NHS
Nottingham and Nottinghamshire

Integrated Care Board Meeting Agenda (Open Session)

Thursday 12 January 2023 09:00 – 11:30

Chappell Meeting Room, Arnold Civic Centre
Arnot Hill Park, Arnold, NG5 6LU

"We will enable each and every citizen to enjoy their best possible health and wellbeing."

Principles:

- We will work with, and put the needs of, our **citizens** at the heart of the ICS.
- We will be **ambitious** for the health and wellbeing of our local population.
- We will work to the principle of **system by default**, moving from operational silos to a system wide perspective.

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.

	Item	Presenter	Type	Time
Introductory items				
1.	Welcome, introductions and apologies	Kathy McLean	Verbal	09:00
2.	Confirmation of quoracy	Kathy McLean	Verbal	
3.	Declaration and management of interests	Kathy McLean	Paper	
4.	Minutes from the meeting held on: 10 November 2022	Kathy McLean	Paper	
5.	Action log and matters arising from the meeting held on: 10 November 2022	Kathy McLean	Paper	
Leadership				
6.	Chair's Report	Kathy McLean	Paper	09:05
7.	Chief Executive's Report	Amanda Sullivan	Paper	09:10
Health inequalities and outcomes				
8.	Supporting the Nottingham City Place-Based Partnership to be a delivery vehicle for ICS priorities	Mel Barrett/ Dr Hugh Porter	Paper	09:25
9.	Citizen Story: Green Social Prescribing	Rosa Waddingham	Paper	09:45
10.	Transforming Personalised Care and Co-production	Rosa Waddingham	Paper	10:00
11.	Digital Transformation: Strategic Progress Update	Dave Briggs	Paper	10:20

Assurance and system oversight

12.	Integrated Performance Report		Paper	10:40
	a) Finance	Stuart Poynor		
	b) Service Delivery	Lucy Dadge		
	c) Health Inequalities	Dave Briggs		
	d) Quality	Rosa Waddingham		
	e) Workforce	Rosa Waddingham		
13.	Committee Highlight Reports		Paper	11:05
	a) Strategic Planning and Integration	Jon Towler		
	b) Quality and People	Marios Adamou		
	c) Finance and Performance	Stephen Jackson		
	d) Audit and Risk	Caroline Maley		

Closing items

14.	Risks identified during the course of the meeting	Kathy McLean	Verbal	11:25
15.	Questions from the public relating to items on the agenda	Kathy McLean	Verbal	
16.	Any other business	Kathy McLean	Verbal	

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)

Date and time of next Board meeting held in public: 9 March 2023 at 9:00 (Arnold Civic Centre)

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/01/2023
Paper Title:	**Declaration and management of interests**
Paper Reference:	ICB 22 048
Report Author:	Jo Simmonds, Head of Corporate Governance
Report Sponsor:	Lucy Branson, Associate Director of Governance
Presenter:	Kathy McLean, Chair
Recommendation(s):	The Board is asked to **RECEIVE** this item.

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**.

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.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	No
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	No
Duties as to reducing inequalities	No
Duty to promote involvement of each patient	No
Duty as to patient choice	No
Duty to obtain appropriate advice	No
Duty to promote innovation	No
Duty in respect of research	No
Duty to promote education and training	No
Duty to promote integration	No
Duty to have regard to the wider effect of decisions	No
Duties as to climate change	No
Duties regarding public involvement and consultation	No
Public sector equalities duties	No

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, for the purposes of this meeting, from the ICB's full Register of Declared Interests.

• 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 - providng eductional and advisory services	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
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	National Institute for Health and Care Research	Member of Health Technology Assessment Prioritisation Committee			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
BRIGGS, David	Medical Director	British Medical Associaton	Member		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Mid Nottinghamshire and Greater Nottingham Lift Co (public sector)	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Valley Road Surgery	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Nottingham Schools Trust	Chair and Trustee			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Care Workers Union	Director (not remunerated)			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Cleaners Union	Director (not remunerated)			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Nottingham Business Improvement District (BID)	Non-Executive Chair		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
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	Non-Executive Director		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Derbyshire Health United CIC	Non-Executive Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.

Name	Current position(s) held in the ICB	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To:	Action taken to mitigate risk
JACKSON, Stephen	Non-Executive Director	IBC Ltd (currently inactive)	Joint Owner and Chief Executive Officer	✓				01/07/2022	Present	There is no contract in place with this organisation - therefore this interest will be kept under review and specific actions determined as required.
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.
LIM, Dr Kelvin	Primary Care Partner Member	Primary Integrated Community Services	Director	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangement) relating to services that are currently, or could be, provided by PICS.
LIM, Dr Kelvin	Primary Care Partner Member	NEMS	Shareholder	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LIM, Dr Kelvin	Primary Care Partner Member	Church Walk Medical Services	Shareholder	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LIM, Dr Kelvin	Primary Care Partner Member	Eastwood Primary Care Centre	GP Partner	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to General Medical Services.
LIM, Dr Kelvin	Primary Care Partner Member	Eastwood Primary Care Centre	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MAJID, Ifti	Mental Health Partner Member	Nottinghamshire Healthcare NHS Foundation Trust	Chief Executive	✓				07/12/2022	Present	This interest will be kept under review and specific actions determined as required.
MALEY, Caroline	Non-Executive Director	Village Health Group	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	University Hospitals of Derby and Burton NHS Foundation Trust	Trust Chair	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Kathy McLean Limited - Private limited company to offer health related advice	Director	✓				01/07/2022	Present	There is no contract in place with this organisation - therefore this interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Barts Health NHS Trust (London)	Non-Executive Director	✓				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.
MCLEAN, Kathy	ICB Chair	Public Sector Consultancy	Senior Clinical Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS England/Improvement	Lay Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS Providers Board	Trustee		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
POYNOR, Stuart	Director of Finance	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable

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
ROBINSON, Paul	NHS Trust and NHS Foundation Trust Partner Member	Sherwood Forest Hospitals NHS Foundation Trust	Chief Executive	✓				01/07/2022	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.
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.
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	YPO - a publicly owned central purchasing body based in Wakefield, Yorkshire. It is owned and governed by a consortium of county, metropolitan and borough councils in Yorkshire and the North West England. It provides a wide range of resources and services to schools, councils, charities, emergency services, and other public sector organisations.	Independent Director	✓				01/07/2022	31/10/2022	Interest expired no action required.
TOWLER, Jon	Non-Executive Director	The Conservation Volunteers: a national charity bringing together people to create, improve and care for green spaces.	Chair (Trustee and Director)	✓				01/12/2022	Present	This interest will be kept under review and specific actions determined as required.
TOWLER, Jon	Non-Executive Director	The Conservation Volunteers: a national charity (also registered as a limited company) bringing together people to create, improve and care for green spaces.	Fellow director and trustee is a senior manager at Mental Health Concern and Insight IAPT				✓	01/12/2022	Present	This interest will be kept under review and specific actions determined as required.
UNDERWOOD, Catherine	Local Authority Partner Member	Nottingham City Council	Corporate Director of People	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
UNDERWOOD, Catherine	Local Authority Partner Member	Ruddington Medical Centre	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
WADDINGHAM, Rosa	Director of Nursing	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
WILLIAMS, Melanie	Local Authority Partner Member	Nottinghamshire County Council	Corporate Director for Adult Social Care and Health	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
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.
The following individuals will be in attendance at the meeting but are not part of the Board's membership:										
BRANSON, Lucy	Associate Director of Governance	St George's Medical Practice	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
HUBBER, Lucy	Director of Public Health, Nottingham City Council	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable

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
10/11/2022 09:30-11:50
Chappell Room, Civic Centre, Arnot Hill Park

Members present:

Dr Kathy McLean	Chair
Professor Marios Adamou	Non-Executive Director
Lucy Dadge	Director of Integration
Dr Dave Briggs	Medical Director
Stephen Jackson	Non-Executive Director
Dr Kelvin Lim	Primary Care Partner Member
Caroline Maley	Non-Executive Director
Stuart Poynor	Director of Finance
Paul Robinson	NHS Trust/Foundation Trust Partner Member
Amanda Sullivan	Chief Executive
Jon Towler	Non-Executive Director
Catherine Underwood	Local Authority Partner Member
Rosa Waddingham	Director of Nursing
Melanie Williams	Local Authority Partner Member

In attendance:

Lucy Branson	Associate Director of Governance
Anne-Maria Newham	Deputy NHS Trust/Foundation Trust Partner Member
Dean Royles	Interim People and Culture Senior Responsible Officer
Dr Stephen Shortt	Clinical Lead (for item ICB 22 036)
Sue Wass	Corporate Governance Officer (minutes)

Cumulative Record of Members' Attendance (2022/23)

Name	Possible	Actual	Name	Possible	Actual
Kathy McLean	3	3	Stuart Poynor	3	3
Marios Adamou	3	3	Paul Robinson	3	2
John Brewin	1	0	Amanda Sullivan	3	3
Dave Briggs	3	3	Jon Towler	3	3
Lucy Dadge	3	3	Catherine Underwood	3	2
Stephen Jackson	3	3	Rosa Waddingham	3	3
Kelvin Lim	3	1	Melanie Williams	3	3
Caroline Maley	3	2			

Introductory items

ICB 22 029 **Welcome, introductions and apologies**

Kathy McLean welcomed members to the meeting of the Board and a round of introductions was undertaken. There were no apologies for absence.

ICB 22 030 **Confirmation of quoracy**

The meeting was confirmed as quorate.

ICB 22 031 **Declaration and management of interests**

No interests were declared in relation to any item on the agenda. Kathy McLean reminded members of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.

ICB 22 032 **Minutes from the meeting held on: 08 September 2022**

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

ICB 22 033 **Action log and matters arising from the meeting held on: 08 September 2022**

The actions from the last meeting were confirmed as complete.

Leadership

ICB 22 034 **Chair's Report**

Kathy McLean presented the item and highlighted the following points:

a) In the context of growing winter pressures on the local health and care system, thanks were given to NHS staff who were working hard to manage both the current pressures and the work towards future integrated care population health management models. It was likely that NHS and local authority budgets would become more constrained in coming months and years, and as such, it was more important than ever that organisations work together to maximise resources.

b) The Integrated Care Partnership would play a key role in directing the use of resources. Its inaugural meeting had taken place on 13 October to progress the development of the initial Integrated Care Strategy and the engagement of citizens in its development. An

ICS Partners Assembly meeting had also taken place on 25 October. Following the receipt of further guidance regarding decision-making arrangements as a joint committee in the context of the new legislation, a revised terms of reference for the Partnership was appended to the report for the Board's approval. This would also be approved by the Nottingham City and Nottinghamshire County Councils.

c) A small number of housekeeping amendments have been made nationally to the ICB model constitution; these have been replicated within the ICB's Constitution at the request of NHS England.

d) A governance 'stocktake' was being planned to ensure that ICB structures were working well in practice, the outcome of this work would be brought to the next meeting. Prior to this, the Board was asked to approve the move of responsibility for the oversight of research and patient and public engagement and consultation from the Quality and People Committee to the Strategic Planning and Integration Committee to ensure better alignment to Committee remits.

The Board:

- **NOTED** the Chair's Report; noting in particular the minor amendments to the ICB's Constitution as directed by NHS England.
- **APPROVED** the amended terms of reference for the Nottingham and Nottinghamshire Integrated Care Partnership.
- **APPROVED** the proposed change in committee oversight arrangements for research and patient and public engagement and consultation, and the associated amendments to the quality and People and Strategic Planning and integration Committees' terms of reference.

ICB 22 035 Chief Executive's Report

Amanda Sullivan presented the item and highlighted the following points:

a) The system continued to operate under significant pressure, with several factors impacting on services, including a rise in Covid infections, staff absence and vacancies. A further critical incident had been declared on 28 September, which required actions from all partners to be taken to ensure safe services; and it was stood down at the earliest opportunity. Learning from this and the previous incident had been incorporated into preparations for winter.

b) The report detailed several new national requirements to help with winter pressures, which had been incorporated into the local system action plan, including the establishment of a system control centre to balance clinical risk across the system.

c) Following on from the last report in September, an update was given on how system partners were developing offers to support staff and citizens during these unprecedented times of rising food, fuel, energy and living costs.

d) The Board was asked to approve the signing of Mencap's 'Treat me Well' pledge to demonstrate the ICB's commitment to people with a learning disability. The report gave further detail of the range of support provided for individuals with learning disabilities and autism.

e) Good progress was being made in embedding citizens' voices within the ICB's structures, and the report gave further detail on the groups and opportunities for individuals to engage with the ICB.

f) Noting the publication of the report into maternity care at East Kent Hospitals University NHS Foundation Trust, members were asked to note that learning would be incorporated into the action plan for maternity services at Nottingham University Hospitals NHS Trust. Of note in the report was the extent that external regulatory bodies were able to recognise early warning signs of a failing service.

g) NHS England had recently launched a consultation on proposed changes to its Enforcement Guidance and the ICB would be responding to it. Members were invited to comment and views would be collated in a response by the deadline of 9 December 2022.

The following points were made in discussion:

h) Members queried preparations for a possible industrial action by members of the Royal College of Nursing. It was noted that industrial action was incorporated into existing Emergency Planning Resilience and Response (EPRR) arrangements.

i) Reflecting on the publication of recent national reports by the Care Quality Commission and the National Audit Office, members noted the tension between the challenging financial environment, meeting national targets and addressing local need.

j) Regarding winter planning, members queried emerging metrics relating to delay-related patient harm. It was noted that existing measures did not fully capture impacts across the system and improved methodology would enable systems to flex capacity

during critical incidents. It was agreed to report progress through the Quality and People Committee.

k) Regarding the update on actions to be taken to support people in coping with the rising cost of living, members requested additional detail on measures to support NHS staff. It was noted this would be included in a workforce progress report to the next Quality and People Committee.

l) Approving the signing of the Mencap Pledge, members noted the good system leadership in this area and requested that an assurance report to a future Quality and People Committee should map current actions against the Mencap Pledge to ensure all commitments within the Pledge were being addressed.

The Board **NOTED** the Chief Executive's Report and **APPROVED** the signing of the Mencap pledge.

