	**2.2%**
Total Outpatients FUp (Spec Acute) - NUH	38,550	39,101	551	1.4%	119,326	121,216	1,890	1.6%
Total Outpatients FUp (Spec Acute) - SFH	21,307	21,482	175	0.8%	64,327	66,438	2,111	3.3%

Metric Name	June Only				April to June			
	Plan	Actual	Variance	% Variance	Plan	Actual	Variance	% Variance
Elective Ordinary - ICS population	1,907	2,213	306	16.0%	5,911	6,727	816	13.8%
Op Plan Diagnostic Activity - ICS population	39,052	38,995	-57	-0.1%	115,940	107,435	-8,505	-7.3%
Total Day Cases - ICS population	13,200	14,310	1,110	8.4%	40,922	43,728	2,806	6.9%
Total Outpatients 1st (Spec Acute) - ICS population	25,647	29,373	3,726	14.5%	79,505	88,827	9,322	11.7%
Total Outpatients FUp (Spec Acute) - ICS population	46,885	63,231	16,346	34.9%	145,345	196,927	51,582	35.5%

* Population data now includes specialised commissioning actuals; however plans were submitted excluding specialised as instructed

Position

The Day Case, Elective Ordinary and Outpatient first and follow ups were below plan in June.

The ICB Position is influenced by the movement of specialised services transferring from NHSE to the ICB from 1st April. Planning guidance for 2024/25 stated that ICB's should plan in line with 2023/24 for consistency with prior years. This has meant that the plan is based on prior ICB activity only, however the actuals are inclusive of specialised activity, which driving the over performance.

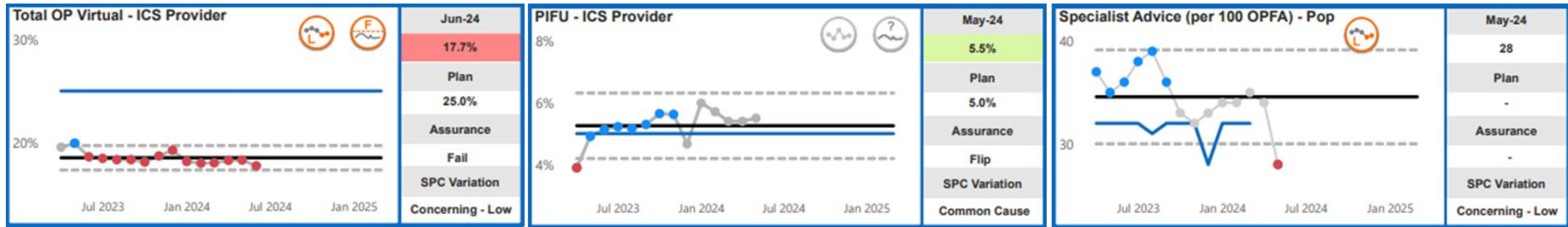
Work is taking place within the SAIU to isolate the over performance that was directly caused by the transfer of commissioning responsibility. This would provide further clarity behind the position and would allow understanding of a position pre and post transfer of specialised services.

Triangulation is taking place between the operational activity plan, contractual plans and the Elective Recovery Fund (ERF) calculations to ensure any variation is understood and consistent messages can be communicated within the system.

7.3.3 - Planned Care - Productivity and Transformation

NHS Nottingham and Nottinghamshire

Oversight Level	Enhanced Oversight



Outpatient Virtual Appointments - There has been a reduction in the percentage of outpatient attendances delivered virtually since April 2021. The latest position for the system is 17.7%, which is below the national standard of 25%. Since April 2022, the position for the system has reduced from 24% to 17.7% reported in June. In May, NUH and SFH delivered 22.3% and 14.2% of outpatients virtually respectively.

Patient Initiated Follow Up (PIFU) - can be described as patients having the ability to initiate an appointment when they need one, based on their symptoms and individual circumstances. It can be used by patients with long or short-term conditions in a broad range of specialties. In line with the operational planning guidance, Providers are expanding the uptake of PIFU to all major outpatient specialties, the ambition was to move or discharge 5% of outpatient attendances to PIFU pathways. The performance level for the system in May 2024 was 5.5%. This was 6.5% at SFH and 5.0% at NUH.

Advice and Guidance - The utilisation rate in May 2024 was 28 against a national standard of 16 per 100 outpatient first attendances. This is a decrease against the previous utilisation rate of 34 per 100 seen in April, however, is expected to rise following submission of refreshed data later this month. Diversion rates indicate the proportion of specialist advice requests that are returned to the referrer with advice where it is expected that the advice diverted a referral. The pre-referral diversion rate was 35.9% in May and the post referral diversion rate was 12.1%. Variation at PCN level in utilisation of Advice & Guidance has been published within the national dashboard.

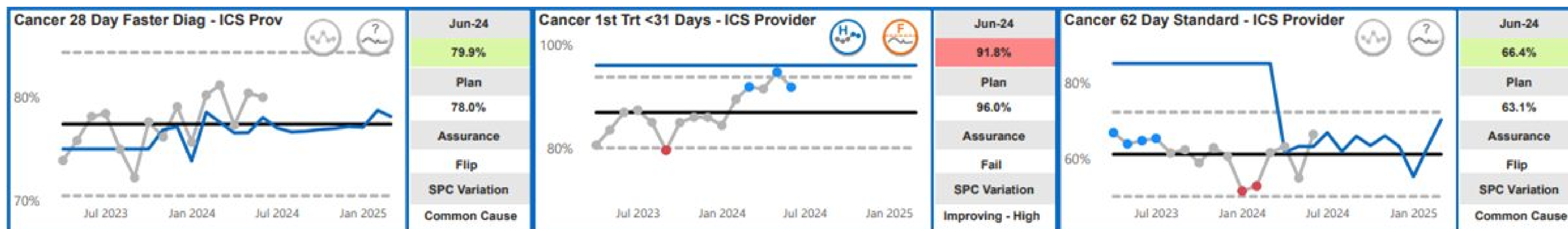
The newly established Getting It Right First Time (GIRFT) board will have a focus on elective transformation within the system. A range of measures will be scrutinised by the board including those above and the outpatients with a procedure metric (ambition 46%), which was introduced in April 2024.

Rushcliffe Arena, 09:00-12/09/24

7.3.4 - Planned Care – Cancer

Oversight Level | Escalated Risk

NHS Nottingham and Nottinghamshire



Position

Performance in the 28-day Faster Diagnosis Standard (FDS) continues be strong for both providers with June performance at 79.9% against the plan of 78.0%.
31day performance was below standard in June at 91.8% against the 96% standard.
62-day performance achieved the operational plan in June with 66.4% against a plan of 63.1%. NUH achieved the 62-day trajectory in June (65.4% v 60.8% plan). The key specialties of concern are the largest referring sites, such as Urology and LGI. Other areas include Gynaecology and Head & Neck due to the number of breaches per month. At SFH, Performance was 70.3% in June (v plan of 70%).

The backlog of cancer patients waiting 62 days or more remains above the planned level but is reducing. The 62-day backlog volume continues to be a challenge at NUH and is at 246 patients at 25/08/24, currently above the local trajectory (242). Urology remains the largest backlog at 92 patients however is under trajectory of 93. The trust is working to achieve the fair shares target of 233 patients by September.

Actions

Urology at NUH continues to remain a high risk. There have been challenges by the service not being able to secure a Locum Consultant and other clinical posts not being available until September 2024, which have led to the backlog growing and exceeding the trajectory. The service are continuing to work towards securing a locum and outsourcing support from Medinet for diagnostics and OPA activity.

Recovery

62 Day combined – SFH forecast 71.24% for July (off plan), 61% for August. NUH current unvalidated position is 61.4% against 63.94% trajectory (forecasting 76.9% in August against 60.15% plan). Ongoing validation is taking place to ensure accuracy of the July positions.
28 FDS – Both Trusts are forecast to achieve July and August.
31 Day combined – Both Trusts are forecast to achieve July

7.3.5 - Planned Care – Diagnostics

NHS Nottingham and Nottinghamshire

Oversight Level	Enhanced Oversight

Position

The total volume of patients waiting for diagnostics and those waiting more than 6 weeks (Diagnostic Backlog) increased between May and June by 280 patients. The backlog remains above planned levels at 8,896 against a plan of 7,056 patients. Echocardiography, MRI and Audiology are key drivers of the position due to having a high volume of patients waiting over six weeks at system level. Activity delivery within the system was below plan in June by 3.7% with 34,160 tests undertaken against a planned volume of 35,480, which is an improving position.

Both providers were below plan for the percentage of patients waiting less than 6 weeks for a test. In June, NUH delivered 69.3% of tests within 6 weeks against a plan of 70.7%. SFH delivered 70.9% within 6 weeks against a plan of 72.6%. The largest backlog within the system relates to Echocardiography at SFH with 2,300 patients from a total waiting list of 3,397 patients in June (32.3% performance) This is a significant challenge and will take time to reduce.

Diagnostic activity in June was below plan but was above historical levels. At SFH, Activity delivery was high in Echocardiography and above May 2024 and June 2023 levels. CT and Gastroscopy also delivered higher activity levels than in May and June 2023.

Actions

Both providers have implemented weekly oversight across divisions for Diagnostics to track that improvements are made. SFH have insourcing providers in place to support Echocardiography along with other improvement actions. Detailed review of performance is undertaken at the System Oversight Group, which includes tracking of the position against the recovery trajectories. MRI at NUH capacity will be bolstered from October with 130 additional slots per week from an additional mobile scanner from CDC accelerator funding. In NOUS at NUH, 3 new scanners are progressing through the commissioning/device approval process and will be available from October.

Recovery

NUH and SFH are forecast to be below the operational plan in July at Trust level. SFH have forecast delivery of the plan in August. NUH are refining weekly plans, which will enable tracking at modality level towards a trust target of 82% by March 2025. Given current over performance in some modalities, it may be possible for NUH to deliver the 82% ambition in advance of March.

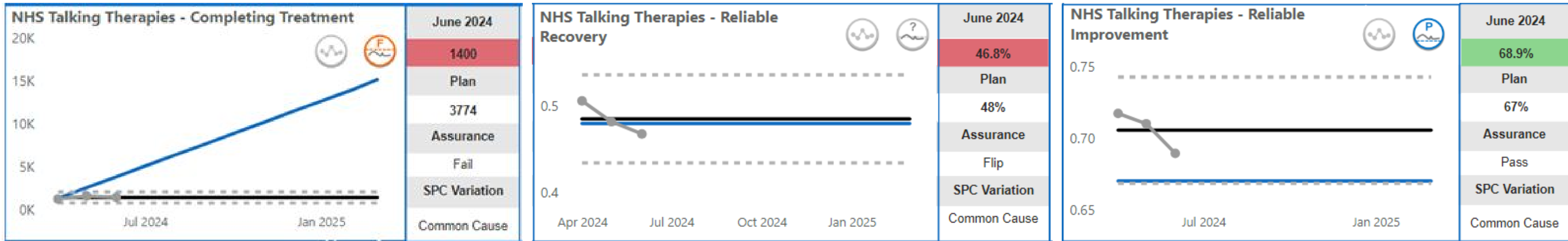
7.4 Service Delivery Mental Health Performance

7.4.1 – Exception Reports Mental Health IAPT
7.4.2 – Exception Reports Mental Health OAPs
7.4.3 – Exception Reports Mental Health Adult Services
7.4.4 – Exception Reports Mental Health Access
7.4.5 – Exception Reports Mental Health CYP

7.4.1 - Mental Health – Talking Therapies

Nottingham and Nottinghamshire

Oversight Level | Further Information Required



Position
NHS Talking Therapies (formerly IAPT) delivered against the improvement trajectory for 1st to 2nd wait in June (60% v 70% plan) and are forecasting to deliver 45% in July against a plan of 65%.

Treatment numbers (3-month) rolling access performance remains under target, numbers entering treatment in May 2024 were 6,810 which is below previous months volumes. The service continues to achieve and exceed the 6 week (98.7%) and 18 week (100%) waiting time standards.

Patients waiting over 90 days between 1st and 2nd treatments continues to reduce and is currently 61 days with a median of 48 days. The total number of patients waiting over 90 days has halved since the beginning of June 2024.

The Reliable Recovery target for 2024/25 is 48% and reported performance in June was 47.6% based on national data. The year-to-date position of 49.3% is above target and provisional data for July shows performance below target at 46.9% but this may change with validation.

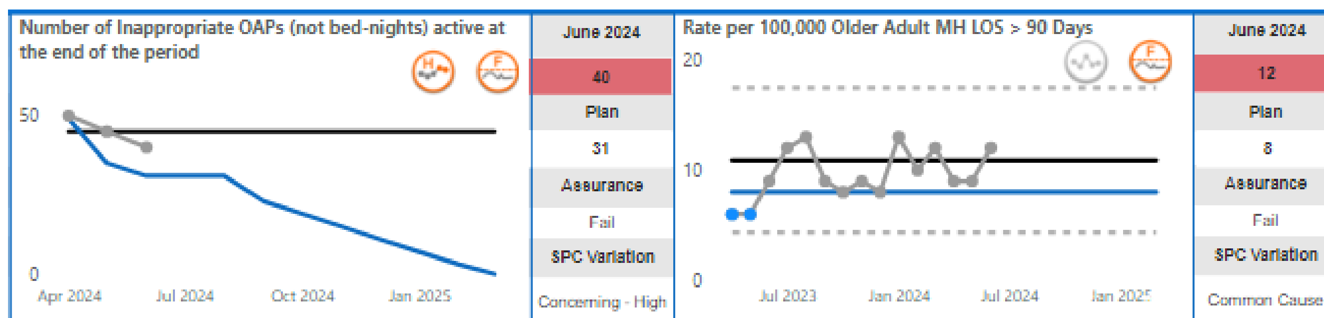
Actions
Additional workforce – 12.2WTE commenced in May/June 2024 adding 219 additional 2nd appointments; 8.9WTE started in July adding 173 appointments (capacity varies dependent on the modality of treatment) Workforce capacity has been reviewed and 5WTE have increased treatment appointments and reduced assessment appointments from June 2024, with no impact on 6 or 18 week wait targets.
Trainee capacity – 52 trainees will qualify in 2024/25, 37 to commence training in October, increasing capacity as training progresses
Waiting Well process is in place and includes a telephone check in call, validating the waiting list and offering a webinar if suitable
Appointment booking policy has been updated to limit the number of times a patient can decline a suitable appointment before being discharged

Recovery
Recovery plan for 1st to 2nd Waits for July 2024 is to achieve <65%.
Recovery plan for patients waiting over 90days between 1st and 2nd treatments is <60% for August.

7.4.2 - Mental Health – OAPs

NHS Nottingham and Nottinghamshire

Oversight Level	Enhanced Oversight



To Note: The OAPs metric for 2024/25 will move to be number of patients currently placed out of area and will move away from 3 month rolling OAPs Bed Days, once April national reporting data is available.

The operational plan for 2024/25 set a plan to improve from 49 in April to zero in March 2025.

Position
OAPs - The number of inappropriate out of area patients reported in June 2024 is 40 against a plan of 31. Local data as at 27/08/2024 indicates there are currently 22 OAPs against a trajectory of 11 and are on track to achieve the target of zero by October 2024. There has been an increase in male bed demand over the last 2 months which has been challenging, however steps are in place to increase discharges allowing further repatriation of patients.

Actions
OAPS - Continues to be one of the most challenging areas for the system. The Recovery Action Plan has been refreshed focusing on the optimum care pathway and flow and will be supported through the implementation of the 3-year mental health inpatient strategy programme.

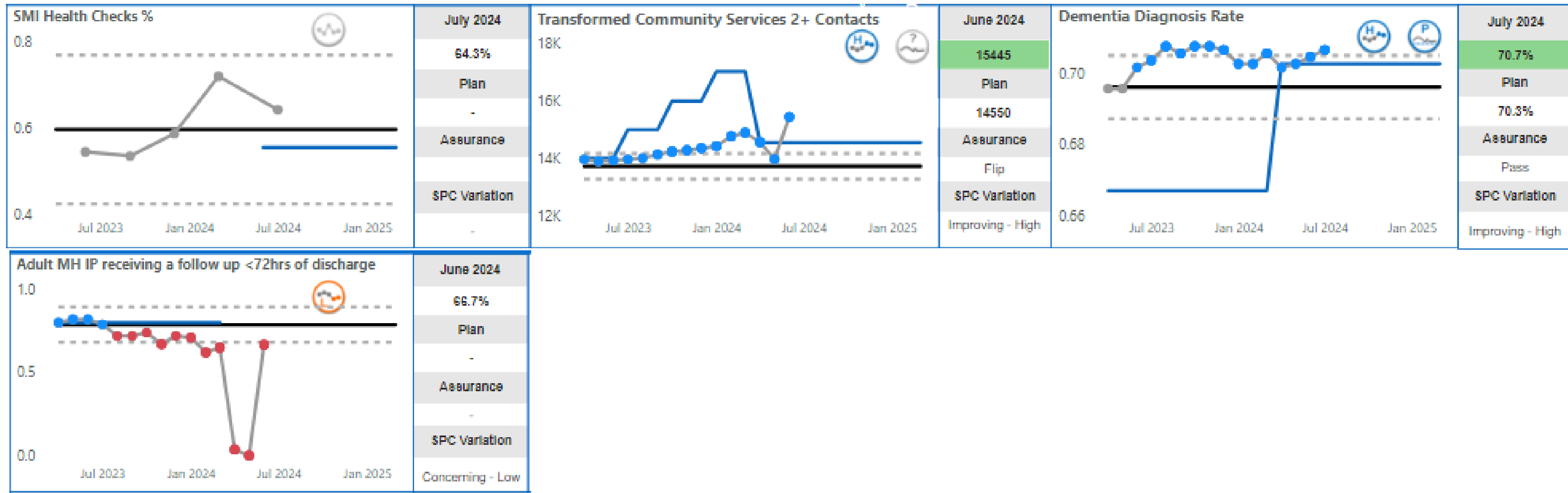
A senior flow nurse has now been appointed on a permanent contract and a consultant started on 1st August 2024. This has led to the development of a clinically led 'complex case' process to clinically review patients that have long lengths of stay. Increased visibility of leadership team on wards with a 'buddy' system and prompt sheets for colleagues to observe flow processes and to offer additional support.

Recovery
Improvements are being made and the local data reports indicate achievement of the weekly local improvement trajectory at 27th August, 22 patients v local target of 11. This is a material reduction from 44 out of area placements at the start of the financial year.

7.4.3 - Mental Health – Adult Services

Oversight Level | Enhanced Oversight

NHS Nottingham and Nottinghamshire



Position

72 Hour Follow Ups - the performance is below the plan for the eleventh consecutive month in June. At ICB level this is impacted by placements made Out of Area, for which a data query has been lodged with the national team. Local data shows performance as higher than published national data.
SMI Physical Health Checks - In 2024/25 the ICS target is 4050, the July 2024 performance remains above target, and is an improved position compared to the same time last year.
Dementia –The ICB continues to exceed the national dementia diagnosis rate standard (70.5%) in June 2024. Performance remains above the regional average.

