Integrated Care Board Meeting Agenda (Open Session)

Thursday 13 March 2025 09:00-11:45

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: 09 January 2025	Kathy McLean	Decision	✓	-
5.	Action log and matters arising from the meeting held on: 09 January 2025	Kathy McLean	Discussion	✓	-
	Leadership and operating context				
6.	Citizen Story: Best Years Hub	Maria Principe	Discussion	✓	09:05
7.	Chair's Report	Kathy McLean	Information	✓	09:15
8.	Chief Executive's Report	Amanda Sullivan	Information	✓	09:20
	Strategy and partnerships				
9.	ICS People Plan	Rosa Waddingham/ Philippa Hunt	Decision		09:35
10.	Joint Forward Plan: Delivery Report and Annual Refresh	Sarah Fleming	Decision/ Assurance	✓	09:55

	Item	Presenter	Type *(For Assurance, Decision, Discussion or Information)*	Enc.	Time
	Delivery and system oversight				
11.	ICS Digital Data and Technology Strategy: Delivery Update	Dave Briggs/ Andrew Fearn	Assurance		10:15
12.	Quality Report	Rosa Waddingham	Assurance	✓	10:35
13.	Service Delivery Report	Maria Principe	Assurance	✓	10:50
14.	Finance Report	Marcus Pratt	Assurance	✓	11:10
	Governance				
15.	Committee Highlight Reports: • Strategic Planning and Integration Committee • Quality and People Committee • Finance and Performance Committee • Audit and Risk Committee • Remuneration and Human Resources Committee	Committee Chairs	Assurance	✓	11:25
	Information items *The following items are for information and will not be individually presented. Questions will be taken by exception.*				
16.	NHS Nottingham and Nottinghamshire Integrated Care Board Constitution	-	Information	✓	-
17.	2024/25 Board Work Programme	-	Information	✓	-
	Closing items				
18.	Risks identified during the course of the meeting	Kathy McLean	Discussion	-	11:40
19.	Questions from the public relating to items on the agenda	Kathy McLean	-	-	-
20.	Any other business	Kathy McLean	-	-	-
	Meeting close	-	-	-	11:45

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)

2025/26 Schedule of Board Meetings:

Date and time	Venue
14 May 2025, 09:00-12:00	Mansfield Civic Centre
09 July 2025, 09:00-12:00	Chappell Room, Arnold Civic Centre
10 September 2025, 09:00-12:00	Mansfield Civic Centre
12 November 2025, 09:00-12:00	TBC
14 January 2026, 09:00-12:00	Rushcliffe Arena
11 March 2026, 09:00-12:00	Rushcliffe Arena

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/03/2025
Paper Title:	**Declaration and management of interests**
Paper Reference:	ICB 24 105
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.

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ADAMOU, Marios	Non-Executive Director	Leeds Becket University	Visiting Professor		✓			16/01/2025	Present	This interest will be kept under review and specific actions determined as required.
ADAMOU, Marios	Non-Executive Director	Medical Professionals Tribunal Service	Tribunal Member	✓				26/02/2025	Present	This interest will be kept under review and specific actions determined as required.
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.
BROWN, Gary	Non-Executive Director	Westinghouse LLC (nuclear energy provider)	Employed as Chief Privacy Officer	✓				01/03/2025	Present	This interest will be kept under review and specific actions determined as required.
BROWN, Gary	Non-Executive Director	Westinghouse UK Holdings Limited (UK subsidiary of Westinghouse LLC - nuclear	Named Director		✓			01/03/2025	Present	This interest will be kept under review and specific actions determined as required.
BROWN, Gary	Non-Executive Director	Venturezen Limited (UK consultancy company)	Named Director		✓			01/03/2025	Present	This interest will be kept under review and specific actions determined as required.
BROWN, Gary	Non-Executive Director	Venturezen Consulting Limited (UK consultancy company)	Named Director		✓			01/03/2025	Present	This interest will be kept under review and specific actions determined as required.
BROWN, Gary	Non-Executive Director	Saralistair Limited (UK consultancy company)	Named Director	✓				01/03/2025	Present	This interest will be kept under review and specific actions determined as required.
BROWN, Gary	Non-Executive Director	Community Academies Trust (multi academy trust governing schools)	Appointed as a Non-Executive Director			✓		01/03/2025	Present	This interest will be kept under review and specific actions determined as required.
BROWN, Gary	Non-Executive Director	Triumph Learning Trust (multi academy trust governing schools)	Appointed as a Non-Executive Director			✓		01/03/2025	Present	This interest will be kept under review and specific actions determined as required.
BROWN, Gary	Non-Executive Director	Frolesworth Parochial Church Council	Appointed as a Trustee			✓		01/03/2025	Present	This interest will be kept under review and specific actions determined as required.
BROWN, Gary	Non-Executive Director	Frolesworth Parish Meeting	Appointed as Responsible Financial Officer			✓		01/03/2025	Present	This interest will be kept under review and specific actions determined as required.

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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.
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	31/12/2024	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

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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.
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.
JACKSON, Stephen	Non-Executive Director	Birmingham Women's and Children NHS Foundation Trust	Non-Executive Director	✓				01/10/2024	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Futures Housing Group	Non-Executive Director	✓				01/02/2025	Present	This interest will be kept under review and specific actions determined as required.
LALANI, Mehrunnisa	Non-Executive Director	University Hospitals of Birmingham	Non-Executive Director	✓				01/01/2025	01/04/2025	This interest will be kept under review and specific actions determined as required.
LALANI, Mehrunnisa	Non-Executive Director	British association for counselling and psychotherapy	Fitness to Practice Panel Member	✓				01/01/2025	Present	This interest will be kept under review and specific actions determined as required.
LALANI, Mehrunnisa	Non-Executive Director	Coventry University Group	EDI Strategic Lead	✓				01/01/2025	Present	This interest will be kept under review and specific actions determined as required.
LALANI, Mehrunnisa	Non-Executive Director	Post Office Scandal Research Advisory Group	Member			✓		01/01/2025	Present	This interest will be kept under review and specific actions determined as required.
LALANI, Mehrunnisa	Non-Executive Director	Sara (Leicester) LTD	Consultant	✓				01/01/2025	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 Sara (Leicester) LTD.

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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 decision-making.
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.
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.
MCGREGOR-RILEY, Dr Victoria	Acting Director of Strategy and System Development	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.

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MCGREGOR-RILEY, Dr Victoria	Acting Director of Strategy and System Development	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 should be able to participate in discussions relating to this practice but be excluded from decision-making.
MCGREGOR-RILEY, Dr Victoria	Acting Director of Strategy and System Development	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	Acting Director of Strategy and System Development	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.
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	NHS Employers	Member of the Workforce Policy Board		✓			01/07/2022	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.

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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.
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.
MCLEAN, Kathy	ICB Chair	Oxehealth Ltd (vision-based patient monitoring and management)	Advisor	✓				01/11/2024	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities)
MCLEAN, Kathy	ICB Chair	ICS Network Board, NHS Confederation	Chair	✓				01/04/2024	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.
PRATT, Marcus	Acting Executive Director of Finance	Mapperley Practice	Registered Patient			✓		01/07/2024	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

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PRINCIPE, Maria	Acting Director of Delivery and Operations	Boho Beauty	Owner	✓				01/10/2024	Present	This interest will be kept under review and specific actions determined as required.
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	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	31/12/2024	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
WADDINGHAM, Rosa	Director of Nursing	Nottingham Trent University	Honorary Professor		✓			11/11/2024	11/11/2027	This interest will be kept under review and specific actions determined as required.
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.

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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.
HUBBER, Lucy	Director of Public Health, Nottingham City Council	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
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.
MURPHY, Vicky	Local Authority Partner Member	Nottingham City Council	Corporate Director of Adults Social care, Commissioning and Health	✓				01/11/2024	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 City Council

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NAGRA, Mandy	Interim System Delivery Director	Nottinghamshire Healthcare NHS Foundation Trust	Engaged as Interim Director (from 01.10.24, three days per week focussed on Trust performance and financial improvement)	✓				01/10/2024	Present	To be excluded from all commissioning activities and decision making relating to services that are currently, or could be, provided by Nottinghamshire Healthcare NHS Foundation Trust (NHT) (this includes exclusion from ICB-led service review, procurement, and contracting activities. Involvement in other ICB-led business activities that relate to services provided by NHT, which could lead to a pereception of pre-decision making influence, will need to be carefully considered. While exclusion may not always be necessary, it will be important from a transparency perspective to be clear about any involvement and to which role it relates. To also be excluded from ICB-led provider oversight and assurance arrangements relating
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

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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
VAN DICHELE, Guy	Local Authority Partner Member - Deputy	Vantage Recruitment Agency	Non Executive Director	✓				15/04/2024	17/04/2025	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 Vantage Recruitment Agency

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
09/01/2025 09:00-12:15
Rushcliffe Arena

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
Victoria McGregor-Riley	Acting Director of Strategy and System Development
Vicky Murphy	Local Authority Partner Member
Marcus Pratt	Acting Director of Finance
Amanda Sullivan	Chief Executive
Jon Towler	Non-Executive Director
Rosa Waddingham	Director of Nursing
Melanie Williams	Local Authority Partner Member

In attendance:

Lucy Branson	Director of Corporate Affairs
Sarah Bray	Associate Director of Performance and Assurance (on behalf of Maria Principe)
Sarah Collis	Chair, Healthwatch Nottingham and Nottinghamshire (for item ICB 24 089)
Lucy Hubber	Director of Public Health, Nottingham City Council
Philippa Hunt	Chief People Officer
Daniel King	Voluntary, Community and Social Enterprise Alliance Chair
Lindsey Sutherland	Head of Programme Management Office and Programme Director for Net Zero (for item ICB 24 091)
Sabrina Taylor	Chief Executive, Healthwatch Nottingham and Nottinghamshire (for item ICB 24 089)
Sue Wass	Corporate Governance Officer (minutes)
Gemma Whysall	System Delivery Director - Urgent Care (for item ICB 24 092)

Apologies:

Mehrunnisa Lalani	Non-Executive Director
Ifti Majid	NHS Trust/Foundation Trust Partner Member
Maria Principe	Acting Director of Delivery and Operations
Paul Robinson	NHS Trust/Foundation Trust Partner Member

Cumulative Record of Members' Attendance (2024/25)

Name	Possible	Actual	Name	Possible	Actual
Kathy McLean	5	5	Vicky Murphy[5]	1	1
Marios Adamou	5	4	Stuart Poynor[1]	1	1
Dave Briggs	5	5	Marcus Pratt[2]	4	4
Lucy Dadge[3]	3	1	Maria Principe[4]	2	1
Stephen Jackson	5	5	Paul Robinson	5	1
Mehrunnisa Lalani[5]	1	0	Amanda Sullivan	5	5
Kelvin Lim	5	5	Jon Towler	5	5
Ifti Majid	5	2	Catherine Underwood[1]	1	1
Caroline Maley[3]	3	2	Rosa Waddingham	5	5
Victoria McGregor-Riley[4]	2	2	Melanie Williams	5	2

1 – Board membership ceased June 2024
2 – Board membership commenced July 2024
3 – Board membership ceased September 2024
4 – Board membership commenced October 2024
5 – Board membership commenced January 2025

Introductory items

ICB 24 081 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.

The Chair reminded members of the principles and core values that the Board should seek to uphold during the course of the meeting.

ICB 24 082 Confirmation of quoracy

The meeting was confirmed as quorate.

ICB 24 083 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 24 084 Minutes from the meeting held on: 14 November 2024

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

ICB 24 085 Action log and matters arising from the meeting held on: 14 November 2024

Seven actions were noted as open and on track for completion and all remaining actions were confirmed as completed. No other matters were raised.

Leadership and operating context

ICB 24 086 Citizen Story: Targeted Lung Health Checks

Dave Briggs presented the item and highlighted the following points:

a) The genesis and eligibility criteria of the Targeted Lung Health Checks Programme was given. Nottingham and Nottinghamshire had been an early adopter of this scheme, initially in Mansfield and Ashfield and more latterly in Nottingham City.

b) The approach of the Programme was to ensure that individuals experiencing health inequalities were actively targeted and to date the Programme had delivered 26,000 scans, detecting 264 cancers, with 65 per cent classified as early-stage cancers.

c) In addition to improved outcomes for the individuals, the Programme had been able to deliver wider benefits, such as screening for other lung conditions and increased take up of smoking cessation services. Feedback from users had been overwhelmingly positive and the Programme provided a blueprint to address other health conditions, such as hypertension and diabetes.

At this point Lucy Hubber joined the meeting

The following points were made in discussion:

d) Noting that the service model provided positive opportunities to address health inequalities, members queried whether an evaluation of wider benefits would be carried out; it was confirmed that this was currently being undertaken.

e) Discussing the opportunities to roll out the model to address other health conditions, a member noted the need for greater empirical data on the impact on health inequalities to take learning into other potential programmes. It was noted that this would be considered as part of the ongoing process to refresh the Joint Forward Plan.

f) Members queried the impact of the Programme in terms of increased activity in secondary care, and whether this was being considered as part of operational planning for future programmes. In response, it was noted that there had been an initial spike in secondary care activity, but it had not been sustained. In the longer term the approach led to earlier diagnosis and therefore less burden on secondary care services.

g) Although noting that the report had not explicitly focused on a citizen's story, it was albeit welcomed by members.

The Board **noted** the report.

ICB 24 087 Chair's Report

Kathy McLean highlighted the following points from her report:

a) Thanking all health and care staff in the system for their hard work over the Christmas period, it was noted that 2025 would bring an additional focus on how to implement the 'three shifts' in the Government's Ten-Year Plan: from treatment to prevention; hospital to community; and from analogue to digital. This would need to be considered alongside addressing the immediate challenges of yet another testing winter season.

b) The next Partners Assembly on 3 February 2025 would provide an excellent opportunity to engage with a broad range of partners to discuss both the refresh of the Integrated Care Strategy and how to take forward the Ten-Year Plan.

c) Welcoming the confirmation of new members to the Board, the formal approval of changes to committee chairing arrangements was requested and was agreed.

The Board:

- **Approved** the appointment of Committee Chairs, as set out in paragraph 19 of the paper.
- **Noted** the Chair's report for information.

ICB 24 088 Chief Executive's Report

Amanda Sullivan highlighted the following points from her report:

a) Despite significant pressure on urgent and emergency care services, the enactment of the Winter Plan meant that pathways continued to operate as planned.

b) Although it was a very challenging winter period, it was appropriate to also consider the notable progress in a number of areas that continued to be made. Recent achievements included the establishment of a live site for community pharmacy independent prescriber pathfinders, improving access to on the day consultations without the need for a GP, the launch of an all-age mental health website, and a 24-hour mental health response vehicle. Details relating to these and further achievements were set out in the paper.

c) The Board was asked to approve some minor amendments to the ICB's Standing Financial Instructions (SFIs) following their review by

the Audit and Risk Committee at its December 2024 meeting. The full SFIs with proposed tracked changes were included with the papers for the meeting.

d) An update on the work of the East Midlands Joint Committee over the past year had been provided in the report, along with a detailed briefing on the next tranche of delegated services, which related to a number of acute specialised services and mental health, learning disability and autism services.

e) A listening exercise had been launched in November 2024 to seek views on the development of a new Fertility Policy, which would standardise the offer across the East Midlands footprint.

At this point Vicky Murphy joined the meeting

f) The spring Covid Vaccination Programme would commence on 1 April 2025. Locally the approach would be to continue to support increased uptake by using temporary sites within communities, mobile units, and dedicated support to care homes.

g) Mention was made of recent leadership appointments, including Vivienne Robbins, who had been confirmed as Director of Public Health for Nottinghamshire County Council; and Dr Nanthakumar, who had taken over as Clinical Director for Bassetlaw Place Based Partnership.

h) As expected with an incoming Government, there currently was a highly active national policy environment and attention was drawn to recent policy papers on English devolution and plans to transform adult social care.

The following points were made in discussion:

i) Members acknowledged the achievements set out within the paper.

j) As Chair of the Audit and Risk Committee, Stephen Jackson confirmed that the Committee had endorsed the proposed changes to the SFIs and had recommended these to the Board for approval.

k) In response to a query regarding vaccination rates within the local population and for ICB staff, it was noted that rates were broadly commensurable with previous years; however, following a slight drop in younger and at-risk cohort take up, they would be a focus for the 2025 campaign. It was noted that only front line ICB staff were eligible for vaccinations.

l) Discussing the Government’s plans to transform social care, members agreed that a dedicated session to explore greater

collaborative opportunities with Local Authorities would be welcome, on the assumption that very little new funding would be available in the immediate future.

m) With regard to the listening exercise for fertility policies, it was queried whether there was a risk that current policies were not aligned. It was agreed that this was an issue currently; however, it was important to ensure the new policy was both mindful of guidance from the National Institute for Health and Care Excellence, considered the changing nature of families, and was consistently applied across a larger geographical area to avoid a 'postcode lottery' for families.

The Board:

- **Approved** the Standing Financial Instructions.
- **Noted** the Chief Executive's Report for information.

Action: Lucy Branson to schedule a Board session focussed on integration of health and social care as part of the Annual Work Programme for 2025/26.

Strategy and partnerships

ICB 24 089 Healthwatch Report: Understanding local people's experiences of health and social care in Nottingham and Nottinghamshire

The Chair welcomed Sarah Collis and Sabrina Taylor, who were in attendance to present their report, confirming that Healthwatch were seen by the ICB as both valued partners and 'critical friends' and their insights were very much valued.

Sabrina Taylor and Sarah Collis presented the item, and highlighted the following points:

a) The report provided an overview of the key issues impacting on the local population. The most common issues raised with Healthwatch related to complaints procedures, mental health services, and access to GP services, community pharmacies and dentistry. The report provided more detail on the concerns raised by citizens and recommended possible next steps.

b) It was acknowledged that many of the key concerns were long standing national issues, nevertheless, it was important that citizens' voices continued to be heard to prevent the issues being 'normalised'. For example, a drop in the number of complaints about

access to NHS dentistry services could be indicative of disillusionment that the service was not improving.

c) It was also important that a robust feedback loop with the ICB continued to be maintained to enable the public to understand that the ICB was responding to their concerns and what specific actions were being taken.

d) Sarah Collis advised members that Sabrina Taylor had now been confirmed in post as Chief Executive, following her period of operating in an interim capacity. Healthwatch Nottingham and Nottinghamshire had also recently been awarded a new three-year contract.

The following points were made in discussion:

e) Discussing complaints handling, members expressed concern that only a third of patients felt confident to submit a complaint and queried how the ICB could address this. It was agreed that this would be explored further by the Quality and People Committee. A suggestion was also made that it could form a future citizen story for the Board, which was welcomed.

f) It was noted that although it was early days, the ICB had invested additional funding into dentistry services and was exploring options to incentivise take up of NHS patients.

g) Although considerable work had been undertaken to improve access to GP services, it was acknowledged that the ICB had not solved this issue if the experiences of patients was not improving.

h) Members were advised that the issue in the report relating to the transfer of services from Primary Integrated Community Service (PICS) had been actioned by Nottinghamshire Healthcare NHS Foundation Trust, rather than the ICB; however, the ICB was actively monitoring the situation.

i) The Board welcomed the report, emphasising the importance of being able to hear the voices of citizens in ICB strategies. It was important to maintain and build on relationships with Healthwatch Nottingham and Nottinghamshire to ensure that work to address the issues raised in the report was being communicated.

The Board **noted** the report.

Action: Rosa Waddingham to present a report on the actions being taken to improve complaints procedures to an upcoming meeting of

the Quality and People Committee; to be complemented by a citizen story for a future Board meeting.

At this point Sabrina Taylor and Sarah Collis left the meeting

ICB 24 090 Integrated Care Strategy for Nottingham and Nottinghamshire 2023-2027: March 2025 review and refresh

Victoria McGregor-Riley presented the paper, highlighting the following points:

a) At its October 2024 meeting, the Nottingham and Nottinghamshire Integrated Care Partnership agreed to commence a light touch review of the Integrated Care Strategy for consideration at its 28 March 2025 meeting. This would be presented to the Board for endorsement at its 13 March 2025 meeting.

b) The NHS Joint Forward Plan was also required to be refreshed. However, following the Government's announcement regarding its Ten-Year Health Plan and delays to NHS England Planning Guidance it was proposed to delay its annual refresh and defer approval to a Board meeting post March 2025. This would enable the Joint Forward Plan to be fully consistent with the new policy direction.

The following points were made in discussion:

c) Members were supportive of the proposal if it was within the ICB's gift to delay the publication of the refreshed Joint Forward Plan.

The Board **noted** the report and supported the proposed delay in the annual refresh of the NHS Joint Forward Plan, pending the publication of national operational and planning guidance and the Ten-Year Health Plan.

At this point Lindsey Sutherland joined the meeting.

Delivery and system oversight

ICB 24 091 Integrated Care System Green Plan Progress Report

The Chair introduced the item by noting its link to the ICB's strategic risk relating to a sustainable infrastructure and the net zero commitment, as detailed within the Board Assurance Framework.

Lindsey Sutherland went on to present the paper, highlighting the following points:

a) The report provided an update on the delivery of the Nottingham and Nottinghamshire Integrated Care System (ICS) Green Plan.

b) Since the last update to the Board good progress continued to be made on the system-wide approach. The report provided an overview of delivery to date and performance measures.

c) Nottingham and Nottinghamshire ICS was an exemplar for the way that it had secured clinical capacity to focus on sustainability and much progress had been made against a range of measures. However, there were areas, particularly within the adaptation chapter, that were proving somewhat intractable, and consideration was being given to an NHS local system-wide plan, as all NHS providers were struggling to address the actions within this Chapter. This would also be taken into the refreshed Green Plan for 2025-2028, which was being progressed.

d) The challenge for the future was to stop treating the Green Plan as a separate and discrete area of work and bring it more into everyday decision making.

The following points were made in discussion:

e) Members were reminded that progress against the plan was overseen and scrutinised in detail by the Finance and Performance Committee, and members of the Committee noted the need to harness the financial opportunities presented by taking a net zero approach.

f) Members noted the good progress that had been made from a regulatory perspective, nevertheless it was emphasised that there was much more that could be achieved and questioned whether the challenge was one of system engagement and leadership. It was confirmed that a whole-system approach was being taken; however, a closer connection to the Integrated Care Partnership (ICP) was being explored due to links with the Integrated Care System's fourth aim to support broader social and economic development. A report on this was due to be presented to the ICP in March.

g) The role of GP practices and wider primary care providers in the delivery of the Green Plan was queried. It was noted that their contribution mainly related to estates and medicines optimisation.

h) Members queried what more the Board could do to support this area of work, and it was noted that a webinar training module to gain a basic level of carbon literacy could be undertaken.

i) A discussion ensued regarding how best to bring the net zero considerations into 'business as usual' decision making. A suggestion of adding it to the ICB's Equality and Quality Impact Assessments was made.

j) It was agreed to further explore the points raised through the Board's discussion in the next scheduled update on the Green Plan to the Finance and Performance Committee.

The Board **noted** the report.

Action: Marcus Pratt to ensure that responses to the points raised regarding system leadership, carbon literacy training, and integrating net zero considerations into 'business as usual' processes are included in the next scheduled Green Plan update to the Finance and Performance Committee.

At this point Lindsey Sutherland left the meeting, and Gemma Whysall joined the meeting.

ICB 24 092 Emergency Preparedness, Resilience and Response Annual Report

Gemma Whysall presented the item and highlighted the following points:

a) The report provided assurance to the Board on the ICB's Emergency Preparedness, Resilience and Response (EPRR) activities undertaken to ensure that the organisation was adequately prepared to respond to any major business continuity incidents.

b) The annual self-assessment with NHS England on compliance with core standards had rated the ICB as partially compliant. All areas of partial compliance had an action plan to ensure full compliance in next year's review. Progress against the action plan would continue to be overseen and scrutinised by the Audit and Risk Committee on behalf of the Board.

c) The overall assessment for the NHS local system was one of substantial compliance, with several areas of good practice highlighted by NHS England.

d) Key activities over the coming months were noted as training exercises designed to test and develop the ICB's plans and procedures, with a focus on high-risk areas, such as cyber security.

The following points were made in discussion:

e) Discussing the potential risk to services of a cyber-attack, members sought assurance that the ICB was managing the risk effectively. It was noted that the risk was being managed though the ICB's risk management procedures; mitigations included the Board approved system-wide Cyber Security Strategy and the role of the EPRR Team to ensure business continuity in the event of a cyber-attack. Actions were contained within the Incident Response Plan, which had been refreshed and exercised to ensure it continued to be current.

f) In response to a query as to whether the ICB was an outlier in its compliance rating, it was noted that it was not and that most systems had been asked to review their arrangements for business continuity planning.

g) As co-chair of the Local Health Resilience Partnership, Lucy Hubber asked the Board to note the ICB's strong and effective leadership within the local EPRR system.

The Board **noted** the report.

At this point Gemma Whysall left the meeting.

ICB 24 093 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 that were currently off track.

b) A high level of oversight continued to be maintained as Nottinghamshire Healthcare NHS Foundation Trust continued to progress a comprehensive and complex programme of improvement work to address identified quality and safety concerns. The Trust's implementation of the 'Safe Now' approach was seen as best practice for oversight arrangements. There would be significant focus on the findings of the Independent Homicide Review into the unlawful killings of Ian Coates, Barnaby Webber, and Grace O'Malley-Kumar, which was likely to be released by the end of the calendar month. Considerable progress had been made at Rampton Hospital, which was now compliant with High Secure Directions.

c) A stocktake of improvements made over the last five years was being developed at Nottingham University Hospitals NHS Trust (NUH) in anticipation that National Oversight Framework arrangements would move to focus solely on the organisation's financial challenges.

d) Positive quality and patient safety improvement had been evidenced on the urgent and emergency care pathway, with the use of dynamic risk assessments.

e) Strong partnership working with Local Authorities continued to address several issues within children's services.

The following points were made in discussion:

f) Members discussed arrangements for triangulation of intelligence to identify early warning signs of quality concerns, and it was stressed that learning from past situations was required to secure the right pace and momentum for change across the system.

g) As Chair of the Quality and Performance Committee, Marios Adamou noted that limited assurance continued to be taken regarding the quality of a range of services. Whilst there was a good level of assurance on actions being taken to improve the quality of services, without long term transformation and prevention activities it was difficult to see how sustained improvements could be made.

The Board **noted** the report.

ICB 24 094 Service Delivery Report and Winter Plan

Sarah Bray 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) Urgent care performance remained a significant challenge, with the system achieving 62 per cent for four-hour accident and emergency waits in November 2024, which was below the target of 74.3 per cent. There had been a marked increase in non-elective admissions during October 2024. However, during October and November, ambulance handover performance had showed an improvement and discharge rates remained positive.

c) Significant progress had been made in reducing planned care long waiting times, with a decrease in 65-week wait volumes. However, achieving the goal of zero 65-week waits remained challenging.

d) Cancer care metrics continued to show notable improvement and overall diagnostic backlogs had reduced significantly.

e) The position on mental health out of area placements continued to improve, with the expectation that there would be zero patients by month end.

f) Elimination of 52-week waiters for community services was forecast by the end of December 2024.

The following points were made in discussion:

g) Asking members to keep in mind the unavoidable lag in performance reporting, which meant that this report did not necessarily reflect the current position, the Chair noted worrying trends on several metrics, including the accident and emergency department four hour waiting target and the percentage of GP appointments booked within two weeks. A point of accuracy was also raised relating to paragraph 22 of the report and it was confirmed that this should read

h) There was a query as to whether the issues regarding mental health services at Nottinghamshire Healthcare NHS Foundation Trust were impacting on their delivery of community services. It was noted that the issue regarding long community waiting times was specific to speech and language services, which needed to be set against a significant increase in referrals, which was a national trend. The Trust was fully engaged, and the Nottingham and Nottinghamshire Special Needs and Disabilities Oversight Boards also had a focus on this issue.

i) Members discussed the use of virtual wards and whether they were being used most effectively and to capacity. It was noted that in practice the use of virtual wards in some specialities had not had the desired impact and had been stood down. It was anticipated that virtual ward technology would now focus on frailty and respiratory pathways to reduce length of stay metrics. It was agreed that a report on this issue should be taken to the Finance and Performance Committee for review.

The Board **noted** the report.

Action: Maria Principe to present a review of virtual ward usage and capacity to an upcoming meeting of the Finance and Performance Committee.

ICB 24 095 Finance Report

Marcus Pratt presented the item and highlighted the following points:

a) At month eight, the NHS system was £17.3 million adverse to plan but remained on forecast to deliver a break-even position. The primary reason was the impact of the phasing of non-recurrent

income. Other drivers of the deficit were the consultant pay award and a shortfall of industrial action income. The system's efficiency plan was ahead of trajectory and remained on forecast to meet the target.

b) The ICB was reporting a £1.3 million deficit, driven in the main by NHS England's re-affirmation that any underspend arising against dental expenditure budgets should be ring-fenced. However, the overall forecast remained as a break-even position and the efficiency plan remained on forecast.

c) A considerable level of risk remained in the plan, particularly around the delivery of the required efficiency targets, as efficiencies were profiled to deliver materially more in the later part of the financial year. Tighter grip and control measures and governance arrangements remained in place to support delivery, but several technical non-recurrent actions may need to be implemented to meet the financial targets.

d) Cash flow was an increasing risk for the NHS system, particularly for NUH, which had implications for the 2025/26 financial year and for the achievement of Better Payment Practice Code targets.

The following points were made in discussion:

e) Summarising discussions held at an informal catch up of Finance and Performance Committee members in early January 2025, Jon Towler, interim Chair of the Committee, asked the Board to note that using non-recurrent solutions to meet the 2024/25 target would potentially impact on the level of funding available during 2025/26, and the Committee's members had queried whether tactically, this would be the best use of resources. In response, it was agreed that there would be very little tolerance at the national level if the ICB failed to meet its 2024/25 financial target.

f) Members queried how the ICB ensured that financial restraints did not impact on the quality of care. In response, it was noted that the efficiency programmes concentrated on taking waste and inefficiency out of processes and driving productivity up.

g) There was further discussion on how to ensure sustained financial recovery. It was noted that although this year had seen the implementation of robust governance systems and processes and improving 'grip and control' mechanisms, the next financial year would necessitate a focus on service transformation and reviews of services that offered limited clinical value.

The Board **noted** the report.

Governance

ICB 24 096 Freedom to Speak Up Report

Rosa Waddingham presented the item and highlighted the following points:

a) The report outlined the current status of Freedom to Speak Up (FTSU) arrangements within the ICB, highlighting progress to date with the implementation of national requirements.

b) In June 2022, NHS England and the National Guardians Office published an updated FTSU guide and improvement tool to support organisations with delivering a speaking-up culture for their workers.

c) The ICB's FTSU Policy had been updated and a FTSU Guardian had been appointed. Independent support for the arrangements was also available via a Board appointed Non-Executive Director, which enabled an objective perspective to be provided on arrangements.

d) ICBs also had a wider system leadership role to ensure that robust FTSU arrangements were in place among partners. All local NHS trusts had adopted the national guidelines; and the ICB had established a FTSU offer for General Practice. Further work would be undertaken on this model to ensure its fitness for purpose and expansion across the other primary care groups.

e) Next steps were noted as transferring senior leadership responsibility for FTSU to the ICB's Director of Corporate Affairs and to progress a FTSU improvement plan, to be overseen by the Audit and Risk Committee.

The following points were made in discussion:

f) Noting the seven cases dealt with by the ICB's FTSU Guardian to date, Board members sought assurance that appropriate actions and learning had been taken. It was confirmed that all cases had been taken forward appropriately; however, due to the small number of cases, with some still ongoing, it was difficult to draw any particular conclusions. It was noted that some assurance could be taken from the fact that none of the issues raised had been done so anonymously and the focus of the Executive Team on embedding values and expected behaviours was welcomed. Members were also advised that there was a system forum to discuss broader learning and themes from FTSU cases.

g) Members emphasised the need to respond to staff in a timely manner whatever route they chose to raise their concerns, and this was acknowledged.

The Board **noted** the report.

ICB 24 097 Committee Highlight Reports

The report presented an overview of the work of the Board's committees since its last meeting in November 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 report also provided a summary of the high-level operational risks being oversighted by the committees.

The Chair noted that updates from Committee Chairs had already been provided during related discussions under agenda items ICB 24 093, ICB 24 094 and ICB 24 095. Further updates from the Committee Chairs were invited by exception and no other points were highlighted.

The Board **noted** the reports.

Information items

ICB 24 098 ICB Standing Financial Instructions

This item was received for information.

ICB 24 099 2024/25 Board Work Programme

This item was received for information.

Closing items

ICB 24 100 Risks identified during the course of the meeting

No new risks were highlighted.

ICB 24 101 Questions from the public relating to items on the agenda

No questions had been received.

ICB 24 102 Any other business

There was no other business, and the meeting was closed.

Date and time of next Board meeting held in public: 13 March 2025 at 9:00 (Rushcliffe Arena)

NHS
Nottingham and Nottinghamshire

ACTION LOG from the Integrated Care Board meeting held on 09/01/2025

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
Closed – Action completed	12.09.2024	ICB 24 048: Chief Executive's Report	To present an update on current arrangements for preventative care to the Strategic Planning and Integration Committee, alongside an options appraisal for scaling up arrangements. The output of this work to then be incorporated into the annual refresh of the Joint Forward Plan.	Dave Briggs	06.02.2025	Paper on prevention presented to the Strategic Planning and Integration Committee at its 6 February 2025 meeting. See agenda item 10 for Joint Forward Plan refresh.
Closed – Action completed	12.09.2024	ICB 24 050: ICS People Plan	To present an updated ICS People Plan to the January 2025 meeting of the Quality and People Committee and subsequently to the Board for approval in March 2025	Rosa Waddingham	13.03.2025	On this agenda at item 9.
Open – On track	14.11.2024	ICB 24 064: Experience of autistic people and citizens with a learning disability	To provide the Board with an update on the impact of the Oliver McGowan training to the May 2025 meeting.	Rosa Waddingham	14.05.2025	Not yet due – scheduled for presentation at the 14 May meeting of the Board.

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
Open – On track	14.11.2024	ICB 24 071: Quality Report	To schedule a Board seminar early in 2025/26 focused on the community transformation programme and development of integrated neighbourhood teams.	Lucy Branson	31.03.2025	Not yet due – to be added to the Board's work programme for 2025/26.
Open – On track	14.11.2024	ICB 24 073: Finance Report	To schedule a Board seminar early in 2025/26 focused on the system's ambition to work differently with VCSE partners through Place-Based Partnerships.	Lucy Branson	31.03.2025	Not yet due – to be added to the Board's work programme for 2025/26.
Closed – Action completed	14.11.2024	ICB 24 074: Board Assurance Framework – Biannual Update	To review the scope of strategic risk eight, relating to infrastructure, to incorporate the need to maximise the opportunities of system working.	Lucy Branson / Marcus Pratt	12.02.2025	Reported to the Audit and Risk Committee at its 12 February 2025 meeting.
Open – On track	14.11.2024	ICB 24 075: Committee Highlight Reports	To include the actions taken by the ICB following the adoption of the Race Health Inequalities Maturity Matrix within the Annual Equality Diversity and Inclusion Report for 2024/25.	Rosa Waddingham	14.05.2025	Not yet due – scheduled for presentation at the 14 May meeting of the Board, following initial review by the Quality and People Committee.
Open – On track	09.01.2025	ICB 24 088:	To schedule a Board session focussed on integration of health and social care as part of the	Lucy Branson	31.03.2025	Not yet due – to be added to the Board's

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
		Chief Executive's Report	Annual Work Programme for 2025/26			work programme for 2025/26.
Open – On track	09.01.2025	ICB 24 089: Healthwatch Report	To present a report on the actions being taken to improve complaints procedures to an upcoming meeting of the Quality and People Committee; to be complemented by a citizen story for a future Board meeting.	Rosa Waddingham	31.03.2025	Not yet due – to be added to the Quality and People Committee's work programme for 2025/26.
Open – On track	09.01.2025	ICB 24 091: Integrated Care System Green Plan Progress Report	To ensure that responses to the points raised regarding system leadership, carbon literacy training, and integrating net zero considerations into 'business as usual' processes are included in the next scheduled Green Plan update to the Finance and Performance Committee.	Marcus Pratt	31.03.2025	Not yet due – to be added to the Finance and Performance Committee's work programme for 2025/26.
Closed – Action completed	09.01.2025	ICB 24 094: Service Delivery Report	To present a review of virtual ward usage and capacity to an upcoming meeting of the Finance and Performance Committee.	Maria Principe	31.03.2025	Review of virtual ward usage and capacity reported to the Strategic Planning and Integration Committee at its 6 March 2025 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)

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/03/2025
Paper Title:	**Citizen Story: Best Years Hubs**
Paper Reference:	ICB 24 108
Report Author:	Willem-Lewis Henderson, Transformation Officer Alison Pipes, Transformation Officer
Executive Lead:	Maria Principe Acting Director of Delivery and Operations
Presenter:	Maria Principe Acting Director of Delivery and Operations

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

Summary:

The Best Years Hubs is a new pilot Ageing Well service, launched in June 2024, for residents of Newark and Sherwood. The service has been initially funded through a successful bid to the ICB's Health Inequalities Investment Fund (HIIF). The bid was led by the Mid-Nottinghamshire Place Based Partnership, as the service aligns with the place-based approach by addressing frailty, social isolation and access to health services in a community setting to ensure that healthcare is more accessible, patient-centred and preventative.

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. Volunteers will also help increase Advanced Care Planning so that every patient has a chance to discuss what matters to them.

This paper presents a citizen's story, which brings to life the work of the Best Years Hubs and sets out the background to what the Best Years Hubs are, and the activities used to support the ageing population in Mid-Nottinghamshire.

Recommendation(s):

The Board is asked to **discuss** this item.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	The Best Year Hubs support the ICB's Ageing Well and Frailty agendas by providing those aged 65 and over, living with a long-term condition, to access a range of support in the place where they live. The Best Years Hubs align with the Integrated Care Strategy by supporting frail older people with underlying conditions to maintain their independence and health; making every contact count and signposting to relevant services, alongside a focus on prevention with health management talks and Advanced Care Planning.
Tackle inequalities in outcomes, experience and access	By working with communities and tailoring the offer to them, Best Years Hubs are able to address health inequalities in the population through working with Place

How does this paper support	the ICB's core aims to:
	Based Partners and local voluntary, community and social enterprise (VSCE) organisations
Enhance productivity and value for money	The relationship between health and loneliness is well documented and the impact is similar to that of smoking and obesity. The Best Years Hubs are designed to reduce social isolation, thus reducing the impact on primary and secondary care services. In particular, the Hubs are designed to support local social prescribing teams with their less complex caseload.
Help the NHS support broader social and economic development	By working in partnership with VCSE partners, these organisations are being supported to be sustainable and empowered to support their communities.

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.

Citizen Story: Best Years Hubs

Mavis' story

1. Mavis and her husband's journey with Best Years began through a targeted approach to reaching those most in need within identified priority places for frailty and isolation. As an older adult caring for a spouse with dementia, Mavis was at high risk of isolation and frailty, struggling to navigate available support.
2. Research from Nottingham Trent University and Age UK highlighted that many individuals like Mavis, particularly those in Newark and Sherwood, experience loneliness at levels comparable to serious health risks, such as smoking and obesity. Recognising this, the Best Years Hubs proactively seek out those in similar situations through referrals from health professionals, community outreach and word-of-mouth recommendations or self-referral.
3. A friend who was already attending the Clipstone Hub encouraged Mavis to reach out and she was soon introduced to one of the Best Years Liaison Officers, Tracey, who conducted a home visit assessment. Tracey took time to listen to their situation with care to help identify the support they needed. Trust played a key role in Mavis' decision to engage, as she was reassured that Best Years was a service designed around real patient voice. This targeted but also relationship-based approach gave Mavis the confidence to begin attending the Clipstone Best Years Hub weekly.
4. As the primary carer for her husband, who has dementia, Mavis often felt overwhelmed and profoundly isolated. Her ability to get out of the house had been severely limited since her husband had to stop driving, leaving her dependent on others for any outings. With no social engagements of her own and the constant responsibility of caregiving, Mavis felt trapped in her home, with little opportunity to relax or engage with others. She found it difficult to navigate the support systems available to them and felt that other services were often too busy to provide real help. Best Years arranged a volunteer driver, Anna, who now provides transport for Mavis each week to the Hub. "Anna has done so much for me" Mavis shared, reflecting on how Anna has made it possible for her to attend the Hub regularly.

5. Before attending Best Years, Mavis' world had become incredible small. She rarely left the house and each day felt repetitive and isolating. She worried about leaving her husband alone, which meant that any personal time was non-existent. At the same time, her husband had no real outlet for social interaction either. Without support, both were becoming increasingly cut off from the outside world.
6. Now, the weekly friendship group has given them both a renewed sense of purpose and connection. "I look forward to it every week" Mavis said. The Hub has become a place where she has formed friendships, found support and has a space to take a break from her caregiving role. She particularly appreciates that the Hub offers a welcoming space for men as well as women, which allows her husband to engage socially while she enjoys time for herself. "I think my husband loves it too, in his own way" she added.
7. Beyond the weekly gatherings, Best Years has supported Mavis in multiple ways, improving both her social and physical well-being. She now has access to community transport, a volunteer befriender who checks in on her weekly and a network of people she can rely on. Mavis has also been offered support with accessing digital services, including the NHS App. She has learned valuable information about keeping her home warm in winter and has received guidance on financial benefits she had not previously known she was entitled to. The Best Years team has provided answers to the small but important health and wellbeing questions which had once left her feeling uncertain. "I know if I need help with anything, they will be there" she affirmed.
8. One of Mavis' favourite aspects of the Hub is sharing a bite to eat and a cup of tea with her friends, which not only gives her companionship but also takes away some of the daily burden of meal preparation. She enjoys the weekly bingo and the varying activities that bring everyone together, fostering a sense of engagement and participation. When food is provided at the Hub, it relieves some of the pressure of preparing meals at home, giving her a welcome respite from daily responsibilities. The seated exercise sessions have helped her maintain mobility and prevent frailty, supporting her physical health as well as her social wellbeing. She has also enjoyed special outings, including two coach trips organised by Best Years staff and a summer event where the seaside was brought to them. These experiences have brightened her life, offering moments of happiness and relaxation. "Even my family have noticed a difference in me" she said.
9. For Mavis, Best Years has been more than just a community group, it has been a lifeline. The combination of the practical support, social connection and emotional reassurance has transformed her outlook. The variety of activities ensures that she benefits holistically, from emotional support to improved mobility and even better access to essential services. "Everyone is so lovely and helpful" she said. Best Years has given her something to anticipate each

week, a newfound confidence and a network of people who truly care. In her words “the Community and Voluntary Service really care” and that care has made all the difference in her life.

Background to the Best Years Hubs

10. The Best Years Hubs is a new pilot Ageing Well service, launched in June 2024 for residents of Newark and Sherwood. The service has been initially funded through a successful bid to the Health Inequalities Investment Fund (HIIF). The bid was led by the Mid-Nottinghamshire Place Based Partnership as the service aligns with the place-based approach by addressing frailty, social isolation and access to health services in a community setting to ensure that healthcare is more accessible, patient-centred and preventative. The Hubs are delivered by Newark and Sherwood Community and Voluntary Service and are supported by an integrated team of professionals and volunteers working across health, social care, local authority, community, and voluntary sectors to create a joined-up system of care tailored to local needs.
11. The ethos of the Hubs is “Everyone should be able to enjoy the ‘best years’ of their life and be in control of their future and have access to the right types of help when and where they need it”.
12. Activities and services at Best Years Hub:
    a) **Digital Support for NHS App** – Helping patients manage appointments, prescriptions, and GP health records, to reduce administrative strain on General Practice and encourage self-care.
    b) **Completing Advanced Care Plans** – Support to ensure future care preferences are documented, reducing uninformed crisis decisions and unplanned GP visits.
    c) **Strength, balance and falls prevention activities** – Improving mobility and hand to eye coordination. Mostly delivered by commissioned services to increase course uptake.
    d) **Referral pathway for Social Prescribing Link Workers** – Provides a dedicated service for low complexity patients, reducing caseloads.
    e) **Targeted educational videos for older adults with long-term conditions** – Covering topics such as living with dementia, hydration, continence and Advanced Care Plans to promote self-care and reduce unnecessary healthcare appointments.
    f) **Friendship groups providing a physical hub** – Reducing loneliness and isolation, improving mental health to reduce GP visits from loneliness related concerns. Groups also include day trips to the seaside, garden centres and community health events.

g) **Volunteer listening line (launched early 2025)** – Provides befriending and emotional support over the telephone to reduce GP demand from loneliness related concerns.

h) **Volunteer befrienders for home visits** – Offers companionship and welfare checks, helping to identify early signs of declining health and reduce loneliness and isolation.

i) **Health messages from professionals** – Provides preventative education on key health topics, reducing avoidable GP and hospital visits.

13. Future opportunities being explored:

a) **Community based Clinical Frailty Score assessments** – Supports early identification of frailty, enabling proactive interventions to prevent hospital admissions.

b) **Increasing onward referrals** – Connecting high-risk patients to multidisciplinary teams to ensure timely and coordinated care.

c) **Partnerships with community pharmacies** – Supporting safe medication use through pharmacist-led health messages and medicine disposal information.

14. The Hubs also benefit from the volunteer Door-to-Door community transport scheme, which offers free transport to and from the Hubs from resident's home.

15. Starting off in June 2024, with two Hubs, one in Hawtonville (Newark), and one in Clipstone, there are now Hubs in Collingham, Southwell, Blidworth, Farnsfield, Farndon, Gladstone House in Newark and Ashfield Health and Wellbeing Village, with plans underway to expand the service across the Mid-Nottinghamshire footprint. Case studies are available and a video of the work of the Best Years Hub can be found at: https://healthandcarenotts.co.uk/best-years-hub.

16. Progress made in the first six months of the Best Years Hubs can be found at: Best Years The First 6 Months.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/03/2025
Paper Title:	**Chair's Report**
Paper Reference:	ICB 24 109
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.
- **Endorse** the proposed changes to the ICB's Constitution (as provided at item 16 on the agenda), for onward submission to NHS England for formal approval.

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.

Report Previously Received By:

Not applicable.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Chair’s Report

Introduction

1. It was with great shock and sadness that we heard the news that Paul Robinson, Partner Member of our Board and Chief Executive of Sherwood Forest Hospitals NHS Foundation Trust, died on Monday 17 February, following a year-long battle with severe illness. Paul worked in the NHS for more than 30 years and was a highly respected and well-liked colleague, and his contributions to our Board and the wider system were invaluable. He will be greatly missed and our thoughts are with his family at this sad time. As further details of how the Trust will be planning to remember Paul become available, I will pass them on to colleagues.
2. Since our last Board meeting there have also been a number of high-profile developments within our NHS family that I would like to address.
3. The publication in early February by NHS England of the Independent Mental Health Homicide report into the events of June 2023 gives Nottinghamshire Healthcare NHS Foundation Trust (NHT), the ICB and NHS England, as well as wider partners much to respond to and reflect upon. It is right that all organisations have accepted the findings in full and have already published an action plan to address the failings identified – further details on this are included within the Chief Executive’s Report to this meeting. For the ICB we will need to continue with our work to support and challenge the Trust to deliver on the improvements needed and also make sure our work to embed the oversight and monitoring of mental health services continues to progress. As always, our thoughts remain with the families of Grace, Barnaby and Ian and also with those injured in the attacks: Wayne, Sharon and Marcion.
4. Last month, there were also further developments regarding the Independent Maternity Review of services provided by Nottingham University Hospitals NHS Trust, led by Donna Ockenden. The only and final report from Donna’s work will now be published in June 2026 rather than September this year. I am reassured that Donna’s team have been in regular contact with the Trust’s Chief Executive and wider team throughout the review process, and recommendations from her findings are being implemented as they arise rather than waiting for the final report – again, further details on this are included within the Chief Executive’s Report to this meeting.
5. Also, since our last meeting NHS England published the 2025/26 Priorities and Operational Planning Guidance. Board colleagues have already benefited from our development session in February on our emerging plans for next year and this detailed information is being worked through by ICB and NHS Trust colleagues in a highly collaborative manner.

6. As I write this update some bright spring sunshine is on display and we can hopefully look forward to the longer days and warmer weather. This also prompts me to reiterate my thanks, and those of the Board, for the excellent collaborative and innovative work displayed across the health and care system throughout winter. Whilst we have encountered some challenges it is clear that our planning and preparation to support flow through and out of the hospitals has paid dividends. I know that planning is already underway for next winter but it is important to recognise the not inconsiderable effort delivered by teams throughout this recent period.

Developing our system

7. I very much enjoyed spending time with over two dozen local GPs at a celebration event for the Phoenix Fellowship Programme recently. The Fellowships support GPs to gain management and leadership skills, build professional connections and understand more about the wider health and social care system. This can open up career opportunities, with some GP fellows becoming involved in local and national leadership roles. It was fascinating to hear about some of the work the fellows have been doing on the programme. The projects they are working on really demonstrate our Integrated Care System principles of prevention, equity and integration. Not only is the programme benefiting those GPs taking part, but it is also demonstrating a positive impact on our local communities. I am looking forward to seeing these projects embedded and spread.

8. The National Rehabilitation Centre, which we are privileged to have in our area, is shortly due to open and so I was very pleased to be able to pay a visit towards the end of February. The facilities on offer at the Centre really are extraordinary and we are lucky to be at the forefront of this joint working with the military facility already in place and also in partnership with academic research.

9. I was delighted to be at the latest meeting of our Integrated Care System's Partners Assembly in February. The event was a huge success, bringing together over 150 people from organisations across our health and care system, giving them opportunities to network, collaborate on ideas and deliver inspirational stories and case studies. The key focus of the event was the Government's emerging Ten-Year Plan for Health, including the proposals to deliver on three key shifts, which are hospital to community services, analogue to digital and treatment to prevention. It was excellent to see several ICB Board members at the event interacting with community representatives and other partners.

10. The Assembly was one of the ways that we took the time to listen to our population and develop a submission into the Government's 'Change NHS'

consultation. Alongside this event, the ICB's Engagement Team also made sure to draw on existing insights and data developed over recent years from within the system. This was further supplemented by bespoke events with elected members, the voluntary, community and social enterprise sector, foundation trust governors, and non-executive directors. The resulting report, which has been submitted into the national process, provides a good level of support for the Government's plan and also some areas where our population and stakeholders think some additional elements need to be considered. I want to record my thanks to the team in the ICB who lead on coordinating this work, the report is really comprehensive and shows widespread engagement across our system.

11. Alongside this wider system engagement, I have made sure to remain connected with the ICB's staff, including through joining the monthly online all-staff briefing session in February. It was great to be able to say thank you to staff for their hard work over the winter period and in the run-up to year-end. I was also able to share my perspective on the emerging national policy landscape linked to the Ten-Year Plan for Health and the NHS Planning Framework.

12. I also took the time to write for the HSJ (Health and Social Care Journal) on this topic (https://www.hsj.co.uk/policy-and-regulation/trust-and-icb-leaders-must-resist-the-temptation-to-blame-others-for-the-nhss-woes/7038657.article). In particular I would call the Board's attention to these passages: "We know we cannot just continue to cut services, right-size our budgets and cut our waiting lists. We also need to reform the system so that it is more sustainable and works better for our communities" and also, "Crucially, when placed under serious financial and operational strain, leaders within providers and ICBs must fight the instinct to look for others to blame and instead work together to find shared solutions. The system that has developed over the last few years may be pushed to its limits". Our own prioritisation of some important transformational projects and also our strong foundation for joint system working stands us in good stead for this challenge, but it will not be easy.

Looking forward

13. As referenced above, we now have the Planning Guidance, and with the emerging themes from the Government's Ten-Year Plan for Health starting to come into focus, we now need to make sure that the NHS Joint Forward Plan is in good shape to start the year, but also agile enough to react when the Ten-Year Plan is published. I am pleased that this is set out so clearly later on for this meeting – the cross-NHS working to develop the Joint Forward Plan will set us in good stead for the year ahead.

14. My own participation in the 'Accountability and Oversight' working group for the Ten-Year Plan tells me that this will be an important document for the future of our health and care services, nationally and locally, and as soon as we have more details, I will ensure that the Board has sufficient time to discuss this in depth.

15. Similarly, the ICB will be a key part of the discussions later on in March at the Integrated Care Partnership (ICP). Alongside the City and County Council the joint work to refresh our Integrated Care Strategy will be presented to the Partnership for discussion with wider colleagues. Our Strategy is well developed and well supported, including through discussions at our last Board meeting and at the Assembly last month – but this year really must be a year of delivery on our transformational priorities. The refreshed strategy will be shared with Board members, once approved.

19. Finally, I have continued to maintain connections with Claire Ward, Mayor of the East Midlands and look forward to seeing her and her team again early next month. ICB colleagues have been working with Combined County Authority (CCA) colleagues on a number of joint areas of work including the link between employment and health and also the CCA's Inclusive Growth Plan.

20. The final few weeks of this year will be critical both in terms of how our financial outturn concludes and also how we set ourselves up for the year ahead – my thanks once again to the Board and to the ICB's hardworking staff for all they do.

Board matters

21. We welcome at this meeting for the first time our new Non-Executive members of the Board, Mehrunnisa Lalani and Gary Brown. As agreed by the Board at the last meeting, Mehrunnisa will Chair the Remuneration and Human Resources Committee and Gary will Chair the Audit and Risk Committee, alongside their other committee memberships.

22. I am also pleased to confirm that following a comprehensive external recruitment process, Bill Shields will be joining the Board as substantive Director of Finance from 1 April 2025. Bill, who is appointed to a joint role with NHS Derby and Derbyshire ICB, has 28 years of Board-level experience and is currently interim Chief Executive at Torbay and South Devon NHS Foundation Trust, appointed from his substantive post as Chief Finance Officer and Deputy Chief Executive at NHS Devon ICB. I would like to take this opportunity to recognise the outstanding work of Marcus Pratt since taking on the role of Acting Director of Finance in July 2024. I am sure you will all join me in thanking Marcus for his efforts during this time.

23. In order to facilitate the appointment to the new joint Director of Finance post, which will be hosted by NHS Derby and Derbyshire ICB, we are required to

apply to NHS England to make a non-material change to the ICB's Constitution. The model ICB constitution currently includes within the eligibility criteria for all Executive members of the Board that they *"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."* As ICB organisations are not included within paragraph 19(4)(b) of Schedule 1B to the 2006 Act, the model constitution as currently written prevents the proposed appointment. Discussions with national NHS England colleagues have resulted in an agreement to amend the above wording in the model constitution. This will be actioned for all ICBs at the time of the next scheduled update; however, to enable a start date of 1 April for our local arrangement, we are required to submit an individual application to make this change ahead of the national update.

24. In line with the above, an application has been prepared for submission to NHS England to amend the stated wording from paragraphs 3.9.1(a), 3.10.1(a), 3.11.1(a) and 3.12.1(a) of the ICB's Constitution, which relate to the appointment process for Executive members of the Board. Rather than limiting this application to the Director of Finance role, the proposed amendment is being requested for all Executive roles (other than the Chief Executive) for the sake of future-proofing the ICB's Constitution. The full Constitution with tracked changes is shared with members for information as part of this pack of papers, and the Board is requested to endorse this for onward submission to NHS England for formal approval.

25. Finally, as Chair of the Board, I have responsibility for ensuring that the Board's committees are supported by appropriate governance arrangements. As such, I have spent some time recently observing meetings of all committees, which has assured me that they are operating effectively. I was also pleased to receive a report from a recent internal audit review of the ICB's governance arrangements, which has provided independent 'substantial assurance' that our arrangements are effective.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/03/2025
Paper Title:	**Chief Executive's Report**
Paper Reference:	ICB 24 110
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 Undertakings Action Plan
B: ICB Response to Healthwatch Report on Community Pharmacies

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

Independent Mental Health Homicide Review

1. On 5 February 2025, NHS England published an Independent Mental Health Homicide Review which examined the case of Valdo Calocane.
2. We welcome NHS England's publication of the Independent Homicide Investigation report and fully accept the recommendations. We have developed an action plan to address these. Since the attacks, and the publication of the Care Quality Commission's Section 48 Special Review, we have worked extensively to support the delivery of improvements in mental health services in Nottingham and Nottinghamshire.
3. Following the attacks extensive governance arrangements, including oversight arrangements from the ICB, and regional and national NHS England teams, were set up to monitor Nottinghamshire Healthcare NHS Foundation Trust's response to quality and regulatory concerns. Senior ICB leaders are part of this process, including the Chief Executive and Director of Nursing.
4. These arrangements provide scrutiny for operational and quality risks and provide wider stakeholders, including specialised commissioning teams within NHS England and the Care Quality Commission, with a single forum to support and challenge the progress of improvements, as set out in the Trust's quality improvement and transformation programmes.
5. We are committed to safe and high-quality services for our communities, and we will continue to provide support and challenge to Nottinghamshire Healthcare NHS Foundation Trust to ensure sustained improvements in the delivery of safe services.
6. An action plan has been published to address the recommendations of the Independent Homicide Investigation report, which can be read in full here: https://notts.icb.nhs.uk/wp-content/uploads/sites/2/2022/04/Independent-investigation-into-the-care-and-treatment-of-Valdo-Calocane-Integrated-Care-Board-action-plan-.pdf.
7. Actions already taken include:
    a) The ICB has instigated enhanced surveillance on a broad range of quality concerns and improvement plans.
    b) An Improvement Oversight and Assurance Group (IOAG) has been set up jointly with NHS England Midlands to monitor Nottinghamshire Healthcare NHS Foundation Trust's response to the current quality and regulatory concerns. Senior ICB leaders are part of this process, including the Chief Executive and Director of Nursing.

c) Alongside the IOAG process, the ICB holds regular ‘Safe Now’ meetings with the Trust and use shared reporting and metrics to assess progress against the more immediate safety challenges.

d) A ‘Safe Now’ dashboard supports immediate actions for safety and improvement, with appropriate escalations. This will become part of routine ‘Ward to Board’ escalation pathways as it is embedded.

e) ICB representatives attend the Trust’s Improvement Board and associated workstreams to triangulate data and actions.

f) A system risk register has been established to ensure that strategic risks are collectively understood and owned.

g) A patient safety specialist forum has been established to support Patient Safety Incident Response Framework implementation and learning.

8. This area of work will continue to be overseen by the ICB’s Quality and People Committee on behalf of the Board.

9. The ICB will also fully support any submissions required by the judge-led public inquiry, following the recent Government announcement – we await further details of how this will operate.

Independent Review into Maternity Services at Nottingham University Hospitals NHS Trust (NUH)

10. In February, Donna Ockenden, Chair of the Independent Review, confirmed that the publication date for the Review’s report will now be published in June 2026, rather than the end of September 2025 as initially anticipated. The original reporting date was set at a time when there were approximately 1,700 families in the review; however, since this time, the number of families has increased to approximately 2,500. The extended timeframe is to allow the review team to provide support to all families, and to allow for all cases to be reviewed to the highest professional standards.

11. The Trust continues in its commitment to the Independent Review, and although it is recognised that there is further work to do, maternity services at the Trust have improved thanks to a huge amount of work from colleagues in the service. More midwives and consultants have been recruited, and local and national surveys are consistently showing improved feedback. Additional services are being provided, including a full home births service, and extensive work has taken place to ensure services are more inclusive.

12. The ICB will continue to work alongside colleagues at the Trust to ensure quality improvements are achieved and embedded, with ongoing oversight by the ICB’s Quality and People Committee on behalf of the Board.

NHS Nottingham and Nottinghamshire ICB Enforcement Undertakings

13. In May 2024, 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.

14. An action plan was subsequently drafted and the ICB's Finance and Performance Committee has been overseeing progress of its delivery on behalf of the Board. The action plan is now substantially complete and the Committee asked for the Board to be updated on progress in order to provide assurance that the necessary arrangements for ensuring delivery of the ICB's statutory financial duties, and joint financial planning duties with its partner NHS Trust and NHS Foundation Trusts, have been implemented and embedded.

15. The full action plan can be found at Appendix A.

New Hospitals Programme

16. Further to my recent updates on the national review of the New Hospitals Programme, on 20 January 2025, the Secretary of State for Health and Social Care published the outcome of the review and announced a new programme, with a new timeline, which means the main schedule of work on the Tomorrow's Nottingham University NHS Hospitals Trust (TNUH) programme is not now due to commence until after 2035. As such, all development of the scheme and enabling works have paused.

17. Whilst this is disappointing news, the TNUH Partnership Board intends to continue the positive momentum generated by the work undertaken to date and will consider in the widest possible context how the system can deliver on both the clinical service reconfiguration and estate improvements required.

New NHS England Operating Model and 2025/26 Planning Guidance

18. On 30 January 2025, NHS England published planning guidance for 2025/26 and their new Operating Model, which sets out how they will work with ICBs and providers to deliver the 2025/26 priorities, whilst living within the resources available and continuing to lay the foundations for future reforms that the Ten-Year Health Plan will set out. It also describes what practical tools and guidance we can expect from NHS England and when.

19. The Operating Model describes a more collaborative and simplified approach to the development, agreement and oversight of operational plans and emphasises that a key role for ICBs will be effective strategic commissioning. A Strategic Commissioning Framework is in development, which will include

effective practice at system, place and neighbourhood levels, and strengthen commissioning of general practice, dentistry, optometry and community pharmacy.

20. A new NHS Management and Leadership Framework will also be implemented in 2025/26, as well as further support for the NHS workforce.

21. Regarding the drive for efficiency, the document also discusses changes in commercial arrangements, the need for a strategic approach to estates, supporting digital infrastructure and reducing healthcare inequalities.

22. The full Operating Model can be found here: https://www.england.nhs.uk/long-read/our-new-operating-model-supporting-you-to-deliver-high-quality-care-for-patients/.

23. NHS England's planning guidance for the next financial year sees a significant streamlining of priorities and success measures, from 32 to 18, and a new national ambition for 65% of patients to receive elective treatment within 18 weeks by March 2026, with every Trust asked to deliver at least a 5% improvement on their performance this year. The plans also signal that improving access to mental health care for patients will be a key priority for the NHS next year, with all local systems expected to meet the Mental Health Investment Standard in 2025/26. Improving access to general practice and dentistry is a priority and a minimum of 78% of patients should be seen within four hours at accident and emergency departments.

24. The guidance places a real focus on treatment to prevention, analogue to digital and shifting from hospital to community, placing innovation and reform at the centre. The guidance is explicit that, in a very challenging financial environment, difficult choices will also have to be made, so the focus of our plans must be on reducing duplication and waste and improving efficiency and productivity in all areas.

25. The ICB has been co-ordinating the development of the 2025/26 Operational Plan with NHS system partners and an overview was provided to the Board at its February 2025 development session. Following scrutiny by the ICB's Finance and Performance Committee in February, the final plan will be approved at an extra ordinary meeting of the Board on 26 March 2025.

Changes to the GP Contract in 2025/26

26. Following the conclusion of the consultation on changes to the GP contract, NHS England has confirmed arrangements for the forthcoming year. The changes are intended to move forward the Government's mission to shift care into the community and focus on prevention and digital. The new contract includes:

    a) A 7.2% cash growth on the contract funding envelope.

b) The removal of 32 Quality Outcome Framework indicators in order to reduce bureaucracy.

c) From 1 October 2025, practices will be required to keep their online consultation tool open for the duration of core hours for non-urgent appointment requests, medication queries and administrative requests.

d) Also from 1 October 2025, practices are to ensure that GP Connect is enabled, which will further reduce administrative burden.

e) The publication of a patient charter.

f) The Additional Roles Reimbursement Scheme will increase in flexibility to support Primary Care Networks to respond to their local workforce requirements.

27. The Government has also agreed to fund in full in 2024/25 the 6% pay recommendation for GPs, as recommended by the Review Body on Doctors and Dentists Remuneration.

Healthwatch Nottingham and Nottinghamshire Report: Community Pharmacies

28. Healthwatch Nottingham and Nottinghamshire has recently published findings of their research into the experiences of local residents with pharmacies in the ICB's area. Their key findings were:

a) High Usage: 97.5% of respondents had used a community pharmacy in the past year.

b) Accessibility: 75% found pharmacies easy to access.

c) Medicine Shortages: two in five respondents faced difficulties obtaining medication, leading to stress and multiple pharmacy visits.

d) Pharmacy First Scheme: 40% were aware of this NHS initiative, but confusion around eligibility and scope persists.

e) Prescription Costs: 25% of those who pay for prescriptions struggle with affordability.

f) Challenges for vulnerable groups: individuals living with disabilities or long-term conditions, as well as carers and those they care for, face significant barriers in accessing community pharmacies. These include difficulties with medicine supplies and unmet needs for dispensing adjustments.

29. This is a much-welcomed report from Healthwatch as it helps the ICB to understand the patient voice and needs. There are however some caveats to the results, as noted below.

a) There were a limited number of participants as a percentage of the population for Nottingham and Nottinghamshire. This was a similar issue

experienced in the undertaking of the last Pharmaceutical Needs Assessment, where similar numbers were not seen as representative, but could be used as awareness but not firm recommendations.

b) Almost 50% of the respondents came from one district, Rushcliffe. 80% of the respondents identified as women, and over 88% of the respondents were from white ethnic backgrounds, so the survey may not be representative of the whole Nottingham and Nottinghamshire population.

c) Most responses were around July when Pharmacy First had only been operational for six months, which will impact on understanding of the service.

d) Some recommendations about cost of prescriptions are national issues rather than directly related to community pharmacy commissioning.

30. Despite these caveats this report does provide important insights into the patient experience of community pharmacy. A full response to the recommendations can be found at Appendix B.

31. The Pharmaceutical Needs Assessment, which under Section 128A of the NHS Act 2006, requires each Health and Wellbeing Board to assess the need for pharmaceutical services in its area and to publish a statement of its assessment, is currently being updated and will be published later this year. It will provide a useful corroboration and triangulation of the findings from the Healthwatch report.

New emergency care complex at Bassetlaw Hospital

32. A new state-of-the-art emergency care complex has opened at Bassetlaw Hospital following years of planning, consultation and collaboration with clinicians, construction partners and the local community. Urgent, acute and paediatric services moved into the new facility during January and February, which offers a welcoming environment and is aimed at improving patient flow. The previous emergency department area will be refurbished to accommodate minor injuries and same day emergency care services.

Recent leadership changes

33. At a national level:

a) Dr Penelope Dash has been appointed by the Government as the next Chair of NHS England. Dr Dash is currently the Chair of the NHS North West London ICB and is leading a major review into the regulation of health and social care quality in England. A former NHS doctor, senior partner at McKinsey and Company working on healthcare globally, and Head of Strategy at the Department of Health and Social Care, Dr Dash

has a wealth of experience in the public, private and government sectors. As Chair of NHS England, she will be drawing on her vast knowledge in these fields to focus on rebuilding the NHS as part of the Government's Ten-Year Health Plan. Dr Dash's four-year term of office will commence on 1 April 2025.

b) Amanda Pritchard has announced that she will be standing down as Chief Executive of NHS England at the end of this financial year. Amanda has been Chief Executive since August 2021 and Chief Operating Officer since 2019, leading the NHS through the most challenging period in its 76-year history. Sir James Mackey will be taking over as Transition Chief Executive of NHS England, working closely with Amanda for the next month before taking up post formally on 1 April 2025. Sir James Mackay will step in on a secondment basis, with a remit to radically reshape how NHS England and the Department of Health and Social care work together. He is currently the Chief Executive of Newcastle Hospitals NHS Foundation Trust and National Director of Elective Recovery; and was previously Chief Executive of NHS Improvement.

c) Professor Sir Stephen Powis has also announced that he will be stepping down from his role as Medical Director of NHS England this summer, after over seven years in the role. He will continue until early July, focusing on the medical training review for postgraduate doctors, ongoing work to improve stroke care, as well as ongoing inquiry commitments.

34. At a local level:

a) Following the departure of Adam Hill, I am pleased to welcome Theresa Hodgkinson as the new Chair of Mid-Nottinghamshire Place-Based Partnership. Teresa is Chief Executive of Ashfield District Council and will bring a wealth of experience and a proven commitment to partnership working with her.

b) Sherwood Forest Hospitals NHS Foundation Trust has announced a number of changes to its Board of Directors, following a recent recruitment exercise. Lisa Maclean and Richard Cotton have been appointed as Non-Executive Directors and Professor Sir Jonathan Van-Tam has been appointed to a new Associate Non-Executive Director role to help lead Trust's research and innovation ambitions. Lisa Maclean has previously served as a Director of Nursing in a number of NHS and independent sector organisations. Richard Cotton has spent much of his career in the private sector in a range of industries, including with pharmaceutical and medical technology companies. Professor Sir Jonathan Van-Tam was the Government's Deputy Chief Medical Officer, leading on health protection between October 2017 and March 2022. We look forward to meeting them at our regular ICS Non-Executive Director meetings.

c) Nottingham CityCare Community Interest Company has appointed Dr Nicole Atkinson as its Chief Executive and will be starting in post later this year from her current role as Medical Director at East Midlands Ambulance Services NHS Trust. Dr Atkinson has extensive leadership experience, having also worked as a GP partner in Nottinghamshire for 20 years and at all levels of an Integrated Care System including leading the development of Nottinghamshire's ICS clinical and community strategy and being Clinical Lead of the former Nottingham West Clinical Commissioning Group.

d) Amy Harhoff has been appointed as the first permanent Chief Executive for the East Midlands Combined County Authority (EMCCA). Amy will join EMCCA from Durham County Council, where she has been Corporate Director for regeneration, economy and growth. As Chief Executive, Amy will be responsible for leading EMCCA's work on regional transport, housing, economic development, net zero, jobs and skills priorities.

e) Following my report to the last meeting, Nottingham City Council has now appointed Sarah Nardone as its substantive Corporate Director for Children and Education.

Health and Wellbeing Board updates

35. The Nottingham City Health and Wellbeing Board last met on 26 February 2025. The meeting received a report on the Race Health Inequalities Matrix, a joint report on the annual review of the Integrated Care Strategy and an updated Health and Wellbeing Strategy. The papers and minutes from the meeting are published on Nottingham City Council's website here: https://committee.nottinghamcity.gov.uk/ieListMeetings.aspx?CId=185&Year=0

36. The Nottinghamshire County Health and Wellbeing Board last met on 5 March 2025, and received a joint report on the annual review of the Integrated Care Strategy and an updated Health and Wellbeing Strategy. The papers for the meeting can be found here: https://www.nottinghamshire.gov.uk/dms/Committees/tabid/62/ctl/ViewCMIS_CommitteeDetails/mid/381/id/548/Default.aspx.

Appendix A: ICB Undertakings Action Plan

Requirement (main)	Comment	RAG Rating
Financial Governance		
1. To develop a single financial recovery plan with its system providers.	Medium Term Plan has been developed; a version of which sent to NHS England (NHSE) (end of September). The system continues to build on this plan. This includes working on additional levels of detail as the 2025/26 financial plans are being developed.	Green
2. To submit the single financial recovery plan to NHSE to an agreed date.	An initial plan was submitted to NHSE at the end of September. A meeting between the system and the Region's Director of Finance took place in November. Currently in the process of working up the detail to support the initial plan submission.	Green
3. The single recovery plan should reflect the views of its key stakeholders.	The single system recovery plan is being used by all system NHS partners as the basis of their own individual organisational level plans. The development of that plan and its delivery continues to be the agreed way forward amongst the system NHS partners.	Green
4. The ICB, with system partners to demonstrate to NHSE: • A period of successful implementation of the single recovery plan. • Assurance over a continued focus, capability and capacity to sustainably maintain financial recovery and delivery.	Efficiency plans, on the whole, remain on track. Delivery is planned to accelerate through 2024/25 and into 2025/26. System governance is via the System Financial Recovery Group (FRG). The focus of the System FRG is delivery of the single system financial control total. Processes for this and the next financial year are fully embedded. The benefits of transformation plans remain under development and as such have yet to be fully implemented (noting the system is in the first year of a two-year recovery trajectory). Consequently, the system has yet to experience a period of sustained financial recovery.	Amber
5. The ICB, with system partners to keep the single financial recovery plan under continuous review and update as required (subject to NHSE approval).	Robust financial and efficiency governance is in place through weekly System FRG.	Green

Requirement (main)	Comment	RAG Rating
6. ICB to make reasonable efforts to provide whole system leadership, enabling and ensuring accountability for delivery of the Plan.	In addition to comments made elsewhere, senior finance leads are aligned to provider organisations to enable scrutiny and challenge. Formal ICB/Provider meetings are in place for some providers. The System FRG is chaired by the ICB's Chief Executive and the vice chair is the ICB's Director of Finance.	Green
Financial Controls		
7. The ICB will commit to recurrent delivery of efficiency schemes from Q1 2024/25 to achieve a FYE to compensate for any non-recurrent measures required to achieve 2023/24 plans.	The ICB on behalf of the system had plans for 2024/25 that reflected recurrent delivery. At the same time, the ICB and the system remains a large user of non-recurrent efficiencies despite there being plans that focus on the recurrent delivery of efficiencies. The above status is expected to continue into 2025/26 despite plans reflecting delivery of recurrent savings. The difference between that and the need to still deliver non-recurrent measures is a result of the phasing of recurrent savings in plans (i.e. when they are expected to be realised) and/ or managing in-year pressures that may arise. As previously advised, the ICB remains committed to delivering recurrent efficiency schemes.	Green
8. The ICB will fully engage in national pay and non-pay savings initiatives, in particular around national agreements for medicines and other non-pay purchasing.	The system is fully engaged in regional workforce savings groups, specifically including attendance at regional workforce/agency/medicines groups. For medicines management the ICB is maximising use of national rebates schemes, and use of generics. For agency, the system is meeting agency caps. The ICB along with its NHS system partners have reviewed the national learning with the aim of ensuring such learning is reflected/ embedded in its own systems, controls, and processes	Green
9. The ICB will monitor agency usage and compliance with usage and rate limits.	The ICB monitors agency usage and compliance on a monthly basis. It reports this to FRG meetings, Chief People Officer meetings, and individual system meetings. A fortnightly dashboard has been developed. This will include information on agency usage, meaning the monitoring thereof moves to being fortnightly.	Green

Requirement (main)	Comment	RAG Rating
10. The ICB will request prior approval form NHSE regional team for any revenue consultancy spend above £50,000 and non-clinical agency usage, based on agreed regional process.	In addition to making the request to NHSE, all requests are signed off by the ICB's Director of Finance and taken to the monthly system Directors of Finance meeting for information.	Green
11. The ICB will ensure robust financial controls and processes and reporting must be in place and overseen through appropriate financial governance procedures and a track record of identifying and addressing financial issues when they arise.	This is discharged via monthly reporting to system Financial Directors meeting and system FRG for action. Track record demonstrated of action through development of recovery plans/transformation plans.	Green
12. The ICB should be able to demonstrate internal capabilities around financial resource management (grip and control), and the effectiveness of these controls.	Self-assessment of checklist and internal audit undertaken. Grip and control added to the ICB and system through addition of Director of Delivery and Operations. Regular reporting of checklist to Finance and Performance Committee is in place.	Green
Programme Management and Reporting		
13. Implement sufficient programme management and governance arrangements to enable delivery of undertakings.	ICB Programme Management Office (PMO) is supporting system financial delivery. In addition, each system NHS partner has its own PMO teams in addition to support programmes. Consideration to be given to capacity to embed and sustain this. It has been agreed that ICB's PMO will operate as a system co-ordinator. Its function will involve, for example, (1) ensuring the development of project initiation documents (PIDs) is done on a consistent basis by following one approach to PID development and (2) ensuring the oversight of the delivery of plans is undertaken on a consistent basis. Discussions are underway over the capacity necessary to ensure the approach as described becomes fully embedded. There is a commitment to set aside resources in 2025/26 to support the system element of the process.	Amber

Requirement (main)	Comment	RAG Rating
14. Enable the Board to: • Obtain clear oversight over the process in delivering these undertakings • Obtain an understanding of the risks to the successful achievement of the undertakings and ensure appropriate mitigation; and • Hold individuals to account for the delivery of the undertakings	The ICB's Finance and Performance Committee is responsible on behalf of the Board for assessing progress on delivery of undertakings and escalation to the Board as appropriate. Delivery of the single financial recovery plan is embedded into organisation's reporting and oversight processes.	Green
15. Provide to NHSE direct access to its advisors, programme leads and board members as needed in relation to matters covered by these undertakings.	Monthly system review meeting in place with NHSE including scrutiny of progress on undertakings. In addition to the monthly system meetings, there are oversight meetings taking place with NUH and NHT, at which NHSE officers are in attendance. Also, there are NHSE officers from the national team, who have financial recovery support responsibilities and who regularly attend the system FRG meetings.	Green
16. Ensure it has sufficient capacity and capability to deliver the improvement plans referenced above. Where deemed necessary by NHSE, obtain external support from sources and according to a scope and timescale to be agreed with NHSE.	ICB PMO is supporting system financial delivery. In addition, each system NHS partner has its own PMO teams in to support programmes. Discussions are underway over the capacity necessary to support and manage the system transformation process. There is a commitment to set aside resources in 2025/26 to support this approach.	Amber

Rushcliffe Arena, 09:00-13/03/25

Appendix B: ICB Response to Healthwatch Report on Community Pharmacy

Healthwatch recommendation	Other evidence in this area	Current activity	Future plans	Issues and limitations
We recommend that pharmacies adjust their opening hours to better align with the needs of working individuals.	The last Pharmaceutical Needs Assessment patient questionnaires did not identify these needs, but did have the same limitations as the Healthwatch survey around limited number of respondents and limited ethnicity and gender background of the respondents.	The Pharmaceutical Needs Assessment is designed to support these plans. The decisions around opening hours are for pharmacies to determine within the national contractual framework and are dependent on business factors such as financial viability, but the Pharmaceutical Needs Assessment will underpin commissioning plans around this. Pharmacy First referrals from NHS 111 are less impacted by this, as they will only return pharmacies that are open and continue to be open in the next 30 minutes and hence will identify available pharmacies to patients, which will be late night or weekend opening if the request is made at these times.	The Pharmaceutical Needs Assessment is due for publication later this year and is being undertaken along with Nottingham City Council and Nottinghamshire County Council colleagues. This will look at gaps in provision. Pharmacy First has also been noted as an essential service in this work. There are some pharmacies with later opening hours, weekends and distance selling pharmacies. We will explore how this is communicated to patients.	As Pharmaceutical Needs Assessments are long-term pieces of work, they cannot guarantee that changes will occur, so this needs to be triangulated with other local intelligence. It is for the determination of pharmacies within the legal national Community Pharmacy Contract as individual service providers to operate in hours that make their service financially viable and there are no provisions within the contract framework to allow for commissioners to enforce changes.
Pharmacies should ensure good communication between pharmacists and patients including: • Affordability • Reasonable adjustments	General Pharmaceutical Council standards – standard 3: Communicate effectively Standards for pharmacy professionals | General Pharmaceutical Council.	The ICB website in the Community Pharmacy section: Community pharmacy - NHS Nottingham and Nottinghamshire ICB includes information about pre-payment certificates and	More information about these areas will be included in the ICB Community Pharmacy Newsletter to encourage this communication.	There is limited local action that can be taken on this issue, as it is a national contractual issue.

Healthwatch recommendation	Other evidence in this area	Current activity	Future plans	Issues and limitations
• Supporting vulnerable patients	Company Chemists' Association report Pfizer/Pharmacy First Report found more pharmacy first provision in areas of higher deprivation.	a section called managing medicines, which explains the types of reasonable adjustments including advantages and disadvantages.	Promotion of information that is already available through ICS partners will be requested, including Healthwatch, as the ICB website may not be a page that patients are familiar with.	
Improved clarity in communication will enhance the effectiveness and long-term sustainability of the Pharmacy First scheme: • Eligibility awareness • Building public confidence • Effective signposting	Initial uptake potentially has not been as high as hoped across all areas, so cross-organisational communications and working is required to support this.	The ICB has information available on the Community Pharmacy section of its website: Community pharmacy - NHS Nottingham and Nottinghamshire ICB, includes the main eligibility. The Pharmacy First task force is continuing to deliver its communications plan, which includes social media where conversations have occurred with the general public about eligibility. Pharmacy First taskforce work continues with identified practices to improve electronic referral rates.	Communications to patients will continue to be strengthened as part of the Communications Plan within the Pharmacy First taskforce.	Initial national communications did not specify age related criteria, which led to confusion. Confusion nationally, including with stakeholders about the difference between prescribing and patient group directives. Patient group directives are legal protocols which set inclusions and exclusions that allow the supply for prescription only medicines as part of Pharmacy First.
The ICB should take a proactive approach in communicating with the public about medicine shortages and pharmacy closures.	The House of Commons Report, which can be accessed here: Pharmacy, found that pharmacies may be spending over four hours a day trying to source medicines.	ICB information is available on the Community Pharmacy section of the ICB website here: Community pharmacy - NHS Nottingham and Nottinghamshire ICB, which gives general advice about	The Medicine Supply Team in the Department of Health and Social Care and the NHS Medicines Procurement and Supply Chain team in NHS England are reviewing how supply issues are	Individual product information about medicine shortages is commercially sensitive, so the national supply tool available via the specialist pharmacy is password protected and is

Healthwatch recommendation	Other evidence in this area	Current activity	Future plans	Issues and limitations
		shortages, the cause, and what to do. The ICB has developed a good practice document for GP practices and community pharmacists to encourage effective communication and collaboration to minimise the impact of shortages, which can be found here: shortages_workingtogether_v11.pdf.	communicated to healthcare professionals. The ICB will engage with this process and look for patient centred approaches. Communication avenues will be explored with patients, including community newsletters and integrated neighbourhood working, within the limitations of the legal barriers of this very important national issue, which can have severe impacts on patients.	not allowed legally to be shared directly with the public. The ICB does not have access to stock levels at the different wholesalers, which wholesaler an individual Community Pharmacy uses or stock levels in individual Community Pharmacies. There is no legal mechanism to require this sharing of information across pharmacies, though some chains, such as Boots, do have a stock checker for patients.
As part of its monitoring of relevant indicators of contractual obligations, the ICB is expected to actively monitor and mitigate the effects of closures.	This is monitored monthly through East Midlands-wide governance meetings as well as being monitored continually by area contracting teams. In the last year we have not seen these in great numbers.	The Pharmaceutical Needs Assessment for City and County Councils is currently underway. No gaps in provision have been identified. Supplementary reports are submitted as part of the Pharmaceutical Needs Assessment when there is a closure. Monthly monitoring by the East Midlands Primary Care Team takes place, and as part of this, the ICB is developing ways to be proactive in trying to identify potential at risk sites sooner.	Organisational governance will continue to monitor and manage this as well as using tools to review access and pharmacy usage.	It is not within the control of the commissioner if a pharmacy decides to close, so a proactive approach is taken to reduce the risk of closures.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/03/2025
Paper Title:	**Integrated Care System People and Workforce Plan**
Paper Reference:	ICB 24 111
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 a 'one workforce' approach by leading system development and implementation of the Integrated Care System (ICS) People and Workforce Plan.

In September 2024, the Board was presented with an updated People Plan which formed part one of a two-part ICS People and Workforce Plan. Both parts have been combined into a single document: 'Planning for the future: transforming the health and social care workforce: the ICS People and Workforce Plan'.

The ICB's Quality and People Committee has overseen development of the plan and endorsed the plan at its meeting in February 2025.

Recommendation(s):

The Board is asked to **approve** the ICS People and Workforce Plan.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	This paper describes the progress in developing the ICS People and Workforce 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 – ICS planning for the future: transforming the health and social care workforce: A System People and Workforce Plan.
Appendix B – Template for Strategic Workforce Planning for Efficiency and Transformation.

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • 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 has overseen the development of the ICS People and Workforce Plan.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Nottingham and Nottinghamshire ICS People and Workforce Plan

Introduction and context

1. The ICS People and Workforce Plan (attached at Appendix A) is the result of more than 18 months' partnership 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, NHS Joint Forward Plan and NHS Long Term Plan, whilst taking account of social and economic changes to the environment and the impact on staff.
2. The ICS People and Workforce Plan has two distinct parts:
    a) Part one, the people plan section, relates to the NHS People Promise and the ten outcomes-based functions that we must deliver, as presented to the Board in September 2025.
    b) Part two sets out current challenges, future ambitions and sets a potential workforce trajectory for the next five years, with an illustrative whole time equivalent workforce summary. This part of the Plan will iteratively develop, driven by transformation approaches and clarity around the detail of new models of care.
3. Significant work has been undertaken to ensure that part two has given due consideration to providing a practical framework and exploration for delivery of the requirements of our health and care service, building on national people plans but going further to drive our integration ambitions.
4. A review into other ICBs' people and workforce plans has been conducted both across the Midlands region and more broadly, to further inform the Nottingham and Nottinghamshire plan. This review concluded that there is significant variation in ICB plans; findings include:
    a) Not all ICBs have published people or workforce plans.
    b) Those ICBs who have plans vary considerably in detail and length, ranging from three to 50 pages.
    c) Most are people plans not containing any or limited workforce numbers and primarily focus on the NHS People Promise and ten outcomes.
5. It is recognised that this plan is written and developed in a rapidly changing landscape with new national and people plans expected in the summer of this year. However, it remains a significant document to ensure a clear and common foundation for transformation, recognising that the workforce is both a key enabler, and critical delivery element of our system transformation priorities.
6. This plan is deeper in its scope and more localised in its delivery than any national plan could hope to be, it is recognised that there is still a requirement

for granular workforce plans driven by transformation priorities, this work is underway and in the first refresh of the plan we will include a more detailed cross programme view of the workforce impacts.

7. Support is being provided to system programmes to develop detailed granular workforce transformation plans, using a strategic workforce planning approach (a standardised template is being used for this work, which is provided at Appendix B for information). The ambition is to have a plan to align with our 'one workforce' approach, including health and care, with a strong focus on greater integration through partnership working to address three key questions:

    a) Why do we need to transform the health and care workforce?

    b) What needs to change to transform the workforce?

    c) When and how will the transformation be delivered?

8. Development of the plan has been overseen by the ICB's Quality and People Committee, and in its endorsement of the plan, the Committee recognised the following points:

    a) The Committee acknowledged that this is an evolving plan and future iterations of the plan will have greater granular detail supporting workforce transformation.

    b) The Committee recognised the ambition to have a 'one workforce' approach, a workforce drawn from a range of health and social care disciplines, working seamlessly as a productive, multi-functional team across clinical pathways, for the benefit of patients/service users, and hoped to see the data of a wider range of partners in future versions of the document.

    c) The Committee noted that due to constraints relating to the availability of workforce data for partner organisations this document can only currently focus on the NHS provider workforce data.

    d) The Committee asked if a standard definition of the community workforce existed for the purposes of workforce planning. Additional information has been added to the plan as a result.