ACTIONS:

Quality and People Committee to receive future reports in relation to:

- **Actions being taken to reduce delay-related patient harm.**
- **Actions being taken to support local NHS staff in coping with the rising costs of living.**
- **Actions being taken in relation to the Mencap Pledge to ensure all commitments are being addressed.**

Health inequalities and outcomes

ICB 22 036 **Nottingham and Nottinghamshire ICS Primary Care Strategy**

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

a) The report presented the Primary Care Strategy for approval. Primary care was the bedrock of the healthcare system, fundamental to the provision of personalised care, preventative care, and the reduction of health inequalities.

b) A well performing primary care sector was critical to improving health and wellbeing outcomes and patient experience. However, at present, the sector was not performing well, and the draft Strategy aimed to transform the experience of primary care, both for patients and for the staff that worked in the sector.

c) The Strategy had been developed through wide engagement with a range of stakeholders and was arranged into ten objectives under three themes, which were set out within the paper.

d) The Strategy had been built on several developments and new models of care, introduced during previous years, such as the creation of Primary Care Networks (PCNs).

e) Delivery of the Strategy would be led by providers and would require local planning and customisation. Headline programme monitoring indicators would be developed to track progress.

The following points were made in discussion:

f) Members welcomed the Strategy, noting it was a significant investment, and in the early years would be focused on General Practice, pending the delegation of wider Primary Care responsibilities from NHS England.

g) Members noted the Strategy contained the right actions, but queried confidence of achievement of its aims, given competing priorities. It was noted that the Strategic Planning and Integration Committee, whilst endorsing the Strategy, had not been assured that it could be implemented and there was a need to understand in more depth how the financial, resource and cultural challenges of the Strategy would be overcome.

h) It was noted that the Strategic Planning and Integration Committee would oversee the development of a delivery plan and would seek assurance on its progress.

i) Support for the further development of PCNs to build stronger links with community and wider care services was discussed.

j) Members noted that the Strategy did not sit in isolation and needed to be considered alongside the Community Transformation Programme and PCN and Place development plans.

The Board **APPROVED** the ICS Primary Care Strategy.

Dr Stephen Shortt left the meeting at this point.

ICB 22 037 Strategic approach to transforming health and care for people with mental health needs

Lucy Dadge presented the item and highlighted the following points:

a) The report provided an overview of the strategic approach to improve mental health provision across Nottingham and Nottinghamshire to reduce local health inequalities.

b) The system's local approach was well established, as set out in the Nottingham and Nottinghamshire Integrated Care System (ICS) Mental Health Strategy 2019 to 2024; and in response to the NHS Mental Health Long Term Plan (LTP).

c) The fundamental organising principle underpinning service transformation was a single set of system priorities and outcomes for mental health improvement, which required an integrated strategic planning approach, encompassing health, public health, social care and support dimensions.

d) The Covid pandemic had resulted in an increase in demand for mental health services, across all ages. There had however also been an increase in the availability, range, expertise and integration of services and pathways, developed using co-production.

The following points were made in discussion:

e) Members welcomed the report, and the emphasis on co-production and collaboration with the voluntary sector. It was noted that a key challenge going forward would be to engage further with diverse communities to understand differing health needs and adapt services to meet needs. It was noted that next steps would be to develop programmes at Place level to run in tandem. Members noted the need to strengthen the role of Place-Based Partnerships in delivery.

f) The need for a holistic approach was also raised, given the inter-connectivity between mental and physical health.

g) Members queried whether there would be a stock take of achievements pending the work to draft a refreshed strategy, including any return-on-investment analysis. It was noted that this was work in progress. Given that demand continued to exceed supply, the need for a focus on prevention was emphasised.

h) It was agreed that the refreshed strategy should also include a portrayal of what 'good' mental health services should look like.

i) The need to ensure inter connection with other strategies was noted.

The Board **ENDORSED** the progress of the Mental Health Transformation Programmes and the system approach to co-production,

strategic planning, and service delivery to meet the needs of the population.

ICB 22 038 Strategic approach to transforming health and care for children and young people

Lucy Dadge presented the item and highlighted the following points:

a) This paper outlined the collaborative approach of the ICS in the context of meeting children and young people's health needs.

b) There was a strong track record of joint strategic planning between Local Authorities, Public Health, and the ICB; informed by co-production with children, young people, and their carers. Examples were given of joint approaches that were having a positive impact on a range of programmes.

c) Future challenges were detailed. Of note was the need to invest in reducing childhood obesity, transition from child to adult services, thinking differently about workforce and the opportunities the devolvement of specialised commissioning could afford.

The following points were made in discussion:

d) Welcoming the report, members acknowledged that funding for a concerted investment in areas such as childhood obesity could be impacted by financial challenges faced by Local Authorities.

e) Members welcomed a proposal to escalate these priorities into local Safeguarding Boards.

f) Reflecting on the items for discussion at today's meeting, members noted the investment required to make a sustained improvement in services and welcomed the proposal to bring together system leaders for a broader discussion on investment priorities as part of the work to develop the ICB's Joint Forward Plan.

The Board **ENDORSED** the progress of the Children and Young People's Transformation Programmes and the system approach to co-production, strategic planning, and service delivery to meet the needs of the population

ICB 22 039 ICS Health Inequalities Plan

Dave Briggs presented the item and highlighted the following points:

a) An ICS Health Inequalities Strategy had been approved in 2020. This Plan focused on delivery within the context of the introduction

of the NHS Core20+5 framework and supported the system's existing Joint Local Health and Wellbeing Strategies.

b) The Plan, which had been endorsed by the Strategic Planning and Integration Committee, was presented for approval prior to submission to NHS England.

The following points were made in discussion:

c) Noting that much of the delivery of the Plan would be undertaken at Place-level, members discussed the need for a systematic monitoring process to ensure interventions had the desired impact and queried whether evaluation tools were required.

d) Members discussed the financial implications of the Plan. It was noted that there would not necessarily be financial implications associated with all elements of the plan, as some aspects were more about cultural changes in attitudes and working practices.

e) Members queried how the Strategic Planning and Integration Committee would oversight implementation of the Plan. Using the Outcomes Framework as the basis for oversight was suggested, and it was agreed that proposed options for the oversight of the Health Inequalities Plan would be presented to a future meeting of the Committee.

The Board **APPROVED** the ICS Health Inequalities Plan.

ACTION: Dave Briggs to report to the Strategic Planning and Integration Committee on proposed options for the oversight of the Health Inequalities Plan.

At this point Catherine Underwood left the meeting

Assurance and system oversight

ICB 22 040 **Integrated Performance Report**

Stuart Poynor, Rosa Waddingham and Dave Briggs presented the item and highlighted the following points:

a) At the end of month six, the NHS System was reporting a £36.3 million deficit position, which was £12.9 million adverse to plan. The main drivers of the deficit related to Covid costs, efficiency shortfalls, a funding gap for Community Diagnostics Centres, pay award shortfalls and urgent care capacity above planned levels.

The forecast position remained a break-even position. However there remained significant risk to this position and discussions with NHS England continued. All actions required by NHS England were in train.

b) The system was failing to meet the majority of operational planning targets and action was being taken in each area to target improvement. System flow continued to be the main driver of deteriorating performance and focus remained on initiatives to improve discharge rates. System flow was also impacting elective care activity; however, cancer treatment continued to be the highest priority. Demand for cancer services was higher than before the pandemic, which had impacted on waiting times.

c) The Integrated Performance Report contained a new dashboard for health inequalities, which would be refined to focus on meaningful metrics, given that many indicators in this area needed to be viewed over the long term.

d) The system-wide Improvement Oversight and Assurance Group for Nottingham University Hospitals NHS Trust was reporting good progress on the implementation of an action plan to address concerns that had been raised by the Care Quality Commission. System support mechanisms were also in place for Nottinghamshire Healthcare NHS Foundation Trust to address concerns raised by the Care Quality Commission during a recent inspection.

e) The Learning Disability and Autism Partnership Programme remained under enhanced surveillance due to adult inpatient numbers. The target was forecast not to be met. Needs assessment and market development work was being strengthened.

f) Flu and Covid vaccination programmes had commenced and uptake across the system was positive. Initial focus was on ensuring that the most vulnerable were protected, including care home residents and housebound patients.

g) Infection prevention and control and hospital acquired infection targets were higher than planned across a range of targets; however, this was also being seen in other areas and the system was not an outlier.

h) Workforce metrics showed an increase in sickness absence rates in acute, community and mental health trusts; wellbeing plans remained in place in all organisations. Staff turnover and use of agency staff remained at higher than planned levels.

The following points were made in discussion:

f) Members noted a low level of confidence of achieving financial targets, given the predicted rise in bed occupancy and the use of agency staff to mitigate the impact of the expected industrial action.

g) It was noted that Local Authorities were due to consult on their budgets and reductions in services would need to be made to achieve a balanced budget.

h) The need for a focus on increased productivity was highlighted as a means to meet targets. It was noted that senior leaders would be brought together from across the system to focus on how to operate within system resource allocations.

The Board **NOTED** the report.

ICB 22 041 Committee Highlight Reports

The report presented an overview of the work of the Board's committees since its last meeting in September 2022; it aimed to provide assurance that the committees are effectively discharging their delegated duties and included assessments of the levels of assurance the committees have gained from their work during the period.

Stephen Jackson, Marios Adamou, Jon Towler and Caroline Maley, as chairs of the relevant committees, presented the report and highlighted the following points:

a) Finance and Performance Committee members had noted the need to further refine performance reporting to the Committee to enable a greater level of assurance to be taken. Members flagged the need for a continued focus on meeting financial targets without causing pressure on next year's budgets. The ICB's Green Plan had been well received.

b) Quality and People Committee members had welcomed the addition of Partner Non-Executive Directors to its membership, which gave more of a system view on quality concerns. Members had only been able to take limited assurance in response to the People and Culture Report, pending further development. The committee had approved the ICB's Co-production Strategy.

c) Strategic Planning and Integration Committee members had taken reasonable assurance from, a range of system development updates, covering Provider Collaborative, Place and Primary Care Network development, and evolving population health management processes. A number of investment and contract award decisions had been made, as set out in the report.

d) Audit and Risk Committee members had received substantial or reasonable assurance in relation to all items at their meeting in September. This had included an update on evolving system risk management arrangements.

The Board **NOTED** the report.

ICB 22 042 Board Assurance Framework

Lucy Branson presented the item and highlighted the following points:

a) The report presented the current position of the ICB's 2022/23 Board Assurance Framework for scrutiny and comment. This built upon the opening position, presented in September 2022, which confirmed the strategic objectives and strategic risks for the organisation following its establishment in July 2022.

b) Most risks remained some way from their target risk scores; however, a good level of control had been identified across all risks. It was anticipated that the ICB's control environment, and controls being established as part of system governance arrangements, would strengthen and embed over the remainder of 2022/23.

c) A good level of planned assurances had been identified across each of the strategic risk areas. Assurances are scheduled to be routinely received by both ICB and system governance forums; many of which had already commenced.

d) The importance of ensuring that there was an appropriate balance between managing today and making tomorrow better was highlighted in strategic risk 2 (system resilience) and risk 3 (transformation).

e) The majority of the 'gaps' identified related to known areas where work was already underway.

The following points were made in discussion:

f) Members welcomed the report and agreed that the heat map presented a helpful summary.

g) It was noted that a dedicated session to discuss the ICB's risk appetite had been scheduled.

h) Members noted the Audit and Risk Committee's role in seeking further assurance. The targeted risk reports would examine in more detail progress to meet target risk scores, and of note, to examine those risks with no current external assurances.

The Board **REVIEWED** the current position of NHS Nottingham and Nottinghamshire ICB's Board Assurance Framework.

Closing items

ICB 22 043 **Risks identified during the course of the meeting**

No new risks were identified.

ICB 22 044 **Questions from the public relating to items on the agenda**

A question had been received in advance of the meeting from a member of the public, querying the efficacy of covid vaccinations and calling for the ICB to support a public audit of the NHS covid response.

In response, Rosa Waddingham stated that the ICB had full confidence in the expert judgement and processes of the Medicines and Healthcare products Regulatory Agency, the official UK regulator, which had approved Covid-19 vaccines for use in the UK. It was noted that the ICB would comply with requests from the national public inquiry, currently underway, which would investigate the response to the pandemic and lessons to be learnt.

A member of the public observing the meeting raised a question regarding support for victims of domestic abuse, with reference to the IRIS programme. Rosa Waddingham responded that there were several statutory agencies involved in support for victims of domestic abuse, including the Nottinghamshire Adult and Children Safeguarding Boards, who were reviewing support, given the impact of the pandemic, and IRIS was one of several possible support tools. It was agreed that the Quality and People Committee should be sighted on the ICB's statutory duties and focus in this area.

ACTION: Domestic Abuse support measures to be added to the forward work programme for the Quality and People Committee.

ICB 22 045 **Any other business**

No other business was raised, and the meeting was closed.

Date and time of next Board meeting held in public: 12 January 2023 at 9:00 (Arnold Civic Centre)

NHS
Nottingham and Nottinghamshire

ACTION LOG for the Integrated Care Board meeting held on 10/11/2022

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
Closed	08.09.22	Chief Executive's Report	To bring a report on system workforce issues to the November Board meeting	Rosa Waddingham	10.11.22	Discussion held at the December Board Development Session.
Closed	10.11.22	Chief Executive's Report	Quality and People Committee to receive future reports in relation to: • Actions being taken to reduce delay-related patient harm. • Actions being taken to support local NHS staff in coping with the rising costs of living. • Actions being taken in relation to the Mencap Pledge to ensure all commitments are being addressed	Rosa Waddingham	12.01.23	Added to the Quality and People Committee Work Programme
Closed	10.11.22	ICS Health Inequalities Plan	To report to the next meeting of the Strategic Planning and Integration Committee on proposed options for the oversight of the Health Inequalities Plan.	Dave Briggs	12.01.23	Update scheduled for the Strategic Planning and Integration Committee meeting on 2 February 2023
Closed	10.11.22	Questions from the public relating to items on the agenda	Domestic Abuse support measures to be added to the forward work programme for the Quality and People Committee	Rosa Waddingham	12.01.23	Added to the Quality and People Committee Work Programme

Key:

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

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/01/2023
Paper Title:	**Chair's Report**
Paper Reference:	ICB 22 051
Report Author:	Dr Kathy McLean, ICB Chair
Report Sponsor:	Dr Kathy McLean, ICB Chair
Presenter:	Dr Kathy McLean, ICB Chair
Recommendation(s):	The Board is asked to: • **RECEIVE** this item 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 the Nottingham and Nottinghamshire Integrated Care Board (ICB).