Actions

- SMI Physical Health Checks - System performance is tracked through the ICB trajectory, providing updates on actions and phasing of activity. Some areas of activity are currently not included in MHSDS returns. Work continues with VCSE Providers and Primary Care to ensure the data can be flowed in the activity count against target as a system (core metric and transformed metric).
- Dementia - MAS teams continue to flex staffing, to ensure equitable waits across the system. The MAS service leads have also undertaken a demand and capacity review within all areas and are now assured they have the appropriate capacity within the model to reduce the waiting times without the need for the extra clinics. However, the recovery trajectory and extra clinics in Newark & Sherwood will be kept under review. There is a recovery action plan in place for MAS which includes a trajectory developed using the NHSE Core Model for Capacity and Demand. The recovery action plan will be kept under review.

Rushcliffe Arena, 09:00-12/09/24

7.4.4 - Mental Health – Children & Young People Services

NHS Nottingham and Nottinghamshire

Oversight Level **Further Information Required**

Current Position

Please note that the latest data for these metrics is not available until late August due to an upgrade to the MHSDS system.

CYP Access (1+ Contact) - The ICS is exceeding the access target of number of children and young people (CYP) receiving support (1-contact); 20,190 CYP were recorded as having at least 1 contact in the rolling 12 months ending June 2024 exceeding the annual plan of 19820.
CYP ED Routine (< 4 weeks) – Common Cause variation due to performance returning to the mean. It is not expected that the service will meet the required standard.
CYP ED Urgent (<1 week) – Concerning - low variation due to the deterioration in performance in Q4 2024-25.

Actions

CYP Eating Disorder Service The root cause for underperformance is patient choice, the need for a Consultant Psychiatrist to attend a clinical emergency, and a lack of clarity in what a patient was referred for. A 'deep dive' is being undertaken to understand how to mitigate likelihood of these exceptions. Recovery trajectories are being developed for 2024/25.
The service is working on several initiatives to eliminate the risk of service-related breaches including:
Clinical space and service model - Reviewing space utilisation to expand access to clinical room availability; Continued protected time with Community CAMHs where joint assessments are required; The service is considering the possible formation of an all-age Eating Disorders Hub; The service has also completed their first round of Non-Violent Resistance (NVR) training specific to Eating Disorders
Engagement - Patient Choice; The service will complete a "deep dive" into breaches attributable to patient choice;

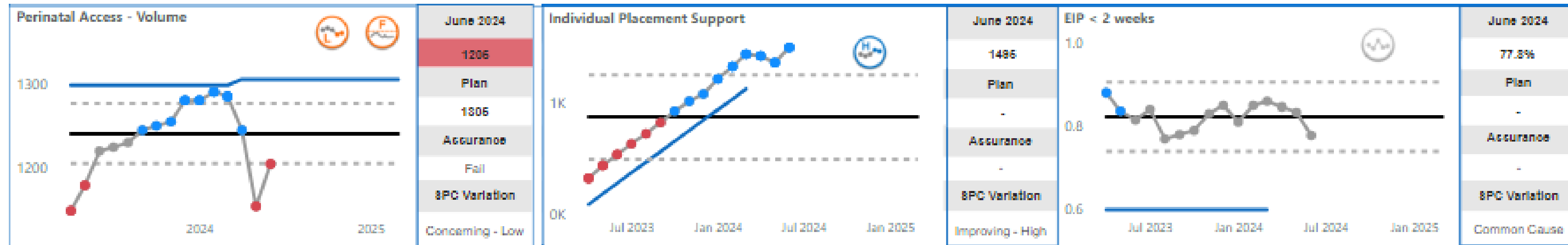
Recovery

For CYP Access (1+ contact) an ambitious trajectory for 2024/25 has been set as a stretch target based on previous performance. This exceeds the LTP target.

7.4.5 - Mental Health – Access

Oversight Level Enhanced Oversight

NHS Nottingham and Nottinghamshire



Current Position

- **Perinatal** – The rolling 12-month performance to June 2024 was 1,205 people accessing the service against a target of 1,305. Performance in Nottingham and Nottinghamshire is below the access rate of 10% (% of birthrate) and the original forecast trajectory, with the two biggest contributors being low referral numbers into the service and disengagement within the service.
- **IPS** - The number of people accessing IPS continues to increase with 1,486 people accessing support in June 2024.
- **EIP** - The access standard has been consistently exceeded at an ICS level. Data for June 2024 shows a decrease in performance to 77.8% of patients accessing EIP within 2 weeks.

Actions

- **Perinatal** - To increase the number of women accessing the service the actions agreed are as follows:
- Communications - Continuous ICS wide communications campaign, Telephone/initial contact prior to appointment, Text messaging system innovation
- Equity of access - Alternative venues for service delivery within Nottingham City and the North of the County, Continuous targeted work within areas where there is underrepresentation, Enhanced engagement pathway, Improvements in data completeness relating to ethnicity

- **IPS** - Performance is continually monitored to ensure achievement of target continues
- **EIP** - Now at level 3 or above for all CAMHS standards. Challenges remain around family intervention and paired outcome scores. Family intervention recovery plan aims to recover by end of Q3 and paired outcomes aims to recover by January/February 2025. NCAP are highlighting the team as qualifying as outstanding team within the Midlands and rated as level 4 overall.

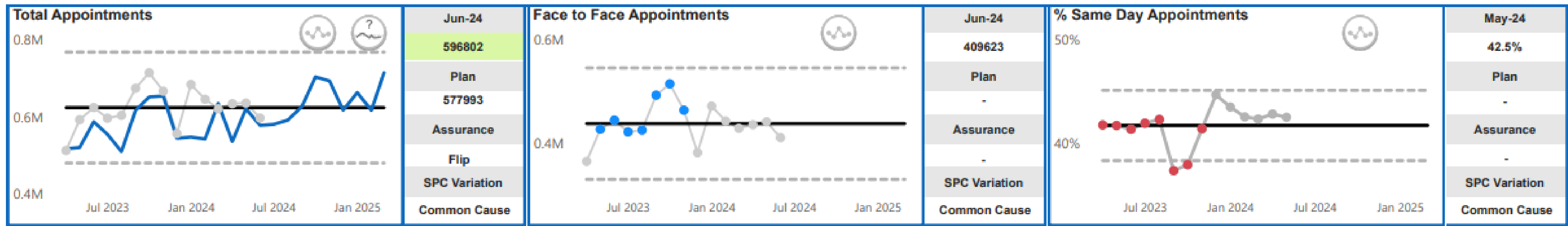
7.5 Service Delivery Primary & Community Performance

7.5.1 – Exception Reports Primary
7.5.2 – Exception Reports Community

7.5.1 - Primary Care

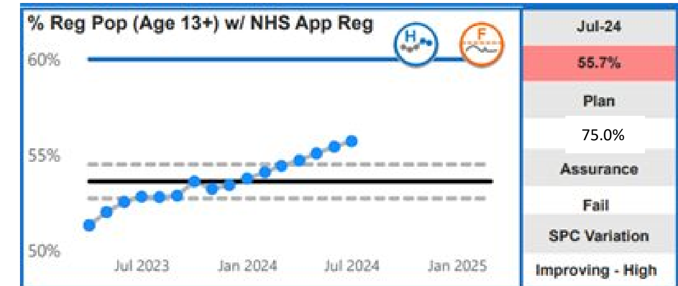
Oversight Level	Enhanced Oversight

NHS Nottingham and Nottinghamshire



Current Position

The volume of Total GP Appointments in June was 3.2% above the planned level. 80.6% of appointments were offered within two weeks in June 2024, which is below the operational plan of 81%.



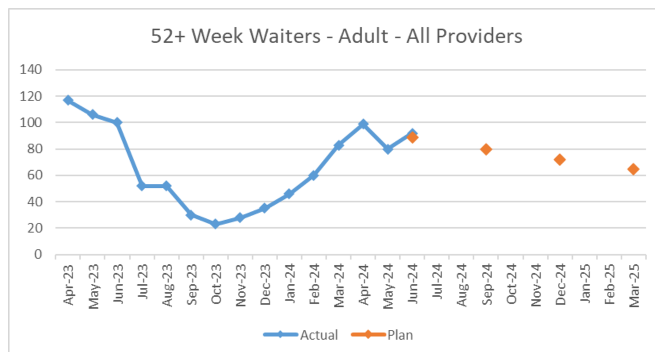
Monthly monitoring against the access metrics is included within the Place based Primary Care Support and Assurance Group meetings and will progress opportunities to support improvement at practice level. Engagement work is being undertaken with specific GP Practices, where it has been identified that there is a coding issue with how the 14-day appointments are being captured, there is high confidence that were this to be corrected the system would report delivery against the 85% expected position.

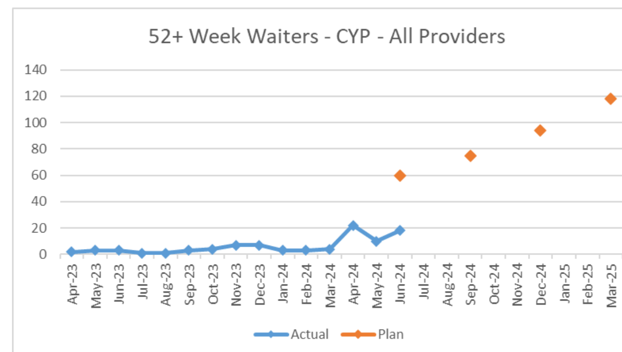
NHS App - registrations onto the NHS App have continued to increase, however the ICB remains under the target of 75% with the current position at 55.7% in July 2024.

7.5.2 - Community Care

Oversight Level	Enhanced Oversight

Nottingham and Nottinghamshire





Provider	No. 52ww in June 2024		
	Adult	CYP	Total
CityCare	17	0	17
NUH	0	4	4
NHT	75	14	89
SFH	0	0	0
Total	92	18	110

Current Position

The vast majority of 52ww are waiting for services at Nottinghamshire Healthcare NHS Trust. The latest published 52ww for NHT is June, which details 92 Adults and 19 CYP patients waiting. The July unvalidated position for NHT is 75 Adults and 14 CYP. All of the CYP patients are waiting for speech and language therapy. From the 14, there are 2 recording errors, so the accurate position is 12. Of the 75 Adults waiting over 52 weeks at the end of June, 62 are continence and accurately recorded breaches. The remaining 13 are recording errors, which are being focused on internally by the provider. In summary, the waiting list position for CYP 52-week waiters is increasing, but it is below the operational plan of 60 patients at end of June. The position for Adults is ahead the planned level with 62 patients against a plan of 89.

Actions

The trust is undertaking training and education programme with staff to improve the data quality. The trust have implemented power BI dashboards which are reviewed by services to enable them to track the position and take steps to improve it. Currently, this is updated weekly, but will move to daily refresh in future. New guidance has also been developed as a further effort to standardise operating procedures and improve data quality.

Demand and Capacity work is being undertaken on the Community Speech and Language service (SLT), which will inform the improvement plan. Similar analysis has previously been undertaken on the Autism pathway. The third element of SLT is 'Complex SLT' which is performing adequately at present. So key demand pressures are seen at Community SLT and Autism SLT. Additional recovery action plans are also in place for Podiatry and Paediatric Diabetes, which are monitored through contract meetings.

7.6 Provider Level Overview

7.6.1 – Urgent Care Overview
7.6.2 – Planned Care Overview

7.6.1 - Provider Overview – Streamline Urgent Care and Flow

NUH

Section / Name	Latest Period	Plan	Actual	Variance	V	A
Pre-Hospital Flow Volumes						
EMAS Calls - NUH	-	-	-	-		
111 Calls Answered - NUH	-	-	-	-		
Pre-Hospital - Alternatives to ED						
Urgent Care Response (UCR) - NUH	-	-	-	-		
UCR Response % - NUH	-	-	-	-		
Front Door - Flow Volumes						
Ambulance Conveyances to ED (Vol)	-	-	-	-		
Ambulance Conveyances to ED (%)	-	-	-	-		
Total A&E Attendances - NUH	Jul-24	18481	18754	✗ 273		
In-Hospital Flow						
Total NEL admissions - ICB NUH	Jun-24	7609	8178	✗ 569		
NEL Conversion Rate from ED Atds - %	Jun-24	-	43.8%	-		
SDEC % of Total Admissions - NUH	Jul-24	33.0%	37.0%	✓ 4.0%		
% Bed Occupancy - NUH	May-24	95.5%	91.7%	✓ -3.8%		
Flow out of Hospital						
Number of MSFT > 24 Hours	Jul-24	-	102	-		
No Criteria to Reside	Jul-24	204	176	✓ -28		
Length of Stay > 21 days	Jul-24	290	252	✓ -38		
Pthy 0 - Discharges Home	-	-	-	-		
Pthy 1 - Disch home w/ hlth and/or social care	-	-	-	-		
No. Patients utilising Virtual Ward	Jul-24	-	140	-		

SFH

Section / Name	Latest Period	Plan	Actual	Variance	V	A
Pre-Hospital Flow Volumes						
EMAS Calls - SFH	-	-	-	-		
111 Calls Answered - SFH	-	-	-	-		
Pre-Hospital - Alternatives to ED						
Urgent Care Response (UCR) - SFH	-	-	-	-		
UCR Response % - SFH	-	-	-	-		
Front Door - Flow Volumes						
Ambulance Conveyances to ED (Vol)	-	-	-	-		
Ambulance Conveyances to ED (%)	-	-	-	-		
Total A&E Attendances - SFH	Jul-24	16379	17436	✗ 1057		
In-Hospital Flow						
Total NEL admissions - ICB SFH	Jun-24	3741	3905	✗ 164		
NEL Conversion Rate from ED Atds - %	Jun-24	-	23.0%	-		
SDEC % of Total Admissions - SFH	Jul-24	33.0%	34.0%	✓ 1.0%		
% Bed Occupancy - SFH	May-24	94.5%	95.1%	✗ 0.6%		
Flow out of Hospital						
Number of MSFT > 24 Hours	Jul-24	-	75	-		
No Criteria to Reside	Jul-24	111	97	✓ -14		
Length of Stay > 21 days	Jul-24	110	106	✓ -4		
Pthy 0 - Discharges Home	-	-	-	-		
Pthy 1 - Disch home w/ hlth and/or social care	-	-	-	-		
No. Patients utilising Virtual Ward	Jul-24	-	103	-		

7.6.1 - Provider Overview – Urgent Care Compliance

NHS Nottingham and Nottinghamshire

NUH

EMAS Performance Compliance

Name	Latest Period	Plan	Actual	Variance	V	A
Ambulance (mean) resp time Cat 1 (Notts)	-	-	-	-		
Ambulance (mean) resp time Cat 2 (Notts)	-	-	-	-		
% Cat 2 waits below 40 minutes (Notts)	-	-	-	-		
Ambulance resp time Cat 3 - 90th Centile *	-	-	-	-		
Ambulance resp time Cat 4 - 90th Centile *	-	-	-	-		

Acute Performance Compliance

Name	Latest Period	Plan	Actual	Variance	V	A
Hospital Handover Delays > 30 Minutes	Jul-24	-	1909	-		
Hospital Handover Delays >60 minutes	Jul-24	0	774	✗ 774		
Ambulance Total Hours Lost	Jul-24	2178	1899	✓ -279		
A&E 4hr % Perf (All)	Jul-24	67.0%	68.8%	✓ 1.8%		
12 Hour Breaches ED	Jul-24	0	329	✗ 329		
12 Hour Breaches as % ED Atds	Jul-24	2.0%	7.2%	✗ 5.2%		

SFH

EMAS Performance Compliance

Name	Latest Period	Plan	Actual	Variance	V	A
Ambulance (mean) resp time Cat 1 (Notts)	-	-	-	-		
Ambulance (mean) resp time Cat 2 (Notts)	-	-	-	-		
% Cat 2 waits below 40 minutes (Notts)	-	-	-	-		
Ambulance resp time Cat 3 - 90th Centile *	-	-	-	-		
Ambulance resp time Cat 4 - 90th Centile *	-	-	-	-		

Acute Performance Compliance

Name	Latest Period	Plan	Actual	Variance	V	A
Hospital Handover Delays > 30 Minutes	Jul-24	0	146	✗ 146		
Hospital Handover Delays >60 minutes	Jul-24	0	7	✗ 7		
Ambulance Total Hours Lost	Jul-24	0	146	✗ 146		
A&E 4hr % Perf (All)	Jul-24	76.0%	71.7%	✗ -4.3%		
12 Hour Breaches ED	Jul-24	0	148	✗ 148		
12 Hour Breaches as % ED Atds	Jul-24	2.0%	2.8%	✗ 0.8%		

7.6.2 - Provider Overview – Planned Care

NHS
Nottingham and Nottinghamshire

NUH

Elective Recovery - Total Waiting List & Long Waits

Name	Latest Period	Plan	Actual	Variance	V	A
Total Waiting List Size	Jun-24	85835	86675	✗ 840		
Incomplete RTT pathways >52 Wks	Jun-24	3390	3676	✗ 286		
Incomplete RTT pathways >65 Wks	Jun-24	220	526	✗ 306		
Incomplete RTT pathways >78 Wks	Jun-24	0	0	✓ 0		

Elective Recovery - Activity

Name	Latest Period	Plan	Actual	Variance	V	A
Total Referrals	Mar-24	-	13048	-		
Total Ordinary Electives	Jun-24	2235	1799	✗ -436		
Total Daycases	Jun-24	12037	9889	✗ -2148		
Total Outpatients 1st (Spec Acute)	Jun-24	19560	14933	✗ -4627		
Total Outpatients FUp (Spec Acute)	Jun-24	38550	39101	✓ 551		
Total Diagnostic Activity	Jun-24	20898	19817	✗ -1081		

Elective Recovery - Productivity & Transformation

Name	Latest Period	Plan	Actual	Variance	V	A
Total Outpatients - Virtual(%)	Jun-24	25.0%	22.2%	✗ -2.8%		
Patient Initiated Fups (%)	Jun-24	5.0%	4.9%	✗ -0.1%		
Advice and Guidance (% of 1st OP)	-	-	-	-		
Completed Adm RTT Pathways	Jun-24	3561	3285	✗ -276		
Completed Non-Adm RTT Pathways	Jun-24	17455	13424	✗ -4031		

SFH

Elective Recovery - Total Waiting List & Long Waits

Name	Latest Period	Plan	Actual	Variance	V	A
Total Waiting List Size	Jun-24	34908	35720	✗ 812		
Incomplete RTT pathways >52 Wks	Jun-24	1230	1177	✓ -53		
Incomplete RTT pathways >65 Wks	Jun-24	110	109	✓ -1		
Incomplete RTT pathways >78 Wks	Jun-24	0	0	✓ 0		

Elective Recovery - Activity

Name	Latest Period	Plan	Actual	Variance	V	A
Total Referrals	Mar-24	-	9047	-		
Total Ordinary Electives	Jun-24	395	381	✗ -14		
Total Daycases	Jun-24	3817	3578	✗ -239		
Total Outpatients 1st (Spec Acute)	Jun-24	11022	11367	✓ 345		
Total Outpatients FUp (Spec Acute)	Jun-24	21307	21482	✓ 175		
Total Diagnostic Activity	Jun-24	14582	14343	✗ -239		

Elective Recovery - Productivity & Transformation

Name	Latest Period	Plan	Actual	Variance	V	A
Total Outpatients - Virtual(%)	Jun-24	25.0%	14.4%	✗ -10.6%		
Patient Initiated Fups (%)	Jun-24	5.0%	6.8%	✓ 1.8%		
Advice and Guidance (% of 1st OP)	-	-	-	-		
Completed Adm RTT Pathways	Jun-24	1096	1069	✗ -27		
Completed Non-Adm RTT Pathways	Jun-24	6011	5744	✗ -267		