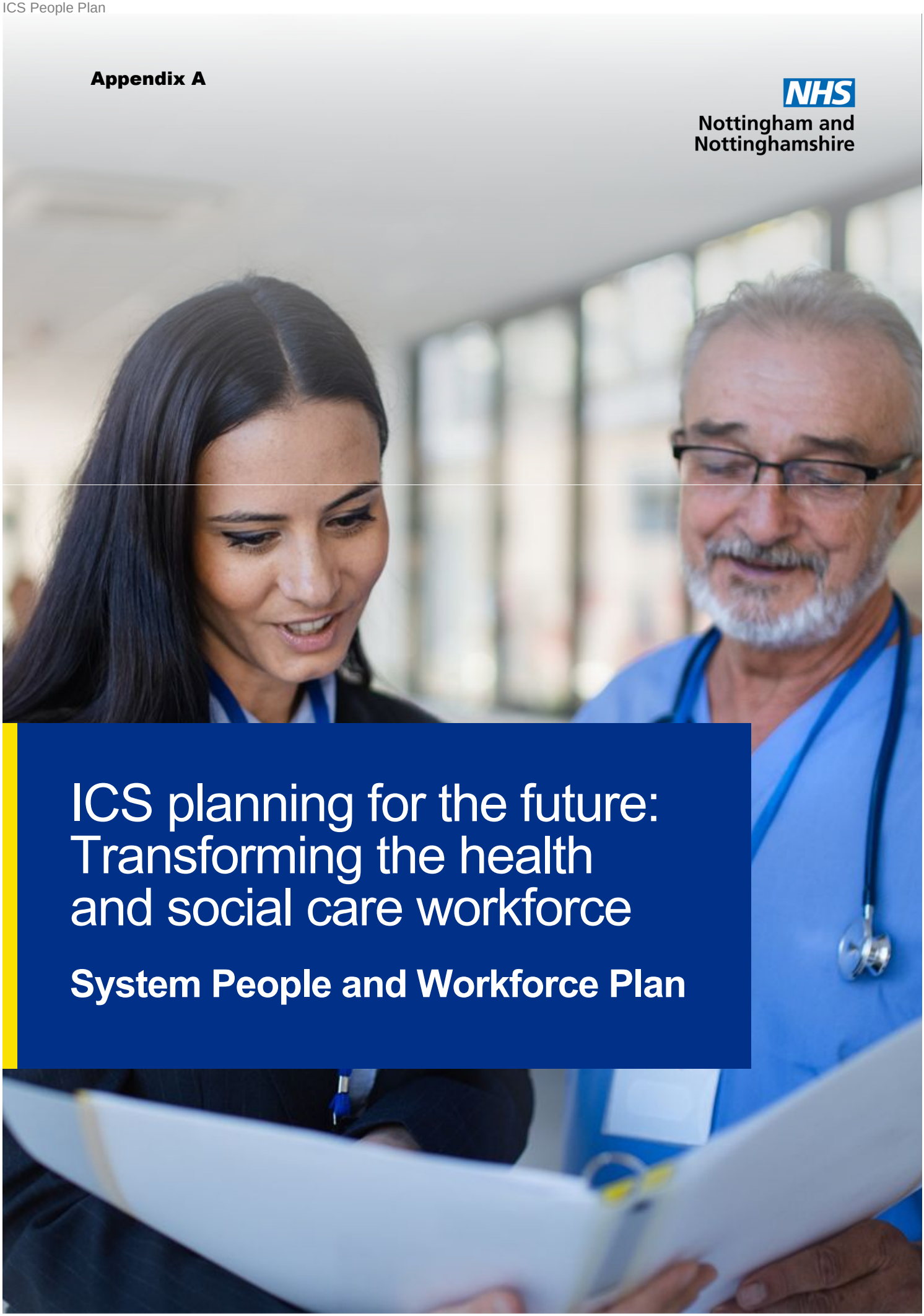
    e) The Committee acknowledged that as a system plan, this covers multiple partner organisations who will have their own priorities and workforce plans within the framework of the ICS plan. Not all of whom are NHS organisations and will recognise the NHS People Promise.

    f) The Committee sought assurance regarding system partners' commitment to the plan and asked for detail on the engagement process to be included, which has now been incorporated within the plan.

9. The ICS People and Workforce Plan will be refreshed and represented to the Board at least annually and be updated to reflect both national and local transformation and commissioning priorities.

Appendix A

NHS
Nottingham and Nottinghamshire



ICS planning for the future: Transforming the health and social care workforce

System People and Workforce Plan

ICS planning for the future

NHS
Nottingham and Nottinghamshire

> “Our plan sets out how we will develop an integrated approach towards the development of ‘One Workforce’ across our health and care providers.

Dr Kathy McLean OBE
Chair, Nottingham and Nottinghamshire ICB

ICS planning
for the future

NHS
Nottingham and
Nottinghamshire

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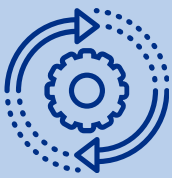


ICS planning for the future

NHS Nottingham and Nottinghamshire

ICS planning for the future

NHS
Nottingham and Nottinghamshire

Foreword

As Chair of the Nottingham and Nottinghamshire Integrated Care Board, I have the privilege of meeting and working with people dedicated to the delivery of health and care services, regardless of the organisation or sector in which they work. People continue to deliver care and services despite the enormous challenges that not only our system, but that we face nationally, both in relation to the increasing demand and complexity of need, the escalating cost, and the available funding.

The issues for our people and wider workforce are being tackled by individual organisations. More than ever there is a need to have a medium to long-term focus on an innovative and sustainable approach to workforce and utilisation of the immense assets we have in Nottingham and Nottinghamshire to continue to deliver high-quality care. We must collaborate to develop integrated solutions to shared problems: collaborating with partners across the system so that spend on the workforce is an investment in human capital that contributes to wider economic health and benefits the local population.

Our plan sets out how we will develop an integrated approach towards the development of 'One Workforce'[i] across our health and care providers, with an overarching ambition to provide a model that focuses on sustainable population health improvement, aligned to the delivery of the NHS Long Term Plan, the NHS People Promise and the wider ICS requirements of a people function.

> *"Our priority focus for the first 12 months is identifying where our skills, capabilities and innovation reside within the system.*

This will enable us to pilot initiatives and scale successful projects over the next five years and to start to transform our care delivery models and workforce skills and capability to reduce health inequalities and have a positive impact on the wider determinants of health. I look forward to seeing our plans develop and for the benefits to be realised.

Dr Kathy McLean OBE
Chair Nottingham and Nottinghamshire ICB

ICS planning for the future

NHS Nottingham and Nottinghamshire

Introduction

The Integrated Care System People and Workforce 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 18 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.

The people and workforce context is complex, the ICB has three specific roles:

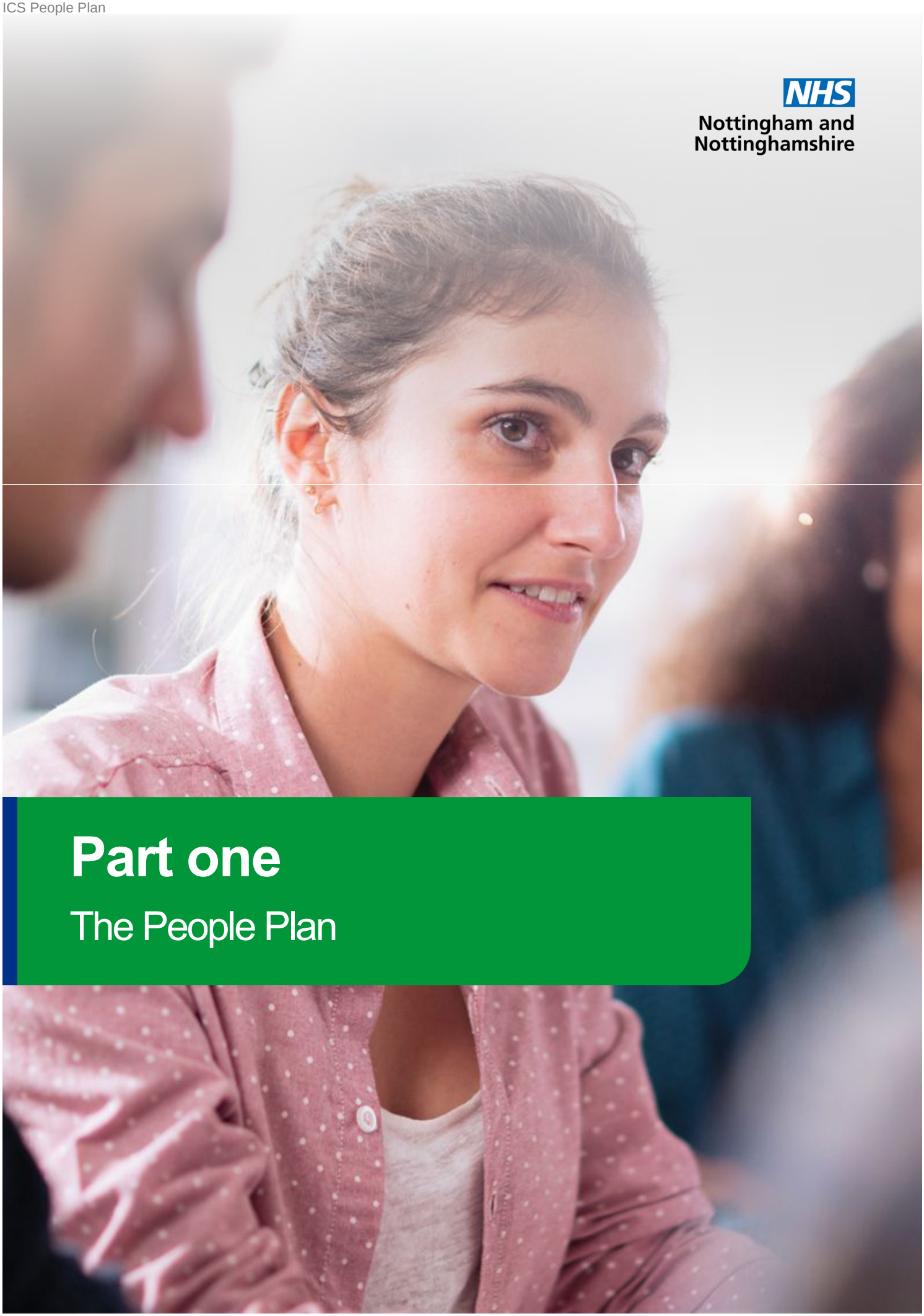
- As an employer and system partner
- As an assurer with oversight responsibilities
- As a leader planner and facilitator of ICS development.

The Provider Collaborative, whose members are also individual partners, who collectively have the largest employed workforce in the ICS, have a key role to play in delivery of the People and Workforce Plan for the ICS.

Working as an Integrated Care System brings opportunities for local teams and organisations to work together differently. We can make the most of the collective experience and expertise within a local area, and in the way that best meets local needs, relationships and circumstances – whether that is through the ICP, ICB, through provider collaboratives, or other local arrangements.

The ICS People and Workforce Plan has two distinct parts. Part one, the People Plan section relates to the NHS People Promise and confirming the cultural framework for supporting an effective NHS workforce based on the ten outcomes-based functions[ii]. Part two, the Workforce Plan section, is concerned more with our workforce transformation agenda and is financially focussed. It supports delivery of our efficiency targets related to the pay bill and is part of the annual operational planning process and Joint Forward Plan. It sets out current challenges, future ambitions and sets an initial workforce trajectory for the next five years, with an indicative whole time equivalent workforce summary. Although we anticipate the Workforce Plan will become more comprehensive over time (inclusive of our wider health and care professional sector), the scope of consideration is currently limited to the NHS provider workforce. This is primarily due to the robustness of data quality and completeness across the wider provider landscape. **We will seek to incorporate this wider workforce as confidence in this data develops, commencing with NHS primary care provider organisations.**

It is anticipated that the Integrated Care Board will receive no less than annual updates on delivery of the People and Workforce Plan and as necessary as national or system priorities evolve.



Part one

The People Plan

Development of the ICS People Plan

The 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.

The People Plan is driven by the NHS People Promise and the ten outcomes-based functions that we must deliver, written on the next page.

The ICS People Plan

Functions	Outcomes
Supporting the health and wellbeing of all staff. **Looking after our people**	People in the ICS feel safe and supported in their physical and mental health and wellbeing.
Growing the workforce for the future and enabling adequate workforce supply. **Growing for the future**	The ICS is retaining, recruiting and growing its workforce to meet future need and is representative.
Supporting inclusion and belonging for all, and creating a great experience for staff. **Belonging in the NHS**	Work, develop and thrive in a compassionate and inclusive environment.
Valuing and supporting leadership at all levels, and lifelong learning. **Belonging in the NHS**	Leaders at every level live the behaviours and values set out in the People Promise.
Leading workforce transformation and new ways of working. **New ways of working**	Service redesign is enabled through new ways of working, using technology and wider innovation to meet population health needs.
Educating, training and developing people, and managing talent. **Growing for the future**	Education and training plans and opportunities are aligned and fit for the needs of staff.
Driving and supporting broader social and economic development. **Cross-cutting theme**	Leaders encourage a vibrant local labour market.
Transforming people services and supporting the people profession. **Cross-cutting theme**	High-quality people services.
Leading coordinated workforce planning using analysis and intelligence. **Cross-cutting theme**	Integrated workforce, activity and finance planning to meet population need.
Supporting system design and development. **Cross-cutting theme**	The approach creates a system-wide culture that is driven by purpose; enables people, places and the system to fulfil their potential.

The ICS People Plan

A = Annual
M = Monthly

Current actions	NHS measures
Looking After our People Flexible working Staff wellbeing including OH & EAP Placement quality	Number of ER cases (A), Sickness absence % (M) %Flexible working req approved (A), Retention ¼, Placement feedback (A) Staff survey (A) EAP/OH statistics (M), Roster fill rates & finalisation (M), Appraisal rate (M), Mandatory training rate (M)
Growing for the future System retention plan Placement capacity Scoping a collaborative Bank	NHS all staff leaver rate % (M), NHS/SC turnover rates % (M) NHS Staff survey Qs related to learning PP (A), Placements used (A), No of Bank shifts (M), Agency usage (M), TTH (M), Vacancies (M), WTE (M).
Belonging in the NHS Career conversations, 6 High impact areas, FTSU network, Dyslexia support, Career progression for BAME practitioners, System wide allyship training	No of conversations, NHS/SC turnover rates (M), WRES/ WDES/MRES (A), Staff survey (A), No. of guardians and champions (A), Number trained (M).
New ways of working Passporting training portability	No of passports issued (M). No of honorary contracts issued. CTSF compliance (A)
Cross cutting themes Scaling people services vanguard	Contract savings (A), TTH process aligned (M), Levels of attainment (A)

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ICS People Plan ambitions

The People Plan has four key ambitions.

A healthy and well workforce.

Achieved by looking after the health and wellbeing of all our people.

An 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.

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.

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.

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ICS People Plan ambitions

The priorities for each of these ambitions have been developed with three lenses.
Designed to make the Nottingham and Nottinghamshire system the place in which they want to work.

1. Managing today's 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.

2. 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.

3. Developing a future right sized, right skilled workforce across health and care.

Ensuring our people are healthy and well; Engaged, representative and included Right sized and affordable; Able to deliver excellent care.

The People Plan has been summarised into a shared single set of ambitions (Table 1), which is reflected in the ICS individual NHS organisations' People Plans. As such, the combined delivery of these plans (which are specific to their own organisational context), will demonstrate overall collective delivery of the People Plan ambitions and priorities.

Table 1 – The Nottingham and Nottinghamshire ICS People Plan

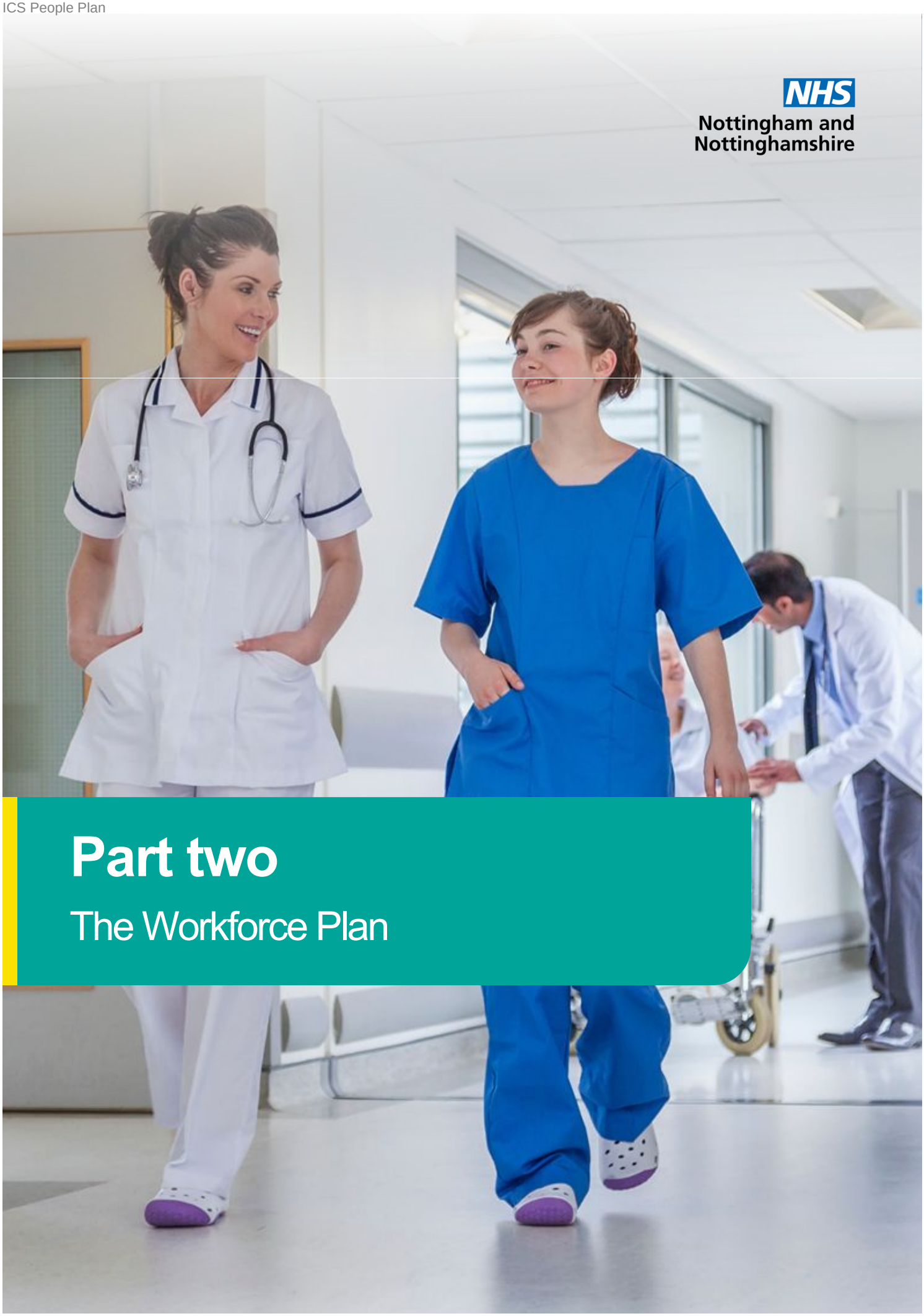
People Plan ambitions	A healthy and well workforce	A fully inclusive and representative workforce	A right sized, talented, well skilled, educated and trained, affordable workforce	A transformed workforce, delivering priorities in new ways and or at different locations.
Managing today's ICS workforce	**Enabling** - flexible working **Improving** - staff wellbeing **Improving** - placement quality and student experience **Supporting** - all NHS organisations sign the 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 including 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, and 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.
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.

Table 2: Delivery Plan 2025/26 (supported by partner organisation People Plans)

	September 2024 to June 2025	June 2025 to March 2026
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 (six steps process) across programmes. • Map workforce elements of each programme to understand 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 within 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. e.g. e-rostering, digital solutions to reduce non-clinical capacity requirements, promoting digital/IT solutions for patient monitoring and remote care, using AI to reduce clinical time, e.g. diagnostics and reporting of diagnostic information.



Part two

The Workforce Plan

Introduction: Workforce Plan

Scoping a transformed future workforce

The need for change and transformation is clear. The demographic data we have on population growth, economic activity, and disease prevalence predications shows that the needs of our population are changing as people are living longer with more complex needs.

The statement opposite remains true, what is different is the context is vastly different from post war Britain, when the NHS was created.

> *Illness is neither an indulgence for which people have to pay, nor an offence for which they should be penalised, but a misfortune the cost of which should be shared by the community.*
>
> *Aneurin Bevan*
> *Former Secretary of State for Health and Social Care*

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It is important from the outset that we are clear about, what is within the scope of this and what is not. This Plan sets out the foundations, framework, and an initial road map for the next five years. It aims to highlight in broad terms how many people within health and care are needed, and where they may be working both in terms of organisationally and geographically and the evolving skills needed over the next five years.

The National NHS People Plan and the People Promise to have informed and shaped the thinking set out below setting out the overall sense of what working in the health and care sector needs to feel like and describes the practical delivery challenges and opportunities this presents.

The ambitions for our Nottingham and Nottinghamshire workforce go much further than those national plans. This is a planning document for health and care, and it has a strong focus on greater integration; through an evolving 'one workforce' approach and partnership working.

Nottingham and Nottinghamshire will continue to work to support the delivery of the national NHS People Plan and the Adult Social Care Workforce Strategy and the four strategic aims of the ICS.

This approach will drive meaningful integration that not only looks at how we deliver better services within the current parameters, but how we as a system can influence the national agenda. Our 'One Workforce' ambition looks at how our people work together in delivery of our shared goals in health and care, starting with behaviours and the way we work at a system level, as well as how every member of our health and care workforce feels that they belong and are treated fairly. We recognise that there are areas that are out of our sphere of control, for example implementing the real living wage in the independent care sector. However, in these areas we must make the most of the opportunity to influence local partners as well as the national agenda.

Our 'one workforce' ambition includes all of those working in health, care, the VCSE sector, volunteers, and unwaged carers.

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In summary, this plan is a practical framework and exploration for delivery of the requirements of our health and care service, building on national people plans but goes further to drive our integration ambitions. A more comprehensive cross-sectoral approach recognising the collaborative commitment we have made across health and care, statutory and non-statutory partners to meet the needs of our population within our financial limits. It extends a scope of reference and commitment therefore beyond the expectations of the NHS People Plan to encompass all partners in the delivery of 'one team', bound by a common interest in delivering our integrated care strategy. The workforce plan therefore sets the strategic tone and ambition of this work over the next five years, mirroring the requirements of the Integrated Care Strategy and provides a high level Delivery Plan against which the shift of our collective human resources will be assessed.

This is a plan for health and care, it has a strong focus on greater integration; through an evolving 'one workforce' approach and partnership working and has been written to address three key questions:

1. Why do we need to change and transform the health and care workforce – the data shows the need for change.

2. What needs to change – the journey with the priority programs show what needs to change.

3. How much change and transformation are needed and by when – planning for how to deliver change and when is evolving in line with system, and political priorities.

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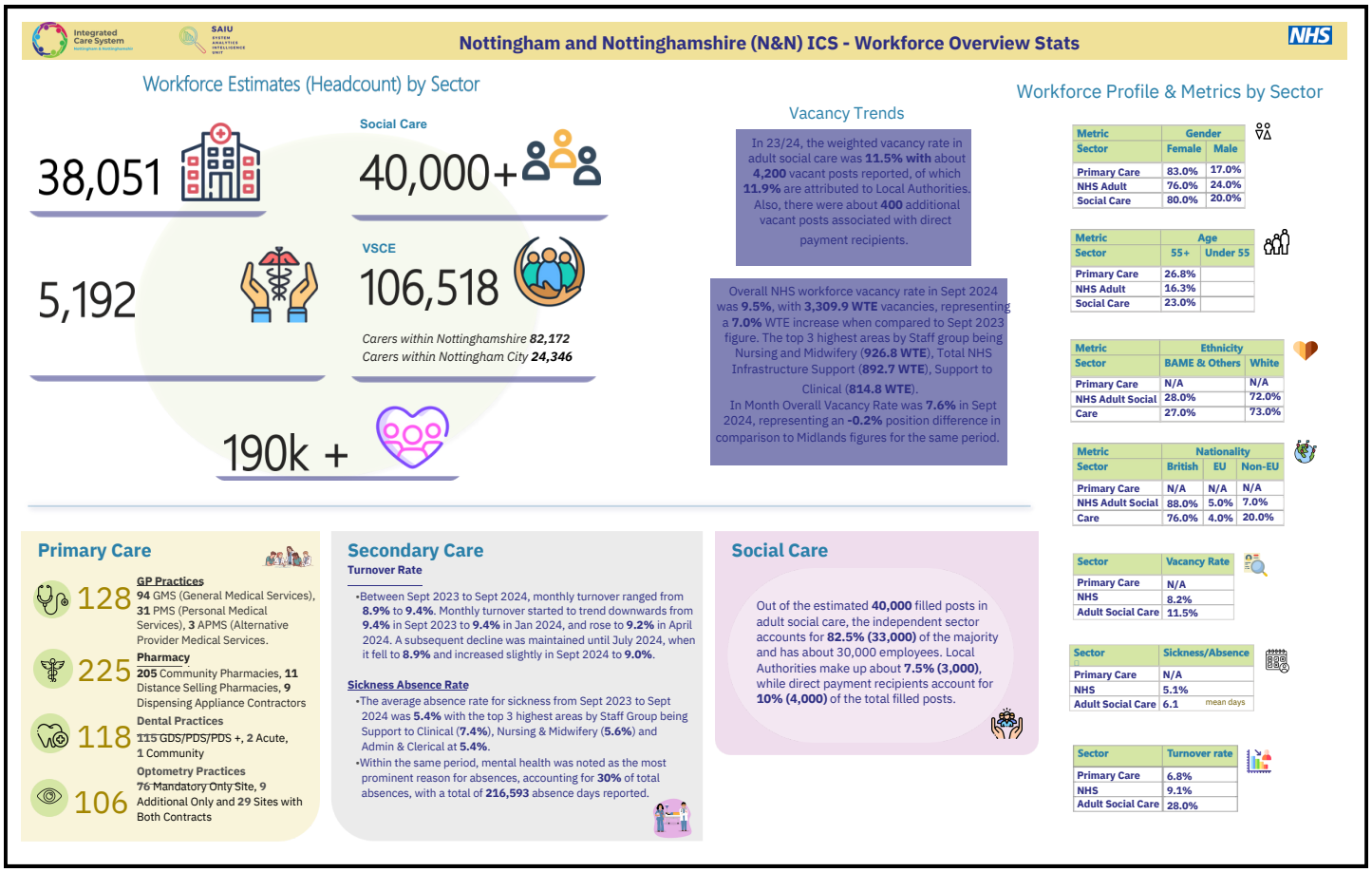
Why do we need to change and transform?

The way, the skills, and the location in which we deliver health and social care will need to change if we are to meet the needs of our population in a sustainable, affordable, and equitable way. We will need to show bold ambition for the system partners to create a vision of the future needed to transform the way health and social care are delivered through a transformed workforce.



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Community health service workforce

The community health services workforce accounts for about a fifth of the workforce in NHS trusts. The workforce includes:

- Registered community nurses
- Specialist nurses
- Advanced practitioners
- Allied health professionals, such as physiotherapists, occupational therapists, speech and language therapists, dieticians and podiatrists
- Consultant doctors
- Consultant nurses
- A significant range of un-registered staff roles

Professionals in community health services support people with episodic needs, with an increasing number of services available for people to self-refer to. They also support people managing long-term conditions, often providing highly specialist services to enable people with complex needs to live at home.

Increasingly professionals in the community work as part of multi-professional teams to support the most complex patient groups to manage their health needs in the community. (For example, frail elderly, palliative and end of life care patients, and children with complex needs). These teams also work together to manage people's worsening health conditions in the community wherever possible, supporting patients' care and wellbeing. However, the extent of multi-professional working for complex patient groups varies across the country. Staff also work within urgent care services such as urgent community response (UCR), virtual wards and rehabilitation services in the community to support patients with escalating health needs or on discharge from hospital. In many places these are relatively new services. Ref: https://www.england.nhs.uk/long-read/standardising-community-health-services/

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Workforce numbers will be accurate at a fixed point in time and will constantly be changing, due to joiners and leavers in the workforce. The following table is on the 31st of October 2024 for illustrative purposes.

The system has three main NHS providers Nottingham University Hospital (NUH), and Sherwood Forest Hospital (SFH) NHS Trust provide primarily Acute based care. Nottingham Health Care Foundation Trust (NHFT) provides primarily community-based care in addition to Mental Health in and outpatient care, and Offender Health Services. Given the way workforce information is recorded giving a definitive split between the workforce delivering acute and out of hospital (OOH) workforce for NHS providers is only indicative in the table below.

Occupation types	Acute	OOH (inc. Mental Health)	Social Care	Total
Medical & dental	3,127	1,213		4,340
Nursing	6,984	3,325	750	11,059
Registered/ qualified scientific, therapeutic and technical staff	3,038	2,092	175	5,305
Support to clinical staff	3,883	2,382	30,825	37,091
Other	7	8	4,925	4,940
Non-patient facing	6,349	4,773	2,625	13,747
Grand total	**23,388**	**13,793**	**39,300**	**76,481**

Acute	OOH (inc. Mental Health)	Social Care
72%	28%	0%
63%	30%	7%
57%	39%	3%
10%	6%	83%
0%	0%	100%
46%	35%	19%
31%	**18%**	**51%**

The analysis includes Nottingham University Hospitals, Sherwood Forest Hospitals, Nottinghamshire Healthcare, City Care, NEMS, PICS, EMAS Nottinghamshire division, General Practice, Primary Care Networks and the ICB, with the social care workforce based on estimates by Skills for Care.

Community health services are delivered by a range of professions and are organised in many ways depending on the structure of the integrated care systems including the third sector non-profit making organisations, charities and voluntary and community groups. This plan currently focuses on the core service provision that should be considered for every neighbourhood. It does not cover the complete organisational form or operating model for community health currently within the Nottingham and Nottinghamshire system. **The aspiration is to build the one workforce to include all service providers over time.**

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ICS population data

The ICB System Intelligence and Analytics Unit (SIAU) demographic projections account for age-related growth in the population that is expected in Nottingham and Nottinghamshire, based on the Office for National Statistics projections of the population changes over the next 20 years. The projections do not model:

- The potential impact on the population of which may be becoming more or less unhealthy due to societal factors.
- The impact of additional activity that might be needed to treat people on the waiting lists is also excluded.
- Any existing workforce skills and capacity shortfalls
- The impact of any transformational changes.

With those caveats aside, what is the data showing us?

- The working age population for Nottingham and Nottinghamshire is set to increase by just 3.5% over the next ten years and about 4% over the next 20 years.
- In contrast, the population aged 70 and over is expected to increase by 18% in the next ten years and 29% in the next twenty years.
- This means there will be an imbalance between additional demand from people who will need care compared to the natural growth in the number of people who will be able to care for them.

The situation is slightly different in different parts of the county and city

- In Bassetlaw, Mid Nottts and South Notts we will also expect to see bigger increases in absolute terms in those older age groups over the next 20 years.
- In Nottingham City we see lower absolute growth due to a younger population.

Additionally, using our patient-level data in GPRCC, we can also model the growth in specific long-term conditions that we might expect in the aging population, based on the age-specific prevalence in the current population but projected forward based on age-related growth. Over the next 10 years, we would expect the number of people with:

- Heart failure to increase by 20%
- Stroke by 17%
- COPD by 15%
- Moderate or severe frailty by 24%.
- Over the next 20 years, we might expect to see the number of people with some of these complex long-term conditions to increase by between 40% to 50% compared to what we see today, and we could expect the number of people with dementia to increase by up to 55%.

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We also know that we are currently seeing growth in some conditions that is not caused by age alone. So, for example, we are seeing increased demand for services for Type 2 diabetes and cardiovascular conditions, due to lifestyle factors, such as diet and exercise; and for neurodivergent conditions such as Autism and Attention Deficit Hyperactivity Disorder (ADHD). Workforce plans will need to plan for managing these conditions and preventing or delaying the onset of physical health conditions where possible.

Future iterations of this SAIU strategic model over the next 12 months will attempt, with Public Health input, to estimate and model these additional demand growth areas, and identity the potential for preventing or mitigating these. We also recognise that, over a lifetime, people rarely have just a single physical health condition or a mental health condition; they have combinations of multiple long-term conditions.

The SAIU have developed a segmentation approach that looks at these combinations of long-term conditions. The model outputs show that the segments of the population where there will be the most growth over the next 10 years are the most complex cohorts with multiple long-term conditions:

- 25% growth in the number of people with two or more complex long-term physical health conditions with dementia.
- 18% growth in the number of people with two or more complex long-term physical health conditions without dementia.
- This compares to an estimated 5% growth in the overall population over the same time period.
- The analysis is a local methodology and still requires further clinical review and approval before the ICB can fully adopt it and use the quantified outputs it produces for detailed workforce planning; but the indicative outputs at this stage are sufficiently accurate to guide the strategic direction of travel.

The SAIU also aim to project the additional resource required in financial and activity terms, as well as quantified estimates of the type and number of additional workforces required for each population segment. Detail is contained in Appendix B.

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The system will not be able to meet our future population health needs by continuing to grow the workforce based on the current model of service delivery.

It is clear that the demands on the system in the future will be significant and different to those faced today. Given the modelling we cannot continue to deliver services as we do today. There simply will not be the workforce (based on working age population) nor the estate in the traditional acute hospital configuration to expand services to meet these needs.

Current workforce challenges

This workforce plan has been developed against the backdrop of an unprecedented workforce crisis. Addressing our workforce challenges is the biggest barrier to improving the way we provide health and care in our communities. It is vital that we get it right for our workforce so we can provide the best possible care for the people of Nottingham and Nottinghamshire.

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Key workforce challenges

Recruitment and retention

It is nationally recognised that health and care face challenges in recruitment and retention – areas including nursing and midwifery, dental nursing, care workers and within the VCSE sector face the biggest issues. It is also nationally known that we have an ageing workforce and that retention rates for both students and newly qualified entrants are poor. We are committed to:

- A coordinated approach at a system level to attract more people to work in the sector, with clear career pathways and a commitment to being good employers to become an employer of choice.
- To develop how workforce move more easily across the system as part of the review to retain our people.

Diversity in our workforce

Our workforce does not reflect the diversity of the 1.2m population we serve. We need diversity in our workforce at all levels to ensure decisions are being made and care is being provided, that meets the needs of everyone.We have a significant way to go to ensure we have a workforce that represents the people we are serving, particularly at senior leadership levels. To do this requires positive action at a system level and addressing inequalities is a key priority within this strategy.

Health and wellbeing

The pandemic and subsequent recovery has been truly challenging for our workforce. Staff members have worked tirelessly to provide care when demand has been high, resulting in high sickness absence levels compared to pre-pandemic levels. This continues to place further strain on our workforce, our finances, and the services we provide. We recognise that we must take more action to help keep our workforce well; focusing on sustainable workplace wellbeing, cultivating balance and flexible ways of working that minimise the causes of sickness.

Cost of living crisis

As the biggest collective employer in Nottingham and Nottinghamshire, we have a fundamental role to play as an anchor institution to support our workforce and wider communities through economic growth and recovery. The East Midlands Combined County Authority is developing an Inclusive Growth Strategy for our region, and we want to make sure that we are both contributing to this development and aligning its outputs to our workforce plans.

ICS planning for the future

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Social care parity across the system

The pandemic further reinforced the lack of parity between our NHS and Social care workforce. We acknowledge that we have so much more to do as a system to improve the experience of colleagues in social care, to use our collective power and influence to share many of the benefits enjoyed by NHS colleagues. This will be extended to our primary care and VCSE workforce too. We recognise our workforce in social care, primary care and VCSE should benefit from receiving the living wage, having access to occupational sick pay and occupational health and wellbeing support.

The national political context

A new government has brought a new focus and approach to NHS planning, and whilst there is a short-term focus on financial balance there is a longer-term planning process under way.
A 10 Year Health Plan and a refreshed workforce plan is to be unveiled in the spring and summer of 2025.

Lord Darzi's report laid bare the systemic issues which have over a number of years resulted in poorer experiences for patients and staff.

The data shows that nationally:

- There are almost 16% fewer fully qualified GPs in the UK than other high-income countries relative to our population.
- The number of nurses working in the community fell by at least 5% between 2019 and 2023.
- There was a reduction of 20% in the number of health visitors – who can be crucial to the development in the first five years of a child's life – between 2019 and 2023.
- The number of mental health nurses has just returned to its 2010 level.

Whilst the NHS 10-year plan will focus on the delivery of three big shifts in the focus of healthcare.

- Hospital to community.
- Analogue to digital.
- Sickness to prevention.

ICS planning for the future

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The Government's White paper 'Get Britain Working'[iii] sets out an ambition to scale up and deepen the contribution of the NHS and wider health system to improve employment outcomes, which will influence the transformation agenda for the ICB. The paper sets out the strong evidence on the health benefits of good work, including:

- Supporting the NHS to provide 40,000 extra elective appointments each week and deploy dedicated capacity to reduce waiting lists in NHS Trusts in England with the highest levels of health-related economic inactivity.
- Address key public health issues that contribute to worklessness, through an expansion of Talking Therapies, our landmark Tobacco and Vapes Bill and a range of steps to tackle obesity (including trials of new treatments).
- Expand access to expert employment advisers as part of treatment and care pathways, in particular mental health and musculoskeletal services. And to expand access to Individual Placement and Support (IPS) for severe mental illness, reaching 140,000 more people by 2028/29.

ICS planning for the future

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The local political and social context

In March 2024, the East Midlands Combined County Authority (EMCCA) published its strategic approach and framework for growth. The vision for the EMCCA is:

"We will make our region more prosperous, sustainable and fairer, helping our people and businesses to create and seize opportunities."

The goal goes beyond the purely economic, towards an ambitious agenda of transforming the life chances sustainably of everyone in the EMCCA area. While economic growth and high productivity are central ambitions for EMCCA, inclusive growth is an approach enabling as many people as possible to contribute to and benefit from greater prosperity. EMCCA's prioritisation of three areas will be most relevant:

"Aligning skills to economic need to increase productivity and wellbeing" which aligns to our drive for productivity and recognises the benefits of good quality work on mental and physical health.

"…more and higher paid … jobs" which will include improvements to skill mix, training, and education to ensure that we have the right roles, in the right places delivering the care needed.

"Reducing inequality and promote social mobility" which aligns to our role as an anchor institution to drive local growth and development in business but also as an employer to ensure we recruit staff from our local population and move towards becoming representative of the population we serve."

The local authority plans have a golden thread of aligning and raising skills, creating more jobs, and supporting residents into employment.This aligns with the Integrated Care Systems strategy and our ambition to develop our workforce, support local economic development and be representative of the population we serve.

ICS planning
for the future

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What needs to change?

A workforce based on system service transformation

The ICS transformation areas have been used as a framework for the development and delivery of a strategic workforce plan, and provide the building blocks for the development of a workforce plan driven by transformation objectives rather than financial envelopes. An ICS People Planning Framework has been developed to ensure consistency of approach and ensure alignment around the four standard workforce objectives detailed in NHS people plans.

Work across transformation priorities to have clear workforce strategies and plan, including all system partners within a program – matrix working will be key to understanding dependencies and opportunities across programs.

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.

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).

Digital technology as an enabler to flexibility and resourcing a systems footprint not an organisational one with coordinated implementation of workforce digital technology e.g. e-rostering and e-job planning.

System leaders will need to increasingly make some fundamental decisions regarding the organisational arrangements for the delivery of care. These decisions will potentially have a material impact on the employment model and how the workforce transformation can be planned and delivered over the next five years.

ICS planning for the future

2025

Priority programme service transformation

Priority transformation programs will continue to be developed concurrently with a phased delivery plan over the next five years and will include:

- Strategic workforce efficiency and transformation
- Frailty, including Proactive Personalised Care
- Community Transformation, including Primary Care
- UEC Transformation, including respiratory, admission avoidance, UCCH (UEC Board)
- Mental Health (Mental health board)
- Elective pathway redesign and increased productivity, led by the provider collaborative (Planned Care Provider Transformation)
- End of Life / Hospice Care (Planned Care Provider Transformation)
- Digital Transformation, with a single digital transformation approach across health and care (Digital and Intelligence)
- Best Value Services and Waste Elimination (Clinical and Professional Transformational Senates)
- Provider Collaborative
- Planned Care Provider Transformation

And not a program:

- Children and young people.

Each programme will be expected to drive meaningful workforce integration that not only looks at how we deliver better services within the current parameters, but how we as a system can influence the national agenda.

Our ‘One Workforce’ ambition looks at how our people work together in delivery of our shared goals in health and care, starting with behaviours and the way we work at a system level, as well as how every member of our health and care workforce feels that they belong and are treated fairly.

We recognise that there are areas that are out of our sphere of control, for example implementing the real living wage in the independent care sector. However, in these areas we must make the most of the opportunity to influence local partners as well as the national agenda.

Our ‘One Workforce’ ultimate ambition would be to have a workforce plan that includes all of those working in health, care, the VCSE sector, volunteers, and unwaged carers.

ICS planning for the future

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As a system, we have a strong history of working together to deliver health and care services, we still have more work to do to undertake the culture change needed to truly transform the way we deliver care.

What will influence the workforce transformation?

We recognise we must work with our workforce across all organisations and all levels to shape the culture and ways of working we want to see. We acknowledge we need to challenge and call out behaviours and outdated nonvalue adding ways of working to promote this culture shift where collaboration, trust, and openness are at the heart of everything we do.

Financial affordability and the impact of funding arrangements

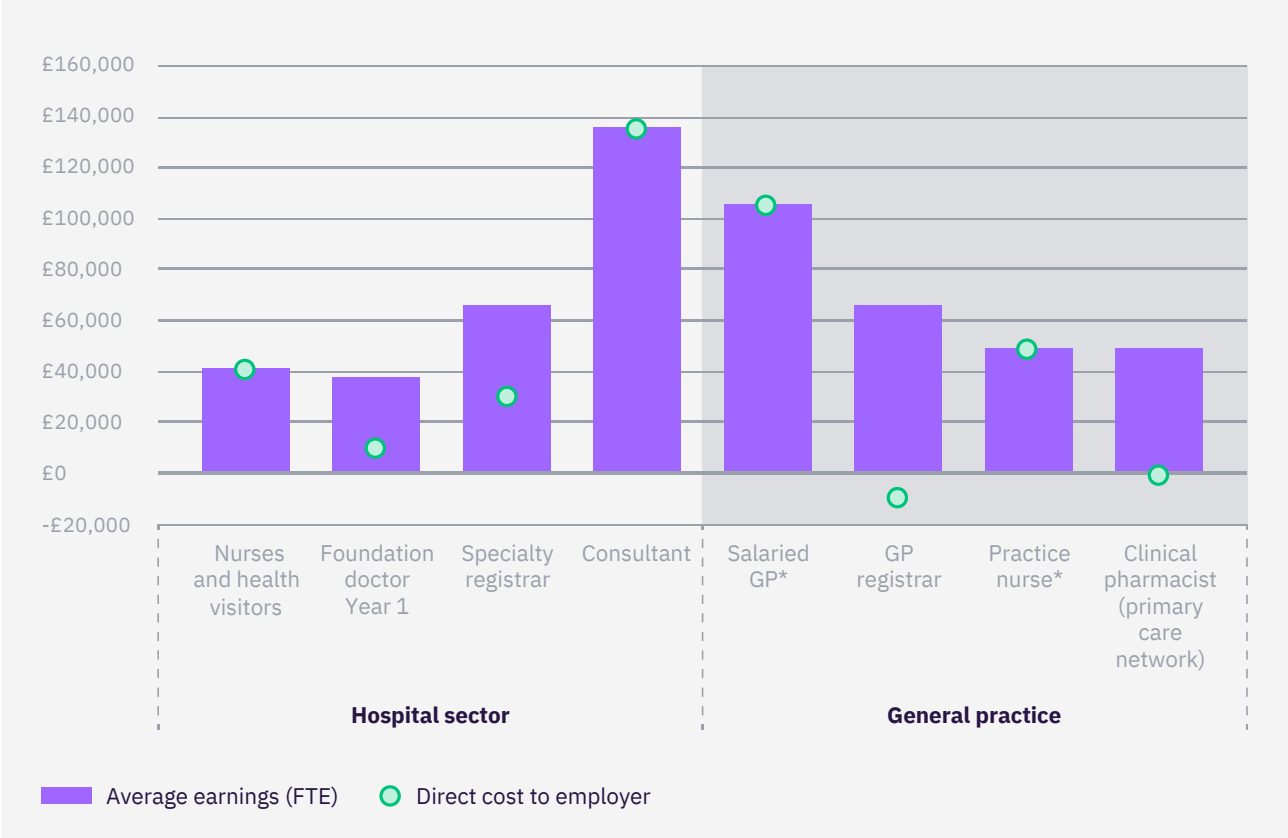
All our health and care services are facing unprecedented financial pressures. Our people are our greatest asset, but due to significant growth during the pandemic the workforce is contributing to the current financial pressures with our running costs at unsustainable levels– with higher sickness absence rates, agency and locum spend and reduced workforce productivity. It is critical that we take action to resolve these workforce challenges in a sustainable way.

This will not necessarily be about our overall headcount, but focusing on retention, improving wellbeing initiatives, as well as thinking about working in a different way, embracing digital advancements, and reducing costly agency and locum spend, and premium pay.

Our current planned spend across the system (our three main providers NUHT, SFH, NHT plus ICB expenditure – correct as of December 2024) is £4,295 million for the financial year 2024-25 of this, direct pay expenditure amounts to £1,850 million. To deliver this plan £257 million of efficiencies are required from the four system organisations, of which £202 million are recurrent.

Current funding arrangements may be distorting local decisions on skill mix, given that the salary costs to providers differ significantly from the actual costs from a taxpayer perspective. In particular, NHS trusts are incentivised to plan to use junior doctors rather than other staff, because NHS England covers half of the basic salary costs of doctors-in-training – and all GPs in training – with further national funding for their training placements. This means, for instance, that the costs to an NHS trust of employing a nurse is around four times that of a newly qualified doctor and broadly similar to that for a specialty registrar.[iv]

Table 3: Average earnings and costs to employers of selected professions employed by NHS trusts or in general practice

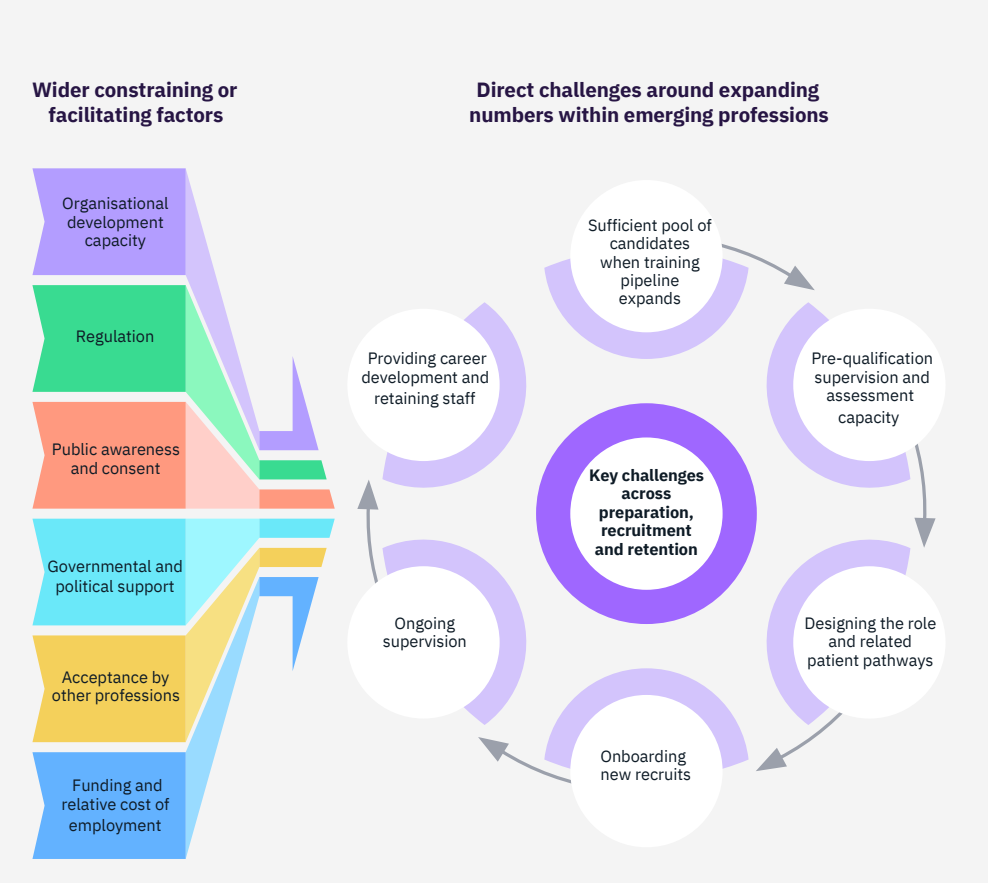


Source: Nuffield-Trust-In-the-balance-report.pdf
Note: Recently qualified GPs can also be employed through ARRS since 2024 (with general practice nurses set to be added in 2025) and have salary costs covered centrally.

How much change and transformation are needed and by when?

It is important for the system to learn the lessons from previous national and ongoing initiatives to introduce new and emerging roles and reshape the workforce. Important factors that need to be considered when embarking on such work now and in the future, encompassing challenges, constraints and facilitators are presented below. Although each priority program has, and will continue to have, unique challenges and opportunities, most of these factors run through all initiatives.

Table 4: Challenges, constraints and facilitators to the use of new and emerging roles



The ICB working assumption is that the service delivery model will need to transform, delivering more preventative care in community settings and less in line with the current acute in hospital model.
To achieve this, it is estimated based on current evidence that a 20% shift in service delivery will be needed over the next five years, as there will be little funding to grow the workforce, this will mean a shift of up to 20% in staff delivering acute episodes of care to out of hospital and preventative models. Subject to NHS planning guidance zero workforce growth is assumed in year one, 2025/26 with a modest 2% growth in years two to five.

The current workforce numbers and impact over the next five years

As of 31st October 2024, 51%, of the total workforce delivers Social Care, 31% Acute Care and 18% Out of Hospital Care (inc. Mental Health). At the end of year five of the plan this could have changed to 51% delivering Social Care, 24% Acute Care and 24% Out of Hospital Care (inc. Mental Health).

If the priority service transformation plans are fully delivered, the indicative impact in the whole-time equivalent workforce numbers as detailed on the next page.

ICS planning for the future

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	25/26 Year 1 0% shift	26/27- Year 2 3% shift	27/28 Year 3 10% shift	28/29 Year 4 7% shift	29/20 Year 5 2% shift
% Workforce delivering services in acute care settings	31% c23.3k	30% c23.1k	27% c31.3k	25% c20.2k	24% c20.1k
% Workforce delivering care in Out of Hospital (inc. Mental Health) settings	18% c13.8k	19% c14.7k	22% c17.3k	24% c19.2k	24% c20.0k
% Workforce delivering care in Social Care settings	51% c39.3k	51% c40.0k	51% c40.8k	51% c41.7k	51% c42.5k
Transformation Focus	Frailty program communication and staff engagement	This is when the bulk of the transformation shift happens as all the preparatory work, recommissioning and retraining have happened. All priority programs start to deliver workforce transformation. Good communication will be necessary to ensure staff are engaged with all the transformation programs - public engagement and consultation will also be necessary to explain the shift of care delivery.	Continuation of transformation shift from Year 2 (left, 26/27)	Embedding the transforming workforce, evidence of new skills and ways of working having an impact on patient outcomes.	Final year of transformation
People Team Actions	Actively recruiting into non acute roles	Switch to non acute transformation delivery plans in all programs.	Depending upon the employment model developed in years 1&2 staff transfers TUPE may be necessary. Implementation of more flexible ways of working.	Continuation of work in Year 3	Continuation of work in Year 3 and Year 4
Work to support training		Work with HEIs to adapt education to fit the new care delivery model.	Education and training programs in place to support transformation as set out in skills work with transformation programs.	Continuation of work in Year 3	Continuation of work in Year 3 and Year 4

Overall workforce growth
No workforce growth in year one assumed 25/26 with very modest shifts from acute delivery of care. An assumed 2% growth in years 2-5.

ICS planning
for the future

2025

Workforce Transformation Plan

Optimising use of the current workforce and introducing transformational changes

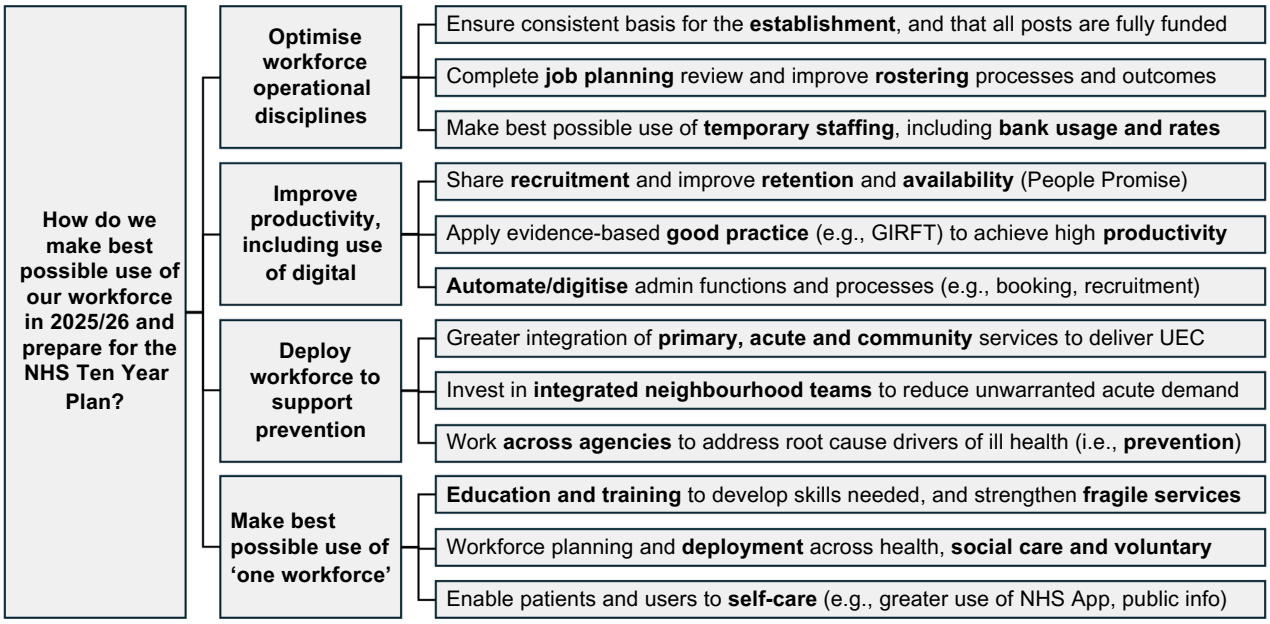
Whilst we need to develop our future workforce the need to effectively control and deploy our existing workforce continues as a priority focused on four key themes:

Optimising workforce operational disciplines

Improving productivity including digital utilisation

Left shift workforce to support prevention

Achieve the 'One Workforce' ambition

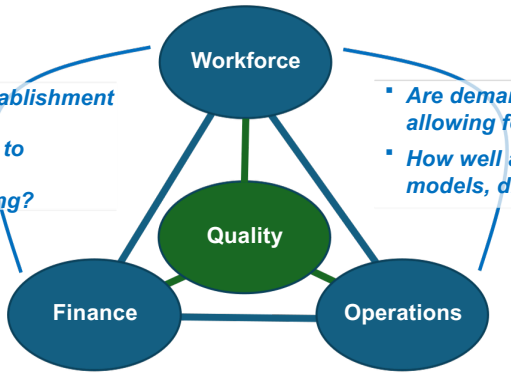


It is essential that the work of transformation programs is both internally integrated to ensure that alignment of workforce, finance, operations and quality of care and also that across the programs there is a system level of alignment.

ICS planning for the future

2025

Making best possible use of the existing workforce and introducing transformational changes



- *What is the staffing establishment and is it fully funded?*
- *What needs to be done to optimise use of temporary staffing?*

- *Are demand assumptions aligned with workforce, allowing for productivity improvement?*
- *How well aligned are the service and workforce models, drawing on best practice?*

Sustainable financial planning, based on demand and productivity assumptions, and efficient use of workforce

Local and system capacity planning and improvement, by service, setting and pathway, with a focus on productivity

- *Have stretching improvement goals been set based on the available benchmarking data and national tools?*
- *How does the financial plan account for planned capital investment, and improvements in elective and UEC performance?*

The process of transformation workforce planning

Programs are encouraged to follow the skills for care six steps methodology for workforce planning.

The Six Steps Methodology offers:

A systematic practical approach that supports the delivery of quality patient care, productivity and efficiency. Assurance that workforce planning decisions taken are sustainable and realistic. A scalable approach, from small ward-based plans to large organisations. A joined-up approach with social care, where the same approach has been adopted.

Step 1: Defining the plan
Step 2: Mapping service change
Step 3: Defining the required workforce
Step 4: Understanding workforce availability
Step 5: Planning to deliver the required workforce
Step 6: Implement, monitoring and refresh

Joint forward plan commitments

The ICS priority areas and actions have been summarised into the single side people and workforce joint forward plan summary.

ICS workforce strategic themes	Issues and risks to delivery	Year 1 2025/ 26 Baseline and plan transformation and delivery.	Year 2 2026/ 27 Deliver and review	Year 3 2027/ 28 Deliver and refresh plans	Years 4-5 2028/29 & 30 Deliver
The resources, infrastructure, and governance. Deliver Planning for the future: Transforming the health and social care workforce for Nottingham and Nottinghamshire	Work pressures and delivery of today's financial efficiency priorities. The challenge of linking the education plans to the long-term workforce plan.	Governance mechanisms have been established will as needed evolved & embedded. Stage 1: Performance and risk will be managed monthly to create a more dynamic 'one workforce' ICS WTE plan with pay bill and activity triangulation.	'One workforce' becoming a reality. Providers workforce - right sizing. Competition for roles in high demand will have been replaced with collaborative approaches that support the system 'one workforce' approach. Economies of scale and the benefits of, Simplification, Standardisation, Consolidate and Automate are delivered.	Population health needs drive plans. Stage 2: workforce planning delivers clinical service transformation, new roles and new ways of working, integrated education and training becomes directly informed by and aligned to population health predicted data. The dynamic one workforce plan becomes long-term looking with partners at 5-15 years	Stage 3: the processes put in place at stage 2 are reviewed and refined to ensure optimum deliver of aligned workforce plans.
Resourcing/right sizing (including retention)	Balancing the needs of the system with the aspiration of the Long-Term Work Force Plan.	Focus on collaborative approach to shortage skill areas to develop system working approaches. Establish collaborative standard bank rates, stage one alignment of existing bank pay. Introduce system talent half yearly development program. Agree a system wide Equality and anti-racist strategy.	System approach attraction and retention. Stage 1: of integrated system resourcing. Introduce digital enabled solutions for system recruitment. Grow the contingent workforce to include multi agency working. System wide implementation of regional talent academy.	Expand digital solutions & AI supported recruitment. Stage 2: establish full recruitment hub based on evaluation of proof of concept and identified economies of scale	Operational system recruitment hub. Stage 3: review, evaluate and further develop all resourcing approaches and consider further consolidated working
Strategic workforce planning: System-wide integrated workforce approach linked to population health predictions and education needs.	Data sharing .	Establish a common workforce planning approach. Integrate workforce data, analysis and intelligence into system planning to inform capacity, demand and affordability. Developing 'one version of the truth' through agreed system metrics and dashboards.	Establish a common approach to productivity measurement. Develop 3 – 5-year digital skills workforce development and training plan as part of wider ICS workforce planning. Develop a system wide approach to measuring workforce performance and productivity.	Explore further opportunities for alignment across the system to support service transformation planning and Integration	Review, evaluate and further develop Strategic workforce planning
Delivering the future of HR: The professionalisation and standardisation of HR policies, procedures, and practices across the ICS		All NHS providers being registered and fully utilising the digital staff passport to support movement of staff between organisations	Developing a rotational scheme to support professionals to move between sectors (e.g. NHS providers, primary care and social care) and pathways	Establish core HR working across the NHS providers including Primary care	Review evaluate and seek further opportunities

ICS planning for the future

Optimising use of existing workforce

Transformation of models of care and workforce deployment

Rushcliffe Arena, 09:00-13/03/25

ICS planning
for the future

2025

What transformation looks like?

Transformation of models of care and workforce deployment – a move to integrated care and integrated neighbourhood teams (INT)

The aim of integrated care is to give patients control over their care provision by coordinating services around them; in contrast to the existing arrangements with care coordinated around the service providers. Integrated care isn't (usually) about structural/organisational integration, it's about a range of different organisations across the NHS, voluntary sector, social care etc working together, supported by common purpose, shared data/analysis, a joint approach to service/workforce planning, shared approaches to quality improvement, shared approaches to public/patient involvement etc.

There has tended to be an assumption that staff in teams and services know each other and have a good understanding of their respective roles and capabilities that will allow them to do this. Very often this is not the case and especially not as INTs will be bringing together GP practice, wider primary care, social care, community and a range other staff including many people from other parts of the system into new teams. These staff will have often worked separately and been loosely connected. The nature of their work means that much of their time is spent in one-to-one consultation with patients or contact with clients rather than colleagues.

Work by Michael West [v] and others [vi] shows a clear link to effective teamwork and performance. However, too often in healthcare people work in 'pseudo-teams', i.e. they are in work groups which lack vital elements. West identifies several elements of high functioning teams:

- A limited number of clear objectives.
- Clear roles and responsibilities.
- High-quality and frequent communication and interdependent working.
- Reflectiveness – the team comes together regularly to reflect on their practice, how they work as a team, their relationship with other teams and how these can be improved.
- Conflict is identified and resolved.

This helps to create an environment of 'psychological safety' [vii] in which staff can voice concerns, try out ideas and talk about things that have not gone well. This is also closely associated with high levels of team effectiveness, innovation, productivity and higher quality care. In addition, mentoring, peer support and feedback on progress are needed to help with the continued development of the team and sustaining progress.

The following are eight priorities for the system to include in addition to specific employer actions:

1. **Developing employment models** that enable staff to work for a local health system rather than just one organisation within that local health system.
2. **Supporting flexible career paths** across roles in health and care.
3. **Working with schools, colleges and local communities** to attract local people into health and care careers.
4. **Working with local enterprise partnerships** to help increase employment opportunities, including improving access to skills training.
5. **Optimising apprenticeships** and getting best value from the apprenticeship levy.
6. **A more systematic, scaled-up approach to developing multidisciplinary teams** that make better use of existing skills – and equip staff with new/enhanced skills – to reflect new models of integrated care.
7. **Proposals for how the system can use OD to bring together local clinical and operational leaders from across different sectors** – as well as staff, patients, service users and carers, to redesign workforce models, particularly for service transformation priorities.
8. **A strategic approach to system growth, training and education of the future workforce** includes a big emphasis on developing a more agile, flexible workforce, with a stronger bedrock of generalist skills and with a good understanding of population health, social determinants of health etc. and better able to work in multidisciplinary teams and across traditional sectoral boundaries.

ICS planning
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Priority activities for collaborative action led by the ICB:

Making the NHS the best place to work:

Developing employment models that enable staff to work for a local health system rather than just one organisation.

Designing a core induction and a standard set of statutory and mandatory training requirements for all new starters across a local health system

Supporting flexible career paths across roles in health and care, including enabling staff to move easily between roles in different employers.

Developing employment models for primary care networks that enable staff to work across different settings.

Developing collaborative approaches to measuring and improving equality, inclusion and diversity

Improving the leadership culture:

Succession planning and talent management to develop local current and future leaders with the right skills.

Workforce redesign:

Spreading and adopting new roles and new ways of working to better meet local population health needs.

Releasing time for care:

Developing strategies to build digital literacy across the local workforce and ensure staff are equipped to realise the potential of digital technologies.

ICS planning
for the future

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Priority activities for collaborative action led by the ICB:

Growing and training our future workforce:

Working with schools, colleges and local communities to attract local people into health and care careers.

Working with local enterprise partnerships to help increase employment opportunities, including access to skills training.

Overseeing distribution of clinical placements and medical rotations across providers.

Optimising apprenticeships and getting best value from the apprenticeship levy.

Developing collaborative arrangements for international recruitment across local providers that help address workforce shortages and adhere to ethical recruitment standards

Developing collaborative approaches to managing temporary staffing, including establishing collaborative staff banks.

Underpinning activities:

Developing an agreed system-wide approach to measuring and analysing workforce data and performance.

Aggregating local workforce requirements to support discussions with national bodies on priorities for education, training and workforce development.

ICS planning for the future

2025

Embedding a workforce transformation framework

The workforce transformation framework is being developed with the ICB transformation delivery group program office. Project initiation documents for all the priority programs will need to be reviewed and from these an overall workforce plan with milestones and deliverables for the system workforce plan will be developed. This work is planned for February and March 2025.

Conclusion

Planning for a future one workforce is a complex and multi faceted process, with multiple dependencies. The additional out-of-hospital workforce will need to balance managing greater prevalence of long-term conditions, coordinating the care of individuals with complex care needs through Integrated Neighbourhood Teams (INTs), and more preventative work helping people live healthier lives and supporting older adults with challenges such as social isolation.

The skills of both the current and new workforce will need to be focussed on these areas, with education, training and development especially centred around meeting the needs of a growing older population with multiple physical and mental health conditions.

The ICB will need to regularly review the workforce plan on at least an annual basis using a rolling five-year workforce model and rolling 10-20 year population demand model so that we might anticipate the future needs of the population and plan the future workforce accordingly, in a proactive manner.

References

[i] Definition of ‘one workforce’ - NHS ICS Design Framework – ‘we expect ICS NHS bodies to adopt a ‘one workforce’ approach and develop shared principles and ambitions for people and culture with local authorities, the VCSE sector and other partners’ Embedding a workforce transformation framework
The workforce transformation framework is being developed with the ICB transformation delivery group program office. Project initiation documents for all the priority programs will need to be reviewed and from these an overall workforce plan with milestones and deliverables for the system workforce plan will be developed. This work is planned for February and March 2025.

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

[iii] Get Britain Working White Paper - GOV.UK

[iv] National Audit Office (2016) Managing the supply of NHS clinical staff in England. National Audit Office. www.nao.org.uk/reports/managing-thesupply-of-nhs-clinical-staff-in-england. Accessed 4 October 2024.

[v] West MA, Lyubovnikova J. Real Teams or Pseudo Teams? The Changing Landscape Needs a Better Map. Industrial and Organizational Psychology. 2012 5(1):25–8. Embedding a workforce transformation framework
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[vi] Fiscella K, Mauksch L, Bodenheimer T, Salas E. Improving Care Teams’ Functioning: Recommendations from Team Science. Joint Commission journal on quality and patient safety. 2017;43(7):361–8.

[vii] HBS Working Knowledge. 2023. Four Steps to Building the Psychological Safety That High-Performing Teams Need Today. http://hbswk.hbs.edu/item/four-steps-to-build-thepsychological-safety-that-high-performing-teams-need-today

ICS planning
for the future

NHS
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Appendix A

Currently out-of-scope and working assumptions

The scope of this People and Workforce Plan contains a number of working assumptions and exclusions that will be addressed in future iterations of the plan:

- Detail relating to the workforce employed in General Practice and Social Care and other system providers has not been included, at this stage the plan focuses on the NHS provider workforce as a starting point.
- Assumptions relating to workforce growth have been included for years 2-5 this is subject to detail yet to be published in annual and long-term planning guidance.
- The plan recognises the demographic profiling for the future population health needs as a predictor of future demand for activity.
- An indicative 20% shift in service delivery, to move to more of a prevention upstream model of delivery from the current treatment in hospital model in recognition of the population health predictions has been used.
- A model of employment and system organisation configuration is not included, the focus of the workforce plan is to outline the transformation shift in service delivery to out of hospital.
- Detailed workforce plans relating to the priority programs will be developed by each program, the workforce plan will reflect the sum of these priority programs transformation including skills mix, location of service delivery and workforce integration.
- The plan currently uses a whole-time equivalent level not a professional or specialty level, this degree of detail will be included in future versions of the plan.
- Future iterations of the plan will include detail relating to education and training, retention and attraction based on the developing professional system strategies, for example Nursing and Midwifery.

Appendix A

Nottingham and Nottinghamshire

- The plan focuses on transformation not improved operational and transactional efficiencies.
- Governance and oversight of delivery for the workforce plan is part of a wider consideration for governance and oversight of system transformation which as yet to be confirmed.
- Digital transformation will have a potentially significant impact on workforce, automation and training will be key, the workforce plan will be aligned to the emerging digital strategy.
- The whole-time equivalent numbers are based on establishment in NHS providers and therefore will be subject to review as part of the annual operational planning round.
- This Workforce Plan is dependent upon the evolving Integrated Care Strategy. As such it is anticipated that the People and Workforce Plan will evolve both as the ICS strategy evolves and in relation to the emerging national requirements as set out in the anticipated 10 NHS plan and the updated Workforce Plan.
- This Workforce Plan will need to evolve as the transformation priorities develop to include more detail of workforce transformation in general practice and in the local authority and social care workforce.

ICS planning
for the future

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Appendix B

Building our Integrated Neighbourhood Teams: A Workforce Perspective 2025/6

Integrated Neighbourhood Teams (INTs) (and associated multi-disciplinary approaches supporting people to maintain independence at home) need practical support from the system in which they operate, including clarity on their overall purpose and performance metrics which reflect their integrated care responsibilities.

Evidence suggests that integrated health and care teams, incorporating MDTs, can lead to a range of positive impacts for individuals and families, including increased survival rates for people diagnosed with cancer, reductions in the number of people at risk of abuse being taken into care, and gradual reductions in people with long term conditions and/or older people undergoing unplanned admissions to hospital. MDTs can also result in professionals feeling more supported and positive about their work, and therefore improving their overall wellbeing and motivation. However, other studies have found that MDTs have little or no impacts in relation to reducing people's reliance on health and social care services on a population level and that they can result in people feeling less, not more, able to influence decisions over their care. Consequently, the way in which MDTs are designed, implemented and resourced is crucial to positive impacts being achieved (Multidisciplinary teams working for integrated care - SCIE). In order to maximise our opportunity for success the design and oversight of the INT approach rests with the Community Transformation and Frailty Transformation Programme Boards as part of a broader programme of transformational change across our system.

Initial consideration of the make-up of our INTs, with specific reference to the development of our frailty pathway in 2025/6, is under development. We have identified Frailty as our starting point for a wider model of integrated working, with rapid inclusion of integrated approaches for addressing the needs of people with long term conditions, severe multiple disadvantage and for children and young people with complex needs from 2025/6 onwards.

Our Model for Multi-disciplinary working within the Frailty INT in 2025/6. We are focussed on function rather than form in this initial development period. We are proposing a core 'management' capability comprising a senior clinical leader, a senior managerial lead and a senior care professional.This capability will need to demonstrate the following characteristics of skills and competencies.

Appendix B 2025

A) Core Skills and Competencies

Facilitative Leadership:

- Team leaders of MDTs should generally be facilitative in approach to encourage different contributions but be ready to be more directional when necessary.

Experienced leadership capability:

- An awareness of team dynamics and a willingness to challenge poor collaborative practice are important competencies for team leaders.

A learning environment (culturally and physically supported):

- Supportive physical and/or virtual environments and dedicated team reflection time improve communication and strengthen constructive discussion between members.

Knowledge of local community strengths and assets and maximising MECC approach:

- MDTs need to engage with other teams and services in their local neighbourhoods to help their wider systems better understand the role and skills of the team.

Person centred approach:

- A commitment to person-centred care should be an explicit value within shared practice and processes to encourage members to embed open communication with individuals about their care and options, and so provide genuine opportunities for co-production in decision-making.

Evidence informed and impact aware:

- Timely and accurate evidence of the impact of teams which relate to their overall purpose and the organisation of structured opportunities to reflect on this evidence strengthens their effectiveness.

Appendix B 2025

B) Responsibilities of the INT

It is anticipated that the ‘core’ INT management team will be responsible for the following within each INT:

- Quality assurance.
- Quality Improvement.
- Data monitoring of defined population cohort (e.g. people with severe/moderate frailty).
- Ongoing analysis of resource utilisation and follow up action required at practice/PCN level.
- Crisis management/patient and carer engagement and reassurance or onward referral.
- Live patient experience outcome measures.
- Home visit governance/oversight (expected time of arrival/contact details for reassurance).
- Responsibility for cost benefit analysis of service provision along the pathway.
- In reach into acute environment to support discharge.
- Reducing unexplained variation in outcomes.
- Reducing emergency admissions, reducing LOS and care home placements.

The ability to monitor achievement of these outcomes/deliverables will mature over 2025/6+ supported by our ‘enabling’ transformation agendas across digital/IT, workforce and estates. Identification of individuals within the ‘core INT team will be through existing partners across our health and care sectors – these are existing resources and not additional resources. All partners will need to remain flexible and supportive of this approach to enable its implementation. Specific job roles/descriptions will need to be developed in Q4 2024/5 to support implementation in Q1 2025/6.

Once established the ‘core’ INT team will work with partner organisations and relevant health and care professionals within an identified geographical neighbourhood footprint to design the MDT capacity and capability to provide relevant expert support and advice to local primary care clinicians and community providers to support the ongoing management of a defined patient cohort. A schematic version of this pathway of care for people with frailty is provided below in Appendix A. Each MDT will be sensitively designed to support the specific health and care needs of a specific neighbourhood population. It is anticipated that initially MDTs will be more health focussed but as the model matures over 2025/6 MDT participation will evolve to be more inclusive of a wider arrange of local health and care related professionals including our voluntary and third sector and wider public sector partners to ensure we maintain growing focus on ill health prevention not simply treatment.

To support a broader, multi-disciplinary concept of ‘one team’ at Neighbourhood level, the ‘core’ INT team will work with Place based Partnerships as well as system leaders and transformation programme leads to develop estates, digital and workforce plans in 2025/6. Workforce plans will be aligned to the system Workforce Plan and reinforce the need for agile/flexible working across geographical locations as well as shifting the form of delivery of care using multiple methods e.g. virtual, face to face, telephone. Plans will also focus on the Organisational Development needs of staff to support this transition.

Key success measures of INTs will include:

Improvement of health and wellbeing outcomes for a specific population cohort leading to

- Reduction in emergency admissions.
- Reduction in Length of Stay within an acute hospital setting.
- Reduction in placements into care homes.

In relation to people with severe or moderate frailty (over the age of 65yrs initially) key secondary outcomes will include

- Increase in number of people with personalised care plans.
- Increase in recorded Clinical Frailty Scores.
- Increase in people having a timely structured medication review.
- Fewer people admitted as an emergency admission on EoL pathway.
- Increase in referrals to prevention services including falls, exercise, vaccinations.

Improving staff wellbeing and transition into a ‘one team’ approach

- Health and care professionals report feeling increasingly integrated with peers across health and care sectors.
- Report increasing satisfaction with work and feeling empowered.
- Report that people and patients are receiving appropriate care to meet their needs.
- Report that they operate within an effective learning culture.

Improving patient, carer experience

- People are increasingly satisfied with the care they receive from the INT.
- People are feeling more confident to manage their own condition at home.
- Carers report feeling more supported to undertake their carer responsibilities.

Appendix B **2025**

C)Transitioning our workforce and health and care teams into new ways of integrated working

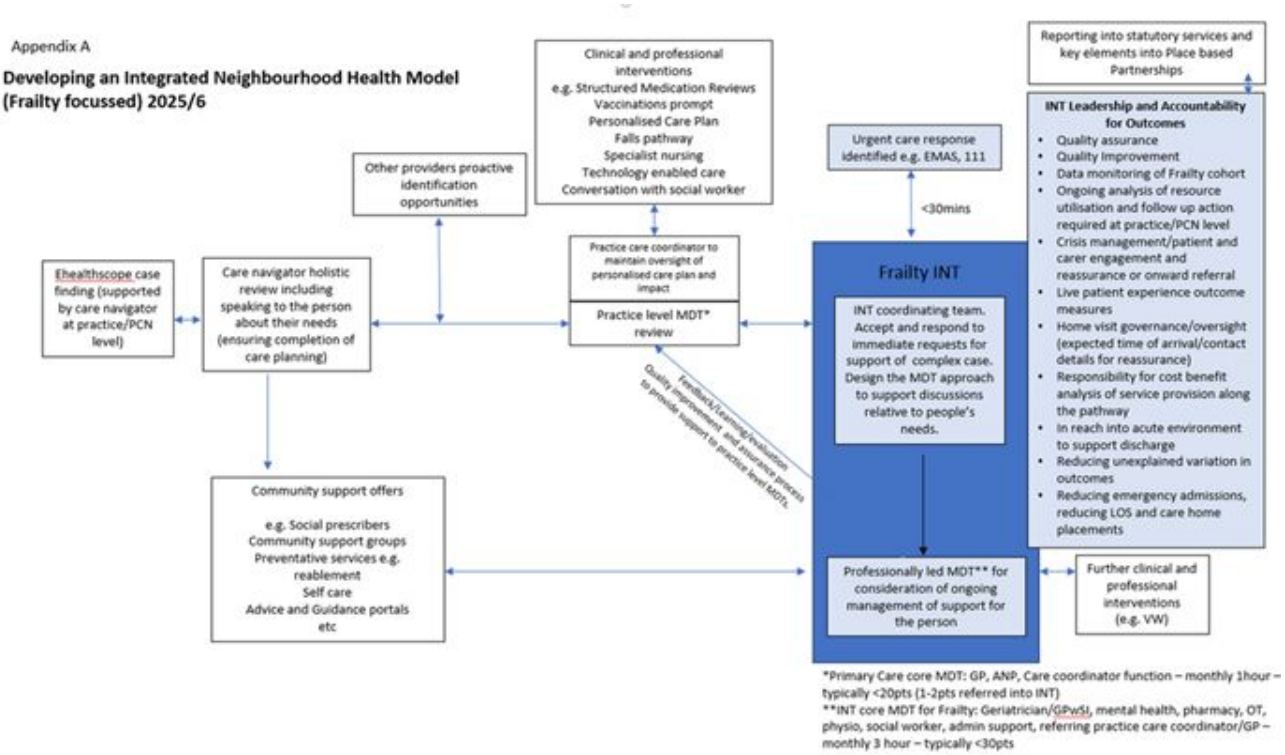
In order to support more care being provided within a community setting and outside of traditional hospital environment, we have made an assumption of a shift in resources from staff based within acute settings into community settings as part of INTs. Current estimates are for a 20% shift in this capacity over time – although the specific skill mix and capability is still to be defined.

As part of this initial development it is proposed that the frailty INT be supported in 2025/6 by:

- An initial tranche of hospital based nurses currently in hospitals to be trained quickly to work as part of community reablement teams building on our existing community teams. Identified nursing capacity would typically be from frailty/and CotE related specialties including respiratory, general medicine, stroke.
- Clinical job plans to change with more designated sessions with an identified community based caseload identified to support care of people identified as severe or moderately frail.
- Divert more trained student nurses to these type of roles to support ongoing succession planning into INTs
- Re-prioritise part of our existing community teams roles to a preventative / hospital admission avoidance / residential care support focus (although need to consider trade off with focus on other community type workloads)
- Promote ‘aggressive’ training of above and INT staff to gain confidence in use of population health data intelligence and frailty assessment tools / patient scoring databases held in GP practices especially in supporting identification of adults at risk (50-60s+) and those withmoderate frailty scores/ conditions in 60s-85s preventing them becoming severe frailty cases that are more prevalent users of services.
- Develop a housebound frailty service support service within each INT team deploying the staff above that could help provide/lead in collaboration with existing PCN teams and dock into Enhanced Care in Care Homes providers. Efficiency of opportunity could be part of this exercise to reduce potential duplication/inefficiency and promote effective use of existing resources consistently across the system.

Appendix B **2025**

- Undertake rapid consideration of closure of some existing acute / hospital beds over a phased three year period to facilitate transfer of existing hospital based staff to enable the above. We would need to be confident of the demand modelling on this and link into existing planned efficiencies of the acute.
- Work as partners across health and care to build and develop the carers role - with on going training and respite support and prioritisation of resources specifically focussed on the frailty related care model.This would include a preventative focus as well as potentially direct provision (befriending/benefits support for cold homes etc).
- Developing OD Plans for systematic as well as Neighbourhood and Place level interventions that enable staff to transition well into the new way of working.
- Identify a dedicated, time limited, INT transformation capability to oversee delivery of INTs comprising of partnership representation and under the governance oversight of the Community Transformation Programme. This team to work closely with partners at a Place level to ensure roll-out of INTs within a core model but with local sensitivity to neighbourhood population requirements.



ICS planning
for the future

Appendix C

NHS
Nottingham and
Nottinghamshire

Responding to the projected demand pressures

It is clear that the demands on the system in the future will be significant and different to those faced today. Given the modelling outputs presented above, we cannot continue to deliver services as we do today. There simply will not be the workforce (based on working age population) nor the estate in the traditional acute hospital configuration to expand services to meet these needs.

At this point, we are using a working assumption that the system can afford 2% workforce growth year-on-year in Years 2-5, but that workforce cannot increase in 2025/26 due to the financial position of the local NHS-funded services. These affordability assumptions still need fully testing with Finance colleagues following the publication of planning guidance.

Furthermore, the ICB working assumption is that the service delivery model will need to transform, delivering more preventative care in community settings and less in line with the current acute in hospital model.

There will need to be greater focus on self-care, enabled by more widespread use of digital technology, including apps, clinical algorithms and AI, digital consultations, wearables and sensors.

To achieve a more preventative, proactive model, it is estimated based on current evidence that an up to 20% shift in service delivery will be needed over the next five years, as there will be little funding to grow the workforce this will mean a shift of staff delivering acute episodes of care to out of hospital and preventative models of care delivery.

Table 1 (next page) shows the indicative current health and care workforce in Nottingham and Nottinghamshire, which totals c.76,500 Whole Time Equivalents (WTEs). Roughly half of this workforce (37,200) is healthcare workforce, and the remainder is social care (39,300).

Of the healthcare workforce, roughly two-thirds is acute-based (23,400), with the remainder working in an out-of-hospital including mental health setting (13,800).

Table 1. Indicative distribution of the workforce delivering acute, OOH (inc. Mental Health) and Social Care as of 31st October 2024.

Occupation types	Acute	OOH (inc. Mental Health)	Social Care	TOTAL	Acute	OOH (inc. Mental Health)	Social Care
Medical & Dental	3,127	1,213		**4,340**	72%	28%	0%
Nursing	6,984	3,325	750	**11,059**	63%	30%	7%
Registered/ Qualified Scientific, Therapeutic and Technical staff	3,038	2,092	175	**5,305**	57%	39%	3%
Support to Clinical Staff	3,883	2,382	30,825	**37,091**	10%	6%	83%
Other	7	8	4,925	**4,940**	0%	0%	100%
Non-patient facing	6,349	4,773	2,625	**13,747**	46%	35%	19%
Grand Total	**23,388**	**13,793**	**39,300**	**76,481**	**31%**	**18%**	**51%**

The analysis includes Nottingham University Hospitals, Sherwood Forest Hospitals, Nottinghamshire Healthcare, City Care, NEMS, PICS, EMAS Nottinghamshire division, General Practice, Primary Care Networks and the ICB, with the social care workforce based on estimates by Skills for Care.

The impact potential impact on the whole-time equivalent workforce of this up to 20% shift over the next five years is shown in Table 2 below, with more detail on the nature of workforce transformation in the following section of this plan.

This shows the 2% annual growth assumed in Years 2-5. No workforce growth in year one assumed 25/26 with very modest shifts from acute delivery of care. Based on this modelling, this would lead to a more equal split between hospital-based healthcare workforce and out-of-hospital workforce by Year 5.

The analysis presented here applies both the workforce % growth and the workforce % shift equally across all staff groups. However this is just for illustration, and the decisions about the additional roles to be added to the workforce need to be determined in the next iteration of this strategic plan through more detailed work at a programme level.

Table 2: By the end of year five the indicative workforce alignment to care delivery of acute, OOH (inc. Mental Health) and Social Care could look like:

Occupation types	Acute	OOH (inc. Mental Health)	Social Care	TOTAL	Acute	OOH (inc. Mental Health)	Social Care
Medical & Dental	2,708	1,990		4,698	58%	42%	0%
Nursing	6,048	5,111	812	11,970	51%	43%	7%
Registered/ Qualified Scientific, Therapeutic and Technical staff	2,630	2,922	189	5,742	46%	51%	3%
Support to Clinical Staff	3,363	3,419	33,366	40,148	8%	9%	83%
Other	6	10	5,331	5,347	0%	0%	100%
Non-patient facing	5,498	6,540	2,841	14,880	37%	44%	19%
Grand Total	**20,253**	**19,993**	**42,540**	**82,785**	**24%**	**24%**	**51%**

The additional out-of-hospital workforce will need to balance managing greater prevalence of long-term conditions, coordinating the care of individuals with complex care needs through Integrated Neighbourhood Teams (INTs), and more preventative work helping people live healthier lives and supporting older adults with challenges such as social isolation.

The skills of both the current and new workforce will need to be focussed on these areas, with education, training and development especially centred around meeting the needs of a growing older population with multiple physical and mental health conditions.

The following tables show the current indicative work force transformation activities over the next 5 years.

The ICB will need to regularly review the workforce plan on at least an annual basis using a rolling 5-year workforce model and rolling 10–20-year population demand model so that we might anticipate the future needs of the population and plan the future workforce accordingly, in a proactive manner.

Appendix C

Year 1

2025/6

Key deliverables

- Single system policies and process – maximising alignment
- E-rostering the clinical workforce: Consistent levels of attainment.
- Flexible contingent system workforce
- System commitment to and embedding of one Workforce Approach
- Workforce plans which align with local service and financial planning
- Sustainable services delivered by right people, right place, right time.

Objective

- Dynamic, integrated workforce with digitally enabled workforce solutions
- Future workforce plans that align to ICS needs
- ICS transformation approach outlines current challenges, future ambitions and sets a 5-year trajectory.
- Better workforce and patient experience

Interdependencies

- Requirements and understanding of the workforce impact of the transformation programmes.
- Understanding of the workforce impact of commissioning decisions

Risks and Considerations:

- Efficiency savings are currently at an early stage of development and are likely to change.
- Lack of understanding/knowledge for cross system workforce planning to achieve true transformation.
- Programmes may have made assumptions regarding workforce availability for qualified and registered roles to meet their resourcing requirements.
- Current skill level in organisations for workforce planning is based on vertical workforce planning within sovereign organisations with limited capacity to deliver horizontal workforce planning to enable transformation.
- Principle of ‘system first’ may not be followed by sovereign organisations.
- As all organisations are lowering their staffing levels there remains a risk of displaced staff because of change.

Appendix C

Year 1

Milestones

2025/6

Move to a one workforce approach.

- Commence work to 'right size' the workforce taking account of priority programmes and available funding.
- Scope a recruitment hub for the ICS.

Development of a flexible system workforce.

- Identification of further reductions in temporary staffing costs and further use of collaborative approaches.
- Scope the development of flexible workforce models.

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.

Work across transformation priorities to have clear workforce strategies - including all system partners withing a programme pathway.

- Work across all providers and social care to map the existing and future workforce.
- Map workforce elements of each programme to understanding timing and resource required.
- Establish education sub-group.
- As part of the annual planning enhance collaboration and triangulation of demand affordability and workforce.
- 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.
- Timescales for measurement may vary depending on programmes from the beginning of Q2 progress and risk reporting will be introduced.
- With NHSE WTE HEIs and in line with the LTWP (establish future needs and start developing Nottingham and Nottinghamshire integrated education approach.