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

Appendices:
None

Board Assurance Framework:
Not applicable for this report.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	Yes
Duty to promote innovation	Yes
Duty in respect of research	Yes
Duty to promote education and training	Yes
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	Yes

Applicable Statutory Duties:	
Duties as to climate change	Yes
Duties regarding public involvement and consultation	Yes
Public sector equalities duties	Yes

Report Previously Received By:
Not applicable for this report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Chair’s Report

Introduction

1. As we enter a new calendar year and start to look towards the end of the financial year for the system, I thought it would be useful to reflect a little on where we are regarding the Government’s ambitions for the health and care system. The financial settlement announced by the Government in the November Budget gives us certainty for the coming period but also clearly signals that we must deliver increased productivity and efficiencies in all that we do. Below I set out some details on our Integrated Care Strategy one of the watchwords of which will be ‘integration’. Integration is important not just because it delivers better care and improved outcomes for our people and communities, but also because it means that we can do more for each pound of public money, retaining the trust of our population in a publicly funded, free-at-the-point of need NHS.

2. The first of January was not only the start of a new year but also the end of the first six months of our existence as an Integrated Care Board. I continue to be positive about the progress that we have made during this time and I feel increasingly confident about our future and the improvements in health and wellbeing we can deliver for our population. But we do face considerable headwinds – the pressures on urgent and emergency care services that led to the calling of system-wide critical incident in late December are just one symptom of that. I am proud of the way that our teams across the system and within the ICB have dealt with these challenges, and the way that a co-ordinated approach has been taken to managing the impact of the industrial action we have seen across December and will potentially continue to see into January and beyond. The pay dispute is a matter for the Trade Unions and the Government, but I know that the Board will join me in hoping that we see a resolution as soon as possible.

3. So, we face some challenges at the moment and I expect that some of these will endure for some time or may be somewhat outside of our control. I remain optimistic, however, that we can find a way through. In fact, we must. 2023 must be a year for delivery on our strategic ambitions and on our transformation plans. Below I update the Board on progress on the Integrated Care Strategy and share some updates on other excellent work going on across the system. We have strong foundations now in place in terms of our structures and our developing collaborative behaviours – this is the year for delivery on those foundations.

Today's situation: operational and financial pressures

4. Other Board colleagues will update in more detail, but I wanted to note the combination of factors that are impacting on the health and care system locally at the moment.

5. The rise in Strep-A infections and the inconsistent supply of antibiotics has caused understandable anxiety from parents as well as an increase in attendance at all parts of the health and care system. Colleagues across the ICS are working to manage this demand, providing reassurance to parents and maximising the benefits of national flexibilities on antibiotic prescribing and dispensing.

6. A combination of the impact of a cold snap of weather, underlying demand and the impact of industrial action meant that the system called a critical incident on 19 December. This means that we could work together collectively to prioritise care to the most needy and support our staff to deliver what was needed. I note that this is the third such incident in recent months and know that Executive colleagues are working hard to find ways to sustainably manage the demands seen on urgent and emergency care services. Of course, the real long-term solution is to invest more in preventative activities.

7. Ensuring that the NHS locally is living within its financial means and in line with the expectations of NHS England and the Department of Health and Social Care is a clear priority. We have benefited in recent months from additional scrutiny from the national NHS England finance team as we continue to manage the money closely. On Friday 16 December our system's leaders came together to discuss the financial position and agree our principles for working together for the rest of this year and into 2023/24. At that meeting we re-confirmed our requirement for the system to achieve financial balance and agreed to do that in a clinically led way, using open-book methodology across all organisations.

Developing the system for tomorrow

8. As I note above, I feel that the foundations for our system are already strongly in place – but there is always more that can be done to shore that up. Therefore I'm pleased that in the Board's December development session we had a very positive discussion around our approach to people and culture. Developing a workplace that is attractive to come to work in and offers development and growth for our people as well as promoting integrated working across organisational boundaries will be one of the key success factors for us for the years ahead and I feel we have made an excellent start on this.

9. Two further meetings to note for the new year – both on 16 February – the next meeting of our ICS Reference Group and then that same day our

inaugural system meeting of NHS Foundation Trust Governors to explore how we can work more closely together in listening to our communities and championing the implementation of our Integrated Care Strategy.

Our Integrated Care Strategy

10. As the Board is aware, our Integrated Care Partnership (the statutory committee jointly formed between the ICB and the two upper-tier local authorities) is now up and running. The ICP is the 'guiding mind' of the health and care system, providing a forum for NHS leaders and local authorities to come together with important stakeholders from across the system and communities. The ICP's main task in recent months has been to support the development and agreement of the Integrated Care Strategy. The ICB has supported wider system partners in the development of this strategy and I'm pleased that the ICP agreed our initial Integrated Care Strategy on 16 December.

11. It was a positive and wide-ranging discussion at the ICP meeting, well supported by my Vice-Chairs, Cllrs Doddy and Williams. This open and positive conversation is symptomatic of the collaborative and co-creative approach taken to the development of the strategy itself. Thanks must go to the strategy and engagement teams who have coordinated all that from the ICB and to all partners who have contributed over a number of weeks. I am also grateful to all the members of the public and representative groups as well as Healthwatch who have supported the active listening to our population throughout the development of the strategy – it is positive that we have heard from so many people to ensure that the strategy is as aligned as possible with the ambitions and aspirations of our population.

12. The Integrated Care Strategy is our starting point for all that we need to do for our population. It clearly sets out the actions we will take in line with the four aims of the ICS (improve outcomes in population health and healthcare; tackle inequalities in outcomes, experience and access; enhance productivity and value for money; and help the NHS support broader social and economic development) and sets out for the first time our three ambitions for our system: equity, prevention and integration.

13. We have two key tasks ahead of us – one to support all system partners to embed this strategy in their organisations, collaboratives and partnerships, ensuring that all colleagues are aware of what they need to do to make a difference and how their work can align to our three ambitions. Secondly, we need to now take this strategy and apply it to the development of our Joint Forward Plan for the NHS – jointly with the NHS partners, the ICB will need to develop this forward plan as a roadmap for delivery of the strategy.

Transformation delivery

14. I have made sure over the last few weeks to continue my regular programme of visits to see services being delivered on the frontline. I'm always keen to hear from anyone who might want me to visit their service, particularly if it's a great example of delivery on equity, prevention or integration.

15. In November, I was delighted to spend some time at St Ann's Allotments with the Green Social Prescribing Team, Nottingham CVS, some of the social prescribers from our Primary Care Networks and other partners. Green social prescribing is a way of connecting people to nature-based activities and green groups, projects and schemes in their local community for support with health and wellbeing. Often this will be through a referral from a Link Worker based at a GP practice or another health professional. The scheme in Nottingham and Nottinghamshire, called GreenSpace, is all about improving people's mental health. Green providers, social prescribers, voluntary organisations and community initiatives help connect many more people with nature-based activities, helping everyone to feel better. As a keen allotment holder myself, this was always going to be a highlight of my month, but I was really blown away by the positive impact that the project is having on some of our most deprived communities locally and more widely across our area.

16. Also in November, I spent some more time with colleagues in Bassetlaw, where it was positive to hear more about the Optometry First initiatives, the Place activation of our winter plans, as well as the cost-of-living support activity across Bassetlaw. In particular, the Optometry First project is a good example of how we can better integrate with the wider primary care offer, especially as we look forward to the delegation of the Pharmacy, Optometry and Dentistry (POD) services to ICB control from April. For this service change, it means that the number of patients waiting over 52 weeks for treatment has reduced by 69%, patients awaiting a date for first outpatient appointment is down 68% and there are now zero patients waiting 104 weeks for treatment.

Summary and looking forward

17. I hope that colleagues have been able to find some time to take a break over the festive period and perhaps spend time with family and friends. The year ahead of us is a big one for delivery and I am confident that we have the right structures, strategies and plans now coming into place – it will require all of us to fully commit to them all to make it a success for our population.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/01/2023
Paper Title:	**Chief Executive's Report**
Paper Reference:	ICB 22 052
Report Author:	Amanda Sullivan, Chief Executive
Report Sponsor:	Amanda Sullivan, Chief Executive
Presenter:	Amanda Sullivan, Chief Executive
Recommendation(s):	The Board is asked to: • **RECIEVE** this item for information. • **APPROVE** the ICB's Incident Response Plan.

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.

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:
Appendix A: EPRR Annual Report. Appendix B: Embedding Citizen Voice in Nottingham and Nottinghamshire Integrated Care System.

Board Assurance Framework:
Not applicable to this report.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	Yes
Duty to promote innovation	Yes
Duty in respect of research	Yes
Duty to promote education and training	Yes

Applicable Statutory Duties:	
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	Yes
Duties as to climate change	Yes
Duties regarding public involvement and consultation	Yes
Public sector equalities duties	Yes

Report Previously Received By:
Not applicable to this report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Chief Executive's Report

System status and planning

Industrial action

1. Trade unions representing NHS staff are in dispute with the Government over the 2022/23 pay award. Several unions have balloted their NHS members to take part in industrial action. As a result, members of the Royal College of Nursing took industrial action on the 15 and 20 December, and members of the GMB, Unite and Unison (ambulance staff) took action on 21 December and members of GMB (ambulance staff) took action on the 28 December. Due to the reduction in nursing and ambulance staff across these organisations, planned surgery and outpatient appointments were affected. Further action is planned for January, with ambulance staff set to take industrial action on 11 January 2023. Action is due to be taken by the Royal College of Nursing on 18-19 January 2023, however NHS organisations in Nottingham and Nottinghamshire have not voted to take part in it.
2. In response to the industrial action, we have agreed a system response structure that brings together People, Operational and Emergency Preparedness Resilience and Response (EPRR) leads in a System Control Centre to ensure that essential services are maintained.
3. Our message remains that regardless of any strike action taking place, it is important that patients who need urgent medical care continue to come forward as normal, especially in emergency and life-threatening cases; and the unions have agreed that emergency and urgent care services will be safely staffed.

Critical incident declared

4. The industrial action, coupled with rising rates of flu and covid, has put unprecedented pressure on services, and the Nottingham and Nottinghamshire healthcare system was forced to declare a further critical incident on 19 December 2022. At the time of writing, it continues to be in place. This action was taken to maintain safe services for our patients and manage emergency care services.
5. Acute trusts have taken the decision to temporarily postpone some elective care treatments and patients affected have been contacted directly with an assurance that their treatment will be rescheduled at the earliest opportunity.
6. Staff at the front line remain under significant pressure in their efforts to provide safe care and patients and members of the public will continue to be asked to use services wisely to ensure those patients with the greatest need can access care and support.

Autumn vaccination programme

7. December marked the two-year anniversary of the vaccination programme. On 8 December 2020 the vaccination programme launched, and since then, nearly three million vaccinations have been administered throughout the city and county at pharmacies, hospitals, GP practices and larger vaccination sites, as well as at innovative locations like churches, community centres, mosques and the vaccination bus.

8. The Ashfield Health Village and Haydn Road Vaccination centres closed their doors for the final time on 30 December. More than 60,000 covid vaccinations have been administered at the two sites since they opened their doors in May and June 2022. As the vaccination programme moves into its third year of vaccinations, the focus will now move to targeting key communities and areas with pop-up clinics. Eligible members of the public will still be able to access a covid vaccination at a number of pharmacy and GP locations across the city and county.

9. I would like to thank everyone for their support over the last two years. The integrated work of all partners across the local healthcare system has helped to vaccinate as many people as possible. So far in Nottingham and Nottinghamshire 61 per cent of eligible people have had the Autumn Booster.

2023/24 Operational Planning and Joint Forward Plan Guidance

10. NHS England has recently released its Priorities and Operational Planning Guidance for 2023/24. It contains fewer, more focussed headline objectives, which align to the three keys tasks facing the NHS over the coming year:

    a) Recovering core services and productivity;

    b) Delivering the key ambitions in the NHS Long Term Plan; and

    c) Transforming the NHS for the future.

11. 2023/24 will be the first full year for ICSs and the guidance points to key priorities for development as:

    a) Developing ICP Integrated Care Strategies and ICB Joint Forward Plans; and

    b) Maturing ways of working across the system, including provider collaboratives and place-based partnership arrangements.

12. NHS England has given ICBs significant flexibility to determine their Joint Forward Plans. Although legal responsibility for their development rests with the ICB and partner trusts, systems are encouraged to use the joint forward plan to develop a shared delivery plan for the Integrated Care Strategy.

13. The 2023/24 priorities and operational planning guidance can be found here: https://www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/.
14. Guidance on developing the Joint Forward Plan can be found here: https://www.england.nhs.uk/publication/joint-forward-plan/.
15. There will be an opportunity for Board members to discuss these requirements at a briefing session scheduled later this morning.

ICB updates and developments

Emergency Preparedness, Resilience and Response (EPRR) Annual Report and Incident Response Plan

16. On the establishment of the ICB, the organisation became a Category One responder with the requirement to meet the full responsibilities of the Civil Contingencies Act 2004. As part of the NHS EPRR Framework and core standards, the Board is required to receive an annual report related to the outcome of a self-assessment against a number of core standards. The Annual Report can be found at Appendix A, which also provides an overview of the EPRR arrangements and activities during 2022/23 and into 2023/24.
17. The Board is also required to approve the ICB Incident Response Plan. The Plan was approved by the Board at its inaugural meeting on 1 July 2022; however, since this time, the NHS EPRR Framework has been published, which is a strategic national framework containing principles for health emergency preparedness, resilience and response for NHS-funded organisations in England. The Plan has also now been exercised.
18. The need to fully align to the national Framework and the findings from the exercise have led to some non-material updates being made to the Plan, which has been provided to Board members separately, and the Board is asked to formally approve the updated version.

Embedding the citizen voice in the Nottingham and Nottinghamshire Integrated Care System

19. Good progress continues to be made in embedding the ICB's structures and systems for working with people and communities. In particular, we have utilised the Citizens Panel, ICS Engagement Practitioners Forum, ICB Citizen Intelligence Advisory Group (CIAG) and the Voluntary, Community and Social Enterprise (VCSE) Alliance in the development of the Integrated Care Strategy. A summary of involvement activity undertaken as part of this work stream can be found at Appendix B.

Partner updates

Expansion of operating theatres at Newark Hospital

20. Using funds from NHS England's Targeted Investment Fund, Sherwood Forest Hospitals NHS Foundation Trust, which manages Newark Hospital, will create extra capacity in elective care for urology and ear, nose and throat surgery, which have the greatest backlogs. In addition, it will also enable clinically appropriate procedures to be moved out of the theatres into minor operations suites to free up space for bigger procedures, in line with the national initiatives. Preparation work is expected to start early in 2023, with the theatre expected to be in use from this summer. An extra 2,600 operations and procedures are expected to take place each year as a result.