7.6.2 - Provider Overview – Planned Care

NHS Nottingham and Nottinghamshire

NUH

Diagnostic Recovery

Name	Latest Period	Plan	Actual	Variance	V	A
Total Diagnostic Activity	Jun-24	20898	19817	✗ -1081		
Diagnostic Waiting List	Jun-24	16463	17550	✗ 1087		
Diagnostic Backlog	Jun-24	4813	5381	✗ 568		
Diagnostics +6 Wks	Jun-24	70.8%	69.3%	✗ -1.4%		

Cancer Recovery

Name	Latest Period	Plan	Actual	Variance	V	A
Cancer 2ww %	Apr-24	93.0%	68.5%	✗ -24.5%		
Cancer - Faster Diag Std 28 Days	Jun-24	77.4%	80.4%	✓ 3.0%		
Cancer - No. 1st Definitive Treatments	Jun-24	-	1018	-		
Cancer - No.receiving 1st Trt <31 days %	Jun-24	91.0%	92.2%	✓ 1.2%		
Cancer - No. patients waiting <62 days %	Jun-24	60.8%	65.4%	✓ 4.6%		
Cancer - 62 day backlog	Jul-24	266	245	✓ -21		

SFH

Diagnostic Recovery

Name	Latest Period	Plan	Actual	Variance	V	A
Total Diagnostic Activity	Jun-24	14582	14343	✗ -239		
Diagnostic Waiting List	Jun-24	8202	12093	✗ 3891		
Diagnostic Backlog	Jun-24	2243	3515	✗ 1272		
Diagnostics +6 Wks	Jun-24	72.7%	70.9%	✗ -1.7%		

Cancer Recovery

Name	Latest Period	Plan	Actual	Variance	V	A
Cancer 2ww %	Apr-24	93.0%	92.6%	✗ -0.4%		
Cancer - Faster Diag Std 28 Days	Jun-24	79.0%	79.2%	✓ 0.2%		
Cancer - No. 1st Definitive Treatments	Jun-24	-	120	-		
Cancer - No.receiving 1st Trt <31 days %	Jun-24	87.0%	88.3%	✓ 1.3%		
Cancer - No. patients waiting <62 days %	Jun-24	70.0%	70.3%	✓ 0.3%		
Cancer - 62 day backlog	Jul-24	73	68	✓ -5		

Nottingham and Nottinghamshire

8: Finance

ICS Aim 1: To improve outcomes in population health and healthcare

ICS Aim 2: To tackle inequalities in outcomes, experience and access

Month 4 Financial Position YTD

Orgn - as at M4 £'ms	YTD Plan	YTD Actuals	YTD Variance	In-month Plan	In-month Actuals	In-month Variance	Total FY Plan	FOT	Variance
NUH	-33.4	-36.5	-3.1	-4.6	-5.8	-1.3	-51.6	-51.6	0.0
SFH	-11.4	-12.3	-0.9	-1.0	-1.4	-0.3	-14.0	-14.0	0.0
NHT	-17.4	-15.3	2.1	-4.4	-2.4	2.0	-16.5	-16.5	0.0
N&N ICB	-5.9	-5.9	0.0	-1.5	-1.5	0.0	-17.8	-17.8	0.0
TOTAL	**-68.1**	**-70.1**	**-2.0**	**-11.5**	**-11.1**	**0.4**	**-100.0**	**-100.0**	**0.0**

Key Messages

- The system has a reported a £70.1m deficit at month 4, which is £2m adverse to plan against the June plan submitted.
- The system has agreed a £100m deficit Revenue Financial Plan Limit with NHSE and it is expected this will be supported by an equivalent non-recurrent allocation if costs were to be contained within this plan.
- £3.9m of the adverse variance relates to industrial action impacts and is reported in line with NHSE guidance. CHC and prescribing pressures are £4.5m adverse to plan and efficiency across the system £11m ahead of plan.
- The actual deficit at month 4 is £70.1m and reflects the way that planned efficiencies are profiled to deliver later in the financial year.

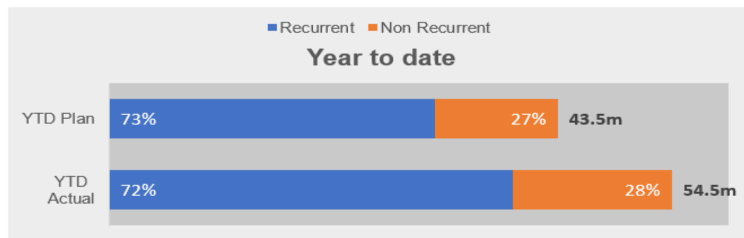
- The month 4 paybill shows the costs are below plan by 1.1m overall and the forecast spend is below plan by £5.3m. The underspend is due to substantive staffing being below plan by £5.8m year-to-date (offset by bank £5.1m over and agency £0.4m under).
- The agency forecast at M4 is £9.1m under the agency cap & £2m over plan.
- Year-to-date agency as a total of pay bill is 2.7% with the forecast outturn (FOT) being 3% (plans 2.8% against national requirement of 3.2%).

- The system's assessment of risk to the forecast outturn for 2024/25 is £125.3m gross (£124.2m at M3) and fully mitigated in the M4 reporting.
- The main risk across all organisations relates to the delivery of efficiency plans.
- In addition, other main risks at the ICB relate to the impact of growth and price increases relating to CHC and with providers, relate to pay awards/uplifts, energy inflation and Medically Safe for Transfer.

Efficiency

- £54.5m delivered to month 4 which is £11m favourable to plan.
- £15.4m of year-to-date reported as non-recurrent with £62.1m non recurrent in forecast.
- Year to month 4 delivery represents 21% of annual forecast delivery with a further 79% (£202.5m) to be delivered in the remainder of the year to achieve the forecast position against target.
- 65% of the total efficiency plan is recognised is fully developed with a further 29% as plans in progress, 5% remains as identified opportunities, and 1% remains as unidentified.
- Forecast at M4 is £257m which is line with plan.

System Efficiencies



Efficiency Development Status	2024/25 Plan	M4 Reporting
	£'m	£'m
Fully Developed	144.1	166.5
Plans in Progress	36.4	75.7
Opportunity	58.1	12.2
Unidentified	18.4	2.6
Total Efficiencies	**257.0**	**257.0**

	RECURRENT				NON - RECURRENT				TOTAL						
CIP/Transformation Performance £'m	YTD Plan	YTD Acts	Plan	FOT	YTD Plan	YTD Acts	Plan	FOT	YTD Plan	YTD Acts	Variance YTD	Plan	FOT	Variance Full year	% achieved YTD of plan
NUH - CIP	12.8	12.9	82.2	82.2	4.1	4.5	13.5	13.5	16.9	17.4	0.5	95.7	95.7	0.0	18%.
SFH - CIP	1.6	0.9	7.3	11.0	6.2	6.8	31.1	27.5	7.7	7.7	0.0	38.5	38.5	0.0	20%
NHT - CIP	5.7	6.1	51.5	1.5	0.2	1.8	2.9	12.9	5.9	7.9	2.0	54.4	54.4	0.0	14%
ICB – QIPP	11.5	19.3	60.5	60.4	1.5	2.3	8.0	8.1	13.0	21.6	8.6	68.5	68.5	0.0	32%
SYSTEM TOTAL	**31.5**	**39.1**	**201.5**	**195.0**	**11.9**	**15.4**	**55.6**	**62.1**	**43.5**	**54.5**	**11.0**	**257.0**	**257.0**	**0.0**	**21%**

Nottingham and Nottinghamshire

9.0 People and Culture

ICS Aims: All 4 (Outcomes, inequalities, productivity and social and economic development)

- 9.1 – Workforce – Exception Report Provider Workforce – Operational Plan v Actual
- 9.2 – Exception Report Provider Turnover & Sickness
- 9.3 – Exception Report Provider Temporary and Agency Staffing
- 9.4 – Exception Report – General Practice – Operational Plan v Actual
- 9.5 – Social Care Employment Overview
- 9.6 – Social Care Projections
- 9.7 – Care Homes Workforce

Rushcliffe Arena, 09:00-12/09/24

Total ICS Provider Workforce - Actual vs Operational Plan 24/25

NUH

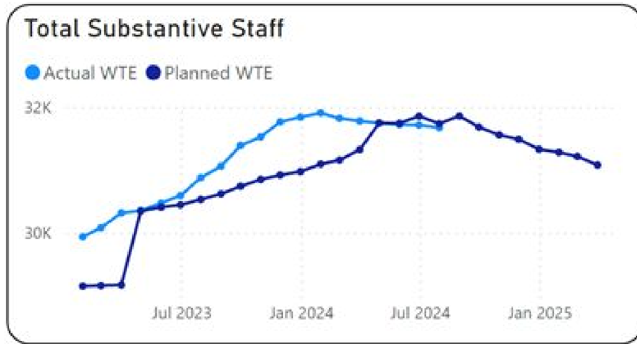
July 2024	Planned WTE	Actual WTE	Variance to Plan	Variance %
Total Agency Staff	209.6	165.2	-44.5	-21.2%
Total Bank Staff	993.6	936.6	-57.1	-5.7%
Total Substantive Staff	17,984.1	18,059.4	75.4	0.4%
Total WTE all Staff	19,187.3	19,161.1	-26.2	-0.1%

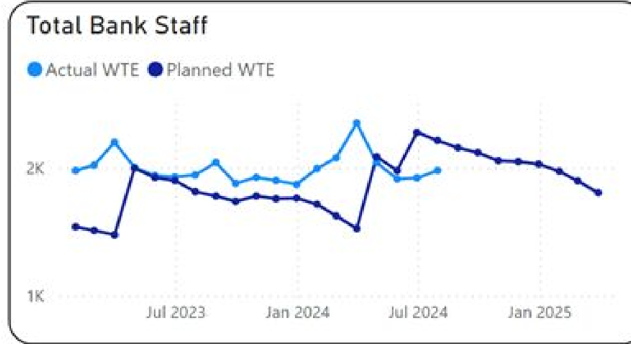
SFH

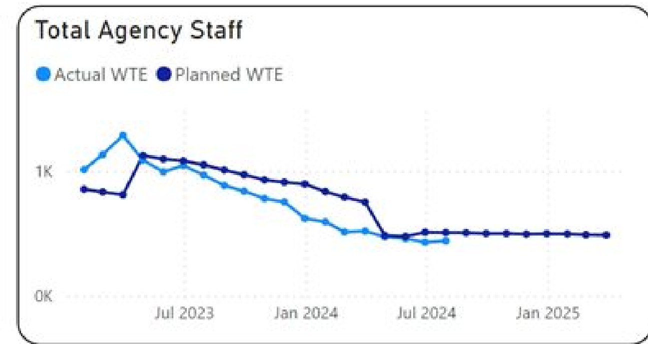
July 2024	Planned WTE	Actual WTE	Variance to Plan	Variance %
Total Agency Staff	107.0	101.6	-5.4	-5.1%
Total Bank Staff	436.7	440.2	3.5	0.8%
Total Substantive Staff	5,288.6	5,260.2	-28.3	-0.5%
Total WTE all Staff	5,832.3	5,802.0	-30.3	-0.5%

NHCT

July 2024	Planned WTE	Actual WTE	Variance to Plan	Variance %
Total Agency Staff	190.9	174.7	-16.2	-8.5%
Total Bank Staff	783.0	602.0	-181.1	-23.1%
Total Substantive Staff	8,462.3	8,351.2	-111.1	-1.3%
Total WTE all Staff	9,436.2	9,127.8	-308.4	-3.3%







Total Provider Current Position:

All Trusts have over performed against their total month 4 plans being under plan by 364.9WTE (1.1%) which is predominately driven by NHCT (308.4 WTE). NUH have underperformed against the substantive WTE in month, due to the F1 DiT rotation. SFH have marginally underperformed against their bank plan due to industrial action. Overall, the Trusts are 1.5M adverse to their month 4 pay bill plan with SFH over plan by 1.7M and NUH over plan by 0.3M. Only NHCT is under plan by 0.6M. All Trusts continue to be over plan for bank spend totalling 2.5M (NUH 1.1M, SFH 1M and NCHT 0.4M).

The workforce financial efficiencies remains on plan in month 4 and is over delivering against its target by 3.468M. Analysis has been undertaken in individual providers and as a system to understand workforce growth since 2019 and consider areas of further short-term actions (including accelerating existing schemes) and medium-term transformation opportunities. As a result of this work the 'risk adjusted' plan has reduced from 11.93M to 9,797M deficit in month 4 with increased confidence in delivery.

Workforce

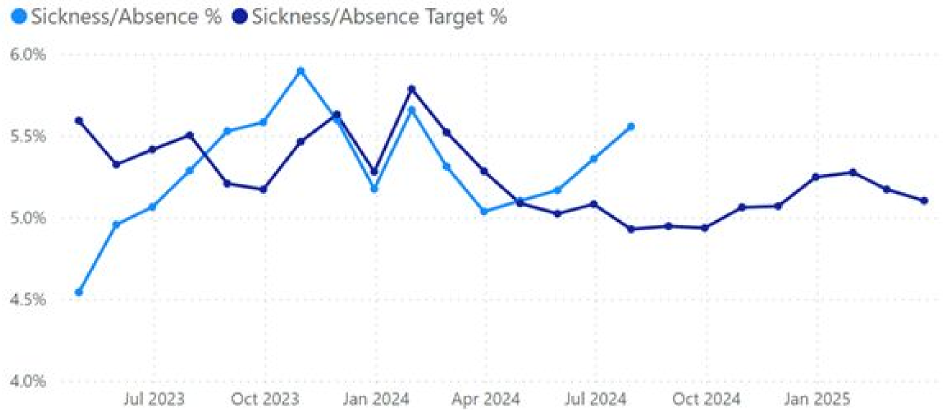
Key Performance Indicators	Date	Plan	Actual	Variance	Exception Report
Total WTE Substantive Workforce	Jul-24	31734.9	31670.8	-64.1	Section 9
Bank Staff	Jul-24	2213.4	1978.7	-234.7	
Agency Staff	Jul-24	507.5	441.4	-66.1	
12 Month Rolling Average Sickness Absence %	Jul-24	4.9%	5.60%	0.70%	
12 Month Rolling Average Staff Turnover %	Jul-24	10.7%	10.8%	0.10%	
12 Month Rolling Average Staff Appraisals%	Jul-24	-	84.2%	-	
12 Month RollingAverage Mandatory Training %	Jul-24	-	87.0%	-	
Total WTE Primary Care Workforce *	Jun-24	3776	3740	-36	

* Quarterly target figures requested in the Operational Plan Submission

P&C Group Limited Assurance - Further Information Required:

Level of assurance is limited due to the upward trend in workforce WTE, the pay bill spend and the risk adjusted gap in workforce efficiencies. There remains a greater risk of variance to the delivery plans later in the year due to the phasing of delivery.

Total ICS Provider Workforce - Sickness/Absence and Turnover



Date	Sickness/Absence %	Sickness/Absence Target %
May 2024	5.2%	5.0%
June 2024	5.4%	5.1%
July 2024	5.6%	4.9%

Date	Turnover %	Turnover Target %
May 2024	10.9%	10.7%
June 2024	10.7%	10.8%
July 2024	10.8%	10.7%

Total Provider Current Position:

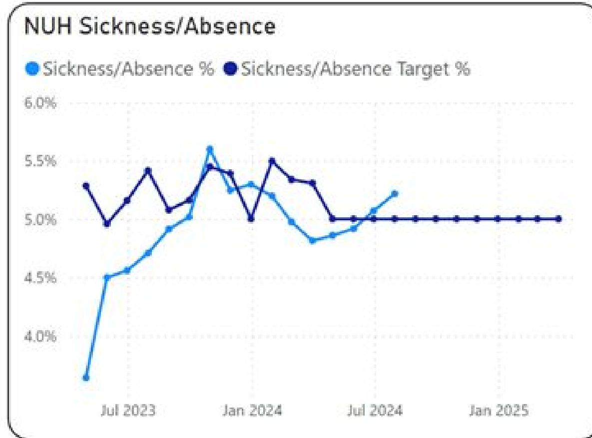
All organisations are above their sickness plan figure and overall, we have seen an increase in every Trusts sickness in Month 4 with it rising by 0.2% compared to month 3 and being 0.7% above plan for the system. Sickness has risen due to cases of summer COVID but also due to stress/anxiety some of which has been identified as relating to the impact of efficiencies and the continued demand and pressure on services. There have been significant improvements in absence over the last 12 months but appears to be rising. All Trusts are closely monitoring this and have in place several interventions to address this including a comprehensive staff wellbeing programme which covers physical and mental health and financial wellbeing, in house Occupational Health and Staff physiotherapy.

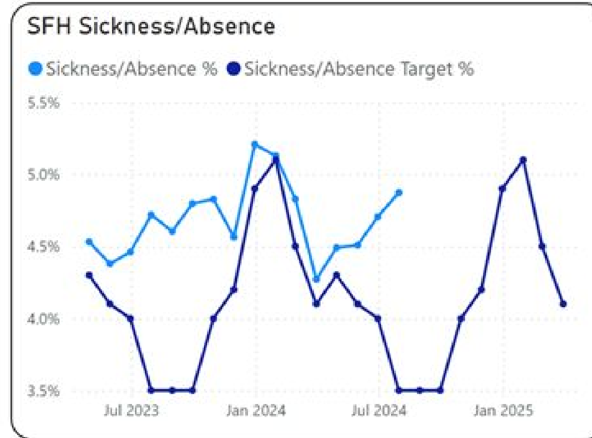
The system is over its target for turnover this month by 0.1%. Both SFH and NUH are under their targets. NCHT remains over its target but improvements in turnover have been seen with it being over 15% at its peak in October 22, it has now reduced to 13.5% and 12.04% in month.

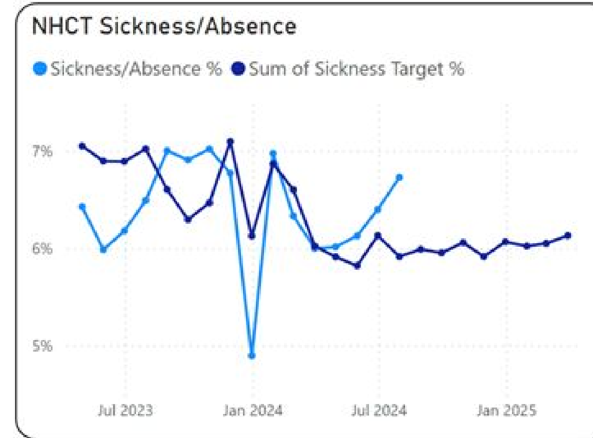
P&C Group Limited Assurance - Further Information Required:

Assurance is limited due to the continued upturn in sickness in month 4, the underperformance against turnover and the actions still in progress to address underperformance in organisations.

Sickness/Absence %







Sickness/Absence %	Sickness/Absence Target %
5.2%	5.0%

Sickness/Absence %	Sickness/Absence Target %
4.9%	3.5%

Sickness/Absence %	Sickness/Absence Target %
6.7%	5.9%

Provider Current Position:

NUH have marginally exceeded their absence target in month 4 at 5.2%. This is the second month that they have exceeded their target and absence has increased by 0.1% compared to month 3. They continue to monitor this closely and indicated that summer COVID but also work on the financial efficiencies including loss of good is having an impact. They have a monthly review of cases via the people business teams to ensure timely and compassionate management of all cases with a focus on reviewing colleagues on Long Term Sickness.