Appendix C

Year 2 - Workforce Transformation Programme (2026/27)

Key deliverables:

- Delivery plans for workforce transformation fully aligned with local service and financial planning.
- Sustainable services delivered by right people, right place, right time.
- Frailty program initial priority program to go live, communication and staff engagement.
- Actively recruiting into non acute roles utilising the newly developed recruitment hub.
- System approach attraction and retention.
- Integrated system resourcing to support transformation.
- Introduce digital enabled solutions for system recruitment.
- System wide talent academy.
- Work with HEIs to adapt education to fit the new care delivery model.

Starting in year 2 through years 3 and 4 - Workforce Transformation Programme (2027/29)

Key deliverables:

- This is when the bulk of the transformation shift happens as all the preparatory work, recommissioning and retraining have happened.
- All priority programs start to deliver workforce transformation.
- Good communication will be necessary to ensure staff are engaged with all the transformation programs.
- Public engagement and consultation will also be necessary to explain the shift of care delivery.
- Population health needs drive further transformation planning, new roles and new ways of working.
- Integrated education and training become directly informed by and aligned to population health predicted data.

Year 5 - Workforce Transformation Programme (2029/30)

Key deliverables:

- Final year of transformation close down programs during the year and move to business as usual if not already done.
- Review, evaluate and further develop strategic workforce planning.

Appendix B

Strategic Workforce Planning for Efficiency and Transformation

Strategic workforce plan and delivery

Strategic workforce planning, education and transformation covers a spectrum of activity ranging from long term strategic workforce planning to immediate operational efficiencies driven change and the creation of new roles.

The workforce elements of transformation are both actual transformation and enablers, which run as a golden thread throughout all areas service and program delivery. **'System first'** which may result in differential benefits for organisations yet delivers an overall benefit for the system is the primary principle driving this programme.

Enablers

1. Digital technology as an enabler to flexibility and resourcing on a system footprint not an organisational one.
    - We will need to upskill our workforce to maximise the opportunities from technological and digital innovations, and embed new and different ways of working, successfully harnessing technological advances will require staff to work in fundamentally different ways, and will necessitate the growth of specialist digital, technology and genomics roles.
2. Work across transformation priorities to have clear workforce strategies – including all system partners within a program pathway.

Deliverables

3. Move to a **'one workforce approach'** recognising that the future workforce will want to have flexible rewarding careers within the system not, just an organisation, which supports and develops talent and is representative of the population of Nottingham and Nottinghamshire.
4. 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).

System first

Is the primary principle in development of the ICS People, this may result in differential benefits for organisations yet deliver an overall benefit for the ICS.

Strategic Workforce Planning

Is the process of analysing, forecasting and planning workforce supply and demand, assessing gaps, and determining targeted talent management interventions to ensure that an organisation has the right people – with the right skills in the right places at the right time – to fulfil its mandate and strategic objectives.

Strategic Workforce Planning is composed of six phases:

1. Strategic Direction - understanding key efficiency and transformation goals

2. Supply Analysis - understanding the current workforce (baseline)
3. Demand Analysis - understanding the volume and profile of demand
4. Gap Analysis - understanding the gaps between workforce demand and supply
5. Solution Formulation - determine the appropriate workforce interventions
6. Monitoring Progress - determine if the plan is delivering.

Why do Strategic Workforce Planning?

The environment today is one of rapid change and uncertainty.

Changing political direction, rapid technology advances, and increased pressure to do more with less, are just some of the factors leading to increased pressure to ensure that the required affordable resource is in place to effectively respond to changing priorities. When properly implemented, workforce planning ensures that an ICS and its partner organisations has an affordable workforce with the right people with the right skills in the right places at the right time.

Common challenges workforce planning can help resolve:

Efficiency and productivity initiatives

By strategically planning its workforce, an ICS can ensure that it can afford the right mix of skills needed to meet current and future population health needs.

Skills gaps

By strategically planning its workforce, an ICS will know where there is a skill need for its current and future state. Enabling workforce planning plan talent distributions to meet the skills needs of today and tomorrow.

Realignment

The skills will shift over time as new advances in treatment and or medicines become available. By using work-force planning, an ICS will know where it has existing skillsets and can support partner organisations to support reskilling and redeployment.

New priorities

A change in priorities be that new targets or an emergency response can mean a change in the scope of work in an ICS, e.g.

- Move from analogue to digital
- Care out of hospitals into the community

- Treatment to prevention

By having an active workforce plan and ICS will be able to proactively reshape its existing and future workforce skills.

Involve your Stakeholders

Who do you need to involve?

Developing a workforce plan is no small feat. There are many factors to consider, perspectives to acknowledge, and moving pieces to track during the process.

In developing the workforce plan it is important to **involve the right stakeholders at the right time** in the process. Not every stakeholder will have input at each point in the process, however, giving them an opportunity to be involved will ultimately help to secure buy-in when the time comes to implement the plan.

Who should you talk to?

The image to the right identifies examples of possible stakeholders to engage for different stages of the workforce planning cycle.

Strategic Drivers

What direction is your ICS going?

Determining the strategic direction for the ICS workforce plan involves **understanding key efficiency and transformation goals** and future objectives set by commissioners and partners in the ICS to understand how the workforce needs to be aligned to achieve them.

Questions to consider:

- What are the expected program changes over the next 1-3 years? What will drive these changes?

Cost savings and decommissioning will have an impact on the shape and size of the workforce in organisations and across the ICS.

- What are the short-term and long-term plans/strategies?
- What are the specific workforce challenges the organisation is expected to face in the short and long-term?

Skills gaps in specific professions will impact what changes are realistic over different timeframes.

- What challenges exist in the emerging medicine, economic and political environments?
- What legislative, policy or regulatory changes may impact achieving the ICS plans?

Supply Analysis – working with educators and NHSE

What is your workforce supply?

Conducting a supply analysis involves **understanding the current workforce (baseline)** and how it is projected to change over time, due to attrition and other trends. This phase is about painting a picture of the ICS workforce in terms of the right number of people with the right skills including the pipeline of trainees and their likelihood of remaining in the system post qualification.

Questions to consider:

- Current workforce baseline establishment and skills profile.
- What are your attrition rates? How will turnover affect your organisation's ability to deliver services?
- What is the current distribution of employee years of service?
- How much of your workforce will be retirement eligible in the coming years? Are these individuals in leadership/mission critical/hard to fill positions?
- Will employees who have left be replaced? If so, will it be done with internal or external hires?
- What are the costs of replacing skills internally vs. externally?

This is all more in the HR and people teams' space but must be informed by the ICS strategy and direction of travel

Demand Analysis – predicted population health needs

What is your workload demand?

Conducting a demand analysis involves **understanding the volume and profile of demand** the ICS and its partner organisations have historically handled, currently handles, and/or anticipates handling at a specific point in the future.

This information is used to project the number of staff resources (headcount and skills) needed to perform work in various job functions, taking into consideration current workload and emerging drivers. And needs to factor in transformation for and not limited to:

- Move from analogue to digital
- Care out of hospitals into the community
- Treatment to prevention

Questions to consider:

- How is delivery and performance are measured?
- How many people does (multi-disciplinary teams) it take? Is this anticipated to change in the future due to efficiency gains or program changes?
- Based on the strategic plan (or other projection of demand), how much activity is anticipated per year?
- Does the supply of employees meet the anticipated demand?

Gap Analysis

What workforce gaps do you have?

This involves **understanding the gaps between workforce demand and supply** and to define top priority gaps with the greatest impact on efficiencies or transformation delivery.

Depending on the supply and demand analysis, you may identify workforce gaps in different areas such as skills, competencies, staff numbers, location, occupations, etc.

Questions to consider:

- What gaps do you see between your workforce supply and workforce demand data?
- Which gaps are most critical considering your strategic goals?
- How would you prioritize your gaps in terms of what to address first?
- Which gaps are most difficult to close? Easiest?
- Do some gaps have more of an impact on organizational performance than others?

Common types of workforce gaps:

1. Skills - Current staff do not have the skills needed to accomplish the work that needs to be done.
2. Staffing Level - Current staffing levels do not meet the required workload demand.
3. Affordability – Current staffing levels are not affordable

Solution Formulation and Implementation

What is the appropriate solution?

Now that you have conducted a supply and demand analysis and determined and understand critical gaps, you are ready to **determine the appropriate workforce interventions** to close those gaps and enable your ICS and partner organisations to meet its strategic goals.

Questions to consider:

- What existing workforce intervention strategies can you leverage?
- Are there strategies other systems and organisations with similar problems we can leverage?
- Do you have multiple critical gaps? Do you need a multi-pronged approach?
- What factors might impede the success of your strategy (unions, employment law, organisational policies, etc.)?
- What will the short-term implementation activities be? What will the long-term activities be?

Examples of intervention strategies:

- Right-Size programs
- Consolidate/centralise functions
- Administrative efficiencies
- Re-engineer business processes
- Vacancy controls Strategic Sourcing (outsource to third parties)

Monitoring and Evaluation

Is the strategy working?

Now that you have implemented your intervention strategy, how do you tell if it worked? **Determine if the plan is delivering.**

It is important to monitor the performance of your implemented workforce planning solutions and their impact on the gaps they were designed to address, and to continuously improve solutions to maximize their effectiveness.

As the strategic direction, workforce supply, and workload demand changes over time, strategies need to be updated accordingly.

Questions to consider:

- How will workforce solutions be monitored and how will progress be measured? What metrics or key performance indicators will be used?
- What are the implementations critical success factors?
- How will revisions to the approach be implemented? Have there been changes in the internal or external business environment that would cause the plan to need revision?
- Has the ICS and partner organisations established processes to collect relevant workforce data and trends for this plan?

Template: Strategic Workforce Plan

		Narrative	Lead
1.	**Executive Summary** Provides a high-level overview of the proposed changes that will impact the workforce		
2.	**Stakeholders Involved** Also note any formal governance required		
3.	**Strategic Drivers**		
	Short and long-term ICS goals		
	Expected program changes over the next 1-3 years and what drives these changes		
	Specific workforce challenges the ICS is expected to face in the short and long-term		
	Challenges in emerging financial, operational and political environment		
	Stakeholder engagement strategies		
	Upcoming legislative, policy, or regulatory changes that may affect the ICS		
4.	**Supply Analysis** (baseline)		

Rushcliffe Arena, 09:00-13/03/25

		Narrative	Lead
	Current workforce demographic		
	Assessment of workforce alignment/support to current business strategy and needs		
	Number of employees at each impacted organisation inc. band and ESR designation		
	Attrition rates and the effect on organization's ability to deliver services		
	Current distribution of employee years of service		
	Overall workforce retirement eligibility in (X) years		
	Workforce retirement eligibility in (X) years for leadership/mission critical/hard to fill positions		
	Plans (if any) to back fill employees who have left (recruitment sources, internal/external hires, grades, etc.)		
	Costs of replacing staff internally vs. externally		
5.	**Demand Analysis**		
	Plan or strategy to measure demand and workforce impact in the ICS (include units of measurement)		

		Narrative	Lead
	Amount of met demand anticipated per year, based on the strategic plan (or other projection of work)		
	Number of people needed to accomplish current demand profile		
	Any anticipated workload changes due to efficiency gains, program changes, or other circumstances e.g. new technology or medical advances		
6.	**Gap Analysis**		
	Describe the gaps between your workforce supply and workload demand		
	Identify what gaps are most critical considering the strategic goals		
	Prioritise the gaps in terms of what to address first, second, third, etc.		
	Identify which gaps are most difficult and easiest to close		
	Identify which gaps have more of an effect on organisational performance		
7.	**Solution Formulation and Implementation**		
	Identify any existing workforce intervention strategies		

Rushcliffe Arena, 09:00-13/03/25

		Narrative	Lead
	Identify any applicable strategies other ICS or partners used when faced with similar problems		
	State the most critical gaps to address		
	Assess if the solution needs a multi-pronged approach (if so, describe possible approaches)		
	Identify any factors that might impede the success of the strategy (unions, law, organisational policies, etc.)		
	Describe short-term and long-term implementation activities		
8.	**Monitoring and Evaluation**		
	Describe how workforce solutions be monitored and how progress will be measured (include any metrics or key performance indicators)		
	Identify any factors critical to the success of workforce planning and implementation efforts		
	Describe how revisions to the approach will be implemented. Identify any changes in the internal or external business environment that would cause the plan to need revision		
	Describe the ICS established processes to collect relevant workforce data and trends for this plan		

Rushcliffe Arena, 09:00-13/03/25

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/03/2025
Paper Title:	**Joint Forward Plan: Delivery Report and Annual Refresh**
Paper Reference:	ICB 24 112
Report Author:	Joanna Cooper, Assistant Director of Strategy
Executive Lead:	Victoria McGregor-Riley, Acting Director of Strategy and System Development
Presenter:	Sarah Fleming, Programme Director for System Development

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

Summary:

This paper provides the bi-annual progress update on delivery of the current 2024/25 NHS Joint Forward Plan (JFP) key milestones including a high-level assessment of risk to ongoing delivery.

The paper also provides assurance in respect to the refresh of the JFP (2025-2030) and its alignment with the proposed refreshed Integrated Care Strategy (2025/26), which will be considered by the Integrated Care Partnership at its meeting on 24 March 2025.

A light touch refresh has been undertaken for both the JFP and Integrated Care Strategy in line with national guidance and in recognition of the proposed publication of the Ten Year Health Plan in late spring 2025. The paper seeks consideration and approval of the Nottingham and Nottinghamshire NHS JFP for 2025-2030.

Recommendation(s):

Board is asked to:

- **Note** progress with delivery of key milestones in the NHS Joint Forward Plan during 2024/25.
- **Approve** the annual refresh of the NHS Joint Forward Plan for 2025/26, pending a further iteration being developed following publication of the Ten Year Health Plan.

How does this paper support	**the ICB's core aims to:**
Improve outcomes in population health and healthcare	The Joint Forward Plan 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, 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.

How does this paper support	the ICB's core aims to:
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 1: Involvement and engagement approach in the development of the NHS JFP refresh
Appendix 2: NHS Joint Forward Plan Delivery Plan Progress Update
Appendix 3: Draft NHS Joint Forward Plan 2025-2030
Appendix 4: Example of detailed delivery plans underpinning the Joint Forward Plan

Board Assurance Framework:

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

- 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 Board and the Strategic Planning and Integration Committee at their previous meetings.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

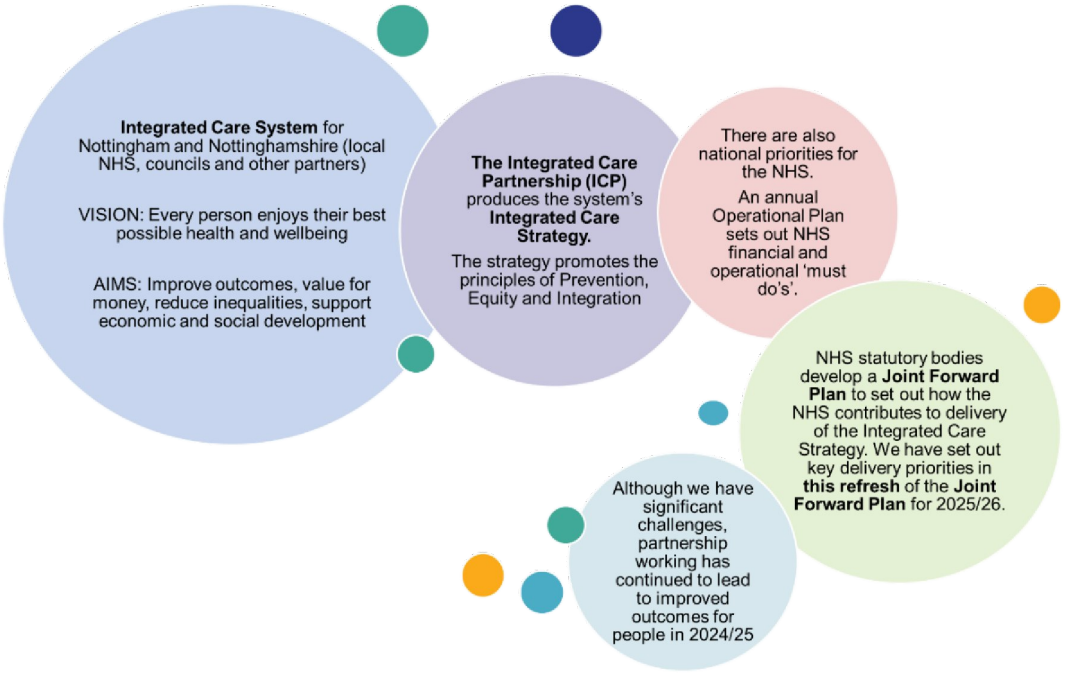
No.

Joint Forward Plan: Delivery Report and Annual Refresh

Background

1. The NHS Joint Forward Plan (JFP) was initially developed in 2023/24 following extensive engagement across health partners. The purpose of the document is to provide clarity on NHS implementation of the Nottingham and Nottinghamshire Integrated Care System's (ICS) Integrated Care Strategy, as well as delivery of the NHS Mandate and operational plan priorities. Figure 1 shows the connections between these key documents.

Figure 1.



2. The JFP has since been refreshed on an annual basis. The 2024/25 JFP and earlier iterations are published on the ICS website.[1]

3. At its 9 January 2025 meeting, the Board agreed to the annual refresh of the JFP being deferred into early 2025/26 due to a delay in the publication of national planning and operational guidance. It was agreed that a light touch refresh would be undertaken, subject to this being in accordance with the planning guidance, recognising that a more significant refresh was likely to be required in 2025/26 following publication of the anticipated Ten Year Health Plan (due late Spring 2025).

[1] NHS Joint Forward Plan - NHS Nottingham and Nottinghamshire ICS

4. NHS England guidance was published on 30 January 2025 confirming the requirements for only a limited refresh of the Joint Forward Plan by end of March 2025.[2]

5. Consequently, a light touch refresh of the 2024/25 JFP has been undertaken and overseen with engagement from NHS partners and public health colleagues (as set out in Appendix 1). This process has been overseen by the Integrated Care Strategy and JFP Working Group with membership from NHS and Local Authority partners.[3]

Joint Forward Plan: Delivery 2024/25

6. The Working Group has developed a Delivery Plan Progress Update for the Board with assurance on key areas of delivery across the four clinical priority areas in the 2024/25 JFP:

    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.

7. The progress update is provided at Appendix 2. This includes a delivery confidence rating against each of the key delivery areas. Delivery of the plan is broadly on track, recognising that this will take time to transact into a demonstrable impact on performance and longer-term population health outcomes. Work is continuing with partners to refine our approach.

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

    a) **Targeted lung health check** expansion plans continue to be implemented. The ICS has improved early diagnosis rates to 61%, above the national average and highest in Midlands. This will improve further with expansion of the Targeted Lung Health Check programme and new Pancreatic Cancer Surveillance Project.

    b) An **urgent care coordination hub** has been developed to act as a single point of access for health professionals. The hub receives an average of 290 calls transferred each week, of which, 61% of calls are managed without an emergency response. The urgent care coordination hub is also supporting more efficient use of other services. There has been an

[2] NHS England » Guidance on updating the joint forward plan for 2024/25
[3] Previously the JFP Delivery Group

increase in calls resulting in a response from the urgent community response, increasing from 50% to 84% due to calls being made to the most appropriate service to support patients.

c) **Physical health checks for people with severe mental illness** are ahead of trajectory. In 2024/25 the national target was exceeded by 2% at 62%, and is an improved position compared to the same time last year.

d) We have increased the number of **winter health checks** to support high-risk chronic obstructive pulmonary disease (COPD) patients who are at risk of hospital admission (~9,000 patients). Self-management plans have now been put in place for 47.6% of patients compared to 32.8% of patients the previous year. Work has commenced with Connected Notts to digitise the COPD self-management plan within the Patients Know Best platform. This will make the plan more accessible for the patient and support them to manage their own health and wellbeing.

e) **Broxtowe Learning Disability Collaborative** designed and implemented a series of Learning Disability Health and Wellbeing Roadshows aimed at improving the outcomes and experiences of people with learning disabilities. The roadshows provided a safe space for people with learning disabilities to have their voices heard and to share their experiences about what matters to them. They also encouraged uptake of the annual learning disability review, raised awareness of the wider determinants of health and promoted a holistic approach to health and wellbeing.

f) A co-located designated **Urgent Treatment Centre (UTC) is now open at Queens Medical Centre**. Phase one went live in July 2024 – launching a new expanded inclusion criteria with an aim of increasing the number of patients streamed to the UTC. Phase two commenced in October with the co-located UTC seeing, on average, an additional 40 patients per day above baseline. The co-located UTC is currently managing 120 patients per day, which represents a shift in the percentage of Emergency Department activity managed through this service from 17% to 22%.

9. Several actions are noted as off track with recovery plans in place:

a) Development of targeted case finding specifically focused on population health needs across Places and system priorities, for example, frailty, severe multiple disadvantage, obesity.

b) 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.

c) System-wide approach to personalised care planning across all sectors (acute, community and primary).

d) Develop Place-Based Partnership 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.

e) Increase immunisation and screening uptake for 'at risk' groups.

f) 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.

g) Virtual wards fully established and meeting target activity levels. Integrated care pathways with social care established for specific cohorts.

h) Develop an urgent care coordination hub, which will act as a single point of access for health professionals.

i) Develop an integrated urgent care response, virtual wards and Pathway one service delivery model to increase, and maximise use of, urgent care response capacity

j) Continued support to eliminate waits of over 65 weeks for elective care.

k) 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.

Joint Forward Plan: 2025/26 Refresh

10. The Working Group has overseen a light touch refresh of the JFP in line with guidance published by NHS England on 30 January 2025:

"We expect that ICBs and trusts will wish to perform a limited refresh of existing plans before the beginning of the new financial year given the anticipated publication of the 10-year health plan in the Spring of 2025 and a multi-year financial settlement for the public sector as part of the Spending Review 2025.

We will work with systems to develop a shared set of expectations and timetable for a subsequent more extensive revision of JFPs aligned to wider reform of nationally co-ordinated NHS planning processes. This will include a shift from single to multi-year operational and financial planning."

11. The system's Integrated Care Strategy is currently being refreshed to the same timeline. No further guidance from the Department of Health and Social Care has been published to inform the Strategy refresh. The Strategy will be considered at the Integrated Care Partnership meeting on 24 March. The

Strategic Planning and Integration Committee considered these two draft documents on 6 March 2025 to ensure the strategic fit of the JFP. Verbal feedback will be provided at the Board meeting.

12. The refreshed JFP, which is provided at Appendix 3, has been developed with increased emphasis on the approach to be taken by NHS partners in 2025/26 to accelerate delivery of JFP and Integrated Care Strategy ambitions. It does not revisit the ambitions themselves, given the extensive nature of original engagement and ongoing alignment with national policy and NHS England operational and planning guidance.

13. The approach is highly consistent with the three national policy shifts of treatment to prevention, analogue to digital, and hospital to home, and reaffirms our commitment to the three system strategic principles of promoting prevention, equity, and integration.

14. NHS statutory bodies, working closely with local authority partners, agree that our focus of joint work during 2025/26 should be the continued design and implementation of transformational priorities under the remit of the System Transformational Delivery Group. This includes community transformation, frailty, planned care, urgent and emergency care, digital, workforce, corporate optimisation, estates and facilities, best value, medicines optimisation, and procurement.

15. Our transformation of broader system working, as outlined within the draft Integrated Care Strategy, is also referenced in the refreshed JFP document. The expectation is that both documents, when refreshed in full later in 2025/26, will include more detailed focus on:

    a) The way in which teams work together in a more integrated way through the development of integrated neighbourhood health teams.

    b) Improved collaboration across our health and care provider landscape including shared infrastructure and resources.

    c) Development of our strategic commissioning arrangements across the system, ensuring a more joined up approach to commissioning of services, which ensures improved outcomes for people within our collective resources and helps deliver on our shared commitment towards achieving financial balance.

16. The JFP is underpinned by detailed programme plans. Appendix 4 provides an example of the activity and outcomes that are being monitored across the JFP and transformation programmes.

17. The Board is required to confirm the JFP for the coming year with the caveat that the document will be revisited later in the year as further national guidance emerges.

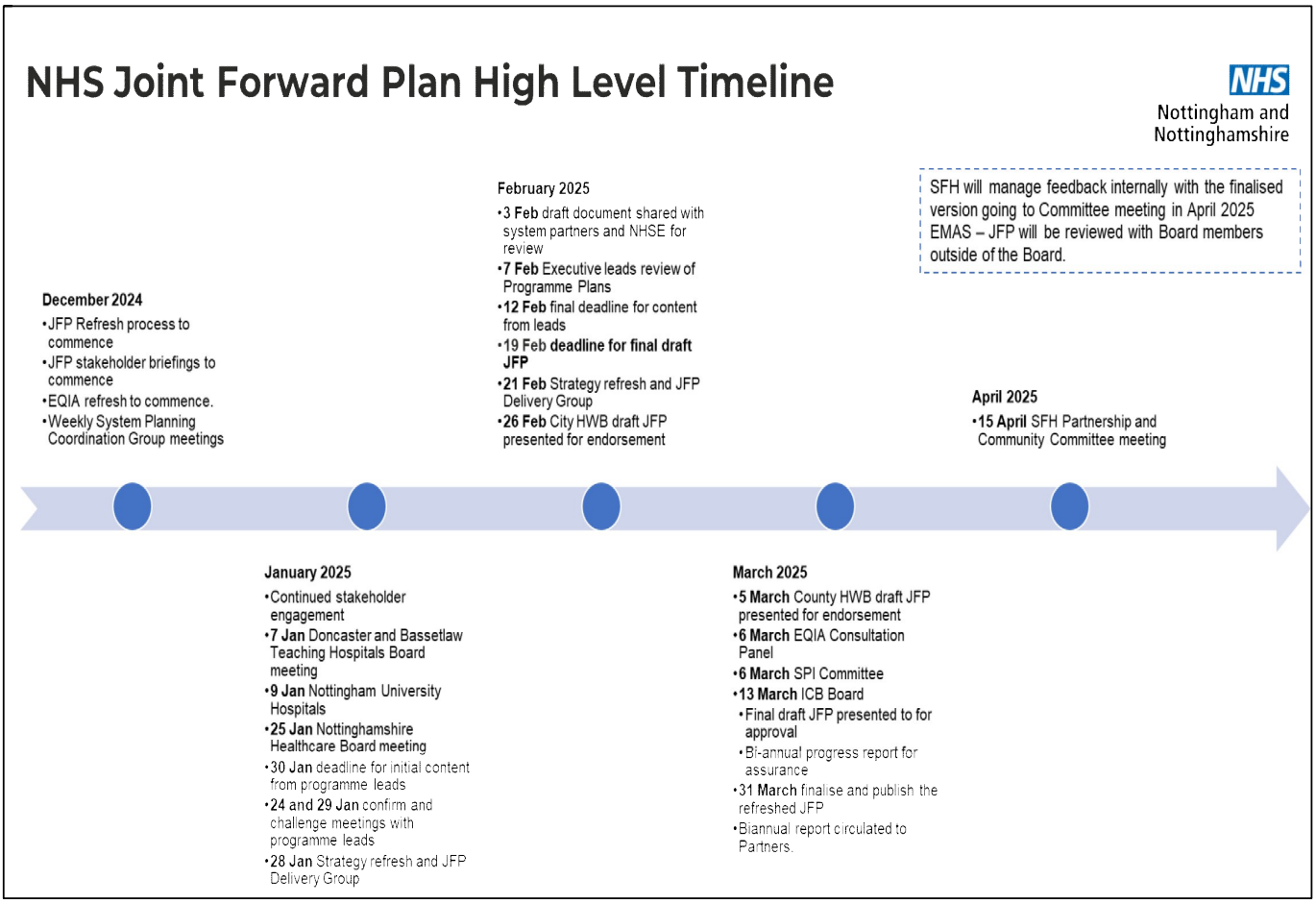
Next steps

18. Governance arrangements with partners for the delivery and oversight of the JFP are being updated. This will ensure greater clarity of ownership for, and delivery of, key deliverables and associated monitoring metrics. This work will be aligned to Project Initiation Documents currently being refined across all transformation programmes. This approach will also confirm the contribution that individual providers make to JFP delivery and ensure organisational leadership teams and Boards can recognise their responsibilities to delivery.
19. The JFP Oversight Group will meet bi-monthly and establish reporting mechanisms into the ICS Transformation Delivery Group.
20. The Board will receive an update on JFP outcomes at its 10 July 2025 meeting.
21. At the 11 September 2025 meeting, the Board will receive an update on JFP delivery as well as further information on how we will progress the Ten Year Health Plan.

Appendix 1: Involvement and engagement approach in the development of the NHS JFP refresh

In refreshing the plan for 2025 activities included:

- Discussions with partner forums during December 2024 – March 2025.
- Targeted meetings with key stakeholders.
- Specific meeting discussions with the two Health and Wellbeing Boards to ensure that the plan was aligned to the strategy.
- Listening to and gathering insights from across our Place Based Partnerships.
- A Citizens Insight report focussed on our Integrated Care Strategy priorities.
- An Equalities Impact Assessment has been completed to support the refresh.
- NHS providers have confirmed organisation specific approaches to engaging with their own Boards or Committees to consider the JFP.
- Feedback was requested by 19 February 2025 to inform the final version of the plan. 27 responses logged.



NHS
Nottingham and Nottinghamshire

Appendix 2: NHS Joint Forward Plan Delivery Plan Progress Update

March 2025

Delivering the right care at the right time

NHS Nottingham and Nottinghamshire

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

NHS
Nottingham and Nottinghamshire

- Overall, delivery of the focus areas within the Joint Forward Plan remains on track recognising that this will take time to transact into a demonstrable impact on performance and longer-term population health outcomes. Work is continuing with partners to refine our approach.
- 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.
    - System-wide approach to personalised care planning across all sectors (acute, community and primary).
    - 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.
    - Increase immunisation and screening uptake for ‘at risk’ groups.
    - 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).
    - Virtual wards fully established and meeting target activity levels. Integrated care pathways with social care established for specific cohorts
    - Develop an urgent care coordination hub (UCCH) which will act as a single point of access for health professionals.
    - Develop an integrated urgent care response (UCR), virtual wards (VW) and Pathway 1 service delivery model to increase, and maximise use of, UCR capacity
    - Continued support to eliminate waits of over 65 weeks for elective care.
    - 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.
- 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.
- Deep dives of two priorities are included in this report:
    - Priority 2: Proactive management of long-term conditions and frailty to support early identification and avoid unnecessary escalation
    - Priority 3: Improve navigation and flow to reduce emergency pressures in physical and mental health settings

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 March 2025	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. Nottingham City using the findings from the accelerator programme to target hypertension case finding as part of "Heart Health" programme. Hypertension diagnosis rates have increased over the last 2 years across the ICS with over 21,000 new cases diagnosed between September 2022 and December 2024. • Severe Mental Illness (SMI) healthchecks commissioned via SMI Locally Enhanced Service (LES) and Health Improvement Workers in place. Exceeded national target by 2% at 62% in 24/25. • Cancer staging - Since 2021 have increased number of cancers diagnosed at stage 1 and 2. Lung Health Check programme targeted to areas of highest need and deprivation seeing approx. 38% including in cancers diagnosed at stage 1 and 2.	• Will be part of Prevention Plan which will provide clear actions and increased focus on a targeted approach. • Will continue to progress plans in line with Core20+5
Based on identified local and system priorities, Place Based Partnerships (PBPs) will develop integrated neighbourhood teams (INTs) to curb demand growth, focusing on keeping people out of hospital wherever possible.	**Green**	• Community transformation programmes are being embedded following learning and a 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 • County Council have progressed with a system wide training platform for Making Every Contact Count.	• Effective Care and Support planning requires increased level of training. 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 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 March 2025	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.	**Amber**	• PBP plans aligned to system-wide approach to Frailty. • NUH and EMAS are not yet sending Clinical Frailty Scores. • System Analytics and Intelligence Unit (SAIU) Data Management Team are working on a risk algorithm to identify patients most at risk of emergency admission in the next 12 months – to be completed by the end of May 2025, and the outputs will be available for clinicians via the single register and appropriate workflows in eHealthScope. • Design and implementation of Integrated Neighbourhood Teams (INTs) underway.	• 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. • SAIU on track to launch practice packs by the end of March 2025. The packs will use advanced automation techniques in Power BI to pull in all the data into one single insight pack for each practice to ensure that practices do not have to do the analysis themselves.	
Frailty same-day emergency care (SDEC) embedded.	**Completed**		
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. Ongoing monitoring of vaccination uptake across the population. Seasonal vaccinations had the same uptake as 23/24. • Plans in place to deliver mobile clinics in areas of historic low uptake. • NUH offer of vaccinations to unvaccinated citizens attending outpatient appointments. • Ongoing monitoring of uptake in Trusts with potential additional COVID clinics on Trust sites if required. • Incorporated into PBP delivery plans.	• Low uptake for both flu and covid for frontline Healthcare workers.

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 March 2025	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**	• Strategy being considered by ICB Board at their May 2025 meeting. • Actions aligned to Prevention, Identification and management of Long-Term Conditions (LTC)/Frailty are being implemented and are aligned to System Clinical Transformation Recommendations.	• 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**	• Severe Mental Illness (SMI) healthchecks commissioned via SMI Locally Enhanced Service (LES) and Health Improvement Workers in place. Exceeded national target by 2% at 62% in 24/25. • 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 Mental Health Services Data Set (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).	
Re-launch of the Core Respiratory self-management plans (SMPs), namely COPD, Bronchiectasis and Asthma to further promote self-management and early intervention for respiratory disease management.	**Green**	• Asthma self-management plan already under review in line with the New NICE Asthma guidance published late 2024. • COPD winter health check letter issued November 2024 to reinforce the benefits of SMPs for those with COPD and the early intervention benefits. • Area Prescribing Committee guidance for COPD exacerbation management reviewed and updated. • Digital development of the COPD SMP in progress, to further develop on the accessibility of this support tool. • Collaborative support in discussion with pharma for COPD quality reviews to further enhance SMP uptake. • Performance monitoring in place via the transformation dashboard. Analysis shows that for every 5 SMPs in place 1 non-elective admission is avoided.	

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

Winter Health checks for COPD patients

The respiratory steering group have been looking at methods to identify and support high-risk chronic obstructive pulmonary disease (COPD) patients who are at risk of hospital admission. Our population health data showed that there were 3,000 COPD patients with no recorded review in the last 12 months (some Primary Care Networks (PCNs) had over 400 patients in this cohort) and 6,000 who were at risk of an exacerbation. A search engine was developed to support easy identification of this cohort of patients who may need prioritising for a COPD review to help protect them over the colder months.

Registers were developed to support practices and Care Navigators to identify patients who hadn't had a COPD review in the last 12 months, or who were at risk of an exacerbation, to prioritise them for a review and encourage them to have vaccinations against covid, pneumonia and influenza. Protocols were added into clinical systems to make this as easy as possible to reach the right patients. Self-management plans have now been put in place for 47.6% of patients compared to 32.8% of patients the previous year.

Work has commenced with Connected Notts to digitize the COPD self-management plan within the Patients Know Best platform. This will make the plan more accessible for the patient and support them to manage their own health and wellbeing.

Broxtowe Learning Disability Collaborative

Broxtowe Learning Disability Collaborative designed and implemented a series of Learning Disability Health and Wellbeing Roadshows aimed at improving the outcomes and experiences of people with learning disabilities.

The roadshows provided a safe space for people with learning disabilities to have their voices heard and to share their experiences about what matters to them. They also encouraged uptake of the annual learning disability review, raised awareness of the wider determinants of health and promoted a holistic approach to health and wellbeing.

As a result, a number of actions have been implemented including training experience for every PCN trainee nursing associate, Oliver McGowan training with leisure staff, setting up sensory flu clinics for people with learning disabilities and creation of a learning disability advise and information repository.

Video: https://www.youtube.com/watch?v=DTejBqlkD14&list=PLbn-i-zL-roP2OgJkjij9MEA2wWVV4osb

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 March 2025	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. Actions have been embedded in transformation programmes. • Winter Plan for 2024/25, system approach commended by NHSE. Daily system calls clearly outline all capacity including UCR, Virtual Wards, community beds.	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 has been co-designed with the Health and Social Care workforce.	
Virtual wards (VW) fully established and meeting target activity levels. Integrated care pathways with social care established for specific cohorts	**Amber**	• Virtual wards approach being reviewed. Best value and impact consolidated across frailty and respiratory pathways.	There is a risk that the financial efficiencies programme will impact available capacity to support flow. This will be mitigated by maximising the use of all available capacity.
Develop a co-located urgent treatment centre (UTC) at QMC to reduce demand on Accident & Emergency.	**Green**	• A co-located designated Urgent Treatment Centre is now open at Queens Medical Centre. 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'. Phase 2 commenced in October with the co-located UTC seeing, on average, an additional 40 patients per day above baseline and an increase in the proportion of ED attends from 17% to 22%. We are working towards NHSE designation for April 2025	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 capital funding from NHSE will support this.
Deliver medically safe for transfer plan target and develop trajectory for years 2 to 5.	**Green**	• Significant improvements seen in medically safe for transfer (MSFT), no criteria to reside (NCTR), and long length of stay (LLOS) at both trusts. Pathway 1 activity has increased which is supporting a reduction in MSFT.	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. The ICB is looking to recommission our P1 model and P2 beds in 25/26 with a P2 new medical model designed by the ICS partners.

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 March 2025	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.	**Green**	• During 2024 SDEC pathways and services were expanded 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. • 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. • Expanded discharge lounge capacity has been put in place.	
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.	**Green**	• New Pathway 2 clinical model agreed. Much work has been done to reduce LOS in P2 beds • A Pathway 3 bed pilot has been completed.	In 25/26 the ICB will recommission P2 beds and review our P3 beds across the ICS to ensure a consistent model.
Develop an urgent care coordination hub (UCCH) which will act as a single point of access for health professionals.	**Amber**	• Call activity has significantly increased from November – January with the UCCH taking on average 84 calls per day to support with system pressures vs 44 calls per day baseline • Outcomes have been maintained with 63% of calls managed without an ambulance response or referral to Emergency Department (ED) and 20% of calls managed with self-care • To support efficiency, an automated transfer of calls process has now gone live	Investment is required to sustain the increase in call activity for 25/26
Develop an integrated urgent care response (UCR),VW and Pathway 1 service delivery model to increase, and maximise use of, UCR capacity	**Amber**	• Integrated community urgent and emergency care service delivery model in development	Risk that the expected available capacity will not be realised. Mitigated by early staff engagement and clinical leads developing the new model.

Priority 03 | Improve navigation and flow to reduce emergency pressures in physical and mental health settings. Annual Deep Dive.

The urgent care coordination hub (UCCH) has been implemented to act as a single point of access for health professionals into urgent care services.

The service is supporting health professionals to access the right service, first time. This supports patients to access urgent care when they need it most, from the most appropriate service/s, and also supports the health and care workforce by making the best use of their time.

The service is improving outcomes for our patients and making the best use of our resources:

- 78% of CAT 3 calls (urgent calls which require a response within 120 minutes) are transferred from 999 to the UCCH and managed without ambulance response. 63% of these calls are managed without ambulance response or referral to the Emergency Department.
- Of these CAT 3 calls, the Nottinghamshire service benchmarks well against other services closing 20% of calls with self-care vs 2.2% delivered by an alternative provider, 22% referred to ambulance vs 34% with an alternative provider.
- 96% of calls to UCCH from ambulance crews were managed without referral to ambulance or Emergency Department.

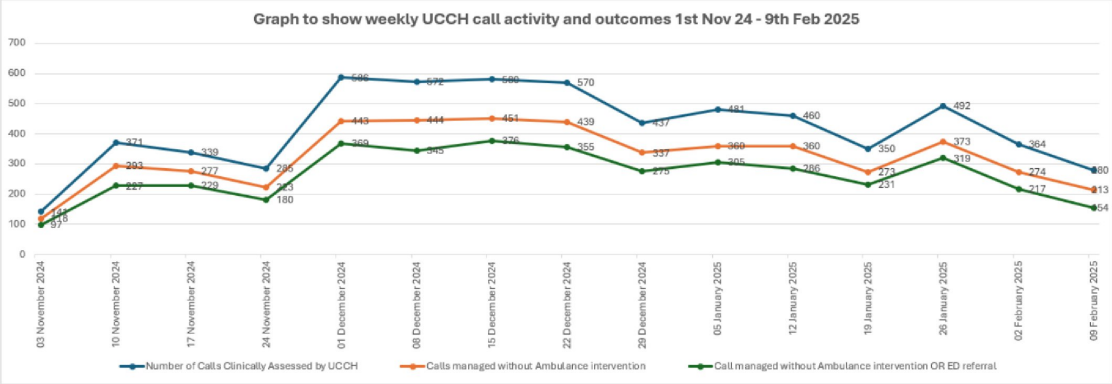
We're looking at ways to develop the service further. There is a pilot of 11 care homes with direct access to the UCCH underway until March 2025. This pilot is supporting our care staff to access urgent care for residents and will help us to test if there are benefits to working in this way.

A co-located urgent treatment centre (UTC) has been opened at Queens Medical Centre (QMC) in Nottingham to reduce demand on Accident & Emergency services. 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'.

Phase 2 commenced in October with the co-located UTC seeing, on average, an additional 40 patients per day above baseline.

The co-located UTC is currently managing 120 patients per day, which represents a shift in the percentage of Emergency Department activity managed through this service from 17% to 22%.

We are working towards NHSE designation for April 2025 to firmly establish the service at QMC.



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

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 March 2025	Recovery Actions / Mitigations / Issues / Risks
Continued support to eliminate waits of over 65 weeks for elective care.	Amber	• The long wait positions continue to reduce for both 65 and 52 weeks, adult and CYP. Pace needs to increase. • 78 week waits: The system had 0 78-week waiters at the end of November. • 65 weeks: There were 102 patients waiting over 65 weeks at the month end (58 at NUH including 14 Corneal transplants, 41 at SFH and 3 at IS providers). • 52 weeks: Volume continues to reduce; NUH 2209 v 2488 plan achieved; SFHT 633 v 260 plan missed.	• 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 began in June 2024. Phase 3 to commence in 2025/26. • Newark hub opened in November 2023.	• 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. • NHSE have supported through additional funds for radiographers and admin, however further service improvement actions will be identified and enacted during Q4 and into 2025/26, as part of improvement across the whole NUH breast pathway. • ICS has improved early diagnosis rates to 61%, above national average and highest in Midlands. This will improve further with expansion of TLHC and new Pancreatic Cancer Surveillance Project.	• 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	• 52 weeks CYP: Position continues to improve, but pace is slow. SFHT 58 patients against a plan of 0, NUH 242 against a plan of 256 patients at 15/12/24.	
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	• Outpatient virtual appointments - The latest position for the system is 17.6%, which is below the national standard of 25%. Since April 2022, the position for the system has gradually reduced from 24% to 17.6% reported in October 2024. In October 2024, NUH and SFH delivered 17% and 13.1% of outpatients virtually respectively. • Reduction in outpatient follow ups in acute and NHS providers. Increasing Patient Initiated Follow Ups (PIFU) utilisation where clinically appropriate. Increase use of A&G focusing on highest impact specialties.	

Key

NHS
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

DRAFT Version 5.2
7 March 2025

NHS
Nottingham and Nottinghamshire

Nottingham and Nottinghamshire NHS Joint Forward Plan 2025/26

2025 - 2030

Our NHS Joint Forward Plan for Nottingham and Nottinghamshire has been developed with our NHS statutory partners.

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

NHS Nottingham University Hospitals NHS Trust

NHS Sherwood Forest Hospitals NHS Foundation Trust

NHS Nottinghamshire Healthcare NHS Foundation Trust

NHS East Midlands Ambulance Service NHS Trust

The plan has also been developed with our wider stakeholder community. Special thanks to the following partners for their support including the VCSE Alliance.

Bassetlaw Place-Based Partnership

Mid-Nottinghamshire Place-Based Partnership

Nottingham City Place-Based Partnership

South Nottinghamshire Place-Based Partnership

NHS England

Nottinghamshire County Council

CityCare

Nottingham City Council

Foreword from our Chief Executives

This document is a 'light touch' refresh of the 2023-2027 Joint Forward Plan. It outlines the ongoing commitment of NHS organisations to work collaboratively with partners across our Integrated Care System to the achieve the ambitions of the 2025/26 Integrated Care Strategy. This includes supporting people to live longer healthier lives and reducing health inequalities across Nottingham and Nottinghamshire so that every person will enjoy their best possible health and wellbeing.

This Joint Forward Plan refresh also considers how we will deliver NHS national planning and operational guidance in 2025/26. These delivery expectations adhere to our Integrated Care Strategy strategic principles of **promoting prevention, equity and integration in all that we do**. By conforming to these principles we also demonstrate our alignment with the emergent national policy 'shifts' of treatment to prevention, analogue to digital and hospital to home. As a light touch refresh this document provides only key delivery expectations for NHS organisations in 2025/26 (see pages 9-35). These plans signal the work we will do together primarily across NHS partners but often in conjunction with our local authorities, voluntary and community sector organisations, Place based Partnerships, local people and communities.

Delivery of these plans will continue to challenge us. We are experiencing increased demand for services from an increasingly older population with more complex needs. Our desire to constantly improve patient outcomes and address significant local patient safety and quality concerns, combined with our commitment to maintain financial balance means our focus must remain on meeting the demands of today as well as transforming services to meet the needs of our communities in the future. For NHS partners this will require an ongoing focus in 2025/26 on implementing our agreed transformation programmes and achieving associated efficiency and productivity gains. We will do this whilst also continuing to deliver national planning and operational expectations. We have made significant progress in 2024/25 and will build on this momentum of improvement into 2025/26. We applaud our dedicated staff, who continue to rise to this challenge, and display unwavering determination to provide the best possible care for local people within available resources.

The Local Government Reform agenda, the evolving work of the East Midlands Combined County Authority, and the anticipated NHS 10year Plan will also undoubtedly add further stimulus to transforming the way in which we operate during 2025/26 and beyond. We will of course continue to work together to respond innovatively to these dynamic circumstances but will remain steadfast in our commitment to our shared principles of **promoting prevention, equity and integration in all that we do**.

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

NHS Nottinghamshire Healthcare NHS Foundation Trust

NHS Nottingham University Hospitals NHS Trust

NHS Sherwood Forest Hospitals NHS Foundation Trust

NHS East Midlands Ambulance Service NHS Trust

How NHS organisations come together with partners across Nottingham and Nottinghamshire

Integrated Care System for Nottingham and Nottinghamshire (local NHS, councils and other partners)

VISION: Every person enjoys their best possible health and wellbeing

AIMS: Improve outcomes, value for money, reduce inequalities, support economic and social development

The Integrated Care Partnership (ICP) produces the system's **Integrated Care Strategy.**

The strategy promotes the principles of Prevention, Equity and Integration

There are also national priorities for the NHS.

An annual Operational Plan sets out NHS financial and operational 'must do's'.

NHS statutory bodies develop a **Joint Forward Plan** to set out how the NHS contributes to delivery of the Integrated Care Strategy. We have set out key delivery priorities in **this refresh** of the **Joint Forward Plan** for 2025/26.

Although we have significant challenges, partnership working has continued to lead to improved outcomes for people in 2024/25

Reflecting on successes from 2024/25

Examples of what we have achieved in 2024/25 across our NHS partners

PREVENTING PEOPLE FROM DEVELOPING CANCER
Targeted Lung Health Check (TLHC) expansion plans continue to be implemented. ICS has improved early diagnosis rates to 61%, above national average and highest in Midlands. This will improve further with expansion of TLHC and new Pancreatic Cancer Surveillance

BUILDING OUR INFRASTRUCTURE TO IMPROVE PEOPLES EXPERIENCES OF SERVICES
A co-located designated **Urgent Treatment Centre is now open at Queens Medical Centre.** 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'. Phase 2 commenced in October with the co-located UTC seeing, on average, an additional 40 patients per day above baseline. The co-located UTC is currently managing 120 patients per day, which represents a shift in the percentage of Emergency Department activity managed through this service from 17% to 22%.

SUPPORTING PEOPLE WITH MENTAL ILLNESS
Physical Health Checks for people with Severe Mental Illness (SMI) are ahead of trajectory. In 2024/25 the ICS target was 60%, which has been exceeded and is an improved position compared to the same time last year.

TRANSFORMATION THROUGH DIGITAL AND IT INNOVATION
We continue to **be national leaders in the roll-out the NHS App and Patient Engagement Portal.** 58% of people are now accessing the App resulting in over 115,000 repeat prescriptions ordered monthly and 41,500 online consultations. Our target for 2025/26 is 75% accessing the App. We are saving 800 tonnes of cardon per yr in one hospital due to increased use of digital correspondence. Increased use of home monitors and sensors has meant smoother discharge for people and reduced the need for residential care.

RESPONDING TO URGENT CARE NEEDS
An **urgent care coordination hub** (UCCH) has been developed to act as a single point of access for health professionals. The hub receives an average of 290 calls transferred each week, of which, 61% of calls are managed without an emergency response.
The UCCH is also supporting more efficient use of other services. There has been an increase in calls resulting in a response from the urgent community response (UCR), increasing from 50% to 84% due to calls being made to the most appropriate service to support patients.

SUPPORTING PEOPLE WITH COMPLEX NEEDS
We have increased the number of **Winter Health Checks** to support high-risk chronic obstructive pulmonary disease (COPD) patients who are at risk of hospital admission (~9,000 patients). Self-management plans have now been put in place for 47.6% of patients compared to 32.8% of patients the previous year.

SUPPORTING CHILDREN AND YOUNG PEOPLE
100% of secondary schools and colleges and 70% of primary schools in Nottingham City now have a Mental Health Support team in place, with 79% and 40% respectively in Nottinghamshire County. Teams were prioritised to schools with greater health inequalities. The number of Support Teams will increase in 2025/26, with 100% coverage across all educational settings expected across City and County from 2029/30.

SUPPORTING PEOPLE WITH LEARNING DISABILITY
Broxtowe Learning Disability Collaborative designed and implemented a series of Learning Disability Health and Wellbeing Roadshows aimed at improving the outcomes and experiences of people with learning disabilities.

The roadshows provided a safe space for people with learning disabilities to have their voices heard and to share their experiences about what matters to them. They also encouraged uptake of the annual learning disability review.

Further examples of how we have already started to meet the 3 national policy shifts of treatment to prevention, analogue to digital and hospital to home can be found in Appendix C.

Delivering for today: Our NHS delivery priorities for 2025/26

DELIVERING SUSTAINABILE SERVICES THAT MEET THE NEEDS OF OUR COMMUNITIES

In order to maintain resilience in meeting the needs of local communities, improving health outcomes and reducing health inequalities we need to ensure good financial stewardship. Partners have agreed ambitious plans for 2025/26 in response to significant financial sustainability challenges. The financial challenge requires a real-terms reduction in spend and efficiency delivery of c. £250m in 2025/26. In addition to savings of £25m already achieved, we are targeting £100m from system-wide transformation, £100m from organisational productivity and efficiency and £25m through reviews of commissioned services. We will continue to work collaboratively with our partners and our communities to deliver these efficiencies, making sure every penny of public money is spent as wisely as possible and supports us to achieve our strategic priorities outlined within our Nottingham and Nottinghamshire Integrated Care Strategy and this NHS Joint Forward Plan.

DELIVERING OUR TRANSFORMATIONAL PRIORITY PROGRAMMES

In response to this challenge NHS and local authority partners have confirmed key Transformation Programmes (see below). These are areas where we have identified the greatest opportunity to support improved care for people and ensure best use of our available resources. Detailed delivery plans are in place for these programmes. Progress on their implementation will be overseen by a system Transformation Delivery Group in 2025/26. In addition to this work, we have developed Delivery Plans for improving outcomes and transforming care across our wider NHS responsibilities. These delivery plans, alongside our Transformation Priority Programmes, all contribute to the delivery of the Joint Forward Plan. Summary versions of Delivery Plans are provided in Section 1. A Joint Forward Plan Oversight Group will monitor progress on delivery of the JFP.

- Frailty
- Urgent and Emergency Care
- Workforce
- Planned Care
- Community Transformation
- Best Value Opportunities
- Digital
- Medicines Optimisation
- Corporate Optimisation
- Estates and Facilities
- Procurement

Delivering for today: Our NHS delivery priorities for 2025/26 (cont.)

MAINTAINING FOCUS ON PREVENTION, INTEGRATION and EQUITY

The 'golden thread' of prevention, equity, and integration continues to run throughout these programmes of work. This light touch refresh of the JFP highlights those areas of work we will place greater emphasis on in 2025/26 to achieve even greater impact on population health outcomes and reduce health inequalities. We will deliver benefits in these areas through ongoing collaboration with our partners, local people and communities at neighbourhood, place and system level.

PREVENTION
Supporting people into good work or staying in employment
Promoting healthy eating and moving for good health
Supporting people to stop smoking
Proactive case finding and support for people with complex needs or are vulnerable (aligned with our CORE20+5 approach)
EQUITY
Supporting 'best starts' in life and implementing Keeping Children Safe and Helping Families Thrive initiatives
Supporting people experiencing severe multiple disadvantage
Use of population health management data and intelligence to inform our commissioning approach and use of resources
INTEGRATION
Development of integrated working across front line health and care staff in the form of Integrated Neighbourhood Health Teams
Continued roll out of 'Making Every Contact Count' to support people to access appropriate services

ACHIEVING NHS DELIVERY COMMITMENTS

Our Transformation Programmes and Delivery Plans also support achievement of national priorities set out by NHSE in 2025/26 Operational Planning Guidance. This includes improved access to urgent and emergency care and planned care, 4-hour emergency department waits, ambulance turnaround times, cancer, mental health waiting times, and improvements in productivity and efficiency. Delivery Plans also support our achievement of Primary Care national access standards (GP and dental care) and implementation of the new GP contract.

Key developments in digital, analytics and IT, estates and workforce planning will continue to be fundamental to the achievement of all our programmes of work in 2025/26 and beyond. This includes our ongoing promotion of digital maturity to enable sustainable transformation including digital communication with patients and promotion of the NHS App. It also means continuing initiatives to support a more flexible and agile workforce able to transition into more integrated ways of working.

Delivering transformation of our system to ensure a sustainable tomorrow

Through delivery of our priority transformation programmes and maintaining our collective focus on prevention, equity, and integration we will establish a firm foundation for future sustainability. Overall, our NHS landscape will look very different by March 2026. This changing landscape can be characterised in the following way:

Current	Changes beginning in 2025/26
Place Based Partnerships in place. Some well-developed integrated neighbourhood teams and integrated ways of working including at system level: Better Care Fund, End of Life Alliance, Primary Care Networks, Maternity, Mental Health, SEND and Safeguarding teams	Integrated neighbourhood teams (INTs) across all Places, with wrap around services tailored to specific population needs (physical and mental, all-age). NHS and partner resources aligned to INTs. Increased flexibility of acute staff to work in/with INTs to support people to stay well at home. Scope of INTs increasing to include all age, physical and mental health needs.
Place-based partnerships in place, developing vibrant multi-organizational partnership working contributing to improved health outcomes / reducing health inequalities	Whole public sector alliances and shared assets through INT and Place working. Places focussed on delivery of improvements in health and wellbeing/ prevention interventions based on building blocks of life which address health inequalities and promote equity.
NHS institutions beginning to collaborate, provider collaboration across acute organisations forming clear plans for working together to create organisational and service resilience and increased efficiencies	Increased collaboration across/within acute and community-based providers (including primary care, voluntary and community, and care sector). Shared assets, infrastructure, staff and integrated service delivery models ensuring delivery and sustainability. Transformation is digitally enabled and supported. Collaboration also in strategic commissioning arrangements based on population outcomes to support and incentivise system transformation.

Our transformational shift

Maintaining our oversight of improved outcomes for people

Our system has extremes of high and low deprivation, with some neighbourhoods in Nottingham City among the most deprived in England. From ongoing feedback from our communities and partners we know local people want to see a shift towards prevention. People in our ICS are dying earlier than they should, and living with illness and disability longer. The data shows the clear correlation between deprivation and poor health outcomes across these different domains. Our overall success is measured by key outcomes established in 2024/25 and monitored via our System Outcomes Dashboard. For our JFP, we have selected a number of key metrics which contribute to the delivery of our System Outcomes Framework ambitions to improve healthy life expectancy, improve life expectancy and reduce health inequalities. A latest snapshot is shown below. All programmes of work contribute directly or indirectly to securing long term sustainable improvements in these outcomes.

Period: 202412

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 in 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	29,137	1	224.0	181.3	200.0	85.1	33.5	19.0	18.2	39.9	42.7	12.9	14.7	7,784	342.1	79.2	81.0
Radford & Mary Potter	37,520	1	190.0	184.9	198.7	114.0	24.1	14.4	17.5	45.2	35.8	14.4	23.2	7,650	353.0	76.5	82.7
Aspire	39,606	1	224.5	174.8	180.2	83.4	33.6	15.9	16.7	37.2	40.9	9.0	11.8	7,826	328.9	78.0	81.3
Bulwell & Top Valley	47,407	1	242.8	195.5	181.1	71.3	33.5	15.1	17.0	35.0	45.3	10.0	7.2	7,915	331.5	78.6	80.9
Nottingham City East	68,629	1	188.1	180.7	163.7	73.5	28.7	13.7	16.8	34.4	41.7	13.6	13.4	7,318	385.9	75.5	81.7
Newgate Medical Group	30,235	2	236.2	161.5	145.3	67.0	31.0	14.1	12.6	29.4	42.2	7.9	10.0	6,092	296.5	78.6	83.7
Clifton & Meadows	35,048	2	228.7	180.0	188.0	77.4	33.6	14.3	18.8	37.5	41.4	9.7	8.0	7,348	326.5	78.5	80.1
Ashfield North	51,838	2	263.7	158.8	174.4	69.6	25.8	17.8	14.8	36.4	48.9	7.5	8.5	7,783	320.2	77.1	82.2
Rosewood	52,135	2	224.6	173.8	156.2	65.3	28.1	12.4	14.1	36.1	44.0	7.7	8.4	7,546	290.6	79.1	82.8
Bestwood & Sherwood	55,725	2	199.2	151.8	157.1	65.1	22.0	12.9	16.2	32.6	43.8	10.1	8.9	6,200	295.3	78.1	82.9
Mansfield North	59,541	2	240.8	148.0	176.7	67.5	26.1	13.7	13.6	35.8	44.3	5.8	9.5	7,579	300.5	79.3	82.0
Larwood & Bawtry	38,355	3	234.7	128.7	174.3	67.7	30.9	19.9	15.0	33.3	47.5	7.4	11.9	6,207	245.6	79.2	82.9
Byron	39,347	3	234.7	137.4	162.4	61.8	24.3	12.2	14.6	32.9	48.2	6.1	18.3	7,611	284.5	77.9	80.5
City South	39,895	3	165.9	105.3	153.1	57.3	16.9	8.8	12.6	33.0	44.2	7.1	7.2	6,179	211.6	82.2	84.0
Ashfield South	41,038	3	261.6	150.2	156.9	67.5	26.8	11.4	14.7	34.2	46.1	6.7	6.5	7,756	308.3	77.4	80.4
Retford And Villages	59,176	3	237.9	128.2	155.3	58.1	22.9	11.8	12.2	28.1	45.7	5.9	9.1	5,487	227.4	79.8	84.4
Sherwood	64,114	3	238.1	136.4	172.9	64.4	24.3	13.6	13.7	35.6	47.2	5.9	9.4	6,974	229.4	79.7	81.5
Stapleford	22,315	4	230.8	131.3	167.6	58.8	21.9	9.0	12.5	28.9	45.1	6.1	5.2	6,133	219.8	81.0	86.1
Arnold & Calverton	34,303	4	208.2	120.5	146.4	49.3	18.3	8.7	15.7	29.1	47.8	6.8	8.0	5,829	204.4	79.6	84.2
Synergy Health	36,110	4	218.4	143.7	155.1	53.8	18.1	11.7	15.3	30.2	47.9	9.4	20.2	6,396	264.2	80.5	83.1
Eastwood/Kimberley	38,086	4	227.6	118.9	156.7	56.9	20.5	14.7	14.3	32.5	48.3	5.8	7.2	6,299	232.5	80.4	85.4
Newark	79,645	4	200.2	133.3	150.3	51.0	15.4	11.3	12.3	29.7	49.8	5.5	7.1	5,678	236.7	80.5	84.3
Arrow Health	40,161	5	187.5	115.1	148.7	45.5	15.4	9.8	13.0	28.0	47.1	6.6	5.8	5,857	204.3	81.6	85.0
Rushcliffe North	42,913	5	182.9	94.5	140.6	39.5	15.0	9.0	12.3	27.4	47.5	4.1	5.6	4,978	159.2	81.3	84.2
Rushcliffe South	44,505	5	177.1	85.1	139.4	39.4	11.4	9.2	12.5	25.5	47.0	4.3	4.3	4,776	165.9	83.7	84.8
Beeston	50,286	5	182.5	105.8	152.7	51.6	16.8	11.0	14.0	28.1	47.8	7.2	11.0	5,482	221.9	79.9	82.8
Rushcliffe Central	53,346	5	137.7	64.6	138.7	42.0	10.7	9.6	12.4	26.1	48.1	5.6	5.6	4,879	182.6	79.6	86.3
Unity (Nottm)	46,768	4	114.5	64.8	152.8	40.1	10.4	9.2	8.7	20.9	44.5	3.9		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

Poor Outcomes | Good Outcomes

Our Delivery Plans in Summary

High level commitments across our key programme areas that will deliver or enable the four aims and three strategic principles of our ICP Integrated Care Strategy, while continuing to meet national policy expectations for NHS partners.

Section 1. Our delivery commitments

Frailty

Current state: Our challenges

- Frailty is a common medical condition that is frequently associated with ageing. Over the next 20 years there will be a significant increase in frail people in our ICS.
- The Nottingham and Nottinghamshire system has identified frailty as one of the system priorities where our resources are currently significantly committed and an area of high growth in spend.
- The cost of frailty is not just financial. It is a cost to our people, our quality of care, our services.
- The electronic frailty index shows that across the 65 and over population at PCN level:
- People identified as Fit varies from 31% - 52%
- People identified with Mild Frailty varies between 28% and 33%
- People identified with Moderate Frailty varies between 12% and 21%
- People identified with Severe Frailty varies between 10% - 18% (excluding Bassetlaw)
- 21.5 % of the following two areas accounts for all over 65 emergency admissions(2019)
- 7,800 admissions for falls, Injuries and fractures equating to approximately70,000 bed days.
- 5,100 Flu and pneumonia emergency admissions equating to 43,000 bed days

Future state: Our ambition

- Maintaining independence by focusing on prevention for as long as possible in one's own home, increasing healthy life years, improving personalised care, achieving cost efficiencies and savings for the system.
- The goal is to reinforce the focus on personalised and proactive care that will enable us to deliver a fully integrated approach to Frailty and aims to:
- Delay the onset of health deterioration where possible
- Maintain independent living
- Reduce avoidable exacerbations of ill health
- Reduce use of unplanned care
- We aim to empower older adults to lead healthier, independent and fulfilling lives by providing holistic and person-centred care to older people and (where present) carers.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Establish the frailty programme	Programme and workstreams established	Frailty Programme Board meetings held 6 times per year.	Frailty Programme Board meetings held 6 times per year.	Frailty Programme Board meetings held 6 times per year.	Frailty Programme Board meetings held 6 times per year.	Frailty Programme Board meetings held 6 times per year.
Establish a continual learning approach	Frailty senate held and practice packs circulated.	Learning Labs. Confirm best practice guidance in delivery of MDTs and INT responsibilities for quality assurance	Learning Labs. Evaluation of mobilisation and early implementation of INTs – support expansion of patient cohorts	Learning Labs. Ongoing refinement of INT approach, building cohort of patients under responsibility of INTs	Learning Labs. Ongoing refinement of INT approach, building cohort of patients under responsibility of INTs	Learning Labs. Ongoing refinement of INT approach, building cohort of patients under responsibility of INTs
Prevention of frailty	Increased vaccinations. Vaccination dashboard established. Increase in Making Every Contact Count (MECC) training.	Promotion of initiatives to prevent frailty and progression of frailty in over 65 years population incl. Falls, therapy services and rehabilitation pathways.	Develop further plans based on evidence of local neighbourhood need to reduce emergency admissions	Develop further plans based on evidence of local neighbourhood need to reduce emergency admissions	Develop further plans based on evidence of local neighbourhood need to reduce emergency admissions	Develop further plans based on evidence of local neighbourhood need to reduce emergency admissions
Identification of frailty	Identification of digital technology/ sensors and devices to support independence. CFS Scoring uptake and RESPECT form uptake improved.	Establish refined targeted and proactive approach to identifying frail population and appropriate management to understand their support needs using predictive tools.	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.
Management of frailty	Established Same Day emergency Care (SDEC) and silverline (SFH) Technology Enabled Care roll out.	Enable access to appropriate support to mitigate the risk of escalation of frailty inc. roll out of Care Navigation.	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.

Rushcliffe Arena, 09:00-13/03/25

Planned Care Transformation

Current state: Our challenges

- Long waits for elective care
- Backlog of patients waiting for overdue follow ups
- Short notice or on the day cancellations
- Lack of access to digital apps and information for some patients

Future state: Our ambition

- Reduce the time people wait for elective care
- Maximise advice and guidance (A&G) to reduce unwarranted clinical variation in referrals.
- Enable access to the most appropriate care first time.
- Reduction of unnecessary outpatient Follow ups
- Empowering patients through offering patient choice and information to support self-management where appropriate
- Collaboration with system digital colleagues to maximise opportunities to use digital tools to support patient choice and offer personalised care
- Make the best use of resources through improved productivity and efficiency
- Pathway Redesign: exploring options for future community services which include musculoskeletal (MSK), women's health, pain management, dermatology and eye health services.
- Theatre Optimisation: Standardise processes for prioritising patients and improving theatre utilisation.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Equitable access and shared resource: Shared waiting lists linked to strategic workforce plan, shared physical resource across elective hubs	Weekly System elective hub meetings in place Theatre productivity programmes in place at NUH and SFH System access policy in development	Maximise opportunities to utilise capacity at the elective surgical hubs. Launch system wide access policy.	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.
Pathway transformation and productivity; including getting it right first time (GIRFT) programme, outpatient transformation and perioperative screening	Early health screening tools pilot underway at NUH and SFH. Patient initiated follow up (PIFU) offered as an alternative to routine follow ups where appropriate. Reduction of did not attends (DNAs)	Explore options to offer/expand community services which include ear, nose and throat (ENT) and Audiology. Focus on reducing unnecessary Follow up's across all providers.	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.

Joint Forward Plan: Year-end Delivery Report and Annual Refresh
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Section 1. Our delivery commitments

Urgent and Emergency Care Transformation

Current state: Our challenges

- People are assessed for their long-term needs in hospital.
- People spend too long in our hospitals.
- People arrive at the emergency department and are admitted to hospital when their needs could have been met in the community.
- People spend too long in our emergency departments waiting to be assessed and treated.
- People spend too long waiting for an ambulance.
- People often have to navigate several services before they reach the one that is most suitable for their needs.
- Our teams and pathways are not always integrated across the ICS.
- We do not have seven-day working across all services.
- We have inequity of service provision across the ICS.
- We have delays in transferring people from one service to another.
- We have several different entry points for our pathways and services which can be confusing for professionals.
- Demand for urgent and emergency care services is rising.

Future state: Our ambition

- To deliver safe and consistent Urgent and Emergency Care services across the health and care system.
- We will maximise admission avoidance opportunities and pathways
- We will effectively manage in-hospital flow
- We will improve discharge pathways and processes
- We will reduce re-admissions to hospital within 90 days
- We will develop a single team culture
- We will deliver the key pillars of the Urgent and Emergency Care Recovery Plan

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Admission Avoidance	Integrated UCR (urgent care response) and UCCH (urgent care coordination hub). Mobilised the co-located UTC (urgent treatment centre) at QMC.	Reduce non-elective admissions by 9%. Expand the UCCH offer. Designate the co-located UTC. Go live of new integrated UCR and VW (virtual wards) offer.	Equitable IUC offer across the ICS. Include the Transfer of Care Hubs in the UCCH/SPA (single point of access) model.	One true single point of access across Nottingham and Nottinghamshire	Monitor impact of actions	Monitor impact of actions
Internal Flow	Expanded discharge lounge capacity. Mobilised surgical same day emergency care (SDEC). Patient transport service (PTS) coordinators in acute trusts.	Expansion of SDEC offer to include frailty. Efficient use of assessment areas. Optimise use of discharge lounges. Re-procure PTS offer.	Integrated front and back door discharge teams with links to the UCCH/SPA	Monitor impact of actions	Monitor impact of actions	Monitor impact of actions
Discharge	Pathway 1 (P1) Service activity increased supporting a reduction in medically safe for transfer (MSFT). New P2 clinical model agreed. P3 bed pilot completed.	Mobilise integrated P1 service. Commission new P2 bed base and model. Commission new P3 pathway. Move discharge posts into ICB.	Commission consistent P1 service. Deliver 7 day integrated discharge services. Integrate discharge to assess (D2A) and UCCH.	Monitor impact of actions	Monitor impact of actions	Monitor impact of actions
Re-admissions	Data analysis completed of 90-day readmissions Clinical senate held Priority actions agreed	Report progress of priority actions to Urgent Care Board. Reduce 90-day readmissions rate by 30%.	Monitor impact of actions	Monitor impact of actions	Monitor impact of actions	Monitor impact of actions

Community Transformation, including End of Life

Current state: Our challenges

- On-the-day demand impacts ability to focus on people with long-term conditions, escalations and continuity of care.
- Increasing complexity in patients means more timely access to specialist advice and guidance is required.
- Inequity and inefficiency through unwarranted variation in Community Health Service provision across ICS due to legacy commissioning arrangements.
- Recruitment and retention challenges causing additional pressure on workforce.
- Lack of communication with public around self management opportunities impacts on ability to 'see right professional at right time'.
- Movement of services from secondary care to community care requires appropriate shift in resourcing
- Most deprived neighbourhoods tending to experience greatest access challenges.
- Estates constraints hinder integrated neighbourhood working.

Future state: Our ambition

The vision of the Community Transformation Programme is to deliver the long term ambition of transitioning away from hospital care and into community delivery. The programme aims to address this challenge in a number of ways:

1. Creation of capacity in community providers through the implementation of a self-care/self-management approach.
2. Delivery of integrated neighbourhood working - removing the duplication between community, primary care and social care services – experienced by services and citizens.
3. Commissioning services to deliver greatest value - be that through procurement, alignment to a single provider or delivery against a standardised service specification.
4. Directing community services at the most clinically effective interventions and the cohorts with greatest needs (clinically and geographically)
5. A collaborative plan and approach to delivery across the system (e.g. across ICB, Local authorities and community providers).

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Efficient use of financial resources to target the most effective interventions, patients, equipment (ICELS) and geographical areas.	Reviews across eight community health services.	Embed appropriate use of equipment. Implement outcome of Long COVID review. Care Homes Transformation.	Mobilisation of system wide Community Wheelchairs Service.	Develop further plans.	Develop further plans.	Develop further plans.
Movement of existing activity to a self-care/self-management approach.	Opportunities in self-management identified: insulin administration and wound care.	Q1:Development of clinical pathway for self-care. Q2: Implementation within Community Nursing.	Continued spread of self-approach into further services – focus on therapy services.	Spread of self-care best practice developed within Community into further Health and Social Care sectors.	Develop further plans.	Develop further plans.
Utilising the programme to support delivery of ambitions of wider system partners and/or programmes	Development of Integrated Neighbourhood Team (INT) delivery model. Collaboration to prioritise Frailty INTs	Q1: Frailty Integrated Neighbourhood Teams (INTs) in 4 areas Q2: Evaluation Q3/4: Further roll out to maximise system coverage.	Development of further INT models – with focus on Long Term Conditions. Implementation of LTC INT model across system.	Development of further INT models – with focus on Children and Young People (CYP). Implementation of CYP INT model across system.	Development of further INT models – with focus TBC. Implementation of further INT model across system.	INT approach fully embedded as business as usual with all priority areas implemented. Identification of any further INTs.
Working closely with place and VCSE to ensure services and approaches are tailored to the needs of populations and/or cohorts of citizens.	Continuation of the Local Design Team approach – increased geographical spread.	Refine long term condition metrics management, with ability to deliver targeted and tailored interventions at place.	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.

Digital Transformation

Current state: Our challenges

- Patient-facing digital assets are disjointed and used in silos, which provides inequitable access to health and care services. Technology enabled care to support remote monitoring/remote consultations/virtual wards is limited to pilots or relatively small-scale use in specific teams/organisations. Social care data is not available on the individual – often gets missed as clinical data is prioritised. Data between social care and health still disjointed.
- Data is not held or collected in all digital assets which limits the utilisation of rich data sources to enable intelligence-based decision-making. Where data is held in a digital asset, there are no consistent standards applied.
- Organisations do not have a fully digitised electronic patient record, digitisation does exist but often there are multiple systems which hold patient data in one organisation.
- While information sharing across digital assets has improved, clinical data is often not available to the clinician or professional from one organisation to another to enable them to provide the right care, in the right place.
- Moving to a digital approach to access can exacerbate health inequalities when people do not have access to digital or the skills.
- Significant skills gaps exist across our workforce which means that digital assets cannot be exploited to the full benefit.

Future state: Our ambition

- Deliver the Digital Notts Strategy 2023-28 - https://prezi.com/view/WAlBPVywyhc231fdWMlx/
- Develop our patient-facing digital services.
- Support intelligent decision-making - use data to better understand the health and care needs of our local population, helping to focus and tailor resources where they have the most impact.
- Recognising key factors helps us to adapt future local services to improve the overall health of the population.
- Digitise our services to support the frontline.
- Utilising digital assets such as electronic patient records, electronic prescribing, medicine administration systems and automation technologies to reduce burdensome processes.
- Enable interoperability across the system - our population will receive the right care at the right time, always.
- By providing health and care providers with access to key information about the person, reduces unnecessary diagnostics, treatment and enables efficient access to health and care services.
- Support our population and workforce through digital inclusivity - our population and workforce are given access to support, training and equipment to enable them to use digital assets to benefit their health and wellbeing or deliver effective care services.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Patient facing digital services.	Digital Correspondence delivered in two acute settings. eMeet and Greet enabled across two acute settings.	Expand technology enabled care to support remote monitoring. Develop Internet of Things (IoT) platform.	Digital care planning, expand record access; deploy robotics process automation and Artificial Intelligence (AI) technology.	Personalised approach to health and care services through digital technology. AI technology to increase Productivity.	Digital contact becomes the default route for health and care services. Smart homes.	Optimise and enhance assets based on digital advancements
Support intelligent decision making.	Infrastructure in place to ensure data can be used.	Establish Secure Data Environment for Research. Develop Federated Data Platform..	Embed a systematic approach to developing and monitoring system outcomes.	Secure Data Environment for Research embedded. Augment AI and human skills in designing care services.	Augment AI and human skills in designing care services.	Augment AI and human skills in designing care services.
Digitise frontline services.	Electronic prescribing and drug administration. Enabled 60% of our social care provision with a digital social care record	Staff enabled to work across any location. Electronic patient record (EPR) deployed in Acute Care. Implement services in line with frameworks.	EPR deployed in Acute Care. Implement services in line with procurement frameworks.	EPR deployed in Acute Care. Implement services in line with procurement frameworks.	Optimisation and exploitation of frontline digital assets.	Optimisation and exploitation of frontline digital assets.
Interoperability.	Four of our largest organisations live and onboarded with the Notts Care Record (NCR)	NCR available to all staff and organisations onboarded. Decommission existing shared care record.	NCR embedded. Phase three development including additional community services.	Further developments in the application including regional sharing, enhanced functionality and features	Develop further plans.	Transition to business as usual.
Digital inclusivity.	VCSE grants. Delivered over 1,000 digital support sessions with 10,000 people supported to get online	Role of Digital Champions, Digital Carers and Digital Inclusion Co-ordinators to be established.	Develop a model to enable a roving workforce across digital specialty roles	Develop new pipeline talent to address skills gaps across digital.	System workforce development programme.	Digital Inclusivity is built into all core aspects of what we do.

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Medicines Optimisation

Current state: Our challenges

- Between 5 to 10% of all hospital admissions are medicines related and around two-thirds of these admissions are preventable.
- at least 10% of the current volume of medicines may be overprescribed
- 30 to 50% of the medicines prescribed for long-term conditions are not taken as intended
- Medicines account for about 25% of emissions within the NHS in England.
- Nationally agreed funding model for community pharmacies threatens sustainability of sites
- National challenges regarding the supply chain for medicines impact on our capacity to deliver transformational plans due to the need to manage medicines shortages
- Availability of funding for new medicines - Investment in medicines to optimise health outcomes and reduce hospital admissions is not maximised.
- Lack of interoperability between clinical systems in organisations increases the risk of harm from medicines as people move between care settings.
- Current working practices and prescribing systems incentivise prescribing rather than reducing medicines waste
- Pharmacy workforce pressures and support required for pharmacy graduates to use their prescribing qualifications in all sectors constantly challenge the delivery of system ambitions to transform pharmacy services and optimise medicines use.
- The need to deliver financial savings for ICS against medicines budget could impact on progress of transformational medicines optimisation projects

Future state: Our ambition

As detailed in our Medicines Optimisation Strategy 2024-2029, our shared purpose is;

To ensure all medicines have value and provide the best outcomes for all people

We will do this by delivering against our 5 strategic aims;

1. Medicines are clinically effective and prescribed safely
2. Pharmaceutical Care is joined up across our ICS; locally agreed information is shared
3. Medicines waste is reduced and sustainability is promoted
4. Medicines are equitably accessible across our ICS
5. System value from medicines is achieved

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025-30
Medicines are clinically effective and prescribed safely	Strengthen Pharmacy Workforce Faculty and develop 3-year workforce plan Safe prescribing and reducing medicines harm.	• Implement data driven systematic structured medication reviews for patients taking multiple medicines • Increase learning and sharing from medicines safety related incidents to reduce preventable harm from medicines • Implement data driven systematic structured medication reviews for patients taking high-risk medicines. • Develop decision making tools with Experts by Experience focused on supporting patients to take their medicines safely and participate in decisions about their care
Pharmaceutical Care is joined up across our ICS; locally agreed information is shared	Medicines optimisation strategy agreed. Integration of clinical services in Community Pharmacy to build Primary Care capacity.	• Strengthen use of, and prescribing decisions adherence to the joint formulary • Improve access to and understanding of guidelines and formularies through standardised and single point of access to medicines information across care pathways for prescribers and patients • Improve consistency in adoption of shared care protocols across the ICS • Improve medicines optimisation around transfers of care
Medicines waste is reduced and sustainability is promoted	Reduction in inappropriate polypharmacy. Focus on improvement in the National Oversight indicators.	• Identify potential areas of medicines waste across our system and work to reduce this • Work with Patient Groups, Primary Care Practices and Community Pharmacies and Digital Notts to help people to 'Only Order what they need' • Work with the Greener Programme to recommend medicines with the lowest carbon footprint within formularies and guidance where clinically appropriate
Medicines are equitably accessible across our ICS	Streamline system working. Further develop contractual principles and governance for prescribing.	• Increase provision of community pharmacy clinical services to improve access to medicines • Scope further provision of specialist pharmaceutical care closer to home • Implement consistency of communication with professionals, patients and carers, to manage access to medicines in short supply
System value from medicines is achieved	Develop ICS system medicines and prescribing efficiency plans.	• System: Strengthen MOPB governance and accountability to maximise medicines value • Place: Robust prescribing processes and responsibility to maximise medicines value • Person: Work with Experts by Experience to increase the knowledge, skills and confidence people have to manage their own health and their medicines

Section 1. Our delivery commitments

Best Value Opportunities

Current state: Our challenges

Best Value is newly established programme and in its infancy. Opportunities have been identified over the course of 24/25 and work now continues with the Programme Boards to transact the outputs of this work into Programme Boards through to delivery.

Future state: Our ambition

- Best Value is an enabling programme through the lens of clinical stewardship across transformational change and service development.
- The aim is to identify opportunities, inform clinical best practice through data and intelligence insights, lead transformational change, ensure adherence to clinical thresholds to improve efficiency, reduce unwarranted variation and provide impactful measurable interventions that achieve positive health and care outcomes for our local population.
- Continue to work system wide to identify priority areas of transformation and improvements to meet local and national statutory requirements.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Triage and Referral pathway review	CVD, COPD and SMI clinical senates held to advise on clinical and professional approved best practice	Identify and reduce duplicated referrals. Reduction in unplanned procedures. Reduction in unwarranted clinical variation of referrals. Improved compliance with Value Based Commissioning Policy.	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.
Diagnostics activity review (CT Imaging, MRI)	Clinical intervention dashboard established to monitor impact	Diagnostics are requested based on necessity. Reduced mobile scanning activity. Diagnostics Board to support resource utilisation (shared resource).	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.
Reduction in readmission rate for over 75s within 90 days of discharge	90 day readmission, End of Life, Frailty clinical senates held to advise on clinical and professional approved best practice	Reduce readmission rates by 30% including impact on length of stay (average 5 days). Embed concept of clinical stewardship to inform broader transformational change.	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.

ICS Strategic Workforce

Current state: Our challenges

- Workforce numbers and related pay bill costs are potentially the largest rate limiting factors in our ability to deliver the ICS strategy and improve health outcomes for our population.
- Workforce planning is short term riven by operational targets and is not informed by population health projections. This does not address the medium to longer term need for strategic workforce and education planning.
- The health and wellbeing of our workforce continues to be a cause for concern with sickness absence remaining high.
- Our workforce does not reflect the diversity of the population we serve, and NHS recruitment processes can be seen as long and difficult to navigate.
- Post-covid recovery and waiting lists pressures are additional challenges, with workforce productivity remaining lower than pre-pandemic levels.
- Organisations interventions to attract high demand staff groups have a negative impact on system staff and adds to cost pressures

Future state: Our ambition

- The system 'one workforce' will consist of the right number of people, to meet demand and improve health outcomes, working at the right location to deliver the treatment and care our populations deserve, with the skills and training to support prevention as well as treatment to enable the population to stay healthy and at a cost that is affordable.
- Organisations will collaborate to 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.
- Digital technology will be an enabler to flexibility and resourcing on a systems footprint not an organisational one.
- There will be multiple entry points to employment, supporting all levels of academic and physical ability, to create meaningful and fulfilling opportunities for all that desire a career in health and care.
- The financial pressures exacerbated by workforce availability will be reduced by system partners working together on solutions to ensure that we are to utilise our existing workforce efficiently.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
The resources, infrastructure, and governance. Deliver Planning for the future: Transforming the health and social care workforce	Governance mechanisms have been established will as needed evolve and be embedded.	Performance and risk will be managed monthly to create a more dynamic 'one workforce' ICS WTE plan with pay bill and activity triangulation.	Providers workforce - right sizing. Collaborative approaches that support the system	Population health needs drive plans. Workforce planning delivers clinical service transformation, new roles and new ways of working	The processes put in place are reviewed and refined to ensure optimum deliver of aligned workforce plans.	The processes put in place are reviewed and refined to ensure optimum deliver of aligned workforce plans.
Right sizing the workforce: Resourcing including retention.	Work commenced on bank rates, grip and control increased. Service reviews undertaken/in progress.	Collaborative approach to shortage skill areas to develop system working approaches. Continued staging alignment of bank rates.	Introduce digital solutions for system recruitment. Grow the contingent workforce. Implementation of regional talent academy.	Expand digital solutions and AI supported recruitment.	Establish full recruitment hub based on evaluation of proof of concept and identified economies of scale.	Operational system recruitment hub. Review, evaluate and further develop all resourcing approaches consolidated working.
Strategic workforce planning: System-wide integrated workforce approach linked to population health needs	ICS workforce plan supported with population health data. Data sharing discussion commenced. Social Care data shared with ICB.	Establish a common workforce planning approach. Integrate workforce data and intelligence into system planning.	Develop a system wide approach to measuring workforce performance and productivity.	Develop 3-5-year digital skills workforce development and training plan as part of wider ICS workforce planning.	Explore further opportunities for alignment across the system to support service transformation planning and Integration.	Review evaluate and seek further opportunities.
Delivering the future of human resources.	Passporting piloted/in use in 2 organisations. Training Memorandum of Understanding (MOU) signed by all organisations	All NHS providers being registered and fully utilising the digital staff passport to support movement of staff between organisations.	Developing a rotational scheme to support professionals to move between sectors.	Establish core HR working across the NHS providers including Primary care	Review evaluate and seek further opportunities.	Review evaluate and seek further opportunities.

Section 1. Our delivery commitments

Primary Care

Current state: Our challenges

- On-the-day demand impacts ability to focus on people with long-term conditions, escalations and continuity of care.
- Primary care contracting model can be a barrier to innovation / transformation.
- Increasing complexity in patients means more timely access to specialist advice and guidance is required.
- Recruitment and retention challenges causing additional pressure on workforce.
- Opportunities for primary care at scale model not fully realised.
- Lack of communication with public about new roles in primary care impacts on ability to 'see right professional at right time'.
- Challenges with capacity to enable longer consultation times for people with complex needs.
- Movement of services from secondary care to primary care requires appropriate shift in resourcing
- Most deprived neighbourhoods tending to experience greatest access challenges.
- National capitation funding not necessarily reflective of need.
- Estates constraints hinder primary care service delivery.
- Ensuring integration of pharmacy, dental and optometry contracts and services including Pharmacy First.

Future state: Our ambition

- Integrate pharmacy, optometry and dentistry within neighbourhoods and Primary Care Networks (PCNs)
- Primary care providers integrated into neighbourhood teams to support population health management and proactive care
- Enhanced services support effective delivery in primary care
- Services / pathways across primary and community care are seamless and effective
- Optimum care within community settings with unwarranted clinical variation systematically identified and addressed
- Review and update our approach to primary care workforce, development, recruitment and retention
- PCNs across Nottingham and Nottinghamshire continue to mature allowing them to be in a positive position for leading the ongoing implementation of Integrated Neighbourhood Teams (INTs).
- Provide effective and efficient management of Primary Care contracts
- Develop Primary Care estate in line with system and PCN estates strategies

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Pharmacy, Optometry and Dental	Primary Care Strategy development underway	Finalise pharmacy, dentistry and optometry chapters within Primary Care Strategy. Establish working group to support integration into PCNs.	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.
Contractual Transformation	Early Supported Discharge Quality Scheme (Frailty and long term conditions) Enhanced services review completed. Modern general practice model (MGPAM) funding allocated.	Service / Pathways Reviews with Community Providers. Promote referral optimisation, pathway efficiencies Review role of Referral Support Service (RSS). Practice visit programme to address unwarranted variation.	Integration of Primary Care providers within INTs.	Develop further plans.	Develop further plans.	Develop further plans.
Supporting primary care resilience and delivery (incl PCN Directed Enhanced Service (DES), workforce development and Primary Care Estates).	Embedded benefits of PCN investment Workforce programme funding secured. ICB Primary care estates strategy completed. Individual practice support.	Promote GP Additional Roles Reimbursement Scheme (ARRS) role. Re-establish Primary Care Workforce Group. Progress Primary Care Estates Strategy.	Learn from national PCN pilots and implement locally.	Develop further plans.	Develop further plans.	Develop further plans.