Health and Wellbeing Board updates

21. The Nottinghamshire County Health and Wellbeing Board met on 7 December 2022. The meeting received a report on planning requirements for the 2022/23 Better Care Fund, an update report on the Joint Local Health and Wellbeing Strategy and a covid impact assessment on domestic abuse. The papers for this meeting are published on Nottinghamshire County Council's website here: https://www.nottinghamshire.gov.uk/dms/Committees/tabid/62/ctl/ViewCMIS_CommitteeDetails/mid/381/id/548/Default.aspx.

22. The Nottingham City Health and Wellbeing Board met on 30 November 2022. The meeting received updates on the delivery of the Joint Local Health and Wellbeing Strategy and the Joint Health Protection Board; and received the Safeguarding Adults Annual Report. 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.

National updates

Independent review of integrated care systems

23. In November the Department of Health and Social Care announced that an independent review of ICS' would be undertaken. Led by former Health Secretary the Rt Hon Patricia Hewitt who is currently chair of NHS Norfolk and Waveney Integrated Care Board, it will consider and make recommendations on:

    a) How to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending.

    b) The scope and options for a significantly smaller number of national targets for which ICBs should be both held accountable for and supported to improve by

NHS England and other national bodies, alongside local priorities reflecting the particular needs of communities.

c) How the role of the Care Quality Commission (CQC) can be enhanced in system oversight.

24. A draft report is due by 31 January 2023, with a final report by no later than 15 March 2023 and a call for evidence has been issued in support of the review, which closed on 9 January 2023.

25. We welcome the review, which holds the potential to give ICBs the tools to make integration a success.

Born in a Storm: The First Days of Statutory Integrated Care Systems

26. Over the summer, the King's Fund has undertaken an assessment of ICSs, speaking to 25 chairs and chief executives of ICBs and chairs of ICPs, asking them to reflect on the early days of ICSs as statutory entities. Recognising that ICSs were launched during very challenging times, it argues that the political, economic, performance and workforce challenges all pose a significant risk that the original vision of better integrated care cannot be fulfilled. It concludes that to succeed ICSs need the freedom of action to deliver what they have been set up to do. The report can be found here: https://www.kingsfund.org.uk/publications/first-days-statutory-integrated-care-systems

Adult Social Care Discharge Fund

27. On 18 November 2022 the Department of Health and Social Care announced details of a £500 million Adult Social Care Discharge Fund in recognition that delays discharging people continued to have an adverse impact on all parts of the health and social care system. £200 million will be distributed to local authorities and £300 million distributed to ICBs. The funds can be used flexibly but should prioritise those approaches that are most effective in freeing up the maximum number of hospital beds. The funding can also be used by local authorities to boost social care workforce capacity.

Health and Wellbeing Boards: Final Guidance

28. Following consultation, the Department of Health and Social Care has recently issued final guidance to support ICB and ICP leaders, local authorities and Health and Wellbeing Boards to better understand how they should work together to ensure effective system and place-based working, following the principle of subsidiarity. Health and Wellbeing Boards will remain a formal statutory committee of the local authority, and will continue to provide a forum where political, clinical, professional and community leaders from across the health and care system come together to improve

the health and wellbeing of their local population and reduce health inequalities. Health and Wellbeing Boards will continue to be responsible for Joint Strategic Needs Assessments and Joint Local Health and Wellbeing Strategies, which will need to take into account Integrated Care Strategies to ensure they are complementary. The expectation is that all Health and Wellbeing Boards will be involved in the preparation of the Integrated Care Strategies, which is the case in Nottingham and Nottinghamshire.

The NHS Confederation's Anti-Racism Strategy

29. The NHS Confederation has recently launched an anti-racism strategy that has been developed by members and staff at all levels to support healthcare organisations to tackle racism in the workforce and reduce health inequalities. The full strategy can be found here: https://www.nhsconfed.org/publications/commit-understand-act-anti-racism. The ICB is committed to developing an Anti-Racism Strategy for Nottingham and Nottinghamshire, which will incorporate the findings of a recent local survey on racism and discrimination in primary care, the results of which can be found here: https://healthandcarenotts.co.uk/tackling-racism-and-discrimination-in-primary-care/

NHS Digital

30. In line with the transfer of NHS Digital's functions into NHS England to create a single statutory body responsible for data and digital technology for the NHS, it has now been confirmed that the target date for NHS Digital to complete the transfer is 31 January 2023, to come into force on 1 February 2023. This has been agreed by the Secretary of State for Health and Social Care and remains subject to parliamentary process and approval.

APPENDIX A: Emergency Preparedness, Resilience and Response (EPRR) Annual Report

Introduction

1. On establishment of the ICBs, the organisation became a category one responder with the requirement to meet the full responsibilities of the Civil Contingencies Act 2004. As part of the EPRR Framework and core standards, the Board is required to receive an annual report related to the outcome of the self-assessment against the core standards. This briefing provides an overview of the outcome for the ICB and the wider system.

Annual assessment against EPRR core standards

2. The EPRR Core Standards outline the minimum emergency planning standards that NHS organisations must meet and covers nine domains including governance, duty to maintain plans, duty to risk assess, command and control, training and exercising, response, warning and informing, cooperation and business continuity. An annual national programme of self-assessment against the NHS EPRR Core Standards is carried out by commissioners and providers.

3. In 2022, the core standards self-assessment reflected the requirements for ICBs as category one responders and has therefore served as a beneficial process to confirm the status of the Nottingham and Nottinghamshire arrangements and provide an action plan in response to areas for development. Following a self-assessment and an extensive confirm and challenge process with NHS England, the ICB has been rated as partially compliant. At its November meeting, the ICB's Audit and Risk Committee received a detailed report on the action plan to address areas of partial compliance and was assured that robust arrangements were in place to move the ICB towards full compliance.

4. The ICB has adopted a work programme for 2022/23 and 2023/24 to address those specific areas where further work is necessary:

    a) Further development of ICB Business Continuity Management System.

    b) Delivery and monitoring of training in line with the ICB Training Needs Analysis, which includes essential and mandatory training over a three-year cycle. Training is for on-call staff and loggists. Training for 2022/23 includes NHS England Principles of Command Training, ICB Incident Response Training, ICB on-call handbook training, and loggist training.

    c) Annual exercise plan taking into consideration risks, national and regional exercises and local arrangements. Exercises undertaken and planned include critical incident and incident response plan (major fire in a care home with

concurrent system pressures), flooding, industrial action, cyber-attack, power outage, communications cascade.

d) Updating plans based on review date including pandemic flu, business continuity.

e) Completion of system Concept of Operations, including cyber and mass casualty.

5. The ICB and NHS England worked jointly on reviewing the self-assessments of acute trust, community, mental health and out of hours providers within the Nottingham and Nottinghamshire Integrated Care System. A report on the providers' compliance levels was presented by NHS England to the November Nottingham and Nottinghamshire Local Health Resilience Partnership, and as a system, we are partially compliant. To address any gaps identified, all providers have action plans covering 2022/23 and 2023/24 and the ICB is working closely with those that have been identified as non-compliant.

Incidents over the past 12 months

6. In the 12 months to December 2022, the NHS in Nottingham and Nottinghamshire has faced several incidents that required the implementation of response arrangements at different levels based on the impact, including:

a) The ongoing Covid-19 response.

b) Three critical incidents due to system pressures.

c) Industrial action.

d) A Metrological Office red alert for extreme heat.

e) A major IT outage that impacted on NHS 111 and the GP Out of Hours Service. This was categorised as NHS EPRR Level 3 Incident nationally.

f) Monkeypox outbreaks.

g) Avian flu outbreaks.

h) Streptococcus A outbreaks.

Next steps

7. The foundations for the EPRR arrangements are robust in relation to the ICB being a Category One Responder, as indicated by the core standards self-assessment. Due to the level of risk of concurrent incidents and to resilience locally, regionally and nationally, priorities for the remainder of 2022/23 and into 2023/24 include strengthening integration across the system and ensuring that ICB arrangements are enhanced to be fully resilient.

APPENDIX B: Embedding the citizen voice in the Nottingham and Nottinghamshire Integrated Care System

Citizens Panel

1. The Panel was launched in late September in pilot form in Nottingham City and recruitment of citizens continues. There are now 101 members of the Panel, in line with our recruitment targets. The first engagement survey was issued in November and focused on the development of the Integrated Care Strategy. Surveys will be issued every three months and the survey schedule will be developed in conjunction with the ICS Engagement Practitioners Forum and City Place-Based Partnership (PBP) colleagues. The next survey will be issued in early February.
2. A comprehensive communications plan highlighting the planned work including an activity plan, social media launch, and press release is progressing, and is being implemented in line with Panel recruitment.
3. The Engagement Team continue to work closely with key stakeholders such as Nottingham CVS, Healthwatch Nottingham and Nottinghamshire, Nottingham Trent University, University of Nottingham Business School, Nottingham CityCare Partnership CIC, Nottingham University Hospitals NHS Trust and other City PBP representatives. The Engagement Team has recently met with counterparts at Nottingham City Council to explore further ways of working together on the Citizens Panel as an ICS.

ICS Engagement Practitioners Forum

4. On 22 November 2022 we held our second Engagement Practitioners Forum meeting with 17 engagement professionals across the system in attendance. At the meeting we heard from the ICB Engagement Team in partnership with Nottinghamshire County Council around the Children and Young People Early Intervention Services engagement, together with an update from Healthwatch Nottingham and Nottinghamshire regarding their GP Access Survey. The Forum has also started to identify key priorities across partner organisations and will be aligning these to the Integrated Care Strategy.
5. The ICS Engagement Practitioners Forum will continue to provide a platform for all system partners working with people and communities to work collaboratively, share resources, knowledge and expertise and maximise existing knowledge and insights.

Citizen Intelligence Advisory Group (CIAG)

6. The CIAG is a group of experts in the fields of insight and engagement working across the system, to provide assurance and challenge that the appropriate work is being

done to listen to and involve our citizens. This Group has a link to the ICP and the ICB's Board.

7. The first formal meeting took place on 1 November 2022. The Terms of Reference were agreed and the Integrated Care Strategy was discussed. In particular, the importance of building relationships with communities (specifically in the County) who do not connect with health and care services until in extreme situations was highlighted.

8. The Group also received an update on the Community Transformation Programme and were supportive of this piece of work and progress to date, specifically around engaging people and communities.

Voluntary, Community and Social Enterprise (VCSE) Alliance

9. The most recent Voluntary, Community and Social Enterprise (VCSE) Alliance meeting took place on 16 December 2022 with members from 26 different VCSE organisations in attendance.

10. The substantive item for discussion was the Integrated Care Strategy, and the following key points were made:

    a) The importance of raising the profile of the Alliance within our system as a powerful body of organisations that can provide invaluable insights into needs of deprived local communities and thus contribute to delivering more informed commissioning decisions and deliver broader integration.

    b) The need for the Alliance to understand commissioning priorities to best contribute to informed decisions.

    c) The need to truly integrate the workforce of both the VCSE sector and the ICS to ensure optimum collaboration and non-duplication of activity.

11. These key messages have been shared with the Integrated Care Partnership.

Involving people and communities in the development of the Integrated Care Strategy

12. The overarching aim of this work was to involve citizens in the development of the Integrated Care Strategy for Nottingham and Nottinghamshire. Using a two-step approach, first a desktop research exercise was undertaken to understand the needs of our citizens and how these can be met, people and communities who are not to understand who we need to involve, and gaps in our knowledge that could form the basis of our involvement work.

13. The second stage involved a number of listening activities to test the findings from the desk research, explore gaps in our knowledge, test the emerging content of the

Integrated Care Strategy and test the Vision and purpose for our ICS. In total, just under 750 individuals involved in a range of activities which took place between October and November 2022.

14. Key findings included:

    a) Concerns about how the Integrated Care Strategy would actualise the ICS purpose and vision, with specific concerns around resourcing the right services for citizens.

    b) Support for the focus on prevention, but queries about how realistic it was to shift resources away from treatment of acute illnesses and into prevention.

    c) Agreement that resources should be directed to populations with the greatest needs, who require the most immediate support and preventative activity.

    d) Support for services to become more integrated and that working as a system, including the realignment and sharing of resources (including governance and some back office functions), was the key to success.

    e) Concerns regarding the issues that the system is facing today, specifically access to primary care services (specifically GPs and dentists), elective backlog, mental health service provision and pressures on emergency departments also require attention.

    f) Great value placed on the VCSE sector, recognising the extensive support always offered to communities, especially during a crisis (the response to Covid-19 was cited a number of times), and to support the prevention of ill health.

    g) Support for a model of health and care that is person-centred and coproduced with people with lived experience.

15. The involvement report can be found here: Integrated-care-strategy_engagement-report_final1.pdf (healthandcarenotts.co.uk).

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/01/2023
Paper Title:	**Supporting the Nottingham City Place-Based Partnership to be a delivery vehicle for ICS priorities**
Paper Reference:	ICB 22 053
Report Author:	Rich Brady, Programme Director, Nottingham City Place-Based Partnership
Report Sponsor:	Mel Barrett, Lead, Nottingham City Place-Based Partnership
Presenter:	Mel Barrett, Lead, Nottingham City Place-Based Partnership
Recommendation(s):	The Board is asked to • **NOTE** the development of the Nottingham City Place-Based Partnership and its approach to delivery. • **ENDORSE** the direction of travel for the Nottingham City Place-Based Partnership to mature into a delivery vehicle for system priorities and objectives and discuss potential areas of strategic added value between the ICB and the Nottingham City Place-Based Partnership.

Summary:

The passing of the Health and Care Act 2022 has brought significant opportunity for collaboration and partnership working at all levels within the health and care system. Place-Based Partnerships (PBP) are noted as having a key role to play and are well placed to support Integrated Care Boards (ICB) to deliver their four core aims, priorities and objectives. Since the formation of the Nottingham City PBP in June 2019, partners have held a clear ambition to mature the partnership into a key delivery partner in the Nottingham and Nottinghamshire Integrated Care System (ICS), supporting delivery to best meet the needs of the population.

The Nottingham City PBP brings together statutory and voluntary sector organisations with a track record of working together, with communities, to improve population health and wellbeing in an area where health inequalities are among the starkest in the ICS. In its formative years, PBP partners have focused on delivering a series of population focused programmes and projects across the PBP and its Primary Care Networks (PCN), targeted at cohorts of the population where partners have determined they can collectively have a positive impact on health and wellbeing outcomes of the local population.