Provider Current Position:

Within the operational plan SFH vary their sickness target on a month-by-month basis and this month has seen a reduction in the target of 0.5%. Internally the Trust work to a monthly average target of 4.2%. SFH continue to be above sickness plan figure at 4.9% in month 4. This elevated level is due to current pressure across the Trust relating to Opel 4 which is leading to staff burnout and increased levels of COVID over the summer. They understand service level hot spots and manage cases on an individual basis

SFH became a People Promise exemplar in April 2024 and have a People Promise manager in post. They have produced an action plan and are undertaking work which is predicted to support and stabilise levels of sickness/turnover levels. The key areas of work are in the domains of; Compassionate and Inclusive, Safe and Healthy and Working Flexibly.

Provider Current Position:

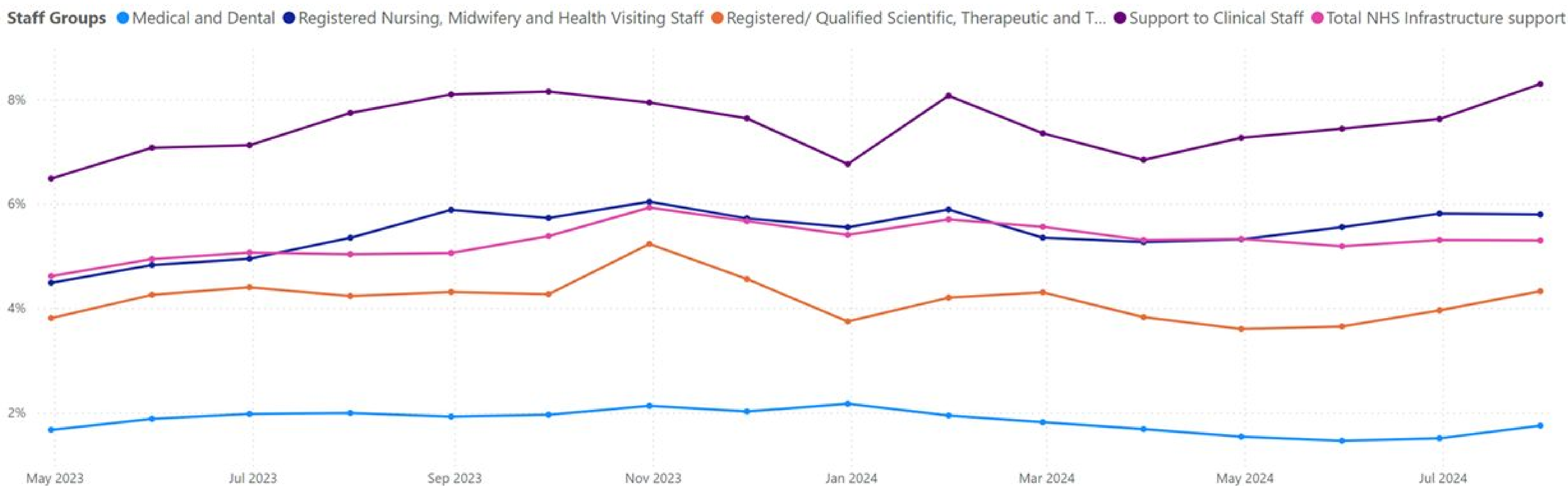
NCHT are above sickness plan at 6.7% in month 4. This is a further increase on June however it is noted that July historically shows an increase. Sickness is plateauing after a reduction since the winter months. They benchmark as the best performing Trust against peers in the East Midlands Mental Health Alliance, regarding long-term sickness and are focusing action on short term sickness. They share a monthly sickness report and arrange deep dives in hot spots where colleagues have multiple episodes of short-term sickness or display a pattern of short-term sickness. Heads of People and Culture meet the Employee Relations team monthly to discuss more complex cases. They are also refreshing the Attendance Management Policy and are in consultation with staff side colleagues. NCHT became a People Promise exemplar in April 2024 and have a People Promise manager in post. They have produced an action plan and are undertaking work which is predicted to support and stabilise levels of sickness/turnover levels. The key areas of work are in the domains of, Working Flexibly, the Team and Education and Development.

Staff Group Sickness/Absence %

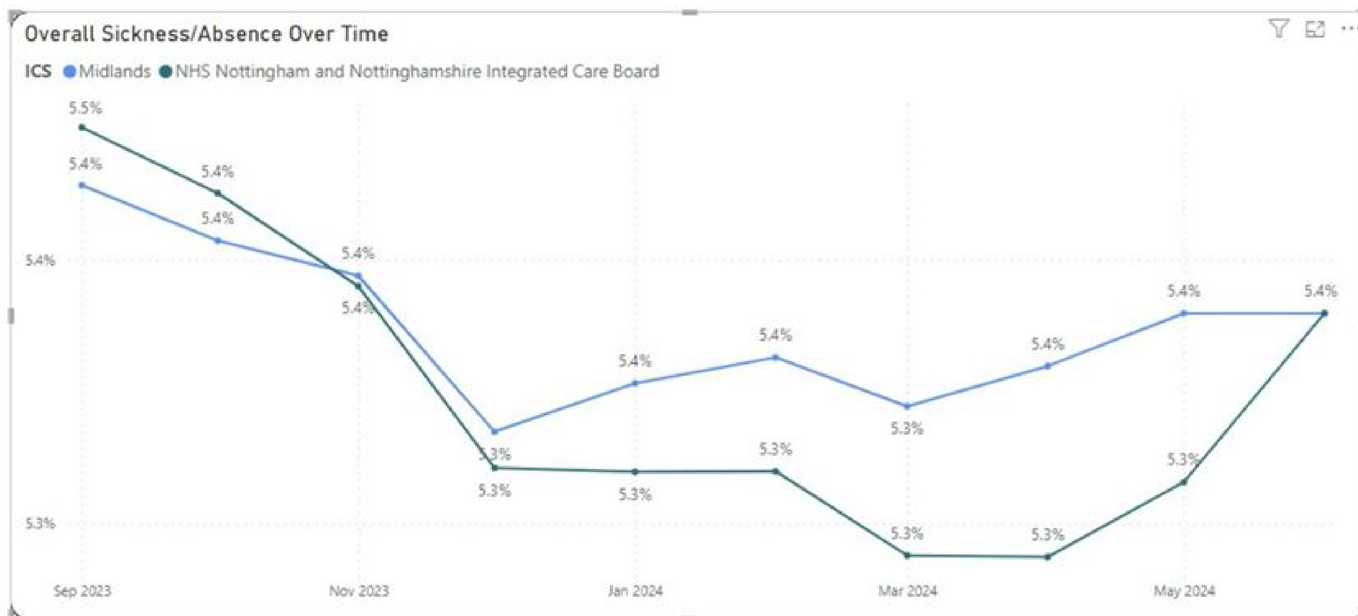
Total Provider Current Position:

Support to Clinical staff and Registered Nursing, Midwifery and Health Visiting continue to show the highest levels of absence. All staff groups have shown a marginal increase in Month 4 when compared in Month 3. The largest increase is within the registered/qualified Scientific, therapeutic and technical staff (0.7%) and Support to Clinical Staff (0.8%)

Staff Groups	Sickness/Absence %
All Substantive Staff	10.9%
Medical and Dental	3.2%
Registered Nursing, Midwifery and Health Visiting Staff	11.6%
Registered/ Qualified Scientific, Therapeutic and Technical staff	8.3%
Support to Clinical Staff	15.9%
Total NHS Infrastructure support	10.6%



Sickness/Absence % Benchmarking



Take from NHSE data source where "NHS Nottingham and Nottinghamshire ICB" represents all NHS Organisations using ESR, therefore this collection contains data from Nottingham University Hospitals Trust, Sherwood Forest Hospitals Trust, Nottinghamshire Healthcare Trust, Nottingham CityCare Partnership CIC and Nottingham and Nottinghamshire Integrated Care Board.

ICS	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024
Midlands	5.4%	5.4%	5.4%	5.3%	5.4%	5.4%	5.3%	5.4%	5.4%	5.4%
NHS Nottingham and Nottinghamshire Integrated Care Board	5.5%	5.4%	5.4%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.4%

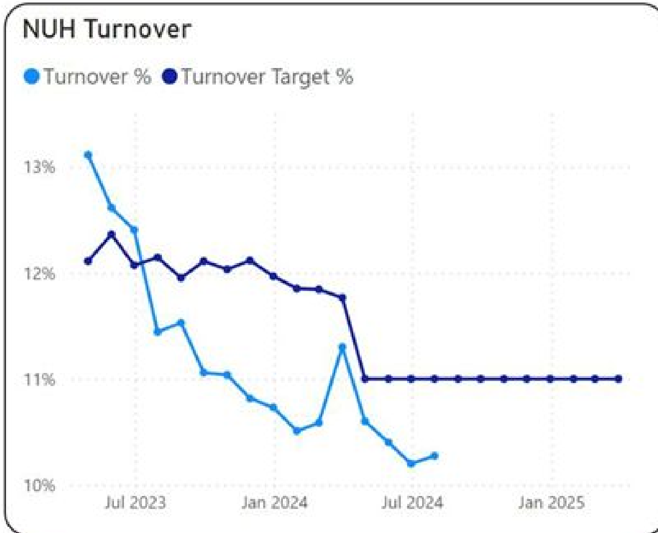
Total Provider Current Position:

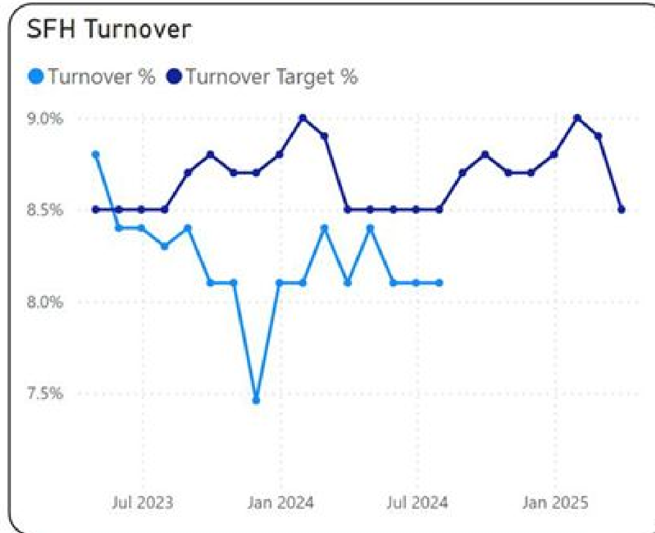
The benchmarking of absence across the Midlands region demonstrates that we are not an outlier for absence when compared to other systems in the region and track on/below the Midlands average for both our plan and actuals.

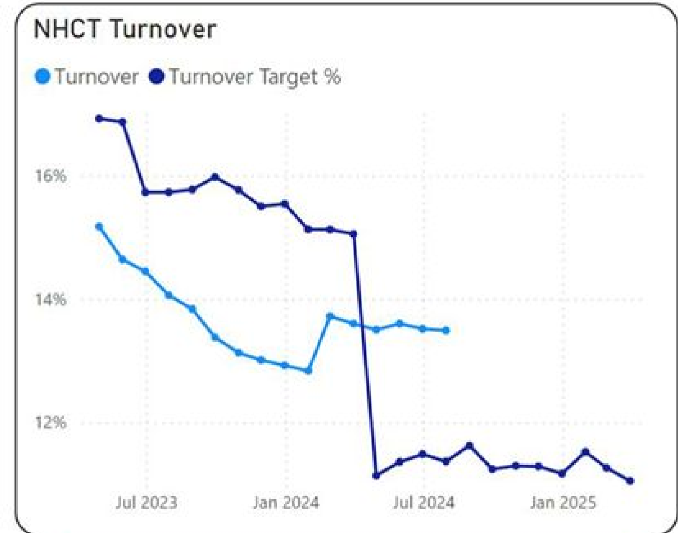
When considering absence by staff group the graphs over time indicate that we have consistently performed below the benchmark in Healthcare Scientist and Nursing and Midwifery. Within Admin and Clerical staff, we are consistently above the Midlands average. For the remaining staff groups: Medical and Dental, Allied Health Professionals, Scientific, Technical and Therapeutic, and Support to Clinical Staff there has been a reducing trend over time so we now benchmark below the Midlands average in each of these areas.

At, June 24 we are in line with the the Midlands benchmark, and we are below or in line with the benchmark across all staff groups except admin and clerical where we continue to be higher.

Turnover %







Turnover %	Turnover Target %
10.3%	11.0%

Turnover %	Turnover Target %
8.1%	8.5%

Turnover %	Turnover Target %
13.5%	11.4%

Provider Current Position:

NUH turnover has remained at a consistent level for the last 12 months (after falling from a high of over 13.1% in April 23) and remains below their target. The Trust has a retention strategy focusing on 4 main areas: strong foundations, reward and recognise staff, enable flexible working, offer training, development and wellbeing support

Provider Current Position:

SFH turnover is currently below plan but is being closely tracked monthly. SFH have a People Promise manager in post and the work they are undertaking is predicted to support and stabilise levels of sickness/turnover levels

Provider Current Position:

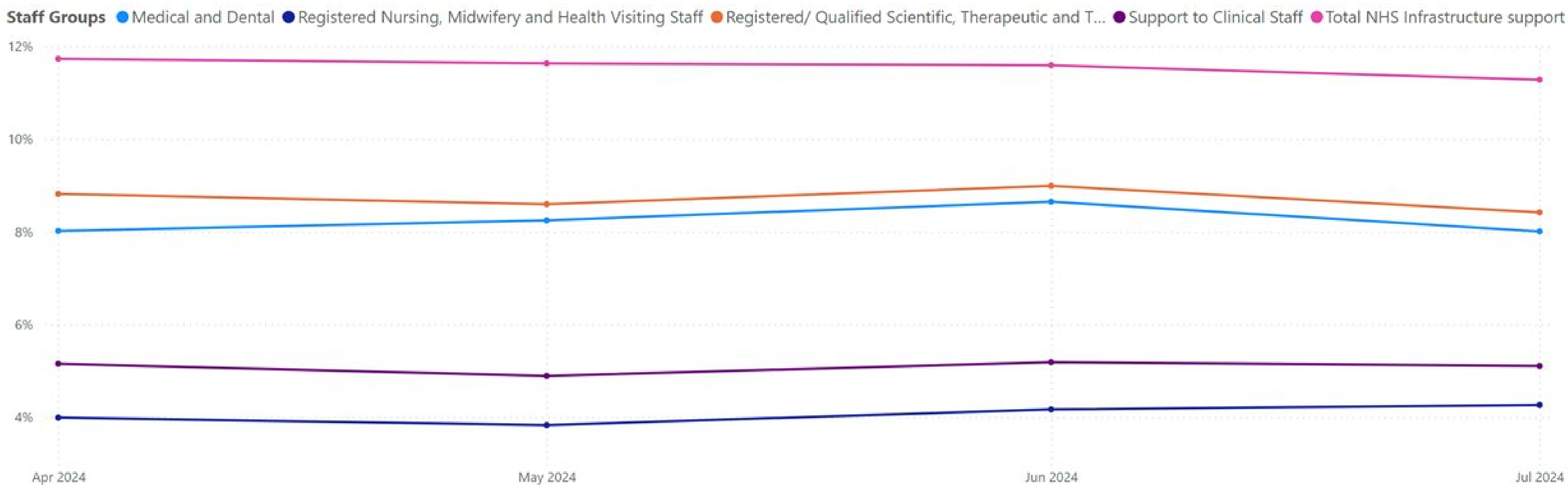
NCHT turnover is reported at 13.5% and is 12.04% in July which is an in-month reduction compared to month 3. This metric has seen significant progress over the previous 12 -18 months (after falling from a high of over 15% at its peak in October 22) but has now started to remain at a consistent level. They have several actions in place to support their aspiration to be a 'great place to work'. Modelling suggests this metric will oscillate and settle within a range of 10.50% and 12.20%. Some of this relates to the transformation of services and the TUPE transfer of staff. They benchmark in line with peers in the East Midlands Mental Health Alliance.

Staff Group Turnover %

Total Provider Current Position:

This month we have started to consider turnover by staff group. NHS infrastructure support is consistently the highest area of turnover this year. All staff groups except registered nursing, midwifery and health visiting have seen a marginal reduction in month.

Staff Groups	Turnover %
All Substantive Staff	10.8%
Medical and Dental	8.0%
Registered Nursing, Midwifery and Health Visiting Staff	4.3%
Registered/ Qualified Scientific, Therapeutic and Technical staff	8.4%
Support to Clinical Staff	5.1%
Total NHS Infrastructure support	11.3%



Turnover % Benchmarking

Turnover and Leaver - 12 months rolling % rate - March 2024

	Administrative and Clerical	AHPs	Healthcare Scientists	Medical and Dental	Nursing & Midwifery	Other Scientific, Therapeutic and Technical Staff	Support to Clinical	Total Workforce
Birmingham and Solihull	9.5%	9.2%	8.7%	4.6%	8.6%	10.0%	11.6%	9.4%
Black Country	8.5%	7.2%	9.5%	6.1%	7.9%	10.6%	9.3%	8.4%
Coventry and Warwickshire	11.7%	9.2%	10.4%	5.8%	8.0%	13.3%	12.6%	10.3%
Derby and Derbyshire	10.2%	8.1%	10.3%	5.2%	7.4%	11.6%	8.5%	8.6%
Herefordshire and Worcestershire	10.0%	10.5%	10.1%	7.2%	7.4%	10.4%	11.2%	9.4%
Leicester, Leicestershire and Rutland	7.7%	8.7%	5.9%	5.3%	7.3%	10.1%	11.2%	8.4%
Lincolnshire	10.1%	10.3%	10.3%	4.0%	8.7%	14.9%	12.4%	10.3%
Northamptonshire	11.3%	10.9%	14.6%	7.4%	8.6%	12.5%	12.5%	10.6%
Nottingham and Nottinghamshire	9.7%	8.8%	7.6%	6.1%	7.9%	12.4%	10.4%	9.2%
Shropshire, Telford and Wrekin	9.2%	9.5%	10.2%	5.5%	8.0%	11.5%	10.6%	9.1%
Staffordshire and Stoke-on-Trent	9.0%	10.0%	6.5%	4.8%	7.4%	7.4%	10.6%	8.8%
Midlands	8.7%	6.9%	6.7%	4.6%	6.4%	8.3%	9.6%	7.8%

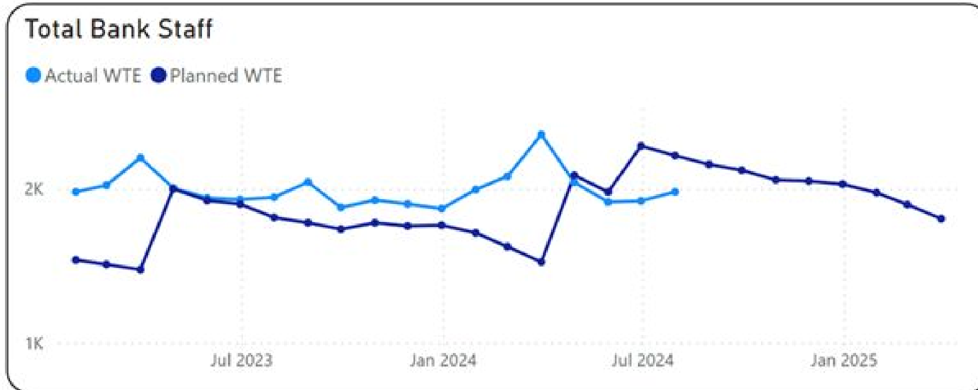
Take from NHSE data source where "NHS Nottingham and Nottinghamshire ICB" represents all NHS Organisations using ESR, therefore this collection contains data from Nottingham University Hospitals Trust, Sherwood Forest Hospitals Trust, Nottinghamshire Healthcare Trust, Nottingham CityCare Partnership CIC and Nottingham and Nottinghamshire Integrated Care Board.