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Primary Care Transformation

Current state: Our challenges

- Pressures on primary care limit the capacity for Primary Care Networks (PCNs) to deliver population health management identified opportunities.
- Capacity and demand in primary care are challenging.
- Workforce pressures growing across primary care, impacting on resilience across the PCNs.
- In order to manage current challenges, different models of care are being tested by developing new roles through the national Additional Roles Reimbursement Scheme (ARRS) and through system clinical transformation programmes.
- Estates for the growing workforce and community-based delivery of care is restricting delivery.
- A review of current estate and needs for future delivery has been undertaken and plans are being developed to address challenges, maximising the available estate as flexibly as possible.
- Need to work with other providers such as Community Pharmacy with significant communication barriers between the various parties

Future state: Our ambition

- Primary Care Strategy implementation supports resilient / vibrant primary care.
- Primary Care services delivered at an appropriate scale to meet patient need and deliver services in a cost and clinically effective way.
- Primary Care Provider Collaborative playing a full role in the system.
- Integrated Neighbourhood teams (INTs) established and providing pro-active care to address population health needs.
- Patient experience of accessing primary care is significantly improved.
- Patients make appropriate use of the extended PC workforce and digital access to care
- Practices are supported to continually improve their access models.
- Primary Care providers are positively engaged and active partners within the local health and social care system
- The interfaces between primary, community and secondary care services support the delivery of good, integrated care and good outcomes for patients.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
New Models of Care.	Effective GP Federations and PCNs in place. Primary Care Provider Collaborative scoping underway. Safer Working initiatives in Primary Care being supported	Provider Collaborative Established. Primary care engagement within initial INT development. Explore appetite for alternative same day access models in primary care.	INTs established with robust engagement from Primary Care providers.	Develop further plans.	Develop further plans.	Develop further plans.
'Primary Care Access (incl. dental)	Good practice engagement with GPIP and Modern general practice model (MGPAM) . 14 Day Access improvement plan being implemented. All practices achieve NHSE Delivery Plan for Recovering Access.	Local support offer for practices to improve access models developed. Pharmacy First and Independent Pharmacy Prescribers embedded.	New same day access models contribute to improved performance.	Develop further plans.	Develop further plans.	Develop further plans.
Primary Care Engagement and interface Issues	City Thriving Programme. Developed mechanisms to better engage practices. Primary and Secondary Care interface groups established.	Practice visit programme implemented. Engagement / good practice programme of events implemented. Implementation of interface work programmes.	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.

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Mental Health

Current state: Our challenges

- Section 48 review identified failings in the quality of care delivered in inpatient, community and crisis services
- The length of stay in hospital is longer than clinically needed, causing pressures in services and worse outcomes for patients including out of area placements
- Waiting times remain too long for access to assessment with hidden waits between services where specific mental health services/organisations operate in silos.
- Pathways are not always clear, do not provide local early support and intervention to reduce escalation, maintain independence in the community and reduce the need for acute services.
- Mental and physical health and wellbeing and social needs are inextricably linked; however, services operate in silos not always recognising how to optimise resources to meet the needs of the person.
- National review has indicated that police spend a significant amount of time responding to people in a mental health crisis, which is being addressed through the implementation of Right Care, Right Person
- Limited alternatives to A&E for people in mental health crisis –which is not the best environment for people's needs.
- Limited housing and accommodation impacting pathway flow including discharge from both hospital and supported accommodation
- There are growing numbers of people with autism in mental health inpatient services requiring care and support.
- Finances are a significant challenge for all system partners

Future state: Our ambition

- Clear communication to the public and professionals on access routes into mental health services, accessing support as early as possible
- Transitioning from treatment to prevention.
- Sustainable local community care model of delivery that aims to optimise people's independence by addressing their physical, mental health and social needs and intervening before people reach crisis point
- Through integrated care, and better communication, people will be cared for in the most appropriate setting for their need, by the people with the right skills.
- We will make every contact count for areas which have been traditionally health focused, incorporating signposting to other services to improve overall health and wellbeing
- People will only stay in hospital for the time they need to, with partners working together to identify and act upon any housing and support needs to enable people to go to the place they call home as soon as they are ready
- Partners will undertake integrated commissioning to ensure we meet the needs of the population and achieve value for money for the system

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Integrated mental health services focused on prevention, robust community service delivery and inpatient discharge	Integrated Mental Health Pathway Strategic Plan for Adults and delivery plan agreed. Coproduction Group launched. Place-based prevention models aligned to community transformation. Launch of NottAlone.	Hub developed building on place based mental health and wellbeing model. Inpatient bed model development. Level Two Inpatient Rehabilitation Model and step-down model developed.	Implementation of 2026/27 priorities based on review of 2025/26 deliverables	Implementation of 2027/28 priorities based on review of 2026/27 deliverables	Implementation of 2028/29 priorities based on review of 2027/28 deliverables	Implementation of 2029/30 priorities based on review of 2025/26 deliverables
Improve mental health services to address recommendations from Section 48 and deliver Long Term Plan ambitions	Implemented new pathways. Increased psychological therapy service delivery. Performance for Adult and Children and Young People services/ pathways meeting standards.	Agree blueprint for community mental health team model. Progress agreed actions for Assertive Engagement service/pathway implementation Review of Personality Disorder pathway	Implementation of improvement plan, monitoring impact and ensuring infrastructure to enable continuous quality improvement.	Implementation of improvement plan, monitoring impact and ensuring infrastructure to enable continuous quality improvement.	Implementation of improvement plan, monitoring impact and ensuring infrastructure to enable continuous quality improvement.	Implementation of improvement plan, monitoring impact and ensuring infrastructure to enable continuous quality improvement.
Review and transform mental Health urgent and crisis care incorporating Section 48 recommendations for crisis services	Implementation of Right Care, Right Person (RCRP). Implementation of 111 Mental Health Option Develop Mental Health Action Cards. Mental Health Response Vehicle in place.	Deliver Crisis Core fidelity Standards. Implement section 48 recommendations for crisis services. Reduce emergency department delays. Improve timeliness of access to crisis support.	Embed and review new pathways and service delivery models.	Embed and review new pathways and service delivery models.	Embed and review new pathways and service delivery models.	Embed and review new pathways and service delivery models.

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Maternity, babies, children and young people

Current state: Our challenges

- Rates of obesity are continuing to rise in childhood, increasing short-term and lifelong negative impact on health outcomes.
- Significant health inequalities exist in maternity and neonatal care meaning worse outcomes for women and babies from minority ethnic groups.
- Access to health services for the most vulnerable groups of babies, children and young people can be disjointed and inequitable.
- Numbers of children and young people experiencing mental ill health are increasing.
- Children and young people (aged 0-25) with Special Educational Needs or Disabilities (SEND) are not always identified, assessed or able to access services in a timely way.
- Demand on local services, particularly services supporting children and young with neurodevelopmental disorders has significantly risen in recent years, significantly impacting waiting times.
- Engagement of children and young people in decisions about their needs and health care is not systematised.
- Transitions between children and young people services and adult services are improving but remain inconsistent and difficult for many
- Increasing numbers of children and young people are experiencing mental ill health and are presenting with more complex needs and comorbidities.

Future state: Our ambition

- Children, young people and their families continue to co-produce service improvement and transformation across the system.
- All health service planning incorporates prevention for under-25s, where there are modifiable factors.
- Be child friendly. Children and young people's needs are identified accurately and assessed in a timely and effective way.
- Children and young people are well prepared for their next steps, achieve desired outcomes, have supportive and successful transitions into adulthood.
- Children and young people are valued, involved in decision-making about their lives, visible and included in their communities.
- Every woman and birthing person from minority ethnic groups has a safe and positive birthing experience in the place of their choosing.
- A firm foundation for good mental health of children and young people through evidence-based support in the first 1,001 days of a child's life.
- Families, babies, children and young people are able to access seamlessly delivered support, even in pathways where different elements may be commissioned or delivered by different organisations.
- Children and young people with the most complex needs, are able to have their needs met effectively and efficiently, accessing the right service at the right time.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Focus on the under-fives to have the maximum preventative impact.	Co-design new pathways with system partners for healthy lifestyles and infant mental health.	Develop data and intelligence driven interventions, priority focus on best start partnerships and health inequalities.	Commission and deliver integrated services to support the best start in life for infant mental and physical health.	Continued focus on evidence-based needs led commissioning and improvement, working in partnership.	Continued focus on evidence-based needs led commissioning and improvement, working in partnership.	Continued focus on evidence-based needs led commissioning and improvement, working in partnership.
Reduce inequity of services in maternity and for children and young people.	Single Point of Access (SPA) for healthy weight. Progressing maternity and Neonatal staff training, and maternity equity action plan.	Maintain focus on quality and safety of services and reduce inequalities (Core20+5). Maternity and neonatal 3 year delivery plan.	Maintain and review impact of the maternity programme. Evaluation and review of emerging guidance.	Continued focus on evidence-based needs led commissioning and improvement, working in partnership across the system.	Continued focus on evidence-based needs led commissioning and improvement, working in partnership across the system.	Continued focus on evidence-based needs led commissioning and improvement, working in partnership across the system.
Achieving improved outcomes for vulnerable children and young people, including those who are looked after or with SEND.	Increased access for speech language services. Delivered Mental health support teams in schools (MHST) and Partnerships for Inclusion of Neurodiversity in Schools (PINS).	Continued reduction in waits for therapy services and neurodevelopmental diagnosis. Deliver Keeping Children Safe, Helping Families Thrive. Increase coverage of MHST and continue PINS	Improve therapy services wait targets. Improve outcomes for looked after children's mental health. Continue to integrate services. Consider learning.	Continue to work with partners and children and young people to embed sustainable ongoing improvement.	Continue to work with partners and children and young people to embed sustainable ongoing improvement.	Continue to work with partners and children and young people to embed sustainable ongoing improvement.
Improved outcomes for women and babies.	Preterm Birth Clinics - Relaunch of systemwide PERIPrem passport, Optimisation, Refresher BadgerNet training.	Ockenden review. Embed evidence-based practice in antenatal, intrapartum and postnatal care.	Maintain and review impact of the maternity programme. Evaluate what works and develop further plans.	Deliver against national guidance and local improvement plans.	Deliver against national guidance and local improvement plans.	Deliver against national guidance and local improvement plans.

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Section 1. Our delivery commitments

Prevention

Current state: Our challenges

- Having the resources to progress priorities in relation to prevention, including the NHS leading on secondary prevention
- Concerted effort across prevention priorities with a strategic approach across PBP, primary care, community and secondary care
- Implementing Making Every Contact Count (MECC) at scale with the relevant supportive pathways – MECC is the tool through which health and care services are able to impact on building blocks of health
- Providing an equitable approach that ensures we do more of or do differently based on population need
- Recognition of ROI that supports a concerted effort and provides the relevant prioritisation within decision making

Future state: Our ambition

- Commitment to priorities that allows for a shift in resources from treatment to prevention
- Return on Investment - Priority areas approved and prevention plans adopted across all NHS partners to allow for a co-ordinated and concerted effort and in return, the greatest impact on the population. The priorities are understood across all partners in terms of the value and return on investment they offer.
- Neighbourhoods and Communities - Effectively integrating service offers at a local level by demonstrating alignment with Local Authorities and as part of neighbourhood and Place Based Partnership delivery plans.
- Transformation - Transformation Programmes and priorities clearly outline the mandate for prevention aligned with approach to impact on health inequalities.
- MECC – Accelerating system wide commitment and plans for MECC, in order to impact on the Building Blocks of Health, including ensuring it is clinically relevant and provides an achievable end goal
- Maximising Current Offer - Driving forward proactive prevention for priorities by maximising capacity and service redesign, efficiently and effectively targeting resources in relation to population need and risk factors.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
MECC incl housing and physical activity	Nottinghamshire County Council MECC Training and platform identified framework for action.	Phased implementation of MECC. Establishing pathways for housing. Brief advice and integration of physical activity.	Evaluation and expansion of roll out. Evaluation includes impact on building blocks of health and removing access barriers.	Further development of pathways taking learning from housing.	Develop further plans.	Develop further plans.
CVD and Diabetes	Increase in numbers diagnosed with hypertension Development of INTs for Heart Health.	Increase Type 2 diagnosis in young people. Increase uptake of CVD case finding and management. iMeds work for CVD and Diabetes.	Integration of physical activity Cardiac Rehab and innovation Optimising health checks Link to weight management plans.	Evaluation and development of plans across different points of intervention.	Develop further plans.	Develop further plans.
Smoking, Weight Management (WMS), Alcohol	NICE weight loss inject tables published. Investment and disinvestment in alcohol smoking services in Trusts (+SATOD).	Implement WMS NICE guidance. Agree smoking alliance strategy. Alcohol services integrated with primary care.	Further development of WMS; integration with physical activity PBP integration with alcohol services.	Develop further plans.	Develop further plans.	Develop further plans.
Immunisation and Vaccination	Implementation of new RSV vaccination Seasonal vaccinations same uptake as 23/24.	Delegation to ICBs. New model of care for primary care. Community specific plans with PBP.	Targeted community based approach across all vaccinations Targeting maternity and under 65.	Develop further plans.	Develop further plans.	Develop further plans.
Screening	Learnings from targeted offer including more lung cancers diagnosed at stage 1 or 2.	Delegation to ICBs: alignment of screening to symptomatic pathways, and women's health Hubs.	Alignment with Local Authorities on community based plans to increase uptake.	Develop further plans.	Develop further plans.	Develop further plans.

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Place Based Partnerships (PBPs)

Current state: Our challenges

- Low healthy life expectancy has significant consequences for individuals, communities and services.
- 'Today' challenges consume capability to develop and implement 'tomorrow' solutions relating to prevention and ill health avoidance.
- Voluntary sector infrastructure, capacity and resilience is significantly reduced.
- Balancing NHS national/regional/ICB priorities and those generated by non-NHS PBP partners within current Place based resource constraints.
- The ability to create a cultural shift from a paternalistic approach to one where communities are empowered to make the changes themselves.
- Lack of trust in services by our communities; particularly in areas of high deprivation and among minority communities.
- Historical commissioning decisions which impact on service delivery.
- Need for recurrent funding streams to facilitate sustainable Place-based transformation activities beyond existing ICB investment.
- Local government reorganisation may mean partner organisations are not fully focused on delivering health and wellbeing interventions

Future state: Our ambition

- We will see a reduction in health inequalities through transformation of services informed through community insight, co-production and sensitive to local population health needs.
- We will have coordinated communications. We will move from community engagement to community empowerment and asset-based approaches in all we do.
- A strong and sizeable community and voluntary sector, maximising community assets to create resilient communities.
- Making every contact count across all partners, communities and people
- We will maximise our social value capacity to address building blocks of health. The 'Place focused' workforce will have shared purpose/values.
- We will have truly integrated teams following a successful roll-out of integrated neighbourhood teams (INTs) across voluntary and statutory services including primary, community, secondary care and social care services, maximising our skill sets.
- PBPs will hold increased level of commissioning responsibility for delivery with appropriate resources and risk management.
- We will maximise joint commissioning opportunities, particularly around primary and secondary prevention and with our local authority partners.
- Transformation of services will be sustained through long term investment in evidenced based services with reduced reliance on short-term funding and pilots.
- Our service delivery will maximise use of community buildings and assets.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Integrated neighbourhood teams (INTs) building on learning from the Integrated Neighbourhood Working approach	Support the workforce across organisational boundaries aligned to integrated neighbourhood working.	Understand how the workforce will be aligned to INTs. Learning from health and social care integration models	Build on areas of good practice to spread and embed the cultural change required. Understand how resources are aligned	Fully embedded neighbourhood teams Learning and evaluation shared	Ongoing learning and evaluation	Ongoing learning and evaluation
Implementation of Place Partnership Plans with targeted interventions to tackle frailty and Long Terms Conditions (alongside PBP priorities)	Collaborative leadership of INTs embedded. Primary Care Network (PCN) active participation in INTs.	Improve identification and management of health conditions. Improved alignment of self-care and non-clinical interventions.	Ongoing development and rollout - review of Place impact and spread of learning. Complete evaluation.	Neighbourhood working fully embedded. Ongoing review and development of PBP role, function and impact.	Ongoing learning and evaluation	Ongoing learning and evaluation
Maximise joint commissioning opportunities across health and social care maximising opportunities across all partners.	Opportunities for alignment Of the Better Care Fund (BCF)	Identify opportunities for improve integration of services. Opportunity to align BCF plans and consider shadow arrangements	Jointly commission preventative services with local authority partners.	Review the impact of a jointly commissioned services on patients and staff.	Ongoing learning and evaluation	Ongoing learning and evaluation
Development and maturity of Place to enable functions to be delivered at Place and neighbourhood level, based on local need and population sensitive.	Place responsibilities and assurance models established. Recurrent transformational resources established	Embed agreed level of responsibility for delivery with associated resources Place specific contracts managed at Place where appropriate	Ongoing review and development of PBP role, responsibility, function and impact. Understand impact of Local Government reorganisation	Consideration of place level budgets	Ongoing learning and evaluation	Ongoing learning and evaluation

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Section 1. Our delivery commitments

Early cancer diagnosis

Current state: Our challenges

- Late presentation
- Variation in Cancer Screening rates across the ICS (particularly in areas of deprivation and mixed ethnicity).
- Variation in GP Urgent Cancer Referral rates.
- Low early diagnosis rates for less survivable cancers.
- Large backlog of patients waiting for cancer treatment.
- There are long waiting times for diagnostic tests which can cause unnecessary delays in diagnosis.
- Variation in GP Direct Access CT scanning across the ICS

Future state: Our ambition

- Meet National ambition of 75% Early Diagnosis rates by 2028.
- Cancer and Diagnostic waiting times are within national performance requirements.
- Elective hubs are in place, underpinned by best practice in productivity.
- Community diagnostic hubs established and GP direct access enabled.
- Expansion of Lung Cancer Screening.
- Breast cancer – implementing community-based breast screening in areas of low uptake.
- Implement Pancreatic Cancer Case finding project
- Lynch Syndrome testing fully utilised.
- Increase GP Urgent Cancer Referrals where rates below ICS average.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Reduce cancer backlogs	Meet all cancer standards as defined in operational performance requirements and enable earlier diagnosis (maintain faster diagnosis standards).	Meet all cancer standards as defined in operational performance requirements and enable earlier diagnosis (maintain faster diagnosis standards).	Expansion of targeted lung health programme complete.	Monitoring and evaluation.	Monitoring and evaluation.	Monitoring and evaluation.
Establish Elective Hubs and Clinical Diagnostic Centres (CDCs)	Complete roll out of Newark elective Hub (opened November 2023) Implement GIRFT principles Complete Phase 1 and phase 2 City elective hub roll out	Complete City elective hub phase two. Commence City elective hub phase three. Opening of Mansfield and Nottingham CDCs.	Opening of Nottingham City based CDC	Develop further plans.	Develop further plans.	Develop further plans.
Screening and Case Finding: Lung Cancer Screening; Pancreatic Cancer Case Finding; GP Direct Access CT; Breast Screening	Phase 3 Lung Cancer screening implemented successfully	Phase 3 Lung Cancer screening round to commence in Mansfield and Ashfield Pancreatic Cancer Pilot in 2 PCNs CT scanning for Lung at SFH and Abdo pelvis NUH Increase mobile provision in areas of low uptake	Phase 4 Lung cancer screening and final phase to complete 100% roll out. Expand pancreatic screening. CT scanning for Abdo pelvis SFH Increase mobile provision in areas of low uptake	Continuation of phase 4	Develop further plans.	Develop further plans.

Learning Disabilities (LD) and Autism

Current state: Our challenges

- There are too many autistic adults and adults with learning disabilities being admitted to hospital as their needs are not being met in the community
- The length of stay in hospital is longer than clinically needed, causing pressures in services and worse outcomes for patients
- There are long waiting times for an Autism and ADHD assessment and diagnosis, with limited waiting well and post-assessment support, which means that people are not receiving the support they need
- There is a growing need for more specialist housing and accommodation provision for adults with complex needs
- There are growing numbers of autistic people in mental health services requiring care and support and an environment that meets their needs
- Autistic people and those with learning disabilities experience significant health inequalities, including having poorer health outcomes and a lower life expectancy than the general population. These are linked to barriers in accessing services linked to a failure to meet communication and sensory needs and make reasonable adjustments
- Pathways for autistic people are unclear and fragmented
- The reviews of the learning from the Lives and Deaths of people with learning disabilities and autistic people (LeDeR) are not embedded into system and service improvements
- Finances are a significant challenge for all system partners

Future state: Our ambition

- There will be an enhanced community model in place to provide support to enable people to live independently in the community and to provide early support and a crisis response to avoid hospital admission
- People will only stay in hospital for the time they need to, with partners working together to identify and act upon any housing and support needs to enable people to go to the place they call home as soon as they are ready
- An improved ADHD and Autism pathway and support offer
- Annual Health checks will continue to be delivered, sustaining the progress that has been made over the last two years to ensure that as many people with learning disabilities as possible receive a health check and that the health check is carried out to a high standard leading to positive health outcomes
- Reviews undertaken as part of the LeDeR programme are of a good standard and influence system and service improvements
- A skilled workforce able to meet the needs of autistic people and people with Learning Disabilities.
- Services will make reasonable adjustments which will be identified and shared through the use of the Reasonable Adjustments Digital Flag.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Community model of support with skilled workforce and providers who are able to meet complex needs	Specialist residential and supported living schemes have been developed. Specialist roles in place.	Review services for people with learning disabilities and autistic people	Implement recommendations and learning from the pathway review	Monitor improvements and review priorities	Monitor improvements and review priorities	Monitor improvements and review priorities
A responsive early support and crisis response offer so that hospital admissions are avoided	Unplanned care model is in place to avoid hospital admissions. All-age Dynamic Support Register in place	Review of Intensive Community Assessment and Treatment Team (ICATT), Orion Unit and Day service	Implement recommendations from the ICATT, Orion Unit and Day services review	Monitor improvements and review priorities	Monitor improvements and review priorities	Monitor improvements and review priorities
At least 75% of people with learning disabilities have had a good quality annual health check	The ICB is forecasting to achieve 82% by 31st March 2025.	Sustain annual health checks Quality audit developed to ensure consistent standards	Promote the uptake of annual health check and undertake annual quality audits of checks	Promote the uptake of annual health check and undertake annual quality audits of checks	Promote the uptake of annual health check and undertake annual quality audits of checks	Promote the uptake of annual health check and undertake annual quality audits of checks
LeDeR reviews are carried out to a high standard and learning is embedded	Reviews carried out within timescale Annual report is published identifying key themes	Audit LeDeR reviews and implement learning into commissioning plans	Promote the LeDeR reviews and implement learning into commissioning plans	Promote the LeDeR reviews and implement learning into commissioning plans	Promote the LeDeR reviews and implement learning into commissioning plans	Promote the LeDeR reviews and implement learning into commissioning plans
A clear and responsive pathway for autistic people, those with ADHD and people with Learning Disabilities that is clearly communicated to people	Autism strategy in place and is being refreshed. A Joint Strategic Needs Assessment (JSNA) developed	Implement the recommendations from the JSNA and refresh the autism strategy. Develop a LD JSNA and Strategy	Implement the recommendations of the autism strategy and implement the recommendations of the LD JSNA and Strategy	Monitor improvements and review priorities	Monitor improvements and review priorities	Monitor improvements and review priorities

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Section 1. Our delivery commitments

Safeguarding

Current state: Our challenges

- Partnership working on safeguarding and promotion of the health and welfare of children, young people and adults needs to be strengthened.
- Learn from local and national safeguarding rapid reviews, child safeguarding practice reviews and Safeguarding adult reviews including Domestic Homicide Reviews to improve outcomes.
- No system approach to capturing the voice of children, young people and adults to improve the experiences in all areas of care
- Lack of specialist provision for domestic abuse survivors within primary care.
- Increasing numbers of referrals into the domestic abuse Multi-Agency Risk Assessment Conference.
- Appropriate access and identification of asylum seekers and survivors of trafficking and modern slavery.
- Child sexual exploitation and abuse across the system and increase in contextualised safeguarding.
- Assessing and authorising within the community – in patients' best interest and least restrictive options. Deprivation of Liberty Safeguards not fully embedded across community teams.
- Children being cared for in inappropriate settings.
- Implementing the new duties around serious violence and the Domestic Abuse Act 2021 within the ICB and prepare for future duties in the Victims and Prisoners Bill.
- Developing data to evidence safeguarding assurance across the system.

Future state: Our ambition

- The ICB Safeguarding Children team will work to deliver the plan across the system and in conjunction with the local agendas for safeguarding children and young people.
- Survivors of domestic abuse are identified and appropriate support provided.
- Survivors of modern slavery and trafficking identified within the system and appropriate support given. Those who lack capacity within the community are supported to make decisions and live their lives with the appropriate care and support.
- The ICB is a valued contributor to the Violence Reduction Partnership and meets our Serious Violence Duties.
- We have reliable data which supports the identification of emerging themes and gives assurance around statutory duties being met across the system.
- Ensure there is safeguarding connectivity across the ICS with the NHS agenda.
- We will work with partners across the ICS and other areas to ensure children and young people are in the most appropriate setting, receiving the right services at the right time, to improve outcomes.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Children and young people will receive the right care, in the right setting, at the right time.	Developed D2N2 appropriate care settings for children and young people.	Continued development of D2N2 appropriate care settings	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.
Develop and enhance transitional safeguarding.	Development of transitional safeguarding.	Integral member of Adult and Children Safeguarding Boards/ Partnerships	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.
Embedding a trauma informed approach across the system.	Data informed approach in place. Local NHS role in Serious Violence Duty and Domestic Abuse Act 2021 defined.	Fully integrated approach with primary care for domestic abuse that includes children as victims. Refine process for survivors of child sexual exploitation and abuse.	Data dashboard implemented	Ongoing developments towards model of integrated, data informed approach.	Fully integrated, data informed approach.	Develop further plans.
Working with our partners to improve outcomes for children in local authority care.	Children leaving care have a comprehensive leaving care plan.	Processes embedded for children in care/looked after children to have their health assessments completed in a timely way.	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.
Support provided to adults in the community.	Mental Capacity Act cohort identified and risk profiled to proceed in the patients' best interests and least restrictive option.	Rolling programme of training provided. Monthly meetings with case managers to identify cases needing progression.	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.

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Working with people and communities

Current state: Our challenges

- While we have a strong foundation of listening to and working with our population and have made good progress of embedding this into our system forums, this is not consistent and not fully implemented.
- We have made good progress in moving from an episodic approach based around service change proposals to a continuous listening programme but this needs more work to be shared across the whole system.
- The opportunity presented by the formation of the ICP and our even closer working with local authority and other partners needs to be fully maximised to the benefit of the NHS and our population.
- We are not maximising the assets that all of our partners have across the whole health and care system and have not yet fully realised the opportunities we have through our ICP to hear regularly from our population to feed into our decision-making arrangements.
- The embedding of our co-production approach requires a significant culture change for our staff across the system.

Future state: Our ambition

- Our citizen Intelligence approach is fully embedded across all system partners. Our starting point for all consideration of how we deliver services starts with insights from our population on what services they value, how they want to access them and how they are best delivered.
- Co-production is embedded as default across the system - people with lived experience have an equal voice in all aspect of service development and change. These population insights are jointly gathered by all NHS and wider partners and freely available to all organisations within our system and also our residents.
- We consistently measure and monitor satisfaction with the health and care services we deliver and feedback on where we can do better or build on positive examples. This guides our focus.
- Staff know how to share their insights on how services can be better tailored for our population and how to signpost local people to get involved in improving their services.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Insights hub.	Co-design new hub model with partners	Ongoing development of the Insights Hub to increase members and insight reports	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.
Citizens panel	Evaluation of panel and development of mechanisms at Place	Recruit additional 800 panel members	Evaluation	Develop further plans.	Develop further plans.	Develop further plans.
Coproduction	Review and roll-out of training offer.	Develop appropriate data and local intelligence to continue to embed cultural change	Ongoing oversight of all co-production activity as part of Integrated Care Strategy commitments	Develop further plans.	Develop further plans.	Develop further plans.
ICP and ICB reports	Ongoing annual and periodic reports	Ongoing annual and periodic reports	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.
Service change	Support the Strategic Development activity for the Tomorrow's NUH programme.	Deliver public engagement and consultation as required.	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.

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Broader social and economic development

Current state: Our challenges

- Across the 10.8 million population in the midlands, healthy life expectancy at birth is notably lower in compared to the England average, with women in Nottingham living only 57.1 years in good health.
- Economic inactivity due to long-term health issues has increased by 400,000 since 2019, with 53% reporting mental health conditions.
- In 2022/23, 22% of 16–64-year-olds in the midlands were economically inactive, with a quarter due to long-term sickness.
- The top causes of disability in the midlands include lower back pain, depressive disorders, and neck pain, affecting younger adults.

The Integrated Care System (ICS) is committed to tackling disparities and help the NHS support broader social and economic development – the 4th aim of our ICS.

We haven't taken a structured programme approach to delivering the aims we set and the key actions we need to complete. Instead, existing ICS groups have been responsible for delivering their elements. Whilst this has been a practical solution for the past 2 years, it hinders our ability to track meaningful progress and measure impact.

The East Midlands Combined County Authority (EMCCA) has also expressed a desire to focus on similar ambitions to our ICS 4th aim, providing an opportunity to work across our ICS boundary with neighbouring ICS, "Joined Up Care Derbyshire".

Future state: Our ambition

- We understand and harness the power we have for anchor roles.
- We have transitioned from focusing on NHS anchor institutions to creating anchor systems, to ensure strategic alignment among our organisations to enhance community health and economic outcomes.
- We have a vibrant, multi-partner programme of work delivering wider social and economic growth concentrating on:
  - Theme 1: Net Zero ICS (the existing Net Zero programme will be subsumed here)
  - Theme 2: Health and Work
  - Theme 3: Economic Growth for Social Value
- We work with EMCCA, in our ICS but also taking opportunities to amplify learning with our neighbouring ICS in Derby and Derbyshire.
- Agreement of a collective procurement social value strategy for ICS partners, gaining efficiencies from our combined purchasing power, and supporting sustainability and social value in our communities by March 2024.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Programme Approach	New for 2025/26	Programme governance established. Outcomes and Measurement mechanism identified with defined baseline.	Measurement of programme delivery. Refine as appropriate	Measurement of programme delivery. Refine as appropriate	Measurement of programme delivery. Refine as appropriate	Measurement of programme delivery. Refine as appropriate
Building strong partnership working	Universities for Nottingham Civic agreement approved across all organisations party to the agreement	Programme priorities for implementing the Civic Agreement identified. Active participation in Anchor networks.	Continue to mature partnership working	Continue to mature partnership working	Continue to mature partnership working	Continue to mature partnership working
Net Zero ICS Programme Theme	This work sits as a separate delivery programme, page 37					
Health and Work Programme Theme	New for 2025/26	Mapping of NHS initiatives. Participation in Health and Work Collaborative. Work with targeted communities to reduce worklessness.	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.
Economic Growth for Social Value Programme Theme	New for 2025/26	Create pipeline of young people that will grow into roles within organisations. Review of opportunity for Tomorrow's NUH plans.	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.

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Greener NHS / Sustainability

Current state: Our challenges

- Our ICS Green Plan runs from 2022 to 2025.
- Limited carbon emission data is available. Indicative data suggests we have stopped the increasing trajectory of our carbon footprint given the increase in activity we have but are not decreasing it to a level required ot reach NHS net zero by 2040.
- Our 2025-2028 ICS Green Plan is being drafted and will build on the individual plans/ strategies of our health and care partners.
- Organisations have refreshed their plans, have strong stakeholder buy-in and are delivering well within the confines of their organisation, and we endeavour to amplify learning gained at a system-level.
- The trajectory to carbon net zero cannot be achieved without the buy-in of clinicians and service users, and we are now held up as an exemplar ICS for sourcing clinical capacity to lead this work.
- We are starting to bring together our strategies and programmes across the ICS for Net Zero, infrastructure, and the ICS 4th Aim.

Future state: Our ambition

- Our carbon net zero journey is clinically-led, managerially delivered.
- Healthcare and the councils work as one to deliver their net zero targets.
- We work across ICS and public sector boundaries when we identify opportunities.
- Local people are empowered – they know the steps they can take to reduce their own footprints - and take hem.
- Local people travel more 'actively'; relying less on cars, preferring walking, cycling or taking public transport instead.
- All our sites (where possible) have green spaces supporting wildlife and biodiversity, and supporting the wellbeing of local people and staff.
- Staff are empowered to make changes and reduce waste in their own work areas.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Deliver our ICS Green Plan.	Delivered > 90% of objectives. Regarded as a high performing system by NHSE Single Programme Director operating across ICS Net Zero, and Infrastructure,	Refresh/refine ICS Green Plan for 2025-2028. Annual delivery plan agreed and implemented.	Annual delivery plan agreed and implemented.	Annual delivery plan agreed and implemented.	Refresh/refine ICS Green Plan for 2028-2031. Annual delivery plan agreed and implemented.	Annual delivery plan agreed and implemented.
Securing and embedding clinical/ professional leadership and design for sustainable services.	Set up Faculty for Clinical Sustainability, supporting clinicians and managers early in their careers to make a difference. Held up as a national exemplar for our clinically-led sustainability approach	Working with our Universities, grow our faculty for Clinical Sustainability, complementing it with managerial capacity. Staff across all organisations are empowered to make changes, reducing waste in their work.	Faculty for Sustainability embedded and priorities defined for next 3 years. Increased influence to change clinical training syllabi to incorporate sustainability training.	Delivery of faculty priorities	Delivery of faculty priorities	Delivery of faculty priorities
Achieve national NHS Net Zero targets.	Continue with delivery - strengthen with primary care focus.	Refine delivery to ensure annual objectives are covered.	Refine delivery to ensure annual objectives are covered.	Achieve 80 net zero for NHS footprint emissions. Refine delivery to ensure annual objectives are covered.	Refine delivery to ensure annual objectives are covered.	Refine delivery to ensure annual objectives are covered.

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Quality Improvement

Current state: Our challenges

- No collective framework to utilise quality improvement (QI), transformation and how this relates to system efficiencies or performance delivery.
- Mixed QI approaches exist within the system and partners with no central understanding of interdependencies for the impact.
- No collective understanding within the system to enable developing levels of expertise and skills to undertake QI in conjunction with local needs or involvement with the population.
- No clear evidence of co-production principles/ opportunities with patients/clients/families and how this informs the priorities for QI.
- Benchmarking and aim correlation for QI does not always align with data insights from our current data collection schedules.
- Existing quality challenges do not directly link to programmes of QI with measurable outputs.
- Limited learning within the system to enable the adoption and spread of QI inventions where appropriate and embed improvement into the management systems and processes.

Future state: Our ambition

- QI, transformation and efficiencies impacts are understood within the system which drives improvement decision making in a shared vision.
- Systematised QI learning and programmes platform accessible within the system allowing for individual system partners priorities with understanding of collective population benefits.
- QI approaches occur within the system and partners with scoping, supporting levels of expertise to undertake QI are clearly defined and understood to deliver locally.
- System and clinical leadership align to enable and embed ethos that QI is a 'second job'.
- Co-production continues to be a tenet of all QI programmes and this informs QI priorities.
- System agility and agreed QI responses to emerging quality challenges with known measurable outputs becomes ‘normalised’.
- Shared and spread learning of evidence-based, high impact improvements, to be embedded into improvement management systems and processes.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Developing the shared purpose and vision related to quality improvement initiatives.	Development of shared vision by scoping and reporting using the framework of NHS IMPACT and feedback of system partners underway.	Build shared vision using NHS IMPACT and feedback from system partners. Framework to be adjusted to align with transformation programmes impact on population.	Monitor and adjust to align with transformation and improvement programmes as system position collectively matures.	Monitor and adjust to align with transformation and improvement programmes as system position collectively matures.	Monitor and adjust to align with transformation and improvement programmes as system position collectively matures.	Monitor and adjust to align with transformation and improvement programmes as system position collectively matures.
Developing our approach to leadership and culture to embed a QI approach.	System approaches informed by QI building on population engagement networks.	System quality improvement offers and scoping to enable system communities to benefit from a systematised NHS IMPACT Approach.	Monitor and adjust as QI and transformation of services embedded into management systems and processes approach.	Monitor and adjust as QI and transformation of services embedded into management systems and processes approach.	Monitor and adjust as QI and transformation of services embedded into management systems and processes approach.	Monitor and adjust as QI and transformation of services embedded into management systems and processes approach.
Building improvement capacity and capabilities, including benchmarking programme.	Alignment of ICS data insights leading to processes to support QI learning capacity and capabilities.	Evidence base developed. Focus on transformation priorities and alignment of capacity and capabilities to undertake QI informed by insights.	Progress check. Use QI programme developments to redefine or reprioritise year three to five ambitions.	Progress check to inform and adjust priorities. System demonstrates alignment of QI programmes, individual organisations and across sectors.	Progress check to inform and adjust priorities. System demonstrates alignment of QI programmes, individual organisations and across sectors.	Progress check to inform and adjust priorities. System demonstrates alignment of QI programmes, individual organisations and across sectors.
ICS commitment to coproduction Informing QI work.	Arrangements for population engagement confirmed. Work underway to embed QI into management systems and processes.	Codesign and coproduction embedded in QI programmes. Embed QI in management systems and processes.	Monitor and adjust to align feedback of QI programmes and projects’ impact.	Monitor and adjust as system position collectively matures.	Monitor and adjust as system position collectively matures.	Monitor and adjust as system position collectively matures.

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Finance

Current state: Our challenges

- **Underlying financial deficit** – all NHS partners within the system carry underlying deficits, annually managed through non-recurrent means. This has continued in 2024/25 due to under delivery of planned recurrent savings and in year unplanned pressures.
- **Productivity and efficiency** – through the pandemic, efficiency schemes and expectations were stood down and since then system partners have struggled to get the same efficiency as we have had previously. The system has seen a 20% increase of staff in post since March 2020 without a commensurate increase in activity. The significant reduction was made in 2024/25, and the plan for 205/26 expects a continue reduction in workforce to improve productivity.
- **Shape of spend** – the system strategy is based on shifting costs by investing in preventative services and providing care closer to home. This has not been seen in reality with continuing growth in acute hospital services due to continuing urgent care pressures.
- **Capital availability** – system capital funds are scarce and have historically been used to support business as usual maintenance and replacement, relying on national funds to support larger strategic priorities. This has led to some local priorities remaining unfunded for some years.

Future state: Our ambition

- **Financial sustainability** – return to financial balance in year two and achieve recurrent financial balance by end of year three through improved productivity and efficiency, and transformation of services to ease the burden on urgent care services. This will provide improved services for local people and staff and allow for future investment in ICS priorities.
- **Productivity and efficiency framework** – we will implement a framework that will ensure delivery of productivity and efficiency opportunities. The framework looks at clinical transformation, workforce productivity and operational efficiency.
- **Investment in prevention and tackling health inequalities** – £4.5m recurrently invested in health inequalities in 2023/24. Funded schemes remain in place. Additional investment paused in 2024/25 to focus on affordable financial position. Ambition remains to grow this investment further in future years alongside a focus prioritising existing resources to support prevention and equity. Continued further £4.5m investment in plan for 25/26
- **Capital resources used to support strategic aims** – ensure a considerable proportion of the system capital envelope is used to support agreed strategic priorities, improving services and providing better outcomes, access and experience for staff and local people.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Financial sustainability	Reduced underlying deficit	Improving the recurrent underlying deficit Deliver in year balance	Deliver recurrent financial balance. Create headroom to provide resilience	Develop further plans.	Develop further plans.	Develop further plans.
Investment priorities	Embed and evaluate impact of 2023/24 priorities	Increasing investment in prevention and equity 0.4% cumulative	0.6% cumulative	1% cumulative	1.4% cumulative	Develop further plans.
Capital investment	Increasing capital usage to support strategic aims Min. 10%	Increasing capital usage to support strategic aims Min. 15%	Min. 20%	Min. 25%	Min. 25%	Develop further plans.

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Strategic estates

Current state: Our challenges

- Together, the public estate in Nottingham and Nottinghamshire covers 896 points of provision.
- Health care is provided out of 216.
- We have now created a 10-year ICS Infrastructure strategy. This strategy documents what our health infrastructure is and how we wish to use this in the future.
- The strategy complements, but does not cover, infrastructure held by our local authority, police and fire services partners.
- We are now clear how our estate is segmented as Core, Flex, and Tail (see below)
- We still have insufficient capital to address all backlog maintenance and strategic needs.
- The lack of route to decarbonise some of our estate means we are now staying to attract fines for exceeding our carbon emissions limits.

***Core** - excellent condition; utilise to the max*
***Flex** - strategically ideal, may require investment, utilise to the max where possible*
***Tail** - not fit for purpose or does not align with our strategic requirements*

Future state: Our ambition

- Services are located based on need rather than historic arrangements, promoting sustainable travel.
- Co-location of complementary services wherever possible.
- Our Core estate is fully utilised.
- Our Flex estate has an investment plan to support maximum utilisation.
- Create a combined estate which is fit for purpose, big enough to cope with fluctuating demand, but no bigger than necessary.
- We have a clear disposal of land and buildings pipeline
- The cost of premises management is kept to a minimum.
- All our buildings are as carbon-efficient as possible.
- National Rehabilitation Centre (NRC) opportunities are maximised.
- Tomorrow's NUH plans remain part of our focus for the future.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Develop an ICS infrastructure strategy.	Draft joint ICS Infrastructure Strategy (ISS), and identified the programme needs to deliver it.	Programme to deliver the ISS in place. Priority workstreams : * Utilisation assessments across all estate * Professional services hub options appraisal will deliver better quality and financial savings	ISS Delivery Plan refreshed: Core annual delivery requirements for utilisation, workforce development, and capital investment implemented	ISS Delivery Plan refreshed: Core annual delivery requirements implemented	ISS Delivery Plan refreshed: Core annual delivery requirements implemented	ISS Delivery Plan refreshed: Core annual delivery requirements implemented
Rationalise our ICS estate.	Estate categorised as Core, Flex, and Tail. First phase of disposals identified and process to dispose in progress.	Provider Collaborative leading the process of identification and delivery of a disposal pipeline for our acute and community/mental health estate.	Utilisation assessment and transformation schemes identify 'Tail' condition properties for disposal. Potential for AI to streamline infrastructure is becoming clear / used to inform space requirements	Hand back or dispersal of properties.	Hand back or dispersal of properties.	Hand back or dispersal of properties.
Support 'One public sector estate' OPE approaches.	OPE programme reinstated. Formation of the East Midlands Combined Council Authority has provided a much-needed framework on which to drive opportunity analysis.	Participate in OPE, looking for opportunities that align with our ISS, plans for economic development (part of our 2025-2026 4th Aim Programme), and our ICS Net Zero plans.	To be confirmed – based on national One Public Estate priorities	To be confirmed – based on national One Public Estate priorities	To be confirmed – based on national One Public Estate priorities	To be confirmed – based on national One Public Estate priorities

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Research

Current state: Our challenges

- Better aligning the research that is undertaken and the research strengths, expertise and infrastructure of the ICS to the principles and priorities of the Integrated Care Strategy.
- Equity of access to place-based research opportunities with research being delivered where population need is greatest.
- Ensuring that all communities are able to be actively involved in population health and care research including shaping, involvement and participation so that research is representative of our underserved and diverse communities and everyone can benefit.
- Embedding research into everyday practice through opportunities for the workforce to be involved in research as part of their usual roles or to develop a research career.
- Systematically using the evidence from research to inform decision making.

Future state: Our ambition

- Partners from across sectors working together, including NHS providers, Local Authorities, VCSE Alliance, University of Nottingham, Nottingham Trent University, the local National Institute for Health and Care Research (NIHR) infrastructure and Health Innovation East Midlands.
- Our ICS Research Strategy vision is that in five years' time our ICS will have an integrated and supportive research environment, clearly aligned with system priorities, that ensures improved outcomes and reduced health inequalities for our local population and efficiencies for our health and care system.
- Our four strategy pillars are population, workforce, system and implementation.
- We will undertake research to improve the health and care outcomes and reduce the health inequalities of our local population.
- We will support our workforce to drive and deliver research in a culture where research is everyone's business.
- We will maximise the collective capabilities and strengths of the system through collaboration and shared infrastructure.
- We will increase the implementation of research outcomes that shown to improve health and care.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Develop an ICS research strategy.	ICS Research Strategy agreed. Plan and mechanisms in place to operationalise it.	Continued implementation of Research Strategy with partners	Continued implementation of Research Strategy with partners	Continued implementation of Research Strategy with partners	Continued implementation of Research Strategy with partners	Continued implementation of Research Strategy with partners
Better align research to the Integrated Care Strategy	Development of a pipeline of research projects underway	Develop a competitive ICS research grant proposal that aligns to ICS priorities with a focus on prevention	Continue to develop a pipeline of research projects. Continued development of mechanisms to support awareness of and engagement with research activity across the system.	Develop further plans.	Develop further plans.	Develop further plans.
Increasing the diversity of those involved in research.	Complete Research Engagement Network Programme and develop sustainability plan.	Further develop the Research Engagement Network and evaluate	Embed learning and ways of working	Develop further plans.	Develop further plans.	Develop further plans.

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Section 1. Our delivery commitments

Innovation

Current state: Our challenges

- Whilst we have been successful in attracting innovation funding, through successful applications, there is no dedicated funding earmarked for innovative projects.
- Allowing system partners the headspace, opportunity and confidence to consider trialling new options is a challenge. It is often easier to stick with tried-and-tested approaches rather than considering something new – this is understandable but can be restrictive.
- Silo working has been broken down through integration but can still be improved through collaboration around innovative projects.
- Health inequalities, equity of access, and effective patient communication can be further improved through innovative approaches.

Future state: Our ambition

- Building on existing strong foundations, in order to further fulfil the ICB's duty to promote innovation in line with NHS England guidance (page 16 Guidance on Updating the Joint Forward Plan for 2024/25) .
- To build on existing connections and cooperation across the ICS, combined authority and wider region, i.e. the ICB, PBPs, primary care, providers, local HIN (Health Innovation East Midlands, Local Authorities, VCSE Alliance, local universities, NIHR and neighbouring systems.
- To attract new investment into the ICS through true system working and the creation of effective business cases, expressions of interest, bids and project assessment forms.
- To help reduce health inequalities and inequity through our continued and combined focus on health innovation.
- Whenever possible, to consider and investigate innovative solutions to develop new prevention strategies and systems.
- To increase the spread and adoption of innovative solutions to help improve health outcomes for all.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Collaborative working to increase the spread and adoption of innovative systems and devices into pathways.	Dedicated ICB/ICS Health Innovation Programme manager built on links with local HIN and system partners.	Continue to strengthen existing links and continue to introduce innovative solutions into the ICS.	Continue to strengthen existing links and continue to introduce innovative solutions into the ICS.	Continue to strengthen existing links and continue to introduce innovative solutions into the ICS.	Continue to strengthen existing links and continue to introduce innovative solutions into the ICS.	Continue to strengthen existing links and continue to introduce innovative solutions into the ICS.
Ensure that innovation is linked to aims of ICB / ICS Strategy	Dedicated innovation lead joined key strategic meetings and strengthened relationships with stakeholders throughout the ICS.	Ensure that ongoing innovation aims are in line with those of system partners, e.g. long term care team, Place Based Partnerships..	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.
Increase opportunities to secure funding dedicated to innovation projects.	Health Innovation Programme Manager discussed the concept of HIN innovation exchanges with dedicated funding, and successfully helped to secure funding for several projects.	Ongoing collaboration with local HIN, to discuss areas in line with ICS priorities, e.g. community care, frailty etc. Hopefully with associated potential funding.	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.

Key

	Delivery Confidence
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

2024/25 Recovery Plans

Programme	Action	Mitigation	Action Owner
Place Based Partnerships	Place responsibilities and assurance models established. Recurrent transformational resources established	Lack of published national guidance impacted on this action. Neighbourhood Guidance now issued. The development of Place maturity has been reprofiled into 2025/26.	Place Based Partnership Programme Director

Appendix A: Statements of support from our Health and Wellbeing Boards

Nottingham City Health and Wellbeing Board

Agreed on 26 February 2025

“The Nottingham Health and Wellbeing Board is satisfied that the NHS Joint Forward Plan for Nottingham and Nottinghamshire takes full account and outlines the ICB’s contribution to the delivery of the Nottingham Joint Health and Wellbeing Strategy.”

Nottinghamshire County Health and Wellbeing Board

Agreed on 5 March 2025

“The Nottinghamshire Health and Wellbeing Board is satisfied that the NHS Joint Forward Plan for Nottingham and Nottinghamshire takes full account and outlines the ICB’s contribution to the delivery of the Joint Health and Wellbeing Strategy.”

Appendix B: Summary of our NHS Annual Operating Plan Priorities for 2025/26

Delivering our NHS Commitments

The Integrated Care Board (ICB) has led the development of an ambitious and credible 2025/26 NHS operational plan which covers the whole population of Nottingham and Nottinghamshire. The plan supports delivery of the local priorities set out in the Integrated Care Strategy and the refreshed NHS Joint Forward Plan.

It also supports delivery of the national priorities as set out in the NHS England 2025/26 Priorities and Operational Planning Guidance, published on 30 January 2025. It balances the immediate pressures of today with a 10 year vision for the future and includes:

1. Focussed objectives including Elective Care, Primary Care, Urgent and Emergency Care, Mental Health, Efficiency and Productivity
2. ICBs and providers must develop and submit robust, appropriately triangulated, and deliverable operational, workforce and finance plans
3. Streamlined planning submissions including 27th February (HEADLINE plans) and 27th March (FULL plans).
4. NHSE / ICS reviews between submissions, and a Board to Board in April to sign off plans. Boards to 'check and challenge' plans and sign 'assurance statements'

In delivering on these priorities for patients and service users, ICBs and providers must work together, with support from NHS England, to:

1. drive the reform that will support delivery of our immediate priorities and ensure the NHS is fit for the future. For 2025/26 we ask ICBs and providers to focus on:
    - reducing demand through developing Neighbourhood Health Service models with an immediate focus on preventing long and costly admissions to hospital and improving timely access to urgent and emergency care
    - making full use of digital tools to drive the shift from analogue to digital
    - addressing inequalities and shift towards secondary prevention
2. live within the budget allocated, reducing waste and improving productivity. ICBs, trusts and primary care providers must work together to plan and deliver a balanced net system financial position in collaboration with other integrated care system (ICS) partners. This will require prioritisation of resources and stopping lower-value activity
3. maintain our collective focus on the overall quality and safety of our services, paying particular attention to challenged and fragile services including maternity and neonatal services, delivering the key actions of 'Three year delivery plan', and continue to address variation in access, experience and outcomes

The ICS is expecting the final version of the NHS operational plan to be compliant with these national objectives. In the few areas where there remains a challenge to meet the national objective the ICS will continue to push hard for achievement in year. The ICS has made significant progress improving local operational performance, quality and safety, however there remain areas for continued focus in 2025/26:

- The elective waiting list has remained static despite delivering 18% more value weighted activity compared with 2019/20.
- There has been significant growth to in ED attendances (4.5%) and Non-elective 1 day + admissions (6.5%) with significant differential between South and Mid Notts which has placed the system under severe pressure in the context of funding / capacity constraints.
- There has been a real terms reduction in the pay bill, supported by strong progress reducing agency spend and bank. Further work is required to right-size the substantive workforce.
- Positive progress delivering the £257m efficiency programme, however significant challenge remains in Q4. The ICS has improved implied productivity, but further improvements are required.
- 2025/26 financial allocations are expected to be extremely challenging requiring high levels of efficiency delivery and real-terms reduction in system spend

Partners have agreed ambitious financial plans for 2025/26 in response to significant financial sustainability challenges across the system. The financial challenge is expected to be considerable, requiring real-terms reduction in spend and efficiency delivery of c. £250m (6%). In addition to the Fully Year Effect (FYE) savings, we are targeting £100m from system-wide transformation, £100m from organisational productivity and efficiency and £25m through review of commissioned services

These NHS commitments will be delivered through the following ongoing and emergent actions and interventions over 2025/26 across our NHS partners and in collaboration with our wider partners and communities.

Threaded throughout our collective response to these NHS delivery requirements as well as our transformational agenda will be the core strategic principles of **equity, integration and prevention.**

Appendix C. What we will deliver in 2025/26

Shifting care from hospital to closer to home…….

Optimise Out of Hospital Care

- Reduce Non-Elective Admissions: Achieve a 10% reduction through proactive local team empowerment and community-driven strategies.
- Strengthen Integrated Neighbourhood Teams: Enhance community health and wellbeing through integrated, proactive care delivery.
- Transform GP Workforce: Radically innovate recruitment, retention, and workforce models to address primary care challenges.
- Improving same-day access to primary care services, Promote the use of pharmacy-first approaches for minor illnesses.
- Optimise and Redesign Care Services: Redesign and reprocure community services, and streamline referral support for efficient, cost-effective care.
- Review and Align ICELS and Equipment: Ensure community equipment services (e.g., wheelchairs, continence supplies) are financially efficient, fit-for-purpose, and system-aligned.
- Implement the Nottingham and Nottinghamshire three-year Integrated Mental Health Strategy.

Enhanced Need Care for Frailty and People with complex needs

- Improve Frailty Management: Increase clinical frailty scoring, establish frailty registers, and enhance personalized care planning for moderate-to-severe frailty and end-of-life care.
- Focus on Prevention and Early Intervention: Prioritize falls prevention, early COPD/hypertension screening, diabetes monitoring, and wellness initiatives addressing isolation, smoking, and healthy lifestyles.
- Leverage Technology for Care Delivery: Use digital tools to streamline care processes and enhance system-wide delivery.
- Combat Social Isolation: Implement programs like "Best Years Hub" to reduce loneliness and frailty in older adults through social engagement.
- Strengthen Integrated Neighbourhood Teams: Set strategic direction for community-focused, coordinated care, emphasizing proactive and preventive approaches to frailty.

Streamline Urgent Care and Rapid Access Pathways

- Implement UCCH for improved patient flow at the hospital front door.
- Expand Same Day Emergency Care (SDEC) pathways and Virtual Ward (VW) services.
- Establish a co-located Urgent Treatment Centre (UTC) at QMC for better access and streamlined pathways.
- Enhance System-Wide Urgent Care Response: Develop a two-hour Urgent Community Response (UCR) framework. Strengthen UCR and create an Integrated Single Point of Access for coordinated care delivery.
- Reduce Delays and Improve Efficiency: Achieve 45-minute ambulance handovers and optimise PTS (Patient Transport Services) demand and capacity. Align system capacity by redesigning and reprocuring P1 and P2 pathways, ensuring timely social service assessments.
- Reduce non-elective admissions by 9% and 90-day readmissions by 30%.Standardise and optimise weekday and weekend discharges to improve patient flow.
- Standardise and optimise discharge support for mental health patients. Enhance urgent and emergency mental health care pathways.

Reforming Elective Care

- Optimise Elective Pathways: Reduce follow-ups through patient-centered decision-making and PIFU (Patient Initiated Follow-Up).
- Redesign pathways for MSK, ENT, eye health, and gynaecology; expand community care for dermatology, urology, and gastroenterology.
- Improve Efficiency and Productivity: Implement GiRFT recommendations to enhance theatre productivity and perioperative health screening.
- Maximise diagnostic resources by reducing unnecessary tests, rolling out CDCs, and expanding GP direct access.
- Meet National Standards: Achieve national elective access targets (65% within 18 weeks RTT). Implement the National Cancer Plan locally for earlier diagnosis and improved outcomes, extending TLHC programmes.
- Leverage Technology and Resources: Use AI and digital technology to enhance patient-centered care. Align shared waiting lists, workforce plans, and physical resources across elective hubs for better collaboration.

Appendix C. Shifting care from treatment to prevention and supporting the building blocks of health.

- Delivering “Keeping Children Safe and Helping Families Thrive: Keeping Children Well and Healthy”
- Delivering “Keeping Children Safe and Helping Families Thrive: Keeping Children Safe”
- Tackle obesity*
- Tobacco cessation*
- Vaccination and Immunisations
- Delivering our Net Zero Plan
- Promote exercise and ‘moving more’*
- Social Isolation and Loneliness including addressing digital literacy and confidence
- Promoting self care and independence including rehabilitation and reablement
- Proactive case finding (people with additional and complex needs, long term conditions including dementia, CVD, COPD, respiratory illness, cancer, diabetes)*
- Support appropriate Housing*
- Develop our collaboration on social value
- Promote Good Work and Employment*

*Prioritised in our Integrated Care Strategy

Appendix C. Shifting from analogue to digital.

Our innovative Digital Notts programme aims to connect health and care information across Nottingham and Nottinghamshire – for the right person, at the right time and place, to help make the best decisions. Always. Our plans can be found on the Digital Notts website https://digitalnotts.nhs.uk/

Implementation of our 5 year Data, Digital and Technology Strategy in October 2023 and underpinning five strategic priority programmes which are Public Facing Digital Services (inc. Technology Enabled Care), Digital Inclusion, Frontline Digitisation, Interoperability and intelligence led decision making.

Frontline Digitisation

Electronic Patient Records (EPR) implementation - EPR implementation is one of the biggest digital transformation programmes the NHS as seen. All three Trusts are on this journey and a significant amount of digital, operational and clinical resource is required to ensure that the programme is a success.

Commercial, Infrastructure and service delivery

The Nottingham IT Managers group are developing a joint procurement and infrastructure priority plan. The first priority is replacing the Wide Area Network (WAN). A significant system wide infrastructure project.

Interoperability

Notts Care Record roll out and optimisation - The Notts Care Record is nearing completion of phase 1 and moving towards phase 2 in the new year which extends the user base and functionality. The programme board will evolve and provide the governance, and a core team needs to be established with funding to support partner development costs.

Public Facing Digital Services

Digital Correspondence / engagement, uptake of Patient Engagement Portals and increase utilisation of the NHSApp – As a system we need to move towards a model of digital as default for all patient correspondence and use patient facing digital services (via NHSApp) to provide a more personalised and convenient healthcare service. This needs to timed with other digital developments (e.g., EPR roll-outs) but there are significant existing opportunities to shift from paper/postal to digital correspondence and from SMS to cheaper alternatives e.g. NHSApp notifications/Comms Annex. Proactive engagement and early digital communication interventions with patients will also reduce queries and phone calls, helping to streamline admin processes.

Supporting Intelligent Decision Making

Our three year data and analytics strategy will launch in April and set out our commitments to support system improvements in (a) population health, (b) flow and performance, (c) quality and safety, and (d) productivity and resource utilisation. Our objectives over the next year focus on ensuring the right intelligence and insight is available to decision-makers across the system to help deliver our shared priorities, increased collaboration with data, analytics and digital teams in partner organisations, improving data confidence across the non-analyst workforce, upskilling our analysts, deploying AI solutions, and making key decisions on local infrastructure going forward, including use of Federated Data Platform (FDP).

NHS
Nottingham and Nottinghamshire

Appendix 4: Example Programme Detailed Delivery Plans

Our Governance Arrangements and Delivery Plans

Oversight of delivery of the JFP will continue to be provided by the JFP Oversight Group comprising Executive leads of each of our statutory partners reporting into the ICB Board on an annual basis.

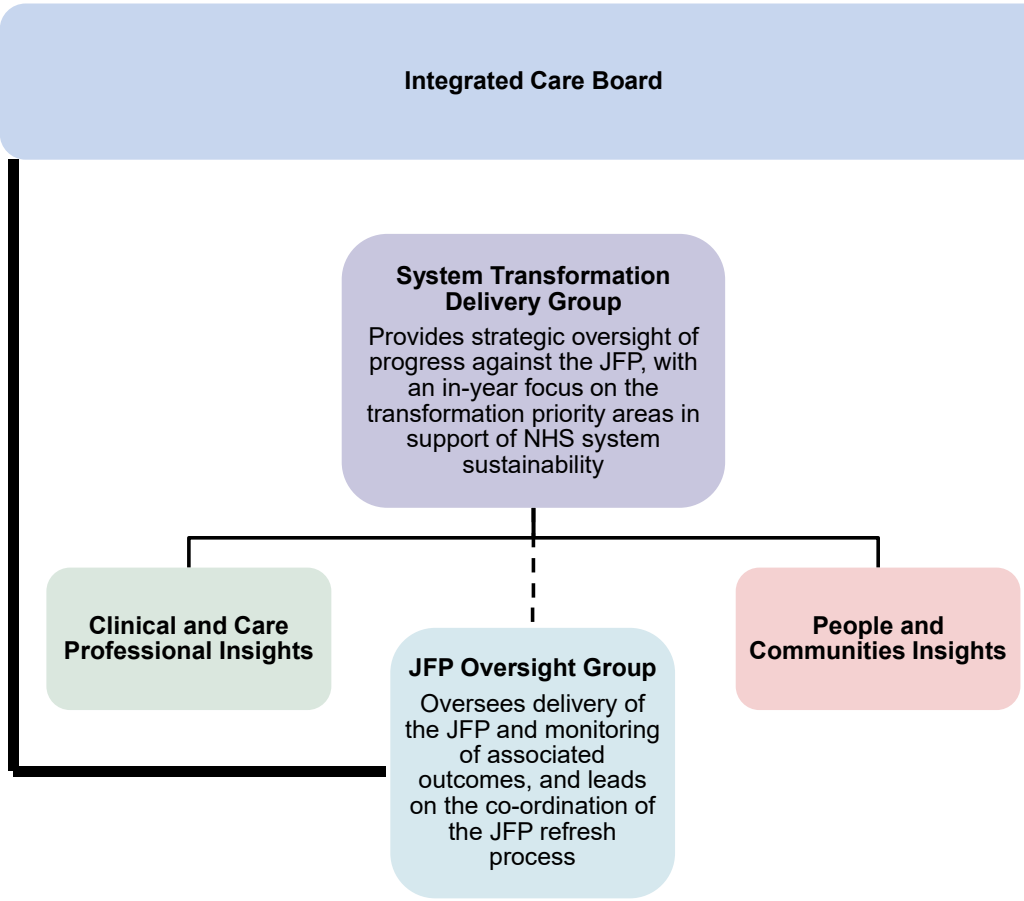
High level Delivery Plans are articulated in the JFP for each programme. These are underpinned by a more detailed delivery plan for programme leads to deliver against.

Key success factors for the JFP have been identified for each programme and will be overseen by the JFP Oversight Group. The delivery plans demonstrate how the plans contribute towards the ICS Outcomes Framework.

Transformation Programmes have each developed a detailed Programme Initiation Document (PID). These are overseen by the System Transformation Delivery Group.

A worked example of a delivery plan is shown below for the Frailty programme:

- Slide 3 shows a high level 5-year delivery plan.
- Slide 4 shows key success factors to support 2025/26 delivery.
- Slide 5 shows the detailed template for the programme PID being used to deliver all aspects of the programme.



Frailty

Current state: Our challenges

- Frailty is a common medical condition that is frequently associated with ageing. Over the next 20 years there will be a significant increase in frail people in our ICS.
- The Nottingham and Nottinghamshire system has identified frailty as one of the system priorities where our resources are currently significantly committed and an area of high growth in spend.
- The cost of frailty is not just financial. It is a cost to our people, our quality of care, our services.
- The electronic frailty index shows that across the 65 and over population at PCN level:
- People identified as Fit varies from 31% - 52%
- People identified with Mild Frailty varies between 28% and 33%
- People identified with Moderate Frailty varies between 12% and 21%
- People identified with Severe Frailty varies between 10% - 18% (excluding Bassetlaw)
- 21.5 % of the following two areas accounts for all over 65 emergency admissions(2019)
- 7,800 admissions for falls, Injuries and fractures equating to approximately70,000 bed days.
- 5,100 Flu and pneumonia emergency admissions equating to 43,000 bed days

Future state: Our ambition

- Maintaining independence by focusing on prevention for as long as possible in one's own home, increasing healthy life years, improving personalised care, achieving cost efficiencies and savings for the system.
- The goal is to reinforce the focus on personalised and proactive care that will enable us to deliver a fully integrated approach to Frailty and aims to:
- Delay the onset of health deterioration where possible
- Maintain independent living
- Reduce avoidable exacerbations of ill health
- Reduce use of unplanned care
- We aim to empower older adults to lead healthier, independent and fulfilling lives by providing holistic and person-centred care to older people and (where present) carers.

SUMMARY of what we intend to do over the next 5 years

What	2024/25 Progress	2025/26	2026/27	2027/28	2028/29	2029/30
Establish the frailty programme	Programme and workstreams established	Frailty Programme Board meetings held 6 times per year.	Frailty Programme Board meetings held 6 times per year.	Frailty Programme Board meetings held 6 times per year.	Frailty Programme Board meetings held 6 times per year.	Frailty Programme Board meetings held 6 times per year.
Establish a continual learning approach	Frailty senate held and practice packs circulated.	Learning Labs. Confirm best practice guidance in delivery of MDTs and INT responsibilities for quality assurance	Learning Labs. Evaluation of mobilisation and early implementation of INTs – support expansion of patient cohorts	Learning Labs. Ongoing refinement of INT approach, building cohort of patients under responsibility of INTs	Learning Labs. Ongoing refinement of INT approach, building cohort of patients under responsibility of INTs	Learning Labs. Ongoing refinement of INT approach, building cohort of patients under responsibility of INTs
Prevention of frailty	Increased vaccinations. Vaccination dashboard established. Increase in Making Every Contact Count (MECC) training.	Promotion of initiatives to prevent frailty and progression of frailty in over 65 years population incl. Falls, therapy services and rehabilitation pathways.	Develop further plans based on evidence of local neighbourhood need to reduce emergency admissions	Develop further plans based on evidence of local neighbourhood need to reduce emergency admissions	Develop further plans based on evidence of local neighbourhood need to reduce emergency admissions	Develop further plans based on evidence of local neighbourhood need to reduce emergency admissions
Identification of frailty	Identification of digital technology/ sensors and devices to support independence. CFS Scoring uptake and RESPECT form uptake improved.	Establish refined targeted and proactive approach to identifying frail population and appropriate management to understand their support needs using predictive tools.	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.
Management of frailty	Established Same Day emergency Care (SDEC) and silverline (SFH) Technology Enabled Care roll out.	Enable access to appropriate support to mitigate the risk of escalation of frailty inc. roll out of Care Navigation.	Develop further plans.	Develop further plans.	Develop further plans.	Develop further plans.

Frailty

Key actions in 2025/26	Timeline	Lead	ICS Outcomes Framework contribution	Metrics
Implementation of SDEC, Frailty Assessment Services and Silver Line/Urgent response support service offered across NUH and SFH	April – May 2025	NUH, SFHT, DBTH (oversight by the Urgent and Emergency Care Programme Board)	Reduction in average number of years spent in poor health. Reduction in avoidable premature mortality.	Reduce Emergency Admissions Frailty-related (Rate) contributing to overall 12% reduction 2025/26 Acute Emergency Admissions Avoided Age 65+ with LOS 1+ from Care Homes – Nursing and residential
Virtual Wards established to focus on Frailty and respiratory patients.	April 2025	UEC Programme Director	Increase in number of people being cared for in an appropriate care setting. Increase in appropriate access to primary and community-based health and care services.	Reduce Emergency Admissions Frailty-related (Rate) contributing to overall 12% reduction 2025/26 Frailty MDTs undertaken at Home. Reduction in Patients aged 65 yrs + in Nursing and Care Homes supported by Local Authority - City and County
Implement Integrated Neighbourhood working model (frailty pathway at initial stage of mobilisation). Key contributory elements: ongoing focus on prevention by Place based Partnerships, Proactive case finding, MDT best practice standards employed across primary care.	June 2025	Frailty/Community Transformation Programme Director (active support from Place Director)	Increase in number of people being cared for in an appropriate care setting. Increase in appropriate access to primary and community-based health and care services.	Reduce Emergency Admissions Frailty-related (Rate) Acute Emergency Admissions Avoided Age 65+ with LOS 1+ from Care Homes – Nursing and residential Improve Immunisation and Vaccination rates over 65yrs Increase in recorded Clinical Frailty Scores Increase in Medicines Use Reviews Reduction in falls
Use of AI to predict and identify people likely to become frail allowing earlier intervention and slowing pace of decline	June 2025	Digital Notts	Increase in number of people being cared for in an appropriate care setting	Reduce Emergency Admissions Frailty-related (Rate)
Identify priority cohorts to roll out MECC training/train the trainer, alongside identification workstream	June 2025 – March 2026	Frailty Transformation Programme Director - Prevention workstream	Increase in number of people being cared for in an appropriate care setting Increase in appropriate access to primary and community-based health and care services	Reduce Emergency Admissions Frailty-related (Rate) Increase in Clinical Frailty Scale (CFS) scores undertaken within 12 months for the ICB population

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Ensuring a focus on population health need through informed interpretation of data and community insight.	Enabling a 'place and neighbourhood' first approach with local partner and community expertise, and currently underserved populations informing delivery.
Enhance productivity and value for money	**Support broader social and economic development**
Ensure service delivery is as local as possible and joined up across partner organisations to optimise public spend.	Bringing together partners around a broad approach on health and wellbeing with a focus on addressing the wider determinants.

Transformation Programme PID Template

Programme is underpinned by a detailed transformation PID, which is overseen by the System Transformation Delivery Group.

Associated workforce, digital/IT and estates plans are being developed.

ADD REFERENCE	PROGRAMME NAME			ADD DATE COMPLETED
		SRO	ADD	
		Programme Manager	ADD	
		Finance Lead	ADD	
		Development Status	SELECT	
		EQIA Required?	SELECT	
		EQIA Endorsed	SELECT	

Vision and Objective	Key Deliverables
What are the vision and objectives of this programme?	*What are the programmes key deliverables? What changes are needed to realise the visions and objectives?*

Dependencies and Interdependencies	Impacts
List any interdependencies with other Transformation Programmes or existing service delivery. *What dependencies / requirements does the programme have in order to deliver?*	*Provide a brief but clear outline of the anticipated positive and negative impacts on service users, other organisations / partners and other parts of the ICB, including impacts on staff.* *This should make clear who will be affected, how they will be affected and what the likely consequences of this will be. Proposals which have impacts on specific geographic areas should also ensure this is detailed.* *Specifically, please consider the impact on health inequality, equity and impact on population health management.*

Activity ref	Activity Measures	Baseline	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	2026/27	Owner	Scheme / Programme	Comments
I01	*Document how delivery will be monitored and success measured e.g. •Reduce demand / service usage of XX by XX% will deliver a saving of £XX from XX budget.* *What is the current performance baseline? Please detail both inputs and outputs.*																	
I02																		
I03																		
I04																		
I05																		

Workforce ref	Workforce Impacts	Baseline	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	2026/27	Owner	Scheme / Programme	Comments
R01	*Detail workforce changes resulting from the transformation programme i.e. current establishment is XX, will be reduced / increased by XX.* *Where posts are transferring to other services please provide this detail.*																	
R02																		
R03																		
R04																		
R05																		

Milestone ref	Milestone	Original date	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	2026/27	Owner	Scheme / Programme	Comments
M01	*Key Milestones to deliver the programme, include all key steps required to achieve key deliverables, not just the overall delivery deadline.* *Please consider all governance and consultation steps in your milestones.*																	
M02																		
M03																		
M04																		
M05																		

Saving ref	Savings (£000)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	2026/27	Owner	Scheme / Programme	Comments
S01	*Detail savings delivered directly by the programme at an individual scheme level. e.g. Implementing a new service deliver model will save £XX. Recommissioning service XX will save £XX.*																
S02																	
S03																	
S04																	
S05																	

Cost Ref	Cost Description (including proposed funding source and rationale)	Funding Type	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	2026/27	Owner	Scheme / Programme	Comments
C01	*Include any delivery costs e.g. additional staffing resource, ICT development costs etc.*																	
C02																		
C03																		
C04																		
C05																		

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/03/2025
Paper Title:	**ICS Digital Data and Technology Strategy: Delivery Update**
Paper Reference:	ICB 24 113
Report Author:	Alexis Farrow, Programme Director
Report Sponsor:	Andrew Fearn, Chief Digital Information Officer
Presenter:	Andrew Fearn, Chief Digital Information Officer Dave Briggs, Medical Director for the ICB

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

Summary:

This report provides the Board with assurance of progress against the Integrated Care System (ICS) strategic digital priorities and goals laid out in the ICS Digital, Data and Technology (DDaT) Strategy that was approved at the Board's November 2023 meeting.

The overall programme is rated as being on track for delivery and the report presents further information on progress against each of the strategic priorities. Delivery reporting will continue to evolve over time as our programmes move forward; metrics continue to be developed along with our benefits reporting. This report includes a summary update on delivery during 2024/25.

The Digital Maturity Assessment was submitted on 13 May 2024. Headlines have been included in the report. These were delayed due to challenges nationally with the new process. Whilst included in the report, it is not recommended to make any year-on-year comparisons due to significant changes in the assessment process.

Since the last report, the ICB's internal audit function has completed an audit of the programme's governance. This resulted in an opinion of 'significant assurance'. Agreed actions are being progressed during 2025.

As part of its duty to oversee the delivery of the ICS DDaT Strategy, the Board is asked to note the content of the report for assurance that, overall, satisfactory progress is being made against our strategic priorities.

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 performance report tracks progress to give assurance on the delivery of the ICS digital priorities as outlined in the Digital, Data and Technology Strategy. These all contribute to the core aims of the ICB.
Tackle inequalities in outcomes, experience, and access	As above

How does this paper support	the ICB's core aims to:
Enhance productivity and value for money	As above
Help the NHS support broader social and economic development	As above

Appendices:
Appendix One – Digital Programme Status Appendix Two – System Digital Maturity Assessment Analysis

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 7: Digital transformation – Failure to drive forward digital transformation and utilise system intelligence solutions to address health inequalities and improve outcomes.

Report also received by:
ICB Finance and Performance Committee – 26 February 2025 Nottingham and Nottinghamshire ICS Digital Strategy Oversight Group – 26 February 2025

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

ICS Digital Data and Technology Strategy: Delivery Update

1. The Digital, Data and Technology (DDaT) Strategy for Nottingham and Nottinghamshire Integrated Care System sets out five strategic priorities:
    a) Public Facing Digital Services.
    b) Digital Inclusion.
    c) Interoperability (Shared Care Records).
    d) Frontline Digitisation.
    e) Intelligence Led Decision Making.
2. Each of the above strategic priorities are underpinned by clear performance metrics and are tracked through the system's transformation programme boards. These priorities are underpinned by three enabling workstreams:
    a) Workforce.
    b) Sustainability.
    c) Infrastructure.
3. The full DDaT Strategy can be accessed here: https://prezi.com/view/WAlBPVywyhc231fdWMlx/.
4. Performance against the five strategic priorities above is detailed below; a full summary can be found at Appendix One.
    a) **Public Facing Digital Services:** The programme is on track to deliver against plans for 2024/25. Whilst the key deliverables for 2024/25 are on track some of the target measures will not be achieved, such as 75% of the population registered for the NHS App. Whilst this measure will not be met, the Nottingham and Nottinghamshire system remains in the upper quartile for this measure nationally. The programme has made a significant impact in supporting our population in accessing digital health and care services through the NHS App as the digital 'front door.'

        In 2024/25:

        i) 99% of GP practices enabled with online consultation tools; 75% via NHS App delivery, 41,500 online consultations per month.
        ii) Digital letters enabled in both acute trusts – 31% of letters sent digitally, saving thousands of pounds in postage costs and over five tonnes of carbon per month (cumulatively eight hundred tonnes of carbon saved).
        iii) Digital letters have seen a 2% reduction in 'Did Not Attends'.

iv) Over 115,000 repeat prescriptions ordered via NHS App per month. The total number of repeat prescriptions for 2024/25 is over 1.2 million, saving over £400,000 in administrative time.

b) **Digital Inclusion:** the programme is on track to deliver against target metrics for 2024/2025. Significant work has taken place to support people in becoming more confident and capable of using digital tools for their health and care needs. In 2024/25 the key programme achievements were:

i) 5,521 people supported to get online and improve their skills and confidence.

ii) 1,272 people supported through the project and each Council of Voluntary Services (CVS) initiatives with 234 skills sessions delivered to support service users with digital skills and digital healthcare access.

iii) 1,261 skills sessions delivered to support NHS App and digital healthcare access.

iv) Supported eight CVS organisations to embed digital inclusion delivery within their service offering.

v) Trained forty-one staff and volunteers as Digital Health Champions.

vi) Supported 15 ad-hoc local healthcare/ community events.

c) **Interoperability (Shared Care Records):** The programme is currently slightly off-track. During 2024/25, the focus was on the phase one build of the Notts Care Record. This included the development of the functionality to allow existing shared care record users to move from the old shared care record, to the new Interweave solution. Users and contributors of data in this phase are:

i) Nottinghamshire County Council.

ii) Nottingham City Council.

iii) Sherwood Forest Hospitals NHS Foundation Trust.

iv) Nottingham University Hospitals NHS Trust.

v) Nottinghamshire Healthcare NHS Foundation Trust.

vi) Primary Care (data shared through GPConnect and GP Repository for Clinical Care).

Four of the six partners are now contributing live data into the Notts Care Record. However, due to delays in the upgrade of the Laboratory Information Management System in the NHS Trusts, the diagnostics data feed into the Notts Care Record has been delayed.

d) **Frontline Digitisation:** The programme is slightly off-track due to procurement and system migration delays in 2024/25 but is still on track to deliver over the life of the programme. In 2024 the programme has supported the delivery of:

   i) 88% of adult social care providers granted funding to deploy a digital social care record.

   ii) Electronic Patient Record deployment across the three NHS Trusts; either expansion, optimisation, or procurement to ensure productivity gains and improve patient flow.

   iii) Deployment of electronic prescribing and medicines administration technology across three NHS Trusts.

   iv) Upgrading Laboratory Information Systems.

   v) Deployment of cloud-based telephony across primary care.

   vi) Piloting robotic process automation for document management across primary care.

   vii) Wider Area Network re-procurement (system-wide) to enable improved infrastructure and drive economies of scale.

e) **Support Intelligent Decision Making:** The Programme is currently on track. In 2024/25 key deliverables have been achieved such as:

   i) Analysis of system wide transformation programme priority areas, to ensure that we are staging deployment of digital technologies when there is most need/impact.

   ii) Working with Systems Analytical and Intelligence Unit colleagues to understand population need/those most at risk, to support utilising technology enabled care products.

   iii) Evaluation of digital deployments to ensure they are fit for purpose and targeting the right people and supporting our workforce.

5. The Digital Maturity Assessment is a national assessment process, which aims to support Integrated Care Systems in levelling up their digital maturity across a number of domains. The 2024 assessment scored Nottingham and Nottinghamshire as above average nationally.

6. The Assessment was first launched in 2023 with the expectation that systems would complete the assessment annually to demonstrate progress in delivering digital advancements across health organisations.

7. Learning from the first round resulted in significant changes to the assessment process. This has meant that 2024 assessment outputs are not comparable to the outputs of 2023. The 2023 assessment also did not include primary care, which was captured as part of the 2024 assessments.

8. Whilst improvements to the process have been welcomed, the inability to compare progress (such as changes to scoring mechanism, addition of questions and amendments to previous questions) has meant that we cannot track any progress made across our system over the last 12 months using the Digital Maturity Assessment.
9. A full analysis of the Digital Maturity Scores can be found in Appendix Two.

Appendix One – Digital Programme Status

Programme	Aim	2024/25 Progress	Status
Public Facing Digital Services	We are empowering our communities by giving them greater control over their health and care. By providing access to a digital health and care record so patients can self-serve, self-manage and access key information and services – all from the comfort of their own home and communities.	99% of practices enabled with online consultation tools; 75% via NHS App delivery 41,500 online consultation per month. 100% record access technically enabled across primary care with 78% of practices enabling record access to 90% or more of their patients. Digital letters enabled in both acute trusts – 31% of letters sent digitally saving thousands pounds in postage costs and over five tonnes of carbon per month (cumulatively eight hundred tonnes of carbon saved). Digital letters have seen a 2% reduction in 'Did Not Attends'. Fifty-eight percent of population registered for NHS App. Patient engagement portals deployed in both acute trusts. Wait list validation tools deployed across both acute trusts to reduce waiting list size. Meet and Greet technically enabled to enable waiting well. Over 115,000 repeat prescriptions ordered via NHS App per month. The total number of repeat prescriptions for 24/25 is over 1.2 million, saving over £400,000 in administrative time. Discharge to assess project has enabled seventy-five patients to be discharged to their home with the support of technology enabled care sensor and monitors saving pathway two beds. Fourteen care homes using sensor-based falls technology to reduce conveyances to accident and emergency departments. Digital Care Planning for COPD, Asthma, B-Fit and Paediatric Epilepsy. Scoping and evaluating opportunities to use Artificial Intelligence in wound care assessment, Parkinson's tremor monitoring, enhanced diagnostics, and care planning.	On Track
Digital Inclusion	Support our population and working by giving access to support, training, and equipment, enabling them to	Transitioned Digital Inclusion into its own strategic workstream. Established Nottingham and Nottinghamshire ICS Digital Inclusion Board in May 2024.	On Track

Programme	Aim	2024/25 Progress	Status
	use digital assets for the benefit of their health and wellbeing.	Strengthened public and patient voice through our Citizens Digital Forum. Presented at four national conferences and webinars, raising awareness of digital inclusion activity in Nottingham and Nottinghamshire. Supported at 15 ad-hoc local healthcare/ community events. Participated in Get Online Week: October 2024 – held 15 Digital Health Hubs in GP surgeries with <55% NHS App uptake to help patients access digital tools. 135 people spoken to, 55 full NHS App registrations. Digital Inclusion Co-ordinators: • Nominated for ICB Health and Care Awards under the Equity category. • First Digital Inclusion Co-ordinator recruited to secondary care in September 2024. • 5,521 people supported via a Digital Inclusion Co-ordinator to get online and improve their skills and confidence. • 1,261 skills sessions delivered to support NHS App and digital healthcare access. CVS Collaboration Project: • Supported eight CVS organisations to embed digital inclusion delivery within their service offering. • Trained forty-one staff and volunteers as Digital Health Champions. • 1,272 people support through the project and each CVS' initiatives. • 234 skills sessions delivered to support services users with digital skills and digital healthcare access. • Twelve case studies produced. Digital Health Literacy: • Developed and launched a bespoke Health and Digital Literacy eLearning course in collaboration with the Patient Information Forum (PIF), for all ICS staff. • Fifty-five staff members across the ICS have enrolled onto the course.	
Frontline Digitisation	Our workforce will have access to effective and efficient digital	Eighty-eight percent of adult social care providers granted funding to deploy a digital social care record.	Slightly Behind

Programme	Aim	2024/25 Progress	Status
	assets and infrastructure, enabling them to provide the best health and care services.	Electronic Patient Record (EPR) deployment across the three Trusts either expansion, optimisation, or procurement of a new to ensure productivity gains and improve patient flow. Deployment of electronic Prescribing and Medicines Administration technology across the Trusts. Upgrading Laboratory Information Systems. Deployment of cloud-based telephony across primary care. Piloting Robotic Process Automation for document management across primary care. Wider Area Network re-procurement (system wide) to enable improved infrastructure and drive economies of scale.	
Interoperability (Shared Care Record)	Our aim is for our population to receive the right care, at the right time, always. By giving health and care providers access to key information about the person they are treating, reduces unnecessary diagnostics, treatment duplication and ensures prompt access to health and care services.	Four organisations (Nottinghamshire County Council, Nottingham University Hospitals NHS Trust, Nottinghamshire Healthcare NHS Foundation Trust (mental health data) and Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust data has been backloaded into the Notts Care record. We have a target to onboard Sherwood Forest Hospitals NHS Foundation Trust and GPRCC by the end of March. Four organisations are ready to consume data – Sherwood Forest Hospitals, Nottinghamshire County Council, Nottingham University Hospitals, Nottinghamshire Healthcare Trust have been onboarded: • There are approximately 3.5 million records created in the Notts Care Record. • There are over 5,100 users currently using a Shared Care Record in per month. • Over 51,000 patient records accessed via a Shared Care Record per month. We have also been preparing data maturity projects for go-live: • Work has been ongoing for care planning to prepare a proof of concept for About Me. • Work has been ongoing with the ICS to get system-wide buy in to deliver Discharge to Assess (with scope to potentially include mental health).	Slightly Behind

Programme	Aim	2024/25 Progress	Status
		• A workshop has taken place to identify data sharing of county council children and young people's data to potentially reduce unnecessary assessments for Autism and ADHD. Benefits: • Based on modelling from OneLondon, from the number of records viewed in existing Shared Care Record, we have saved £0.97 million in staff time and efficiencies	
Supporting Intelligent Decision Making	Use data to better understand the health and care needs of our population to focus our digital resources where they have the most impact and helps to design and target interventions to prevent ill-health and to improve care and support for people with long-term conditions	Analysis of system wide transformation programmes priority areas to ensure that we are staging deployment of digital technologies when there is most need/impact. Working with SAIU colleagues to understand population need/those most at risk to support utilising technology enabled care products. Evaluation of digital deployments to ensure they are fit for purpose and targeting the right people and supporting our workforce. Targeted communications to specific patient groups and communities to reduce health inequalities. Utilising data to ensure we are engaging with community groups which are more likely to be facing inequalities due to the use of digital technologies. Undertook external evaluation of Digital Inclusion Co-ordinator roles via Niche Consulting. Progressing an Options Appraisal to decide future approach.	On Track

Appendix Two – System Digital Maturity Assessment Analysis

'What Good Looks Like' Pillar	2023 score	2024 score	National average for 2024	Narrative
Well Led	2.3	2.7	2.1	The Well Led pillar is a strength for all organisations thanks to the work that has been done creating, embedding, and funding digital transformation strategies. However, we should be mindful that future NHSE funding is still uncertain and to secure local funding financial benefits must be proven.
Ensuring Smart Foundations	2.8	2.6	2.7	Most organisations highlighted the impact of a long-term lack of funding in their technical and legacy debt scores. EPR is mentioned in the Ensuring Smart Foundations pillar (2.29- 3.50), so advancements that organisations make in implementing their EPR will increase this pillar's score. EPR progress may also affect the Empower Citizens pillar as we could use it to develop our communications with patients.
Safe Practice	2.7	3.0	2.7	Data Governance is the biggest challenge in this pillar.
Support People (workforce)	2.2	3.0	2.3	There is an interesting relationship between the level of digital literacy (scoring 1-2 for the digital literacy domain) that we have assumed that our staff have and the fact that the DMA results show a lack of training and user centred design. We know that when there is a lack of training and user centred design, it is challenging to realise benefits from digital projects. If our staff had the level of digital literacy we are assuming, then this could mask the training need to an extent. This potentially shows that our staff have a lower level of digital literacy than we assumed and therefore the training need is much higher. Addressing this will increase the Support People pillar (currently scoring 1.33-3.00)
Empower Citizens	1.6	2.8	2.3	The Empower Citizens and Improving Care pillars are the weakest across the ICS, and this is in line with national and regional scores.
Improve Care	2.3	2.4	2.4	The Empower Citizens and Improving Care pillars are the weakest across the board, and this is in line with national and regional scores. The DMA showed that it would recognise a lot of the benefits that will be released with the use of the Notts Care Record. The NCR will address the shared care record domain but also will influence the care coordination capabilities domain of the Improve Care pillar (one of our lowest scoring pillars at 1.4-2.5). NCR is intrinsic to the increase in the Improve Care pillar score.
Healthy Populations	2.2	4.2	2.7	Whilst the question set for the ICB was different to the trusts and primary care, there appears to be a mismatch between the strong PHM work done at the ICB and how it is used in organisations (4.2 in the ICB compared to 1.8-3 in the other organisations). This could need further investigation.