Through the delivery of these programmes and projects the Nottingham City PBP has facilitated increased coherence, trust and confidence across partners, which has delivered:

a) Cross-partner buy-in for the delivery of the refreshed Nottingham City Joint Health and Wellbeing Strategy, with reducing health inequalities at its core.
b) Improved outcomes for people who experience severe multiple disadvantage, through a place-based delivery model that has driven efficiencies across partners.
c) Improved collaboration within PCNs, with partners increasingly working at scale to deliver integrated care in neighbourhoods in line with the 'Fuller stocktake review'.
d) A race health inequalities maturity matrix co-designed between partners and communities to support organisations to review structures and processes that may be exacerbating inequalities in minority communities.
e) Demonstrable learning and shared best practice with the wider system.

Summary:
The Nottingham City PBP has established a collaboration of partners to achieve transformational change, testing innovative approaches and demonstrating early impact. Supporting the principle of subsidiarity, the ICB can work through the Nottingham City PBP and its constituent PCNs to improve outcomes of the Nottingham City population. The PBP recognises the importance of its role to support the delivery of national and local priorities, alongside other system partners. This paper seeks to engage ICB partners in considering how the Nottingham City PBP can further add strategic value to ICS priorities, and work with the ICB to explore any additional responsibilities the PBP could take on for key areas of service delivery and transformation to support the ICB's priorities and objectives.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	The Nottingham City Place-Based Partnerships exists to improve population health outcomes of the Nottingham City population. In its formative years the City PBP has demonstrated the ability for partners to improve outcomes in population health and healthcare through increased collaboration between partners and integrated place-based models of delivery.
Tackle inequalities in outcomes, experience and access	Tackling inequalities in outcomes, experiences and access is at the core of the work of the Nottingham City PBP. In its formative years the City PBP has delivered a series of programmes focused on population cohorts who experience some of the starkest inequalities in the ICS. The City PBP is responsible for overseeing the delivery of the Joint Health and Wellbeing Strategy which aims to reduce health inequalities across Nottingham City.
Enhance productivity and value for money	Through increased collaboration and partnership working in the Nottingham City PBP represents significant opportunity to enhance productivity and value for money, for example, through pooling resources and reducing duplication between services.
Help the NHS support broader social and economic development	In addition to NHS partners, the Nottingham City PBP brings together local government and voluntary sector partners with a role to play in supporting broader social and economic development. Partners have committed to this through the PBP executive, 'Social Value Actions' programme.

Appendices:
Appendix A: Nottingham City Thriving General Practice initial programme summary Appendix B: Nottingham City PBP programme governance Appendix C: Nottingham City PBP delivery principles Appendix D: Case Study: Modelling place-based delivery through Changing Futures Appendix E: Severe Multiple Disadvantage programme delivery plan

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 1: Health Inequalities and Outcomes – Failure to adequately address health inequalities and improve health outcomes for the population of Nottingham and Nottinghamshire. • Risk 3: Transformation (for Making Tomorrow Better) – Effective system working may not transform (reform) and improve services to ensure best possible future health outcomes within available resources. • Risk 6: Quality Improvement – Failure to maintain and improve the quality of services.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	No
Duty to obtain appropriate advice	No
Duty to promote innovation	Yes
Duty in respect of research	Yes
Duty to promote education and training	Yes
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	Yes
Duties as to climate change	No
Duties regarding public involvement and consultation	No
Public sector equalities duties	Yes

Report Previously Received By:
N/A

Are there any conflicts of interest requiring management?
No

Is this item confidential?
No

Supporting the Nottingham City Place-Based Partnership to be a delivery vehicle for ICS priorities

Background

1. Since July 2019, partners of the Nottingham City Place-Based Partnership (PBP) have met regularly to plan and support joint working across constituent partner organisations in the city and within its eight constituent Primary Care Networks (PCN). To date the Integrated Care System (ICS) has taken a permissive approach, supporting its place-based partnerships with the freedom to develop at a locally determined pace.
2. Since the formation of the Nottingham City PBP, partners have held a clear ambition to mature the partnership into a key delivery partner within the ICS and have held supported and iterative discussions to develop preparedness. Key elements of this have been acknowledged as supporting the delivery of system priorities and objectives (short and longer term), supporting partners to deliver on statutory responsibilities, while simultaneously working through an integrated approach to improve population health and wellbeing outcomes.
3. The PBP has taken a ‘learn by doing’ approach, enabling the partnership to test and develop new ways of working, helping the partnership to mature at pace. City PBP partners have developed and delivered a series of population focused programmes and projects across the PBP and PCNs, targeted at cohorts of the population where partners have determined they can collectively have a positive impact on health and wellbeing outcomes of the local population.
4. Through the delivery of these programmes and projects the Nottingham City PBP has facilitated increased coherence, trust, and confidence across partners. There is enthusiasm in the partnership to further accelerate development and establish the PBP as a key delivery vehicle for system priorities and support the ICB to achieve its core four aims and deliver national and local priorities.

Current Priorities

5. The priorities of the Nottingham City PBP broadly fit into three categories:
    a) **PBP population health outcome focused programmes.** The PBP oversees the delivery of seven programmes, four of which make up the priorities of the Joint Health and Wellbeing Strategy, which the PBP is responsible for overseeing the delivery of. The PBP provides an assurance report to the Health and Wellbeing Board three times a year.
    b) Complementing these seven programmes there are six **executive led** ‘**enabler’ programmes** focused on improving the conditions for integrated

care to thrive in Nottingham City. The six programmes are underpinned by a programme focused on development of the PBP and PCNs, including:

1. Developing the capacity and capability of the PBP to become 'load bearing' and be accountable for delivery of system priorities.
2. Supporting the development of the PCNs and ensure a thriving and stable general practice provider base (through our 'Thriving General Practice' programme – see Appendix A) aligned to the ICB Primary Care Strategy and recommendations in the Fuller Stocktake report.
3. Support the delivery of system priorities, both short and longer term

c) In addition to the PBP programmes, the eight PCNs have all established **population health management projects** which are supported by PBP partners. These smaller scale projects support grass roots cultural change in PCNs working within a population health management framework.

6. The PBP has established governance which oversees the delivery of all PBP and PCN programmes and projects (see Appendix B). PBP programmes are led by programme leads, supported by programme managers, with executive sponsors from different organisations promoting an integrated partnership approach. All programmes are required to agree delivery plans (see Appendix C as an example) with delivery assurance provided at the PBP Executive and Health and Wellbeing Board. PCN projects are led and coordinated within PCNs with support from the ICB locality team and PBP partners as appropriate.

Achievements

7. In delivering these programmes and projects, partners are evidencing how, through an integrated approach, PBPs and PCNs can improve the coordination of care, support and planning, positively impacting on the health and wellbeing outcomes. While not an exhaustive list, some key achievements include:

a) Through the PBP severe multiple disadvantage (SMD) programme partners have modelled place-based delivery, evidencing the commitment and behaviours needed to work effectively around the needs of people experiencing SMD. Partners have successfully aligned resource to improve collaborative working, positively impacting health and wellbeing outcomes of this cohort. Further information detailed in Appendix D.

b) Through targeted work to increase flu vaccine uptake, the PBP and PCNs successfully coordinated partners to increase vaccination rates across all targeted cohorts, including pregnant women, primary school aged children and over 65's considered at risk of respiratory disease. PBP partners also worked alongside communities to increase covid vaccination rates in minority communities, including by setting up vaccination centres in city mosques and hosting vaccination Q&A sessions on local radio stations.

c) The primary and secondary care interface programme has delivered multiple gains, including supporting the reduction of spirometry backlogs for people with chronic lung conditions built up during the pandemic, and more recently through maximising the use of shared data to increase flu vaccine uptake via the hospital.

d) Through the care leavers programme partners have successfully increased the number of care leavers accessing supported lodging accommodation and improved wrap around support when leaving care.

e) While significant focus has been on aligning service activity, the PBP has also received recognition for its work to affect cultural change, developing a race health inequalities maturity matrix. Co-designed with community representatives the matrix supports organisations to review structures and processes that may be exacerbating inequalities in minority communities.

Maturing the Place-Based Partnership

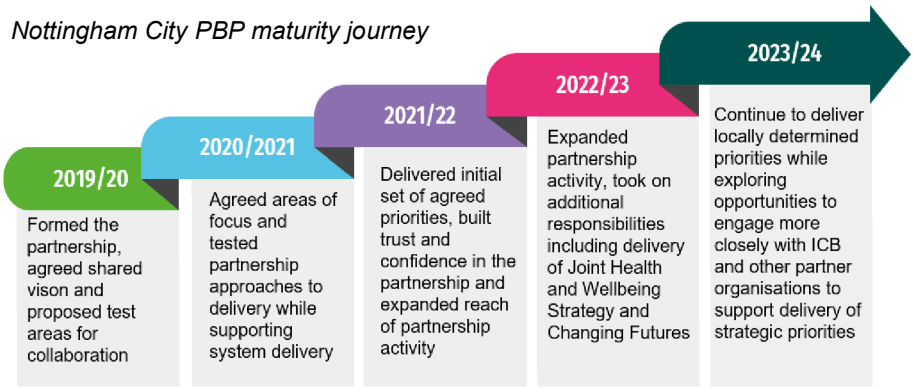
8. In its formative years, the Nottingham City PBP has matured from a group of organisations committed to the principle of working in partnership, to a coalition of partners with a track record of aligning resources to deliver improved outcomes through an agreed set of programmes.

9. Since the formation of the PBP programmes, partners have been testing new ways of working. In addition to the ICS principles and values that PBP partners signed up to, through the PBP programmes, core delivery principles have evolved and are now established in programme delivery (see Appendix E).

10. The success of the PBP approach to delivery was recognised in March 2022, when, following the publication of the Nottingham City Joint Health and Wellbeing Strategy (JHWS), responsibility for oversight of the delivery of the JHWS was discharged to the PBP. This marked an important milestone for the partnership; two partner organisations (Nottingham City Council and the ICB) delegating delivery oversight of a statutory responsibility to the PBP.

11. Through the recently submitted Nottingham and Nottinghamshire Integrated Care Strategy, the development of the ICB's five-year plan and the recently published 2023-2024 NHS operating framework, PBP partners are keen to work with the ICB to explore opportunities for the PBP to play a more supportive role in delivering system priorities, inclusive of ICB objectives.

Nottingham City PBP maturity journey



Exploring opportunities to support system delivery

12. As the partnership has matured, so has the confidence in the ability of the partnership to play a greater role in supporting system priorities and objectives. To test processes for the PBP to take on additional responsibilities for system priorities and objectives, ICB and PBP partners will be engaging in an accelerated design event based on a population cohort or care pathway.

13. The purpose of the event is to test the practical implications of the PBP taking on greater levels of responsibility (from both PBP and ICB perspectives) and explore how the partnership could act differently to deliver improved population health outcomes and system efficiencies aligned to ICS priorities and objectives. Key considerations will include deliverables in the Integrated Care Strategy and the ICB's five-year plan.

14. PBP partners recognise that there is need to evidence that they can act collectively, in the interests of the partnership, the system and each other. It is recognised this level of maturity is critical if in future, the PBP is to take on any level of delegated responsibility from the ICB and/or local authority as they remain statutorily accountable for delivery.

15. In addition to PBP partners being able to evidence that they can act collectively in the interests of the system, such as sharing risk and resource to support delivery, there is also a need to ensure that the PBP has the appropriate infrastructure in place to support delivery. Capabilities such as assessing and monitoring finance, quality and performance are important considerations as these capabilities are not sufficiently embedded in the core capacity of the PBP.

Conclusion

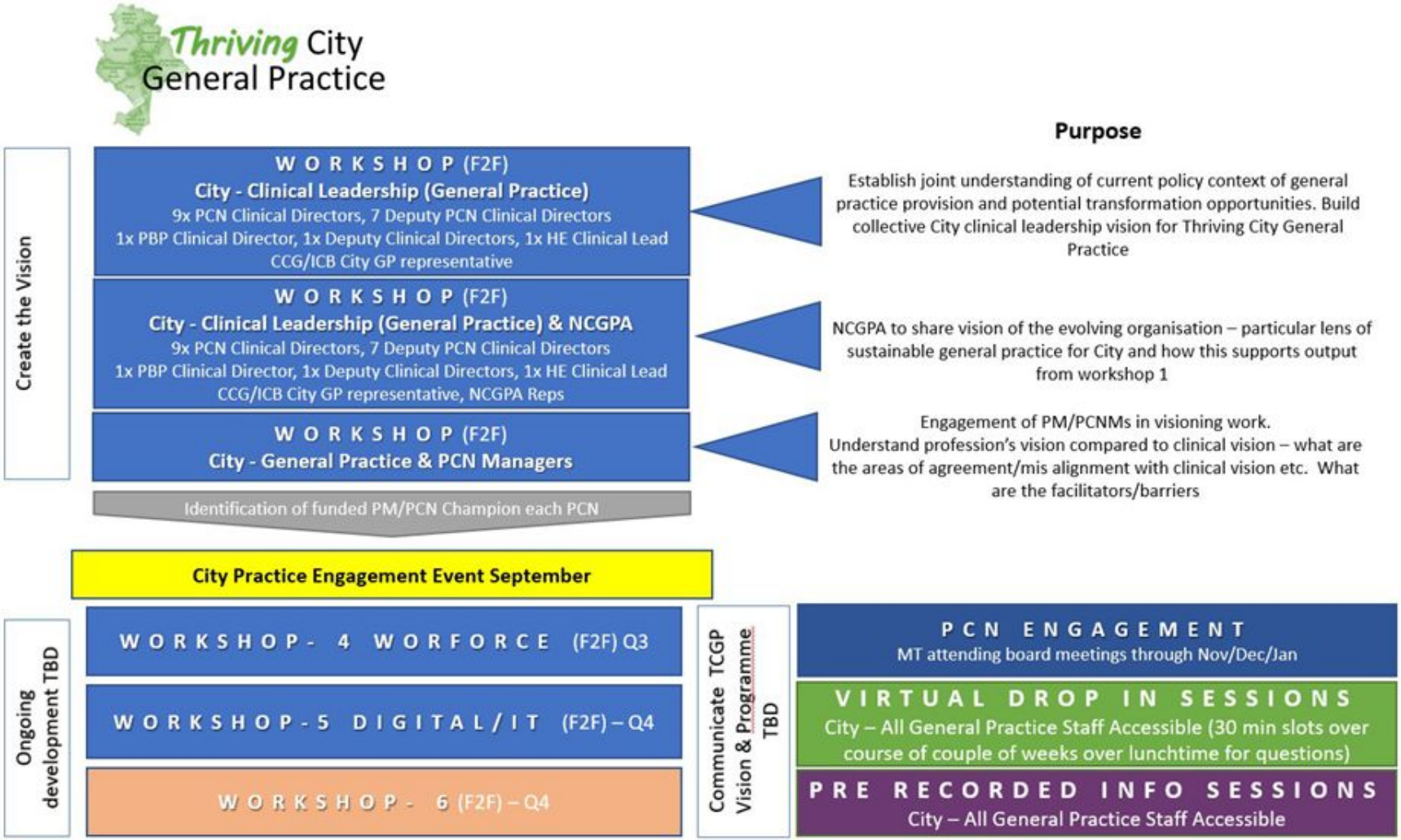
16. The passing of the Health and Care Act 2022 has brought significant opportunity for collaboration and partnership working at all levels within the health and care system with ICS' encouraged to work through place and

neighbourhood level partnerships to deliver on the ICB's four core aims, priorities and objectives.