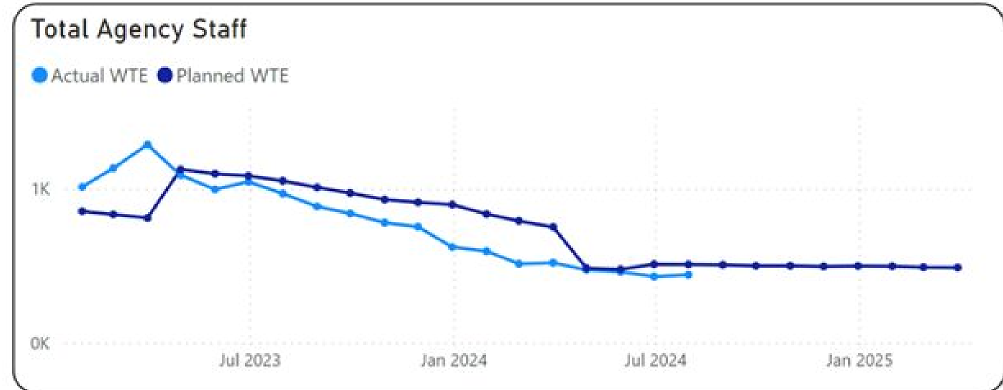
Total Provider Current Position:

Our system turnover rate shows that we benchmark higher than the Midlands average by 1.4% with 5 systems recording higher turnover than us. We benchmark higher in every staff group against the Midlands average with the highest adverse variance being in Other Scientific, Therapeutic and Technical staff (4.1%) and Allied Health Professionals (1.9%).

The system NHS Leaver rate is 6.6% and has been on a downward since Apr 23 (from 7.7%). We are above the regional leaver rate of 6.4% but below the national leaver rate of 7.4%. We are significantly above regional and national rates across all staff groups for staff aged 25 and under.

Temporary Staffing





Bank WTE vs Plan

Provider	Actual WTE	Planned WTE	Variance to Plan	Variance %
ALL	1,978.7	2,213.4	-234.7	-10.6%
NHCT	602.0	783.0	-181.1	-23.1%
NUH	936.6	993.6	-57.1	-5.7%
SFH	440.2	436.7	3.5	0.8%

Agency WTE vs Plan

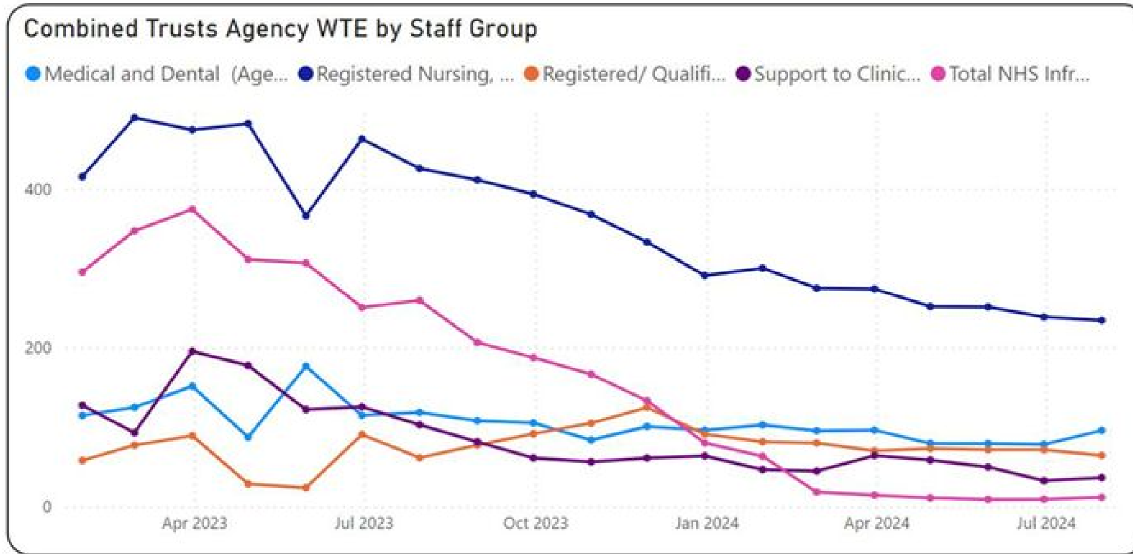
Provider	Actual WTE	Planned WTE	Variance to Plan	Variance %
ALL	441.4	507.5	-66.1	-13.0%
NHCT	174.7	190.9	-16.2	-8.5%
NUH	165.2	209.6	-44.5	-21.2%
SFH	101.6	107.0	-5.4	-5.1%

Total Provider Current Position:

NUH and NHCT are overperforming in their bank WTE against plan. SFH has marginally underperformed in month 4. All Trusts are overperforming on their agency WTE against plan. The total position shows them to be 234.7 WTE below plan for Bank staff and 66.1WTE below plan for agency staff.

In month 4 both NUH and SFH were over plan against their pay bill, with NHCT being under plan. SFH are over plan by 1.7M, NUH over plan by 0.3M and NHCT is under plan by 0.5M. NHCT have met their Agency target, underperformed on Bank (0.4M) and Substantive (0.9M). SFH have underperformed across all 3 staff types (Bank 1M, Agency 0.3M and Substantive 0.4M). NUH have overperformed against Agency (-1M) but underperformed against Bank (1.1M) and Substantive staff (0.2M).
All Trusts continue to be over plan for bank spend totalling 2.5M (NUH 1.1M, SFH 1M and NCHT 0.4M).

Agency Breakdown



Total Agency WTE

Provider	February	March	April	May	June	July
NHCT	194.2	198.0	205.4	194.0	177.8	174.7
NUH	203.5	209.0	171.5	175.1	160.8	165.2
SFH	114.7	111.0	96.1	90.9	91.3	101.6

Off Framework Usage %

Provider	February	March	April	May	June	July
NHCT	0.3%	1.5%	0.1%	0.0%	0.0%	0.0%
NUH	0.7%	0.6%	1.0%	1.6%	2.4%	2.4%
SFH	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%

On Framework Above Price Cap %

Provider	February	March	April	May	June	July
NHCT	6.7%	6.0%	21.6%	19.1%	14.3%	23.0%
NUH	81.2%	73.7%	70.8%	71.5%	78.0%	77.2%
SFH	47.4%	54.4%	46.1%	40.6%	47.2%	48.3%

Total Provider Current Position:

All Trusts are overperforming on their agency WTE against plan.

All providers have submitted a plan to remove off framework agency spend by the end of June and NCHT and SFH continue to achieve this in Month 4. NUH are still utilising off framework agency which has remained at 2.4% in Month 4 and is predominately in Occupational Health. This is a nationally recognised area of difficulty, and the Trust have been offered support by NHSE regarding this. They have appointed new substantive staff and are awaiting these starting to remove the off-framework usage in the coming months. All Trusts have an upward trend for the use of On Framework, over price cap agency usage. NHSE have indicated that the next area of focus will be on agency staff that are on framework but above price cap which has shown no real improvement in year across the Midlands region.

Both SFH and NCHT are above the 3.2% target for agency spend as a percentage of pay bill . In month NCHT is over by 0.12% which is an improvement of 0.3% compared to month 3. SFH is over target by 1.93% which is a deterioration of 0.4% compared to month 3 . The increase in usage aligns to recognised hard to fill medical posts and they have a detailed list who have been employed over the preceding 2 months and are working with services to develop exit strategies. SFH are also focusing locums who are 'on framework' and 'over price cap', with plans to replace with substantive roles, to further reduce 'over price cap' compliance. They have developed a trajectory to understand the impact on usage and costs.
NCHT expected HCA agency staffing to have reduced at a steeper rate. They are continuing with a bank worker recruitment drive and a reduction is still expected at the end of Q2. NCHT are reviewing all agency bookings through an internal dashboard up to 12 weeks in advance allows leaders and our internal agency staffing team a longer time to fill these shifts. They have improved roster sign off and

Total ICB Primary Care Workforce - Operational Plan v Actual 2023/24

Data collection at practice level shows variation due to unclear definitions on the workforce detail to be recorded. The workforce data is therefore indicative data.

Primary Care Workforce published data is always one month behind the system reporting on NHS Trust delivery of the WTE plan. ARRS reporting uses local intelligence through the claims portal.

Primary Care	Actual	Plan	Plan	Plan	Plan	
	Q1	Q1	Q2	Q3	Q4	
Nottingham And Nottinghamshire Health And Care STP	As of the end of June-24	As at the end of Jun-24	As at the end of Sep-24	As at the end of Dec-24	As at the end of Mar-25	Variance to Plan
Workforce (WTE)	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	WTE
Total Workforce	**3740**	**3776**	**3807**	**3820**	**3837**	**-36**
GPs excluding GPs in Training Grade	580	591	590	591	588	-11
GPs in Training Grade	259	253	279	283	277	6
Nurses	362	368	372	374	378	-6
Direct Patient Care roles (ARRS funded)	631*	651	652	652	668	-20
Direct Patient Care roles (not ARRS funded)	266	290	290	290	291	-24
Other – admin and non-clinical	1642	1622	1625	1631	1635	20

Total Provider Current Position:

Month 3 of Quarter 1 has shown a slight upturn compared to Month 2. Direct Patient Care Roles remain under plan by 44wte but has seen an improvement of 8wte compared to month 2. Overall Primary care is 36wte below plan.

There have been differences in the reporting of admin. SAIU are reviewing admin reporting differences to see if this is a general data collection issue or if targeted communication is needed around accuracy of recording going forward. SAIU to inform Primary Care Workforce Group (PCWG) for Practice Manager representative to cascade to PM network.

Retention has been the key focus for this quarter:

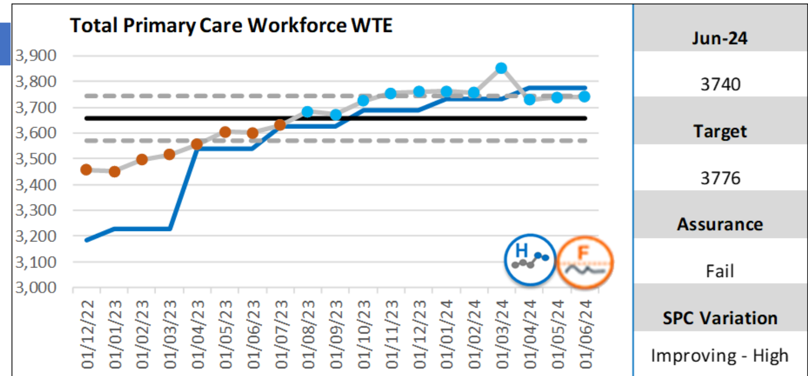
o- ARRS Retention a focus with NATH supporting through ambassador roles, multi-professional Support Unit added to the retention programme for GP, GPNs and non-clinical workforce, which includes wellbeing across all staff groups.

o- GP Training numbers remain slightly higher than plan, 70% are International Medical Graduates. Limited opportunity for substantive employment exist at present given uncertainties on funding within general practice. Phoenix Programme is supporting practices with sponsorship and supporting in transition from trainee into qualified and new to practice schemes.

o- GPN/Nursing remains stable with mid-career/improvement fellowships in progress. GPN leads in post for each place working collaboratively supporting development of transformation/pathway development and utilisation of nursing skills.

o- Non-Clinical career framework established with first cohort of Practice Manager fellows and projects underway. Care navigation is also a priority.

Primary Care Workforce Group is a working group under both the People & Culture Steering Group and People & Culture Planning Performance and Risk Group and so will align to in-year developments linked to transformation and delivery of the Primary Care Strategy.



P&C Group Limited Assurance - Further Information Required:

Assurance can be given on the maintenance of the workforce capacity in WTE but more work is needed to understand the staff experience and the movements generated through turnover as well as the loss of availability through sickness. Without these measures we can only provide an indicative position and therefore a limited assurance level.

Uncertainty within General practice, linked to funding and discontent, with potential industrial action expected adding to the limited recruitment opportunities requires a watching brief on the impact on existing workforce and specifically trainees newly qualified is needed to be assured no negative impact seen on the current and expected workforce within the plan.

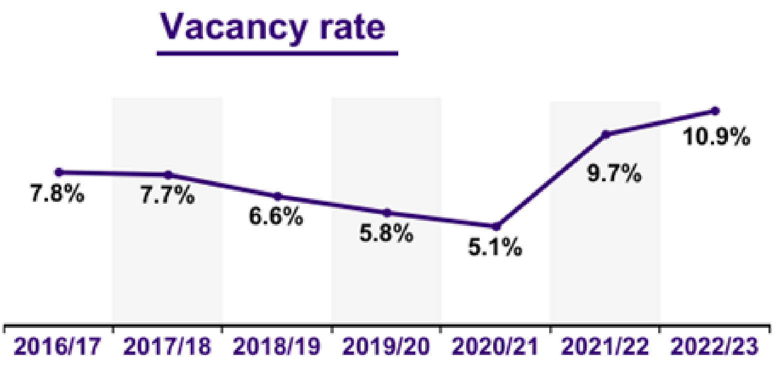
Nottingham and Nottinghamshire Social Care

In the **local authority and independent sector:**

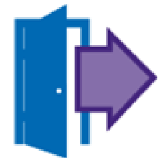
38,000 total posts
34,000 filled posts
26,000 FTE filled posts
(full-time equivalent filled posts)

There was a change of **1,000 filled posts (3%)** since 2021/22 in **local authority and independent sectors.**

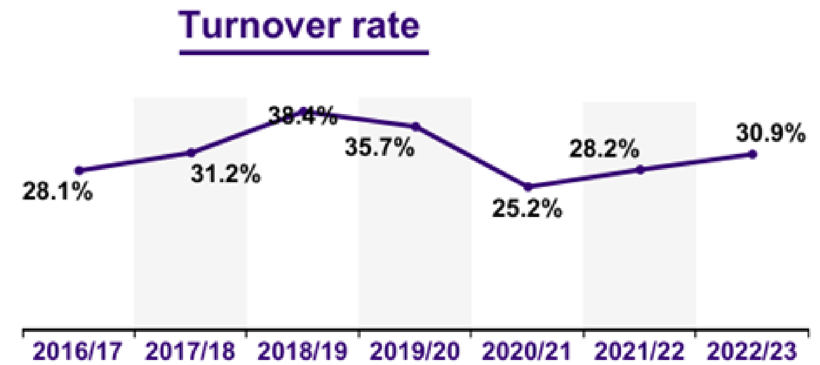
Recruitment and retention



30.9% turnover rate (or 9,600 leavers) in 2022/23



7.9 average sickness days taken in 2022/23

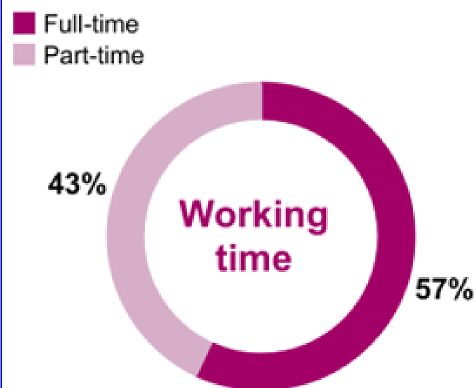


10.9% vacancy rate (or 3,800 vacant posts) in 2022/23

57% of **recruitment** is from **within adult social care**

NHS Nottingham and Nottinghamshire

Employment overview



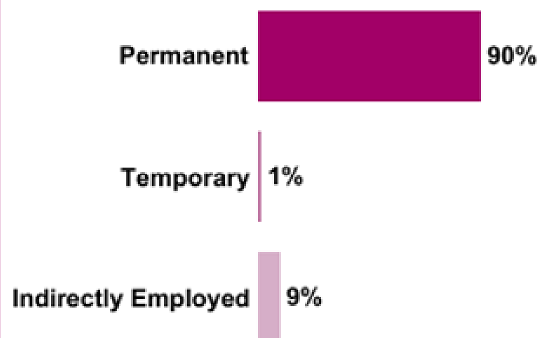
Full-time equivalent filled posts

The **FTE filled posts ratio** in

Nottingham and Nottinghamshire

is **0.77**

Employment status



In 2022/23:

18%

of filled posts were **zero-hours contracts** (or **6,000 filled posts**).

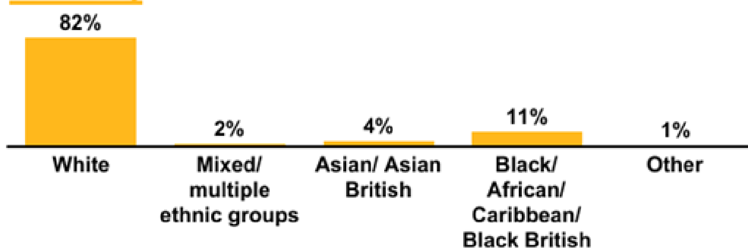
Demographics

Gender

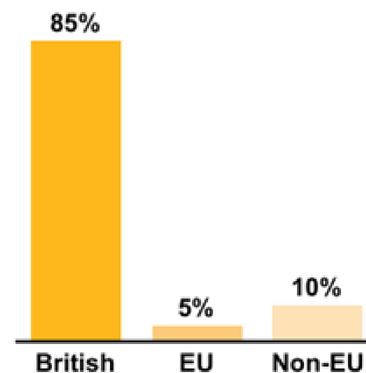
82% of the workforce were **female**

18% of the workforce were **male**

Ethnicity



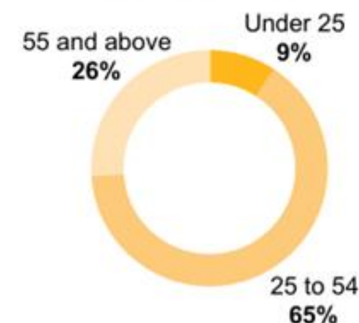
Nationality (2022/23)



Age

The average **age** was

43 years old



Rushcliffe Arena, 09:00-12/09/24

Workforce projections

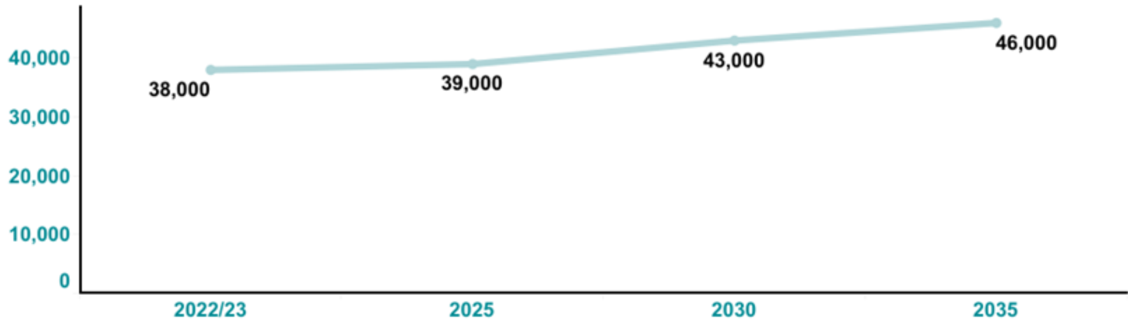
NHS Nottingham and Nottinghamshire

This model projects the size of the workforce if it grows proportionally to the number of people aged 65 and over in the population. This workforce includes adult social care total posts employed by local authorities and the independent sector only. Posts employed by direct payment recipients and those in the NHS are not included.
Please note that demand due to replacing leavers will be in addition to the figures shown below.