Rushcliffe Arena, 09:00-13/03/25

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/03/2025
Paper Title:	**Quality Report**
Paper Reference:	ICB 24 114
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, and where there are escalations 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 provides exception reporting for areas of enhanced oversight, as per the ICB's escalation framework (included for information at Appendix one):

- Nottingham CityCare Partnership Community Interest Company
- Urgent and Emergency Care
- Maternity
- Special Educational Needs and Disabilities
- Looked After Children
- Children and Young People

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 and safety matters are routinely reported to every meeting of 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)

Reflections on previous month:

1. The Care Quality Commission has undertaken one assessment of the Trust's core services during January 2025, this involved the assessment of four Adult Mental Health in-patient wards at Sherwood Oaks Hospital (two wards), Highbury Hospital and the Willows Psychiatric Intensive Care Unit. The Trust has received high-level feedback and is continuing to respond to data requests in support of the findings and final report.
2. There was a focus on 'safe now' reporting, ongoing and sustained improvements in community clinical risk assessment compliance, and the development of a new assertive and intensive treatment pathway digital dashboard to support a daily review of clinical cases.
3. Assurances regarding crisis services making sustained improvement in maintaining up-to-date risk assessments were received. A deterioration in the proportion of patients seen face-to-face in four hours was noted to have been affected by accommodation of patients' preferred dates and times to be seen.
4. Progress against the transition criteria to move out of NHS England's National Oversight Framework was discussed. Five of the seven metrics were reported to be 'on track.' Two of the metrics (financial performance, and leadership and governance) were reported as 'off track,' with recovery of leadership and governance expected in the next quarter.

Monthly exceptions:

5. The Independent Homicide Investigation was published on 5 February 2025. There is learning and actions for NHS England, the Trust and the ICB. A joint action plan has been developed to respond to the areas identified as needing to be improved.

New risks:

6. There is a risk around public confidence in the service and that this may limit people choosing to access Trust services following the publication and media coverage of the Independent Homicide Investigation. This also has the potential to further impact on existing identified risks in relation to services and staff.

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

Reflections on previous month:

7. The ICB's Quality Team is meeting regularly with key individuals in the urgent and emergency care pathway, alongside visits to the Emergency Department to strengthen relationships and provide further understanding of operational and quality challenges, which remain substantial.
8. Continuous improvement efforts have been particularly evident in the urgent and emergency care pathway. Some health and safety improvements have been made, additional staff have been placed at reception and on the ambulance entrance corridor. Time to initial assessment has shown some improvement, and the new national Operational Pressures Escalation Level (OPEL) framework has been implemented.
9. Patient care in unconventional spaces continues on a daily basis in both the Emergency Department and on many hospital wards, along with a high number of single sex accommodation breaches.

Monthly exceptions:

10. January's Improvement Oversight and Assurance Group (IOAG) continued to report a financially challenged position, but assurances were given around how quality is being maintained, and a staff plan is being developed.
11. The IOAG undertook a stocktake into maternity improvements in February which was positive, supported by a positive insight visit between the ICB, Maternity and Neonatal Voices and NHS England.

New risks:

12. There are additional risks in relation to maternity inquests and prosecutions, as detailed in the maternity section.

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

Reflections on previous month:

13. Demand throughout the urgent and emergency care pathways remains high with multiple periods of the full capacity plan being in place. Internal Trust actions to address this are broadly on track.
14. An options paper has highlighted a requirement to increase the number of security staff available in the Emergency Department due to an increase in violence, aggression and use of restrictive practices.

15. The national inpatient survey found several areas of improvements in responses. The patient experience team are reviewing the friends and family survey and will involve divisions to create bespoke surveys targeting any issues found in the survey to develop further evaluation of these areas.

Monthly exceptions:

16. There are no exceptions to report for this quarter.

New risks:

17. No new risks have been identified during this quarter.

Nottingham CityCare Partnership Community Interest Company – Enhanced Oversight

Reflections on previous month:

18. The ICB's Quality Team continue to attend CityCare meetings. During the January 2025 Quality Review Group feedback was provided to CityCare about positive progress and a formal review will be undertaken at March's System Quality Group.
19. A joint quality visit to the Community Nursing Team covering Primary Care Network One took place in January 2025. The impact of high clinical demand was observed. Staff demonstrated professional and compassionate views, and motivation to support preventative work in an area that experiences a high level of deprivation.

Monthly exceptions:

20. Risks managed by Nottingham CityCare's Quality Committee has been shared with the ICB.
21. Nottingham CityCare and the ICB have agreed to undertake a stocktake of progress to the System Quality Group and following this review, will agree if enhanced surveillance is still required.

New risks:

22. No new risks have been identified this quarter.

Urgent and Emergency Care – Enhanced Oversight

Reflections on previous month:

23. Operational pressures within Urgent and Emergency Care (UEC) have remained persistent with patients regularly receiving care in spaces such as corridors or being cared for in any available spaces on wards.
24. Following the implementation of 45-minute handovers at Queen's Medical Centre there has been a significant reduction in pre-handover lost hours.
25. A process has been implemented to support NHS England's request for 'After Action Reviews' to be undertaken for people experiencing long delays in the UEC pathway, including 48- and 72-hour Emergency Department journeys.

Monthly exceptions:

26. A 45-minute deadline for ambulance handovers was introduced in December 2024 at NUH, with an expectation this will become system-wide. This has significantly improved performance around handover delays, and as a result this has significantly improved East Midlands Ambulance Service (EMAS) performance across the system. However, this has caused additional pressures in NUH's Emergency Department, which are being managed through a collaborative approach between ICB, NUH and EMAS.
27. The ICB is implementing dynamic risk assessments across the system following National Quality Board Guidance.
28. The System Quality Group has agreed a set of UEC system-wide reporting metrics supported by all partners.
29. Initial learning from after action reviews do not declare harm. Further thematic review and analysis will be reported as part of the System Quality Group quality metrics and form part of the next UEC deep dive.

New risks:

30. No new risks have been identified this quarter.

Maternity – Enhanced Oversight

Reflections on previous month:

31. The Local Maternity and Neonatal Services and ICB conducted a two-day insight visit to NUH in January 2025 and a draft report is being developed.
32. NUH and SFH have been collating all evidence required to declare compliance with NHS Resolution's Year Six Maternity Incentive Scheme. NUH is on track to declare compliance with nine out of ten safety actions, SFH is on track to declare compliance with all safety actions.

33. NUH has completed the Maternity Care Quality Commission factual accuracy stage with the final report expected imminently.

Monthly exceptions:

34. There have been two inquests and three Care Quality Commission prosecution cases in January and February 2025.

New risks:

35. The Independent Maternity Review has announced an extension before reporting, this delay has the potential to impact the affected families and NUH.

Special Educational Needs and Disabilities (SEND) – Enhanced Oversight

Reflections on previous month:

36. On 14 January 2025, at the Nottingham City local area Special Education Needs and Disability Annual Engagement Meeting, a formal discussion with Ofsted and the Care Quality Commission took place as planned. SEND executive leaders were able to demonstrate joint oversight and understanding of the current position and improvement priorities required.
37. The Nottinghamshire local area SEND partnership participated in a stocktake for the improvement programme on the 20 January 2025. Feedback from regional SEND managers from the Department of Education and NHS England advised that feedback will be issued, but significant progress has been made against the identified priority areas for improvement.
38. Nottingham and Nottinghamshire SEND system strategic leads have co-produced a clear narrative to articulate the risks surrounding the partnership's responsibilities to discharge their statutory duties.

Monthly exceptions:

39. The fixed term SEND Improvement Project Manager post ends in February 2025 as planned, and the Children and Young People's Commissioning Team have restructured slightly, bringing colleagues working on Children and Young People's learning disability and autism into the Children and Young People's Commissioning Team and realigning portfolios across the team.

New risks:

40. No new risks have been identified this quarter.

Looked After Children – Enhanced Oversight

Reflections on previous month:

41. An insight quality visit to the Children in Care Nursing Services is scheduled for Quarter 4 of 2024/25.

Monthly exceptions:

42. No additional exceptions in Quarter Three.

New risks:

43. There is a risk relating to paediatrician capacity in NUH, which is being mitigated through recruitment to a locum paediatrician.

Children and Young People – Enhanced Oversight

Reflections on previous month:

44. There have been some extremely complex young people in inappropriate settings. The increased complexity and lack of available appropriate settings means that resolution often requires high level funding arrangements for transfers to more appropriate settings, usually social care placements.

Monthly exceptions:

45. There are no exceptions to report for this quarter.

New risks:

46. There are risks to ongoing ICB work if the demand for escalation around children and young people in inappropriate settings continues, as the capacity to manage these is limited.

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.

Rushcliffe Arena, 09:00-13/03/25

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/03/2025
Paper Title:	**ICB Service Delivery Performance Report – March 2025**
Paper Reference:	ICB 24 115
Report Author:	Sarah Bray, Associate Director of Performance and Assurance Rob Taylor, Deputy Director of Performance and Assurance
Executive Lead:	Maria Principe, Acting Director of Delivery and Operations
Presenter:	Maria Principe, Acting Director of Delivery and Operations

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.

Urgent and emergency care performance remains a significant challenge, with the system delivering 57.4% of patients seen within four hours in January against the target of 76%. Non-elective admissions were above the planned level by 11.6% in December. Ambulance handover delays showed strong improvement following the implementation of the 45-minute handover protocol at Nottingham University NHS Hospitals Trust (NUH) but remain a key challenge, particularly at Queens Medical Centre, with 1,885 hours lost in January. Significant progress has been made in reducing planned care waiting times, with the volume of long waiting patients over 65 weeks continuing to reduce: 86 patients were waiting in December compared to 269 in September. However, eliminating 65-week waits remains challenging, particularly in specialties with capacity constraints, such as ear, nose and throat services.

Cancer care metrics have shown notable progress, and the system continues to perform well around the 28-day Faster Diagnosis standard, with NUH and Sherwood Forest Hospitals NHS Foundation Trust (SFH) achieving the target in December.

The total volume of patients waiting for diagnostics and those waiting more than six weeks continues to reduce but remains above the planned level. Challenges remain around reducing the backlog volumes for high volume modalities including MRI and Audiology.

The mental health programme continues to perform well, with strong performance around dementia diagnosis and waiting time standards for NHS Talking Therapies. Waiting times from first-to-second treatment are improving; however, they remain above trajectory. Out-of-area placements have continued to improve into January with one reported against a target of seven placements.

The system eliminated waits above 52 weeks for adults in community services. Work is taking place to reduce waits for children and young people from the current level of 11

Summary:
patients, but there is continued significant demand for speech and language therapy services and therefore elimination of 52-week waiting times will be challenging.

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. • 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:
Service delivery matters are routinely reported to every meeting of 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

Key Performance Metric Summary

The table below displays 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. ICB Ranking enables comparable performance to be shown across the 42 ICBs (1/42 = top performing).

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	Nov-24	32965	35063	2098	35574	Common Cause		44
Urgent Care	A&E 4hr % Performance (All types)	Provider	Nov-24	74.3%	62%	-12.3%	78%	Common Cause	41/42	46
Urgent Care	12 hour waits as % of overall attendances	Provider	Nov-24	2%	10.5%	8.5%	2%	Common Cause		46
Urgent Care	% Ambulance Handovers > 30 minutes*	Population	Nov-24	27.5%	26.6%	-0.9%	31.2%	Common Cause	1/5	45
Urgent Care	% Ambulance Handovers > 60 minutes*	Population	Nov-24	11.4%	18.4%	6.9%	15.4%	SC Concerning High	4/5	45
Urgent Care	Ambulance Total Hours Lost	Provider	Nov-24	1695	4146	2451	1265	SC Concerning High		45
Urgent Care	Ambulance Cat 2 Mean Response Time	Population	Nov-24	00:25.04	00:45:49	00:20:45	00:22:38	Common Cause	1/6	48
Urgent Care	No. Patients utilising Virtual Ward	Provider	Nov-24	224	258	34	236	SC Improving High	19/42	47
Urgent Care	Length of Stay > 21 days	Provider	Nov-24	440	354	-86	430	SC Improving Low		
Urgent Care	No Criteria to Reside	Provider	Oct-24	325	250	-75	347	SC Improving Low	23/42	47
Planned Care	78 Week Waiters	Provider	Oct-24	0	1	1	0	SC Improving Low	1/42	
Planned Care	65 Week Waiters	Provider	Oct-24	0	217	217	0	SC Improving Low	20/42	50
Planned Care	52 Week Waiters	Provider	Oct-24	3170	3278	108	2265	SC Improving Low	14/42	50
Planned Care	2ww 62 Day Backlog	Provider	Oct-24	302	352	50	283	SC Improving Low	24/42	
Planned Care	Cancer 28 Day Faster Diagnosis	Provider	Oct-24	76.9%	80.8%	3.9%	78.1%	SC Improving High	11/42	53
Planned Care	Cancer - 62 Day	Provider	Oct-24	63.4%	68.8%	5.5%	70.2%	Common Cause	15/42	53
Planned Care	Cancer - 31 Day	Provider	Oct-24	93.5%	94.0%	0.5%	96.1%	SC Improving High	21/42	53
Planned Care	Op Plan Diagnostics 6-week Performance	Provider	Oct-24	76.5%	73.2%	-3.3%	84.1%	SC Improving High	33/42	54
Mental Health	Inappropriate Out of Area Placement	Population	Nov-24	15	2	-13	0	SC Improving Low	16/42	57
Mental Health	NHS TT - >90 Days 1st & 2nd Treatment	Population	Oct-24	10%	28.8%	18.8%	10%	Common Cause		56
Mental Health	NHS TT - Reliable Improvement	Population	Oct-24	67.0%	69.5%	2.5%	10%	Common Cause		56
Mental Health	NHS Talking Therapies - Reliable Recovery	Population	Oct-24	48%	46.3%	-1.7%	10%	Common Cause		56
Mental Health	SMI Health Checks %	Population	Nov-24	57.3%	64.9%	7.6%	60%	SC Improving High	9/42	58
Mental Health	CYP Eating Disorders - Urgent	Population	Oct-24	95%	100%	5%	95%	Common Cause		59
Mental Health	CYP Eating Disorders - Routine	Population	Oct-24	95%	93%	-2%	95%	SC Concerning Low		59
Primary Care	Primary Care - GP Appointments	Population	Oct-24	703025	827495	124470	713967	SC Improving High		62
Primary Care	Primary Care - % book 2 Weeks	Population	Oct-24	87%	82.5%	-4.5%	90%	SC Improving High	39/42	62
Community	Community Waiting List (0-17 yrs.)	Population	Oct-24	3749	4414	665	4695	Common Cause		
Community	Community Waiting List (18+ yrs.)	Population	Oct-24	8740	9372	632	5888	SC Improving Low		
Community	Community Waiting over 52 wks. (0-17 yrs.)	Population	Oct-24	94	7	-87	118	Common Cause	7/42	63
Community	Community Waiting over 52 wks. (18+ yrs.)	Population	Oct-24	75	15	-57	65	SC Improving Low	17/42	63

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 six 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. * Denotes EMAS position against other ambulance trusts.

Service Delivery Performance Report

Urgent care

1. **Four hour waits:** In January, the system achieved 57.4% performance for four-hour waits against a plan of 76%. Nottingham University Hospitals NHS Trust (NUH) achieved 54.9% against a plan of 76%, with Sherwood Forest Hospitals NHS Foundation Trust (SFH) delivering 61% against a plan of 76%. As an ICB, Nottingham and Nottinghamshire ranks 40 of 42 nationally for four-hour performance. Deterioration in the minor injury performance at NUH and SFH has been seen at all sites. Minor injury weekly attendance volumes at Newark remain above planning assumptions and staffing levels are impacting current ability to achieve 99% for the four-hour standard. There is a united focus towards improving four-hour performance.
2. The total volume of patients waiting 12 hours from arrival across both providers in January increased from the previous month. This was impacted by continued high attendances. The system performed at 10% for January against 2% target for 12-hour breaches as a percentage of Emergency Department attendances.
3. Capacity remains a challenge at both providers, which continues to impact performance. NUH had a decrease in attendances from the previous month in January, which was positive; however, was still 3.5% above planned levels (noting that that these volumes exclude any patients that attend the London Road Urgent Treatment Centre). SFH also saw a decrease in attendances but remained above plan by 7.6%.
4. **Virtual wards:** For January, the ICS reported a reduction in Virtual Ward bed capacity, with 160 beds against a plan of 230, but with occupancy of 77.5% (91.9% in December). Data issues relating to capacity and occupancy figures were identified and work around this continues, which is a factor in the recent reduction of overall capacity within the system. This now reflects a more accurate position of occupancy within Virtual Wards. NHS England expects that wards and systems will reach 80% utilisation of actual capacity. Latest published data for January 2025 shows the ICB ranks 38 of 42 nationally with 12.6 beds per 100,000 registered population (the aggregate England position is 20.0 per 100,000). Virtual Ward utilisation benchmarking shows the ICB ranks 29 of 42 nationally with 77.5% occupancy (the aggregate England position is 80.5%).
5. **Discharge:** Discharge levels at NUH remain high with an average of over 345 discharges per day (all pathways) in January, with SFH averaging over 140 discharges per day for the same period. The January position for patients that have been deemed as not meeting the necessary criteria to reside in hospital and eligible for discharge was 290 patients against a plan of 358 patients. At system-level there is a System Discharge Board in place to enable focus on

addressing these issues, with a focus on right-sizing capacity for the medium term.

6. **Ambulance handovers:** Ambulance handover delays remain a challenge but continue to improve, with January 2025, seeing 3,045 over 30 minutes delays, of which 883 were above 60 minutes. Of the 60-minute delays, 785 were at NUH and 48 were at SFH. There were 2,509 hours lost through ambulances waiting to handover patients to hospitals by providers in Nottinghamshire in January 2025. Since the introduction of the 45-minute handover protocol at NUH, the ICB has reported the lowest number of hours lost within the East Midlands Ambulance Service region for January. This is an achievement that has been recognised by NHS England.

Planned care

7. **78 week waits:** The system did not have any patients waiting more than 78 weeks for treatment at the end of December 2024. However, there were five 78-week waiters at the end of January, of which three were waiting for corneal transplant surgery at NUH. The remaining two were waiting for ear, nose and throat procedures at SFH. It is forecast that 78-week waits will be eliminated by the end of March 2025 within the system.

8. **65 week waits:** NUH reported 46 patients (including 18 corneal transplants) and SFH reported 40 patients at the end of December waiting 65 weeks or more for treatment. There remains a reported risk of 52 patients at NUH waiting more than 65 weeks, of which 16 are awaiting a corneal transplant, and 32 patients waiting more than 65 weeks at SFH by March 2025.

9. **52 week waits:** There were 2,494 patients waiting over 52 weeks at the end of December against a plan of 2,748. The volume continues to reduce gradually; NUH had 1,925 against 2,488 plan and SFH had 569 patients against their plan of 260.

10. **Cancer treatments:** The 28 Day Faster Diagnosis Standard was achieved in December; however, the 31-day Diagnosis to Treatment and 62-day Referral to Treatment standards were not achieved in December by SFH and NUH. SFH has had monies allocated by the East Midlands Cancer Alliance to support with 7-day working and overtime in Histology, the impact of this should be seen during March 2025.

11. **Diagnostics:** The total volume of patients waiting for diagnostics and those waiting more than six weeks reduced between November and December by 227 patients. Delivery within the system increased to 40,637 tests in December, from 36,856 in November, and remains above the planned level. In December, NUH delivered 68.9% of tests within six weeks against a plan of 76.9%. SFH delivered 88.7% within six weeks against a plan of 84.6%. The largest backlog within the system relates to Audiology with 1,378 patients from a total waiting

list of 2,296 patients in December (40.0% performance) This is a significantly challenged modality across the system and is continuing to deteriorate. Echocardiography performance has significantly improved at SFH and continues to be above trajectory each week.

12. The volume of 13-week waiters is reducing within the system. Data at the end of December highlights NUH has 813 patients over 13 weeks and provisional January data shows a reduction to 654 patients. SFH has 159 patients over 13 weeks at the end of December and provisional January data shows a reduction to 111 patients. Both providers are working to eliminate 13-week waiters by the end of March 2025.

Mental health

13. 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.

14. **NHS Talking Therapies:** NHS Talking Therapies did not deliver against the improvement trajectory for first to second wait in December (11.4% against a plan of 10%) and are forecasting to deliver the February plan of 10% (current local data is 15%). The service continues to achieve and exceed the six week (98.0%) and 18 week (100%) waiting time standards.

15. **Children and Young People Eating Disorders:** The routine referrals are not achieving the 95% compliance (88% in December); 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.

16. **Out of Area Placements:** The number of inappropriate Out of Area Placements reported in January 2025 is one against a plan of seven. Local unvalidated data for February 2025 is reporting a position of one placement at the month end. The establishment of a Mental Health Oversight Board aims to strengthen performance monitoring and strategic alignment within the system. Discussions are ongoing with Nottinghamshire Healthcare NHS Foundation Trust (NHT) colleagues to examine the definition of an out of area placement used by the Trust to ensure that it aligns to the NHS England guidance and common practice of other similar NHS organisations. There is a risk that differences between the local and national definition of an out of area placement may lead to material increases in the reported volume, relating to local independent sector provision.

Primary and community care

17. **General Practice:** The volume of total GP appointments in December was in line with the planned level, with 616,639 appointments against a plan of 617,104 (0.08% below plan). 83.3% of appointments were offered within two weeks in December 2024, which is below the operational plan of 87%.

18. A monthly Primary Care Performance and Delivery Group has been established, which monitors delivery against all primary care performance metrics, identifying specific areas of concern and practices that may need specific support for improvement. In addition, contact has been made with identified practices with lower percentage delivery to identify areas of support and review by ICB colleagues, with a follow up meeting to take place in March 2025.

19. **Community:** The majority of community 52-week waiters are waiting for services at NHT. The latest published 52 week wait data is for December 2024, which details a further reduction in the total volume of 52 week waits from 21 patients (15 Adult, six children) to 11 patients (all children). Of the 11 patents, nine are waiting for services delivered by NHT. The elimination of 52-week waiters for adult services is forecast to continue, but high levels of demand remain for children and young people's speech and language services, which may cause a small number of 52 week wait breaches in the future.

NHS Oversight Framework

20. As of 27 January 2025, the 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 across the ICB are:

    a) Diagnostic activity waiting times – patients not seen within six weeks.

    b) Accident and Emergency – percentage of patients managed within four hours.

    c) Inappropriate Out of Area Placements.

    d) GP Appointments (14 days).

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/03/2025
Paper Title:	**Finance Report**
Paper Reference:	ICB 24 116
Report Author:	Clare Hopewell, Assistant Director of System Finance Ian Livsey, Deputy Director of Finance
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:

System:

The system has reported a year-to date £18.5 million deficit position, which when compared with a £4.1 million deficit plan, results in an adverse year-to-date variance of £14.4million. It remains on forecast to deliver the revised break-even position.

The year-to-date position is off plan mainly due to the impact of the non-recurrent deficit income relating to the deficit year-to-date phasing (£3.7 million), consultant pay award pressure (£2.3 million) and a shortfall of industrial action income against the industrial action impact (£1.8 million).

Efficiency delivery is £1 million behind plan at month 10 with £185.3 million delivered to date.

The planned efficiency forecast remains to deliver £257 million savings.

The system's assessment of risk of not achieving forecast outturn is £96 million gross (£110.2 million at month 9), £57.1 million of mitigations have been identified, which leaves an unmitigated risk position across the system of £38.9 million at month 10 (£41.9 million at month 9).

Other risks include impact of growth and price increases relating to continuing healthcare, prescribing, delivery of value-based activity, pay awards and band 2/3 staffing disputes, as well as other inflationary pressures alongside emergency and urgent care pressures.

ICB:

The ICB is reporting a £1.0 million year-to-date deficit, reduced by £0.3 million on last month, with the forecast remaining at breakeven.

Key forecast overspending areas include continuing healthcare costs at £9.7 million, prescribing costs at £7.3 million, section 117 costs £2.6 million and non-NHS community costs at £2.7 million.

The expenditure position for delegated pharmacy, ophthalmic and dental services (PODs) at month 10 remains a reported net overspend, with forecast adverse variances arising in pharmacy of £2.3 million and ophthalmic of £0.5 million. NHS England has re-affirmed that fortuitous underspends arising on delegated dental budgets are to be ring-fenced. This has been accounted for in the reported position. This in turn creates additional pressures of £8.6 million for the ICB to manage (the ICB had previously anticipated such underspends

Summary:
would form part of the ICB's reported position, which was consistent with the approved financial plan submitted to NHS England). Offsets against the overall net pressure that arises from these variances is predicated on underspends arising in reserves. However, this remains a risk and is reflected as such in the ICB's separate risks and mitigations analysis. The ICB's assessment of risk of not achieving forecast breakeven position is £11.1 million gross (£25.3 million at month 9), £10.8 million of mitigations have been identified, which leaves an unmitigated risk position of £0.3 million (£3.3 million at month 9).

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

1. The system received a non-recurrent allocation at month 6 associated with the £100 million deficit plan. As a result, each organisation now reports its financial performance in relation to a break-even plan for 2024/25 (where previously it would report its position in relation to a £100 million deficit plan). The level of financial challenge facing the system remains the same as it was prior to the reporting adjustment.

Indicator Measure	Year To Date Plan	Year To Date Actuals	Year To Date Variance	Plan/ Ceiling/ Envelope	Forecast Outturn (FOT)	Variance	RAG Year To Date	RAG FOT
Financial Sustainability (Variance from break-even)	-34.1	-18.5	**-14.4**	0.0	0.0	**0.0**	Red	Green
Total Pay Spend	-1,621.7	-1,632.0	**-10.3**	-1,933.5	-1,940.7	**-7.2**	Red	Red
Substantive Spend vs Plan	-1,506.0	-1,502.4	**3.6**	-1,798.2	-1,786.6	**11.6**	Green	Green
Bank Spend vs Plan	-71.6	-92.2	**-20.6**	-82.9	-109.8	**-26.9**	Red	Red
Agency Spend vs Plan	-44.1	-37.5	**6.6**	-52.4	-44.3	**8.2**	Green	Green
Agency Spend Vs Ceiling		-37.5		-63.5	-44.3	**19.2**		Green
Whole time equivalent (Provider) - 24/25 plan as at 31.03.25	33,747	34,507	**-760**				Red	
Financial Efficiency Vs Plan	186.3	185.3	**1.0**	257.0	257.0	**0.0**	Red	Green
Recurrent Efficiencies	143.7	119.0	**-24.6**	201.5	156.9	**-44.6**	Red	Red
Achievement of Mental Health Investment Standard		185.9		223.3	223.3	**1%**		Green
Capital Spend Vs System Envelope	71.4	51.4	**-51.4**	92.5	92.2	**0.0**	Green	Green
Elective Recovery Fund Performance	120%	121%	**1%**	121%	121%	**0.0**	Green	Green

2. The system has a reported a £18.5 million deficit at month 10, which is £14.4 million adverse to plan against the June plan submitted. The system continues to forecast it will deliver the revised break-even position.

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	0.0	-1.4	-1.4	0.0	0.0	0.0	0.0	0.0	0.0
Sherwood Forest Hospitals	-4.1	-8.6	-4.5	-1.3	-1.4	-2.7	0.0	0.0	0.0
Nottinghamshire Healthcare	0.0	-7.5	-7.5	0.0	-0.0	-0.0	0.0	0.0	0.0

Nottingham and Nottinghamshire ICB	0.0	-1.0	-1.0	0.0	-0.3	-0.3	0.0	0.0	0.0
TOTAL	**-4.1**	**-18.5**	**-14.4**	**-1.3**	**-1.1**	**-2.4**	**0.0**	**0.0**	**0.0**

3. The year-to-date position is off plan mainly due to the impact of the non-recurrent deficit income relating to the deficit year-to-date phasing (£3.7 million), consultant pay award pressure (£2.3 million) and a shortfall of industrial action income against the industrial action impact (£1.8 million).
4. Continuing healthcare, Section 116 and prescribing pressures are £16.8 million adverse to plan and efficiency across the system £1m behind plan.
5. **Workforce:** Staff costs are £10.3 million overspent across the NHS system at month ten with whole time equivalents (WTEs) being 760 WTEs higher than plan. Agency spend is £37.5 million, which is £6.6 million under the year-to-date plan. The forecast at month 10 is £19.2m under the agency cap and £8.2 million under plan.
6. **Efficiencies:** Efficiency delivery is £1million behind plan at month 10 with £185.3 million being delivered. Recurrent efficiency delivery is £24.6 million adverse to plan at month 10 and is forecast to be £44.6 million adverse to plan by month 12. The forecast remains at £257 million, £100.2 million of which is non-recurrent. Organisations are aware of the relatively high levels of non-recurrent efficiency in their overall plans. Those plans are being reviewed to identify where any of those efficiencies could be made to deliver on a recurrent basis.
7. **Cashflow Position:** The system is facing increasing pressures associated with the management of its cashflow position and is taking actions to mitigate those pressures.
8. **Financial Risk:** The system's assessment of risk to the forecast outturn position for 2024/25 is £96 million gross (£110.2 million at month 9). £57.1 million of mitigations have been identified which leaves an unmitigated risk position across the system of £38.9 million at month 10 (£41.9 million at month 9). The main risk across all organisations is that associated with the delivery of efficiency plans. Other risks include impact of growth and price increases relating to continuing healthcare and prescribing, delivery of value based activity, pay awards and band 2 to 3 workforce disputes as well as other inflationary pressures alongside emergency and urgent care pressures.
9. **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.
10. **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. The system has also been allocated an additional £11.2 million to support the impact of the IFRS16 accounting standard with external bodies, and an additional allocation of £0.7 million to support the Critical Infrastructure Programme. As a result, the total capital envelope is £92.2 million. The forecast remains to spend the total system capital envelope in full.

Nottingham University Hospitals (NUH) NHS Trust and the New Hospitals Programme (NHP)

11. In January 2025, the outcome of the Government's review of the national New Hospital Programme (NHP) was announced. The "Tomorrow's NUH" (TNUH) Programme was part of that review and as a result, the start date revised to 2037-2039 period compared to an original start period of 2025-2027.
12. This represents a significant change for the project leading to the national NHP team advising NUH that all funding associated with TNUH be paused until 2030 at the earliest. That act has an impact on the costs that have been incurred to date (£8.68 million), which so far has been shown as an asset in NUH's accounts. This will now have to be impaired, i.e. reduced in value.
13. At the time of writing the Trust is seeking agreement that £8.46 million be impaired as part of its month 11 financial reporting and for £0.22 million to be remain as an asset in NUH's accounts.

ICB key messages

Key financial performance indicator	Target	Year to Date	Forecast
Delivery planned surplus / deficit	Breakeven	£0.97m deficit	Breakeven
Deliver income and expenditure breakeven	Breakeven	£0.97m adverse to plan	Breakeven
Achieve Mental Health Investment Standard	Spend in full	On target	On target
Deliver Better Payment Practice Code Targets	>95% all four categories	>95% all four categories	>95% all four categories
Do not exceed capital allocation	Spend <£2.02m	On target	On target
Do not exceed running cost allowance	<£19.86m	On target	On target
Delivery efficiency target	Deliver £68.5m	On target	On target

14. The ICB overall financial position is a £1.0 million year-to-date deficit position with a forecast to breakeven. The year-to-date position has improved in month by £0.3 million with the forecast position in line with that reported at month 9. There are a number of risks in delivering the forecast breakeven position and the ICB continues to work on mitigations to ensure delivery of the forecast balanced financial position.

15. Key forecast overspending areas include continuing healthcare costs at £9.7 million, prescribing costs at £7.3 million, section 117 costs £2.6 million and non-NHS community costs at £2.7 million. The net expenditure position for delegated pharmacy, ophthalmic and dental services (PODs) at month 10 remains a reported overspend with forecast adverse variances arising in pharmacy of £2.3 million and ophthalmic of £0.5 million. It has been re-affirmed by NHS England that fortuitous underspends arising on delegated dental budgets are to be ring-fenced. This has been accounted for in the reported position. This in turn creates additional pressures of £8.6 million for the ICB to manage. (The ICB had previously anticipated such underspends would form part of the ICB's reported position, which was consistent with the approved financial plan submitted to NHS England.)
16. Offsetting these overspends is a forecast underspend in reserves representing the mitigating non recurrent solutions. However, an element of this remains a risk and is reflected as such in the ICB's separate risks and mitigations analysis.
17. A number of risks exist in delivering the reported position and total £11.1 million (previous month £25.3 million). Delivery of the efficiency target remains a main risk along with the risk associated with budgetary overspend. £10.8 million of mitigations have been identified which leaves an unmitigated risk position of £0.3 million.
18. The ICB has utilised £2,676 million or 84.3% of its 2024/25 of its cash draw down requirement of £3,174 million. This compares to an expected utilisation of 83.3%. The cash balance held as at 31 January2025 was £0.16 million compared to a maximum target balance of £2.95 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. **ICB business as usual capital:** The annual forecast is as per plan at £2.02 million with £1.2 million spent to date. Estates and IT colleagues remain focussed on ensuring the remaining schemes are delivered by 31 March 2025.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/03/2025
Paper Title:	**Committee Highlight Reports**
Paper Reference:	ICB 24 117
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 January 2025. 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, which enables the Board to consider if its agenda is reflective of the high-level risk areas. All committees of the 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: Highlight Report from the Audit and Risk Committee
E: Highlight Report from the Remuneration and Human Resources Committee
F: Current high-level operational risks being oversighted by the Board's committees
G: Medicines Optimisation Strategy 2024-2029

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.

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.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Appendix A: Strategic Planning and Integration Committee Highlight Report

Meeting Date(s):	**06 February and 06 March 2025**
Committee Chair:	**Jon Towler, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. Primary Care Strategy Update	The report aimed to provide assurance on the development of the Community Pharmacy, Optometry and General Dental (POD) chapters of the Primary Care Strategy and the key indicators for measuring delivery of the Strategy. Members requested that the next report draw out the links to other service transformation programmes, describing how the four contractor groups will work together as part of the integrated neighbourhood health model, define the specific actions to be taken to address the challenges and deliver the success measures whilst increasing the pace of delivery. The final Primary Care Strategy will be presented to the Committee in April 2025 before submission to the Board in May 2025 for approval. However, members noted that there was still significant work to be undertaken prior to this, hence an assurance level of 'partial' was agreed.	**Partial**	**Adequate** (*awarded at the meeting held on 7 November 2024)*
2. Working with People and Communities Update	The report provided an update on work that had taken place during the period 1 October 2024 to 31 January 2025 to advance the system approach to working with people and communities. Discussion around the challenges that Voluntary, Community and Social Enterprise (VCSE) organisations faced when collaborating with NHS and other statutory bodies and the need to think differently to identify potential areas for alignment going forward. An action plan would be co-created over the next six months to address the key issues identified.	**Full**	**Adequate** *(awarded at the meeting held on 3 October 2024)*

Rushcliffe Arena, 09:00-13/03/25

Item	Summary	Level of assurance	Previous level of assurance
	Members asked that the next scheduled update include information around the engagement work being undertaken to support the prevention agenda, alongside practical examples of services changes that have resulted from co-production activities.		
3. Community Services Transformation Programme Update	Members received a report which summarised the history of the Community Services Transformation Programme and outlined how changes to the system's transformation architecture and through national guidance, the focus had evolved to have a greater focus on delivery models that supported integrated health and social care teams to support people to live independently for longer within their own homes. The importance of ensuring that joint commissioning opportunities were identified and included within the Commissioning of Community Health Services workstream was highlighted. Following dicussion around delivery progress, the impact on health inequalities and challenges related to pace and capacity, it was agreed that subject to finalisation of the Board and Committees' 2025/26 Annual Work Plans, the Committee would receive a deep dive report on the four proof of concept Integrated Neighbourhood Teams at its June 2025 meeting.	**Partial**	*Not applicable*

Decisions made:
a) The Committee approved proposed amendments to the Health Care Contributions to Adult Care Packages Commissioning Policy, which had been proposed following a detailed review. The Committee noted the changes that had been made to simplify operation of the policy, including those in response to feedback from local authority partners.
b) The Committee endorsed the 2025/26 refresh of the NHS Joint Forward Plan (JFP) for submission to the March 2025 meeting of the Board for approval, subject to the amendments put forward throughout the discussion. Members noted the need to provide the Board with an overview of the governance and oversight arrangements for delivery of the JFP and a timeline for the development of the next iteration of the JFP following publication of the 10-year Health Plan.

c) The Committee received a number of decision-making papers and approved proposals relating to:
   i) Nottingham and Nottinghamshire Long-COVID Services
   ii) Mental Health Level Two Inpatient Rehabilitation Services
   iii) Targeted Lung Health Check Programme
   iv) Nottingham City Better Care Fund
   v) Bassetlaw Palliative and End of Life Hospice Bedded Unit and Specialist Palliative Care Community Outreach Nursing Team
   vi) Children and Young People Learning Disabilities and Autism Keyworking Service
   vii) Urgent and non-urgent care services
   viii) Care Navigation Services

Information items and matters of interest:

a) Members received a paper that provided an overview of policies, evidence and frameworks that supported the ICB's approach to prevention, an indication of spend across the prevention priorities, and the principles and actions that aligned with plans and strategies to accelerate the approach to prevention. Consideration would be given to how the Committee would be provided with assurance around the appropriate prevention priorities through the Committee's 2025/26 Annual Work Programme, recognising the links to the service transformation programmes and the broader system lens.

b) Members received an update on the latest position on Tomorrow's Nottingham University Hospitals (TNUH), the system's programme within the Government's New Hospitals Programme. The Finance and Performance Committee would receive a report regarding the potential impacts arising from the delayed construction start date for the TNUH programme, particularly in relation to capital allocations and backlog maintenance.

c) The Committee received and discussed the operational risks relating to the Committee's responsibilities. The high scoring risks are provided for the Board's information at Appendix F.

d) The Committee received the Log of Investment, Disinvestment, Procurement and Contract Award Decisions (Healthcare) 2024/25 for information.

Appendix B: Quality and People Committee Highlight Report

Meeting Date(s):	**15 January and 19 February 2025**
Committee Chair:	**Marios Adamou, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. Core20PLUS5: Supporting Earlier Cancer Diagnosis	The report outlined the approach being taken to increase the rates of earlier cancer diagnosis and the impact on health inequalities. The NHS England target for 75 per cent of cancers to be diagnosed at stage one or two by 2028 formed part of the Core20PLUS5 approach to reducing health inequalities. The Nottingham and Nottinghamshire Integrated Care System was expected to achieve 76.8 per cent of cancers diagnosed at stage one or two by 2028, exceeding the target. Members noted a number of examples of the targeted population approach that were being taken to improve performance and experience where disparities were present. Vaccination, screening and child health information services would be delegated to ICBs from April 2026, which may provide the ICB with an opportunity to tailor the programme's needs to the local population. The overall assurance rating of 'adequate' acknowledged that the actions being taken were demonstrating a positive impact on early cancer diagnosis rates.	**Adequate**	*Not applicable*
2. Safeguarding Looked After Children Assurance Report	The Committee received a report that provided an overview of current health assessment, initial health assessment (IHA) and review health	**Partial**	*Not applicable*

Item	Summary	Level of assurance	Previous level of assurance
	assessment (RHA) performance, along with assurance around the wider work being completed across the system to mitigate the risk for children in care. Safeguarding looked after children was an area under enhanced surveillance as per the ICB's oversight model, with escalations and performance reported through the Quality Oversight Report and Integrated Performance Report. A significant amount of work had been undertaken to better understand the data and improve the position; examples of progress to date were detailed within the report. Whilst IHA and RHA performance had improved, additional resource would be needed to further increase compliance. In response to an action arising from the Finance and Performance Committee, the report also outlined the ways in which the ICB was contributing to system work to improve the transition into adult services for children in care who turned 18. The overall assurance rating of partial recognised that more innovative solutions may be required to further improve IHA and RHA performance.		
3. Primary Medical Services Quality Report	The Committee received an overview of the quality monitoring and assurance of Primary Medical Services, with summaries of the 2024/25 quarter two quality metrics. The report also detailed some of the key quality links with the Integrated Care System's Primary Care Strategy. The ICB's primary care quality team had a strong working relationship with GP practices and the Local Medical Committee, and the current quality monitoring processes enabled the ICB to identify potential issues early and provide appropriate support and interventions in a timely way.	**Adequate**	**Adequate** *(awarded at the meeting held on 17 July 2024)*

Item	Summary	Level of assurance	Previous level of assurance
	The importance of ensuring a process was in place to enable two-way engagement between the ICB and primary care was highlighted. The overall adequate assurance rating acknowledged the robust, risk-assessed approach to quality monitoring arrangements across primary care.		
4. NHS Independent Homicide Review	The report outlined learning for the ICB, actions that had been undertaken to date and activities that were planned to ensure that there were additional assurances gained about the robustness of the ICB's provision following publication of the Independent Mental Health Homicide Review (IHR). All findings and recommendations in the report had been fully accepted by NHS England, NHT and the ICB. A shared action plan had been developed between the ICB and NHT in relation to areas for improvement. The action plan would be monitored through the agreed quality oversight arrangements. The findings of a stocktake undertaken by the ICB's quality and nursing team of the ICB's quality assurance, oversight, safety and effectiveness arrangements would be presented to a future meeting of the Committee and quarterly progress updates on delivery of the IHR action plan would be included in the Committee's 2025/26 Annual Work Programme.	**Adequate**	*Not applicable*
5. Continuing Healthcare and Children's Continuing Care Quality Assurance	Members received a report that provided an overview of activity in relation to Children's Continuing Care and NHS Continuing Healthcare (CHC) including Fast Track and Funded Nursing Care. The report also outlined the work of the CHC team during 2024/25, along with the target operating model and the plans for 2025/26.	**Full**	**Partial** *(awarded at the meeting held on 15*

Item	Summary	Level of assurance	Previous level of assurance
	Work was progressing to create a single CHC and Children's Continuing Care Team and it was anticipated that this would increase consistency and quality by providing an opportunity to more flexibly deploy the workforce and develop a single approach and culture. In 2024/25 the strategic focus of patient review work had been on reviewing patients who had a healthcare contribution to a joint funded package of care. In 2025/26, discussions would take place with the relevant system partners to address gaps in community services and market development to reduce demand on CHC.		*November 2023)*
6. Overview of Nottingham and Nottinghamshire Special Educational Needs and Disabilities Local Area Partnerships Arrangements	The report sought to provide assurance on the current position of the Special Educational Needs and Disabilities (SEND) Local Area Partnerships (LAPs) in Nottingham City and Nottinghamshire, of which the ICB was an equal accountable partner, with reference to the respective Self-Evaluation Frameworks (SEFs). The SEND LAPs had developed shared outcomes aimed at improving experiences and ensuring alignment with strategic objectives. This approach ensured compliance with national SEND standards while addressing each LAP's specific local priorities. Whilst the position across both SEND LAPs had improved, there was still work to be done. An area of focus going forward would be the development of robust mechanisms to demonstrate the impact of the improvements made to date. The assurance rating of partial awarded to the Nottingham City SEND LAP recognised that robust partnership arrangements had not yet been embedded. The Committee applied an assurance rating of full to the Nottinghamshire County SEND LAP.	**Partial – Nottingham City SEND LAP** **Full – Nottinghamshire County SEND LAP**	*Not applicable*

Item	Summary	Level of assurance	Previous level of assurance
7. Quality Oversight Report	Members received the Quality Oversight Report and concluded that the assurance provided remained limited. The format of the report had been revised to identify changes since the October 2024 report and to provide additional narrative around the status of the quality and safety of Trusts for which the ICB had principal responsibility for system oversight purposes and areas under enhanced oversight. Some positive changes had been made within the urgent and emergency care pathway during quarter three of 2024/25 and the ICB would be implementing dynamic risk assessments across the system in quarter four following National Quality Board Guidance. Members noted that the ICB Quality Team provided a significant level of support to NHT, with a number of insight visits undertaken since December 2024. The national team was also providing support to the NHT through a number of improvement posts and a rapid quality review of community services was also planned.	**Limited**	**Limited** *(awarded at the meeting held on 15 January 2025)*
8. People Operational Delivery Report	Members received an overview of the month seven, eight and nine workforce operational delivery plan. Sickness absence rates were an area of concern and information was being sought on systems that were performing well in this area. The importance of ensuring the appropriate level of grip and control around the workforce operational delivery plan was noted, along with ensuring a true understanding of the ways in which the plan would be achieved ahead of the planning round. The tension between short term requirements and long-term sustainability was acknowledged. The overall assurance rating of partial recognised that future delivery of the operational workforce plan would be challenging.	**Partial**	**Partial** *(awarded at the meeting held on 15 January 2025)*

Other considerations:

Decisions made:
a) The Committee approved the publication of the full Medicines Optimisation Strategy 2024-2029. The strategy, included at Appendix G for the Board's information, had been developed using a collaborative co-design approach, and would be reviewed and refreshed annually to reset and align priorities. Delivery of the strategy would be overseen by the Medicine Optimisation and Pharmacy Board.
b) The Committee endorsed the ICS People and Workforce Plan for submission to the March 2025 meeting of the Board for approval subject to the amendments put forward throughout the discussion being made.

Information items and matters of interest:
a) The Committee received a progress update on the development of the Integrated Care System People and Workforce Plan. Members discussed the impact of the proposed workforce transformation on health inequalities, ways in which more efficient workforce models could be developed based on population needs to target efforts to address health inequalities and the deteriorating health of the population and challenges around the current financial assumptions and affordability. The plan was now at the final draft stage and would be presented to the Committee in February 2025 for endorsement prior to submission to the Board for approval in March 2025.
b) The Committee received a report that described how averting avoidable deaths could decrease the average life expectancy gap contributing to a narrowing of health inequalities in Nottingham and Nottinghamshire. The report also outlined recommendations to allow for focus and commitment to avoidable mortality and health inequalities. Members noted that the impact of education, housing and heating on avoidable deaths would be captured through the ICS Outcomes Group to provide a more complete picture going forward.
e) The Committee discussed the operational risks relating to the Committee's responsibilities. Members noted that the implementation of confirm and challenge sessions with the Quality and People Directorate senior leadership team provided an opportunity to triangulate risks highlighted through the integrated performance report, committee reports and the operational risk report. Consideration would be given to whether there was an opportunity for some risks to be clustered at the next scheduled risk confirm and challenge session. The high scoring risks are provided for the Board's information at Appendix F.

Appendix C: Finance and Performance Committee Highlight Report

Meeting Date(s):	**29 January and 26 February 2025**
Committee Chair:	**Jon Towler, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. 2024/25 System and ICB Finance Report (Month 10)	The system had reported an £18.3 million year to date deficit position against a £4.1 million deficit plan, resulting in an adverse year-to-date variance of £14.4 million. The system remained on forecast to deliver the revised break-even position. Efficiency delivery was £1 million behind plan. However, the planned efficiency forecast remained to deliver £257 million savings. The ICB was reporting a £1.0 million deficit at month ten but continued to forecast an end of year break even position. Members challenged the confidence that the system and the ICB would meet the financial targets and following an in-depth discussion of the mitigations that would be used and the conversations that had taken place both within the system and with the regional NHS England team, the Committee noted an increased level of confidence that the targets would be met.	**Adequate**	**Partial** *(awarded at the meeting held on 29 January 2024)*
2. 2025/26 NHS Operational Planning	Ahead of the submission of the 'headline' 2025/26 Operational Plan to NHS England by the deadline of 26 February 2025, the Committee had approved the plan, following scrutiny of both the plan and the risks and assumptions within it. The 'headline' plan had demonstrated the system's compliance with national priorities and success measures, a breakeven financial position and a £250 million efficiency requirement.	*Not applied*	*Not applicable*

Item	Summary	Level of assurance	Previous level of assurance
3. Operational Plan 2024/25 Delivery and Service Delivery report	Members received reports highlighting areas of improvement and challenges. Areas of particular concern were highlighted as the GP two-week appointment target, planned care cancer targets and the urgent care four-hour performance target and the actions and mitigations taking place to improve performance were discussed in detail. The Committee asked for a focus on performance at the Sherwood Forest hospitals NHS Foundation Trust Emergency Department to be brought to the March meeting meeting. The overall assurance rating remained at partial, recognising good progress in many areas to date but acknowledging the risks and challenges that remained in achieving the operational plan.	**Partial**	**Partial** *(awarded at the meeting held on 29 January 2024)*
4. Thematic Review: Diagnostics	The Committee had an in-depth discussion on the actions that had been put in place to improve performance of diagnostic services since the Covid-19 pandemic, which had had a significant impact on capacity and waiting times. Although a number of specific services remained a challenge, overall, there had been significant improvement in performance measures. The long-term solution was to provide diagnostic services in community diagnostic centres, which would improve productivity and streamline services. Members noted the continuing challenges attached to continuing progress and welcomed the focus on the risk assessment.	**Adequate**	*Not applicable*
5. Digital, Data and Technology Strategy	The report provided assurance of progress against the ICS strategic digital priorities and objectives contained within the ICS Digital Data and Technology Strategy, which had been approved at the Board's November 2024 meeting. Overall good progress had been made and the Committee challenged actions in areas that had not made expected progress.	**Adequate**	*Not applicable*

Other considerations:

Decisions made:
Members approved in principle the annual investment request of £1.7 million per annum plus inflation / £1.2 million for 2025/26 for the Notts Care Record, subject to the ICB agreeing specific cost apportionment and to proceed with the extension of contracts as required. It was considered an essential investment to the realisation of transformation programmes and would be central to meeting the aims of the Government's Ten-Year Plan. It is estimated that the Notts Care Record had generated circa £4 million of savings to date.

Information items and matters of interest:
An extract from the Operational Risk Register relevant to the Committee's remit was reviewed, which included 13 risks, with seven rated as high risks, which are provided for the Board's information at Appendix F.

Appendix D: Audit and Risk Committee Highlight Report

Meeting Date(s):	**12 February 2025**
Committee Chair:	**Stephen Jackson, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. Board Assurance Framework Target Risk Reports	Members had an in-depth discussion with the Chief Executive and Director of Finance regarding the strategic risks 'owned' in their areas, which included assurance on the control environment and the work being undertaken to address any gaps in control or assurance. Noting that the risks relating to the ICB's operating model and to culture and leadership remained higher than their targeted risk score, members sought to understand whether there were any significant weaknesses in the control environment. The lack of movement was largely due to continuous new and emerging challenges and a good level of control remained in place. Discussing the financial sustainability risk, members were assured that the control environment had continued to be strengthened throughout the year. Nevertheless, mitigating the risk continued to be highly challenging. Members noted that the control environment relating to the NHS system's financial sustainability had been supported by significant non-recurrent additional capacity and would require further consideration in the development of the 2025/26 Board Assurance Framework. An assurance rating of full was provided, reflecting the robust management processes within the ICB for the identification, mapping and reporting of strategic risks.	**Full**	*Not applicable*

Item	Summary	Level of assurance	Previous level of assurance
2. Standards of Business Conduct	The Committee was advised of the arrangements across the ICB to ensure the management of conflicts of interest (including the receipt of gifts and hospitality). Members were informed that an organisation-wide assurance exercise was well underway to ensure that the ICB's Register of Declared Interests was accurate and up to date.	**Full**	*Full (awarded at the meeting held on 7 February 2024)*
3. Policy Management Framework	This report provided assurance that the process for reviewing the ICB's corporate policies was being managed effectively. Following scrutiny, members approved extensions to several policies and minor changes to the Health, Safety and Security Policy and Statutory and Mandatory Training Policy.	**Full**	*Adequate (awarded at the meeting held on 27 March 2024)*
4. Information Governance	Members were assured to the arrangements established within the ICB to ensure compliance with legislative and regulatory requirements relating to information governance. The focus of work was on the development of arrangements to ensure compliance with the requirements of the new Cyber Assurance Framework aligned Data Security and Protection Toolkit. A baseline submission had been made in December 2024 and although the ICB's position was 'Not Achieved' against all outcomes, an improvement plan was in place to meet the required levels of achievement by the submission date. Members were assured that areas of non-compliance were due to the need to gather additional evidence to meet the new requirements, rather than a weak control environment.	**Adequate**	*Full (awarded at the meeting held on 19 June 2024)*

Item	Summary	Level of assurance	Previous level of assurance
5. Annual Local Fraud Risk Assessment	Members received a report on the outcome of the annual fraud risk assessment. This was a process driven by the requirements set out by the NHS Counter Fraud Authority. It provided a list of the ICB's potential fraud risks, their ratings, potential impact, and the controls and mitigations in place to prevent each potential risk from materialising. The outcome of this piece of work would in turn help to inform the ICB's annual Counter Fraud Plan for 2025/26.	**Adequate**	*Rating not applied*

Other considerations:

Decisions made:
a) Changes to the Information Governance Steering Group terms of reference were approved.

Information items and matters of interest:
a) The Committee was asked to note that the ICB had breached the national hourly rate price cap for the use of agency workers within the Continuing Healthcare Team. The rational for the breach was discussed. The Committee was assured that the ICB Executive and NHS England had been aware of the imperative for the breach and noted that a plan was in place to reduce reliance on agency staff.
b) Members received an update on the progress of the 2024/25 Internal Audit Plan and had sought confirmation that the plan could be delivered by the end of the financial year.
c) A risk report on the two risks overseen by the Committee was discussed. The high scoring risks are provided for the Board's information at Appendix F.

Appendix E: Remuneration and Human Resources Committee Highlight Report

Meeting Date(s):	**27 January 2025**
Committee Chair:	**Mehrunnisa Lalani, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. ICB Workforce Report	The Committee received a report which provided a summary of key information relating to performance against a range of workforce metrics including whole time equivalent, head count, rolling sickness absence and turnover, workforce demographics, human resources policies, employee relations matters and employee development activities. The current reasons for sickness absence and the actions being taken to address it were discussed. Members requested that a deep dive into sickness absence be undertaken, with the findings reported to the next meeting of the Committee.	**Partial**	*Not applicable*
2. ICB Staff Survey Action Plan	The Committee received a progress update in relation to the 2023 NHS staff survey action plan for the ICB, which had been developed in collaboration with staff groups. Members discussed the extent of staff engagement across the ICB and feedback from the Staff Engagement Group around the transparency of the ICB's recruitment processes. An open dialogue would be maintained with staff around vacancy control measures going forward, and as appropriate, information would be made available to the public through the Board. Members noted that whilst a significant amount of work had taken place in response to the staff survey action plan, further work was required to ensure the required cultural shift was achieved.	*Not given*	*Not applicable*

Item	Summary	Level of assurance	Previous level of assurance
3. ICB design principles including succession planning and the draft ICB People Plan	Members received an update on the design principles for the ICB including succession planning and development within the overall draft ICB People Plan, noting that a detailed succession plan would be developed once the workforce structures including budgets had been agreed. The actions being taken to ensure the ICB was fit and ready for the future with the appropriate talent within the organisation at all levels were noted. Members also noted that as the ICB did not have the resource for a large-scale talent management programme, alternative development offers would be utilised. A further paper would be developed to provide assurance on the actions being taken in relation to succession planning and talent management.	**Partial**	*Not given*

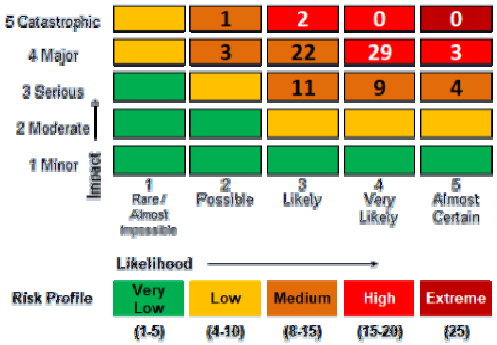
Information items and matters of interest:
a) Members received an update on the pay position for clinicians engaged by the ICB on contracts for services and discussed a potential pay uplift for these roles based on ICB benchmarking and prior agreements from NHS England. Further work would be undertaken to develop the clinical leadership pay review to enable the Committee to make a decision around a potential pay uplift.
b) The Committee received the Operational Risk Report for information.

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

Risk Profile

At the time of writing, there are 84 'live' risks within the Operational Risk Register (including both ICB and system risks). This is a reduction of one risk since the last report to the Board. 34 of the 84 risks are scored at a high-level which account for 40% of the total risks. This proportion is slightly higher than the last report to the Board when it was reported 36% were scored at a high-level. The risk profile is shown in figure 1 below.

Figure 1



The 34 high-level operational risks include six risks classed as confidential, due to the nature of these risks. Risk may be classed as confidential if they are commercially sensitive or at draft stage. The confidential risks are reported separately and excluded from the analysis and detail of this report.

Risk Movement

The remaining 26 high-level operational risks included in this paper are detailed in the below table. This is an overall increase of two risks since the last meeting of the Board. Movement in the high-level risks is described below:

a) Two risks previously reported in the confidential report are no longer classed as confidential and, as such, have been included in this report *(risk 194 relating to achievement of the Nottingham/shire ICB's 2024/25 year-end financial position and risk 212 relating to workforce planning).*

b) One risk (risk 167) relating to potential for harm within hospital settings, as a result of UEC pathway delays, has increased in score since the last meeting of the Board and, as such, now meets the threshold for escalation in this report.

c) The score for risk 166, which relates to ambulance handovers, has decreased to 12 (I4 x L3) following improvements in performance, and as such, no longer meets threshold for reporting to the Board. Improved performance in this area has been reference as a driver in the worsening position in relation to risk 167 in the previous paragraph.

Risk Appetite

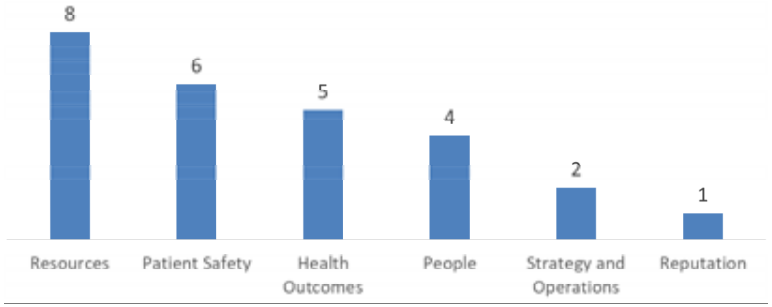
Due to being high-level, all risks reported to the Board are above the organisation's agreed risk appetite levels. Furthermore, Board members should note that 99% of all the operational risks in the ORR are above agreed risk appetite levels.

Risk Domains

As a reminder, there are nine risk domains used when classifying operational risks. Figure 2 below shows how many high-level risks sit which each domain.

There are no high-level risks within the risk domains of health inequalities, legal and social and economic development.

Figure 2



Details of high-scoring risks

Operational risk reports continue to be routinely presented to the Board's committees, enabling the ongoing review and scrutiny of all risks, including those high-level risks.

At present, 54% of the high-level risks are reported to the Quality and People Committee. This is consistent with the last report to the Board when 58% of the high-level risks were reported to the Quality and People Committee.

Risk Ref.	Risk Description	Score	Responsible Committee
ORR084	If organisations within the ICS are unable to access IT systems (i.e. unexpected system outage, successful cyber-attacks or issues with the availability of products and services) 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. It may also result in unfavourable media coverage, reputational damage, and significant cost pressures.	**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 (digital workforce and operational workforce) to engage with and deliver digital transformation schemes alongside business-as-usual delivery it may not be possible to progress the System, Primary Care and ICB digital transformation agenda. Additionally, this may lead to missed opportunities in relation to funding available for digital transformation. This risk may be further exacerbated by current financial challenges and GP collective action.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR194 *	There is a potential risk that NHS Nottingham and Nottinghamshire ICB may not meet agreed 2024/25 year-end financial position. ** This risk was reported in the confidential paper to the last Board.*	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR195	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	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

Risk Ref.	Risk Description	Score	Responsible Committee
ORR197	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
ORR212 *	As workforce planning is based on short term plans set nationally, and due to limitations with access to data, there is a risk the Nottingham/shire system may not have a clear understanding of future NHS workforce requirements. This may lead to inability to identify and implement a sustainable workforce plan, exacerbating the risk to financial stability. ** This risk was reported in the confidential paper to the last Board.*	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR210	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)	Remuneration and HR Committee
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 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.	**High** 20 (I4 x L5)	Quality and People Committee
ORR077	If the NHS continues to implement headcount reductions as part of its financial 'grip and control' measures, while social care providers face their own financial and operational pressures, there is a risk of ongoing workforce strain across both sectors. This could result in increased sickness, exhaustion, and burnout, undermining the psychological safety of the workforce across health, social care, and primary medical services providers.	**High** 16 (I4 x L4)	Quality and People Committee

Risk Ref.	Risk Description	Score	Responsible Committee
ORR083	If discharges from learning disability and autism inpatient settings are delayed due to lack of available capacity in community-based settings, there is a risk patients may stay in inpatient settings longer than necessary or be cared for in a more restrictive environment than required. 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
ORR167 *	If there are delays across the urgent and emergency care pathway, there is a risk of patient deterioration and deconditioning (physical or cognitive functions) within hospital settings, which may lead to increased levels of morbidity and mortality. ** This risk was originally identified in November 2023. The score for this risk has increased since the last report to Board and, as such, now meets the threshold for reporting.*	**High** 16 (I4 x L4)	Quality and People Committee
ORR170	If there continues to be insufficient availability of ongoing appropriate mental health placements (inpatient and community) there is a risk that adults may experience delayed or inadequate treatment or be transferred to out-of-area facilities or inappropriate settings. This could lead to increased distress, potential harm to individuals or others, and a higher likelihood of crisis situations, putting additional strain on both health and social care services.	**High** 16 (I4 x L4)	Quality and People Committee
ORR171	If the ICS Nottingham and Nottinghamshire system cannot facilitate timely discharge of adults requiring ongoing mental health support once their medical or physical issues have resolved there is a risk of delayed discharges. This may exacerbate current challenges across the urgent and emergency care pathway.	**High** 16 (I4 x L4)	Quality and People Committee
ORR177	If system workforce planning continues to be set nationally on a short-term basis, and local operational and financial challenges persist, there is risk medium to longer term strategic education and planning needs may not be addressed. 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

Risk Ref.	Risk Description	Score	Responsible Committee
ORR199	If General Practice (GP) continues to participate in collective action, or increases its level of participation, there may be a risk to the delivery of primary care and community pharmacy services. This could result in potential harm to citizens in managing chronic conditions and urgent medical concerns. Additionally, it may lead to increased activity at other providers.	**High** 16 (I4 x L4)	Quality and People Committee
ORR207	If challenges in the provision and delivery of community mental health services persist, there is risk that these services may not be accessed, or accessed promptly, and/or meet the current and future needs of the population. This may result in worsening health outcomes for adults and children across Nottingham/shire. This risk may also result in increased demand on other services as activity may be displaced to other partners within the system.	**High** 16 (I4 x L4)	Quality and People Committee
ORR221	If ongoing adverse reports in national and local media continue, there is a growing risk of declining public confidence, which may lead to citizens failing to access appropriate services in a timely manner. This could result in delayed interventions, reduced service effectiveness, and further strain on public resources.	**High** 16 (I4 x L4)	Quality and People Committee
ORR224	If Nottingham University Hospitals NHS Trust (NUH) fail to sustain improvements made to date following CQC and external recommendations, there is a risk quality of services may decline. This may lead to compromised patient safety and quality of care which could result in poor patient experience and adverse health outcomes for the population of Nottingham/shire.	**High** 16 (I4 x L4)	Quality and People Committee
ORR230	If societal expectations and pressures for formal mental health diagnoses continue to increase, there is a risk of over-medicalisation of emotional well-being needs. This may result in additional demands on already pressured services. For the individual this may also contribute to stigmatisation, ultimately affecting the well-being of individuals and reducing the effectiveness of mental health services.	**High** 16 (I4 x L4)	Quality and People Committee
ORR232	If the rise in the complexity, comorbidities and volume of people requiring mental health services continues the ICS Nottingham and Nottinghamshire system may struggle to meet the needs of the population. This could lead to delayed treatment,	**High** 16 (I4 x L4)	Quality and People Committee

Rushcliffe Arena, 09:00-13/03/25

Risk Ref.	Risk Description	Score	Responsible Committee
	worsening mental health outcomes, and an increased burden on already overstretched health and social care resources.		
ORR208	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 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	If General Practices, Primary Care Networks, community pharmacy and the ICB do not have appropriate capacity, capability and resources to deliver actions in relation to delivery of ICS Primary Care Strategy, Primary Care Access Recovery Plan (PCARP) and achievement of NHS England's two-week GP appointment target then expected transformation may not be delivered. This may, in turn, impact on the ability to meet the needs of our population.	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee
ORR182	If GP collective action impacts on partnership working, there may be a risk to primary care engagement which may impact delivery of 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

Integrated Care System
Nottingham & Nottinghamshire

Medicines Optimisation Strategy

2024 - 2029

Contents

Integrated Care System
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Foreword

Integrated Care System
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We are proud to introduce our first Medicines Optimisation Strategy for our Integrated Care System.

We want to raise the profile of medicines optimisation and make medicines optimisation everyone's business.

Medicines are the most widely used intervention in health and hence medicines optimisation – getting the right medicine to the right person at the right time – is key to optimising the health of our population and maximising our resources.

Our strategy sets our long-term ambition, purpose and aims for the next 5 years. The document has a system focus and is complemented by organisational medicines optimisation strategies and aligned to our ICS Strategy.

This strategy has been developed through large scale engagement, hearing what matters to local people and health and care professionals. Implementation will be phased and supported by a robust delivery plan agreed by the system each year.

Our approach is to scale and spread what works, address gaps and support people to improve, innovate and transform the way we optimise the use of medicines.

We have presented our strategy in a simple format but acknowledge the complexity and ambiguity people are working in - some of our work will be focused on simplifying processes to make it easy for people to do the right things.

Delivery of this strategy extends beyond pharmacy professionals. It will require a culture change in the way our health and care teams and local people work together This collaboration will enable medicines optimisation that is joined up, person centred and holistic and delivers the best outcomes for our local people and the wider health and care system.

Mindy Bassi
Chief Pharmacist

Dave Briggs
Medical Director

Rosa Waddingham
Chief Nurse

Nottingham and Nottinghamshire Integrated Care Board

Introduction – What is Medicines Optimisation?

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Our definition

Medicines optimisation looks at the **value** which medicines deliver, making sure they are **clinically and cost effective,** so that they **deliver the best outcomes for people, and the wider health and care system.**

Introduction – The Case and Opportunity for Change

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- **Medicines are the most common health intervention in the world** – Approximately half of all UK adults take at least one prescribed medicine
- **Medicines deliver extensive health benefits but have the potential to cause harm**
- **30- 50% of the medicines prescribed for long-term conditions are not being taken as intended**
- **Medicines contribute 25% of the carbon footprint associated with the NHS**
- **Between 5-10% of all hospital admissions are medicines related**, of these admissions, around two-thirds are preventable
- **National drive for health and care professionals to take on more/advanced clinical roles and an increasing number of non-medical prescribers**

= Opportunity to improve health outcomes, reduce costs, waste and reduce inequalities across our system

References: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4310971/, (World Health Organisation – 2003) https://iris.who.int/bitstream/handle/10665/42682/9241545992.pdf

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Our Shared Purpose

To ensure all medicines have value and provide the best outcomes for all people

Co-produced with My Life Choices, a group of local people who use NHS and Social Care Services

My Life Choices
Co-production in action

What's Important for People and Our Health and Care System?

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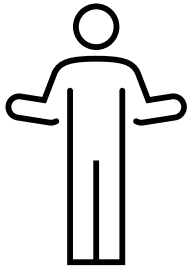
Throughout the engagement undertaken with health and care professionals and local people, we heard that people wanted to focus on;

Patient outcomes - understanding the value of care rather than the cost of medicines



Waste reduction - rather than cost reduction

Person Centred Care - a focus on what matters to people

Themes We Heard About People

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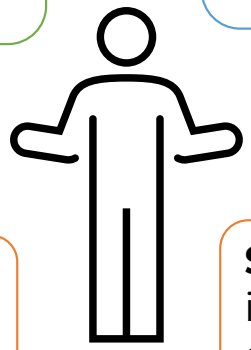
De-medicalisation – evidence based alternative therapeutic interventions and care pathways

Effective and safe use of medicines to improve outcomes – reducing inappropriate polypharmacy

Seamless and consistent care



Accessible provision – closer to home

Shared Decision Making: providing accessible, tailored and consistent information so people have control and can make informed choices in partnership with healthcare professionals

Supported Self Management: increase the knowledge, skills and confidence people have to manage their own health. Develop consistent tools and approaches to support people with this.

Personalised Care - a focus on what matters to people

ICS Strategy guiding principles

1. **Prevention** is better than cure
2. **Equity** in everything
3. **Integration** by default

Themes We Heard About Our System

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Services focused on greatest and specific needs - deprivation, hard to reach groups under represented/easily ignored and people with multiple disadvantage, ageing population, people with mental health needs and long-term conditions

Medicines safety – use of high risk medicines, antimicrobial prescribing, learning from incidents and reducing variation in prescribing

Environmental sustainability and the green agenda

Cost effective and value based use of medicines

Doing things once and consistently for our population - for example, medicines information and access to advice, policies and guidance

Inform, educate and challenge myths and expectations about prescribing and medicines

ICS Strategy guiding principles

1. **Prevention** is better than cure
2. **Equity** in everything
3. **Integration** by default

What Medicines Optimisation Means for Person Centred Care

How health and social care professionals work together to provide person centred care

Starting medicine → Dose adjustment → Stopping medicine

The optimal use of medicines includes the entire prescribing spectrum including starting, dose adjustment and stopping at the point at which harm outweighs benefit.

Wider determinants of health

- Lifestyle
- Activities we can do to prevent becoming unwell

i.e. eating well and exercising regularly, not smoking, getting good sleep, resting, vaccinations

Other Therapies

- Consideration of alternative evidence based therapeutic interventions

i.e. -green social prescribing, holistic therapies

Decision to take medicine

- Accessible, consistent information about evidence-based treatment options to enable a personalised shared decision about the most appropriate therapy
- Effective and safe use of medicines to improve outcomes
- Reduce inappropriate polypharmacy

Help and support in taking medicines

- Availability of medicines
- Accessible, clear and consistent information in appropriate language to enable personalised care, shared decision making and supported self management
- Clarity about where to go for advice if needed -access to pharmacy teams to support people in taking medicines effectively and to manage side effects

Regular reviews of medicines

- Regular reviews of medicines between patients and clinicians
- Accessible, consistent information to enable personalised care by shared decision making about deprescribing, if appropriate

Prevention

Diagnosis

System

- Services focused on specific needs. Reduce unwarranted variation in prescribing. Accessible provision, closer to home
- Medicines safety – system focus on reducing harms from medicines, embed learning from incidents. Antimicrobial stewardship.
- Cost effective use of medicines. Focus on waste reduction, environmental sustainability and overall cost of care
- Do things well once and provide consistent care for our population

Delivery of our Shared Purpose through our Strategic Aims and Key Enablers

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Shared Purpose

To ensure all medicines have value and provide the best outcomes for all people

Strategic Aims

- Medicines are clinically effective and prescribed safely
- Medicines are equitably accessible across our ICS
- Pharmaceutical Care is joined up across our ICS; locally agreed information is shared
- Medicines waste is reduced and sustainability is promoted
- System value from medicines is achieved

Guided by our Principles

Key Enablers

- Digitalisation and technology
- Workforce Development
- Policy, Guidance and Legislation

Key Principles to Guide our Work

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These are the lenses we will use to approach our strategic changes

1 - Person centred care
Empower patients through shared decision making and self-management support, guided by and using the 'It's ok to ask' approach and resources.

2 - Population Health Management
Use of data and intelligence to develop services and interventions to reduce health inequality, focusing on greatest and specific needs.

3 - Improvement and Innovation
Application of improvement methodology to prototype, test, scale and spread new ideas and solve problems in clinical processes, creating spaces for people to learn together. Harnessing the power of Experts By Experience through co-production to ensure our approach focusses on the needs of our local populations.

4 – Research
Undertake research to build evidence to underpin new approaches and practices.

5 - Systems Working
Further connect, collaborate, learn and work with system stakeholders and our population

Key Enablers to Help Deliver this Work

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1 - Digitalisation and Technology

Work in partnership with Digital Notts to help to develop the Shared Care Record to provide accurate and visible medicines records. Exploit opportunities to enable interoperability between systems. Exploring new digital innovations for example in robotics, AI, wearable devices and automation.

2 – Workforce Development

- Improve recruitment, retention and professional development of our workforce, recognising the role of the whole multidisciplinary team in medicines optimisation
- Enable health and care professionals to work to their full scope of practice, develop and grow our non-medical prescribers (including Pharmacists qualifying as prescribers from 2026) to increase access to and consistency of prescribing , expand advanced practice and evolve supportive roles to enable professionals to work to the 'top of their licence'
- Develop and enable 'portfolio careers' through partnership and ensure our teams have an understanding of the entire patient pathway through joint education and training for multi-disciplinary, multi-agency teams so that they can confidently and competently support shared decision making and a person-centred approach to medicines optimisation.

3 –Policy , Guidance and Legislation

Changes in legislation present opportunities to work differently, we will assess how this could improve Pharmacy services for our population. Take direction from National Policy and Guidance in our planning.

Our Improvement Plan

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Strategic Aim	Objective	Outcome
Medicines are clinically effective and prescribed safely	Implement data driven systematic structured medication reviews for patients taking multiple medicines	Inappropriate Polypharmacy is reduced
	Increase learning and sharing from medicines safety related incidents to reduce preventable harm from medicines	Preventable harm from medicines is reduced
	Implement data driven systematic structured medication reviews for patients taking high-risk medicines.	
	Develop decision making tools with Experts by Experience focused on supporting patients to take their medicines safely and participate in decisions about their care	People are empowered to manage their own health and take their medicines safely, improving their health outcomes
Pharmaceutical Care is joined up across our ICS; locally agreed information is shared	Strengthen use of, and prescribing decisions adherence to the joint formulary	Unwarranted variation in prescribing is reduced
	Improve access to and understanding of guidelines and formularies through standardised and single point of access to medicines information across care pathways for prescribers and patients	
	Improve consistency in adoption of shared care protocols across the ICS	
	Improve medicines optimisation around transfers of care	Reduction in medicines related readmissions

Our Improvement Plan

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Strategic Aim	Objective	Outcome
Medicines waste is reduced, and sustainability is promoted	Identify potential areas of medicines waste across our system and work to reduce this	Reduced medicines waste
	Work with Patient Groups, Primary Care Practices and Community Pharmacies and Digital Notts to help people to 'Only Order what they need'	
	Work with the Greener Programme to recommend medicines with the lowest carbon footprint within formularies and guidance where clinically appropriate	Reduction in carbon footprint of medicines
Medicines are equitably accessible across our ICS	Increase provision of community pharmacy clinical services to improve access to medicines	Improved and equitable access to medicines
	Scope further provision of specialist pharmaceutical care closer to home	
	Implement consistency of communication with professionals, patients and carers, to manage access to medicines in short supply	System approach to managing medicines shortages
System value from medicines is achieved	System: Strengthen MOPB governance and accountability to maximise medicines value	Optimised health outcomes from the expenditure on medicines
	Place: Robust prescribing processes and responsibility to maximise medicines value	
	Person: Work with Experts by Experience to increase the knowledge, skills and confidence people have to manage their own health and their medicines	

How Will We Measure Success?

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By implementing plans to deliver this strategy we expect to see improvements in the following outcomes;

Medicines are clinically effective and prescribed safely

- Inappropriate Polypharmacy is reduced
- Preventable harm from medicines is reduced
- People are empowered to manage their own health and take their medicines safely, improving their health outcomes

Pharmaceutical Care is joined up across our ICS; locally agreed information is shared

- Unwarranted variation in prescribing is reduced
- Reduction in medicines related readmissions

Medicines waste is reduced, and sustainability is promoted

- Reduction in carbon footprint of medicines
- Reduced medicines waste

System value from medicines is achieved

- Optimised health outcomes from the expenditure on medicines

Medicines are equitably accessible across our ICS

- System approach to managing medicines shortages
- Improved and equitable access to medicines

Case Studies

Integrated Care System
Nottingham & Nottinghamshire

Making optimal use of medicines really makes a difference to people's lives;

I worked with a patient who was taking a lot of medicines, we worked together to safely remove some medicines.

The results were that he went from never leaving his house to taking a short walk with his dog, he said his pain was 70% improved.

PCN Pharmacist, Nottingham City

Pharmacy First

'I had to pick my daughter up from school due to a sore throat with a fever. I was able to walk into a pharmacy and after a short wait was seen by the pharmacist who was able to provide treatment for the sore throat under a patient group directive. The pharmacist was really good with my daughter, explaining everything to her.

My daughter was able to go back to school the next day and this was much easier than ringing to try and get a doctor's appointment'

Rachael

Case Studies

Integrated Care System
Nottingham & Nottinghamshire

Utilising the full potential of Pharmacists and Pharmacy Technicians within general practice.

The Pharmacy Prevention Service for Hypertension is a specialised clinical pharmacy team who help to screen, diagnose and manage hypertensive patients across 12 practices in Nottingham providing a standardised level of care.

In the first year 312 patients were newly diagnosed with hypertension which we know is already starting to prevent heart attacks and strokes for people living in this area.

"As a GP within Nottingham West PCN I have thoroughly welcomed this initiative at a time when capacity is such an important issue for primary care. The team have demonstrated that they can safely and proactively manage these patients to high clinical standards on behalf of 12 practices.

The capacity this team have released in general practices has the potential to help transform how primary care is delivered in future."

Professor of Primary Health Care Tony Avery

Case Studies

Integrated Care System
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Community Pharmacies and Local GP Practices Working Together to Provide Access to Medicines

A patient receiving palliative care for a fungating tumour needed a special-order pain relief medicine.

The PCN Pharmacist contacted the pharmacy who went above and beyond to obtain the product at the best value to the NHS and delivered to the patient free of charge as the family did not drive.

This made a huge difference to the patient and their family as the medicines helped to reduce the patient's pain at the end of their life.

Vantage Community Pharmacy

Case Studies

Integrated Care System
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Building trust through shared decision-making conversations

The pharmacy service within Nottinghamshire Healthcare Trust is a specialist team with expert knowledge about medicines used for mental health conditions. They support people to get the best outcomes from their medicines.

A patient attended clinic, after looking at her medications, I saw that she was taking a high dose of anticholinergic medication which was for a side effect of a previous medication which she was no longer taking. She also had involuntary facial movements which could be made worst by the anticholinergic medication.

I talked to her about whether she wanted to make some medication changes that may help reduce her involuntary movements, she was adamant to not make medication changes as when this had happened in the past and she had felt unwell.

The patient could not speak clearly due to her facial movements, she also presented with confusion. I assessed she was at significant risk of falls and that the involuntary movements were affecting her day-to-day life.

During the consultation, we discussed the indications of all her medications and talked about her concerns about mental health stability.

I explained why we are concerned about a high dose of anticholinergic medicines as they could contribute to other problems such as falls and confusion. I reassured her that changes in this type of medication should not affect her mental health and that we would keep all changes under review.

After this discussion the patient agreed that she would like to make the change to slowly reduce the anticholinergic medicine over the next few months.

After a few months I observed that she spoke more clearly with less involuntary movements. Her risk of falls has also decreased.

Specialist Mental Health Pharmacist
Nottinghamshire Healthcare Trust

Integrated Care System
Nottingham & Nottinghamshire

Thank you to everyone that has contributed to the production of this strategy

To develop this strategy, we sought input from over 250 people from a range of health and care professions across our health and care system. We held multi-agency, multi-professional focus groups, presented at a variety of different forums and hosted a multi-agency, multi-professional workshop.

We have also had support from My Life Choices as the voice of local Experts by Experience. Thank you to My Life Choices for helping to shape this strategy and for their continued involvement and support of this work.

My Life Choices
Co-production in action

Glossary

Integrated Care System
Nottingham & Nottinghamshire

Term	Description	Source
Indices of Multiple Deprivation (IMD)	The Index of Multiple Deprivation, commonly known as the IMD, is the official measure of relative deprivation for small areas in England.	English indices of deprivation 2019 - GOV.UK (www.gov.uk)
Long Term Condition	A long-term condition is an illness that cannot be cured. It can usually be controlled with medicines or other treatments. Examples of long-term conditions include diabetes, arthritis, high blood pressure, epilepsy, asthma and some mental health conditions.	Long term conditions | The Patients Association (patients-association.org.uk)
Multimorbidity	Multimorbidity is a term used to describe two or more long term conditions	Long term conditions | The Patients Association (patients-association.org.uk)
Polypharmacy	Polypharmacy means “many medications” and has often been defined to be present when a patient takes five or more medications.	https://www.rpharms.com/recognition/setting-professional-standards/polypharmacy-getting-our-medicines-right

Integrated Care System
Nottingham & Nottinghamshire

Appendices

Some Facts about Medicines

Integrated Care System
Nottingham & Nottinghamshire

Medicines are the most common health intervention in the world

Medicines deliver extensive health benefits;

- Vaccinations preventing the spread of disease
- Antibiotics reducing deaths from infection
- Enabling advancements in surgical procedures
- Improved quality of life for people

People living with long-term conditions often take many different medications

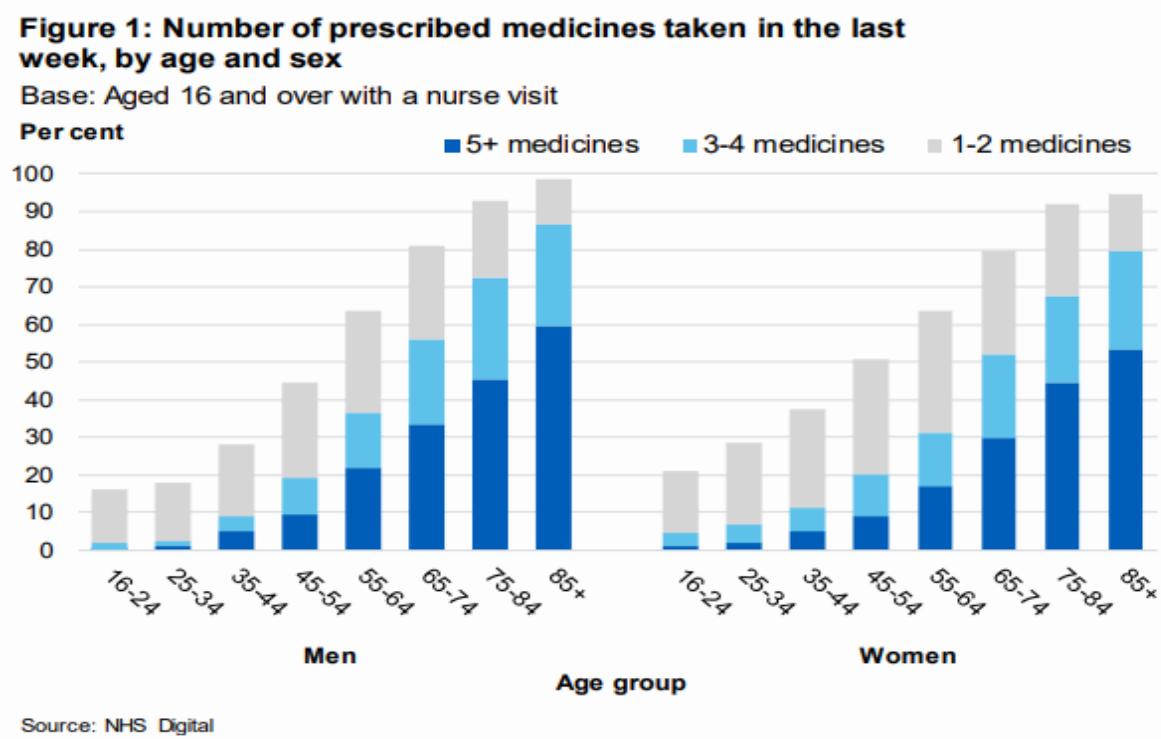
This is called polypharmacy

Taking many different medicines can be associated with harm and waste.

References: NIHR Multiple long-term conditions: How to reduce medications (nihr.ac.uk)
(World Health Organisation – 2003) https://iris.who.int/bitstream/handle/10665/42682/9241545992.pdf

Some Facts about Medicines

Integrated Care System
Nottingham & Nottinghamshire



48% of adults take at least one prescribed medicine and 24% take three or more medicines, not including contraception or nicotine replacement therapy.

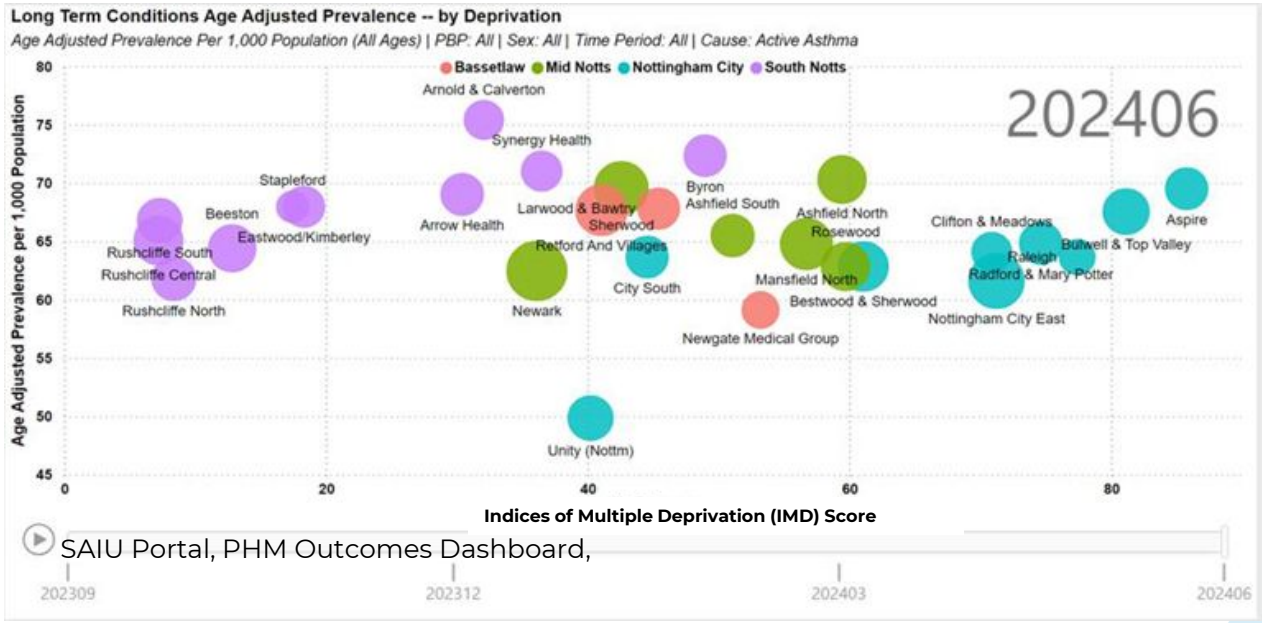
The percentage of people taking prescribed medicines increases with age - more than 90% of those aged 75 or older, take a prescribed medicine compared with 19% of young adults aged 16 to 24

Many people taking 5 or more medicines per day feel overburdened by their treatment

References: NHS Digital and Office of National Statistics (2017), Health Survey for England 2016, https://files.digital.nhs.uk/pdf/3/c/hse2016-pres-med.pdf

Some Facts about Medicines

Integrated Care System
Nottingham & Nottinghamshire



SAIU Portal, PHM Outcomes Dashboard,

People with long term conditions are more likely to live in more deprived communities within our ICS

20% of people living in Nottingham and Nottinghamshire have been diagnosed with one long term condition

16% have two or more long term conditions (multimorbidity)

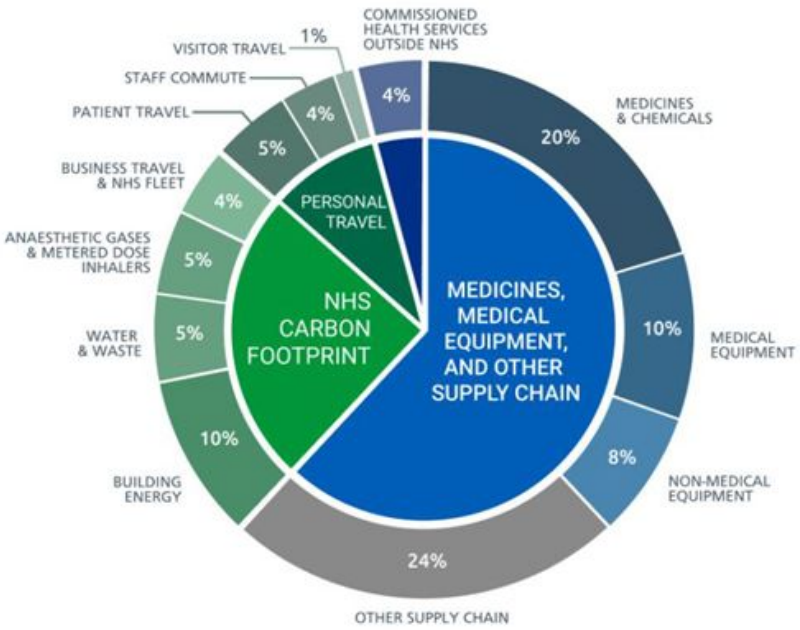
The World Health Organisation estimate that 30- 50% of the medicines prescribed for long term conditions are not being taken as intended

Studies have found that between 5 to 10 per cent of all hospital admissions are medicines related and around two-thirds of these admissions are preventable

References: NIHR Multiple long-term conditions: How to reduce medications (nihr.ac.uk)
(World Health Organisation – 2003) https://iris.who.int/bitstream/handle/10665/42682/9241545992.pdf

Some Facts about Medicines

Integrated Care System
Nottingham & Nottinghamshire



Sources of carbon emissions by proportion of NHS Carbon Footprint

Medicines use in the NHS equates to 1% of the whole of the UK's carbon footprint

Medicines represent the second highest proportion of NHS spend, worth £18.5 billion in England in the 2022 to 2023 financial year.