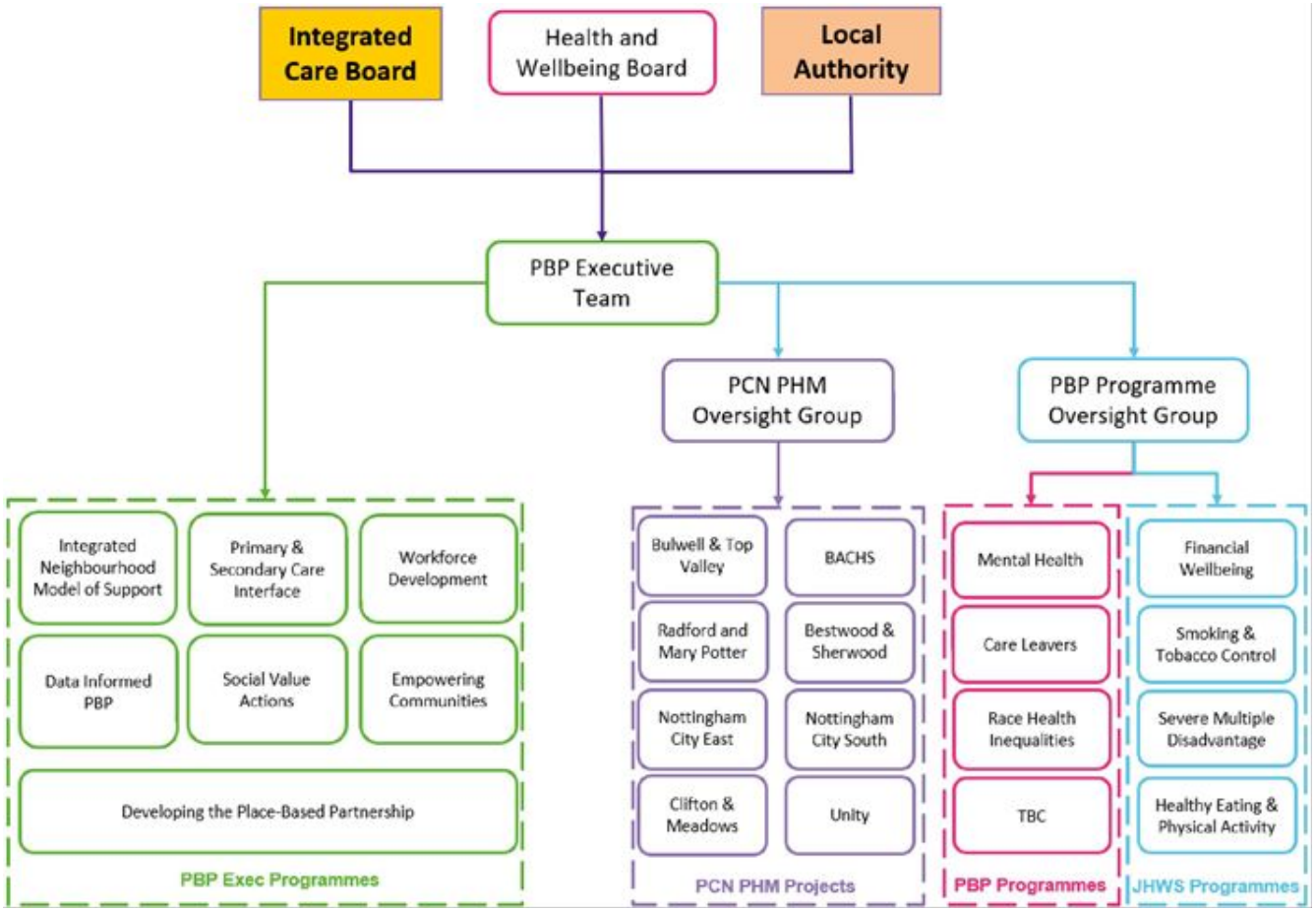
17. The Nottingham City PBP and its eight constituent PCNs have evidenced how, through an integrated approach, PBPs and PCNs can improve the coordination of care, support and planning, positively impacting on health and wellbeing outcomes of the population. This approach has been built on the principle of maximising the value of the partnership's collective resource.

18. While the PBP is continuing to mature as a delivery partnership, it is now an appropriate time to explore further the strategic added value of the PBP and the role the partnership can play in the delivery of ICS priorities. In doing so, the PBP is keen to engage ICB partners in work to understand any additional responsibilities the PBP could take on for key areas of service delivery and transformation to support the ICB's four core aims, priorities and objectives.

Appendix A – Nottingham City Thriving General Practice initial programme summary



Appendix B – Nottingham City PBP programme governance



Appendix C – Nottingham City PBP delivery principles

Principle	What does this mean?
Citizens and communities at the centre	People with lived experience are expected to be involved, from the developmental stages, through to the delivery of the programme.
Data and intelligence informed	Delivery teams use the best available evidence from population and public health data and information to inform decision making. Programmes are developed based upon Joint Strategic Needs Assessments, population health management data and local intelligence.
Outcomes focused	All programmes are developed with a shared set of outcomes which are jointly developed and owned by partners. Partners share accountability for the outcomes of the programmes.
Equal partners	Partners are equal members and decisions are made transparently. All partners, including people with lived experience have an equal voice in decision making.
Best use of resources	All programme plans must add value and ensure efficient use of collective resources. Programmes will seek to make the best use of collective resources to better meet the holistic needs of citizens.
Legacy & Evaluation	All programmes are monitored and evaluated with a focus on ensuring that successes can be built into ‘business as usual’ practice.

Appendix D – Case Study: Modelling place-based delivery through Changing Futures

People facing severe multiple disadvantage (SMD) experience significant health inequalities and have poorer outcomes than the general population. Inflexibility of services and a lack of overall ownership of people's outcomes mean that people facing SMD experience fragmented support, often resulting in higher use of statutory services such as urgent and emergency care and housing.

As part of its Changing Futures programme, in January 2021 the Department for Levelling Up, Housing and Communities (DLUHC) invited local areas to submit place-based delivery plans detailing how partnerships would work together to deliver improved outcomes for adults experiencing multiple disadvantage.

In response, using a theory of change model to agree the outcomes for individuals, and expected outputs for services and the system, the Nottingham City PBP SMD partnership brought together over 70 people from 30 organisations, including people with lived experience to design and submit a place-based delivery model of support. In July 2021 the PBP was informed that it had been successful in its bid to join the programme and was awarded £3.9 million over three years to deliver its place-based plan.

Partners of the Nottingham City PBP now work in partnership with people with lived experience to deliver multi-agency support, providing person centred, flexible and specialist support to people facing SMD in a way that works best for them. In addition to the specialist support provided by the operations and frontline delivery team, SMD practitioners are embedded within partner organisations, championing SMD, improving responsiveness of services and improving data sharing / systems, service delivery and use of resources.

While the frontline service has only been in operation since July 2022, over 100 people are now receiving support from the specialist services and significant improvements have been made in the integration of services in Nottingham. While the Changing Futures programme has delivered improved outcomes for people who experience SMD, through a place-based delivery model it has also driven efficiencies across health, local government the voluntary sector.

Appendix E – Severe Multiple Disadvantage programme delivery plan

A partner of the Integrated Care System

Nottingham City Integrated Care Partnership

Joint Health and Wellbeing Strategy

Severe and Multiple Disadvantage

Initial Delivery Plan
November 2022

Severe and Multiple Disadvantage (SMD)

This delivery plan includes:

- *Context to the programme*
- *What we want to achieve*
- *How we will we achieve it*
- *Who our key stakeholders are*
- *How we will know we have made progress*

Context for the programme

- The term SMD recognises that it is not unusual for people to experience multiple complex issues such as homelessness, substance misuse, mental ill-health, offending and experience of domestic or sexual violence.
- Experiencing multiple and complex issues means people can face real challenges in accessing the right services at the right time, and they are likely to have poorer outcomes compared to people not experiencing multiple complex issues.
- This programme aims to bring organisations together to provide better, joined up care that understands complexity. It is guided by the Nottingham City SMD partnership. This is a large network of service users, partners in the voluntary and community sector and the statutory sector.
- Some of the work described in this plan is funded and delivered through 'Changing Futures'. A national funding stream through which the partnership were awarded £4m of funding over three years.
- The work described in this plan is underpinned by our partnership's three fundamental principles of:
  - ***Co-production***
  - ***Equity, with a particular emphasis on equity for diverse communities and women***
  - ***Learning, and sharing that learning***

Our aims and objectives

As a partnership we have identified what we think are the key barriers for people experiencing SMD in Nottingham. The 'problem' we need to address is: ***In Nottingham City, people experiencing SMD can experience barriers to receiving joined up, flexible, person-centred care from the right services, at the right time and in the right place.***

Through this plan, we aim to address this problem by working together and using our resources in the most effective way. The key objectives are to:

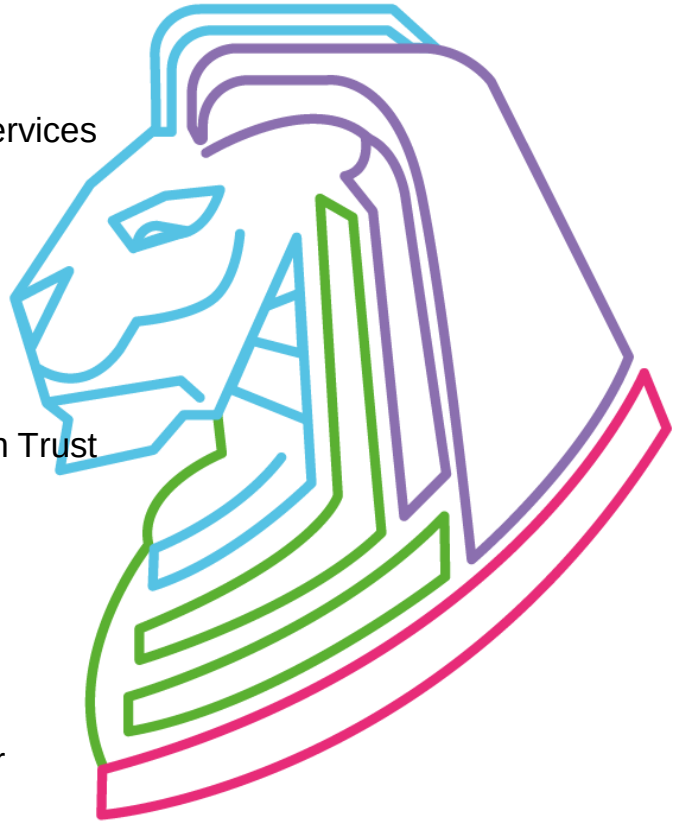
- Listen to the voices of experts by experience, be guided by them and co-produce everything we do.
- Ensure services across Nottingham work in a flexible and joined up way to provide less fragmented and more person-centred care and support.
- Develop and sustain a Multi-Disciplinary Team that helps solve problems for individuals through effective integrated working.
- Support and help develop the Changing Futures programme, that is helping to provide essential one to one support and joining the system offer together.
- Make sure our workforce across organisations and sectors, understands the needs of people experiencing SMD and can respond appropriately. Understanding the role that experience of trauma plays in how people access and receive support.
- Use our data and information to make sure we are getting the best possible outcomes for people and that we can intervene earlier.
- To make sure everything we do is done through that lens of equity, ensuring that the needs of our diverse communities in Nottingham, and the needs of women are well understood and responded to.

Chappell Room, Arnold Civic Centre 09:00-12/01/23

Stakeholders*

This programme is supported by a network that includes the following membership/stakeholders:

- Al-Hurraya
- BAC-IN
- Emmanuel House
- Framework
- Improving Lives
- Juno Women's Aid
- Nottingham Counselling Service
- Nottingham CVS
- POW
- R2C project
- The Bridges Community Trust
- The Big Issue
- The Friary
- Nottinghamshire Sexual Violence Support Services
- Nottingham City Care Partnership
- Nottingham City Council
- Nottingham City Place Based Partnership
- Nottingham City GP Alliance
- Nottinghamshire Healthcare NHS Foundation Trust
- NHS Nottingham and Nottinghamshire ICB
- Nottingham University Hospitals Trust
- Nottingham DWP
- Nottinghamshire Probation Services
- Office of the Police and Crime Commissioner



*The above is based on regular attendees of the SMD Partnership and is not a complete list.

Overview of the plan: Page 1

Purpose	Objectives	Key activity	Short term (0-6 months)	Medium term (6-18 months)	Longer term (18 months to 3 years)
In Nottingham City, people experiencing SMD can experience barriers to receiving joined up, flexible, person-centred care from the right services, at the right time and in the right place. ***Therefore, our objective is:*** ***To ensure that people living in Nottingham City who experience SMD receive joined up, flexible, person-centred care from the right services, at the right time and in the right place.***	**Listen to the voices of experts by experience, be guided by them and co-produce everything we do.**	Support and develop Changing Futures Expert By Experience Board to further develop and guide the programme. Drawing on experience of the well established ABBA group and the work of Opportunity Nottingham as well as wider partners. Support experts by experience to support all aspects of the programme, including individual work streams.	Expert by Experience Board is operational with clear Terms of Reference. Membership of the board is representative. Experts by Experience guide and inform all partnership SMD workstreams.	Expert by Experience Board is fully operational and is guiding the programme. Evaluation of the impact of the board is ongoing. Workstreams have good representation in terms of lived experience and that work is guided by and supported by experts by experience.	Lived experience has greater and demonstrable impact on service delivery at all levels.
	Develop and sustain a Multi-Disciplinary Team	Ensure clear referral routes and clear information for partner organisations. Monitor ongoing engagement by key partners required to sustain the MDT. Monitor referrals. Monitor outcomes for individuals.	Paperwork updated and shared as appropriate. Mapping identifies any areas where referrals would be expected but are not being seen. Information is shared with partners and links are made with networks and meetings as appropriate. Attendance is routinely monitored and shared with partners.	Attendance of agencies is consistent, leading to effective management of cases. Paperwork is updated on an ongoing basis. Purpose of the MDT is well understood by a range of partners. Referrals represent a broader range of sectors and organisations. Reasons why an organisation might choose not to refer are understood.	MDT is well established and well understood and supported by partners. Outcomes are fed back to organisations and this supports ongoing involvement. Staff across the system are more knowledgeable about the MDT and are referring service users. Increase in joint working through the MDT with outcomes for those referred monitored.