If the adult social care workforce grows proportionally to the projected number of people aged 65 and over in the population then the number of adult social care filled posts will...

increase by 21%
(7,800 total posts)

...to around
46,000 total posts by 2035



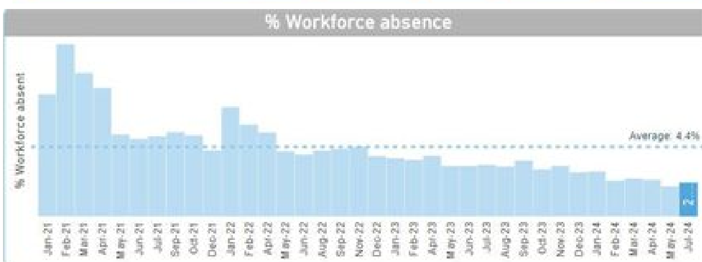
NHS
Nottingham and Nottinghamshire

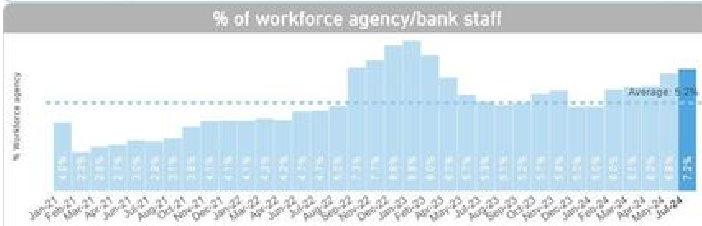
Care Homes Workforce

Workforce absence and agency staff

Monthly staff trend: All staff

Aligned PBP	Employed	Absence	%	Agency	%
Bassetlaw	1,784	16	0.9%	88	4.7%
Mid Notts	4,285	114	2.7%	288	6.3%
Nottm City	2,730	37	1.4%	270	9.0%
South Notts	4,357	116	2.7%	372	7.9%
Total	**13,156**	**283**	**2.2%**	**1018**	**7.2%**





Care Home workforce absence is a currently 2.2%. This is the second lowest rate of absence since Jan 21. Currently, nursing staff have the lowest reporting with only 11 out of 592 (1.9%) staff absences. Compared with Jul 2023 reporting, overall CH staff employed has decreased from 13,212 to 13,156 (-0.4%).

Agency/Bank staff percentage is continuing to increase each month. This is data reported on the National Capacity Tracker which currently reports Agency/Back staff rates combined. Going forward it would be good to report each of these staff groups separately.

Nottingham and Nottinghamshire

10.0 Health Inequalities

10.1 Focus on Avoidable Mortality
10.2 Health Inequality Metrics
10.3 Neighbourhood Overview

10.1. - Avoidable Mortality

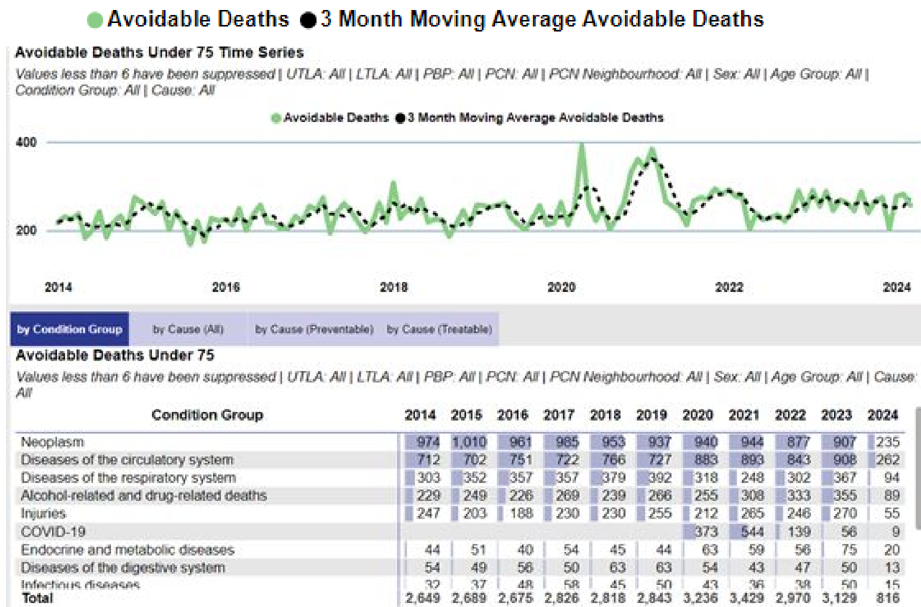
- The top 5 causes of premature avoidable death in Nottingham & Nottinghamshire ICS are:

    1. Cancers
    2. Diseases of the circulatory system (CVD)
    3. Diseases of the respiratory system
    4. Alcohol and drugs related deaths
    5. Injuries

- Since 2020 there has been an increase in avoidable deaths, partly due to COVID-19, but also due to an increase of deaths from CVD, and alcohol or drug related problems and injuries.
- The increase observed in 2022 and 2023 has occurred mainly in the 50-64 and 65-74 age groups.
- 2020 and 2021 saw a spike in avoidable deaths due to COVID-19, but numbers in 2022 and 2023, although lower than 2020 and 2021, have remained higher than the pre-COVID period.
- Avoidable deaths are higher in males than females. Age-standardised rates in males are 314 per 100,000 compared to 201 per 100,000 in females.
- Avoidable deaths are strongly linked with deprivation: the highest age-adjusted mortality rates are observed in the most deprived areas of the ICS. Nottingham City PBP has the highest rates, whilst South Notts PBP has the lowest rates.
- Premature mortality rates from all causes in Nottingham City are significantly higher than England for both males and females, whilst in Nottinghamshire County they are similar to England. This pattern is seen in the main causes of avoidable deaths: deaths from CVD, Cancer and Respiratory diseases, where rates in Nottingham City are significantly higher than England and the Midlands region. Premature deaths from cancer, however, are significantly higher than England in both Nottingham City and Nottinghamshire County.
- Lifestyle interventions and the promotion of a healthy diet are likely to reduce the number of preventable deaths from the leading causes, alongside a focus of detection and optimal management of hypertension and earlier cancer diagnosis in high risk populations.

10.1 Trends in Avoidable Deaths

Avoidable mortality relates to people under 75 years of age who died from causes that are considered either preventable or treatable given timely and effective public health and health care services. A review of avoidable mortality presents insight into our healthcare system, highlighting disparities between areas and population groups as well as conditions requiring attention and the consideration of access to services.



Avoidable Deaths Under 75

Values less than 6 have been suppressed | UTLA: All | LTLA: All | PBP: All | PCN: All | PCN Neighbourhood: All | Sex: All | Age Group: All | Cause: All

Condition Group	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Neoplasm	974	1,010	961	985	953	937	940	944	877	907	235
Diseases of the circulatory system	712	702	751	722	766	727	883	893	843	908	262
Diseases of the respiratory system	303	352	357	357	379	392	318	248	302	367	94
Alcohol-related and drug-related deaths	229	249	226	269	239	266	255	308	333	355	89
Injuries	247	203	188	230	230	255	212	265	246	270	55
COVID-19							373	544	139	56	9
Endocrine and metabolic diseases	44	51	40	54	45	44	63	59	56	75	20
Diseases of the digestive system	54	49	56	50	63	63	54	43	47	50	13
Infectious diseases	32	37	48	58	45	50	43	36	38	50	15
Total	2,649	2,689	2,675	2,826	2,818	2,843	3,236	3,429	2,970	3,129	816

2020 and 2021 saw a spike in avoidable deaths, largely caused by COVID-19, but the numbers in **2023** were still **10% higher than in 2019**. Data for the first half of 2024 does not show a reduction from 2023 levels. Neoplasm, Respiratory Diseases and Circulatory diseases have remained the highest cause of death since 2014. Alcohol and drug related deaths have increased since 2019 and remained at higher levels.

Local Authority	Average 2015-2019	2020	2021	2022	2023	2023 vs. 2015-2019 AVG (n)	2023 vs. 2015-2019 AVG (%)
Ashfield	315	347	394	336	381	66	21%
Bassetlaw	283	326	321	319	298	15	5%
Broxtowe	222	257	267	230	214	-8	-4%
Gedling	221	274	297	243	247	26	12%
Mansfield	283	320	346	294	299	16	6%
Newark and Sherwood	251	303	313	290	294	43	17%
Nottingham	658	794	833	694	744	86	13%
Rushcliffe	188	187	210	173	206	18	10%
Not known or out of area	349	428	448	391	446	97	28%
Grand Total	**2,770**	**3,236**	**3,429**	**2,970**	**3,129**	**359**	**13%**

There has been a 13% increase in avoidable deaths compared to the pre-covid 5 year average (GP registered population).

The increase has occurred mainly in Nottingham City and Mid-Notts (Ashfield and Newark & Sherwood Districts). Nottingham City and Ashfield are two districts with the highest levels of deprivation in the ICS.

10.1 Avoidable Deaths – Cause of Death Preventable and Treatable Conditions

Avoidable Deaths Under 75 (Preventable)

Values less than 6 have been suppressed | UTLA: All | LTLA: All | PBP: All | PCN: All | PCN Neighbourhood: All | Sex: All | Age Group: All | Condition Group: All

Cause	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Lung cancer	383	383	356	372	344	295	329	330	308	300	92
Ischaemic heart diseases	217	209	225	215	217	215	264	278	276	286	82
Chronic lower respiratory diseases	175	194	215	209	205	229	207	162	188	235	63
Alcohol-specific disorders and poisonings	131	146	126	158	123	135	143	169	184	212	49
COVID-19							373	544	139	56	9
Cerebrovascular diseases	79	85	90	81	97	89	99	101	79	99	27
Oesophageal cancer	62	94	74	90	84	88	82	95	78	80	22
Accidental Injuries	65	66	65	88	84	84	82	94	93	101	22
Drug disorders and poisonings	66	57	55	64	84	78	71	105	103	113	28
Total	**1,698**	**1,763**	**1,682**	**1,781**	**1,721**	**1,759**	**2,141**	**2,366**	**1,945**	**1,983**	**532**

Avoidable Deaths Under 75 (Treatable)

Values less than 6 have been suppressed | UTLA: All | LTLA: All | PBP: All | PCN: All | PCN Neighbourhood: All | Sex: All | Age Group: All | Condition Group: All

Cause	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Ischaemic heart diseases	217	209	225	215	217	215	264	278	276	286	82
Colorectal cancer	114	125	141	147	145	166	148	149	154	170	29
Breast cancer (female only)	136	116	127	112	131	125	118	129	108	116	30
Cerebrovascular diseases	79	85	90	81	97	89	99	101	79	99	27
Pneumonia, not elsewhere classified or organism unspecified	84	100	84	93	99	91	61	44	51	63	15
Venous thromboembolism	58	41	52	60	61	39	65	59	40	46	9
Certain conditions originating in the perinatal period	6	6		39	41	49	54	40	52	44	14
Diabetes mellitus	22	26	19	27	23	22	31	30	28	36	9
Uterus cancer	23	17	23	20	20	19	26	17	22	21	6
Total	**951**	**926**	**994**	**1,046**	**1,097**	**1,085**	**1,096**	**1,064**	**1,025**	**1,147**	**285**

The number of avoidable deaths from preventable and treatable conditions is listed in the table.

Ischaemic heart disease is a cause high on both lists, suggesting the need for a focus on early access to diagnosis and treatment of the condition.

Ischaemic heart disease also has links to lifestyle with diet a key risk factor in the development.

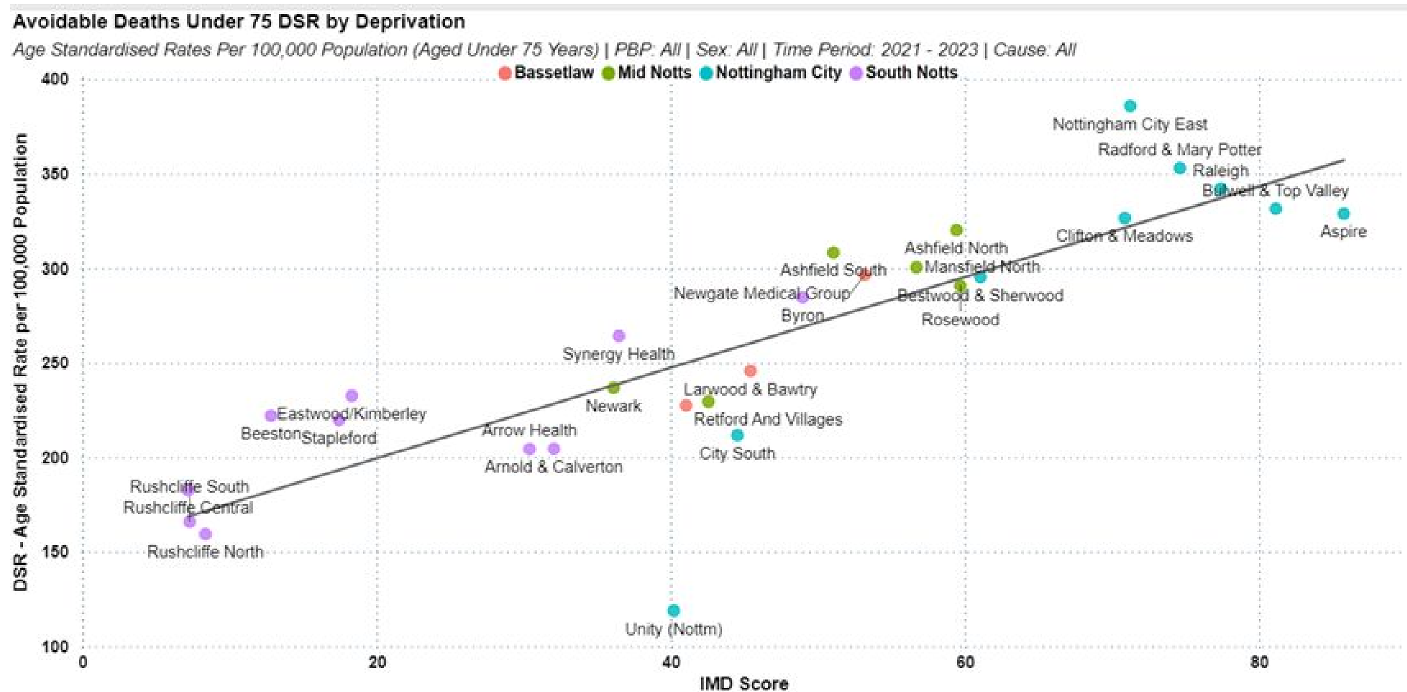
Lung cancer is the biggest cause of preventable deaths, smoking is the cause of 72% of lung cancer cases.

Treatment available for those with cancer depends on the stage of diagnosis, earlier stages (1 or 2) are more likely to have better treatment options and outcomes.

A focus on a healthy diet and lifestyle is likely to reduce the incidence of many preventable deaths.

Rushcliffe Arena, 09:00-12/09/24

10.1 Trends in Avoidable Deaths



There is a clear correlation between socio-economic deprivation (measured by the national index of multiple deprivation – IMD) and avoidable mortality.

PCNs with the highest average deprivation scores have also the highest age-adjusted mortality rates.

Nottingham City East, Radford and Mary Potter, Raleigh and Aspire PCN also have some of the greatest ethnic diversity within their populations, therefore consideration should be taken to understand if there are disparities in avoidable deaths between ethnicities.

10.1 Avoidable Deaths

Cause of Death	Average 2015-2019	2020	2021	2022	2023	2023 vs. 2015-2019 AVG (n)	2023 vs. 2015-2019 AVG (%)
Neoplasm	969	940	944	877	907	-62	-6%
Diseases of the circulatory system	734	883	893	843	908	174	24%
Diseases of the respiratory system	367	318	248	302	367	0	0%
Alcohol-related and drug-related deaths	250	255	308	333	355	105	42%
Injuries	221	212	265	246	270	49	22%
COVID-19		373	544	139	56		
Endocrine and metabolic diseases	47	63	59	56	75	28	60%
Diseases of the digestive system	56	54	43	47	50	-6	-11%
Infectious diseases	48	43	36	38	50	2	5%
Other	78	56	41	54	48	-30	-39%
Total	**2,770**	**3,236**	**3,429**	**2,970**	**3,129**	**359**	**13%**

Age Group	Average 2015-2019	2020	2021	2022	2023	2023 vs. 2015-2019 AVG (n)	2023 vs. 2015-2019 AVG (%)
0-19	66	92	77	88	78	12	18%
20-49	421	429	510	473	468	47	11%
50-64	904	1,039	1,193	1,060	1,096	192	21%
65-74	1,380	1,676	1,649	1,349	1,487	107	8%
Total	**2,770**	**3,236**	**3,429**	**2,970**	**3,129**	**359**	**13%**

The number of avoidable deaths is increasing.

The increase in avoidable deaths over the has occurred mainly in the following conditions:

- CVD
- Alcohol and drug related problems
- Injuries

The increase has been observed mainly in the 50-64 and 65-74 age groups.

Age-standardised rate of deaths from CVD in those aged under 75 in Nottingham City is significantly higher than the England Average. The rate is over twice that in Rushcliffe, highlighting the disparities in premature mortality between the most and least deprived areas.

In addition, age standardised premature mortality rates from respiratory diseases and Cancer in Nottingham City are significantly higher than the England averages.

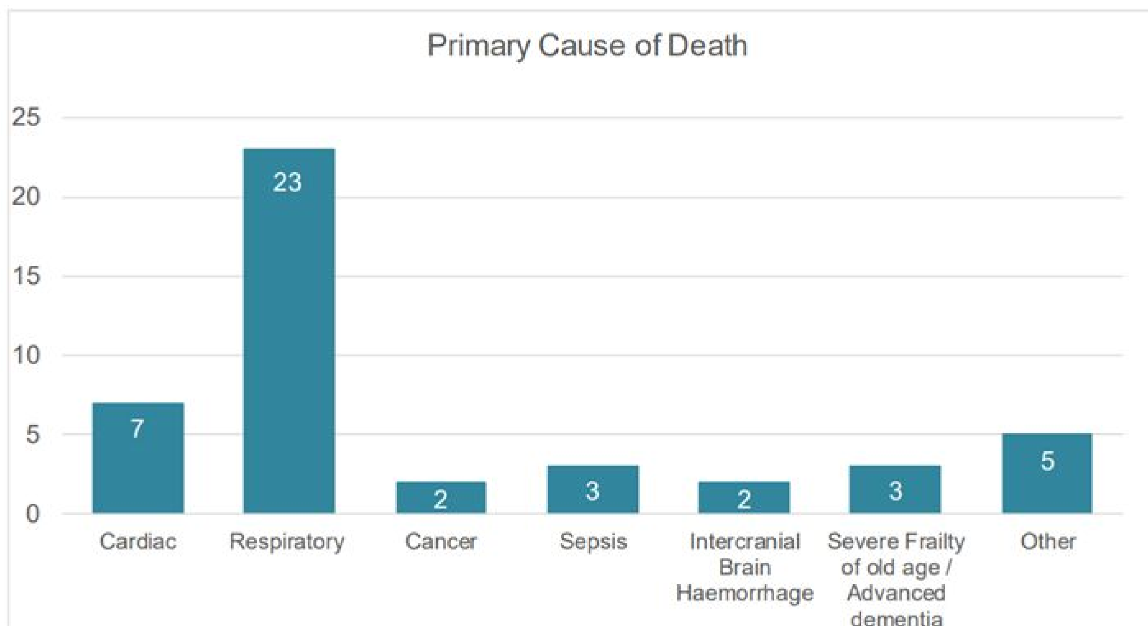
Rushcliffe Arena, 09:00-12/09/24

10.1 Premature Mortality in People with Learning Disabilities and Autistic People

- The Confidential Inquiry into premature deaths of people with a learning disability found that 38% of people with a learning disability died from an avoidable cause, compared to 9% in a comparison population of people without a learning disability. The latest LeDeR National LeDeR report from 2022, found that 42% of deaths in those with a learning disability were avoidable.