25% of the NHS's carbon footprint is medicines related (Medicines (20%), Anaesthetic Gases and Metered Dose Inhalers – 5%)

Medicines that are disposed of incorrectly, increase the risk of environmental harm and can cause long-term impacts on ecosystems

References: https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf
NHS launches latest report on prescribing costs | NHS Business Services News (nhsbsa.nhs.uk)
Systemic review on drug related hospital admissions – A pubmed based search - PMC (nih.gov)

NHS Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/03/2025
Paper Title:	**NHS Nottingham and Nottinghamshire Integrated Care Board Constitution**
Paper Reference:	ICB 24 118
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 paragraphs 23 and 24 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	28 February 2025	To incorporate amendments to 2.2.3, 3.1.1, 3.3.4, 3.5.6, 3.6.6, 3.7.6, 3.8.5, 3.8.6, 3.13, 3.14, 3.15.3, 4.6.8, 7.2.1, 7.2.2, 7.2.8 and Appendix 1 and Appendix 2, addition of 4.6.9 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 remove previous clauses related to the establishment of the ICB.
1.4	TBC	Amendments to 3.9.1(a), 3.10.1(a), 3.11.1(a) and 3.12.1(a) to enable Executive members of the Board to be appointed via secondment from another Integrated Care Board.

Contents

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 (one of whom, but not the Audit and Risk Committee Chair, will be appointed Deputy Chair, and one of whom, who may be the Deputy Chair or the Audit and Risk Committee Chair, will be appointed the Senior Non-Executive member).

(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 The term of office for the Chair will be a maximum of three years and the total number of terms a Chair may serve is three terms.

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 The term of office for these Partner Members will be a maximum of three years. 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 re-appointed, as the appointment process set out at 3.5.5 of this constitution will be followed at the end of each term of office.

3.6 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 The term of office for this Partner Member will be a maximum of three years. 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 re-appointed, as the appointment process set out at 3.6.5 of this constitution will be followed at the end of each term of office.

3.7 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 The term of office for these Partner Members will be a maximum of three years. 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 re-appointed, as the appointment process set out at 3.7.5 of this constitution will be followed at the end of each term of office.

3.8 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 The term of office for a Non-Executive member will be a maximum of three years and the total number of terms an individual may serve is three terms, after which they will no longer be eligible for re-appointment.

3.8.6 Subject to demonstration of continuing competence through a satisfactory annual performance appraisal, the Chair may approve the re-appointment of a Non-Executive member up to the maximum number of terms permitted for their role. No individual will have the right to be automatically re-appointed.

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~~ any public authority in the UK.

(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~~ any public authority in the UK.

(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~~ any public authority in the UK.

(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~~ any public authority in the UK.

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 Deputy Chair and Senior Non-Executive member

3.13.1 The Deputy Chair is to be appointed from amongst the Non-Executive members by the Board subject to the approval of the Chair.

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

3.13.3 The Senior Non-Executive member is to be appointed from among the Non-Executive members by the Board subject to the approval of the Chair.

3.14 Deputy Chief Executive

3.14.1 The Deputy Chief Executive is to be appointed from amongst the Executive members by the Chief Executive subject to the approval of the Chair.

3.15 Board members: removal from office

3.15.1 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.

3.15.2 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.

3.15.3 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.

3.15.4 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.

3.15.5 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.

3.15.6 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.

3.16 Board members: terms of appointment

3.16.1 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.

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

3.16.3 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 committee is responsible for arranging appropriate internal and external audits. The Audit and Risk Committee will be chaired by a Non-Executive member who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters. 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 terms of reference for each of the above committees are published in the Governance Handbook.

4.6.10 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 Board meetings, and committees composed entirely of Board members or that include all Board members, will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed not to be in the public interest.

7.2.2 Papers and minutes of all meetings held in public will be published.

7.2.3 Annual accounts will be externally audited and published.

7.2.4 A clear complaints process will be published.

7.2.5 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.

7.2.6 Information will be provided to NHS England as required.

7.2.7 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.

7.2.8 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 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.
Place-Based Partnership	Place-Based Partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the ICB, local government, and providers of health and care services, including the VCSE sector, people and communities, as well as primary care provider leadership, represented by primary care network clinical directors or other relevant primary care leaders.
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.

4.1.4 The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting, excluding, if thought fit, any item likely to be addressed in part of a meeting that is not likely to be open to the public.

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 (or in their absence, the person presiding over the meeting), 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.

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) A nominated deputy permitted in accordance with standing order 4.5 will not count towards quorum.

(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.

Disputes

4.9.4 Where helpful, the board may draw on third-party support to assist them in resolving any disputes, such as peer review or support from NHS England.

Emergency powers for urgent decisions

4.9.5 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 4.9.6 and 4.9.7 will apply.

4.9.6 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.

4.9.7 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.

4.9.8 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:	13/03/2025
Paper Title:	**Board Annual Work Programme 2024/25**
Paper Reference:	ICB 24 119
Report Author:	Lucy Branson, Director of Corporate Affairs
Executive Lead:	Rosa Waddingham, Director of Nursing
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

NHS Nottingham and Nottinghamshire

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								
Citizen Story	-	-	-	✓	✓	✓	Not applicable	-
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

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
Joint Capital Resource Use Plan	✓	-	-	-	-	✓	Strategic risk 3 and 8	See note 5
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 at Scale	-	-	-	✓	-	-	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

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
Governance								
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	-	-	-	-	✓	-	-	-	-

Topic	11 Apr	30 May	13 Jun	16 Sep	10 Oct	12 Dec	16 Dec	13 Feb	17 Mar
• ~~Primary care (primary medical services and pharmacy, optometry and dental services)~~									
Board Seminar: • Primary care (primary medical services and pharmacy, optometry and dental services) • ~~Population health management approach to frailty~~ • ~~Working with people and communities~~	-	-	-	-	-	✓	-	-	-
ICS Reference Group: • Planning for 2025/26 (operational and joint forward plans) • ICS Research Strategy	-	-	-	-	-	-	✓	-	-
Development Session: • ICB priorities, operational planning, productivity and efficiency requirements, and service transformation requirements. • ~~Board effectiveness/ maturity~~ • ~~Preparing for ICB capability assessment~~	-	-	-	-	-	-	-	✓	-
ICS Reference Group: • Social and economic development • Population health management approach to frailty • ~~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~~ Director of Strategy and System Development 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).~~ Follow-up to now be incorporated within the next annual report, to be scheduled for May 2025.
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~~ Director of Delivery and Operations 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~~ Director of Delivery and Operations 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 Nottingham and Nottinghamshire Provider Collaborative at Scale.
29.	**Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity**	To provide assurance on the completion of the annual assurance process for 2024/25. The Director of Delivery and Operations is the executive lead for EPRR.

Nottingham and Nottinghamshire

Nottingham & Nottinghamshire Integrated Care Board

Integrated Performance Report

Reporting Month: December 2024 / January 2025

Board Month: March 2025

Integrated Performance Report March 2025 – Report Contents

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 104) which will support the escalation of issues to the ICB Board.

The system has not achieved the financial position required for month 10, reporting a £14.4m adverse variance to plan. Efficiencies are adverse to plan for month 10 and ERF is estimated to be slightly ahead of the planned level year-to-date. The finance reporting includes the key performance indicators on slide 11 alongside a narrative to support the finance scorecard table. There is further detailed financial performance and efficiencies tables by the organisations within the system with supporting narratives on slides 79-80. Workforce is over the planned position for month 10, reporting bank and substantive worse than plan and agency better then plan.

The system has made some positive progress on service delivery areas, which include achieving trajectories for cancer faster diagnosis and 62-day standards. The volume of patients waiting over 52 weeks for community therapeutic services continues to reduce along with the number of mental health patients with a placement out of area. Sustained progress has been made with supporting children and young people with Learning Difficulties and Autism in the community, rather than needing to admit to inpatient services, and ensuring that people with LD&A are having timely access to annual health checks.

However, system pressures and challenges remain in some areas. The urgent care system is experiencing significant pressure due to increasing levels of demand and acuity in combination with operational and staffing issues in the acute hospitals. However, handover performance and ambulance category 2 performance has improved following implementation of the 45-minute handover policy in December. Planned care focus remains on ENT pathways to enable further progress to be made to eradicate waits of over 65 weeks. There is also focus on further reducing waits for cancer treatment and enabling additional capacity in key diagnostic modalities such as CT Cardiac and MRI. Too many adults with Learning Disability and Autism continue to remain in inpatient care settings which are being addressed through weekly cross partner discussions.

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 – 95.

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Quality Scorecard

Quality Scorecard	Latest Period	Plan	Actual	Variance	Section
Learning Disability & Autism					
LD&A Inpatients Rate Adults – ICB	Nov-24	09	13	+4	Section 01
LD&A Inpatients Rate Adults – NHSE	Nov-24	27	26	-1	
LD&A Inpatients Rate CYP – NHSE	Nov-24	3	0	-3	
LD&A Annual Health Checks	Jan-25	4119	4255	+136	
Maternity					
No. stillbirths per 1000 total births	Dec 24		2.2	1.02	Section 02
No. neonatal deaths per 1000 live births	Dec 24		1.10	0.41	
Infection Prevention Control Hospital Acquired Infections ICB (QT1)					
MRSA	Dec 24	0	1	-1	Section 10
C-Diff	Dec 24	27	39	-12	
E.coli BSI	Dec 24	96	90	+6	
Klebsiella BSI	Dec 24	30	31	-1	
Pseudomonas BSI	Dec 24	12	11	+1	

Quality Scorecard	Latest Period	Plan	Actual	Variance	Section
Vaccinations					
MMR second dose at 5 years	Sep 23	95%	83%	-12%	Section 06
COVID Vaccination Booster dose	Jan 25		43%		
Seasonal Flu Vaccination	Jan 25		53%		

Content Author: SAIU | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

3a. Service Delivery Scorecard - Urgent Care

Pre-Hospital Flow Volumes								
Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
EMAS Responses Activity	ICB	January 2025	13168	13371	203	✗		
Ambulance Conveyances to ED (%) ICB Population	ICB	January 2025	45%	44.2%	-0.8%	✓		
111 Calls	ICB	December 2024	35785	35184	-601	✓		
% 111 Calls Abandoned	ICB	December 2024	3%	1.5%	-1.5%	✓		
Pre-Hospital - Alternatives to ED								
Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Urgent Care Response Referrals	ICB	December 2024	1600	1880	280	✓		
2 Hour Urgent Care Response %	ICB	December 2024	70%	96.6%	26.6%	✓		
No. Patients utilising Virtual Ward	ICB	January 2025	230	160	-70	✗		
% Virtual Ward capacity utilised	ICB	January 2025	80%	77.5%	-2.5%	✗		
In-Hospital Flow								
Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Total A&E Attendances	Provider	January 2025	31619	33406	1787	✗		
Total NEL admissions	Provider	December 2024	11528	12951	1423	✗		
0 Day NEL	Provider	December 2024	3820	4835	1015	✓		
1+ Day NEL	Provider	December 2024	7760	8320	560	✗		
% Bed Occupancy	Provider	January 2025	94.9%	94.5%	-0.4%	✓		
Flow out of Hospital								
Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
CTR activity	Provider	January 2025	358	290	-68	✓		
Length of Stay > 21 days	Provider	January 2025	455	319	-136	✓		
Pathway 0 - Discharge home with no support needed	ICB	January 2025	8216	13075	4859	✓		
Pathway 1 - Discharge home with health and/or social care	ICB	January 2025	1058	1072	14	✓		
Pathway 2 - Discharge not to usual residence	ICB	January 2025	264	235	-29	✗		
Pathway 3 - Discharge to a care home which is likely to be permanent	ICB	January 2025	161	46	-115	✗		

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3a. Service Delivery Scorecard - Urgent Care

EMAS Compliance								
Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Ambulance (mean) response time Cat 1 (Notts)	ICB	January 2025	00:07:00	00:08:16	00:01:16	✗		
Ambulance (mean) response time Cat 2 (Notts)	ICB	January 2025	00:23:51	00:35:32	00:11:41	✗		
Ambulance (mean) response time Cat 3 (Notts)	ICB	January 2025	03:04:24	02:32:15	-00:32:09	✓		
Ambulance response time Category 4 - 90th Centile *	ICB	January 2025	03:00:00	06:59:39	03:59:39	✗		
% Cat 2 waits below 30 minutes	ICB	January 2025	43.8%	55.6%	11.9%	✓		

Acute Performance Compliance								
Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Average C2 Handover time	Provider	January 2025	00:48:07	00:30:39	-00:17:28	✓		
% Ambulance Handovers > 30 minutes	ICB	January 2025	38.80%	25.7%	-13.1%	✓		
% Ambulance Handovers > 60 minutes	ICB	January 2025	23.1%	10%	-13.1%	✓		
Ambulance Total Hours Lost	Provider	January 2025	1480	2509	1029	✗		
A&E 4hr % Performance (All types)	Provider	January 2025	76%	57.4%	-18.6%	✗		
A&E 12 Hour Waits	Provider	January 2025	0	968	968	✗		
A&E 12 Hour Breaches as % Overall Attendances	Provider	January 2025	2%	10.1%	8.1%	✗		

3b. Service Delivery Scorecard – Planned Care: Elective

Total Waiting list and Long Waits

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
RTT Waiting List	Provider	December 2024	108962	125322	16360	✗		
52 Week Waiters	Provider	December 2024	2748	2494	-254	✓		
65 Week Waiters	Provider	December 2024	0	86	86	✗		
Incomplete> 52 weeks CYP	Provider	January 2025	248	217	-31	✓		
78 Week Waiters	Provider	December 2024	0	0	0	✓		
Total Clock Stops (Adm + Non adm)	Provider	December 2024	24245	21569	-2676	✗		
Total Clock Starts	Provider	December 2024	23081	25405	2324	✓		
% Incomplete 18 wks RTT	Provider	December 2024	-	60.5%	-			

Elective Recovery - Activity

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Elective Ordinary	Provider	December 2024	2273	1990	-283	✗		
Total Day Cases	Provider	December 2024	14805	13060	-1745	✗		
Total Outpatients 1st (Spec Acute)	Provider	December 2024	28493	23590	-4903	✗		
Total Outpatients FUp (Spec Acute)	Provider	December 2024	56810	54155	-2655	✗		
Op Plan Diagnostic Activity	Provider	December 2024	33898	40637	6739	✓		

Elective Recovery - Productivity and Transformation

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Total Outpatients Virtual	Provider	December 2024	25%	17.4%	-7.6%	✗		
PIFU	Provider	December 2024	5%	5.5%	0.5%	✓		
Specialist Advice (per 100 OPFA)	Provider	December 2024	16	22	6	✓		
Missed Appointments %	Provider	December 2024	6.5%	4.7%	-1.8%	✓		
Outpatient procedures - ERF scope	Provider	December 2024	17934	20978	3044	✓		
Proportion of outpatient attendances with a procedure - ERF scope	Provider	December 2024	46%	41.3%	-4.7%	✗		
Outpatient first attendances without a procedure - ERF scope	Provider	December 2024	27411	29248	1837	✓		
Outpatient follow up attendances without a procedure - ERF scope	Provider	December 2024	66711	71358	4647	✓		
Percentage outpatients follow-up without a procedure	Provider	December 2024	59.5%	59%	-0.6%	✓		
Percentage of Lower GI Cancer referrals with an FIT result	ICB	November 2024	78%	86.8%	8.8%	✓		
Number of people referred onto a non-specific symptoms pathway	ICB	December 2024	115	131	16	✗		

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: Diagnostic and Cancer

Diagnostic Recovery

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Op Plan Diagnostic Activity	Provider	December 2024	33898	40637	6739	✓		
Op Plan Diagnostics Waiting List	Provider	December 2024	21915	26130	4215	✗		
Op Plan Diagnostic Backlog	Provider	December 2024	4562	6534	1972	✗		
Op Plan Diagnostics 6 week Performance	Provider	December 2024	79.2%	75%	-4.2%	✗		

Cancer Recovery

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Cancer 28 Day Faster Diagnosis	Provider	December 2024	77.2%	78.8%	1.7%	✓		
Cancer 1st Treatment <31 days	Provider	December 2024	93.1%	90.3%	-2.8%	✗		
Cancer 62 Day Standard	Provider	December 2024	63.2%	66.1%	2.9%	✓		
2ww 62 Day Backlogs	Provider	December 2024	294	370	76	✗		

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3c. Service Delivery - Mental Health Scorecard

Talking Therapies

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
NHS Talking Therapies - Completing Treatment	ICB	December 2024	1282	1385	103	✓		
NHS Talking Therapies - Reliable Recovery	ICB	December 2024	48%	45.1%	-2.9%	✗		
NHS Talking Therapies - Reliable Improvement	ICB	December 2024	67%	68.2%	1.2%	✓		
NHS Talking Therapies- WT 1st Treatment <6 Weeks	ICB	December 2024	75%	98%	23%	✓		
NHS Talking Therapies - WT 1st Treatment <18 Weeks	ICB	December 2024	95%	100%	5%	✓		
NHS Talking Therapies - >90 Days 1st & 2nd Treatment	ICB	December 2024	10%	11.4%	1.4%	✗		

Mental Health Adult Inpatients

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Rate per 100,000 Older Adult MH LOS > 60 Days	ICB	December 2024	8	13	5	✗		
Rate per 100,000 Older Adult MH LOS > 90 Days	ICB	December 2024	8	7	-1	✓		
Adult MH IP receiving a follow up <72hrs of discharge	ICB	December 2024	80%	67.7%	-12.3%	✗		
Number of Inappropriate OAPs	ICB	January 2025	7	1	-6	✓		

Community Mental Health

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Dementia Diagnosis Rate	ICB	December 2024	70.3%	70.9%	0.6%	✓		
SMI Health Checks %	ICB	January 2025	60%	67.4%	7.4%	✓		
Transformed Community Services +2 Contacts	ICB	December 2024	14550	15870	1320	✓		

Mental Health Access

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Perinatal Access - Volume	ICB	December 2024	1305	1270	-35	✗		
Individual Placement Support	ICB	December 2024	1126	1550	424	✓		
EIP < 2 weeks	ICB	December 2024	60%	87%	27%	✓		

Mental Health CYP

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
CYP Eating Disorders - Urgent	ICB	December 2024	-	100%	-			
CYP Eating Disorders - Routine	ICB	December 2024	95%	88%	-7%	✗		
CYP Access (1+ Contact)	ICB	December 2024	19940	20765	825	✓		

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3d. Service Delivery – Primary & Community Scorecard

Primary Care and Community Response

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Primary Care - Total Appointments	ICB	December 2024	617104	616639	-465	✗		
Primary Care - % book 2 Weeks	ICB	December 2024	87%	83.3%	-3.7%	✗		
Primary Care - % NHS App Registrations	ICB	January 2025	75%	58%	-17%	✗		

Community Waits

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Community Waiting over 52 weeks (18+ years)	ICB	December 2024	72	0	-72	✓		
Community Waiting over 52 weeks (0-17 years)	ICB	December 2024	94	11	-83	✓		
Community Waiting List (18+ years)	ICB	December 2024	8740	8690	-50	✓		
Community Waiting List (0-17 years)	ICB	December 2024	3749	4653	904	✗		

Dental

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Child patients seen in previous 12 months	ICB	September 2024	140337	141250	913	✓		
Adult patients seen in previous 24 months	ICB	September 2024	495888	386604	-109284	✗		

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)	-4.1	-18.5	**-14.4**	0.0	0.0	**0.0**		
Total Pay Spend	-1,621.7	-1,632.0	**-10.3**	-1,933.5	-1,940.7	**-7.2**		
Substantive Spend vs Plan	-1,506.0	-1,502.4	**3.6**	-1,798.2	-1,786.6	**11.6**		
Bank Spend vs Plan	-71.6	-92.2	**-20.6**	-82.9	-109.8	**-26.9**		
Agency Spend vs Plan	-44.1	-37.5	**6.6**	-52.4	-44.3	**8.2**		
Agency Spend Vs Ceiling		-37.5		-63.5	-44.3	**19.2**		
WTE (Provider) - 24/25 plan as at 31.03.25	33,747	34,507	**-760**					
Financial Efficiency Vs Plan	186.3	185.3	**-1.0**	257.0	257.0	**0.0**		
Recurrent Efficiencies	143.7	119.0	**-24.6**	201.5	156.9	**-44.6**		
Achievement of MHIS		185.9		223.3	223.3	**0.0**		
Capital Spend Vs System Env (inc IFRS16)	71.4	51.4	**-20.0**	92.2	92.2	**0.0**		
ERF Performance (inc system A&G)	120%	121%	**1%**	120%	121%	**1%**		

- The system has reported a (£18.5m) deficit at month 10, which is (£14.4m) adverse to plan. The position includes £185.3m of efficiency.
- Staff costs are (£10.3m) overspent across the system at month 10 with WTEs being 760 WTEs higher than plan.
- Agency spend is (£37.5m) which is £6.6m under the January year-to-date plan with the forecast to be £8.2m under plan by month 12
- Agency plans (as submitted in June) were to spend £11m below the agency cap and across the system to be 2.8% of the total pay bill).
- Bank staff spend is over plan by (£20.6m) and forecast to be over plan by (£26.9m) by the end of the year.
- Spend to date against the system capital envelope is £51.4m.
- ERF estimated performance year-to-date across the system is 121% against a 120% year-to-date plan.

Total ICS Provider Workforce - All Metrics

Total Workforce WTE
34,507.1

Substantive WTE
32,120.3

Bank WTE
1,980.8

Agency WTE
405.9

Total Workforce WTE
Variance to Plan
760.2
Variance %
2.3%

Bank WTE
Variance to Plan
7.7
Variance %
0.4%

Sickness/Absence
Sickness/Absence %
6.1%
Sickness/Absence Target %
5.3%

Mandatory Training
Man Training %
87.7%
Monthly Trend
0.8%

Substantive WTE
Variance to Plan
842.7
Variance %
2.7%

Agency WTE
Variance to Plan
-90.3
Variance %
-18.2%

Turnover
Turnover %
10.2%
Turnover Target %
10.8%

Staff Appraisal
Staff Appraisal %
83.5%
Monthly Trend
0.0%

Data Source - Provider Workforce Returns and KPI returns

NHS
Nottingham and Nottinghamshire

Quality Integrated Performance Report

January 2025 and Quarter 3 2024/25

National Oversight Framework (NOF)

01 - NOF 4 Nottingham University Hospital NHS Trust

02 - NOF 4 Nottinghamshire Healthcare NHS Foundation Trust

Enhanced Oversight

03 - Nottingham CityCare

04 - Learning Disability & Autism

05 - Maternity

06 - Special Educational Needs and Disabilities

07 - Looked After Children

08 - Children & Young People

Routine Oversight

09 - NOF 2 Sherwood Forest Hospital NHS Foundation Trust

10 - Infection Prevention & Control

11 - Patient Safety

12 - Universal Personalised Care

13 - Co-Production

14 - Adult & Children Safeguarding

15 - Vaccinations

16 - Care Homes and Home Care

17 - Medicine Optimisation

18 - Personal Health Budgets

19 - Continuing Healthcare

20 - Patient Experience

People Capacity/Availability

NHS
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

	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 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

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 Q1 2025/26 due to financial concerns and the need to assure regulators that quality improvements made can be sustained in the light of these challenges. CQC overall 'Requires Improvement' with 'inadequate' rating for 'well led' (reported September 2021) and 'requires improvement for Maternity services in September 2023.

Current Position

- Operational pressures in the Emergency Department (ED) remain 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. A 45-minute deadline for ambulance handovers was introduced on 12th December, and whilst this has released ambulances to the community the department remains pressured. Staff are submitting significant numbers of incident reports relating to receiving patients without handover and to moral injury.
- Improvement work in the ED continues, with the new UTC waiting area and streaming process embedded. Staffing has been increased in the waiting area and on the corridor. The Royal College of Nursing have visited and are supporting with staff wellbeing and health & safety. A continuous flow model showed early promise, but progress has been challenged by the increase in winter admissions.
- Quality Governance structures are under review to strengthen Executive oversight and assurance following the arrival of the new Medical Director. Structural changes to the organisation are planned for 2025/26 including merging the six divisions into four care groups.
- Whilst engagement is positive and improvements evident, significant support systems are still required with ICB, NHS England and CQC partners as active participants.
- IOAG continues to monitor progress against improvement plans and the NOF 4 exit criteria, it should be noted were the Trust to move into NOF 3, enhanced oversight from the IC would continue.

Actions Being Taken & Next Steps

- ICB Quality colleagues continue to meet in person with Deputy Chief Nurse for Operations with a focus on ED pressures, handover delays and boarding on the wards.
- The ICB Quality team continue to meet regularly with ED governance leads and are undertaking regular visits to ED through winter with a focus on improvement work. We will also make a visit in February focused on patient experience. Insight visits to other parts of the UEC pathway are also taking place.
- The development of the system quality dashboard will support the introduction of the quality metrics into the UEC pathway. A set of UEC metrics to support work by the UEC Board and System Quality Group is being finalised.
- IOAG is undertaking a Maternity stocktake in February followed by a Well Led stocktake to assess progress against the NOF 4 exit criteria.
- CQC Maternity inspection report expected (visit in June 2024) to be published in March.

Risks & Escalations

- **(Risk 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.
- **(Risk ORR023)** If Nottingham University Hospitals 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.

Content Author: Rebecca Gorringe | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

02. Nottinghamshire Healthcare Foundation Trust (NHCFT)

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

Nottinghamshire Healthcare Foundation Trust (NHCFT)

National Oversight Framework 4 - February 2024

Rationale for oversight level: Quality, Safety and Financial concerns requiring intensive support. Regional Recovery Support team (MHSIT) supporting improvements. NHFT has been in NOF 4 for 12 months.

Current Position

- **Care Quality Commission –** has undertaken 1 assessment in January 2025 to Adult Mental Health (AMH) in patient areas. High level feedback was mixed. The Trust are awaiting the final published report.
- **Regulation 28 - Preventing Future Deaths Reports.** 0 new PFDs issued in January despite several high-risk PFD inquests scheduled (two have been pushed back), the Trust has been able to provide robust assurance to the coroner to prevent PFD issue.
- **Integrated Improvement Oversight Assurance Group (IOAG) –** The IOAG met in January 2025. The Trust is still awaiting the outcome of the Rampton re-licensing process. The independent homicide review into the case of VC is expected on the 5th of February. Actions 'off track' aligned to the section 48 review recommendations include 4- and 24-hour access to crisis services and calls answered into the crisis line. Progress against transition criteria out of NOF segment 4 were discussed. Five of the seven metrics are on track with more work to do in two of the metrics (Financial performance and leadership and governance).
- **Independent Homicide Review** – The independent homicide review VC was published on 5th of February. There are actions for NHSE, NHCFT and the ICB. A joint action plan has been developed to respond to the areas identified as needing to be improved.
- **Safe Now** – Please see next slide with Safe Now Metrics at end of January 2024. There has been ongoing and sustained improvement in the community services risk assessment compliance. A bespoke digital dashboard has been created to enable a daily review of assertive and intensive treatment pathway clinical cases. A new process has been developed to consider complexity, risk and woder needs of those waiting for assessment and treatment.
- **Crisis Services –** sub-contracted staff are in the final stages of training and will be in place mid-February to support the ongoing improvements required in crisis services.
- **Lings Bar Hospital** – Letter of concerns received from NHSe through the Freedom to Speak Up process. Issues relate to Patient Safety Concerns, Ward Culture and Processes, Raising Concerns and Training.

Actions Being Taken & Next Steps

- Monthly CQC Oversight meeting in place to review progress against CQC 'Must do' actions.
- Weekly CQC enquiries oversight tracker list
- Weekly oversight of coronial cases through the Serious Incident Review Group (SIRG), with internal ICB escalation as appropriate.
- A newly established Evidence and Assurance group, chaired by Northamptonshire Healthcare NHS Foundation Trusts' Improvement Director, met on the 1st of October, the group oversees evidence submitted by the IIP programme SRO's to demonstrate delivery.
- Transition criteria aligned to IIP programmes has been proposed with a focus on 7 key areas.
- Liaison and collaboration with NHCT to answer concerns re: Lings Bar.
- Quality Visit to review in person Lings Bar
- Weekly operational safe now oversight meeting, exceptions and escalation reporting. Monthly safe now steering group. Monthly safe now safety huddle. This is being reviewed and a monthly quality oversight meeting being considered which will also incorporate oversight of actions from the IHR.

Risks & Escalations (Risk ORR191)

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. Last reviewed in October 2024. Risk rating remains 20. Close oversight through the 'safe now' and IOAG process continues.

Rushcliffe Arena, 09:00-13/03/25

02. Nottinghamshire Healthcare Foundation Trust (NHCFT)

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

Nottinghamshire Healthcare Foundation Trust (NHCFT)

		Inpatient Care								
▸	1.1	Number of patients waiting for a bed	5		9	12	records	sunday snapshot	Sunday snapshot (2025-01-26)	11.8
▸	1.2	Number of Patients in a 136 Suite Step Up for over 24 Hours	0%	7	5 (71.4%)	5 (50%)	records	weekly	W/C 2025-01-20	64.0
▸	1.3	Number of admissions from community who waited less than 12 hours	100%	35	30 (85.7%)	36 (92.3%)	records	weekly	W/C 2025-01-20	82.8
▸	1.4	Number of readmissions within 28 days	0		1	1	records	weekly	W/C 2025-01-20	0.9
▸	1.5	Wards with staffing under 85%	0%	91	3 (3.3%)	0 (0%)		weekly	W/C 2025-01-20	4.4
▸	1.6	Wards with staffing over 125%	40%	91	33 (36.3%)	27 (29.7%)		weekly	W/C 2025-01-20	33.9
▸	1.7	NEW: Proportion of admitted patients that have an allocated nurse recorded.	100%	223	218 (97.8%)	219 (98.6%)	records	weekly	W/C 2025-01-20	86.9
▸	1.8	UNDER REVIEW: Proportion of admitted patients with a risk assessment completed within 24hours of admission.	100%	31	20 (64.5%)	22 (71%)	records	weekly	W/C 2025-01-20	61.1
▸	1.9	New: Patients being read their rights under Section 132 of the MHA	100%	156	144 (92.3%)	141 (91.6%)	records	weekly	W/C 2025-01-20	85.9
▸	1.10	Compliance with physical health assessment on admission process	100%	31	23 (74.2%)	25 (64.1%)		weekly	W/C 2025-01-20	70.0
▸	1.11	Compliance with NEWS2 escalation policy	100%	39	37 (94.9%)	34 (91.9%)		weekly	W/C 2025-01-20	93.2
▸	1.14	Number and proportion of NottsHC patients requiring enhanced observations (1:1 or greater)	8%	223	14 (6.3%)	15 (6.8%)		sunday snapshot	Sunday snapshot (2025-01-26)	6.9
▸	1.15	Number and proportion of observations where no issues were found.	100%	3	3 (100%)	15 (100%)		weekly	W/C 2025-01-20	98.9
▸	1.16	IR1s submitted on on problem CCTV	100%	0	0 (-)*	0 (-)*		weekly	W/C 2025-01-20	70.0
▸	1.17	Patient risk assessments up to date (%)	100%	223	221 (99.1%)	219 (99.1%)	records	weekly	W/C 2025-01-20	98.6
▸	1.18	Number of patients secluded (note: week lag)	4		0	0	records	weekly	W/C 2025-01-13	1.8
▸	1.19	Episodes of seclusion (note: week lag)	4		0	0	records	weekly	W/C 2025-01-13	2.2
▸	1.20	Compliance with the Trust Seclusion Policy		0	0 (-)*	1 (50%)	records	weekly	W/C 2025-01-13	22.6

Content Author: Donna Nussey | **Exec Lead: Rosa Waddingham** | **System Oversight: System Quality Group** | **ICB Committee: Quality & People Committee**

02. Nottinghamshire Healthcare Foundation Trust (NHCFT)

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

Nottinghamshire Healthcare Foundation Trust (NHCFT)

▸	1.21	Number of patients prone restrained for anything other than intramuscular tranquilisation (note: week lag)	0		1	0	records	weekly	W/C 2025-01-13	1.1
▸	1.22	Number of patients prone restrained for more than 10 mins (note: week lag)	0		1	0	records	weekly	W/C 2025-01-13	0.3
▸	1.23	Episodes of rapid tranquilisation (note: week lag)	8		6	2	records	weekly	W/C 2025-01-13	7.3
▸	1.24	Compliance with Rapid Tranquilisation Code of Practice	100%	3	2 (66.7%)	0 (0%)	records	weekly	W/C 2025-01-13	23.9
▸	1.25	Number of incidents where patients went AWOL and come to harm (note: week lag)	0		12	9	records	rolling 4 weeks	2024-12-23 - 2025-01-19	9.6
▸	1.27	Number of total incidents of moderate harm and above (note: week lag)	0		11	13	records	rolling 4 weeks	2024-12-23 - 2025-01-19	11.8
▸	1.28	New: Of IR2s completed how many were done so within the specified amount of time (note: week lag)	100%	272	175 (64.3%)	184 (85.6%)	records	weekly	W/C 2025-01-13	75.8
▸	1.29	Number of patients clinically ready for discharge	25		47	47		sunday snapshot	Sunday snapshot (2025-01-26)	42.6
▸	1.30	Quality of Discharge	100%	27	0 (0%)	0 (0%)		weekly	W/C 2025-01-20	0.0
▸	1.30a	NEW: Proportion of Quality of Discharge criteria met	100%	243	133 (54.7%)	126 (53.8%)		weekly	W/C 2025-01-20	50.6
▸	1.31	Deaths within 30days post discharge	0		1	0		rolling 30 days	2024-12-28 - 2025-01-26	0.9
▸	1.33	Proportion of feedback containing fairly or highly critical comments (Inpatient, note: updated monthly)		9	2 (22.2%)	2 (12.5%)	records	monthly	Dec-24	31.5

02. Nottinghamshire Healthcare Foundation Trust (NHCFT)

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

Nottinghamshire Healthcare Foundation Trust (NHCFT)

		Community Services Metrics (Local Mental Health Teams - LMHT, EIP & MHSOP CMHT)								
▸	2.1	Compliance with 72 Hour follow up standard	80%	26	24 (92.3%)	27 (81.8%)	records	weekly	W/C 2025-01-20	85.8
▸	2.2	Compliance with 18 weeks wait standard for assessment	95%	2004	1873 (93.5%)	1851 (93.3%)	records	weekly	W/C 2025-01-20	93.4
▸	2.3	Compliance with Waiting Well Policy for 1st and 2nd Appointments (MHSOP)	95%	42	28 (66.7%)	32 (78%)	records	weekly	W/C 2025-01-20	58.1
▸	2.3a	Attempted compliance with Waiting Well Policy for 1st and 2nd Appointments (MHSOP)	95%	42	30 (71.4%)	33 (80.5%)	records	weekly	W/C 2025-01-20	59.3
▸	2.4	Compliance with Waiting Well Policy for CCO Waits (NEW DEFINITION 20/1/25 - AMH)	95%	157	69 (43.9%)	74 (41.3%)	records	weekly	W/C 2025-01-20	41.2
▸	2.4a	Attempted compliance with Waiting Well Policy for CCO Waits (NEW DEFINITION 20/1/25 - AMH)	95%	157	78 (49.7%)	87 (48.6%)	records	weekly	W/C 2025-01-20	48.0
▸	2.5	Patients accessing Urgent & Emergency Mental Health Care whilst awaiting Assessment			12	8	records	weekly	W/C 2025-01-20	6.0
▸	2.6	Compliance with 18 weeks wait standard for treatment	95%	61	52 (85.2%)	42 (80.8%)	records	weekly	W/C 2025-01-20	80.2
▸	2.7	UNDER REVIEW: Number of patients awaiting CCO allocation not on the active caseload of another NHT team	90		228	264	records	weekly	W/C 2025-01-20	271.1
▸	2.8	Safe Community Discharge (Placeholder)								
▸	2.9	NEW: Patients Discharged due to Disengagement	100%	37	9 (24.3%)	8 (26.7%)	records	weekly	W/C 2024-12-30	28.6
▸	2.10	UNDER REVIEW: Patients declined for service and died by suicide within 6 months (categorised under most recent team)			1	1	records	Rolling 26 weeks	2024-07-22 - 2025-01-26	0.3
▸	2.10a	Patients declined for service and needing Urgent & Emergency Mental Health Care within 6 weeks (developmental)			16	19	records	weekly	W/C 2025-01-20	14.1
▸	2.10b	Patients declined for service and re-referred back to the service within 6 months (developmental).			7	4	records	weekly	W/C 2025-01-20	4.2
▸	2.11	Patient risk assessments up to date (Community)	95%	9229	6976 (75.6%)	6975 (75.9%)	records	weekly	W/C 2025-01-20	72.9
▸	2.11a	CCO Patient risk assessments up to date (Community, developmental)	95%	4742	4477 (94.4%)	4479 (95.1%)	records	weekly	W/C 2025-01-20	88.8
▸	2.12	Number of total incidents of moderate harm and above (note: week lag)			10	14	records	rolling 4 weeks	2024-12-23 - 2025-01-19	17.7
▸	2.13	New: CTO Patients being read their rights under Section 132 of the MHA	100%	140	123 (87.9%)	126 (89.4%)	records	weekly	W/C 2025-01-20	70.7
▸	2.14	NEW: Of IR2s completed how many were done so within the specified amount of time (note: week lag)		31	21 (67.7%)	29 (82.9%)	records	weekly	W/C 2025-01-13	69.3
▸	2.15	Proportion of feedback containing fairly or highly critical comments (Community, note: updated monthly)		34	4 (11.8%)	4 (10.3%)	records	monthly	Dec-24	15.4
▸	2.16	Clinical Vacancy Rate in Community Teams	11%	475.07	32.15 (6.8%)	32.8 (6.9%)		monthly snapshot	Month End Snapshot (2024-12-31)	8.0

Content Author: Donna Nussey | **Exec Lead: Rosa Waddingham** | **System Oversight: System Quality Group** | **ICB Committee: Quality & People Committee**

02. Nottinghamshire Healthcare Foundation Trust (NHCFT)

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

Nottinghamshire Healthcare Foundation Trust (NHCFT)

		AMH & MHSOP - Crisis & Home Treatment Team Metrics								
	3.1	Patient risk assessments up to date	100%	459	437 (95.2%)	403 (91.6%)	records	weekly	W/C 2025-01-20	90.6
	3.2	Proportion of very urgent patients seen within 4 hours.	95%	10	9 (90%)	10 (83.3%)	records	weekly	W/C 2025-01-20	78.1
	3.3	Proportion of very urgent patients seen within 4 hours face to face	95%	10	9 (90%)	8 (66.7%)	records	weekly	W/C 2025-01-20	70.6
	3.4	Proportion of urgent patients seen within 24 hours.	80%	86	53 (61.6%)	51 (58%)	records	weekly	W/C 2025-01-20	62.3
	3.5	Proportion of urgent patients seen within 24 hours face to face	80%	86	42 (48.8%)	39 (44.3%)	records	weekly	W/C 2025-01-20	54.1
	3.6	Number of total incidents of moderate harm and above (note: week lag)			2	2	records	rolling 4 weeks	2024-12-23 - 2025-01-19	4.3
	3.7	NEW: Of IR2s completed how many were done so within the specified amount of time (note: week lag)		22	19 (86.4%)	20 (100%)	records	weekly	W/C 2025-01-13	79.6
	3.8	Proportion of feedback containing fairly or highly critical comments (Crisis, note: updated monthly)		7	0 (0%)	2 (40%)	records	monthly	Dec-24	10.0
	3.9	Clinical Vacancy Rate in Crisis Response Service	11%	212.28	31.22 (14.7%)	30.49 (14.4%)		monthly snapshot	Month End Snapshot (2024-12-31)	14.3

NHS Nottingham and Nottinghamshire

Enhanced Oversight

What does this mean? What is the assessment of risks relating to delivery / quality

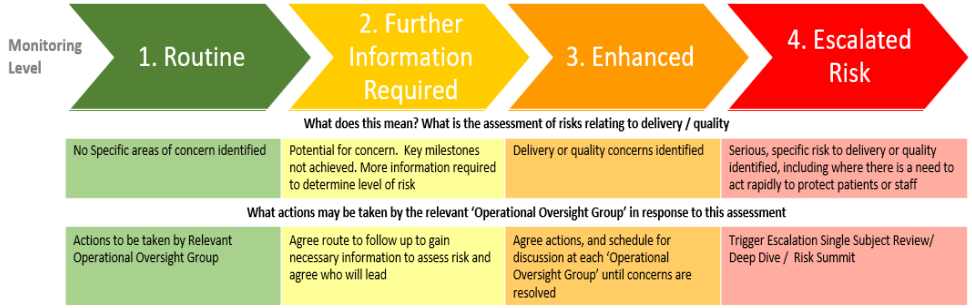
Delivery or quality concerns identified

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

- 03 - Nottingham CityCare
- 04 - Learning Disability & Autism
- 05 – Maternity
- 06 - Special Educational Needs and Disabilities
- 07 - Looked After Children
- 08 - Children & Young People



Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

03. Nottingham CityCare

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

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 - Assurance gained that CityCare Quality Team have oversight of PSI management. Due to prioritisation of high clinical demand challenges to complete PSI investigation continue in nursing teams with the highest number of PSI's. Teams are supported to focus on incidents with new learning as existing quality improvement plans are in place to address repeated themes.

1.2 **Quality insight** - ICB Quality Team continue to attend CityCare meetings to aid insight. Joint quality visit completed to Primary Care Network (PCN) 1 Community Nursing Team, challenges from high clinical demand evident.

2.0 Enhanced Risk:

2.1 Harm free care/Patient Safety – Challenge of high activity at UTC continues impacting achievement of 4-hour target, patient experience, and staff wellbeing. Increase in PSI's relating to difficulty accessing interpreters from the new provider. Working with provider to seek solution.

2.2 Risk Management – Risk register detailing risks managed by Quality Committee (QC) presented to Jan 2025 QC. Interim Governance Lead supporting work to improve presentation of risks cited in the organisations Board of Assurance Framework (BAF) and promoting confirm and challenge of these at relevant meetings.

2.3 Performance - High demand, vacancies and sickness within small teams impacting performance. Successful recruitment of Senior Dietician will help reduce staffing pressures in the paediatric dietetic service.

2.4 Workforce – Reduced agency use is in Community Nursing and ICHS teams but still above target. Papers presented to People and Inclusion Committee provide assurance around how feedback from staff informs improvement work.

2.5 Culture and Leadership - Work continues to embed learning from Cultural Reviews.

2.6 Governance and Oversight - 360 Assurance have completed an audit of Quality Governance processes, await full report. Interim Governance Lead continues to support standardise meetings to ensure governance is aligned.

3.0 Caseload Capping

Awaiting updated Joint Action Plan following advice to update RAG rating and target dates, and to ensure challenges are included along with progress. CityCare cite that caseload capping is no longer taking place.

It is recognised that the position above demonstrates considerable progress over the last year.

Actions Being Taken & Next Steps

- Monthly Quality Review Group (QRG) meetings continue. Feedback has been provided from the ICB regarding the enhanced level of quality surveillance. CityCare's Improvement Plan continues to be reviewed as part of these discussions.
- CityCare to ensure Improvement Work is celebrated and shared externally.
- Organising dates for Quality visits with CityCare to PCN 7 Community Nursing Team, and Diabetes Team.
- Await invite to Care Group Two PSRIF Oversight meeting

.

- City Care and the ICB will present at the system quality group a stocktake of progress to determine if enhanced surveillance remains appropriate

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)**.

Content Author: Rebecca Gorringe | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

04. Learning Disability & Autism

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

Learning Disability and Autism (LDA)

System Quality Group Oversight – Enhanced

Rationale for oversight level: Focus remains on adult inpatient performance with quarterly NHS England system performance meetings in place.

Current Position

Adult Inpatients Overall Performance: The total number of admissions from the community since 1st of April 2024 to 31st of January 2025 is 17. It should be noted that in our forecast at the beginning of the year we stated we would not have more than 7 community admissions this financial year. A detailed analysis of the admissions will be undertaken in quarter one to understand the reason for the admissions.
In total 21 adults have been discharged between the 1st of April to 31st of January 2025 which is good progress. We continue to have high levels of patients who have passed the recommended clinical pathway (28 out of a total of 39 inpatients fall within this category). Our position has continued to deteriorate this financial year, and we have increased our 5 year+ inpatient population by 2 since the 1st of April 2024. Without progress in discharging people who have been an inpatient 5 year + we will continue to struggle in meeting the target set by NHSE. The focus of the Oversight Panels has now shifted to reviewing all patients who are 5 year+ with the intention that this will support discharges into the community. In addition, the Local Authority LDA Commissioner in the City has put in an capital investment bid to develop to bespoke provision within the community to facilitate discharge of two individuals who fall within the 5 year+ category. The system is awaiting to see the outcome of this bid.
Concerted efforts remain across the System to improve the discharge performance particularly within the Orion Unit as well as supporting community services with admission avoidance. This month the system has seen two patients admitted to ICB commissioned beds and one planned discharge to the community. Lack of discharges compared to the previous couple of months has meant that the adult inpatient number has risen from 38 to 39. The ATU is on a block contract for 8 beds with NNICB and the expectation is that they don't admit patients from out of area. Modelling was undertaken in 2016/17 to reduce the unit from 16 to 8 beds which was generally successful, and admission levels have reduced since that time in line with the national LD/ASD transformation programme. The unit does have capacity to open a 9th bed in terms of physical space and can book additional staff to cover this, but this is generally seen as an exceptional situation, and agreement is sought from the ICB as funding ICB on a cost per case basis.

Learning disability Annual Health Checks: As of 30th January 2025, there have been 4,255 heath checks completed putting performance against this year's denominator set by NHSE at the start of the year (based on the 2022/23 all age QOF GP LD Register) at 61% and 60% against the GP LD register on E-healthscope (14 years and over). Start of Q4 performance is 2% above the target trajectory agreed with NHSE (59%). 94% of AHCs are recorded to have a Health Action Plan (HAP) in place, with 146 people recorded to have declined a HAP which equates to a decline rate of 2.0% against the total LD register on E-Healthscope. 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.

Adult Autism and ADHD Waiting Times: The waiting time for a first autism assessment appointment has increased to 111.20 weeks in December 24, with the longest wait reducing from 201 weeks to 184 weeks. The waiting time for a first ADHD assessment appointment has also increased to 61.15 weeks in November 24, with the longest wait increasing from 258 weeks to 262 weeks.

Actions Being Taken & Next Steps

- All patients identified as lacking in progress (LOP) are being reviewed in the system wide mental health escalation meetings weekly with the system turnaround director to ensure the partnership continues to expedite discharges safely
- The partnership has developed several admission avoidance strategies including the adult and CYP Dynamic Support registers and forums, and a range of ICS wide measures to expedite discharges such as Care and Treatment Review (CTR) oversight panels and direct liaison calls with the secure provider collaborative (IMPACT)
- The Learning Disability & Autism (LDA) Board retains oversight of performance, quality and safety across the pathway.
- Quarterly performance meetings with NHS England regional colleagues continue and they have been supported with system escalation meetings.

Risks & Escalations

- Delays with neurodevelopmental assessments continue to impact on CYP and adults not receiving support . A new model of support for adults, informed by system engagement and feedback from people using assessment services, is being developed to improve access to assessments, as well as provide pre-assessment support.
- Continued failure to discharge patients that are medically fit either due to a lack of community placements or lack of clear clinical pathway is impacting on the system achieving target set by NHSE.
- Conversations are ongoing with NHT regarding the contracted beds on Orion Unit and what the admission criteria and process should be and how this fits with the local wider model.

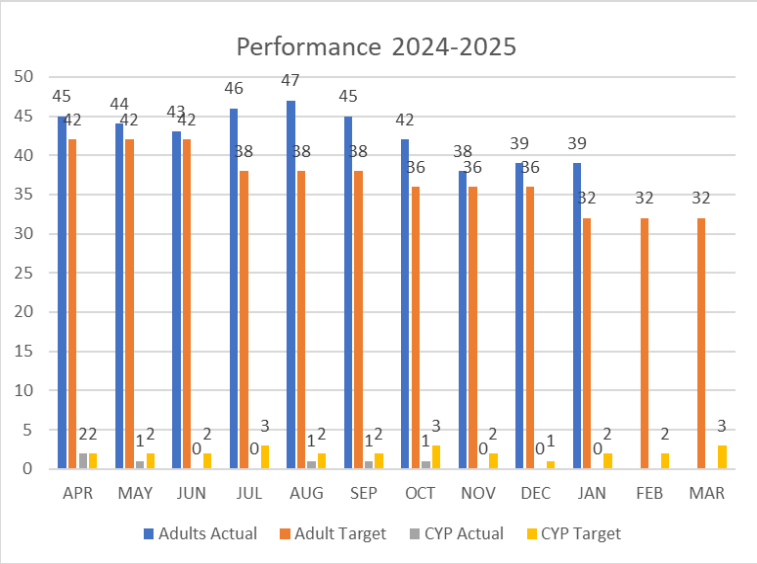
Content Author: Rhonda Christian | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

04. Learning Disability & Autism

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

Learning Disability and Autism (LD&A)



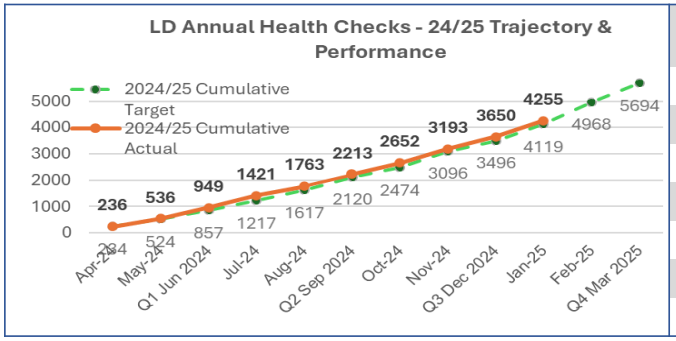
Learning Disability and Autism (LD&A) Inpatient

Data Cut-Off Date: 31/01/2025

Explanatory Note/Insight Analysis and Assurance:
Adult Inpatient Trajectories: Our current inpatient adult total number stands at **39** which is **7** above the trajectory set by NHSE. We have **28** individuals within secure setting which is 5 above our trajectory set by NHSE . We have **11** individuals within our non-secure settings which is 2 above trajectory set by NHSE.

Children & Young People Inpatient Trajectories: We currently have 0 CYP within an inpatient setting. In total we have discharged 5 CYP as of the end of January 2025. We have had 3 admissions since 1st of April 2024. We have improved our performance of admissions compared to previous financial year where we saw 14 admissions. It appears so far this year that we are on track in achieving our target of no more than 3 tier 4 CYP. As a system we continue to perform strongly in supporting CYP effectively within the community.

Learning Disability Annual Health Checks



Jan 25
4255
% NHSE denom.
61%
% EHS denom.
60%
SPC Variation
-

Data Cut-off Date: 30th January 2025:

Explanatory Note/Insight Analysis and Assurance: As of 30th January 2025, there have been 4,255 heath checks completed putting performance against this year's denominator set by NHSE at the start of the year (based on the 2022/23 all age QOF GP LD Register) at 61% and 60% against the GP LD register on E-healthscope (14 years and over). Start of Q4 performance is 2% above the target trajectory agreed with NHSE (59%). 94% of AHCs are recorded to have a Health Action Plan (HAP) in place, with 146 people recorded to have declined a HAP which equates to a decline rate of 2.0% against the total LD register on E-Healthscope. 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.

Rushcliffe Arena, 09:00-13/03/25

04. Learning Disability & Autism – Oliver McGowan Mandatory Training

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

Oliver McGowan Mandatory Training for Learning Disabilities and Autism (OMMT)

System Quality Group Oversight – Enhanced

Rationale for oversight level: An evaluation and options appraisal is being developed, based on the pilot that was run in the system (ending September 2024).

Current Position

Enabling infrastructure:

- The OMMT Steering Group includes representatives from all key partner organisations, including local authorities.
- The LDA Board has provided oversight to the pilot. Formal oversight of the programme moved to the People and Culture Steering Group in October 2024, in preparation for scaling up and moving to BAU.

Developing infrastructure and sufficient trainer capacity by 2024/25:

- Provider organisations are focussing on OMMT e-learning completion.
- Our co-trainer numbers are growing steadily and the next priority is to recruit facilitator trainers to further grow delivery capacity.
- Summary of completer figures:

Delivered in period		NHS T1	NHS T2	NHS Total	NHS Cumulative	Other T1	Other T2	Other Total	Other Cumulative
2023/24	Q3	39		39	39	11		11	11
	Q4	143		143	182	26		26	37
2024/25	Q1	173		173	355	5		5	42
	Q2	344	372	716	1071	22	6	28	70
	Oct	174	366	540	1611	3	19	22	92
	Nov	127	377	504	2115	4	4	8	100
	Dec	93	333	426	2541	2	0	2	102
% of NHS workforce (41,936)					6%				

- Nationally, the Midlands region is the second highest performing region with regards Oliver McGowan Training figures, with planned training intended to reach 22% of the eligible NHS workforce by the end of March 2025. Nottingham and Nottinghamshire's planned figures are planned to increase to 13%. This ranks us just at the mid-point nationally (lowest performing region is at 2% and highest is 33% (which is also the region that supported the development of the Oliver McGowan training nationally).

Actions Being Taken & Next Steps

- We have a hybrid model of delivery, with external Tier 1 and Tier 2 sessions being bought in as we continue to develop our own training infrastructure. Uptake by some providers is good but not all organisations are in a position to book staff on to the part 2 training and therefore become CQC-compliant.
- The focus is on delivering training to all health staff. During the pilot, at least 20% of sessions were made available to social care staff (as agreed with NHSE). BAU roll-out and how all staff are trained will need to be agreed through an options appraisal process.

Risks & Escalations

- In addition to the risks and escalations raised previously, there is further uncertainty over future funding for this programme and no timeline for a funding decision. This will need to be captured in the options appraisal for system partners and it is likely that decision about making the programme BAU will need to be made without this information. Funding received to date is for the NHS workforce, but the ICS is adopting a system approach. Lack of social care funding and future plans places social care roll out at risk.
- KPIs were not met for 2023/24. 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).
- NHSE have escalated the risk around Oliver McGowan Training nationally. Monthly reporting was brought in at short notice in October and is being called the Oliver McGowan Recovery Plan. While current figures are not meeting KPIs, training figures are increasing steadily. Nottingham and Nottinghamshire ICS started the programme later than other areas and our approach has been more conservative. We have safeguarded funding, and plans are in place to increase capacity further into 2025/26. It is important that all possible training spaces are utilised and this depends on appropriate staff communications and staff being released to attend training.
- NHS Trusts are at varying states of readiness to engage with the part 2 training being offered. This means that exact numbers of staff needing Tier 1 and Tier 2 training are still being determined and there is varying uptake of part 2 interactive training.
- The OMMT Code of Practice has not been published. Developing an informed ICS options appraisal will be limited while these details are not fully understood.
- There are concerns from primary care about time needed for staff to undertake the training and effects on service delivery during this time.
- Further infrastructure needs to be developed to recruit facilitator trainers. Venues for Tier 2 training will be needed on an ongoing basis to ensure training sustainability.

05. Maternity

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

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	80%
Element 2	Fetal growth restriction	Partially Implemented	90%	Partially Implemented	95%
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	96%	Partially Implemented	96%
Element 6	Diabetes	Partially Implemented	83%	Partially Implemented	83%
All elements	TOTAL	Partially Implemented	84%	Partially Implemented	91%

A review of evidence was undertaken at both SFHFT and NUHT in Nov/Dec 2024. Both have seen an improvement in compliance levels and are declaring compliance with Safety Action 6 of the NHSR Maternity Incentive Scheme (MIS) requirements.

NUHT are expecting a further improvement in compliance with element 1 at the next review following an intensive programme of training to ensure compliance with CO monitor training and the delivery of very brief advice.

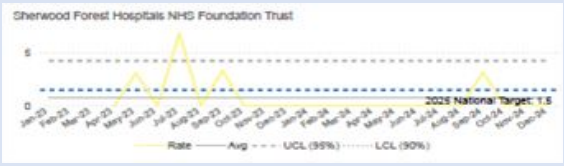
SFH are reporting challenges with USS capacity to provide an USS the next working day following reports of reduced foetal movements.

A further review of evidence is due February/March

LMNS Quality & Outcomes Dashboard – January 2024 (December data).

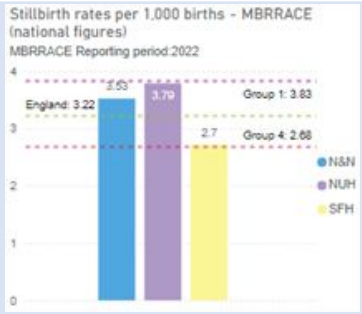
- There were no **stillbirths** reported at SFHFT in December 2024. When comparing with respective peers, SFHFT rate is 2.7 per 1000 births, compared with G4 average of 2.68.

- There were no **neonatal deaths** reported at SFHFT in December 2024, When comparing with G4 peers, SFHFT are marginally higher (1.1 vs 1.05 per 1000 live births).



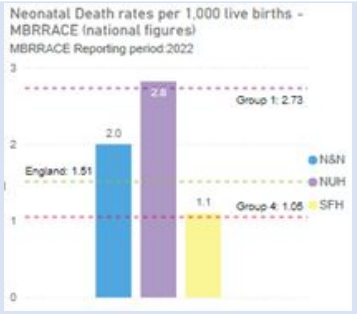
- There were two **stillbirths** at NUHT in December 2024, when comparing with their respective peers, NUHT are marginally better than the G1 comparator average (3.79 vs 3.83 per 1000 live births).

- There was one **neonatal death** reported at NUHT in December 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



05. Maternity

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

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

LMNS Activity

- The LMNS have relaunched the health inequalities working group with system partners and are planning to update the strategy and undertake a maturity matrix in the coming months.
- Evaluation and impact of the Petals Bereavement service was presented at Transformation Board by Bereavement & Petals Leads. The Board were in full support of continuation of service. A report has been written for Commissioning Review Group to request £15k for a 3-month extension of the Petals Service whilst a sustainable funding source is sought for continuation of the service. An EQIA to support this has also been drafted and sent to the Quality Team for review.
- Perinatal Pelvic Health Services Business as Usual by April 2025 on track. NHSE have advised recurrent funding will be added to the ICB baseline for 2024/25.
- CardMedic Pilot extended to end of March 2025. Agreement in principle to fund for a 2nd Year via Transformation Programme. .
- The MNVP continue to attend various meetings with the Trusts, including PIOAG (NUH); PAC (SFH); Safety Champions (both); BFI Leadership (SFH); MNR (NUH) and the Neonatal Steering Group (ICB).
- MNVP and LMNS representative attended the official opening of the new NICU at QMC.

Perinatal Quality Surveillance workstream

- NHSR Maternity Incentive Scheme evidence review is in progress, an extraordinary board meeting has been planned for February to sign off all safety actions at ICB level. NUH are aiming to declare compliance with 9/10 safety actions. SFHFT are on track to meet all safety actions,
- An LMNS insight visit took place at both NUHT sites on 28th and 29th January. Both NHSE's Maternity Independent Advisors and Midlands Perinatal Team were in attendance. Overall, the visit was positive with staff feeling proud to work at NUH and recognising the improvements over the past few years. A formal report is being prepared0
- A stocktake is to be completed looking all recommendations received by NUHT and whether improvements have been made and sustained. This will be completed by February 2025.
- Formal and informal LMNS quality visits planning meeting took place on 22 January 2025. Agreement for LMNS quality visits to take place 6 monthly at both Trusts and ad hoc as required

Actions Being Taken & Next Steps

- The LMNS Executive Partnership Board terms of reference have now been finalised. The meeting will now be called LMNS Perinatal Scrutiny and Oversight Board (PSOB).
- Future Insight visits to be planned and KLOEs agreed.
- Phase two of the LMNS Quality and Outcomes dashboard to be completed before moving to phase 3.
- CardeMedic - Paper to CRG in February for approval from April 1st, 2025
- Project planning paused for Pregnancy & Beyond Link Workers Pilot (formerly Social Prescribing Pilot) - delayed operational planning guidance to inform next steps.

Risks & Escalations

- ORR208. 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.
- ORR120. Due to issues with understanding data requirements, system interoperability and data sharing there is a risk the system may not be able to tangibly measure its impact and demonstrate results, value and performance. This may adversely impact decision-making and result in resources being used ineffectively.

Rushcliffe Arena, 09:00-13/03/25

06. Special Educational Needs and Disabilities

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

Special Educational Needs & Disabilities (SEND)

System Quality Group Oversight – Enhanced

Rationale for oversight level: As a result of various factors including capacity and demand pressures, there is a risk the needs of children and young people with Special Educational Needs and Disabilities (SEND) may not be met effectively. This may lead to unmet needs resulting in poorer educational, health and care outcomes alongside the widening of health inequalities and dissatisfaction among children and young people and their families. This may also undermine the system's ability to deliver all partners statutory SEND responsibilities.

Current Position

- SEND inspectorate Annual Engagement Meeting (AEM) for both Nottingham and Nottinghamshire SEND local area partnerships have concluded. AEM do not provide formal judgements, but notes have been issued, and inspectorates will utilise for their continued evaluation. .
- Nottinghamshire County Stock take. Took place on 20th of January Regional SEND leads from DfE and NHSE advise there would be no further formal monitoring through these routes. The planned Deep Dive in March will remain in situ and support preparation and learning for future inspection. Formal feedback remains to be received
- Nottingham and Nottinghamshire SEND strategic leads have agreed a system approach to management and monitoring of risk – the above rationale for oversight articulates the risk placed on the ICS risk register and partners are reviewing the actions being undertaken to mitigate the risk. To ensure a shared ownership and monitoring.
- The fixed term SEND Improvement Project Manager post comes to an end in February 2025 as planned and the CYP Commissioning Team have restructured, bringing colleagues working on CYP learning disability and autism into the CYP Commissioning team and realigning portfolios across the team. This is anticipated to ensure there remains the appropriate capacity to deliver on SEND Improvement work and day-to-day commissioning for this cohort, whilst also supporting closer working across workstreams and effective management of interdependencies going forward.
- **Tribunals 'Extended Appeals**' raised against the ICB; **24 OPEN**

Actions Being Taken & Next Steps

- Shortlisting ADCO candidates with interviews planned for the 11th of February 2025
- Continued, significant activity around co-producing Nottingham City SEF. Final Draft version being taken to Nottingham City SEND PAIG on the 13th of February for approval and then to SEND Executive leadership for sign off for publication.
- Preparation for Nottinghamshire County Deep Dive on 24th March 2025- focus groups with practitioners being arranged.
- Nottingham and Nottinghamshire local area are planning events for review of quality assurance and audit arrangements for EHC plans on the 4th February to respond to the risk raised as part or PAP outcome 1 &2 for Nottinghamshire. A system approach being facilitated with Nottingham city partners, aim to refresh the QA EHCP framework and strengthen governance arrangements around this across the systems workforce

Risks & Escalations

- No new risks to highlight

07. Looked After Children

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

Looked After Children (LAC)

System Quality Group Oversight – Enhanced

Rationale for oversight level: IHA and RHA statutory timeframes remain in the ICB risk register. System working continues to improve IHA pathways and compliance, as expected there has been an increase in waiting times at NUH for IHAs as the Locum Paediatrician left the service, **Quarter 3 data will not be available until February 2025.**

Current Position

IHA summary Q1 and Q2 2024-25

	DBTH	DBTH	SFHT	SFHT	NUH	NUH
	Q1	Q2	Q1	Q2	Q1	Q2
Total IHA referral received	14	25	47	60	94	90
IHA referral received from local authority within 5 days	3	13	13	12	10	14
IHA completed and sent within 20 days of correct consent *(excluding exemptions*	36% 7	28 % 4	47% 18	23% 14	13.1% 14 (12.2% for city and 9% for county)	20% 18 14% city 16.4 % county
waited times *(IHA completed) In weeks*	2-3	2-3	2-3	3-4	2-3	4-5

RHA summary Quarter 1 and Quarter 2 2024-25 (Provider information only)

	County	County	City	City
	Q1	Q2	Q1	Q2
RHA referrals.	124	200	37	131
NHT sent completed RHA within timescale (excluding exemptions)	94/115 = 81.7%	85/169 =50.3%	25/32 = 78%	27/101 =26.7%
NHT sent completed RHA within timescale (including exemptions)	94/124 =75.8%	85/200 = 42.5%	25/37 = 67.6%	27/131 =20.6%
Waiting times	12 weeks	16-20 weeks	12 weeks	16-20 weeks

Actions Being Taken & Next Steps

Review Health Assessments

- Quality Assurance visit booked for February 10th at NHCT to review impact of RHA remedial action plan and how safeguarding needs of children in care are managed

Initial Health Assessments

- Triangulation data meetings with the local authorities in place. Deep dive into Q2 has identified barriers to referral acceptance and potential data inputting discrepancies.
- NUH have stated that they do not require a Locum Pediatrician due to recruitment and job planning.
- NUH management developing a transformation action plan to improve productivity.

Risks & Escalations

NUH and NHCT data is likely to have increased or not improved.

- CRG paper for increased nursing capacity to be shared in March 2025 (delayed due to additional information required for EQAI)
- Transformation Action Plan in progress for NUH to be shared with commissioners and reviewed by the end of Q4 2024/25.

08. Children and Young People

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

Children & Young People (CYP)

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 internal routes for CYP Governance to include all areas of CYP services, which risks significant gaps, potential duplication, unclear information sharing and decision-making routes. Current funding reviews may increase the risk for CYP.

Current Position

a) Paediatric Audiology Services in DBTH continue in serious incident response, overseen by NHSE. There is a national improvement programme now in place, requiring all recalls and harm reviews to be complete by 31st March 2025. Progress has been slow but recalls have now been offered appointments, which should be complete within the national timescale. The IT installation is complete but data migration will take 3-6 months to complete. Around 1200 CYP are awaiting triage and priority coding, which cannot be carried out by existing team members.

b) CYP continue to present to ED with complex behavioural, mental health and autism related needs where there is no clear route for provision or pathways for care. Escalation pathway being piloted across the system for 3 months. The demand on capacity and joint financial agreements for placements is impacting on the ICB.

c) Sickle Cell Carrier Notification in Mid Notts and Bassetlaw has been raised as an incident and has an incident management team in place. NUH have offered a proposal to support the pathway and funding has been agreed in the ICB.

Actions Being Taken & Next Steps

a) Meetings continue two weekly for CYP and adults separately to progress actions.

b) Cases continue to be escalated up to executive level as required or managed at operational level if appropriate. On average, one case per week.

c) Medical Director, AD for Health Protection and Head of Nursing for CYP are part of the Incident Management Team. Awaiting contract variation completion for NUH.

Risks & Escalations

- 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. Harm has been identified and there is now some progress against previously assured actions.
- Sickle cell carrier status notification process is now under NHSE scrutiny as an incident raised via LFPSE

NHS Nottingham and Nottinghamshire

Routine

What does this mean? What is the assessment of risks relating to delivery / quality

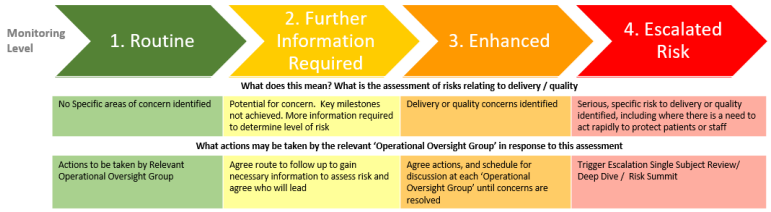
No Specific areas of concern identified

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

- 09 - NOF 2 Sherwood Forest Hospital NHS Foundation Trust
- 10 - Infection Prevention & Control
- 11 - Patient Safety
- 12 - Universal Personalised Care
- 13 - Co-Production
- 14 - Adult & Children Safeguarding
- 15 – Vaccinations



Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

09. Sherwood Forest Hospitals NHS Foundation Trust

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

Sherwood Forest Hospitals NHS Foundation Trust (SFHFT)

National Oversight Framework 2 - Routine

Rationale for oversight level: Ongoing engagement and oversight of the improvement activities underway. NNICB Quality Team maintain attendance at various committees and groups where confirm and challenge is welcomed. Increasing in person visits and presence from the NNICB Quality team planned on a six-weekly basis reflecting routine oversight.

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 protocol has continued to be enacted during this period with the addition of allowing wards to accept two additional patients to support decompression of the emergency department. Further work is underway to support the oversight and focus of quality of care and experience in line with the winter priorities from NHSE.
- An options paper has highlighted the requirement to increase the number of security in the emergency department due to an increase in violence, aggression and use of restrictive practices. This service is subcontracted by SFHFT and will be considered through contractual and financial routes.
- The ED improvement plans will continue to be divisionally led and monitored through the patient safety committee (PSC). The recent report highlighted no concerns to progress of the key workstreams.
- Compliance with enacting aspects of Deprivation of Liberty Safeguards and the Mental Capacity Act remain challenged. An internal action plan is in place which includes external input.
- Following a recent process change a second incident has been reported regarding patient identification within the mortuary process. This has been reviewed at the incident review group and an external incident review has been commissioned.
- HSMR+ and SHMI figures are as expected NNICB Quality Team continue to engage and support as required in the learning from deaths committee at SFHFT.

Actions Being Taken & Next Steps

- Further visits to Newark and Mansfield Community Hospital are planned over the next month. This aligns with the Trusts 15 step peer review and the ongoing informal insight visits.
- NNICB Quality team continue to work with SFHFT to develop our system approach to the NHSE mandated after-action reviews where required. This work will continue over the next quarter to gain themes and insight to guide improvement cycles a focus is required on ensuring data returns are received in a timely manner.
- Following up on previous visits has shown proactive involvement and engagement in the approach of quality insight visits considering continuous improvement approaches.
- A set of UEC metrics to support work by the UEC Board and System Quality Group is being finalised to be shared monthly with the ICB to support thematic improvements across the UEC pathways.
- Further NNICB Quality team involvement in SFHFT improvement groups with a focus on the deteriorating patient and sepsis groups has been discussed to support insight and assurance of continued improvement in this area across the Trust. This continues to be an area of focus and challenge.
- Continued presence at key meetings to support insights and support where required.

Risks & Escalations

- No additional risk or escalations in this period.

Rushcliffe Arena, 09:00-13/03/25

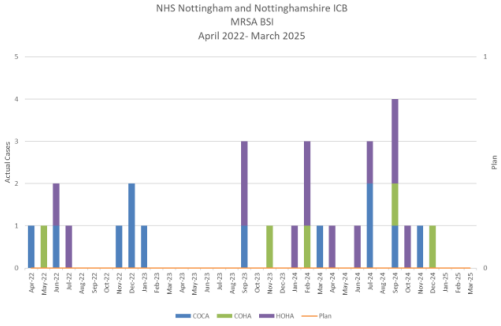
10. Infection Prevention & Control

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

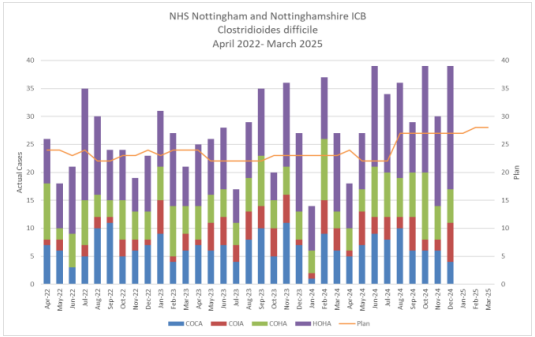
Infection Prevention and Control

HCAI Data 22-25 – MRSA Bloodstream Infections



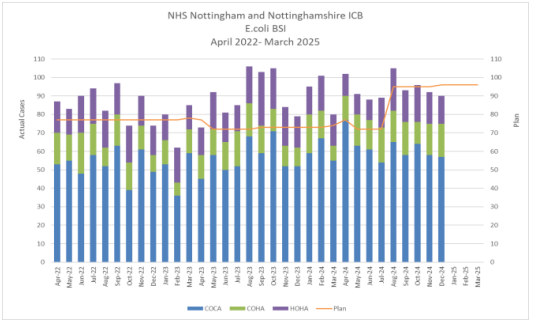
Data Cut-Off Date: 31/12/2024

HCAI Data 22-25 – C.difficile Infections



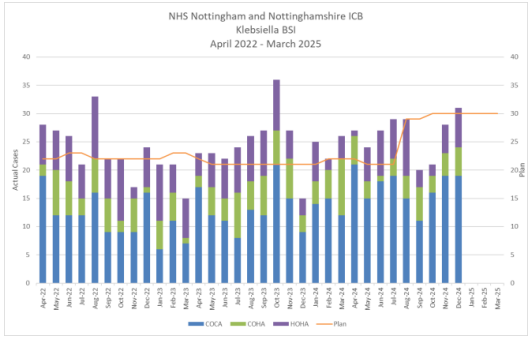
Data Cut-Off Date: 31/12/2024

HCAI Data 22-25 – E.coli Bloodstream Infections



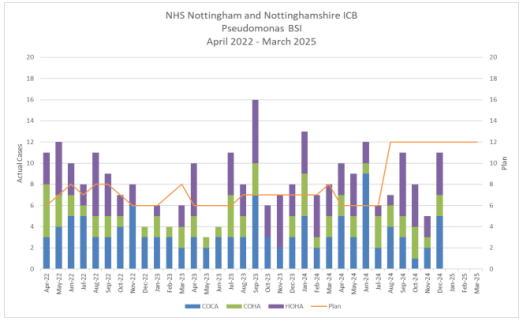
Data Cut-Off Date: 31/12/24

HCAI Data 22-25 – Klebsiella Bloodstream Infections



Data Cut-Off Date: 31/12//204

HCAI Data 22-25 – Pseudomonas Bloodstream Infections



Data Cut-Off Date: 31/12/2024

10. Infection Prevention & Control

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and

Infection Prevention and Control

System Quality Group Oversight – Routine

Rationale for oversight level: Healthcare Associated Infection (HCAI) thresholds remain challenging, The increase in HCAI nationally is reflected locally, Monitoring of rates in addition to cases continues, Cases are clinically reviewed to identify any learning and gain assurance on any key local issues. Increased patient acuity remains a factor and measures taken to improve patient flow in a constantly pressurised health and social care system are considered contributory to the increased risk of acquiring HCAI.

Current Position

- There was a further improvement against gram negative BSI month thresholds in December for E.coli/ Pseudomonas BSI. Despite improvement the ICB remains over year-end plan, achievement remains challenging.
- SFHT reported a community onset MRSA bloodstream infection (BSI) in December, this was later agreed to be contaminated sample rather than actual infection. Contaminated samples still count against SFHT and ICB trajectories. A further MRSA BSI contaminant occurred In January both samples were taken in ED.
- There was an increase in *C.difficile* infection over December with NUHT and SFHT breaching month plans driven by rising HOHA cases. NUHT have exceeded year-end threshold, it is anticipated that SFHT will exceed next month when January data is verified. System pressures continue to require patient boarding and corridor care as supporting measures in exceptional circumstances. Access to side rooms has been challenging at NUHT as the trust experienced high demand for isolation rooms due to Flu/Norovirus.
- Norovirus had reduced after peaking in December but is starting to impact again locally and regionally with wards closed at both SFHT and NUHT.
- NUHT have identified an outbreak of *Klebsiella pneumoniae* through routine screening *at* the NNU QMC campus, five babies have the same typing. Outbreak meetings in place. NHSE have implemented regional NNU IPC review group to look at screening across units.
- UKHSA are leading on contact screening and follow up for TB at HMP Lowdham Grange, further positive contacts identified.
- Confirmed seventh case CLADE 1bMpox linked to travel to Uganda is Nottingham resident. NUHT contact tracing.

***Due to UKHSA data lag HCAI exception reporting is for December**

- **MRSA BSI**, 1 COHA case reported. This case has since been reported as a contaminant by SFHT 1/0. ICB 12 cases against 0 threshold year to date.
- ***C.difficile***, ICB 39/27, NUHT 23/15, SFHT 9/6. ICB remains over year-to-date plan ICB 291/225
- ***E.coli BSI*** *ICB met month plan for second consecutive month. ICB remains over year-to date plan 846/769*
- ***Klebsiella BSI*** *ICB 31/30, NUHT 18/13*
- ***Pseudomonas* BSI** NUHT 8/6

Actions Being Taken & Next Steps

- Previous IPC reported actions continue, Providers have board assurance frameworks in place,
- SFHT are taking actions to further understand the contributory factors leading to a rise in contaminants linked to ED this includes training to improve blood culture taking.
- Risk logs continue to include the exceptional measures taken to improve flow. This remains an IPC area for concern as this impacts IPC and care quality. Boarding and corridor care must not become accepted practice.
- NHSE are gathering evidence on activity impacts on rising HCAI regionally/nationallly
- All cases of *C.difficile* are reviewed for learning, cases at NUHT with an identified lapse are logged on DATIX and actions are taken, SFHT are completing similar clinical reviews not all cases have identified learning. Both trusts as seeing more clusters of cases but typing shows these are not linked, they may indicate increased population carriage.
- Masks remain in use across admission areas, these are also reducing staff acquisition of norovirus during outbreaks.
- NUHT are implementing a range of measures in response to the *Klebsiella* outbreak including IPC audits, environmental samples, review of antimicrobial protocols and seeking external support from UKHSA. Improvements are needed in relation to shared equipment logs and the unit is looking to use BadgerNet in the future. NHSE are reviewing screening and detection across other NNU as this is unlikely to be an isolated NUHT finding.
- Some assurance re identifying further TB cases /contacts. UKHSA have mobile x-ray unit to complete further.
- The Health Protection Lead is working up mpox pathways that include NUHT as the regional vaccine hub. Vaccination of contacts is planned under direction of UKHSA.

Risks & Escalations

•IPC continued concerns re boarding of patients and use of corridor care to support flow particularly at NUHT as these increase the risk of HCAI acquisition.
•Norovirus is recirculating again regionally and locally leading to outbreaks on wards and in care homes, this affects flow
•Increase in blood culture contaminants taken in SFHT now have 3 cases against 0 trajectory.

Content Author: Sally Bird | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

11. Patient Safety

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

Patient Safety

System Quality Group Oversight – Routine

Rationale for oversight level:
- No strategic escalations for the patient safety programme at this time.
- Operational activities around system procedures to support transition are evolving.

Current Position

Patient Safety Specialists
ICB Patient Safety Specialists making good progress with the national Patient Safety Syllabus Levels 3 & 4 (essential to role). Completion of training anticipated by end December 2024.

PSIRF
The ICB Patient Safety Incident Response Policy (PSIRP) has been updated, and Version 2 is now published. An evaluation exercise has concluded and 360 Assurance audit is being finalised for the PSIRF implementation and associated activities will be completed in Q4 and into 25/26.
Additional context will be provided by the 360 Assurance audit. This is in progress with evidence bundle submitted and meeting scheduled to review findings. All system partners are currently undergoing 360 or similar audits of their PSIRF implementation with final reports anticipated in March 2025. In support of our quality framework, building improvement, a PSIRF 1 year on event has been planned to capture, what's worked well, what will be different in year 2 and provide opportunities to showcase any significant learning from patient safety events within the previous year. The event will socialise our systems' patient safety incident response profile and the aligned improvement activity response to our top 3 patient safety harms – Pressure Ulcers, Falls and Medicines management.

Patient Safety Partners
Interviews for the role are scheduled for early Q4. The system approach to retention and support of PSPs, is being developed in conjunction with support provided by Health Innovation East Midlands. Two patient safety partners have been selected.

Primary Care Patient Safety Strategy
A national 'early adopters' scheme is in place for PSIRF implementation in primary care – report updates via the Partner Quality Assurance and Improvement Group (PQAIG). The ICS implementation of the strategy will align with ongoing patient safety strategy development work across provider and primary care.

Actions Being Taken & Next Steps

- Work to align evaluation and 360 Assurance audit to support next stage in implementation work.
- Processes to establish Assurance arrangements for the ICS infrastructure for PSIRF is evolving.
- ICB Primary Care Patient Safety Strategy implementation with the system strategy is ongoing.

Risks & Escalations

- System learning from deaths arrangements not fully established specifically requested by partners as relationships with the coroner continue to develop.

Content Author: Diane-Kareen Charles | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

12. Universal Personalised Care

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

Universal Personalised Care

System Quality Group Oversight – Routine

Rationale for oversight level: Personalisation working through business-as-usual arrangements by embedding personalisation across the system.

Current Position

Personalised Care & Social Prescribing data:

- Social prescribing – Quarter 3 referral data shows a 30% reduction in referrals to PCN social prescribing link workers. Total number of referrals reported to personalised care team for quarter 3 = 2863.
- The Head of Social prescribing role providing system support and ICB oversight is currently in transition and system support offer being reduced – from April 2025 social prescribing activity will continue to sit within the Place based partnerships and social prescribing link workers will remain as part of personalised care PCN workforce.
- Social Prescribing strategic developments will remain at within Place – Updates and progress will feed into the Personalised Care Development's Group and escalations will go into the PCSOG.
- The Personalised Care Roles Community of Practice and The Social Prescribing and Community based approaches Delivery Group both currently under review.
- A Position Statement to be completed by April 2025, updating the position of the social prescribing and system's Green Social Prescribing Programme learning to date.
- Maternity Social Prescribing Link Worker developments – currently under review until mid-March.

Projects and Feedback:

- Health Inequalities project is continuing with good outcomes and learning on the impact of personalised conversations and Personal health budgets.
- Digitalising the About Me: working with system stakeholders to have the About Me in the Shared Care Record, the plan has been built, and people have volunteered to pilot it from Dec 24. This will be run as a 'proof of concept' to develop system learning and inform a broader business case during 205/26 for a wider roll out. Initial discussions with SAIU about how we can develop intelligence over the impact of digitalisation
- Frailty, including personalised care programme has developed an initial set of programme deliverables. Take up at Frailty board to support using the digital 'All About Me' form .
- Digitalisation of the 'All About Me' form awaits a decision by Digital Notts on whether they are taking this forward. Substantial time and work has already been invested by partners alongside the growing appetite by the Frailty programme to utilise a digital approach.

Actions Being Taken & Next Steps

- **Personalised Care Governance:**
- Review of all work currently being undertaken by the ICB team as structural changes will impact ongoing support
- This will be discussed by the Strategic Oversight Group to ensure ownership by system partners as well as opening the discussion about future oversight needs

Risks & Escalations

- **Data –** Developing an agreed view of data will take time, but developing iteratively will support developing more understanding
- **Digital –** Risk that system funding cannot be secured which may halt work
- **Frailty** – programme is developing objectives and deliverables without any service user engagement
- **Green Social Prescribing** – Risk National Feedback, N&NICB Commissioning teams had not been involved in the 1-year extension developments - Integrated Mental Health Commissioning team have now agreed to be involved.

Rushcliffe Arena, 09:00-13/03/25

13. Co-Production

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

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

ICB Strategy Refresh - The themes identified from the Coproduction Listening Events will be used as key discussion pillars for developing the scope of the refresh of the Coproduction Strategy. Insight from the Coproduction Listening events is being used to inform the next stages of the Coproduction Strategy refresh work. Planning continues for task and finish workshop sessions for Quarter 4 with the aim of the outcomes of these sessions updating and refreshing the content of the ICB Coproduction Strategy 2025-2027.

Impact measure – a single model of measuring the impact of Coproduction does not currently exist. Work to test and learn how models such as the Social Care Institute for Excellence and the CQC Engagement Framework can be used, what is useful and where the focus to develop further needs to be.

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 :
•Building relationships across the system –
•Improving connectivity – connecting people who want to coproduce with coproduction activities.
•Avoiding duplication of coproduction work across the system- through better communication and awareness and by sharing best practice through case studies.
•Raising the profile of coproduction approaches and education – the Coproduction Toolkit and Coproduction Newsletter
•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.

LDA Coproduction Experts by Experience coproduction support
Direct Support in embedding a coproduction approach with Experts by Experience continues to be provided by the team to the to the ICB Learning Disabilities and Autism team. This is a new offer of support being provided and is being used to further understand the needs of people with lived experience to be able to easily and effectively embed their voices within service transformation.

•**Raising the profile of a coproduction approach to staff and peers** – the team continue to provide advice, information and guidance about coproduction approaches. The team 's December edition of the Coproduction Newsletter had a focus on SEND , which was well received, and several people have reached out following publication to access the Coproduction Toolkit and to sign up to receive the newsletter. . The Team also continue to lead on the development of a system wide coproduction resource with system coproduction and involvement teams, with the aim of producing a resource to be used to aid others in applying a coproduction approach.