Overview of the plan: Page 2

Purpose	Objectives	Key activity	Short term (0-6 months)	Medium term (6-18 months)	Longer term (18 months to 3 years)
In Nottingham City, people experiencing SMD can experience barriers to receiving joined up, flexible, person-centred care from the right services, at the right time and in the right place. ***Therefore, our objective is:*** ***To ensure that people living in Nottingham City who experience SMD receive joined up, flexible, person-centred care from the right services, at the right time and in the right place.***	**Ensure services across Nottingham work in a flexible and joined up way , including continuity of care.**	New approaches to commissioning trialled to support a more flexible and integrated support offer. Ensure that information is shared appropriately between agencies, avoiding people having to tell their story repeatedly. Support joint working and person-centred approaches through he MDT and Changing Futures embedded roles. Look at possible approaches to integration, to include: -sharing of assets across organisations -IT options for shared processes and sharing of information -flexible working approaches such as co-location -use of pooled budgets Adopt the race health inequalities maturity matrix. Develop a specific work stream around continuity of care for prison leavers.	Develop a programme to test out more personalised approaches to commissioning through the Changing Futures Programme. Current data sharing mapped and opportunities for further sharing identified. Key issues/areas for change relating to need for greater flexibility are identified and agreed Approaches for greater integration are identified and priorities identified. Pilot of the maturity matrix informs areas for priority. Prison leavers work plan is agreed.	Trial of personalised approaches begins and is monitored and evaluated on an ongoing basis. Maturity matrix is embedded into work of he partnership, with progress monitored. Options for a provider alliance approach are developed with partners. Prison leaver work plan is embedded .	Innovative approaches to support personalised and integrated commissioning leads to greater choice and better outcomes. Information sharing protocols are in place, utilising technology where appropriate. Continuity of care for prison leavers improves and outcomes are monitored and reported to the partnership.
	Use our data and information to make sure we are getting the best possible outcomes for people and that we can intervene earlier.	Develop the Learning and Insight Hub, funded through Changing Futures to support evaluation of all initiatives and support training. Commission research to better understand the experience of SMD for diverse communities. Ensure that all data analysis across Changing Futures and includes equity of access and outcome for women and diverse communities. Learn how we can share information appropriately to improve outcomes.	Evaluation plan developed. Research commissioned to better develop our understanding of SMD for our diverse communities in Nottingham. Current data sharing mapped and opportunities for further sharing identified.	Evaluation is ongoing and feeds into the programme. Research is completed and findings/ recommendations are considered for areas of development. Specific gaps in information sharing are identified and proposals developed.	SMD and the experience of women and of people from ethnic minority communities is better understood and this reflected in service design, delivery and commissioning. Information is shared appropriately to support integrated working and care.

Overview of the plan: Page 3

Aim	Objectives	Key activity	Short term (0-6 months)	Medium term (6-18 months)	Longer term (18 months to 3 years)
In Nottingham City, people experiencing SMD can experience barriers to receiving joined up, flexible, person-centred care from the right services, at the right time and in the right place. ***Therefore, our objective is:*** ***To ensure that people living in Nottingham City who experience SMD receive joined up, flexible, person-centred care from the right services, at the right time and in the right place.***	**Support and help develop the Changing Futures programme that is helping to provide essential one to one support and is helping to bring the system offer together**.	Provide intensive one to one support to individuals through the Changing Futures Programme. Ensuring this support is culturally and gender responsive and meets the needs of the population. Support joint working and person-centred approaches through enhanced role of the MDT and Changing Futures embedded roles in key services.	Transition from Opportunity Nottingham to Changing Futures. Beneficiaries identified through referral from partner agencies and embedded posts. Ongoing analysis of referral and outcome data is led by the learning and development lead. This includes analysis of referrals and outcomes by gender and ethnicity. Joint working through embedded roles and MDT is established.	Changing Futures caseload develops and is representative.2 Outcomes for beneficiaries are monitored and barriers to progress identified and resolved through system and joint working. Ongoing analysis of referral data enhances programme. Impact of joint working is monitored and benefits identified.	People with greatest need are able to access specialist support and have greater choice and control in their care. This model is supported by system partners beyond the life of Changing Futures. Partners commit to long term sustainable resource to develop and potentially expand the work of the programme to the wider ICS footprint.
	Make sure our workforce across organisations and sectors, understand the needs of people experiencing SMD and can respond appropriately.	Complete a training needs analysis. Revisit existing SMD training package. Roll out of training and monitoring of uptake as well as ongoing evaluation.	Training needs analysis identifies areas of provision and current good practice in the system and areas for greater focus. Roll out of existing training programme starts and is supported through the hub.	Roll out of training is fully underway with all partners supporting staff to attend.	Staff feel more knowledgeable and able to wok more effectively with people experiencing SMD. SMD is well understood by the system, trauma informed approaches are part of usual business.

How will we measure progress at *population* level?

SMD is a multi-faceted issue and no single population level indicator has the ability to demonstrate change. Ideally we would like to measure life-expectancy but this is not possible. Instead we will use the following population level outcomes:

PHOF Indicator	England value	East Midlands	Nottingham	Ambition
Adults in contact with secondary mental health services that are in stable accommodation	58%	53%	44%	Increase to be in line with regional value
Re-offending levels, % of offenders that re-offend	27.9%	28.6%	35.7%	Decrease to be in line with regional value
Homelessness: Households in temporary accommodation (crude rate per 1000)	4.0	0.9	2.9	Decrease to be more in line with regional value
Adults with substance misuse need who successfully engage in community bases structured treatment on release from prison	38.1%	40.0%	31.4%	Increase to be more in line with regional value
Deaths from drug misuse (DSR per 100,000)	5.0	4.0	5.2	Decrease to be more in line with regional value

How will we measure progress at *service* level?

Service level indicator	How this is collected	Metric*
Increase in joint working through enhanced role of the MDT, the integrated SMD function and embedded roles in key services	Ongoing well developed data collection, with analysis support provided by the learning and insight hub.	Number and source of referrals to MDT. Organisations supporting the MDT. Number of people provided with MDT support. Number/% of successful MDT outcomes. Number/% of people that are survivors, from minoritised groups, are women. Change in joint working and associated outcomes as reported by services and beneficiaries.
Delivery of co-produced SMD training (to include Trauma Informed Care and cultural and gender responsiveness) across VCSE and statutory organisations	Ongoing evaluation and monitoring supported by the learning and insight hub.	Number of training sessions provided. Uptake by organisations and services. Number and % of workforce attending (by service / organisation and by job role). Change in knowledge and understanding.
More effective recording, sharing and use of data and learning	Ongoing evaluation and monitoring supported by the learning and insight hub.	Number of services participating in data and information sharing Number of data sharing agreements in place Change in quality / consistency of routine recording of protected characteristics and use of flags to identify people at risk of or experiencing SMD. Impact of data sharing on joint working

Note that all service level outcome data will be analysed and reported to look specifically at referrals etc that are for people from ethnic minority communities and also for women. This relates to the programme's commitment to race and gender equity.

How will we measure progress at *individual* level?

The Changing Futures programme gives us a unique opportunity to look at change for a group of individuals with perhaps the most complex needs. We will use that data to report the following:

Individual level indicator	How this is collected	Metric*
Improvement in experience of care and support leads to stabilisation	Data collected by CF programme as part of routine recording .Experiential data and information	Change in NDT score Change in Recovering Quality of Life score
Beneficiaries have less need to use emergency or crisis services to meet their needs as care plans and support is well planned and co-produced	.Data collected by CF programme as part of routine recording Experiential data and information	N/% beneficiaries that use emergency hospital care N/% beneficiaries in contact with criminal justice system N/% beneficiaries in planned health service- long term condition management N/% beneficiaries experiencing rough sleeping or eviction
Beneficiaries have greater choice and control in their care, can get specialist support if they want it and can use a personal budget to help them meet their goals and are offered access to technology to aid person centred joint care planning	Data collected by CF programme as part of routine recording Experiential data and information	Number/% of beneficiaries receiving support from navigator Number/% of beneficiaries receiving support from specialist navigator Number/% of beneficiaries receiving a personal budget Number/% of beneficiaries offered choice through a personalised commissioning approach

Note that all individual outcome data will be analysed and reported to look specifically at outcomes for beneficiaries that come from ethnic minority communities and also beneficiaries that are women. This relates to the programme's commitment to race and gender equity.

Milestones and risks

Risks	Mitigation
Current momentum in the partnership and associated support is not sustained.	Currently the partnership is very active and good progress is being made. We have completed a 'stock take' utilising external facilitators to identify how we can continue to develop and we take a solution focussed approach to all issues raised by members. We regularly celebrate success and progress as well as identify areas for greater focus.
Economic downturn increases need and impacts on outcomes	This is an issue we need to acknowledge but have limited ability to influence. This needs to be considered, particularly when interpreting any change in population level outcomes.
Longer term support required by the system is not provided to sustain key areas of work.	Some specific and important aspects of this plan are currently funded through time limited Changing Futures funding. We are already actively looking for opportunities around how this might be sustained going forward, but this is not currently guaranteed.
We lose the support of experts by experience and fail to deliver a co-produced programme and/or participants are not representative of the wider population.	Experts by experience have been pivotal to the success of the programme to date. We are using Changing Futures funds and links with existing expert groups to develop and sustain the level of support we have benefitted from to date. Some targeted work is being done now to try and engage new Changing Futures beneficiaries from minoritized backgrounds.
We lose the focus on equity and learning that are pivotal to the programme.	We have two specific workstreams of the SMD partnership that have been designed to hold the programme to account in terms of race and gender equity. These have agreed workplans. The Learning and Insight Hub has been funded through Changing Futures to provide ongoing evaluation and all workstreams have clear action plans and associated learning is fed back into the partnership.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/01/2023
Paper Title:	**Citizen Story: Green Social Prescribing**
Paper Reference:	ICB 22 054
Report Author:	Maria Willis, Head of Social Prescribing
Report Sponsor:	Rosa Waddingham, Director of Nursing
Presenter:	Amanda Chambers, Greenspace Programme Manager
Recommendation(s):	The Board is asked to **NOTE** this item

Summary:
The report provides an update on the 'test and learn' Green Social Prescribing scheme within Nottingham and Nottinghamshire from a citizen perspective. The scheme is called GreenSpace and is aimed at improving people's mental health. Green providers, social prescribers, voluntary organisations and community initiatives help connect people with nature-based activities to improve mental health and wellbeing, reduce health inequalities and reduce demand on the health and social care system.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	The programme aims to improve the mental health and wellbeing of communities, reduce health inequalities and reduce demand on the health and social care system.
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:
Not applicable.

Board Assurance Framework:
Not applicable.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	No
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	No
Duty to obtain appropriate advice	No
Duty to promote innovation	No
Duty in respect of research	No

Applicable Statutory Duties:	
Duty to promote education and training	No
Duty to promote integration	No
Duty to have regard to the wider effect of decisions	No
Duties as to climate change	Yes
Duties regarding public involvement and consultation	No
Public sector equalities duties	No

Report Previously Received By:
Not applicable.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Citizen Story: Green Social Prescribing

Background

1. The cross government Green Social Prescribing Programme to Tackle and Prevent Mental Ill-health was launched in 2021 to increase use and connection to the natural environment through referral to Green (outdoor) and/or Blue (water-based) social prescribing services within communities in England to tackle and prevent mental ill health. Seven 'test and learn' sites have been funded to test what is required to connect people to these activities and the system changes required to embed and scale up Green Social Prescribing in the future.
2. The Nottingham and Nottinghamshire ICS was selected as one of the seven test and learn sites in December 2020 to run a two-year pilot nature-based programme across the city and county.
3. Locally, the Nottingham Community and Voluntary Service is leading the programme on a day-to-day basis, working closely with Framework, the Canal and River Trust, Nottingham Open Spaces Forum and a network of green and blue nature-based providers across the city and county.

What is Green Social Prescribing?

4. Green Social Prescribing is a way of connecting people to nature-based activities and green groups, projects and schemes in their local community for support with health and wellbeing. Often this will be through a referral from a link worker based at a GP practice or another health professional.
5. The scheme in Nottingham and Nottinghamshire, called GreenSpace, aims to improve people's mental health. Green providers, social prescribers, voluntary organisations and community initiatives help connect many more people with nature-based activities, helping everyone to feel better.
6. It contributes to the ICS' priorities to 'improve outcomes in population health and healthcare' and 'tackle inequalities in outcomes, experience and access'.
7. The programme aims to:
    - Improve the mental health and wellbeing of communities, reduce health inequalities and reduce demand on the health and social care system.
    - Connect local people with nature-based activities and green community projects and initiatives in Nottingham and Nottinghamshire.
    - Embed Green Social Prescribing into local health and social prescribing systems as an intervention of choice and help shape future social prescribing across the ICS.

8. In year one and two, over 1,200 referrals have been made into Green Social Prescribing.

Case study: Jess

9. 27-year-old Jess was referred to the 'Waterways and Wellbeing' stand up paddle boarding course after being severely affected by traumatic experiences and anxiety.

10. Before the six week course, she would find the idea of paddling on the water intimidating and inaccessible. Now, she says it has unlocked a new sense of adventure and given her more courage to explore.

11. "Being near the water and around nature just grounds me. Dipping my feet in the canal and soaking up all the sights, noises and smells. Meeting new people and socialising with a wonderful group who uplift each other and cheer each other on, who find the same things important as you do."

12. Jess believes that the programme really gave her wellbeing a positive boost: "Definitely! It's been a really difficult time for me mentally and being on the waterways this past month has been the highlight of my week. It's given me something to look forward to, something to enjoy and something to feel proud of. It gives me a boost each week just when I need it.