- LeDeR reports suggest that people from ethnic minority groups die at a younger age: males from an 'Asian/Asian British' background with profound and multiple learning disability had a median age at death at around 30, the lowest median age at death of all groups. In comparison, for 'White British' males with profound and multiple learning disability the median age at death was 59. Nationally, 25% of adults who died in 2022 and had a completed review by LeDeR lived in a neighbourhood with one of the two most deprived deciles.

Cause of Death



The chart shows the cause of death taken from the Nottingham and Nottinghamshire LeDeR reviews that were completed during 2022/23 included in the LeDeR annual report. This data has been taken from the primary cause of death, however some of these patients had multiple contributing co morbidities.

<u>In addition:</u>

- Locally, percentages for male deaths are significantly higher than those for female deaths
- Due to analysis of the data, deaths related to cardiovascular/cardiac in origin are now a priority area of local focus.

10.1 Avoidable Deaths - Recommendations

The number of avoidable deaths is increasing and remains high in the areas of high deprivation.

In order to help reduce the number of avoidable deaths across the ICS, the following priority areas are recommended:

- Early detection and optimal management of hypertension, with a focus on at risk populations in areas of high deprivation.
- Promote healthy lifestyle advice and ensure access to lifestyle interventions (weight loss and tobacco dependency services), with a focus on areas of high need.
- Promote access to early cancer screening for Lung, Breast, Colorectal and Cervical cancer screening.
- Support for those with alcohol and drug dependency.
- Support for those living with severe and multiple disadvantage (SMD).

10.2. - Health Inequalities Metrics

NHS Nottingham and Nottinghamshire

- Tables 10.2a-d present the Nottingham and Nottinghamshire position against the NHSE indicators for health inequalities.
- The indicators align with Core20+5 and the national priorities for health inequalities including restoring NHS services inclusively, mitigating against digital exclusion, ensuring datasets are complete and timely, accelerating preventative programmes, strengthening leadership and accountability.
- The data highlights disparities with actions being supported by the priorities within the ICS Strategy and Joint Forward Plan.
- Table 10.4 highlights the stark differences across neighbourhoods and the population profile is supported by the Nottingham and Nottinghamshire Joint Strategic Needs Assessment (JSNA) and supporting dashboard.
- The Nottingham and Nottinghamshire Statement on health inequalities provides a comprehensive understanding of how the data has been used to inform action
- Recent developments to the Health Inequalities Dashboard have included Cancer staging data which was previously unable to be broken down demographically. Disparities can now be understood between population groups. Further analysis is on going and expected in Q3.

10.3 Statement Indicators Summary - Elective & Emergency Activity, and COPD (June 2024)

The health inequalities summary compares indicators for each group to the Nottingham and Nottinghamshire ICB population overall. Values are coloured based on whether they are statistically significantly different to the ICB overall. Indicators are drawn primarily from the NHSE Statement on Health Inequalities and supplemented by locally-determined metrics.

For some indicators, data quality for is not good enough to present accurate statistical comparisons. This is a particular issue when comparing by ethnic group for indicators which use a primary care-based denominator and a secondary care-based numerator such as age-standardised rates of admissions. For these, values are still presented for information but should be interpreted cautiously. 'Other' ethnic group values have been omitted because they are particularly affected by this issue.

Legend

No statistically significant difference to overall	Statistically significantly better than overall	Statistically significantly lower than overall (not better/worse)
Data quality or other issue prevents statistical comparison	Statistically significantly worse than overall	Statistically significantly higher than overall (not better/worse)

Elective & Emergency Activity

Indicator	Period	ICB	Sex		Ethnic group ⓘ					Deprivation quintile				
			Male	Female	Asian	Black	Mixed	Other	White	1 Most deprived	2	3	4	5 Least deprived
Age-standardised rate of emergency attendances per 100,000 pop.	202304 - 202403	35,549	34,672	36,566	22,366	29,541	21,493		33,285	42,510	37,316	34,269	32,098	27,982
Age-standardised rate of emergency admissions per 100,000 pop.	202304 - 202403	10,490	9,932	11,188	6,806	8,436	5,836		9,850	13,237	11,356	10,035	8,793	8,246
Crude rate of emergency admissions in 0-17s per 100,000 pop.	2023/2024	6,430	6,601	6,250	5,055	4,623	5,417		6,396	6,795	6,822	6,711	5,831	5,452
Age-standardised rate of elective admissions per 100,000 pop.	202304 - 202403	16,085	15,857	16,525	7,879	9,686	6,944		13,549	15,807	16,185	16,425	16,218	15,497
Waiting list: waits >18 weeks (cumulative)	30/06/2024	42.5%	42.9%	42.2%	44.4%	43.4%	44.1%	45.8%	42.0%	42.7%	42.2%	42.5%	42.1%	43.0%
Waiting list: waits >52 weeks (cumulative)	30/06/2024	4.1%	4.0%	4.2%	4.9%	5.0%	5.9%	5.4%	3.9%	4.5%	3.9%	4.0%	4.0%	3.8%
Waiting list: waits >65 weeks (cumulative)	30/06/2024	0.6%	0.5%	0.6%	0.8%	0.4%	0.6%	0.6%	0.5%	0.6%	0.5%	0.5%	0.5%	0.5%
Age-standardised rate of outpatient appointments per 100,000 pop.	202304 - 202403	38,868	33,462	44,732	22,114	26,441	20,191		33,692	39,665	39,674	39,234	38,621	37,002
First outpatient appointments attended virtually	2023/2024	11.2%	11.6%	10.9%	9.9%	10.9%	9.0%	9.4%	11.0%	11.2%	11.3%	11.2%	11.1%	10.9%
First outpatient appointments not attended by patient (DNA)	2023/2024	6.8%	7.6%	6.2%	8.5%	10.5%	10.3%	8.0%	6.0%	9.8%	7.5%	5.9%	4.8%	4.1%

COPD

Indicator	Period	ICB	Sex		Ethnic group ⓘ					Deprivation quintile				
			Male	Female	Asian	Black	Mixed	Other	White	1 Most deprived	2	3	4	5 Least deprived
Age-adjusted COPD prevalence per 100,000 pop. (all ages)	202406	2,202	2,409	2,033	729	954	1,348	1,314	2,372	3,797	2,710	2,019	1,526	1,018
COPD patients with medication review (L12M)	202406	66.8%	66.4%	67.1%	64.5%	56.0%	58.4%	50.6%	67.1%	64.0%	65.2%	68.4%	71.5%	70.5%
Age-standardised rate of emergency COPD adm. per 100,000 pop.	202304 - 202403	211	196	227	63	48	101		212	457	229	182	116	77

Source: SAIU Health Inequalities Dashboard [SID06]

Note: Counts below 10 are suppressed and will display as 0.

Rushcliffe Arena, 09:00-12/09/24

10.3 Statement Indicators Summary - CVD and Diabetes (June 2024)

The health inequalities summary compares indicators for each group to the Nottingham and Nottinghamshire ICB population overall. Values are coloured based on whether they are statistically significantly different to the ICB overall. Indicators are drawn primarily from the NHSE Statement on Health Inequalities and supplemented by locally-determined metrics.

For some indicators, data quality for is not good enough to present accurate statistical comparisons. This is a particular issue when comparing by ethnic group for indicators which use a primary care-based denominator and a secondary care-based numerator such as age-standardised rates of admissions. For these, values are still presented for information but should be interpreted cautiously. 'Other' ethnic group values have been omitted because they are particularly affected by this issue.

Legend

No statistically significant difference to overall	Statistically significantly better than overall	Statistically significantly lower than overall (not better/worse)
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Cardiovascular Disease (CVD)

Indicator	Period	ICB	Sex		Ethnic group					Deprivation quintile				
			Male	Female	Asian	Black	Mixed	Other	White	1 Most deprived	2	3	4	5 Least deprived
Age-adjusted Hypertension prevalence per 100,000 pop. (all ages)	202406	15,769	16,410	15,082	17,768	21,630	17,307	14,447	15,814	17,606	16,399	15,792	14,951	13,922
Hypertension pts. prescribed antihypertensive medicine, with review (L15M)	202406	73.5%	73.1%	74.0%	67.3%	62.0%	62.8%	63.2%	74.6%	70.1%	71.5%	73.4%	76.3%	77.2%
CVDP007HYP: Hypertension pts. with BP reading below treatment threshhold	202406	66.3%	64.2%	68.5%	63.2%	56.2%	58.2%	53.9%	67.4%	63.2%	65.4%	66.5%	68.2%	69.1%
CVDP002AF: AF pts. with CHA2DS2-VASc of >=2, prescribed anticoagulant	202406	95.4%	95.6%	95.3%	96.2%	94.0%	92.5%	95.3%	95.5%	95.4%	95.0%	95.3%	95.9%	95.6%
CVDP003CHOL: Pts. with no CVD & QRISK score of >=20%, on lipid lowering	202406	60.1%	60.9%	58.9%	66.2%	57.6%	59.4%	54.7%	60.0%	65.2%	61.4%	59.4%	58.4%	55.7%
Age-standardised rate of emergency Myocardial Infarction adm. per 100,000 ...	202304 - 202403	129	175	85	182	91	58		98	173	141	109	123	94
Age-standardised rate of emergency Stroke admissions per 100,000 pop.	202304 - 202403	179	211	150	140	298	155		154	224	181	178	152	156

Diabetes

Indicator	Period	ICB	Sex		Ethnic group					Deprivation quintile				
			Male	Female	Asian	Black	Mixed	Other	White	1 Most deprived	2	3	4	5 Least deprived
Prediabetic pts. referred to National Diabetes Prevention Programme (L12M)	202406	55.9%	55.2%	56.5%	60.8%	59.7%	57.6%	55.8%	55.5%	53.5%	55.6%	55.0%	58.0%	59.0%
Diabetes Type 1 pts.: all 8 diabetes care processes completed (L12M)	202406	32.0%	33.0%	30.6%	26.8%	33.9%	21.9%	31.0%	32.7%	30.0%	32.8%	32.7%	33.3%	32.4%
Diabetes Type 2 pts.: all 8 diabetes care processes completed (L12M)	202406	47.2%	48.7%	45.4%	39.8%	42.5%	40.7%	37.4%	48.7%	40.6%	46.2%	48.5%	52.3%	55.0%
Diabetes Type 1 pts. prescribed continuous glucose monitoring (L3M)	202406	57.1%	57.6%	56.5%	49.0%	44.9%	50.8%	55.2%	58.3%	53.7%	57.0%	57.2%	57.3%	62.7%
Diabetes Type 2 pts. prescribed continuous glucose monitoring (L3M)	202406	3.5%	3.4%	3.7%	2.7%	2.8%	4.3%	3.4%	3.7%	3.3%	3.2%	3.6%	3.8%	4.0%

Source: SAIU Health Inequalities Dashboard [SID06]

Note: Counts below 10 are suppressed and will display as 0.

10.3 Statement Indicators Summary - Mental Health, Learning Disabilities, and Maternity & CYP (June 2024)

The health inequalities summary compares indicators for each group to the Nottingham and Nottinghamshire ICB population overall. Values are coloured based on whether they are statistically significantly different to the ICB overall. Indicators are drawn primarily from the NHSE Statement on Health Inequalities and supplemented by locally-determined metrics.

For some indicators, data quality for is not good enough to present accurate statistical comparisons. This is a particular issue when comparing by ethnic group for indicators which use a primary care-based denominator and a secondary care-based numerator such as age-standardised rates of admissions. For these, values are still presented for information but should be interpreted cautiously. 'Other' ethnic group values have been omitted because they are particularly affected by this issue.

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Data quality or other issue prevents statistical comparison	Statistically significantly worse than overall	Statistically significantly higher than overall (not better/worse)

Mental Health

Indicator	Period	ICB	Sex: Male	Sex: Female	Ethnic group: Asian	Black	Mixed	Other	White	Deprivation quintile: 1 Most deprived	2	3	4	5 Least deprived
Talking therapies recovery rate	2023/2024	50.4%	52.9%	49.6%	42.5%	46.7%	43.8%	48.2%	51.4%	44.1%	47.8%	50.2%	57.2%	58.0%
Serious Mental Illness Health Checks: All 6 Complete (L12M)	202406	60.8%	58.2%	63.6%	59.8%	57.7%	55.2%	49.6%	62.1%	56.8%	58.9%	63.7%	66.2%	68.9%
Percentage of CYP with at least 1 NHS Mental Health Contact in period	2023-02 - 2024-01	7.3%	7.8%	6.6%	2.2%	4.1%	7.0%	11.5%	7.2%	8.6%	7.8%	6.9%	6.3%	5.4%

Maternity & Children and Young People

Indicator	Period	ICB	Sex: Male	Sex: Female	Ethnic group: Asian	Black	Mixed	Other	White	Deprivation quintile: 1 Most deprived	2	3	4	5 Least deprived
Percentage of births which were pre-term	2023/2024	7.9%		7.9%	8.2%	6.3%	8.9%	8.3%	7.9%	8.8%	8.1%	6.4%	8.4%	6.8%
Rate of tooth extractions in children under 10 per 100,000 pop.	2023/2024	35.4	39.4	31.3	0.0	0.0	0.0	0.0	34.6	41.9	42.6	27.1	38.7	21.3

Learning Disabilities

Indicator	Period	ICB	Sex: Male	Sex: Female	Ethnic group: Asian	Black	Mixed	Other	White	Deprivation quintile: 1 Most deprived	2	3	4	5 Least deprived
Learning Disability Health Checks Completed (L12M)	202406	80.8%	79.7%	82.3%	83.1%	80.2%	81.3%	69.0%	80.8%	77.2%	82.8%	79.9%	84.5%	85.6%

Source: SAIU Health Inequalities Dashboard [SID06]

Note: Counts below 10 are suppressed and will display as 0.

10.3 Statement Indicators Summary - Immunisations & Vaccinations, Lifestyle & Risk Factors (June 2024)

The health inequalities summary compares indicators for each group to the Nottingham and Nottinghamshire ICB population overall. Values are coloured based on whether they are statistically significantly different to the ICB overall. Indicators are drawn primarily from the NHSE Statement on Health Inequalities and supplemented by locally-determined metrics.

For some indicators, data quality for is not good enough to present accurate statistical comparisons. This is a particular issue when comparing by ethnic group for indicators which use a primary care-based denominator and a secondary care-based numerator such as age-standardised rates of admissions. For these, values are still presented for information but should be interpreted cautiously. 'Other' ethnic group values have been omitted because they are particularly affected by this issue.

Legend

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Data quality or other issue prevents statistical comparison	Statistically significantly worse than overall	Statistically significantly higher than overall (not better/worse)

Vaccinations & Immunisations

Indicator	Period	ICB	Sex		Ethnic group					Deprivation quintile				
			Male	Female	Asian	Black	Mixed	Other	White	1 Most deprived	2	3	4	5 Least deprived
MMR dose 1 uptake in patients age 0-24	202406	82.1%	82.7%	81.5%	59.3%	65.6%	80.6%	57.8%	89.5%	80.0%	78.8%	79.8%	85.7%	89.8%
MMR dose 2 uptake in patients age 0-24	202406	69.5%	69.8%	69.2%	48.6%	51.6%	64.4%	42.5%	77.0%	66.2%	66.0%	67.9%	73.9%	77.9%
Influenza vaccination uptake age 18-64 (current/recent season) (IIF VI02)	202406	78.9%	77.4%	80.3%	71.4%	61.8%	63.7%	64.1%	81.3%	68.9%	80.3%	82.0%	85.3%	87.4%
Influenza vaccination uptake age 65+ (current/recent season) (IIF VI01)	202406	90.8%	90.5%	91.1%	81.6%	75.7%	84.4%	74.6%	91.9%	86.6%	89.3%	91.7%	92.3%	93.0%
COVID vaccination dose 1	202406	76.9%	74.2%	79.7%	54.9%	48.6%	52.8%	49.2%	83.3%	65.7%	74.1%	79.1%	84.4%	87.3%
COVID vaccination dose 2	202406	73.6%	70.7%	76.5%	51.6%	43.9%	48.2%	45.4%	80.1%	61.5%	70.8%	76.2%	82.0%	84.3%
COVID vaccination booster	202406	59.2%	55.8%	62.6%	35.0%	24.9%	29.8%	28.7%	66.4%	44.2%	55.5%	61.8%	69.5%	73.3%

Lifestyle & Risk Factors

Indicator	Period	ICB	Sex		Ethnic group					Deprivation quintile				
			Male	Female	Asian	Black	Mixed	Other	White	1 Most deprived	2	3	4	5 Least deprived
Crude GP-recorded smoking prevalence (age 15+)	202406	14.5%	17.2%	11.9%	8.4%	9.5%	17.7%	18.7%	15.2%	22.5%	16.8%	12.5%	9.7%	7.1%
Crude GP-recorded obesity prevalence (age 18+)	202406	24.5%	20.8%	28.2%	12.6%	23.3%	19.5%	15.9%	27.0%	27.0%	25.9%	24.8%	23.3%	20.2%
Crude History of alcohol misuse (age 18+)	202406	16.1%	20.1%	12.2%	4.7%	8.3%	12.5%	6.8%	18.8%	15.2%	15.9%	15.9%	16.6%	17.5%

Source: SAIU Health Inequalities Dashboard [SID06]

Note: Counts below 10 are suppressed and will display as 0.