Actions Being Taken & Next Steps

- Replay of Listening event themes
- Develop T&F group plan

Risks & Escalations

None

Content Author: Rhonda Christian | **Exec Lead: Rosa Waddingham** | **System Oversight: System Quality Group** | **ICB Committee: Quality & People Committee**

14. Adult & Children Safeguarding

Reporting Period:
01 January 25 – 31 January 25

NHS Nottingham and Nottinghamshire

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

- Right Care Right Person/Mental Capacity Act assurance provide to NHSE following discussions with Police lead for Nottinghamshire Policing – reassured that Notts Police are utilising MCA provisions to convey and Right Care Right Person should not impact on this. Roll out of Right Care right Person has been delayed due to IT issues within Notts Police but is now going 'live ' on 10/2/25
- High risk identified in Mid/ North Notts potential DoLs cases not being identified and progressed in a timely way due to resource.
- Rolling programme of MCA training in place until end of March 26 – good uptake across colleagues
- Concerns around management of DHR's in County have been escalated. Agreement to pull all DHR's centrally but this has been put on hold pending reviews undertaken in regard to government papers on Unitary Authorities.
- GP =Leads session on Domestic Abuse now scheduled for June 25
- GP Leads Prevent training session scheduled Feb 25.
- The Safeguarding Children team continue to the multiagency cross partnership audit programme. The previous audits are currently being progressing to smart action plans and targets for updates from relevant professionals.
- The current audit focusses on Domestic Abuse which will look at children and young people as victims.
- The Children Safeguarding Practice Review subgroups of the Safeguarding Children Partnerships continue to progress two commissioned Local Safeguarding Practice reviews following the rapid review findings. The County review report was signed off in January 2025 and the recommendations are now progressing into a multi-agency action plan which has a focus on Education sector . The City review has been delayed, the National Safeguarding Review Panel has agreed to an extension until April 2025, however this is currently under review.
- A request for a partnership review was agreed to progress as a Learning review. This is a case of chronic neglect of a 16yrold. The partnership panel are progressing the review exploring working with cases of long-term neglect. Learning will be taken into the cross-authority Neglect Steering group.
- MASH heath (County) continue to be part of the multiagency redesign. The current work is concentrating on the development of an emergency services pod. This is being discussed with how health will contribute to the development.
- Work continues with the health providers to progress the national Child Protection Information system (CPIS) project extending across service areas with information who are subject to child protection plans and children in care. The health providers are mapping the system and services in their organisations and liaison with the local authorities in progress. After a regional request by several Designated Nurse's Safeguarding Children a meeting with the National team gave some updated details to progress local plans and roll out will be working to implementation by April 2027. A regional forum is to be arranged.
- Conversation about working with education partners relating to the health of children when in school is making progress in the City and a plan to work worth county colleagues is progressing and had been acknowledged by the Nottingham City Safeguarding Partnership Education sub-group.
- There was an increase in unexpected child deaths in the system between mid-December and early January, two raised concerns relating to potential process and safeguarding which will follow the safeguarding partnership review process and a rapid reviews have commenced.
- Children's Safeguarding Parentships are reviewing the key national documents on the implementation of Social Care reforms and also this includes reviewing recommendations from a recent National report Sexual Abuse in the Home Environment. The National panel report into Neglect is anticipated to now be published in February 2025

Actions Being Taken & Next Steps

- Adult Safeguarding Strategy and Workplan now agreed for 25/26, underpinning workplans being develop on deliverables and timescales.
- Task and finish group in progress for CP-IS
- Conversations relating to communications between Education and the Health of children in settings is progressing proposing to working towards a partnership event in 2025.
- Safeguarding Partnerships are working on recommendations from national reports.
- A plan to have themed meeting of the Designated Professionals in the ICB at our Chief Nurse meeting has been agreed due to changes which are legislative.

Risks & Escalations

- Capacity to meet with Mid/North Notts CHC teams to identify and progress community DoLs applications.
- Delay in agreement through governance routes in Notts County Council to bring all DHR's centrally and remove them from CSP duties. .
- Backlog and delays in Notts County DHR's.
- High number of statutory reviews across the systems currently in progress or commencing, capacity in Adults team to manage these.
- Potential requests for additional funding to cover costs of statutory reviews.

15. Vaccinations

Reporting Period:
01 September 2024 – 31 January 2025

NHS Nottingham and Nottinghamshire

Vaccinations

System Quality Group Oversight – Routine

Rationale for oversight level: Uptake for COVID vaccinations is lower than last Autumn, and uptake for flu vaccinations is slightly higher. The COVID Autumn campaign has finished. However uptake for flu vaccinations in the eligible adult population is 1-2% lower than last Autumn. Work is ongoing with system partners to improve the flu position. The reduced uptake has been seen both Regionally and Nationally.

Current Position

Flu

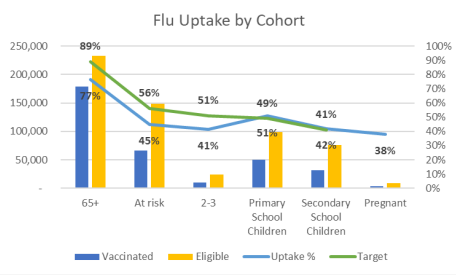
- Vaccinations are 14,116 higher than AW23 (3.9%)
- Uptake 53% (Target 60%, 10% increase on AW23)
- Uptake for citizens aged 65+ or at risk 1-2% lower than AW23
- Uptake for school age children is above AW23
  - Primary school children 12%
  - Secondary school children 11%
- Uptake for 2-3 year olds same as AW23

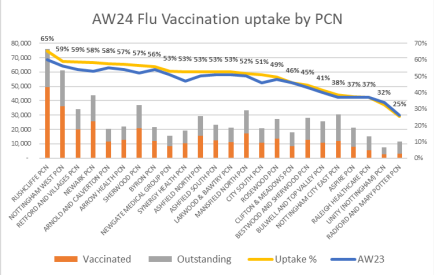
COVID Final Uptake AW24

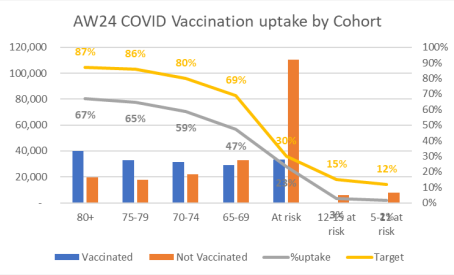
- Vaccinations are 41,307 lower than AW23 (18%)
- Uptake 43% (Target 55%, 10% higher than AW23)
- Uptake in population over 65 is more than 10% lower than AW23
- Uptake in at risk population whilst lower than 65+ is slightly higher than AW23

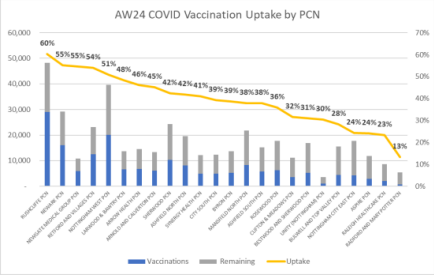
RSV catch up

Eligible population 50,000
Current uptake 51.4%









Actions Being Taken & Next Steps

- COVID vaccinations for eligible citizens ended on 31st January 2025
- Flu vaccinations can be administered to 31st March 2025, work is ongoing with providers to identify opportunities to improve uptake – most vaccinations will be opportunistic at this stage
- NUH offer of flu vaccinations to unvaccinated citizens attending outpatient appointments
- Planning commenced for Spring 25 COVID campaign

Risks & Escalations

- Low uptake for both flu and covid for frontline Healthcare workers., flu vaccinations ongoing on February and March
- New variant of COVID expected, CMDU in place to treat eligible citizens to avoid hospital admissions

	AW24 Uptake		AW24 Vaccinations		AW23 Uptake	
Healthcare worker uptake	COVID	Flu	COVID	Flu	COVID	Flu
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	27.0%	41.0%	3,634	5,510	31.0%	39.0%
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	14.0%	37.0%	1,077	2,768	21.0%	40.0%
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	14.0%	48.0%	677	2,369	23.0%	42.0%

Content Author: Debbie Stiles-Powell Exec Lead: Dave Briggs System Oversight: System Quality Group

16. Quarter 3 Care Homes & Home Care

Reporting Period:
01 October 24 – 31 December 24 (Quarter 3)

NHS Nottingham and Nottinghamshire

Care Homes & Home Care

System Quality Group Oversight – Routine

Rationale for assurance level: City and County both have sufficient capacity in both residential 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 and Bassetlaw has been impacted with their nursing bed provision reducing substantially over the last year. There is also two Nursing Homes suspended across Nottingham City. There has been a loss of nursing beds in South Nottinghamshire due to the closure of a service and the imminent temporary closure of another service for refurbishment.

Current Position

Quality Indicators for Care Homes

Please note City Care Home Quality Concerns and Complaints do not include City Residential Home data

Key	
⇧	Improvement since previous month
⇔	No significant change in performance
⇩	Deterioration in performance since previous month

Area	Indicator/Target	Target	Frequency	Oct-24	Nov-24	Dec-24	Performance shift prev month	Q1 24-25	Q2 24-25	Q3 24-25	Performance shift prev quarter
Care Homes County											
Level of Enhanced Oversight	Number of Care Homes with a **High** Level of Enhanced Oversight		Monthly	9	14	13	⇧				
	Number of Care Homes with a **Moderate** Level of Enhanced Oversight		Monthly	12	5	5	⇔				
	Number of Care Homes with a **Low** Level of Enhanced Oversight		Monthly	9	15	16	⇩				
Contract Status	Number of contract suspension in place		Monthly	9	9	9	⇔				
Provider Failure	Number of Care Home closures / contract terminations		Monthly	0	1	1	⇔				
Quality Concerns	Number of third party alerts received		Monthly	62	87	64	⇧				
Complaints	Number of formal complaints received (LA / ICB)		Monthly	1	2	1	⇧	0	1	4	⇩
Serious Incidents	Number of serious incidents		Monthly	6	10	5	⇧	6	18	21	⇩
Care Homes City											
Level of Enhanced Oversight	Number of Care Homes with a **High** Level of Enhanced Oversight		Monthly	3	3	3	⇔				
	Number of Care Homes with a **Moderate** Level of Enhanced Oversight		Monthly	2	1	1	⇔				
	Number of Care Homes with a **Low** Level of Enhanced Oversight		Monthly	0	0	0	⇔				
Contract Status	Number of contract suspension in place		Monthly	2	3	3	⇔				
Provider Failure	Number of Care Home closures / contract terminations		Monthly	0	0	0	⇔				
Quality Concerns	Number of third party alerts received		Monthly	4	3	8	⇩				
Complaints	Number of formal complaints received (LA / ICB)		Monthly	1	0	0	⇔	2	0	1	⇩
Serious Incidents	Number of serious incidents		Monthly	3	0	2	⇩	3	5	5	⇔

Actions Being Taken & Next Steps

- On-going dialogue with the home care market to understand capacity and address gaps in provision ensuring flow
- Working closely with Notts Care Association (NCA)
- Brokerage service (County) live – Only for older adult placements
- Market engagement (meetings online/in person and events) around fees reviews for 2025/26
- Fortnightly bulletin with key information
- Commissioners working with providers regarding the reduced nursing provision
- Work ongoing to understand current nursing bed capacity and future predicted demand
- Development a new team called the Provider Improvement Team to pro-actively and re-actively support the market (temporary for 18 months) – Half of the team in post
- 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
- Enhanced support being provided to services of concern to aid service improvement
- Ongoing work with providers to ensure serious incidents are reported and in a timely manner and to move to the new PSIRF model
- New nursing homes opening or in the process of being opened

Risks & Escalations

- Financial Viability – Unused residential bed capacity, cost of living, increase in provider national insurance contributions, increase in minimum wage and current demand for home care not meeting available capacity.
- International Recruitment – Two home care providers currently have their sponsorship licences suspended this creates a potential risk to people receiving services and for displaced international staff. The teams are linked into the regional and national support for international recruitment. International Recruitment Leads now in post for both Nottinghamshire County and Nottingham City Councils to support this workstream.
- Market sustainability is an issue for parts of Nottingham and Nottinghamshire following several care home closures. This has significantly impacted Mid-Notts (particularly Mansfield) with a reduced number of nursing beds.
- Delay in CQC inspections across the East Midlands of Adult Social Care Services – The re-inspection report publication delay for one provider has resulted in the closure of the service due to the financial impact.

Content Author: Nicola Ryan **Exec Lead: Rosa Waddingham** **System Oversight: System Quality Group** **ICB Committee: Quality & People Committee**

17. Quarter 3 Medicine Optimisation

Reporting Period:
01 October 24 – 31 December 24 (Quarter 3)

NHS Nottingham and Nottinghamshire

Medicine Optimisation

Current Position

- UTI presentation for Infection Prevention Control PLT delivered Nov-24.
- Medication Safety Officer Report for 2023/24- completed. To be presented at QPC in Mar-25.
- Ongoing 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. Programme for implementation being devised.
- Facilitation of ICS wide process for Directions to Administer to ensure robust, safer medicines administration. Pilot complete.
- Polypharmacy – system wide delivery of work programme under the National Medicines Optimisation Opportunities choices. Project plans and objectives scoping underway.
- Business case for change in progress for 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
- Development of the system and ICB financial efficiencies programmes for prescribing, and review of ICB efficiency projects overall, ensuring that prescribing quality and safety is robust and maintained.
- Improving oversight and safety of prescribing through working with independent health sector providers for them to assume total governance responsibility for prescribing codes they use.
- Scoping for funding into continuation of workforce faculty role – Nov-24.
- Medicines Optimisation Strategy completed. Presented at ICS CCCTLG and Executive team –Nov –24.
- Recruitment into Bassetlaw medicines optimisation pharmacist and Maternity cover Senior Post–Nov-24
- Recruitment into GP prescribing leads posts for Bassetlaw and City areas – Nov 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 incidents 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.
- 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
- Scoping implementation of Continence Prescribing Service in Bassetlaw and Mid Notts, to align with the rest of the ICB areas, in plan from April 25
- Linking polypharmacy work with ICS Frailty programme to maximise impact of structured medication reviews
- Governance and communications for launch of ICS Direction to Administer process in April 2025 underway.

Risks & Escalations

- Lack of engagement from specialists to support clinical guideline reviews
- Lack of engagement from some Primary Care Networks/Place areas due to competing priorities and GP collective action, including decisions in some GP practices to turn off prescribing system that supports safe prescribing.
- Some GP practices have declined to meet with the Medicines Optimisation Team for their annual prescribing visit.

18. Quarter 3 Personal Health Budgets

Reporting Period:
01 October 24 – 31 December 24 (Quarter 3)

NHS Nottingham and Nottinghamshire

Personal Health Budgets

System Quality Group Assurance – Routine

Rationale for assurance level: The ICB have achieved 5884 Personal Health Budgets (PHB's) year to date – NHSE have not set any targets for 2024/25

Current Position

- Undertaking Q3 PHB Direct Payment Financial auditing
- Completed Q2 PHB financial monitoring direct payment alert audit – On going monthly review on actions completed
- NHSE PHB data returns for 2024/25 Q1, Q2 and Q3 have been submitted
- Health inequalities and obesity Personal Health Budget (PHB) projects – to date:
  - 212 PHB referrals received
  - 12 PHB's closed
  - 193 PHB's completed
- Mental Health – Personality Disorder Service PHB Pilot
  - 11 PHB referrals received
  - 0 PHB's closed
  - 11 PHB completed
- Personal assistant hourly rate increase (Dec 24 – March 25) paper approved
- NHSE PHB data returns for 2024/25 Q1, Q2 and Q3 have been submitted
- ICB PHB guidance document updated

Actions Being Taken & Next Steps

- Quarter 3 PHB data will be requested at the end of Mar 25 - NHSE have not set any PHB targets for 2024/25 but the ICB must still submit PHB data returns.
- Personal Assistant Hourly Rates for April 24 – March 26 paper to be written
- Extension to Direct Payment Support Service Framework Contract paper to be written
- Personal Health Budget (PHB) quality framework – Prioritise and planning stage – on hold until 25/26
- Complete Q4 PHB direct payment financial auditing
- Complete Q3 direct payment alert audit

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 Neuro Complex case manager. The Therapy 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 as a core ICB PHB offer.

18. Quarter 3 Personal Health Budgets

Reporting Period:
01 October 24 – 31 December 24 (Quarter 3)

NHS Nottingham and Nottinghamshire

Personal Health Budgets

System Quality Group Assurance – Routine

Rationale for assurance level: The ICB have achieved 5884 Personal Health Budgets (PHB's) year to date – NHSE have not set any targets for 2024/25

Additional Information

'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.
Know your Mind (Looked After Children service) - manage their own PHB offer.
Neuro Therapy PHB's - managed by the Neuro case manager. These PHB's are currently only offered within Bassetlaw place

Current additional PHB projects:
- Autism and Learning Disability Key Working Service - manage their own PHB offer.
- 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. All projects will end by March 2025.
- Mental health – Personality Disorder Service - ICB mental health funded PHB pilot project.

On-going actions:
- Although NHSE have not announced any specific PHB targets for 2025/26 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.

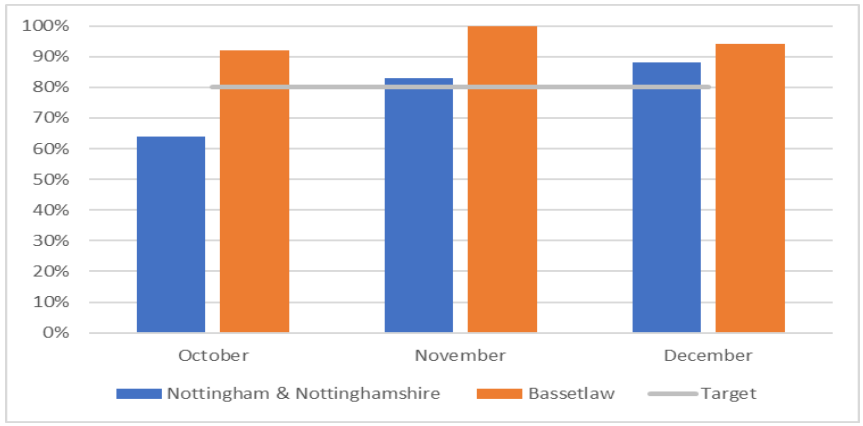
19. Quarter 3 Continuing Healthcare

Reporting Period:
01 October 24 – 31 December 24 (Quarter 3)

NHS Nottingham and Nottinghamshire

Continuing Healthcare

Eligibility decisions made within 28 days from receipt of Checklist



Data Cut-Off Date: 31/12/2024

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 3.

Eligibility decisions exceeding 12 weeks

Quarter 2	October	November	December
Nottingham & Nottinghamshire	2	3	3
Bassetlaw	0	0	0

Data Cut-Off Date: 31/12/2024

Explanatory Note/Insight Analysis and Assurance: the ICB has not consistently met the target of zero eligibility decisions exceeding 12 weeks throughout quarter 2.

19. Quarter 3 Continuing Healthcare

Reporting Period:
01 October 24 – 31 December 24 (Quarter 3)

NHS Nottingham and Nottinghamshire

Continuing Healthcare

System Quality Group Assurance – Routine

Rationale for assurance level: Targets met in Q1 but not Q2 or Q3. Q3 was a period of recovery and currently on track to meet targets in Q4.

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 quarter 1 but did not meet the 28-day target for quarter 2 or Quarter 3.
•The causes for the quarter 3 performance relate to two main areas. 1) Staffing capacity in the previous quarter 2) Focus of staffing resource on embedding new processes in previous quarter. Both areas have now been improved and quarter 3 has been a period of recovery with the ICB currently on track to meet targets in quarter 4
•An improvement plan was submitted to NHSE at the end of quarter 2. This action plan has been completed throughout quarter 3 which has resulted in the ICB exceeding the 80% target in both November and December. This has put us on track to meet the 80% target for the entirety of quarter 4.

•The ICB but did not meet the target for having no decisions exceeding 12 weeks. At the end of quarter 3 we had 3 decisions which fell into this category.
•Case 1 – Initial delay was an admin error; however, this case is now waiting Social Care sign off and has been escalated within the Local Authority and will be going to the next panel for resolution.
•Case 2 - Complex case with patients' capacity and waiting for information, assessment booked and cancelled twice and is now booked in for 19/01/25.
•Case 3 – DST completed and disputed by Social Care. Added to our next dispute panel in January for final resolution.
To ensure we encounter no further delays in the future, commencing in January a new joint panel governance has been established to ensure cases such as those above are resolved earlier.

In housing CHC
The process has begun to TUPE staff over from Nottinghamshire Healthcare Trust and City care no later than the 1st April 2025

Actions Being Taken & Next Steps

- Continue to 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.
- Continue to develop savings and efficiencies plans to meet the target – implement those plans already in place.

Risks & Escalations

- Staffing Challenges – there continues to be vacancies and long-term sick absences within the ICB CHC commissioning 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.
- CHC savings are challenging as the cost per packages are much higher in 23/24.
- There is currently a high use of agency nurses to meet the demands of the joint funded work

Content Author: Sally Dore | **Exec Lead: Rosa Waddingham** | **System Oversight: System Quality Group** | **ICB Committee: Quality & People Committee**

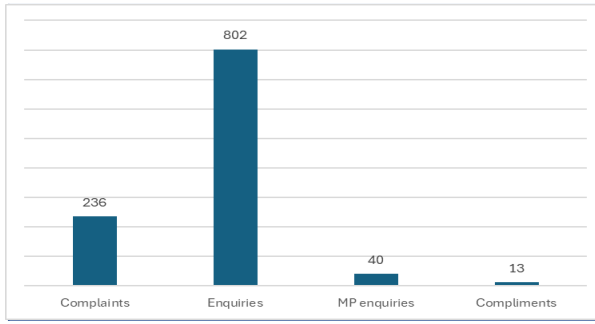
20. Quarter 3 Patient Experience

Reporting Period:
01 October 24 – 31 December 24 (Quarter 3)

NHS Nottingham and Nottinghamshire

Patient Experience

Quarter 3 All Contacts Received

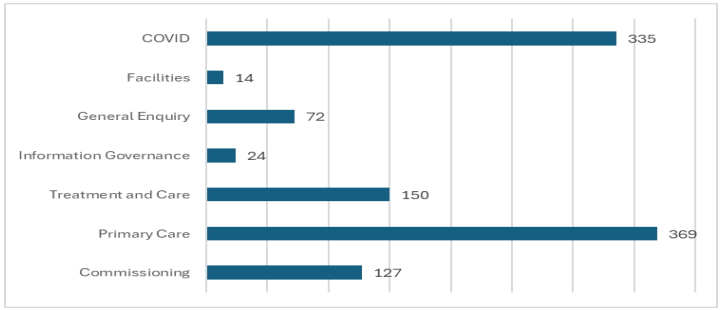


Oct Contacts
433
Nov Contacts
370
Dec Contacts
288
Total contacts
1091

Data Cut-Off Date: 31/12/2024

Explanatory Note/Insight Analysis and Assurance: Breakdown of type of contacts received

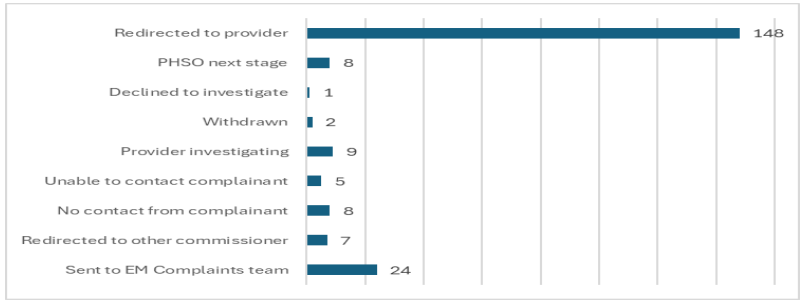
Quarter 3 All Contact Themes



Data Cut-Off Date: 31/12//2024

Explanatory Note/Insight Analysis and Assurance: The database has appropriate categories to log contacts received

Quarter 3 Complaints Not Investigated by PET



Data Cut-Off Date: 31/12/2024

Explanatory Note/Insight Analysis and Assurance: Complaints not for Patient Experience Team (PET) investigation and closed appropriately

20. Quarter 3 Patient Experience

Reporting Period:
01 October 24 – 31 December 24 (Quarter 3)

NHS Nottingham and Nottinghamshire

Patient Experience

System Quality Group Assurance – Routine

Rationale for assurance level: The ICB has a statutory requirement to manage complaints in accordance with the Local Authority Social Services and NHS Complaints Regulations 2009.
The Regulations state that 100% of complaints received must be acknowledged in within three working days (in writing or verbally). 100% compliance has been achieved during Q3. 18 complaints managed and closed in Q3 by the Patient Experience Team (PET) were responded to within the ICB complaint response timescales.

Current Position

- The ICB is required to acknowledge receipt of a complaint within three working days (see above). 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 1091 contacts during the reporting period – an increase of 338 contacts from Q2.
  - 236 complaints (eight fewer than Q2)
  - 802 enquiries (325 more than Q2)
  - 40 Member of Parliament (MP) enquiries (12 more than Q2)
  - 13 compliments (nine more than Q2)
- 48 of the 236 complaints received were agreed for investigation by the ICB; 24 complaints were for the PET to manage, and 24 GP, Pharmacy, Optometry and Dentistry (POD) complaints were for the East Midlands (EM) Complaints team to manage.
- Six complaints received in Q3 are still under investigation by the PET.
- 18 complaints handled by the PET were received and closed during Q3 with the following outcomes:
- 11 complaints were 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 the complainant was satisfied with local resolution as an outcome); these were about access to NHS dentistry (two), S1 access removed from GP practice website (two), acupuncture funding, CHC assessment (two), fast track CHC funding (two), treatment and care by optician, car parking fine at GP practice.
- Five complaints not upheld – two about prescribing for transgender patients in primary care, one about NICE guidance for weight loss medication, one about a PHB and salary sacrifice scheme, one about communication accessibility of the PET.
- Two complaints partially upheld – one about a delay in organising a home care package. Staffing issues within the Bassetlaw CHC team and a lack of appropriate providers were contributing factors.
- One about the closure of the Fracture Liaison Service. Service provision is now via the hospital bone health team and work is ongoing to commission appropriate pathways for patients who require IM and IV treatment.

Actions Being Taken & Next Steps

- On 1 April 2024, NHSE delegated Specialised Commissioning to the ICB. The PET activity will commence in April 2025. Early information provided states that the number of contacts are small; however, this is being explored given the number of PC contacts that the PET received following delegation in July 2023.
- CHC staff from CityCare and NHT will come into the ICB in April 2025. Impact on the PET to be explored.
- A Lessons Learnt template is being sent to AD's along with the final complaint response for completion by the relevant team.
- Monthly maternity contacts report.
- Monthly care home complaints report.
- GP/POD contacts report for the EM Complaints team. The data feeds into reports for the Joint Commissioning Sub Committee and Quality and Risk Group.
- 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 continued, albeit it less, since Q2 and, in Q3, the PET has received five 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 of the Band 5 PET staff is due to resign, and vacancy approval is being sought.

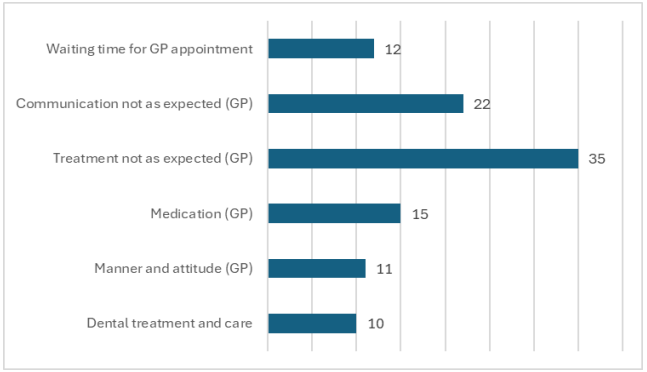
Content Author: Sally Dore | **Exec Lead: Rosa Waddingham** | **System Oversight: System Quality Group** | **ICB Committee: Quality & People Committee**

20. Quarter 3 Patient Experience

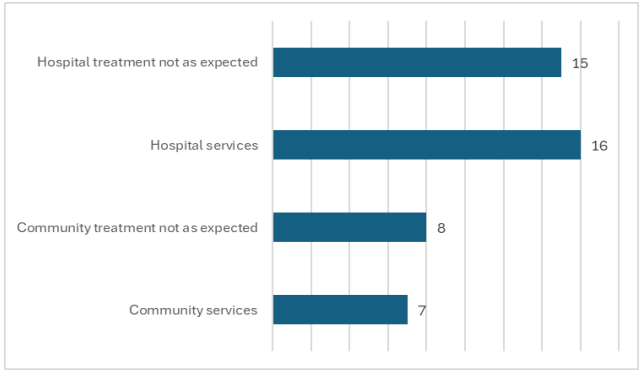
Reporting Period:
01 October 24 – 31 December 24 (Quarter 3)

NHS Nottingham and Nottinghamshire

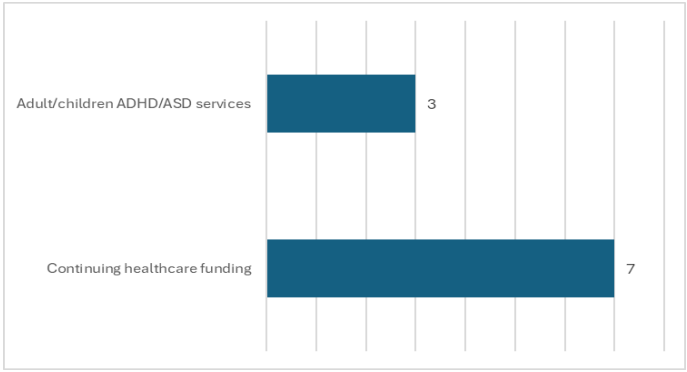
Patient Experience – Complaint Trends and Lessons Learned



Primary Care continues to be the main theme for complaints with 153 complaints received in Q3. The graph above shows the top 6 trends this quarter. This is reported in more detail in the Primary Care quarterly report.



Treatment and Care (acute, mental health, community services) received 55 complaints in Q3. The graph above shows the top 4 trends this quarter.



Commissioning received 18 complaints in Q3. The graph above shows the top 2 trends this quarter.

Complaints closed in Q3

29 complaints in total were closed in Q3. This includes the 18 complaints received in Q3 and mentioned in slide 37.
1 complaint received in Q1 and 10 complaints received in Q2 were closed in Q3.
The 11 complaints received in previous quarters had outcomes as below:

- Not upheld – 8 (1 received in Q1 and 7 received in Q2)
- Partially upheld – 1 (received in Q2) about funding for a children's continuing care package. This was a secondary response as complainant was not satisfied with first response.
- Resolved locally by PET – 2 (received in Q2) about weight loss medication and IVF funding for single women

9 of the 11 complaints were closed within the ICB timescales.
2 complaints were closed in 71 days (legal advice sought to respond) and 90 days (complainant delays in communication with the ICB and delays in receiving information from CityCare)

Lessons Learned and Actions from complaints

- CityCare to improve communication with families regarding delays in annual reviews and to improve outcomes and patient/family satisfaction through case reviews, staff training and recruitment to improve the service offered.
- The ICB is refreshing the autism strategy with partners and people with lived experience and work is ongoing to improve neurodevelopmental assessment pathways to reduce waiting times and improve pre-assessment support and post-diagnostic support offers. The ICB is working with NHSE on the implementation of a national digital reasonable adjustment flag so that these are captured within patient records across health and social care. This is planned to go live in December 2025 across England. Updates to the improved service offer will be shared within the ICB and on the website as they take place.

NHS
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7.0 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 November 2024

Nottingham and Nottinghamshire

February 2025		Assurance: Pass	Assurance: Hit & Miss	Assurance: Falling Below
Variation	Special Cause - Improvement	EMAS Conveyances to ED (Pop) 2 Hour Urgent Care Response % (Pop) 0 Day NEL (Prov) CTR Activity (Prov) Length of Stay >21 days (Prov) P0 - Discharges Home No Support (Pop) Op Plan Diag Activity (Prov) PIFU (Prov) Lower GI Cancer Refs with FIT result (Pop) Cancer FDS % (Prov) TalkTher 1st Treat <6Weeks (Pop) Inappropriate OAPs (Pop) Dementia Diagnosis Rate (Pop) SMI Health Checks (Pop) Tranfs Comm Serv - +2 Contacts (Pop) Individual Placement Support (Pop) CYP Access (1+ Contact) (Pop) Community WL 52ww Adult (Prov) 78 Week Waits (Prov) % 111 Calls Abandoned (Pop) Urgent Care Response Referrals (Pop) Missed Appointments % (Prov)	Cancer 62 Days (Prov) CYP Eating Disorders - Routine (Pop) Dental - CYP seen in last 12mths (Pop) P1 - Discharges Home with H/SC (Pop) 52 Week Waits (Prov) Community WL Adult (Prov)	No Patients Utitlising Virtual Ward (Pop) Total Waiting List (Prov) 65 Week Waits (Prov) Ordinary Electives (Prov) Daycases (Prov) OP Diag Backlog (Prov) OP Diag +6Wks (Prov) TalkTher > 90 days 1st & 2nd (Pop) Perinatal Access Volume (Pop) % Patients able to book in 2wks (Pop) % NHS App Registrations (Pop) Dental - Adult seen in last 24mths (Pop) Cancer 1st <31 days % (Prov) OP Diag Waiting List (Prov) Older Adult MH >60 day LOS (Pop)
	Common Cause - Random	% Bed Occupancy (Prov) % Ambulance Handovers >30 Mins (Pop) OP Proc - ERF Scope (Prov) OP FA Without Proc - ERF Scope (Prov) Op FUp Without Proc - ERF Scope (Prov) TalkTher - Completing (Pop) TalkTher - Reliable Improvement (Pop) TalkTher 1st Treat <18Weeks (Pop) EIP <2Weeks (Pop) Community WL 52ww CYP (Prov) Average C2 Handover Time (Prov) % Ambulance Handovers >60 Mins (Pop)	111 Calls (Pop) % Virtual Ward Capacity Utilised (Pop) A&E Attendances (Prov) 52 Week Waits CYP (Prov) % Op FUp without Proc (Prov) TalkTher - Reliable Recovery (Pop) Total Appointments (Pop) EMAS Response Activity (Pop) Refs on to non-specific symptoms pathway (Pop) Ambulance Response Cat 3 (Pop) % Cat 2 waits below 30 minutes (Pop) Older Adult MH >90 day LOS (Pop)	P2 - Discharge Not Usual Res (Pop) Ambulance Response Cat 1 (Pop) Ambulance Response Cat 2 (Pop) Ambulance Total Hours Lost (Prov) A&E 4hr % (All Types) (Prov) 12 Hour Breaches Actual (Prov) Total Clock Stops (Prov) Outpatient 1st (Prov) Outpatient FUps (Prov) % OP with Proc - ERF Scope (Prov) Cancer 62 Day Backlog (Prov) Ambulance Response Cat 4 (pop) 12 Hour Breaches % Atts (Prov)
	Special Cause - Concern	Specialist Advice (Prov)	Total Clock Starts (Prov)	NEL Admissions (Prov) 1+ Day NEL (Prov) P3 - Discharge Care Home (Pop) Total Outpatients - Virtual (Prov) Adult MH FUp 72hrs (Pop) Community WL CYP (Prov)

***Areas which continue to improve** however are still unlikely to achieve the plan set in the near future*

Items for escalation based on the indicators Falling short of the target and showing Special Cause for concern are as follows:

Non-Elective
- NEL Admissions (Prov)
- 1+ Day NEL (Prov)

Discharges
- P3 - Discharge Care Home (Pop)

Outpatients
- Total Outpatients - Virtual (Prov)

Mental Health
- Adult MH FUp 72hrs (Pop)

Community
- CYP Waiting List (Pop)

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.

***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*

7.2 Service Delivery Urgent Care Performance

7.2.1 - Streamline Urgent Care – Exception Report: Pre-Hospital Flow

NHS Nottingham and Nottinghamshire

Oversight Level	Routine

EMAS - In January 2025, there were 23,766 calls within Nottinghamshire for ambulance services, which is a decrease of 4.6% compared to the volume in January 2024 (24,895). Call volumes decreased by 13.3% from December 2024 to January 2025 (27,155 to 23,766 calls). Over time, we have seen the proportion that are closed without dispatching an ambulance (Hear and Treat) increase. However, these formed 19.5% of the total in January 2025 compared the same 19.5% position in January 2024. 'See and Treat' (treatment carried out at patient's location) formed 28% of the total (Jan '24=29.3%) and 'See and Convey' (arrival at scene followed by ambulance conveyance to a healthcare facility) were 52.5% of the total (Jan '24=51.2%). The Nottinghamshire proportions are in line with the EMAS position for these three metrics.

111 – There were 35,184 calls received for December 2024, an increase of 3,196 from November 2024 but 601 lower than the same period last year (December 2023 – 35,785)

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 December, performance was 96.6% of 1,880 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 around the future single UCR service offer across the ICS.

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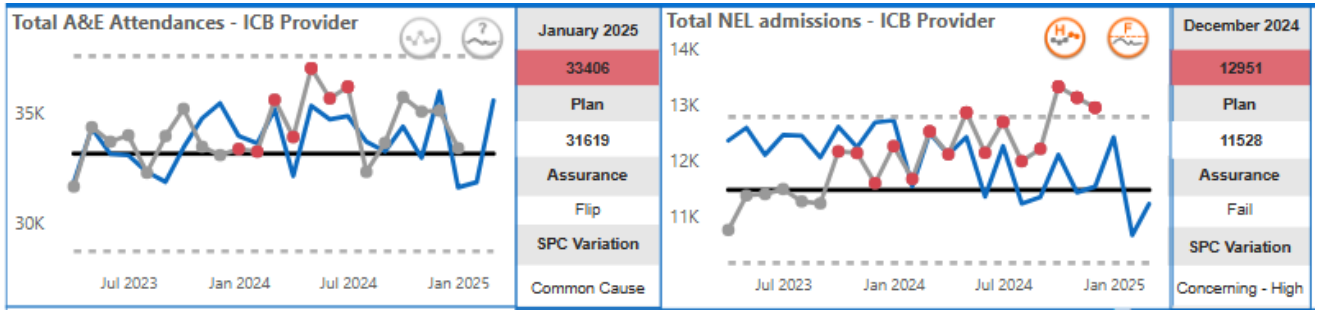
NHS
Nottingham and Nottinghamshire

7.2.2 - Streamline Urgent Care – Exception Report : Front Door & In-Hospital Flow

Oversight Level **Escalated Risk**



Position

A&E and Non-elective activity plans (ICB Provider) – There were 17,444 A&E attendances at NUH in January 2025, which was a decrease from the previous month of 794 attendances. This is above the planned level by 3.5% or 610 attendances. Note that these volumes exclude any patients that attend the London Road Urgent Treatment Centre. At SFH, there were 15,962 attendances in January 2025, which was a decrease from the previous month of 903 attendances. This is above plan by 7.6% or 1,177 attendances.

ED attendances for Notts ICB patients increased by 0.11% in January 2025 in comparison to January 2024. With NUH seeing a 1.02% increase and SFH seeing a 0.87% decrease, for the same period.

In December, Non-elective (NEL) admissions were 11.62% or 1,423 admissions above plan. Admissions into NUH were 1,516 admissions over plan or 18.07%, admissions to SFH were 93 under plan or 2.41%.

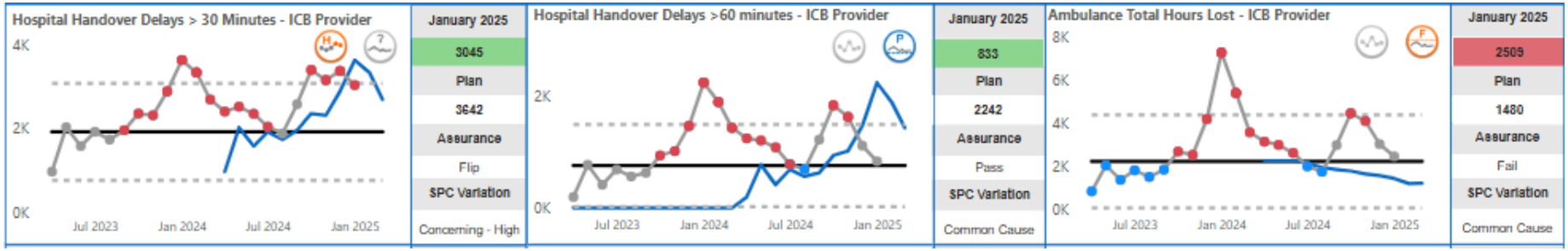
Actions

Capacity remains a challenge at both providers. All additional space at NUH open, with Beeston Ward (respiratory) Newell Ward and D56. 2 hourly capacity and flow calls taking place to best manage current issues. Demand at City and QMC is high from respiratory. Some patients waiting on ambulance on City site and delays in transfers from QMC to City.

SFH attendances continue to be above planned levels. KMH have issues recovering performance issues overnight. The high volume of breaches mean performance unable to be recovered the following day due to attendance volumes seen. SAIU carrying out deep dive into attendances at SFH, preliminary look shows attendances increases are primarily through ambulances.

7.2.3 - Streamline Urgent Care – Ambulance Handovers

Oversight Level **Escalated Risk**



Position

In January 2025, there were 3,045 over 30 minutes, of which 883 were above 60 minutes. Of the 60-minute delays, 785 were at NUH and 48 were at SFH. There were 2,509 hours lost through ambulances waiting to handover patients to hospitals by providers in Nottinghamshire in January. This is time lost above the 30 minutes expected (15 mins pre and 15 mins post-handover time) and 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 January 2025, QMC reported 1,885 lost hours from handover delays – this is the fifth highest reported figure of the 27 reporting hospitals in the Midlands, and a decrease of 476 from the December position. This improvement has been driven by the implementation of the 45-minute handover protocol at NUH. The January position is 3610 hours lower than Leicester Royal Infirmary who reported the highest position. QMC's reported lost hours account for 8.4% of the total EMAS reported lost hours for January (22,327). This is a decrease on the December position where QMC lost hours made up over 9% of the total. By comparison, KMH place 17/27 and Nottingham City place 15/27 within the region. As a County, Nottinghamshire reported 2,942 lost hours for January (719 less than the December position), this includes Doncaster & Bassetlaw Hospitals (101 lost hours), SFH (336), NUH (2,172). This was the lowest within the region, 2,930 hours below Lincolnshire and accounting for 13.2% of total EMAS reported lost hours (14.5% in December).

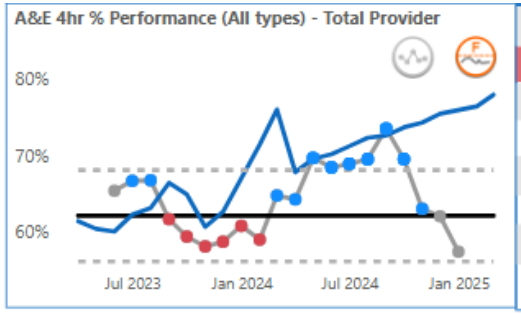
Actions

Monthly pre-handover lost hours improvement trajectories have been calculated as part of the Cat 2 Handover plan within the contract, and this provides the basis for routine improvement monitoring. EMAS continuing to work on how this can be improved. 45-minute handover protocol, which ensures no handover will exceed 45-minutes, continues to show positive signs in delivery, including improvement with number of lost hours, however this is an ongoing piece of work with continued challenges. Due to safety measures, a limit of 22 patients held on corridors at NUH is in place, which is contributing to an increase in patients waiting on ambulances prior to handover. NUH re-looking at corridor workforce model.

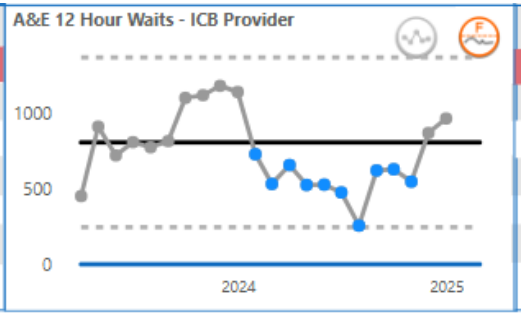
NHS Nottingham and Nottinghamshire

7.2.4 - Streamline Urgent Care – A&E Four Hour Wait

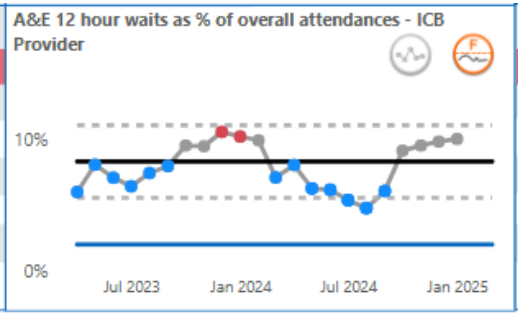
Oversight Level **Escalated Risk**



January 2025
57.4%
Plan
76%
Assurance
Fail
SPC Variation
Common Cause



January 2025
968
Plan
0
Assurance
Fail
SPC Variation
Common Cause



January 2025
10.1%
Plan
2%
Assurance
Fail
SPC Variation
Common Cause

Position

In January, the system achieved 57.4% performance for 4-hour waits against a plan of 76%. NUH achieved 54.9% against a plan of 76%, with SFH delivering 61% against a plan of 76%. As an ICB, Nottingham and Nottinghamshire were 40th of 42 nationally for 4-hour performance. With NUH 186th of 188 providers and SFH 155th.

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 total provider volume of patients waiting 12 hours from arrival in January, saw an increase of 201 at NUH as well as an increase of 95 at SFH. This was impacted by continued high attendances, with SFH above planned level by 7.6% or 1,177 attendances. The System performed at 10.01% for January against 2% target for 12-hour breaches as percentage of ED attendances, an improvement in performance since December (12.6%).

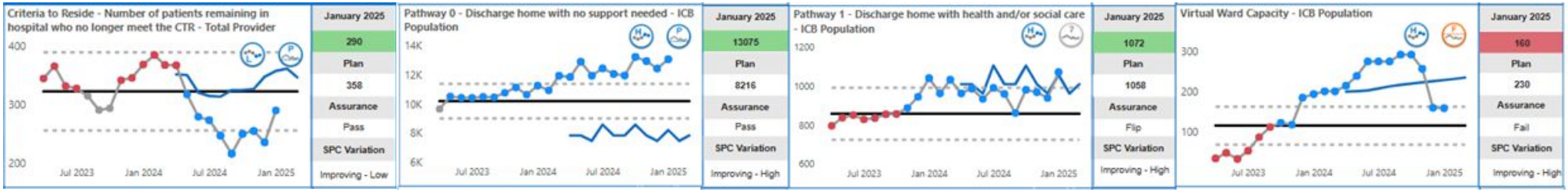
Actions

NUH – Following implementation of 45-minute handovers, focus being put towards 4-hour performance. 4-hour taskforce being set up with daily breach validation as well as thematic reviews. There may be NHSE guidance around a sprint for 78% by the end of March. 12 hours performance is being monitored through weekly meeting where all patients breached over 12-hour are reviewed. SFH – Long waits in ED being caused by large volume of attendees. Evening and overnight breaches remain main areas of challenge, building up from early evening pressures. The trust are focusing on bolstering 12pm-12am period as the staffing model is currently not in line with patient demand for optimal performance.

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 13,075 discharges in January against a plan of 8,216. Pathway 1 discharges remain below planned volumes with 1,072 against a plan of 1,052 discharges in January.

Discharge levels at NUH remain high with an average of over 345 discharges per day (all pathways) in January, with SFH averaging over 140 discharges per day for the same period. Note that pathway 1 discharges are where the patient can return home with support from health and social care. Pathway 0 discharges require no input from health or social care.

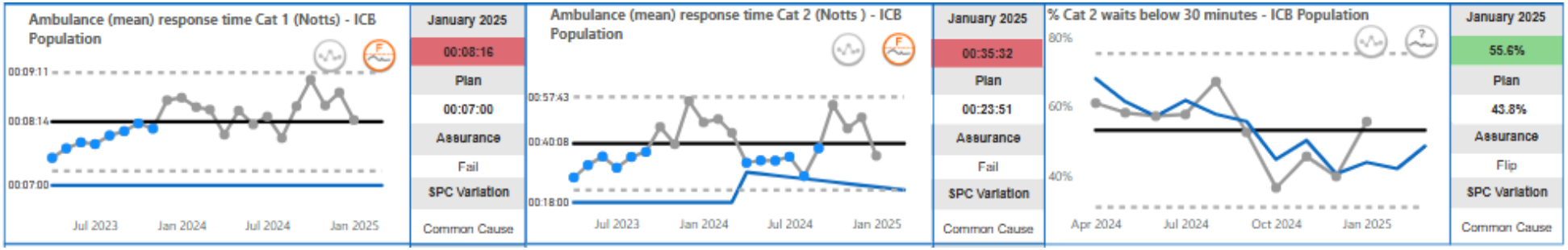
There has been an increase in the volume of patients that have No Criteria To Reside (NCTR) within NUH and SFH. This has moved from 236 in December, up to 290 in January, but remains below the plan of 358 patients. Work continues regarding improvements to discharge readiness through discharge lounges and into pathways, as well as effective utilisation of virtual ward capacity.

For January, the ICS reported a reduction in Virtual Ward bed capacity, with 160 against a plan of 230, but with occupancy of 77.5% (91.9% in December). Data issues relating to capacity and occupancy figures were identified and work around this continues, which is a factor in the recent reduction of overall capacity within the system. This reflects a more accurate position of occupancy within Virtual Wards. NHSE expectations are that wards and systems will reach 80% utilisation of actual capacity.
Latest published data for January shows the ICB places 38th of 42 nationally with 12.6 beds per 100,000 registered population (Aggregate England position is 20.0 per 100,000). VW utilisation benchmarking shows the ICB places 29th of 42 nationally with 77.5% occupancy (Aggregate England position is 80.5%).

7.2.5 - Streamline Urgent Care – Exception Report : Ambulance Performance

Oversight Level **Escalated Risk**

NHS
Nottingham and Nottinghamshire



Position

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< 30 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 January was 35:32 minutes against a plan time of 23:51 mins. An improvement in performance of 14:26 minutes from December. The Category 2 performance level remains a significant challenge for the system despite improvements over recent months. 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.

Actions

Weekly meetings between senior operational leads from EMAS, NUH and SFH continue to take place with main-focus of improving ambulance handover performance. Cat 2 performance continues to be a challenge, discussions taking place with EMAS. Some swing from to Cat 3 demand from Cat 2 seen in recent weeks.

7.3 Service Delivery Elective Care Performance

7.3.1 - Planned Care – Elective Waits

Oversight Level Enhanced Oversight

NHS Nottingham and Nottinghamshire

Position
In December, there were zero patients waiting 78 weeks or more across the two providers. More recent data indicates that there were 5 78-week waiter within the system at the end of January (3 at NUH and 2 at SFH). There were 86 patients over 65 weeks at the end of December (46 at NUH, 40 at SFH) against a plan of 0.

More recent unvalidated 65-week waiter data presented at SOG A indicates that SFH did not achieve the January plan with 28 patients against a plan of 0 patients. NUH also did not achieve their January plan (36 patients against a trajectory of 0 – ENT and Corneal challenges are the main causes).

There were 2,494 patients waiting over 52 weeks at the end of December against a plan of 2,748 which is 254 patients below trajectory. More recent unvalidated data presented at SOG A indicates that NUH achieved their January plan (1,982 patients v 2,022 plan) and SFHT were behind the January position (639 patients v 180 plan).

Actions
ENT across the System is the most significant challenge around delivery of zero 65-week waiters, although at NUH the overall impact is reducing. Corneal remains a risk for NUH in February but they have accessed a third-party supplier to procure graft material and are working to ensure all patients are dated. Urology at NUH is also a concern, SFH have maximised capacity to treat 65ww patients therefore options to source mutual aid support from Lincoln is being explored.

SFH have risks in ENT around achieving zero 65-week waiters. In ENT, the main issue is capacity with many patients needing complex single list surgery. The Trust has acquired support from an IS Provider from February and are working with NUH for mutual aid support.

Forecast
There remains a reported risk to February of 42 65ww patients at NUH of which 16 are awaiting a corneal transplant and 30 patients at SFHT (No corneal transplants).

NHS
Nottingham and Nottinghamshire

7.3.2 - Planned Care – Elective Activity

Metric Full Name	December Only				Dec-24 compared to Dec-23		April to December				Comparison to same period previous year	
	Plan	Actual	Variance	% Variance	Variance	% Variance	Plan	Actual	Variance	% Variance	Variance	% Variance
Elective Ordinary - ICS Provider	2,273	1,990	-283	-12.5%	10	0.5%	23,231	20,275	-2,956	-12.7%	2,681	15.2%
Elective Ordinary - NUH	1,903	1,605	-298	-15.7%	-14	-0.9%	19,528	16,510	-3,018	-15.5%	1,917	13.1%
Elective Ordinary - SFHT	370	385	15	4.1%	24	6.6%	3,703	3,765	62	1.7%	764	25.5%
Total Day Cases - ICS Provider	14,805	13,060	-1745	-11.8%	941	7.8%	146,847	127,790	-19,057	-13.0%	10,317	8.8%
Total Day Cases - NUH	11,232	9,675	-1557	-13.9%	603	6.6%	112,129	94,410	-17,719	-15.8%	6,506	7.4%
Total Day Cases - SFHT	3,573	3,385	-188	-5.3%	338	11.1%	34,718	33,380	-1,338	-3.9%	3,811	12.9%
Op Plan Diagnostic Activity - ICS Provider	33,898	40,637	6739	19.9%	6,865	20.3%	312,698	323,627	10,929	3.5%	12,469	4.0%
Op Plan Diagnostic Activity - NUH	20,668	25,578	4910	23.8%	5,419	26.9%	187,892	187,114	-778	-0.4%	1,032	0.6%
Op Plan Diagnostic Activity - SFHT	13,230	15,059	1829	13.8%	1,446	10.6%	124,806	136,513	11,707	9.4%	11,437	9.1%
Total Outpatients 1st (Spec Acute) - ICS Provider	28,493	23,590	-4903	-17.2%	724	3.2%	282,298	227,535	-54,763	-19.4%	14,093	6.6%
Total Outpatients 1st (Spec Acute) - NUH	18,745	12,830	-5915	-31.6%	-452	-3.4%	185,184	121,410	-63,774	-34.4%	-8,747	-6.7%
Total Outpatients 1st (Spec Acute) - SFHT	9,748	10,760	1012	10.4%	1,176	12.3%	97,114	106,125	9,011	9.3%	22,840	27.4%
Total Outpatients FUp (Spec Acute) - ICS Provider	56,810	54,155	-2655	-4.7%	320	0.6%	557,645	527,545	-30,100	-5.4%	-11,933	-2.2%
Total Outpatients FUp (Spec Acute) - NUH	36,846	33,250	-3596	-9.8%	-1,722	-4.9%	360,580	323,170	-37,410	-10.4%	-29,355	-8.3%
Total Outpatients FUp (Spec Acute) - SFHT	19,964	20,905	941	4.7%	2,042	10.8%	197,065	204,375	7,310	3.7%	17,422	9.3%
0 Day NEL - Provider	3,820	4,835	1015	26.6%	1,015	26.6%	34,760	41,770	7,010	20.2%	7,010	20.2%
0 Day NEL - NUH	2,481	3,595	1114	44.9%	1,095	43.8%	23,324	29,810	6,486	27.8%	7,415	33.1%
0 Day NEL - SFH	1,397	1,240	-157	-11.2%	-80	-6.1%	12,199	11,960	-239	-2.0%	-405	-3.3%
1+ Day NEL - Provider	7,760	8,320	560	7.2%	560	7.2%	68,570	72,305	3,735	5.4%	3,735	5.4%
1+ Day NEL - NUH	5,150	5,645	495	9.6%	390	7.4%	48,413	48,765	352	0.7%	2,225	4.8%
1+ Day NEL - SFH	2,500	2,675	175	7.0%	170	6.8%	21,826	23,540	1,714	7.9%	1,510	6.9%
Total A&E Attendances - ICB Provider	31,619	33,406	1787	5.7%	40	0.1%	338,948	348,059	9,111	2.7%	3,870	2.3%
Total A&E Attendances - NUH	16,834	17,444	610	3.6%	180	1.0%	182,364	181,512	-852	-0.5%	31	0.0%
Total A&E Attendances - SFH	14,785	15,962	1177	8.0%	-140	-0.9%	156,584	166,547	9,963	6.4%	3,839	4.9%

Metric Full Name	December Only				Dec-24 compared to Dec-23		April to December				Comparison to same period previous year	
	Plan	Actual	Variance	% Variance	Variance	% Variance	Plan	Actual	Variance	% Variance	Variance	% Variance
Elective Ordinary - ICS Population	1,907	2,230	323	16.9%	224	11.2%	18,210	19,720	1,510	8.3%	1,642	9.1%
Total Day Cases - ICS Population	13,200	13,340	140	1.1%	463	3.6%	126,065	122,405	-3,660	-2.9%	-1,938	-1.6%
Op Plan Diagnostic Activity - ICS Population	35,880	41,395	5515	15.4%	3,459	9.1%	339,337	364,960	25,623	7.6%	13,890	4.0%
Total Outpatients 1st (Spec Acute) - ICS Population	25,647	25,880	233	0.9%	965	3.9%	244,927	253,650	8,723	3.6%	17,902	7.6%
Total Outpatients FUp (Spec Acute) - ICS Population	46,885	57,290	10405	22.2%	1,184	2.1%	447,758	560,945	113,187	25.3%	-3,423	-0.6%
Total A&E Attendances - ICB Population		38,815			-257	-0.7%		403,481			4,401	2.2%

* Population data now includes specialised commissioning actuals; however, plans were submitted excluding specialised as instructed

The Day Case, Elective Ordinary, Outpatient First and Follow up activity levels were below plan in December for the combined provider position (ICS Provider).

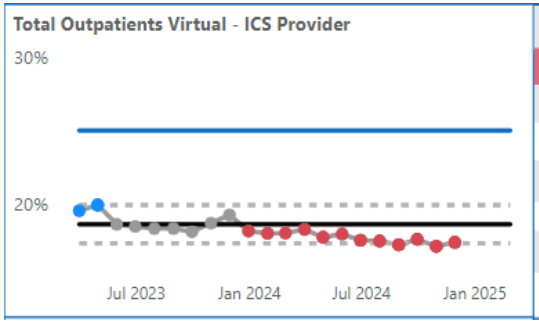
Note that the plans for 2024/25 were ambitious and that the current level of activity for Day Case, Elective Ordinary, Outpatient First and Follow up exceeds that delivered in December 2023 and the year to date.

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 are driving the over performance.

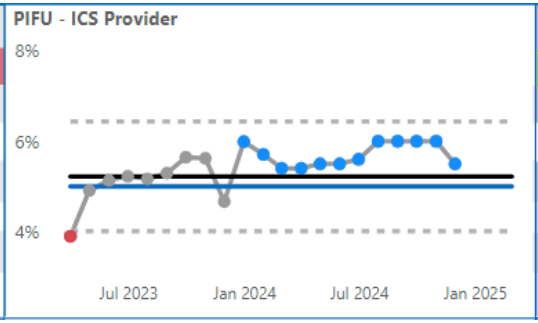
7.3.3 - Planned Care - Productivity and Transformation

Oversight Level: Enhanced Oversight

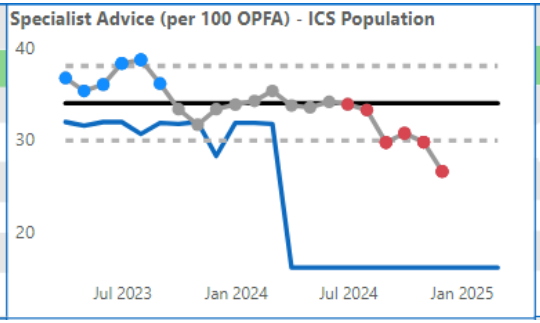
NHS Nottingham and Nottinghamshire



December 2024
17.4%
Plan
25%
Assurance
Fail
SPC Variation
Concerning - Low



December 2024
5.5%
Plan
5%
Assurance
Pass
SPC Variation
Improving - High



December 2024
26.0
Plan
16
Assurance
Pass
SPC Variation
Concerning - Low

Outpatient virtual appointments - The latest position for the system is 17.4%, which is below the national standard of 25%. Since April 2022, the position for the system has reduced from 24% to 17.4% reported in December. In December, NUH and SFH delivered 18.9% and 13.2% of outpatients virtually respectively. Ranking for December places the system in quartile 3 nationally, with NUH placed within the highest quartile and SFH within the lowest.

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 December 2024 was 5.5%. This was 6.8% at SFH and 5.1% at NUH. Overall, the system benchmarks well for PIFU utilisation and is within the highest quartile nationally for December 2024.

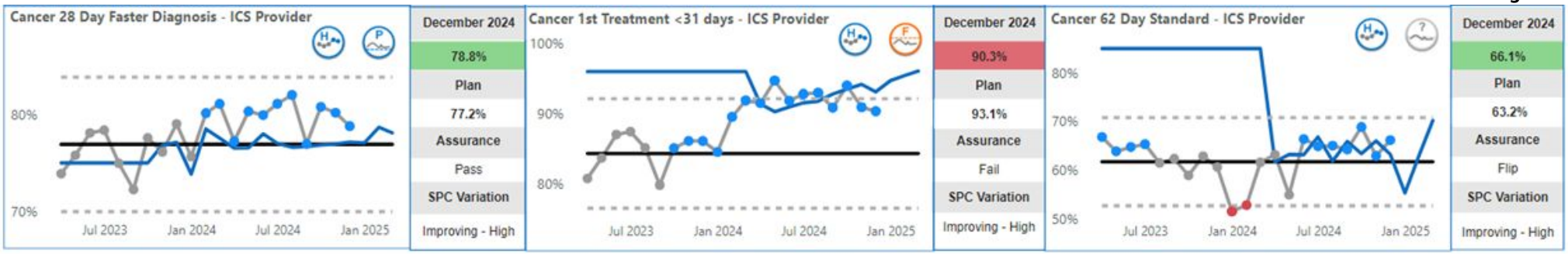
Advice and guidance - The utilisation rate in December 2024 was 26.0 against a national standard of 16 requests per 100 outpatient first attendances, which below the average. The utilisation rate has been lower in the latest four months that was seen historically. Analysis is being undertaken to explore whether this is driven by behaviour at place, practice or specialty level. 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 35.8% in November and the post referral diversion rate was 10.5%, which is in line with previous months.

Proportion of outpatient attendances that attract a procedure tariff - The aim is to prioritise outpatient activities that directly address patients' needs and complete a phase of their treatment pathway ("clock-stopping" activities). Increasing the use of PIFU and remote monitoring can contribute towards reducing follow up attendances and achievement of this metric. The aim is to deliver 46% of outpatient attendances with a procedure by March 2026. The latest data highlights the system is performing at 39.4% against a plan of 46.0% for December 2024. NUH have identified opportunities to improve the accuracy and completeness of the outpatient coding undertaken within the Trust through amending outcome forms and undertaking educational sessions with teams.

7.3.4 - Planned Care – Cancer

NHS Nottingham and Nottinghamshire

Oversight Level Escalated Risk



Position

Performance in the 28-day Faster Diagnosis Standard (FDS) continues be strong for both providers with December performance at 78.8% against the plan of 77.2%.
31day performance was below standard in December at 90.3% against the 96% standard and below the operational plan of 93.1%.
62-day performance achieved the operational plan in December with 66.1% against a plan of 63.2%. NUH achieved the 62-day trajectory in December (67.7% v 62.1% plan). The key specialties of concern are the largest referring tumour sites including Urology and LGI. Other areas include Gynaecology and Head & Neck due to the number of breaches per month. At SFH, 62-day performance was 61.2% in December (v plan of 67.3%). NUH are forecasting to achieve the trajectory in January, but SFH have risks to achievement.
The 62-day backlog volume continued to increase in the post-Christmas period at NUH and is at 415 patients at 09/02/25, currently above the local trajectory (383). Urology remains the largest backlog at 137 patients. SFH have also seen the 62-day backlog volumes increase post-Christmas and is at 110 patients at 09/02/2025. There has been a significant increase in the number of cancer referrals being received at both Trusts which is impacting on the backlog volumes.

Actions

Gynaecology at NUH remains a concern but work to mobilise YMS support for the backlog is due to start mid-February and support from IS providers to date appropriate patients for elective surgery will start during February and March. Work is also ongoing with GPs to improve communication with patients around the importance of attending appointments for suspected cancer. Breast continues to be a risk area at NUH with the loss of another consultant due to sickness, work is ongoing to secure support from YMS.
Histology reporting remains a concern at SFH; however, funding has been secured from EMCA to support extra capacity from the end of February which should improve the backlog position.

Recovery

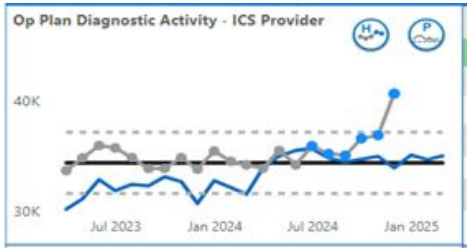
62 Day combined – NUH current unvalidated position is 61.0% against 51.6% trajectory for January.
28 FDS – NUH forecast 70.1% for January against 75.2% plan but expect this to improve with validation and should achieve the trajectory.
31 Day combined – NUH forecasting 79.9% against 94.8% plan for January, this is expected to improve with validation but is not expected to meet the trajectory.

SFH are working to provide forecasts for January.

NHS
Nottingham and Nottinghamshire

7.3.5 - Planned Care – Diagnostics

Oversight Level Enhanced Oversight



December 2024
40637
Plan
33898
Assurance
Pass
SPC Variation
Improving - High

December 2024
26130
Plan
21915
Assurance
Fail
SPC Variation
Improving - Low

December 2024
6534
Plan
4562
Assurance
Fail
SPC Variation
Improving - Low

December 2024
75%
Plan
79.2%
Assurance
Fail
SPC Variation
Improving - High

Position

The total volume of patients waiting for diagnostics and those waiting more than 6 weeks (Diagnostic Backlog) reduced between November and December by 227 patients. The backlog remains above planned levels at 6,534 against a plan of 4,562 patients. 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 increased to 40,637 tests in December, from 36,856 in November, and remains above the planned level. In December, NUH delivered 68.9% of tests within 6 weeks against a plan of 76.9%. SFH delivered 88.7% within 6 weeks against a plan of 84.6%. The largest backlog within the system relates to Audiology with 1,378 patients from a total waiting list of 2,296 patients in December (40.0% performance) This is a significantly challenging modality across the System and is continuing to deteriorate. Echocardiography performance has significantly improved at SFH and continues to be above trajectory each week.

Actions

NHSE have ceased the funding of the MRI accelerator vans at NUH for 2025/26 which will have an impact on activity and performance, NUH are in the process of signing off a business case to fund the activity for this internally. There has been an improvement in Endoscopy modalities at NUH with the continuation of weekend working and overtime booking, this will be further supported by IS capacity during 2025/26. Audiology have planned Saturday working during February to address the increasing backlog and have booked the majority of 13ww patients in February. Conversations are taking place between SFH and NUH to provide mutual aid for modalities that are not meeting plan, however, there are considerations around balancing performance and finance. During December NUH saw a spike in activity in CT, initial findings discovered a data quality issue for Radiology modalities dating back to the period following the end of the COVID period, further discussion is required between the Trust and ICB to explore the issue more fully.

At SFH additional capacity has been put on in February for Stress Echo to reduce the 13ww backlog with sustainable capacity in place from March which should enable full elimination of the 13ww backlog in Echo. MRI are expected to have 2 patients over 13weeks at the end of February, both are Paediatric patients and capacity is limited. Corporate validation posts are now in place and picking up target areas as required. Additional capacity for histology is expected from March which will see an improvement in performance from April onwards. Reporting turnaround times in Radiology improved during December with a pay per point system in place and 7-day working is currently going through approval processes.

Recovery

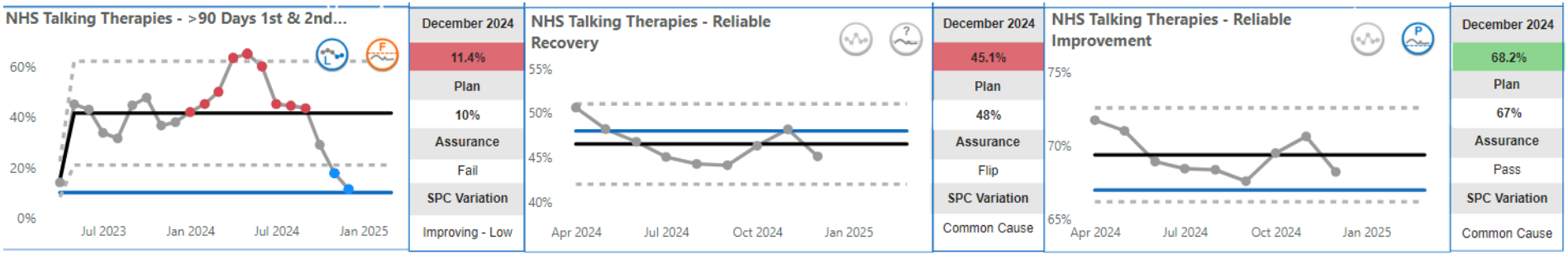
An increase in activity and an impact from validation is required for NUH to achieve their end of March ambition of 82% of patients seen within 6 weeks from their unvalidated January position of 71.2%. SFH delivered their end of March ambition of 86% at the end of December with performance of 89.8% and will continue to work to recover lower performing modalities such as Audiology.

7.4 Service Delivery Mental Health Performance

7.4.1 - Mental Health – Talking Therapies

NHS Nottingham and Nottinghamshire

Oversight Level Further Information Required



Position

NHS Talking Therapies (formerly IAPT) did not deliver against the improvement trajectory for 1st to 2nd wait in December (11.4% v 10% plan) and are forecasting to not achieve the January plan of 10%, current local data as at 04/02/2025 is 15%. Performance has been impacted by reduced activity during the Christmas period and an increase in cancellations and DNAs.

The annual reliable recovery target for 2024/25 is 48%. Reported YTD is 49.2% based on national data, December performance was 45.1%, a decline from the November position and local data for January shows an increase to 49.8%.

As the longest waiters are completing treatment during quarter 3, the monthly reliable recovery rate is increasing and will be more consistent, and the target is forecast to be met in 2024/25.

The 50% recovery rate YTD position remains above target at 50.6%, local data for December shows a decline to 48.5% but an increase to 53.2% in January.

The 67% reliable improvement target continues to be met. Local data was 68.2% for December, a decrease in performance from 71.0% in November but local data for January shows an increase to 71.9%.

Actions

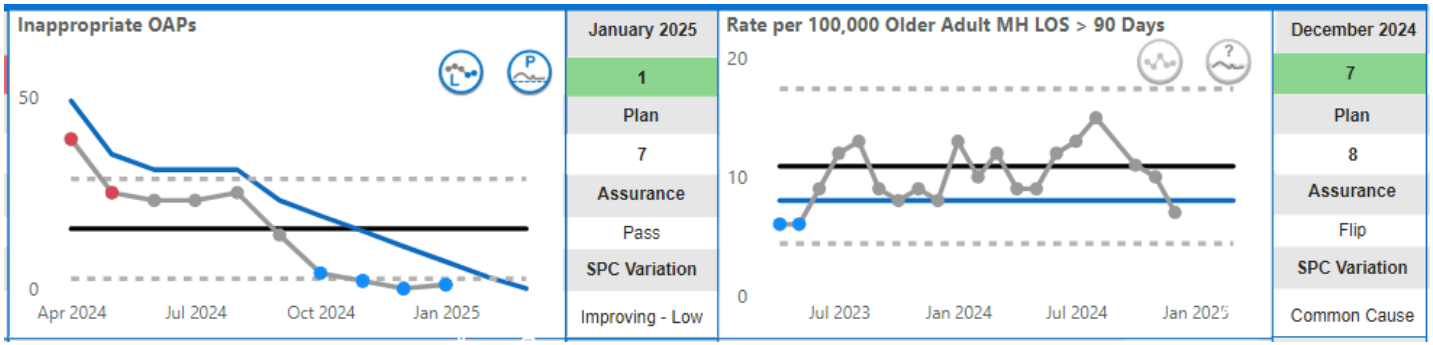
Increased booking for Silvercloud and webinars in January to increase overall activity
Staffing - recovery reviewed during staff supervision; support plans in place for staff not achieving the target; weekly clinical case management
Clinical leadership –steering groups that are responsible for implementing national best practice, conducting audits, developing local best practice guides
Engagement – with patients on readiness to engage with therapy; with partners e.g. Step 4 and LMHTs to ensure access to most appropriate service to meet patient needs

Recovery

Recovery plan for 1st to 2nd Waits for February 2025 is to achieve the <10% national target.

7.4.2 - Mental Health – OAPs

Oversight Level Enhanced Oversight



To Note: The operational plan for 2024/25 set a plan to improve from 49 in April to zero in March 2025.

Position
The number of inappropriate Out of Area Placement OBDs (OAPs) reported in January 2025 is 1 against a plan of 7. Local data for 11th February reported 1 patient remaining OOA. Discussions are ongoing with NHT colleagues to examine the definition of an out of area placement used by the trust to ensure that it aligns to the NHSE guidance and common practice of other similar NHS organisations. There is a risk that differences between the local and national definition of an out of area placement may lead to material increases in the reported volume, relating to local Independent Sector provision.

Actions
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.

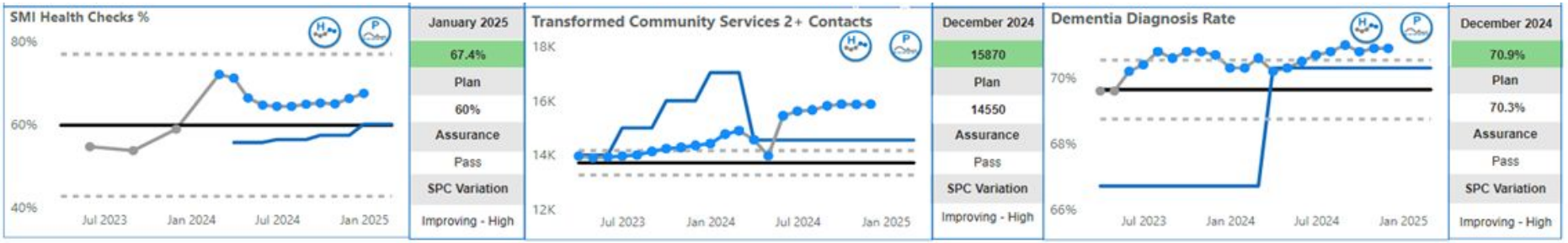
Reviews of patients who can be safely repatriated into the system are still ongoing. Increased visibility of leadership team on wards with a 'buddy' system and prompt sheets for colleagues to observe flow processes and to offer additional support. The focus is now on reducing the private bed numbers (currently at 73) to drive further improvement.

Recovery
NHT have seen continued pressure for inpatient occupancy and have increased to 73 beds, whilst discharge volumes have reduced below the mean level. The Trust are working to recalibrate the trajectory as delivering a reduction to the original plan of 21 beds by the end of March 2025 is not achievable

7.4.3 - Mental Health – Adult Services

Oversight Level Enhanced Oversight

Nottingham and Nottinghamshire



Position

72 Hour Follow Ups - the performance is below the plan for the seventeenth consecutive month in December. At ICB level this is impacted by placements made to providers that are 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 60%, the January 2025 performance remains above target.
Dementia –The ICB continues to exceed the national dementia diagnosis rate standard (70.9%) in December 2024. Performance remains above the regional average. There is no national target for Memory Assessment Service (MAS), however, reducing waits to ensure timely assessment, diagnosis and post-diagnostic support is a key national priority within the planning guidance and a local priority

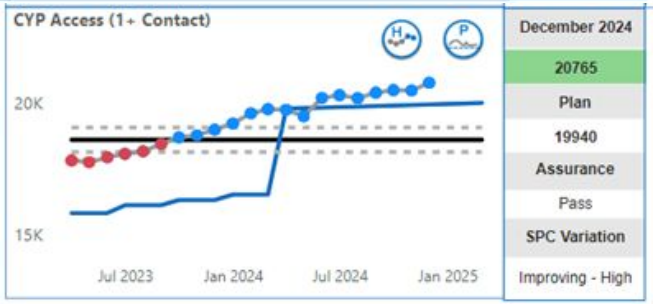
Actions

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 – Flexing staffing and associated clinic capacity across localities with consistently higher average waiting times, streamlining referral, assessment and diagnostic processes in line with Memory Services National Accreditation Programme (MSNAP) standards. Undertaking a redesign of the dementia pathway with NHT proposing to prioritise assessment and diagnosis (not yet agreed) and embedding of learning from the national audit of Dementia, alongside NHSE's regional MAS audit.

7.4.4 - Mental Health – Children & Young People Services

NHS Nottingham and Nottinghamshire

Oversight Level Further Information Required



Current Position

CYP Access (1+ Contact) - The ICS is exceeding the access target of number of children and young people (CYP) receiving support (1+contact); 20,765 CYP were recorded as having at least 1 contact in the rolling 12 months ending December 2024 exceeding the annual plan of 19,940.

CYP ED Routine (< 4 weeks) – The service did not meet the 95% target in December (88%).
CYP ED Urgent (<1 week) – The service achieved 100% in December, data for November was suppressed due to low numbers of patients.

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.
A piece of work is being undertaken on volumes of patients in treatment and is has been flagged by NHSE that the system has low volumes compared to other systems.

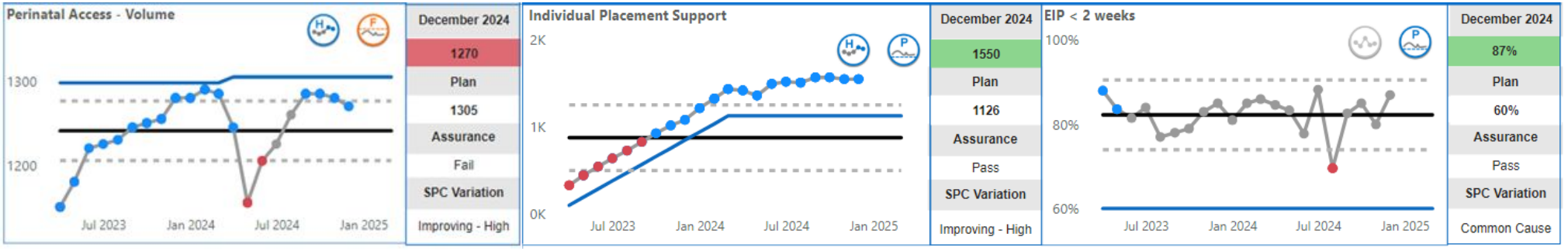
Recovery

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 December 2024 was 1,270 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.
- **IPS** - The number of people accessing IPS continues to increase with 1,550 people accessing support in December 2024.
- **EIP** - Data for December 2024 shows an improvement in performance to 87% of patients accessing EIP within 2 weeks and consistently remains above the target of 60%.

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

Nottingham and Nottinghamshire

Oversight Level Enhanced Oversight

Current Position
The volume of Total GP Appointments in December was 0.07% below the planned level, with 616,639 appointments against a plan of 617,104. 83.3% of appointments were offered within two weeks in December 2024, which remains below the operational plan of 87%. Discussions are taking place with a number of practices around their appointment book mappings to improve accuracy and consistency of recording.

In addition, follow up conversations are scheduled with the Operose management team that oversee the 6 practices for the 13th March. This will include a review of the January appointment data, which is due to be published on the 27th February.

Tracking of the impact of collective action from GPs continue to demonstrate limited impact. Analysis is taking place to explore whether collective action may be impacting the volume of advice and guidance requests, which has reduced but remains significantly above the national standard.

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 58% in January 2025.

Dental - Performance for 2024/25 is improved on 2023/24 for both adults and children's provision. To December, 7 of 9 months demonstrated a higher UDA delivery rate when compared to 2023/24 delivery. Projections for delivery to date anticipate that by year end 1,527,631 UDAs will be delivered across Nottingham and Nottinghamshire ICB. This total would represent a delivery rate of 81.1% of total contracted UDAs against a final delivery position in 2023/24 of 75.1 %.

7.5.2 - Community Care

Oversight Level Enhanced Oversight

Provider	No. 52ww in December 2024		
	Adult	CYP	Total
CityCare	0	0	0
NUH	0	2	2
NHT	0	9	9
SFH	0	0	0
Total	0	11	11

Current Position

The majority of 52ww are waiting for services at Nottinghamshire Healthcare NHS Trust. The latest published 52ww data is for December 2024, which details a further reduction in the total volume of 52ww from 21 patients (15 Adult, 6 CYP) to 11 (0 Adult, 11 CYP). Of the 11 patents, 9 (0 Adults, 9 CYP) are waiting for services delivered by NHT.

There were 11 breaches of 52 weeks for CYP services, of which 9 were at NHT and 2 were at NUH.

Actions

Community Paediatrics (NUH): Efforts are underway to appoint a locum, but uncertainty remains. Without a successful appointment, the service is expected to continue experiencing around two patient breaches per month for 52 weeks.
Paediatric Occupational Therapy (NHT): Staffing challenges due to planned absences and vacancies are affecting capacity. Normal staffing is expected by March, with a low risk of 52-week breaches, which will be closely monitored.
Community Podiatry Services (NHT): There is a significant shortage of Community Podiatrists, especially in biomechanics, leading to increased wait times in specific pathways. The service currently has 11.0 WTE vacancies out of 62.63 WTE, with the shortfall expected to grow

Risks

Paediatric Occupational Therapy (NHT): Staffing challenges due to planned absences and vacancies are affecting capacity. Normal staffing is expected by March, with a low risk of 52-week breaches, which will be closely monitored.
Further risks are around the demand levels for Speech and Language Therapy at NHT, which at the current level are forecasted to lead to 10 CYP 52ww by March 2025.

7.6 Provider Level Overview

7.6.1 - Provider Overview – Streamline Urgent Care and Flow

NUH

In-Hospital Flow

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Total NEL admissions	NUH	December 2024	7631	9147	1516	✗		
Total A&E Attendances	NUH	January 2025	16834	17444	610	✗		
1+ Day NEL	NUH	December 2024	5150	5645	495	✗		
0 Day NEL	NUH	December 2024	2481	3595	1114	✓		
% Bed Occupancy	NUH	January 2025	94.1%	94.1%	0%	✓		

Flow out of Hospital

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
CTR activity	NUH	January 2025	247	208	-39	✓		
Length of Stay > 21 days	NUH	January 2025	340	319	-21	✓		

Pre-Hospital - Alternatives to ED

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
A&E 12 Hour Waits	NUH	January 2025	0	779	779	✗		
A&E 4hr % Performance (All types)	NUH	January 2025	76%	54.9%	-21.1%	✗		
Ambulance Total Hours Lost	NUH	January 2025	1480	2172	692	✗		
Hospital Handover Delays > 30 Minutes	NUH	January 2025	-	2585	-			
Hospital Handover Delays >60 minutes	NUH	January 2025	0	785	785	✗		

SFH

In-Hospital Flow

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Total NEL admissions	SFH	December 2024	3897	3804	-93	✓		
Total A&E Attendances	SFH	January 2025	14785	15962	1177	✗		
1+ Day NEL	SFH	December 2024	2500	2675	175	✗		
0 Day NEL	SFH	December 2024	1397	1240	-157	✗		
% Bed Occupancy	SFH	January 2025	97.1%	95.2%	-1.9%	✓		

Flow out of Hospital

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
CTR activity	SFH	January 2025	111	83	-28	✓		
Length of Stay > 21 days	SFH	December 2024	115	88	-27	✓		

Pre-Hospital - Alternatives to ED

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
A&E 12 Hour Waits	SFH	January 2025	0	189	189	✗		
A&E 4hr % Performance (All types)	SFH	January 2025	76%	61%	-15%	✗		
Ambulance Total Hours Lost	SFH	January 2025	0	337	337	✗		
Hospital Handover Delays > 30 Minutes	SFH	January 2025	0	460	460	✗		
Hospital Handover Delays >60 minutes	SFH	January 2025	0	48	48	✗		

NHS Nottingham and Nottinghamshire

7.6.2 - Provider Overview – Planned Care

NUH

Total Waiting list and Long Waits

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
RTT Waiting List	NUH	December 2024	76493	91175	14682	✗		
RTT Admitted Clock Stops	NUH	December 2024	3309	2889	-420	✗		
Incomplete> 52 weeks CYP	NUH	January 2025	248	163	-85	✓		
78 Week Waiters	NUH	December 2024	0	0	0	✓		
65 Week Waiters	NUH	December 2024	0	46	46	✗		
52 Week Waiters	NUH	December 2024	2488	1925	-563	✓		
% Incomplete 18 wks RTT	NUH	December 2024	-	59.2%	-			

Elective Recovery - Activity

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Elective Ordinary	NUH	December 2024	1903	1605	-298	✗		
Op Plan Diagnostic Activity	NUH	December 2024	20668	25578	4910	✓		
Op Plan Diagnostics 6 week Performance	NUH	December 2024	78%	68.1%	-9.9%	✗		
Total Day Cases	NUH	December 2024	11232	9675	-1557	✗		
Total Outpatients 1st (Spec Acute)	NUH	December 2024	18745	12830	-5915	✗		
Total Outpatients FUp (Spec Acute)	NUH	December 2024	36846	33250	-3596	✗		

Elective Recovery - Productivity & Transformation

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Total Outpatients Virtual	NUH	December 2024	25%	18.9%	-6.1%	✗		
Total Clock Stops	NUH	December 2024	17138	15548	-1590	✗		
RTT Non Admitted Clock Stops	NUH	December 2024	13829	12659	-1170	✗		
RTT Admitted Clock Stops	NUH	December 2024	3309	2889	-420	✗		
PIFU	NUH	December 2024	5%	5.1%	0.1%	✓		
Specialist Advice (per 100 OPFA)	Provider	December 2024	16	22	6	✓		
Missed Appointments %	Provider	December 2024	6.5%	4.7%	-1.8%	✓		
Proportion of outpatient attendances with a procedure - ERF scope	Provider	December 2024	46%	41.3%	-4.7%	✗		

SFH

Total Waiting list and Long Waits

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
RTT Waiting List	SFH	December 2024	32469	34147	1678	✗		
RTT Admitted Clock Stops	SFH	December 2024	1096	1049	-47	✗		
Incomplete> 52 weeks CYP	SFH	January 2025	0	54	54	✗		
78 Week Waiters	SFH	December 2024	0	0	0	✓		
65 Week Waiters	SFH	December 2024	0	40	40	✗		
52 Week Waiters	SFH	December 2024	260	569	309	✗		
% Incomplete 18 wks RTT	SFH	December 2024	-	63.8%	-			

Elective Recovery - Activity

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Elective Ordinary	SFH	December 2024	370	385	15	✓		
Op Plan Diagnostic Activity	SFH	December 2024	13230	15059	1829	✓		
Op Plan Diagnostics 6 week Performance	SFH	December 2024	81.6%	89.9%	8.3%	✓		
Total Day Cases	SFH	December 2024	3573	3385	-188	✗		
Total Outpatients 1st (Spec Acute)	SFH	December 2024	9748	10760	1012	✓		
Total Outpatients FUp (Spec Acute)	SFH	December 2024	19964	20905	941	✓		

Elective Recovery - Productivity & Transformation

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Total Outpatients Virtual	SFH	December 2024	25%	13.2%	-11.8%	✗		
Total Clock Stops	SFH	December 2024	7107	6021	-1086	✗		
RTT Non Admitted Clock Stops	SFH	December 2024	6011	4972	-1039	✗		
RTT Admitted Clock Stops	SFH	December 2024	1096	1049	-47	✗		
PIFU	SFH	December 2024	5%	6.8%	1.8%	✓		
Specialist Advice (per 100 OPFA)	Provider	December 2024	16	22	6	✓		
Missed Appointments %	Provider	December 2024	6.5%	4.7%	-1.8%	✓		
Proportion of outpatient attendances with a procedure - ERF scope	Provider	December 2024	46%	41.3%	-4.7%	✗		

Assurance

7.6.2 - Provider Overview – Planned Care

NUH

Diagnostic Recovery

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Op Plan Diagnostics Waiting List	NUH	December 2024	14579	17858	3279	✗		
Op Plan Diagnostics 6 week Performance	NUH	December 2024	78%	68.1%	-9.9%	✗		
Op Plan Diagnostic Backlog	NUH	December 2024	3210	5695	2485	✗		
Op Plan Diagnostic Activity	NUH	December 2024	20668	25578	4910	✓		

Cancer Recovery

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Cancer - 62 Day Backlog	NUH	December 2024	233	293	60	✗		
Cancer 1st Treatment <31 days	NUH	December 2024	93%	90.1%	-2.9%	✗		
Cancer 1st Treatments	NUH	December 2024	-	868	-			
Cancer 28 Day Faster Diagnosis	NUH	December 2024	75.4%	80.3%	5%	✓		
Cancer 62 Day Standard	NUH	December 2024	62.1%	67.7%	5.6%	✓		

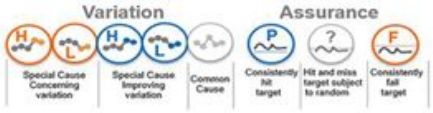
SFH

Diagnostic Recovery

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Op Plan Diagnostics Waiting List	SFH	December 2024	7336	8272	936	✗		
Op Plan Diagnostics 6 week Performance	SFH	December 2024	81.6%	89.9%	8.3%	✓		
Op Plan Diagnostic Backlog	SFH	December 2024	1352	839	-513	✓		
Op Plan Diagnostic Activity	SFH	December 2024	13230	15059	1829	✓		

Cancer Recovery

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Cancer 62 Day Standard	SFH	December 2024	67.3%	61.2%	-6.1%	✗		
Cancer 28 Day Faster Diagnosis	SFH	December 2024	79.60%	76.1%	-3.6%	✗		
Cancer 1st Treatments	SFH	December 2024	-	105	-			
Cancer 1st Treatment <31 days	SFH	December 2024	94%	92.4%	-1.6%	✗		
Cancer - 62 Day Backlog	SFH	December 2024	61	77	16	✗		



NHS
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

- 8.1 – Month 10 Financial Position
- 8.2 – Efficiency at M10

8.1 Month 10 Financial Position YTD

By Organisation £'m - after NR support	YTD Plan	YTD Actuals	YTD Variance	In-month Plan	In-month Actuals	In-month Variance	Total FY Plan	FOT	Variance
NUH	0.0	-1.4	-1.4	0.0	0.0	0.0	0.0	0.0	0.0
SFH	-4.1	-8.6	-4.5	1.3	-1.4	-2.7	0.0	0.1	0.1
NHT	0.0	-7.5	-7.5	0.0	0.0	0.0	0.0	0.0	0.0
N&N ICB	0.0	-1.0	-1.0	0.0	0.3	0.3	0.0	-0.5	-0.5
TOTAL	**-4.1**	**-18.5**	**-14.4**	**1.3**	**-1.1**	**-2.4**	**0.0**	**-0.4**	**-0.4**

Key Messages

- The system has a reported a (£18.5m) deficit at month 10, which is (£14.4m) adverse to plan.
- Following receipt (at M6) of a non-recurrent financial allocation associated with the £100m deficit plan submission, each organisation is now reporting its position against a break-even plan for 2024/25.
- The system forecast at M10 is deliver the break-even plan position.
- The year-to-date position is off plan mainly due to the impact of the non-recurrent deficit income relating to the deficit year-to-date phasing (£3.7m), consultant pay award pressure (£2.3m) and a shortfall of industrial action income against the industrial action impact (£1.8m).