10.4 Preventing Ill Health and Reducing Health Inequalities – Neighbourhood Overview (June 2024)

Period

202406

The stark differences between our PCN / neighbourhoods

		Deprivation	Risk Factors: age-adjusted prevalence per 1,000 people			Long Term Conditions: age-adjusted prevalence per 1,000 people								Age-adjusted rates per 100,000 people		Life expectancy Years	
PCN Neighbourhood	**No of patients**	**IMD Quintile**	**Obesity**	**Current Smoker**	**Hyper-tension**	**Diabetes Type 2**	**COPD**	**Heart Failure**	**Stroke**	**CHD**	**Cancers**	**Serious Mental Illness**	**Severe Frailty**	**Emergency Admissions** (1+ bed days length of stay)	**Avoidable deaths**	**Life expec. at birth (M)**	**Life expec. at birth (F)**
Raleigh	28,175	1	220.9	179.7	198.3	85.0	32.8	19.5	18.3	40.0	42.0	13.6	15.7	7,784	342.1	79.2	81.0
Aspire	39,478	1	223.0	177.4	178.5	82.5	32.4	15.5	16.7	37.7	40.5	9.8	13.1	7,826	328.9	78.0	81.3
Radford & Mary Potter	39,964	1	187.1	182.7	193.9	107.4	24.7	13.8	16.4	44.7	36.1	14.7	18.9	7,650	353.0	76.5	82.7
Bulwell & Top Valley	47,212	1	238.6	196.0	180.6	71.3	34.1	14.7	17.2	36.1	45.0	10.3	6.9	7,915	331.5	78.6	80.9
Nottingham City East	67,516	1	186.7	182.2	162.2	73.8	29.2	14.1	16.7	35.0	40.7	14.6	13.4	7,318	385.9	75.5	81.7
Newgate Medical Group	30,195	2	235.8	172.5	146.0	66.2	30.5	12.6	12.4	29.7	41.9	7.6	10.5	6,092	296.5	78.6	83.7
Clifton & Meadows	34,831	2	225.3	181.5	186.9	76.9	33.3	14.6	18.4	38.5	41.0	9.6	6.9	7,348	326.5	78.5	80.1
Ashfield North	51,613	2	260.8	160.0	171.0	68.5	26.0	17.0	14.4	36.6	49.1	7.7	9.0	7,783	320.2	77.1	82.2
Rosewood	51,967	2	221.8	174.8	154.3	65.0	27.8	12.2	13.7	36.7	43.0	7.9	9.0	7,546	290.6	79.1	82.8
Bestwood & Sherwood	55,390	2	196.9	153.2	155.1	64.6	21.4	12.5	16.0	33.3	42.7	10.4	7.9	6,200	295.3	78.1	82.9
Mansfield North	59,399	2	241.5	150.4	172.4	66.8	26.0	11.3	13.4	36.0	44.3	6.2	10.4	7,579	300.5	79.3	82.0
Larwood & Bawtry	38,110	3	231.6	132.4	167.3	66.9	31.0	19.5	15.0	33.8	45.8	7.5	12.8	6,207	245.6	79.2	82.9
Byron	39,084	3	232.3	138.2	158.2	61.3	23.3	11.9	14.5	32.6	47.6	5.7	16.0	7,611	284.5	77.9	80.5
City South	39,209	3	166.4	106.8	154.2	57.1	17.2	8.8	12.8	33.9	43.7	7.0	7.1	6,179	211.6	82.2	84.0
Ashfield South	40,857	3	257.5	153.2	154.6	66.1	25.7	10.7	14.8	34.1	44.8	7.0	6.6	7,756	308.3	77.4	80.4
Retford And Villages	58,539	3	233.3	131.5	150.7	57.2	23.1	10.7	12.0	28.5	44.6	5.8	9.6	5,487	227.4	79.8	84.4
Sherwood	63,836	3	236.3	139.2	169.2	63.2	23.9	12.8	14.0	36.2	46.3	6.1	10.1	6,974	229.4	79.7	81.5
Stapleford	22,305	4	226.3	134.1	166.1	59.0	21.4	8.7	12.0	29.6	44.6	6.1	4.5	6,133	219.8	81.0	86.1
Arnold & Calverton	34,124	4	204.8	119.5	146.1	49.6	17.6	8.6	15.3	29.6	47.4	7.0	9.1	5,829	204.4	79.6	84.2
Synergy Health	36,157	4	215.5	143.7	152.7	53.4	18.3	11.1	15.5	30.5	47.8	10.1	14.3	6,396	264.2	80.5	83.1
Eastwood/Kimberley	37,905	4	224.9	119.3	154.8	57.0	20.5	14.6	14.4	32.3	47.9	5.9	7.5	6,299	232.5	80.4	85.4
Newark	79,420	4	196.6	134.3	148.6	50.3	15.6	11.1	12.4	29.6	49.1	5.7	7.6	5,678	236.7	80.5	84.3
Arrow Health	39,830	5	185.9	115.0	147.3	46.0	15.0	9.4	12.9	28.1	46.2	6.4	6.0	5,857	204.3	81.6	85.0
Rushcliffe North	42,540	5	181.2	95.4	138.7	39.5	14.8	8.6	12.3	27.6	47.4	4.2	5.6	4,978	159.2	81.3	84.2
Rushcliffe South	43,891	5	176.0	85.5	138.3	39.4	11.2	9.0	12.4	25.7	46.8	4.0	4.2	4,776	165.9	83.7	84.8
Beeston	49,921	5	178.6	105.6	150.5	51.6	16.5	10.6	13.7	28.4	47.5	7.8	11.1	5,482	221.9	79.9	82.8
Rushcliffe Central	52,980	5	136.7	64.9	135.9	41.7	10.7	9.5	12.0	26.6	47.7	5.8	6.1	4,879	182.6	79.6	86.3
Unity (Nottm)	44,645	4	109.6	64.6	147.6	42.1	11.5	9.7	8.7	20.4	41.1	4.0		3,027	118.8		86.1

Bassetlaw Place
Nottingham City Place
South Nottinghamshire Place
Mid Nottinghamshire Place

Unity's population is almost entirely university students and is presented separately due to its atypical population demographics.

IMD value is the index of multiple deprivation (calculated based on weighted average of registered patients' Lower Super Output Areas declines as per GP Repository for Clinical Care).

COPD = Chronic obstructive pulmonary disease
CHD = Congestive heart disease

Most deprived PCN neighbourhood
Least deprived PCN neighbourhood

Rushcliffe Arena, 09:00-12/09/24

Nottingham and
Nottinghamshire

11.0 NHS Oversight Framework

ICS Aim 2: Tackle inequalities in outcomes, experience and access

11.1 – ICB Summary Highest and Lowest Quartile Performance Areas

NHS Nottingham and Nottinghamshire

Nottingham & Nottinghamshire ICB population – NOF Overview @ 29th August 2024

Quality of care, access and outcomes

(35 out of 38 metrics populated @29.08.2024)

Lower Quartile Areas:
- A&E - % patients managed within 4 hours (ICB)
- Diag activity waiting times - % patients not seen within 6 wks (DM01 - Only MRI, CT, NOU, Echo, Colonoscopy, FlexiSig, Gastro) (ICB & NNICB)
- Neonatal deaths per 1,000 total live births (ICB)
- Inappropriate adult acute MH out of area bed days (ICB & NNICB)
- GP apps - % regular appointments within 14 days (NNICB & BICB)
- Clostridium difficile infection rate (BICB)

Higher Quartile Areas:
- Elective Activity - value weighted elective activity growth vs. target (ICB)
- Proportion of patients meeting the faster cancer diag standard (ICB & NNICB)
- Number of CYP accessing MH services - % of pop (ICB)
- Dementia diagnosis rate (ICB & BICB)
- Percentage of 2hr UCR refs where care was provided within 2hrs (ICB)
- MRSA bacteraemia infection rate (ICB & NNICB)
- Clostridium difficile infection rate (NNICB)
- Antimicrobial resistance: total prescribing of antibiotics in primary care (NNICB)
- Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care (ICB & BICB)

Preventing ill-health and reducing inequalities

(7 out of 7 metrics populated @ 29.08.2024)

Lower Quartile Areas:
- Population vaccination coverage: MMR for two doses (5 year olds) (ICB)

Higher Quartile Areas:
- Cervical screening: % aged 25-64 attending within target period (BICB)

People

(14 out of 14 metrics populated @ 29.08.2024)

Lower Quartile Areas:
- Sickness absence rate (ICB)

Higher Quartile Areas:
- Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers (ICB)
- Leaver rate (ICB)

Finance and Use of Resources

(0 out of 4 metrics populated @ 29.08.2024)

Finance Metrics Identified in NOF:
- MHIS – **Achieved**
- Finance Efficiency – **under plan**
- Financial Sustainability – **under plan**
- Agency Cap – **over plan**

Leadership & Capability

(0 out of 0 metric populated @ 29.08.2024)

There are no ICB Leadership & Capability metrics in the 2023/24 NHSOF

Local Strategic Priorities

(No specific metrics)

- ICB – Finance and LD&A
- NUH - Finance
- NHT – CQC, Well led, Staffing, Governance
- Financial Sustainability – Recovery
- Elective Recovery – activity v ERF Plan

62 of the metrics have been populated as at 29th August 2024.

Please note – absolute volumes are used for certain metrics including 52ww, waiting lists, IPC measures – the rankings are therefore skewed to poor performance for larger organisations such as NNCCG and NUH – this is smoothed when looking at the ICS position

Nottingham and Nottinghamshire

Appendices

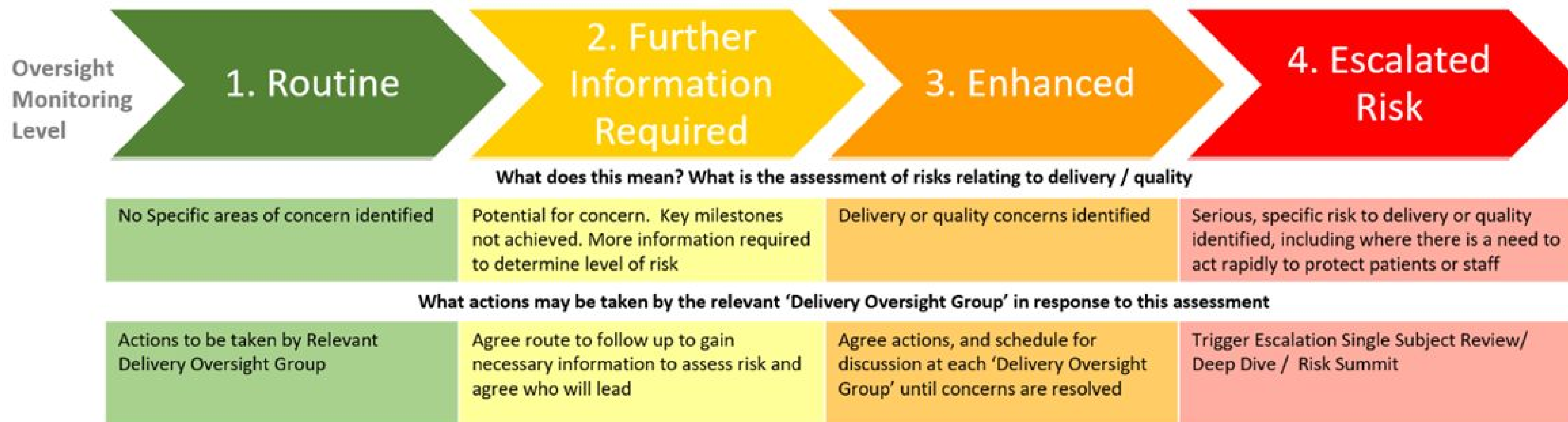
i – ICS Assurance Escalation Framework

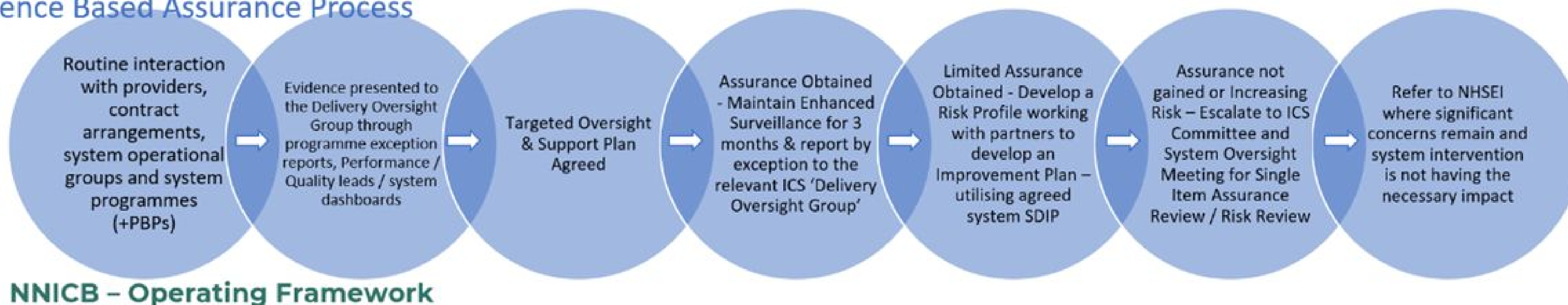
ii - Key to Variation and Assurance Icons (SPC) iii - Glossary of Terms

i – ICS Escalation Framework

NHS Nottingham and Nottinghamshire

Each key deliverable programme or oversight group will propose a level of assurance, aligned to **the escalation framework**, following discussion of reported metrics and key milestones at each group. This approach is still being developed and rolled out across the ICB. The 4 levels are as follows:





ii – Key to Variation & Assurance Icons (SPC) and Assurance Escalation Framework

NHS Nottingham and Nottinghamshire

This performance report incorporates Statistical Process Control (SPC) charts, which plot data over time around a centre line (the average). They help us to understand variation which guides us to make appropriate decisions.
The Upper Control Limit (UCL) and Lower Control Limit (LCL) are derived by the variability of the data. It is expected that 99% of data points will fall within the process limits (probability) and SPC are therefore useful to identify / consider how likely it is that the target will be achieved.

The **Variation Icons** are derived from the movement of the actuals, either as an indication of run rate over 6 data points, or against the mean (higher or lower than the mean), showing whether the process is improving, deteriorating or having no significant change.

The **Assurance Icons** are derived from the position of the Lower Control Limit against the plan or standard – and the confidence level that provides as to whether the target or plan is expected to be achieved in the future. If the plan or target is higher than the lower control limit this will indicate 'inconsistent' passing or falling short. If plan or target is lower than the lower control limit this indicates that the target is being consistently passed. If the plan is higher than the higher control limit, this will indicate consistent falling short.

Essentially, the assurance icon is all about the future not the past. We don't need SPC to tell us whether we've hit our target in the past, we know if we have or not and we can report on that as is customary. However that approach doesn't give much assurance about what happens in future. Even if we've consistently missed our target for the past 10 months, what's the likelihood that we will do so again next month? Traditional reporting does not have an answer for that but SPC does. SPC charts allow us to see how the process we are monitoring is behaving. We can therefore use the mean and limits to 'predict' future performance which is what the assurance icon does.

Variation			**Assurance** (capability of meeting target)		
Common Cause - no significant change; Up/Down arrow no special cause	**Special Cause** of *concerning* nature or *higher pressure* due to (H)igher or (L)ower values	**Special Cause** of *improving* nature or lower *pressure* due to (H)igher or (L)ower values	Variation indicates ***inconsistent*** passing or falling short of target - random	Variation indicates ***consistently (P)assing*** the target	Variation indicates ***consistently (F)alling short*** of the target

Blue lines on the charts represent the operational plan for 2022/23
Red Lines on the charts represent a required target position

Exception Reporting Rules

'Exception Reports' will be triggered if:

- An 'Orange' Variation icon or a 'Falling' short Assurance icon
- A Special Cause Variation (positive or negative)
- An area of escalation proposed via a sub-committee
- An area of escalation highlighted through the Executive Director from ICS Oversight Groups
- An area of escalation relating to sub-organisational level concerns

Further Reading / other resources
The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://improvement.nhs.uk/resources/making-data-count

iii – Glossary of Terms

NHS
Nottingham and Nottinghamshire

Acronym	Meaning	Acronym	Meaning	Acronym	Meaning	Acronym	Meaning
A&E	Accident & Emergency	FD	Finance Director	NEMS	Nottinghamshire Emergency Medical Services	SDMF	Strategic Decision Making Framework
A&E	Accident & Emergency Delivery Board	FOT	Forecast Out-Turn	NHP	New Hospitals Programme	SEG	System Executive Group
AMH	Anit-Mullerian Hormone	G&A	General & Acute	NHSE	NHS England	SFH	Sherwood Forest Hospitals Foundation Trust
BAU	Business as Usual	GI	Gastro-intestinal (often referred to as Upper GI or Lower GI)	NHT / NHC	Nottinghamshire Healthcare NHS Trust	SLA	Service Level Agreement
Blaw	Bassetlaw	HEE	Health Education England	NICE	National Institute for Health & Care Excellence	SMI	Severe Mental Illness
BLM	Back-log Maintenance	HFID	Hospital First Integrated Discharge	NNICB	Nottingham & Nottinghamshire ICB	SOF	System Oversight Framework
CAMHS	Child & Adolescent Mental Health Services	HLE	Healthy Life Expectancy	NRC	National Rehabilitation Centre	SOP	Standard Operating Procedure
CCG	Clinical Commissioning Group	IAPT	Improving Access to Psychological Therapies	NUH	Nottingham University Hospitals	SPC	Statistical Process Control
CDC	Community Diagnostic Centre	IBN	Information Breach Notice	OAPs	Out of Area Placements	SRO	Senior Responsible Officer
CDEL	Capital Departmental Expenditure Limits	ICATT	Intensive Community Assessment & Treatment Teams	OBD	Occupied Bed Days	TIF	Targeted Investment Fund
CDU	Clinical Decision Making Unit	ICB	Integrated Care Board	OOA	Out of Area	UEC	Urgent & Emergency Care
CHC	Continuing Health Care	ICP	Integrated Care Partnership	OP	Out Patients	UTC	Urgent Treatment Centre
CoP	Court of Protection	ICS	Integrated Care System	PBP	Place Based Partnerships	WTE	Whole Time Equivalents
CT	Computed Tomography	IPC	Infection prevention control	PCIT	Primary Care Information Technology	YOC	Year of Care
CV	Contract Variation	IR	Identification Rules	PCN	Primary Care Networks	YTD	Year to Date
CYP	Children & Younger People	IS	Independent Sector	PDC	Public Dividend Capital		
D2A	Discharge to Assess	JSNA	Joint Strategic Needs Assessment	PFDS	Public Facing Digital Services		
DC	Day Case	KMH	Kings Mill Hospital	PFI	Private Finance Initiative		
DDAT	Digital, Data, Analytics and Technology	LD	Learning Disabilities	PHM	Population Health Management		
DHSC	Department of Health and Social Care	LD&A	Learning Disabilities & Autism	PHSMI	Physical Health check for Severe Mental Ill patients		
DST	Decision Support Tool	LINAC	Linear Accelerator	PICU	Psychiatric Intensive Care Unit		
DTT	Diagnosis to Treatment Time	LoS	Length of Stay	PID	Project Initiation Document		
EBUS	Endobronchial Ultrasound	MAS	Memory Assessment Service	PIFU	Patient Initiated Follow Ups		
ED	Emergency Department	MHIS	Mental Health Investment Standard	POD	Prescription Ordering Direct		
EIP	Early Intervention Psychosis	MHST	Mental Health Support Team	PoD	Point of Delivery		
EL	Electives	MNR	Maternity & Neonatal Redesign	PTL	Patient Targeted List		
EMAS	East Midlands Ambulance Service NHS Trust	MOU	Memorandum of Understanding	QDCU	Queens Day Case Unit		
EMCA	East Midlands Cancer Alliance	MRI	Magnetic Resonance Imaging	QMC	Queens Medical Centre		
EMNNODN	East Midlands Neonatal Operational Delivery Network	MSFT	Medically Safe for Transfer	R&D	Research & Development		
EOL	End of Life	N&N	Nottingham & Nottinghamshire	R&I	Research & Innovation		
ERF	Elective Recovery Funding	NCSO	No Cheaper Stock Obtainable (prescribing)	RAG	Red, Amber & Green		
ESRF	Elective Services Recovery Funding	NEL	Non-Electives	RTT	Referral to Treatment Times		