- The month 10 WTES are 760 over the January plan with substantive being 843 WTES over plan, bank being 8 WTES over plan and agency being 90 WTES below plan.
- The month 10 pay bill shows the costs are above plan by (£10.3m) overall and the forecast spend is above plan by (£7.2m).
    - Substantive (and other) staff spend is under plan by £3.6m and forecast to be under plan by the end of the year by £11.6m.
    - Bank staff spend is over plan by (£20.6m) and forecast to be over plan by (£26.9m) by the end of the year.
    - Agency staff spend is under plan by £6.6m and forecast to be under plan by £8.2m by the end of the year.
- The agency forecast at M10 is £19.2m under the agency cap & £8.2m under the plan.

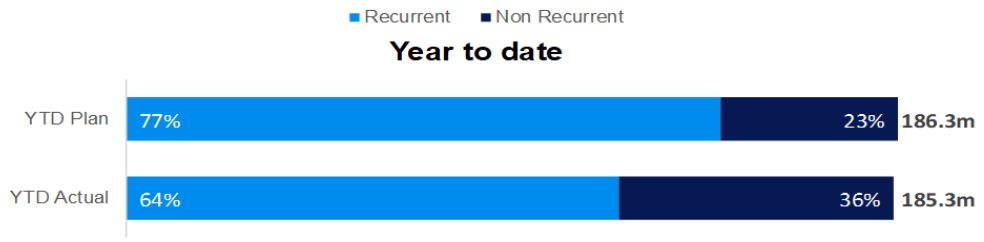
- The system's assessment of risk to the forecast outturn for 2024/25 is £96m gross (£110.2m at M9) with mitigations of £57.1m which leaves an unmitigated risk position across the system of £38.9m (£41.9m at M9). The main risk remains the delivery of efficiency plans.
- In addition, other main risks at the ICB relate to the impact of growth and price increases relating to CHC and with providers, relate to pay awards/B2 to B3 uplifts, urgent and emergency care demand and capacity pressures

- To date, £51.4m of the capital envelope has been spent (against a plan of £71.4m) which includes all spend relating to IFRS16.
- The M10 forecast is to spend the total system envelope plan.

8.2 Efficiency at M10

- £185.3 delivered to month 10 which is £1m adverse to plan (month 9 £160.4m and £4.9m favourable to plan).
- £66.3m of ytd reported as non-recurrent with £100.2m non recurrent in forecast.
- Year to month 10 delivery represents 72% (month 9 – 62%) of annual forecast delivery with a further 28% (£71.8m) to be delivered in the remainder of the year to achieve the forecast position against target.
- Run rate at M10 is £18.5m per month (compared to £17.8m per month at M9). Pro-rotating up would deliver £222.3m of the £257m target which recognises that plans delivery ramp up towards the last quarter of the year.
- Forecast at M10 is £257m in line with plan. However, the recurrent forecasts are £44.6m short of plan with the non-recurrent forecasts £44.6m greater than plan.

Efficiency Development Status	2024/25 Plan £'m	M10 Reporting £'m
Fully Developed	144.1	211.6
Plans in Progress	36.4	30.3
Opportunity	58.1	12.2
Unidentified	18.4	2.8
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	60.6	47.2	82.2	60.2	10.2	16.0	13.5	35.5	70.8	63.2	-7.6	95.7	95.7	0.0	66%
SFH - CIP	5.8	6.9	7.3	8.9	24.9	23.8	31.1	29.6	30.8	30.7	0.0	38.5	38.4	0.0	80%
NHT - CIP	37.4	21.4	51.5	29.1	2.3	16.3	2.9	25.3	39.7	37.8	-1.9	54.4	54.4	0.0	69%
ICB - QIPP	39.9	43.5	60.5	58.8	5.2	10.1	8.0	9.7	45.0	53.6	8.6	68.5	68.5	0.0	78%
SYSTEM TOTAL	**143.7**	**119.0**	**201.5**	**156.9**	**42.6**	**66.3**	**55.6**	**100.2**	**186.3**	**185.3**	**-1.0**	**257.0**	**257.0**	**0.0**	**72.1%**

NHS
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

Total ICS Provider Workforce - Actual vs Operational Plan 24/25

NUH

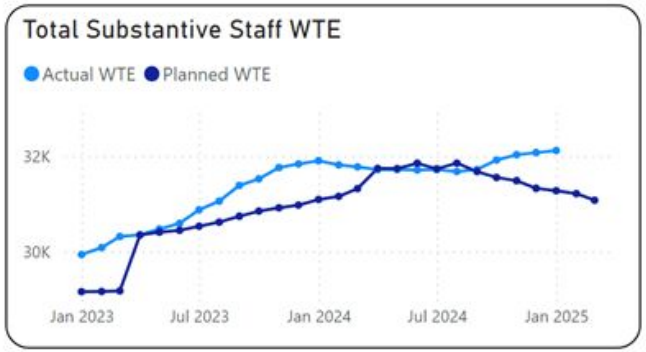
	January 2025			
	Planned WTE	Actual WTE	Variance to Plan	Variance %
Total Agency Staff	209.6	180.6	-29.1	-13.9%
Total Bank Staff	767.2	903.7	136.5	17.8%
Total Substantive Staff	17,703.7	18,238.5	534.8	3.0%
Total WTE all Staff	18,680.5	19,322.7	642.2	3.4%

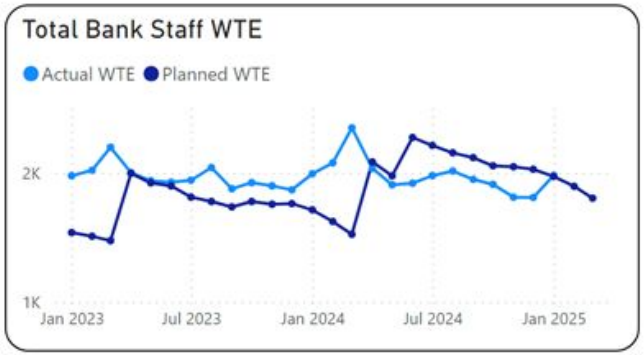
SFH

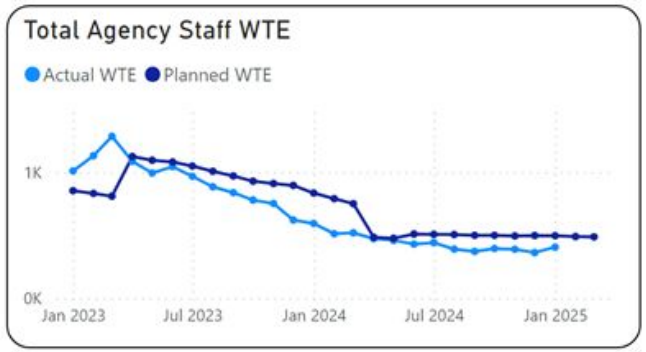
	January 2025			
	Planned WTE	Actual WTE	Variance to Plan	Variance %
Total Agency Staff	107.1	86.4	-20.7	-19.4%
Total Bank Staff	448.2	409.9	-38.3	-8.6%
Total Substantive Staff	5,325.6	5,352.7	27.1	0.5%
Total WTE all Staff	5,880.9	5,848.9	-32.0	-0.5%

NHCT

	January 2025			
	Planned WTE	Actual WTE	Variance to Plan	Variance %
Total Agency Staff	179.5	139.0	-40.5	-22.5%
Total Bank Staff	757.7	667.3	-90.5	-11.9%
Total Substantive Staff	8,248.3	8,529.2	280.8	3.4%
Total WTE all Staff	9,185.5	9,335.4	149.9	1.6%







Total Provider Current Position:

SFH have over performed against their total month 10 plans being under plan by 32 WTE. NUH and NHCT are above plan by 642.2 and 149.9 WTE respectively. NUH are driving the system overall being above plan by 760.2WTE (2.3%) All Trusts have underperformed against their substantive staffing plan by 842.7WTE (2.7%) and overperformed against agency staffing by 90.3WTE (18.2%). SFH and NHCT have overperformed against bank staffing with NUH overperforming. The system is 7.7 WTE (0.4%) above plan for bank staffing.

Overall, the Trusts are £2.54M adverse to their month 10 pay bill plan. NUH and SFH are over plan by £2.91M and £0.56M respectively. NHCT are under plan by £0.93M. All Trusts overspent on bank staff totalling £3.71M (NUH £2.66M, NHCT £0.45M, SFH £0.60M). All Trusts are underspent on agency staff totalling £1.31M (NUH £1.16M, SFH £0.09M, NHCT £0.06M)

The workforce financial efficiencies are under plan in month 10 , for the first time, by £1.094M. Both NUH and NHCT are underperforming by £1.101 and £0.27 respectively, with SFH overperforming by £0.34M. The underperformance is due to enhanced vacancy control schemes within NUH and NHCT being transferred from back office to the workforce programme. The 'risk adjusted' plan has increased slightly from £1.593M to £1.650M.

Workforce

Key Performance Indicators	Date	Plan	Actual	Variance	Exception Report
Total WTE Substantive Workforce	Jan-25	31,277.6	32,120.3	842.7	Section 9
Bank Staff	Jan-25	1,973.1	1,980.8	7.7	
Agency Staff	Jan-25	496.2	405.9	-90.3	
12 Month Rolling Average Sickness Absence %	Jan-25	5.3%	6.10%	0.8%	
12 Month Rolling Average Staff Turnover %	Jan-25	10.8%	10.2%	-0.6%	
12 Month Rolling Average Staff Appraisals%	Jan-25	-	83.5%	-	
12 Month RollingAverage Mandatory Training %	Jan-25	-	87.7%	-	
Total WTE Primary Care Workforce *	Dec-24	3820	3752	-68	

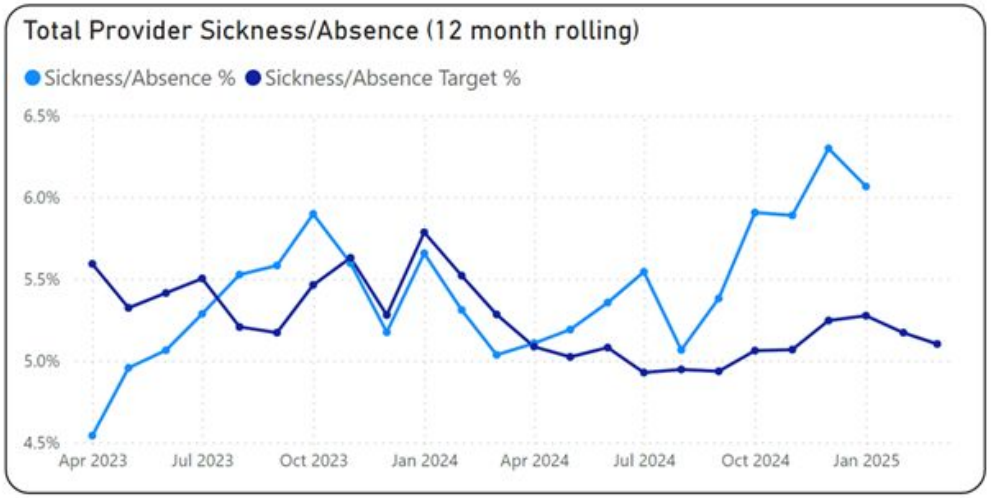
* Quarterly target figures requested in the Operational Plan Submission

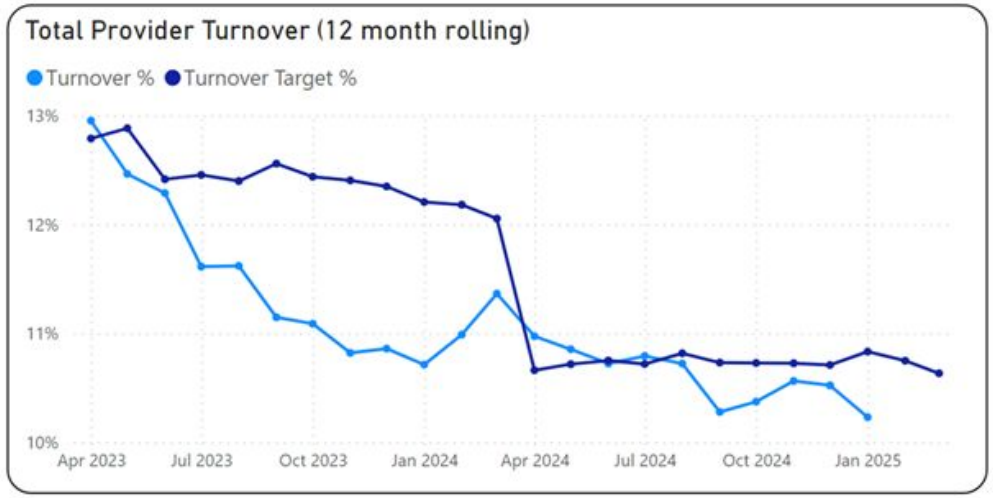
P&C Group Limited Assurance - Further Information Required:

Level of assurance is limited due to the variance in WTE, the variance between WTE and pay bill, the pay bill spend and non achievement of the workforce efficiency target.

>3.5%
0%-3.5%
<0%

Total ICS Provider Workforce - Sickness/Absence and Turnover





Date	Sickness/Absence %	Sickness/Absence Target %
November 2024	5.9%	5.1%
December 2024	6.3%	5.2%
January 2025	6.1%	5.3%

Date	Turnover %	Turnover Target %
November 2024	10.6%	10.7%
December 2024	10.5%	10.7%
January 2025	10.2%	10.8%

Total Provider Current Position:

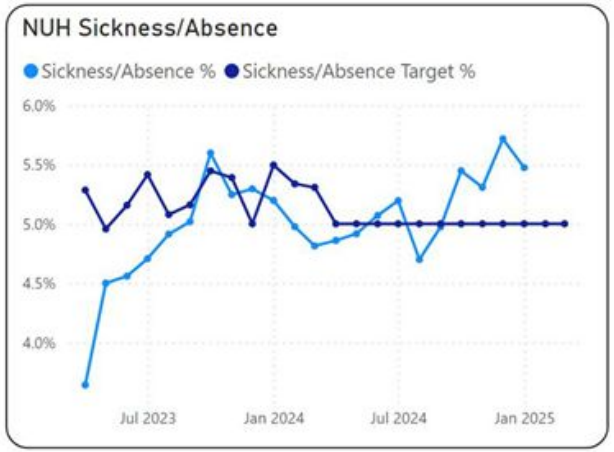
All providers are above their sickness plan. Overall sickness decreased in January by 0.2% compared to December and variance to plan is 0.8%. Decreases in absence are noted in Support to clinical staff (0.3%) and Registered Nursing, Midwifery and Health visiting (0.4%) and NHS Infrastructure (0.2%). All Trusts closely monitor absence and have a number of 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 continues to be under plan for turnover this month by 0.6%. Both SFH and NUH are under their targets. NHCT remains over its target but there has been a reduction of 0.2% between January and December.

P&C Group Limited Assurance - Further Information Required:

Assurance is limited due to the continuing upturn in sickness and the actions still in progress to address underperformance in organisations. Turnover is showing a continual decrease and is likely related to the reduced number of jobs available across the system due to financial efficiency programmes.

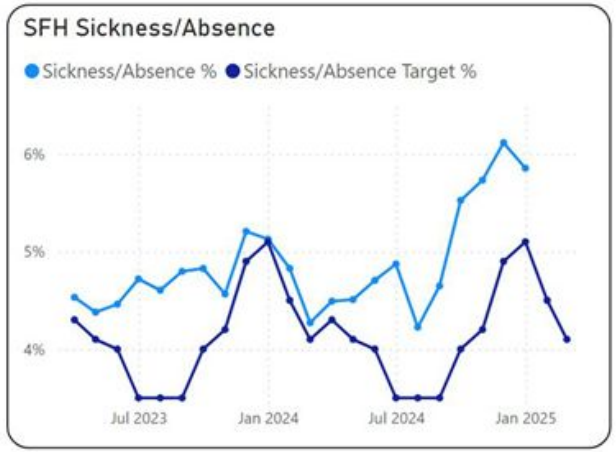
Sickness/Absence % (12 month rolling)



Sickness/Absence %	Sickness/Absence Target %
5.5%	5.0%

Provider Current Position:

NUH sickness remains above plan in month 10 but has decreased by 0.2% compared to month 9. They continue to monitor this closely. It is felt that some of the absence remains related to the reduced staffing in the organisation and the pressures of winter demand.



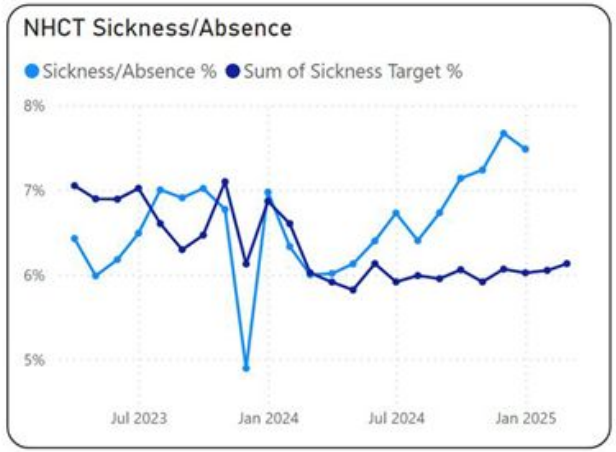
Sickness/Absence %	Sickness/Absence Target %
5.9%	5.1%

Provider Current Position:

Within the operational plan SFH vary their sickness target on a month-by-month basis. Internally the Trust work to a monthly average target of 4.2%.

Sickness has decreased from the previous month by (0.2%). An increased within the winter months was predicted and is reflective of the acuity of the hospital, including being on a high Operational Pressures Escalation Level (OPEL).

They are noting an increase in length of absences due to the impact of NHS waiting and treatment times. A deep dive into sickness has been reviewed at SFH People Committee, and an action plan is being developed for divisions that will be monitored.



Sickness/Absence %	Sickness/Absence Target %
7.5%	6.0%

Provider Current Position:

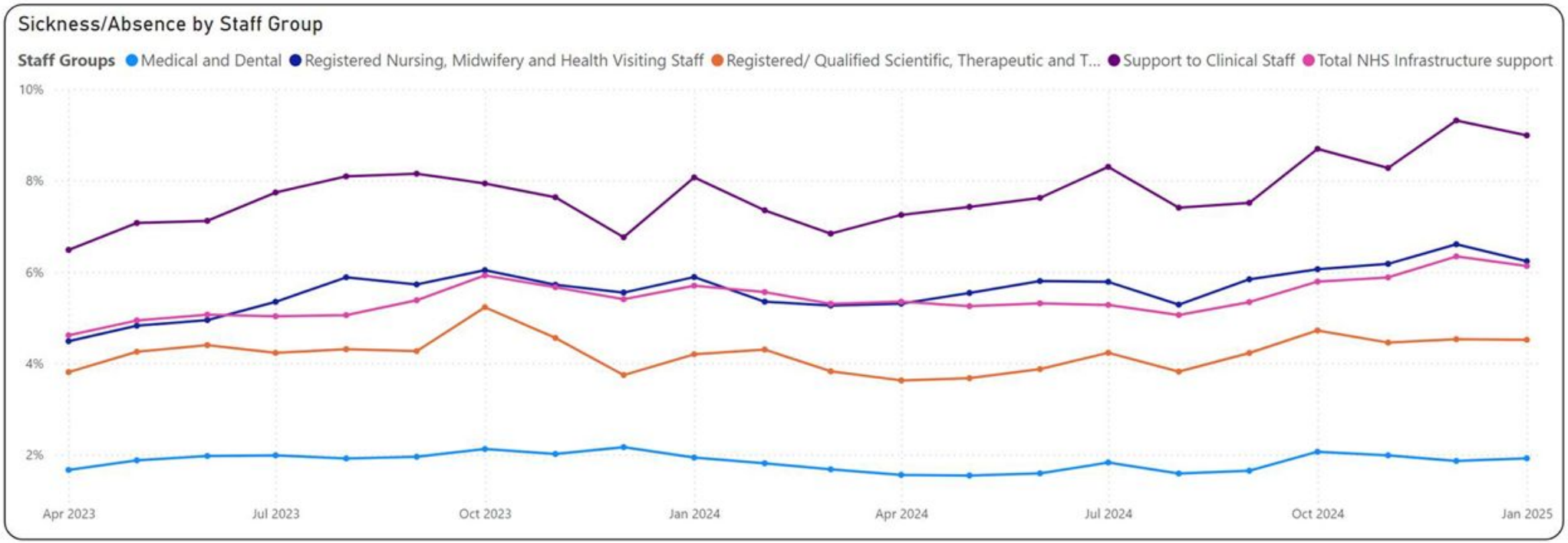
NHCT are above sickness plan but has decreased by 0.2% compared to month 9. They remain above where the model believed sickness would be at this point within the year. This early winter rise is also reflected in their peers. They have seen levels of Cough, Cold or Flu rise by 16% – 19% compared to previous winters and are looking to see if there is any correlation between our low levels of flu vaccination uptake . Other causes include; pressure relating to Trust wide efficiency schemes and societal factors i.e cost of living. They 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 have refreshed the Attendance Management Policy. Where absence is particularly high within a Care Group there several bespoke projects being enacted.

Staff Group Sickness/Absence % (12 month rolling)

Total Provider Current Position:

Support to Clinical staff and Registered Nursing, Midwifery and Health Visiting continue to show the highest levels of absence. Support to Clinical staff, Registered Nursing, Midwifery and Health and NHS Infrastructure staff have all seen a reduction in absence since Month 9. All other staff groups, have remained static.

Staff Groups	Sickness/Absence %
All Substantive Staff	6.1%
Medical and Dental	1.9%
Registered Nursing, Midwifery and Health Visiting Staff	6.2%
Registered/ Qualified Scientific, Therapeutic and Technical staff	4.5%
Support to Clinical Staff	9.0%
Total NHS Infrastructure support	6.1%



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

12 Months Rolling Sickness Absence Rate

	September 2024							
	Administrative and ..	AHPs	Healthcare Scientis..	Medical and Dental	Nursing & Midwifery	Other Scientific, Th..	Support to Clinical	Total Workforce
Birmingham and Solihull	6.0%	4.4%	3.8%	1.1%	6.0%	4.5%	8.2%	5.7%
Black Country	5.1%	4.5%	3.3%	2.0%	6.0%	3.9%	7.0%	5.4%
Coventry and Warwickshire	5.3%	4.2%	4.3%	1.7%	5.7%	3.6%	7.9%	5.4%
Derby and Derbyshire	5.6%	5.7%	4.5%	2.4%	6.2%	3.7%	7.9%	6.0%
Herefordshire and Worces..	4.8%	4.1%	3.8%	2.1%	6.1%	4.2%	7.5%	5.5%
Leicester, Leicestershire a..	4.7%	3.3%	3.4%	2.2%	5.3%	3.6%	6.6%	4.9%
Lincolnshire	4.7%	4.5%	2.3%	2.3%	5.2%	4.1%	6.8%	5.1%
Northamptonshire	5.5%	4.0%	3.0%	2.4%	5.5%	4.2%	6.4%	5.2%
Nottingham and Nottingha..	5.4%	4.4%	3.3%	1.8%	5.7%	3.9%	7.4%	5.4%
Shropshire, Telford and W..	4.6%	4.3%	3.1%	2.2%	6.0%	4.0%	7.2%	5.2%
Staffordshire and Stoke-o..	4.8%	4.0%	3.8%	2.7%	5.6%	4.4%	6.9%	5.3%
Midlands	5.3%	4.5%	3.6%	1.9%	5.8%	4.1%	7.3%	5.4%

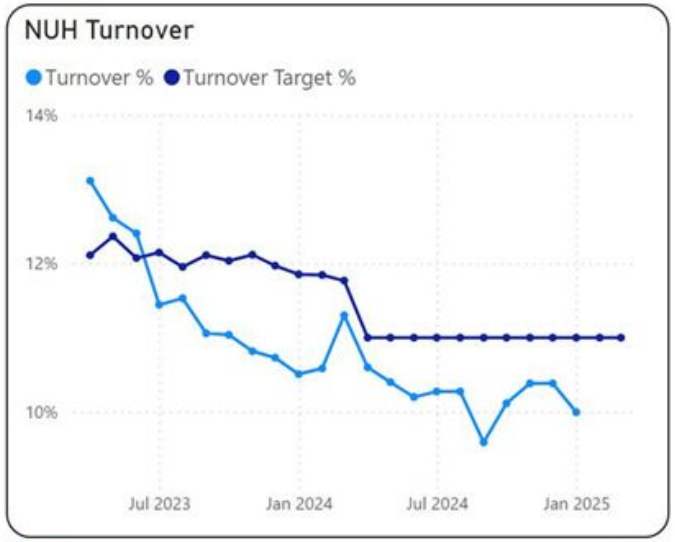
Total Provider Current Position:

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, September 24 we are in line with the Midlands benchmark, and we are below or in line with the benchmark across all staff groups except admin and clerical, and Support to Clinical staff where we are 0.1% higher.

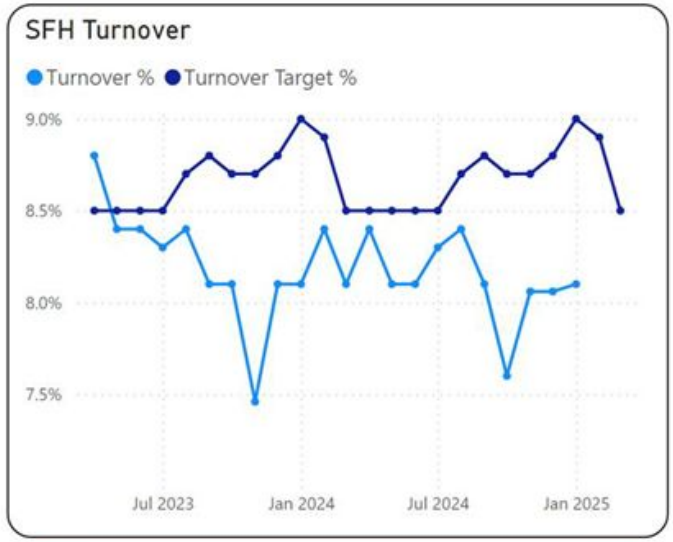
Turnover % (12 month rolling)



Turnover %	Turnover Target %
10.0%	11.0%

Provider Current Position:

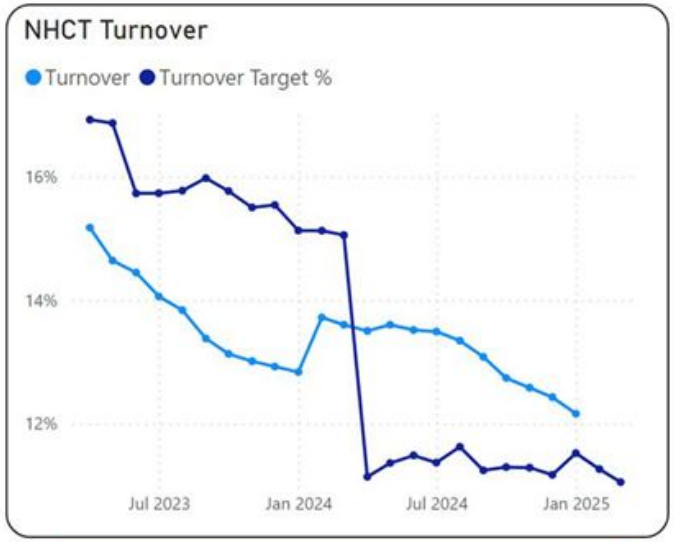
NUH turnover has remained at a consistent level for the last 12 months and remains below their target. The Trust has a retention strategy focusing on 4 main areas: strong foundations, reward and recognise staff, enable flexible working, offer training, development and wellbeing support



Turnover %	Turnover Target %
8.1%	9.0%

Provider Current Position:

SFH turnover is currently below plan but is being closely tracked monthly. 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.



Turnover %	Turnover Target %
12.2%	11.5%

Provider Current Position:

NHCT turnover is reported at 12.2% a 0.2% reduction from month 9 but continues to be above plan. They benchmark in line with peers in the East Midlands Mental Health Alliance.

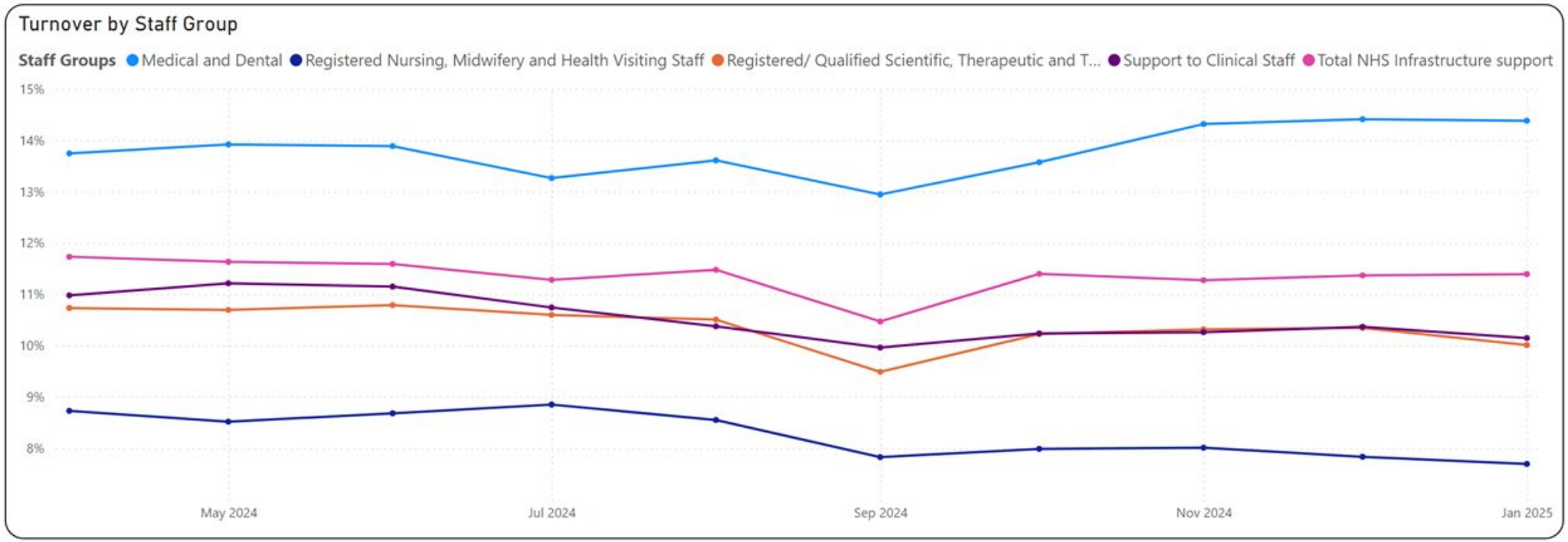
This metric has seen sustained improvement over the previous 12 -18 months but has now started to remain at a consistent level. They have several actions in place to support their aspiration to be a 'great place to work'. They have an developed the exit process to improve intelligence to support retention and support focus on areas that are losing staff at a higher rate. 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.

Staff Group Turnover % (12 month rolling)

Total Provider Current Position:

Overall staff turnover has decreased by 0.3% compared to month 9. Registered Nursing, Midwifery and Health Visiting (0.1%) , Support to Clinical staff (0.3%)and Registered/Qualified Scientific, Therapeutic and Technical staff (0.3%) have all shown a decrease turnover. NHS Infrastructure and Medical and Dental remain static.

Staff Groups	Turnover %
All Substantive Staff	10.2%
Medical and Dental	14.4%
Registered Nursing, Midwifery and Health Visiting Staff	7.7%
Registered/ Qualified Scientific, Therapeutic and Technical staff	10.0%
Support to Clinical Staff	10.1%
Total NHS Infrastructure support	11.4%



Turnover % Benchmarking

Turnover and Leaver - 12 months rolling % rate

NHS England Midlands

Turnover/Leaver Rate: Turnover | Date: September 2024

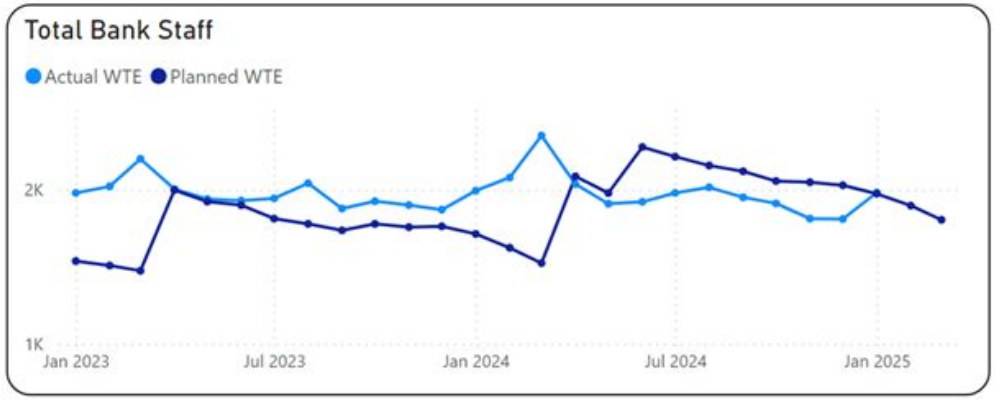
	September 2024							
	Administrative and Clerical	AHPs	Healthcare Scientists	Medical and Dental	Nursing & Midwifery	Other Scientific, Therapeutic and Technical Staff	Support to Clinical	Total Workforce
NHS Birmingham and Solihull Integrated ..	8.9%	9.6%	8.3%	5.0%	7.7%	10.0%	11.9%	9.1%
NHS Black Country Integrated Care Board	9.5%	7.3%	7.6%	6.4%	7.9%	12.8%	9.8%	8.8%
NHS Coventry and Warwickshire Integrate..	11.8%	9.1%	9.9%	6.0%	8.0%	9.7%	12.7%	10.2%
NHS Derby and Derbyshire Integrated Car..	10.4%	7.4%	10.1%	5.7%	7.0%	11.5%	8.9%	8.6%
NHS Herefordshire and Worcestershire Int..	9.6%	10.2%	9.0%	5.7%	7.6%	10.5%	12.3%	9.5%
NHS Leicester, Leicestershire and Rutland..	8.2%	8.5%	8.5%	5.0%	6.1%	8.3%	9.8%	7.8%
NHS Lincolnshire Integrated Care Board	10.2%	9.1%	10.0%	5.1%	6.8%	6.9%	11.8%	9.2%
NHS Northamptonshire Integrated Care B..	10.9%	10.5%	13.4%	7.4%	8.1%	9.8%	9.8%	9.5%
NHS Nottingham and Nottinghamshire Int..	10.4%	8.2%	8.3%	5.2%	7.5%	9.4%	9.9%	8.9%
NHS Shropshire, Telford and Wrekin Integ..	9.6%	9.1%	8.4%	7.0%	7.5%	10.2%	10.4%	9.0%
NHS Staffordshire and Stoke-on-Trent Inte..	8.5%	8.5%	7.2%	6.0%	7.0%	8.4%	11.1%	8.7%
Midlands	8.9%	6.7%	7.0%	4.5%	6.0%	7.4%	9.6%	7.7%

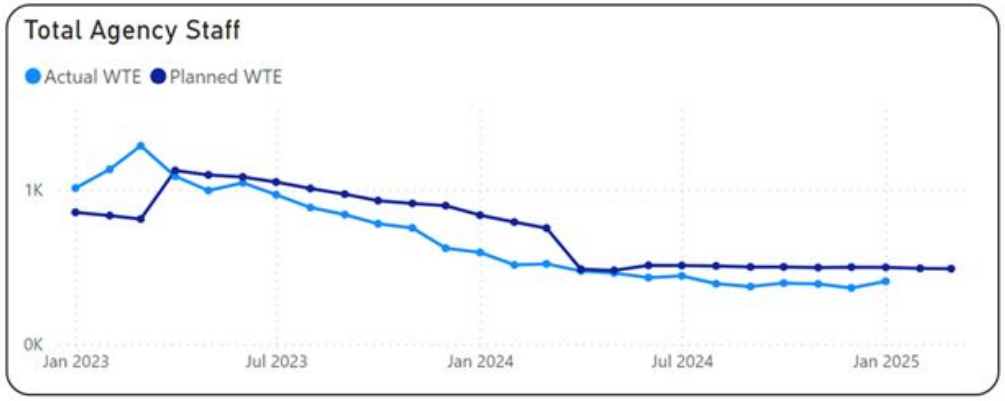
Take from NHSE data source where "NHS Nottingham and Nottinghamshire ICB" represents all NHS Organisations using ESR, therefore this collection contains data from Nottingham University Hospitals Trust, Sherwood Forest Hospitals Trust, Nottinghamshire Healthcare Trust, Nottingham CityCare Partnership 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 1.2% which remains the same as the June data. Six systems continue to record higher turnover than us. We benchmark higher in every staff group against the Midlands average with the highest adverse variance being in Admin and Clerical, Allied Health Professionals (AHP) and Nursing and Midwifery all at 1.5%. Since the June data there has been improvement in all areas except Admin and Clerical (0.2% increase) and Other Scientific, Therapeutic and Technical

Temporary Staffing





Bank WTE vs Plan

Provider	Actual WTE	Planned WTE	Variance to Plan	Variance %
ALL	1,980.8	1,973.1	7.7	0.4%
NHCT	667.3	757.7	-90.5	-11.9%
NUH	903.7	767.2	136.5	17.8%
SFH	409.9	448.2	-38.3	-8.6%

Agency WTE vs Plan

Provider	Actual WTE	Planned WTE	Variance to Plan	Variance %
ALL	405.9	496.2	-90.3	-18.2%
NHCT	139.0	179.5	-40.5	-22.5%
NUH	180.6	209.6	-29.1	-13.9%
SFH	86.4	107.1	-20.7	-19.4%

Total Provider Current Position:

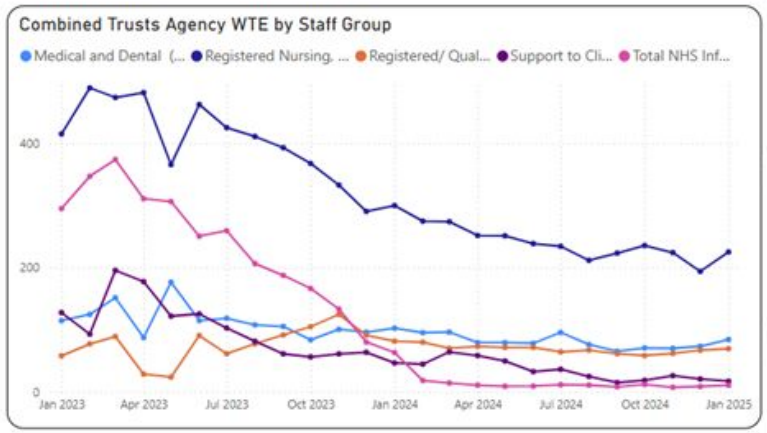
In month 10 all providers overperforming against plan agency WTE. NHCT and SFH are overperforming against bank staffing with NUH underperforming.

The total position shows them to be 7.7WTE (0.4%) above plan for Bank staff and 90.3WTE (18.2%) below plan for agency staff.

The Trusts are £2.54M adverse to their month 10 pay bill plan. NUH and SFH are over plan by £2.91M and £0.56M respectively. NHCT are under plan by £0.93M.
NHCT have overperformed against their Agency target (£0.06M) and Substantive staff (£1.33M), and underperformed on Bank (£0.45M).
SFH have overperformed against their Agency target (£0.09M), underperformed against Bank staff (£0.6M) and Substantive staff by (£0.05M).
NUH have overperformed against Agency (£1.16M) but underperformed against Bank (£2.66M) and Substantive staff (£1.41M).

All Trusts are again over plan for bank spend totalling £3.71M. All Trusts are underspent on agency staff totalling £1.31M.

Agency Breakdown



Total Agency WTE

Provider	September	October	November	December	January
NHCT	137.8	133.8	148.7	140.4	139.0
NUH	156.7	174.5	150.4	138.5	180.6
SFH	77.7	86.3	89.7	84.1	86.4

Off Framework Usage %

Provider	September	October	November	December	January
NHCT	0.0%	0.0%	0.0%	0.0%	0.1%
NUH	0.3%	0.2%	0.0%	2.4%	1.0%
SFH	0.0%	0.0%	0.0%	0.0%	0.0%

On Framework Above Price Cap %

Provider	September	October	November	December	January
NHCT	27.5%	61.6%	57.2%	55.8%	61.9%
NUH	82.2%	75.9%	64.0%	59.6%	57.2%
SFH	44.6%	42.6%	38.3%	37.7%	40.6%

Total Provider Current Position:

All Trusts are overperforming on their agency WTE against plan with a system overperformance of 18.2% (90.3WTE). All providers have shown a small monthly decrease increase in agency.

All providers submitted a plan to remove off framework agency spend by the end of June and NHCT and SFH continue to achieve this. NUH met the target in month 8 but have seen a significant increase in the use of Off Framework in months 9 and 10. In month 10 this remains predominately due to a requirement in Clinical Coding. These posts are on the list of nationally exempt role and NUH, despite efforts, are unable to remove this until they substantively recruit to the roles. The roles are supporting the Trust to meet income related targets, support the increase in volume of coding and therefore mitigate any potential loss of income.

All Providers have an upward in month trend for the use of On Framework, over price cap (OPC) agency usage in month 10. Overall, this area of agency spend has shown no real improvement in year across the Midlands region. Trusts signed up to a regional agreement to reduce the level of agency staff that are on framework but above price cap. NHSE's ambition is to have regional price compliance for nursing by March 25 (General January 2025 and Specialised March 2025). Work on Medical compliance is due to start in February with the ambition to have a rate card in place and in use by Q3. As a system Nottinghamshire is middle of the pack for OPC non-compliance, with a rate of 48.5%. Both NHCT and NUH have high shift usage and both have a significant issue with medical staffing non-compliance (88.5% and 100% respectively) and have not made the same progress on nursing staff as other Trusts being in the top 8 users of OPC nursing shifts. Sherwood Forest has achieved price cap for nursing staff

Month 10 shows small decrease increase in agency as a percentage of pay bill from 2.09% to 1.83%. Both NUH and NHCT have met the 3.2% target for agency spend as a percentage of pay bill but SFH have risen above this in month to 3.56%. NCHT have increased from 2.51% to 2.88%, NUH have increased from 0.82% to 0.83%.

SFH largest area of risk is medical and dental staff over the NHS England price cap. They continue to advertise and fill medical posts, that has gradually reduced agency level and organise medical speciality groups where there is a focus on agency spend and vacancies, with a view to support our service lines in filling these roles substantively, if not moving staff, where possible, on to direct engagement contracts.

NHCT are continuing with their planned bank and substantive staff recruitment drive and are reviewing all agency bookings through an internal dashboard up to 12 weeks in advance which allows internal agency staffing team a longer time to fill these shifts. They have improved roster sign off and introduced tighter controls on when shifts escalate to agency. As a result, of these measures they are seeing reducing agency usage.

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	Plan Q1	Plan Q2	Actual Q3	Plan Q3	Plan Q4	
Nottingham And Nottinghamshire Health And Care STP	As at the end of Jun-24	As at the end of Sep-24	As of the end of Dec-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	**3776**	**3807**	**3752**	**3820**	**3837**	**-68**
GPs (excluding GPs in Training Grade and ARRS funded roles)	591	590	585	591	588	**-6**
GPs in Training Grade	253	279	278	283	277	**-5**
Nurses (excluding ARRS funded roles)	368	372	357	374	378	**-17**
Direct Patient Care roles (ARRS funded)	651	652	654*	652	668	**2**
Direct Patient Care roles (not ARRS funded)	290	290	276	290	291	**-14**
Other – admin and non-clinical	1622	1625	1602	1631	1635	**-29**

Total Provider Current Position:

Month 9/Month 3 of Quarter 3 has shown a reduction in vacancies from 78WTE to 68WTE compared to the previous month. ARRS funded roles are the only area over established by 2 WTE. ARRS funded roles have increased by 13WTE compared to the previous month, however Direct Patient Care Roles remain under plan by 13wte. All other roles remain under plan.

○-ARRS Retention remains 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. There is some uneasiness amongst the ARRS roles concerning the continuation of PCN contract and if their role will continue beyond 2025. The Ambassadors are supporting the roles and communication flows are via the Ambassador lead updates. It has been confirmed that the GP ARRS role will continue into 25/26,however, the funding is yet to be confirmed. Several PCNs are forecasting overspends on their ARRS budget and are having to take corrective action. The ICB are working with PCN's to manage this.

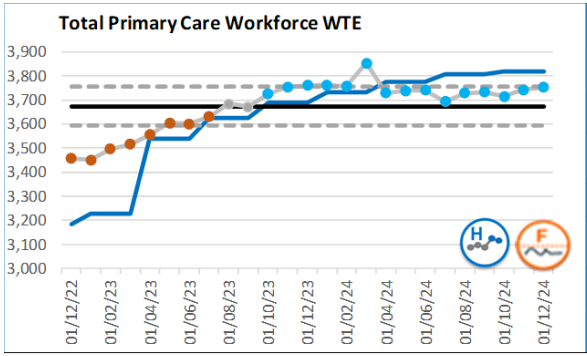
○- GP Training numbers are below plan this month, 70% are International Medical Graduates. Limited opportunity for substantive employment exist at present given uncertainties on funding within general practice. Phoenix Programme is supporting practices with sponsorship and supporting in transition from trainee into qualified and new to practice schemes. The PCN ARRS role as it continues into 25/26 will continue to support CCTs, of which will be subject to confirmation of funding within the PCNs. The ICB is working with the PCNs who have yet to appoint to the GP ARRS role to support here necessary. Phoenix is hoping to continue to support this new ARRS role with mentorship and development support as the new GPs transition into this role subject to SDF funding continuing. The initial challenge for this new ARRs role is how the PCN will support the International Medical Graduates as a PCN cannot legally apply for sponsorship, therefore a lead practice will need to become the sponsor which will impact on the timeframes of the recruitment process. Phoenix team are supporting this process.

○- GPN/Nursing has remained static this month and maintains some stability 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. The GPN Leads have developed a workforce plan that will continue to support the retention of GPNs. The development and ongoing support for GPN through CPD is managed by NATH and is reliant on SDF continuing.

○- Non-Clinical career framework established with first cohort of Practice Manager fellows and projects underway. Care navigation is also a priority. They continue to promote the virtual learning National Care Navigation offer. In previous years NATH have provided a local offer to continue to support general practice and have developed a local programme.

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. Workforce finance is a concern due to the ARRS budget issues and the increase of NI contributions which were announced as part of the Budget. An update was shared on TeamNet with the current position and the ICB have raised these concerns with national NHS leaders and are waiting for further details from NHS England about the potential mitigations for GPs and care providers. This will represent a significant amount of money at practice level and there is a risk that this may impact on staffing numbers depending on the outcome. The Pharmacy Faculty Lead post becomes vacant at the end of March 2025 and a bid has been submitted to extend funding. If this post is not filled this will have a negative impact on the ability to maintain and develop initiatives to support the retention, recruitment and development of the pharmacy workforce across Nottinghamshire.

Work has commenced on operational planning for 25/26. Data produced by NHSE has been used to establish a baseline, but further work is required to refine this. The locally held ARRS workforce information is being validated with PCN's to ensure accuracy. The planning guidance states that SDF funding will be incorporated into baseline budgets and not ringfenced this is a concern as the funds are used to support many of the programmes of work with Phoenix Programme and Nottinghamshire Alliance



Dec-24
3752
Target
3820
Assurance
Fail
SPC Variation
Improving - High

P&C Group Limited Assurance - Further Information Required:

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.

Concerns regarding the finances for the ARRS budget and the increased NI contributions with both potentially impacting on staffing numbers.

Nottingham and Nottinghamshire Social Care

NHS Nottingham and Nottinghamshire

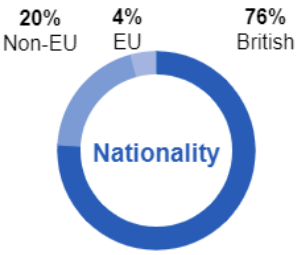
Across Local Authority, Independent sector and Direct Payment Recipients

44,000
Total posts

40,000
Filled posts

4,600
Vacant posts

Local Authority and Independent sector only:



11.5%
vacancy rate in 2023/24

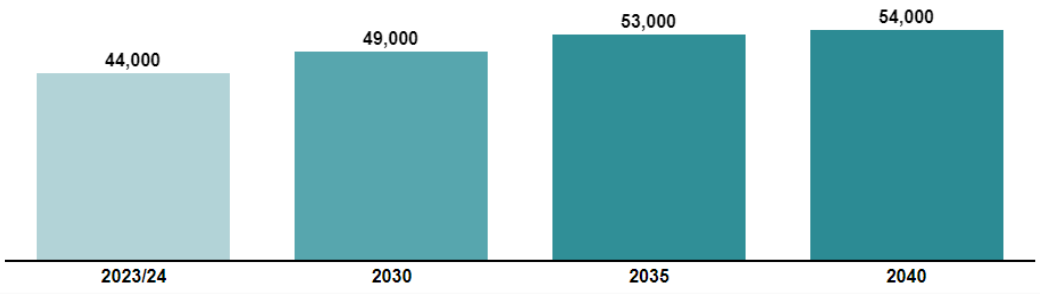
28.0%
turnover rate in 2023/24

Average hourly pay for care workers

Local authority
£11.92

Independent sector
£11.05

Projected number of total posts in adult social care required by 2040



53%
of **recruitment** is from **within adult social care**

6.1
average **sickness days** taken in 2023/24

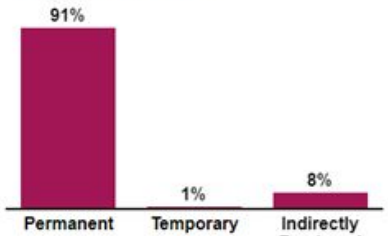
NHS
Nottingham and Nottinghamshire

Employment overview

Full-time equivalent (FTE) filled posts

The **FTE filled posts ratio** in **Nottingham and Nottinghamshire** is **0.76**

Employment status

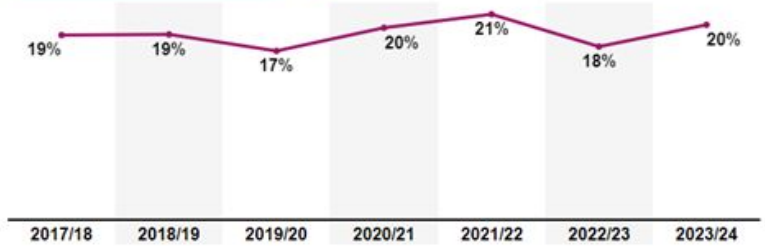


In 2023/24

20%

of filled posts were employed on a **zero-hours contract** (or **7,100 filled posts**)

Zero-hours contract trend



Demographics

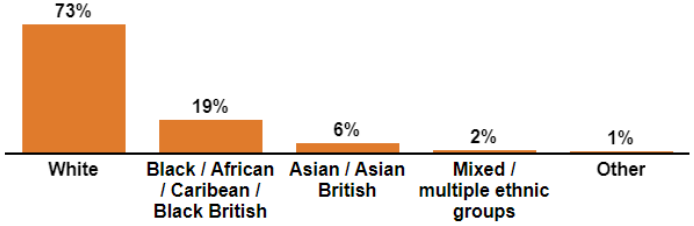
Gender

'Other' gender is collected but not yet included in analysis. See the glossary for more information.

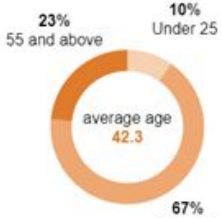
80% of the workforce were **female**

20% of the workforce were **male**

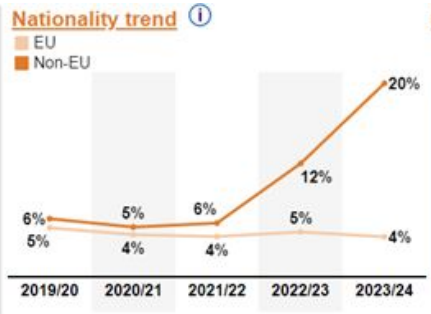
Ethnicity



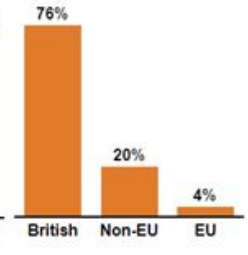
Age



Nationality trend



Nationality (2023/24)

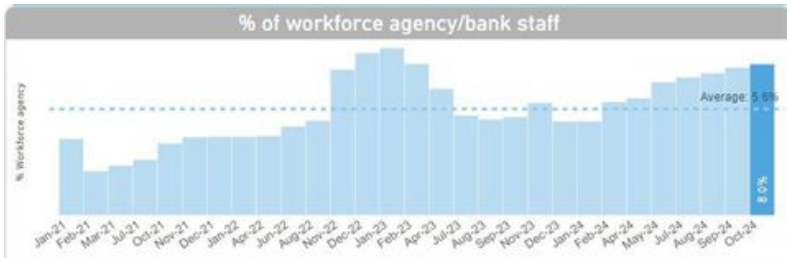


Care Homes Workforce

Workforce absence and agency staff

Monthly staff trend: All staff

Aligned PBP	Employed	Absence	%	Agency	%
Bassetlaw	1,802	30	1.7%	91	4.8%
Mid Notts	4,377	111	2.5%	425	8.9%
Nottm City	2,699	29	1.1%	199	6.9%
South Notts	4,436	115	2.6%	440	9.0%
Total	**13,314**	**285**	**2.1%**	**1155**	**8.0%**



Taken from the Care Homes and Home Care System Insight Report
Data source: National Capacity Tracker

Care Home workforce absence is a currently 2.1%. Absence of CH workforce has remained around 2% since Feb 2024. Currently, nursing staff have the lowest reporting with 11 out of 619 (1.8%) staff absences. Non-Care workers have the largest absences 68 out of 2,839 (2.4%).

The Agency/Bank staff percentage of staff continues to increase each month. This data, from the National Capacity Tracker, currently reports Agency and Bank staff rates combined. Going forward it would be good to report each of these staff groups separately. This has been suggested to the National team, but no changes have been made to date.

SAIU
SYSTEM ANALYTICS INTELLIGENCE UNIT

NHS
Nottingham and Nottinghamshire

10.0 Health Inequalities

10.1 Core20Plus5 Metrics

10.2 Neighbourhood Overview

10.3 – 10.6 Spotlight on Cancer and Health Inequalities

Health Inequalities Metrics

- Table 10.1 presents the KPIs in relation to the Core20Plus5 Approach for adults across as set by NHSE.
- Table 10.2 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.
- 10.3 Provides a spotlight on premature mortality from cancer
- 10.4 Provides an overview of early cancer diagnosis by cancer site.
- 10.5 Provides an overview of the disparities in early diagnosis.
- 10.6 Provides an overview of uptake of screening programmes which support earlier cancer diagnosis.

10.1 Core20Plus5 Adults: Indicators Refresh 2025-26

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
Maternity: Percentage of Pre-term births	Feb 25	7%	0%			8%	6%	9%
SMI: Annual health checks for 60% of those living with SMI	Feb 25	5675	7029	F		5700	5567	5833
Respiratory: Uptake of Covid and Flu Vaccine in people with COPD	Feb 25	69%	0%			71%	63%	78%
Respiratory: Reduction of emergency admissions in people with COPD	Feb 25	5%	0%			5%	5%	5%
Cancer: Percentage of cancers diagnosed at stage 1 or 2	Feb 25	61%	0%			61%	61%	61%
Hypertension: Percentage of all people with hypertension with BP in age appropriate thresholds	Feb 25	66%	0%			68%	60%	76%
Hypertension: Optimal treatment of high risk CVD (QRISK > 20% currently on statins)	Feb 25	76%	0%			75%	70%	80%

Refreshed metrics for 2025;

1. Change to maternity indicator to reflect focus on preterm births.
2. Hypertension optimal management metrics included and removed diagnosis.

10.2 Preventing Ill Health and Reducing Health Inequalities – Neighbourhood Overview (December 2024)

Period: 202412

The stark differences between our PCN / neighbourhoods

PCN Neighbourhood	No of patients	Deprivation: IMD Quintile	Risk Factors: age-adjusted prevalence per 1,000 people: Obesity	Current Smoker	Hyper-tension	Long Term Conditions: age-adjusted prevalence per 1,000 people: Diabetes Type 2	COPD	Heart Failure	Stroke	CHD	Cancers	Serious Mental Illness	Severe Frailty	Age-adjusted rates per 100,000 people: Emergency Admissions (1+ bed days length of stay)	Avoidable deaths	Life expectancy in Years: Life expec. at birth (M)	Life expec. at birth (F)
Raleigh	29,137	1	224.0	181.3	200.0	85.1	33.5	19.0	18.2	39.9	42.7	12.9	14.7	7,784	342.1	79.2	81.0
Radford & Mary Potter	37,520	1	190.0	184.9	198.7	114.0	24.1	14.4	17.5	45.2	35.8	14.4	23.2	7,650	353.0	76.5	82.7
Aspire	39,606	1	224.5	174.8	180.2	83.4	33.6	15.9	16.7	37.2	40.9	9.0	11.8	7,826	328.9	78.0	81.3
Bulwell & Top Valley	47,407	1	242.8	195.5	181.1	71.3	33.5	15.1	17.0	35.0	45.3	10.0	7.2	7,915	331.5	78.6	80.9
Nottingham City East	68,629	1	188.1	180.7	163.7	73.5	28.7	13.7	16.8	34.4	41.7	13.6	13.4	7,318	385.9	75.5	81.7
Newgate Medical Group	30,235	2	236.2	161.5	145.3	67.0	31.0	14.1	12.6	29.4	42.2	7.9	10.0	6,092	296.5	78.6	83.7
Clifton & Meadows	35,048	2	228.7	180.0	188.0	77.4	33.6	14.3	18.8	37.5	41.4	9.7	8.0	7,348	326.5	78.5	80.1
Ashfield North	51,838	2	263.7	158.8	174.4	69.6	25.8	17.8	14.8	36.4	48.9	7.5	8.5	7,783	320.2	77.1	82.2
Rosewood	52,135	2	224.6	173.8	156.2	65.3	28.1	12.4	14.1	36.1	44.0	7.7	8.4	7,546	290.6	79.1	82.8
Bestwood & Sherwood	55,725	2	199.2	151.8	157.1	65.1	22.0	12.9	16.2	32.6	43.8	10.1	8.9	6,200	295.3	78.1	82.9
Mansfield North	59,541	2	240.8	148.0	176.7	67.5	26.1	13.7	13.6	35.8	44.3	5.8	9.5	7,579	300.5	79.3	82.0
Larwood & Bawtry	38,355	3	234.7	128.7	174.3	67.7	30.9	19.9	15.0	33.3	47.5	7.4	11.9	6,207	245.6	79.2	82.9
Byron	39,347	3	234.7	137.4	162.4	61.8	24.3	12.2	14.6	32.9	48.2	6.1	18.3	7,611	284.5	77.9	80.5
City South	39,895	3	165.9	105.3	153.1	57.3	16.9	8.8	12.6	33.0	44.2	7.1	7.2	6,179	211.6	82.2	84.0
Ashfield South	41,038	3	261.6	150.2	156.9	67.5	26.8	11.4	14.7	34.2	46.1	6.7	6.5	7,756	308.3	77.4	80.4
Retford And Villages	59,176	3	237.9	128.2	155.3	58.1	22.9	11.8	12.2	28.1	45.7	5.9	9.1	5,487	227.4	79.8	84.4
Sherwood	64,114	3	238.1	136.4	172.9	64.4	24.3	13.6	13.7	35.6	47.2	5.9	9.4	6,974	229.4	79.7	81.5
Stapleford	22,315	4	230.8	131.3	167.6	58.8	21.9	9.0	12.5	28.9	45.1	6.1	5.2	6,133	219.8	81.0	86.1
Arnold & Calverton	34,303	4	208.2	120.5	146.4	49.3	18.3	8.7	15.7	29.1	47.8	6.8	8.0	5,829	204.4	79.6	84.2
Synergy Health	36,110	4	218.4	143.7	155.1	53.8	18.1	11.7	15.3	30.2	47.9	9.4	20.2	6,396	264.2	80.5	83.1
Eastwood/Kimberley	38,086	4	227.6	118.9	156.7	56.9	20.5	14.7	14.3	32.5	48.3	5.8	7.2	6,299	232.5	80.4	85.4
Newark	79,645	4	200.2	133.3	150.3	51.0	15.4	11.3	12.3	29.7	49.8	5.5	7.1	5,678	236.7	80.5	84.3
Arrow Health	40,161	5	187.5	115.1	148.7	45.5	15.4	9.8	13.0	28.0	47.1	6.6	5.8	5,857	204.3	81.6	85.0
Rushcliffe North	42,913	5	182.9	94.5	140.6	39.5	15.0	9.0	12.3	27.4	47.5	4.1	5.6	4,978	159.2	81.3	84.2
Rushcliffe South	44,505	5	177.1	85.1	139.4	39.4	11.4	9.2	12.5	25.5	47.0	4.3	4.3	4,776	165.9	83.7	84.8
Beeston	50,286	5	182.5	105.8	152.7	51.6	16.8	11.0	14.0	28.1	47.8	7.2	11.0	5,482	221.9	79.9	82.8
Rushcliffe Central	53,346	5	137.7	64.6	138.7	42.0	10.7	9.6	12.4	26.1	48.1	5.6	5.6	4,879	182.6	79.6	86.3
Unity (Nottm)	46,768	4	114.5	64.8	152.8	40.1	10.4	9.2	8.7	20.9	44.5	3.9		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
Low | High
*Opposite is true for Life Expectancy

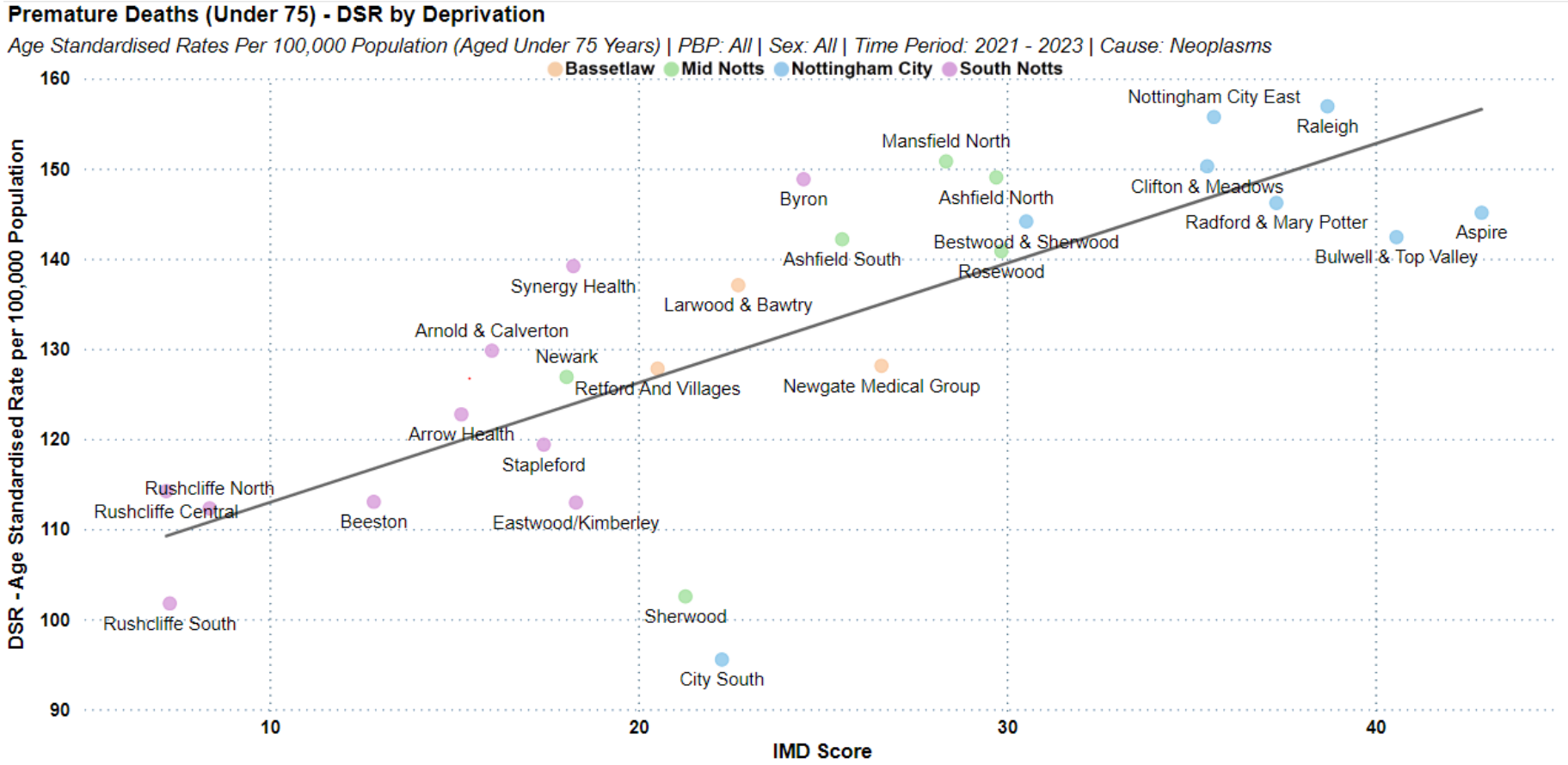
Cancer

The table shows that prevalence of cancer appears lower in areas of high deprivation and high in areas of least deprivation. It is likely this trend is linked to earlier diagnosis and longer life expectancy in more affluent areas.

Over the last 12months, cancer levels in individual PCNs have fluctuated, with some seeing increases and others decreases. Incrceases could be linked to increases in case finding/screening.

10.3 Spotlight on Cancer: Premature Mortality from Cancer

Cancer is one of the leading causes of the inequality in life expectancy across Nottingham and Nottinghamshire, contributing between 18-21% of the life expectancy gap between the most and least deprived areas. The chart below shows the correlation between premature mortality from cancer and deprivation. PCNNs with higher deprivation scores also have higher premature mortality from cancer.

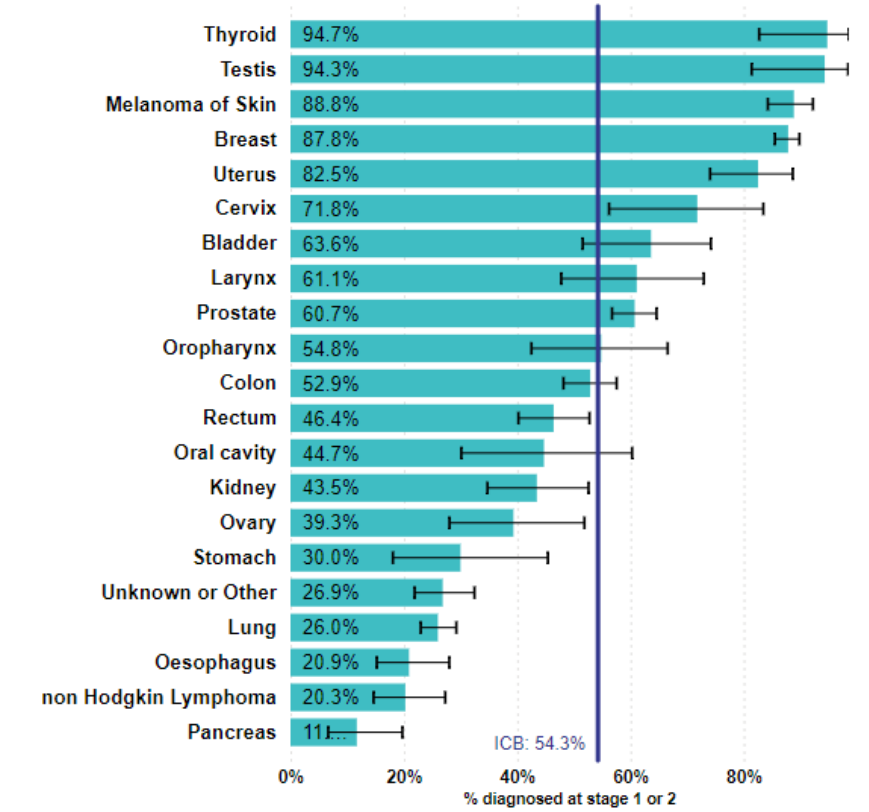


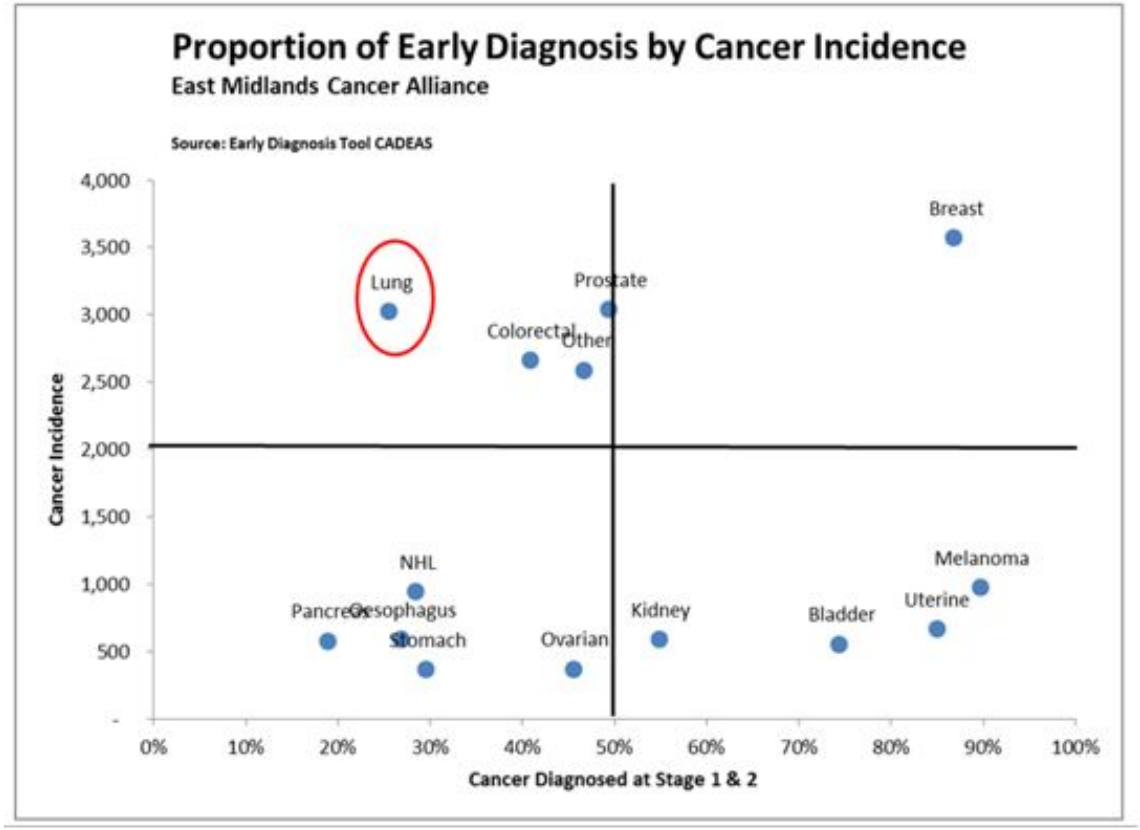
10.4 Spotlight on Cancer: Early Cancer Diagnosis by site

The cancer sites with the most diagnoses are breast, lung, prostate, and colon. In 2021, almost nine in ten breast cancers, 6 in 10 prostate cancers, and around half of colon cancers were diagnosed in the early stage. Only 26% of lung cancers were diagnosed early. This reinforces the need for programmes such as The Lung Health Check Programme, targeting ex and current smokers to detect signs of Lung Cancer earlier.

Percentage of cancers diagnosed at stage 1 or 2

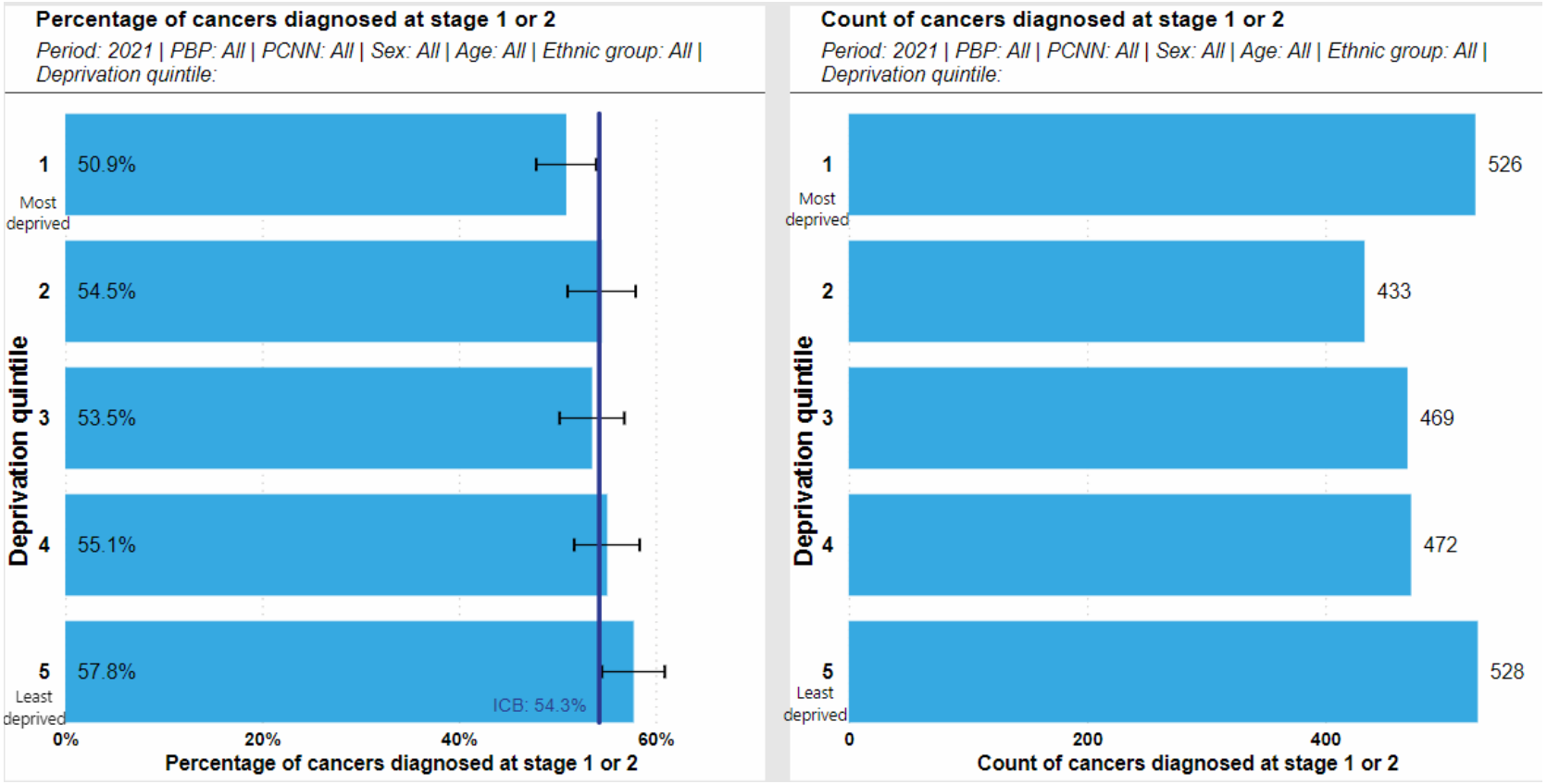
Period: 2021 | PBP: All | PCNN: All | Sex: All | Age: All | Ethnic group: All | Deprivation quintile: All | Cancer Site: All



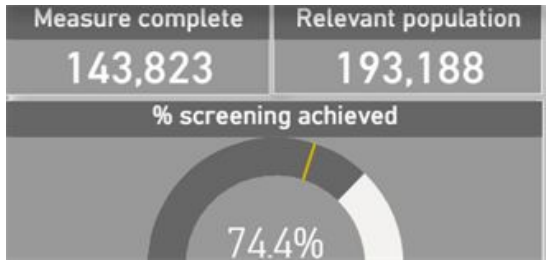


10.5 Spotlight on Cancer: Early Cancer Diagnosis by deprivation

The chart below shows the percentage of cancers diagnosed at stage 1 or 2 by deprivation. People in the most deprived areas are the least likely to have a diagnosis at stage 1 or 2. There is a 7 percentage point difference between diagnosis rates between the most and least deprived areas.
There are no statistically significant differences in early diagnosis rates between ethnic groups.

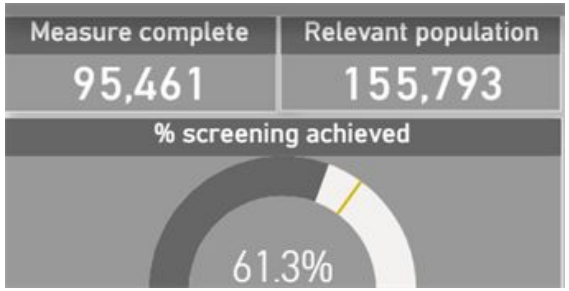


10.6 Spotlight on Cancer: Screening to support earlier cancer diagnosis



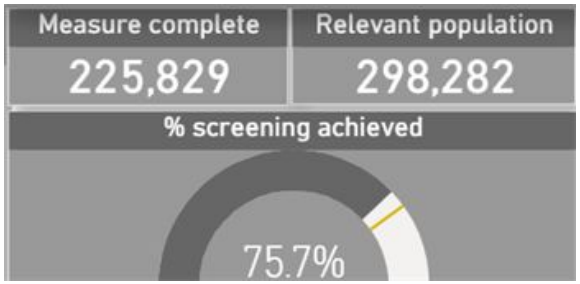
Bowel Screening:

ICS rate currently **above** national ambition of 60%.
Uptake is significantly lower in the most deprived populations, uptake is 15% lower when compared to the least deprived populations.
Uptake is lower in Asian, Black and “Other” ethnic groups.
Uptake is only 55% (lower than national ambition) in those with an ethnicity not recorded.



Breast Screening:

ICS rate currently **below** national ambition of 70%.
Uptake is significantly lower in the most deprived populations, uptake is 9% lower compared to the least deprived populations.
Uptake is lower in Mixed, Asian, Black and “Other” ethnic groups.
Uptake is only 47% in those with an ethnicity not recorded.



Cervical Screening:

ICS rate currently **below** national ambition of 80%.
Uptake is significantly lower in the most deprived populations, uptake is 9% lower compared to the least deprived populations.
Uptake is lower in Mixed, Asian, Black and “Other” ethnic groups.
Uptake is 62.5% (lower than national ambition) in those with an ethnicity not recorded.

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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

Nottingham & Nottinghamshire ICB population – NOF Overview @ 27th November 2024

NHS Nottingham and Nottinghamshire

Quality of care, access and outcomes

(35 out of 38 metrics populated @24.10.2024)

Lower Quartile Areas:

- A&E - % patients managed within 4 hours (ICB)
- Diag activity wait times - % patients not seen within 6 wks (DM01 - Only MRI, CT, NOU, Echo, Colonoscopy, FlexiSig, Gastro) (ICB, NNICB & BICB)
- Inappropriate adult acute MH out of area bed days (ICB & NNICB)
- Virtual ward - % capacity occupied (ICB)
- GP apps - % regular appointments within 14 days (ICB & NNICB)
- 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 & BICB)
- Number of CYP accessing MH services - % of pop (ICB)
- Dementia diagnosis rate (ICB & BICB)
- % of 2hr UCR refs where care was provided within 2hrs (ICB)
- MRSA bacteraemia infection rate (ICB)
- 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 @ 24.10.2024)

Lower Quartile Areas:
No indicators

Higher Quartile Areas:
No indicators

People

(14 out of 14 metrics populated @ 24.10.2024)

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 @ 24.10.2024)

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 @ 24.10.2024)

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

60 of the metrics have been populated as at 27th November 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

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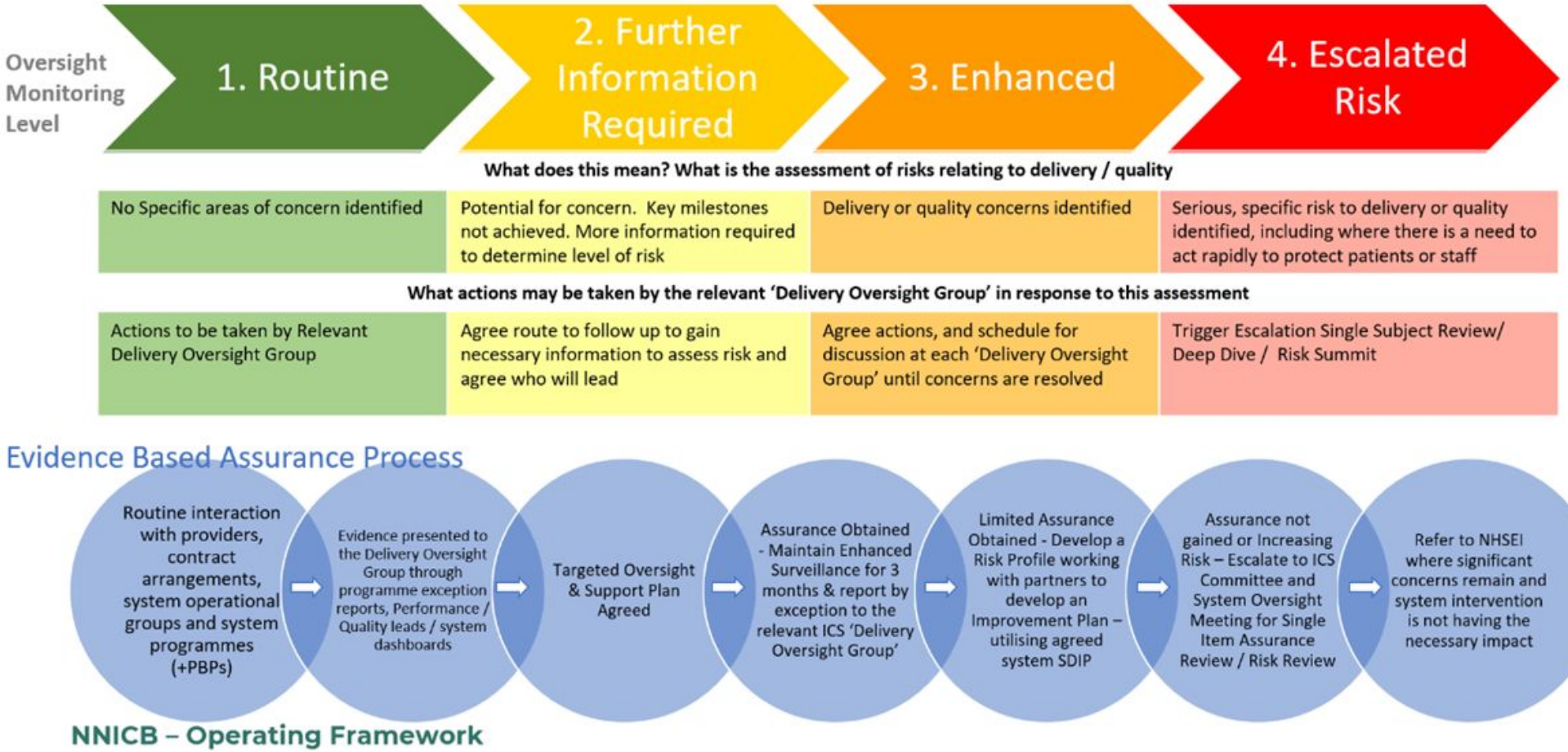
Appendices

i – ICS Assurance Escalation Framework

ii - Key to Variation and Assurance Icons (SPC) iii - Glossary of Terms

i – ICS Escalation Framework

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:



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ii – Key to Variation & Assurance Icons (SPC) and Assurance Escalation Framework

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

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iii – Glossary of Terms

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		