13. "Paddle boarding on the waterways has helped me to grow a little bit of my confidence back, which has been severely knocked by traumatic experiences and anxiety. Being on the water and learning a new skill has helped me practice resiliency, socialise with others and push myself out of my comfort zone."

Case study: Nichola

14. 45-year-old Nichola has an anxiety disorder and found the pandemic a particularly stressful time. The one thing that really helped her was to go for a long walk every day in Wollaton Park.

15. She had to wait a year to receive counselling for her anxiety. Adamant that she did not want to turn to medication, she decided to find something to do that would help with her anxiety and her mental health. She had always wanted to grow vegetables, so she decided to attend the Windmill Community Garden in Bobbers Mill.

16. Windmill Community Garden is a Garden of Sanctuary, committed to being a safe and welcoming space for those seeking sanctuary, which includes refugees and asylum seekers. The team works closely with Refugee Roots and Growing Forward, an organisation providing therapeutic horticulture sessions in a bespoke space within the garden. Members of the community

garden talk about the diverse mix of cultures amongst the people who attend the garden and the fact that they enjoy learning about other people's customs and practices, celebrating different events that are special to their members.

17. Nichola said: "Other than the garden, I wasn't expecting the social aspect. When you've already got friends, you don't realise you need it. Even if you're antisocial, you will still get talking here! I feel happier and calmer now. Doctors should tell people to be outdoors."

Next steps for GreenSpace

18. GreenSpace is currently developing a sustainable long-term plan for Green Social Prescribing in the city and county, working with stakeholders and partners across the system. This may include an extension of the national Green Social Prescribing test and learn programme. This will provide investment and support for another 18 months to two years to help continue embedding Green Social Prescribing into our local system as an intervention of choice. There will also be an opportunity to work collaboratively on a share investment fund approach. Evidence shows the most effective model for funding Green Social Prescribing is a local collaborative approach to shared investment.

19. The shared responsibility and risk will enable and encourage all stakeholders in the local social prescribing system to play their part in ensuring social prescribing is sustainable, with statutory and voluntary organisations as equal partners.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/01/2023
Paper Title:	**Transforming Personalised Care and Co-production**
Paper Reference:	ICB 22 055
Report Author:	Amy Callaway, Assistant Director of Quality and Transformation
Report Sponsor:	Rosa Waddingham, Director of Nursing
Presenter:	Rosa Waddingham, Director of Nursing
Recommendation(s):	The Board is asked to: • **RECIEVE** the progress update regarding the Personalised Care Programme and the system approach to Strategic Co-production. • **ENDORSE** a commitment to embed personalised care and co-production as the fundamental enablers to the way in which the ICB delivers strategic change, including delivery of the Integrated Care Strategy and system transformation programmes.

Summary:

This paper outlines the collaborative approach to the system development of both personalised care and co-production, and their crucial role as fundamental enablers to the way in which we deliver strategic change.

Personalised care and co-production operate hand in hand to create a significant culture change and approach for the ICB and set the foundations for how the system works with people and communities to improve outcomes. They are the core principles to ensure delivery of the Integrated Care Strategy and the 12 system transformation programmes to improve outcomes for our population.

There is a strong track record of collaboration across the system and co-production, with people with lived experience, as equal partners to develop the approach to personalised care and co-production.

The Personalised Care Strategy along with its eight key commitments, and the formation of the Strategic Co-production Group (supported by a shared system strategy), from January 2023, provide the ICB with the opportunity to strengthen the foundations to deliver effective strategic change, but this will require adoption across the whole organisation as well as all partners within our wider system.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	The heart of personalised care is about working with people to support individuals to achieve outcomes. It is an evidence-based approach where every interaction is outcome focussed, based on what matters to the person and want they want to achieve. There is much evidence that this person-centred, holistic approach supports individuals to achieve improved outcomes in relation to health and wellbeing. The co-production approach and way of working spans all system transformation programmes, and in doing so, it contributes to improved outcomes in population health and healthcare. There is also

How does this paper support the ICB's core aims to:	
	evidence demonstrating the positive health and wellbeing impacts for people who take part in coproduced activity.
Tackle inequalities in outcomes, experience and access	Personalised care addresses inequalities by shifting from a reactive, professional-led illness focussed, 'medicalised' approach, towards a proactive, asset based, partnership and holistic care 'socialised' approach. By using Population Health Management data and support networks across the community, it allows the system to give more attention to those at the greatest risk of poor health. Personalised care allows people to access health and care services that are more tailored to their needs, make sense to them and focus on what really matters in their lives. Co-production approaches enable people with lived experience to have an equal voice and an equal role alongside professionals to share experiences and shape service provision to meet real need. The co-production principle to seek out diverse voices will ensure that the views of the diverse population of Nottingham and Nottinghamshire is represented and embedded in service transformation and commissioning, the strategic co-production group and the wider citizen intelligence advisory group.
Enhance productivity and value for money	Established working relationships between the Local Authorities and the ICB bring increased opportunities for collaborative planning and securing integrated provision to support people, whilst also making better use of limited resources. Working together to meet a person's needs in a way that works for them enhances quality, outcomes, productivity and achieves value for money. Personalised care builds on the strengths of people and of community assets and resources, thereby reducing the need for expensive interventions and promoting people's independence. Service provision developed by people with lived experience ensures that provision is based on real need and more likely to be engaged with by people who use services. It enables services to be commissioned right first time and avoids spending money on aspects of services that may not be needed. People with lived experience also have the potential to bring new ideas that professionals may not have thought of.
Help the NHS support broader social and economic development	By working as a system to embed personalised care and improve the health and wellbeing of people supports their ability to access learning, reduces their reliance on services in the future and supports them moving onto employment. Personalised care is place-based and community focussed, offering people greater choice and control, which provides opportunities for micro-providers and community groups. Lived experience individuals working within co-production will be able to access skills, experience and knowledge, which can support them to access employment. They will also be able to be reimbursed for their co-production work. Students working with the co-production team means that there is a greater awareness of co-production in newly qualified staff who will be able to implement the approach in their work areas from the start of their career and in doing so contribute to the wider culture of change.

Appendices:
Appendix A: Personalised Care Performance Appendix B: Co-production Governance Appendix C: Co-production levels within the ICB

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risks: • Risk 1: Health Inequalities and Outcomes – Failure to adequately address health inequalities and improve health outcomes for the population of Nottingham and Nottinghamshire. • Risk 3: Transformation (for Making Tomorrow Better) – Effective system working may not transform (reform) and improve services to ensure best possible future health outcomes within available resources. • Risk 4: Citizen Voice – Failure to effectively work in partnership with citizens and communities. • Risk 6: Quality Improvement – Failure to maintain and improve the quality of services. • Risk 8: Equality, Diversity and Inclusion – Failure to comply with the general and specific Public Sector Equality Duties.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	No
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	Yes
Duty to promote innovation	Yes
Duty in respect of research	No
Duty to promote education and training	Yes
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	No
Duties as to climate change	No
Duties regarding public involvement and consultation	Yes
Public sector equalities duties	Yes

Report Previously Received By:
The Personalised Care Strategy has been approved by the ICB Personalised Care Board and the Co-production Strategy has been approved by the ICB's Quality and People Committee.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Transforming Personalised Care and Co-production

Purpose and ambition

1. System partners are working together to plan and deliver strategic personalised care and co-production approaches as a significant step change in the way the system delivers care and support.
2. Both personalisation and co-production are fundamental approaches for engaging with the people and communities of Nottingham and Nottinghamshire. They represent a cultural shift in how we work with people and act as enablers to delivering services, transformation and change.
3. This paper describes the system ambition in relation to both personalised care and co-production, and their role as co-dependent and overlapping enablers to the way in which we deliver strategic change through a focus on working with people in the delivery of all aspects of care at both the individual and strategic levels.
4. In this way, they form the core principles to commissioning and improvement activity to ensure delivery of the Integrated Care Strategy and the twelve system transformation programmes in a meaningful way that improves outcomes for our population.

Personalised Care

The context and benefits of personalisation

5. Personalised care is one of the five major, practical changes to the NHS, as set out in the Long Term Plan, in recognition that a ‘one-size-fits-all’ health and care system simply cannot meet the increasing complexity of people’s needs. Through personalised care, people can have more control and choice when it comes to the way their physical and mental health care is planned and delivered; and be actively involved in the decision-making process by speaking up on things that matter and are most important to them. This shift from ‘what is the matter with you’ to ‘what matters to you’ empowers people to take control of their own health and wellbeing, supporting the prevention and health inequalities agendas.
6. The comprehensive model of personalised care supports the delivery of this shift by bringing together six evidence-based components, each of which is defined by a standard set of practices, including:
    a) Shared decision making
    b) Personalised care and support planning
    c) Enabling choice, including legal rights to choose

d) Social prescribing and community-based support

e) Supported self-management

f) Personal health budgets and integrated personal budgets (health and social care funded).

7. Research and evidence demonstrate the positive impact that personalised care has on people, systems and professionals, including:

a) Increased satisfaction with experiences of care and support, as well as improved quality of life and emotional wellbeing, as holistic approaches support all elements of a person's life.

b) People who are more confident and able to manage their health conditions (people with higher levels of activation) have 18% fewer GP contacts and 38% fewer emergency admissions than people with the least confidence.

c) 86% of people with a personal health budget (PHB) said that they had achieved what they wanted with their PHB and 77% of people would recommend PHBs to others.

d) PHBs in continuing healthcare (CHC) have been shown to achieve an average 17% saving on the direct cost of home care packages.

e) 59% of GPs think social prescribing can help reduce their workload.

Working differently to improve spread and scale of personalisation in Nottingham and Nottinghamshire

8. The ICS has a strong history and longstanding system-wide commitment to personalised care and is recognised as a national leader in the field.

9. The ICS Personalised Care Strategic Oversight Group provides system oversight and governance for personalised care, supporting the vision '*to maximise independence, choice, control, good health, and wellbeing throughout people's lives, focussing on 'what matters to you'.* It is founded on the principles of co-production and comprises people with lived experience and partners from health, local authority and voluntary sector organisations at a system and place level, working together to strategically embed personalised care and approaches across the system.

10. Personalised care is making good progress and is on track to deliver the operational planning targets and Memorandum of Understanding agreements are in place (Appendix A). The system is recognised as a national leader in shared decision making, and this has led to sharing of practice through support to other systems and delivery of national presentations and webinars.

11. In November 2022, NHS England sent a letter of congratulation to the ICB for the continued delivery and implementation of personalised care as one of the top performing systems of all 42 ICBs, ranking as: first for Shared Decision-Making; tenth for personal health budgets; fourteenth for personalised care and support plans and nineteenth for social prescribing referrals. The system has also overachieved by 25% the trajectory to train the workforce in personalised care.

12. The programme has invested in co-production with people with lived experience and has a well-established co-production group, 'My Life Choices', which works in partnership with the ICS to embed personalised care. Five members are trained lived experience coaches for National Voices Improvement CORE20PLUS5[1] and four members have completed the NHS England peer leadership course. They provide oversight to transformation and improvement activity; co-design resources for the system; promote personalised care within their networks, at system events and meetings, and at national boards; and support recruitment.

13. Key developments this year support the foundations for embedding personalised care at scale. This includes:

    a) Work to promote personalised care so that the public understand what they should expect from health and care services; including information and films made by My Life Choices on the ICB webpages Personalised Care - NHS Nottingham and Nottinghamshire ICB.

    b) A significant system commitment to social prescribing; the system has over 90 Social Prescribing Link Workers employed by 12 provider organisations across the 23 Primary Care Networks, with additional social prescribing link worker resource in secondary care emergency departments, elective care and the cancer rehabilitation pathway at Nottingham University Hospitals NHS Trust.

    c) Primary Care Network recruitment of 43 care coordinators and 17 health and wellbeing coaches, funded through the Personalised Care Additional Reimbursement Roles Scheme (ARRS), along with development of proactive social prescribing plans, identifying specific people with unmet needs and addressing health inequalities.

    d) Development of the system's Green Social Prescribing model, led by Nottingham Council for Voluntary Service, connecting people to nature to support their health and wellbeing. The Big Green Book digital resource provides safe referral pathway to 'trusted' community providers for social

[1] Core20PLUS5 is a national NHS England approach to reduce healthcare inequalities https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

prescribing link workers and health teams; and the co-designed Mental Health Toolkit is being used as a national model.

e) Nottingham City's success as one of eleven areas to secure pilot programme funding for the Active Travel Social Prescribing programme to 2024/25.

14. To support the system to embed large scale personalised care approaches and support the significant culture change required, the Personalised Care Strategy and its eight commitments for the ICB will ensure a clear and aligned system response.

Co-production

Context of co-production in Nottingham and Nottinghamshire

15. The ICB has made a commitment to embed co-production within all elements of system design and delivery, including transformational activity, commissioning activity, service/system redesign and quality improvement. This is part of the ICS vision to embed co-production as a default position in all work across the system to ensure that people are involved in the co-design and co-commissioning of our services in a meaningful way, as a powerful voice alongside those of professionals in the system.

16. The programme of work, led by NHS Nottingham and Nottinghamshire ICB, builds upon best practice from across our health, local authority and voluntary sector partners, and through co-production with people with lived experience in an equal partnership. Throughout 2022, the ICB was one of ten sites to develop and embed co-production through the NHS England Experience of Care Team programme, and the work builds upon this national learning.

17. An ICB Co-production Team has been established to lead this work, with funding support from Small Steps Big Changes, which has provided pump prime resources and shared learning as part of their legacy for the system.

18. The ICB Co-production Strategy has been developed in conjunction with people with lived experience and in partnership with system partners and progress will be overseen by the ICB Quality and People Committee. This forms part of the ICB Working with People and Communities Strategy.

The development of the Strategic Co-production Group and its remit

19. Building on the ICB Co-production Strategy, the strategic co-production group will act as the core principle for how co-production in the ICB will be delivered. Forming in January 2023, the Strategic Co-production Group will ensure that strategic decisions and planning includes people with lived experience as an equal partner. The group will advise on system design, delivery and

commissioning, will be involved in key priority work across the system and will report into ICB Board. Appendix B illustrates governance arrangements.

20. Membership of the group will comprise a minimum of 50% lived experience representatives, with the ambition for the group to be reflective of the diversity of the populations the ICS serves. Training and support for lived experience members to operate in this strategic approach will be provided.

21. The structure, remit and responsibilities of the group and recruitment and reimbursement approach have been coproduced with people with lived experience and system partners via the ICS Co-production Steering Group.

22. In line with the strategic nature of the group, its core remit will be to:

    a) Encourage the adoption of the co-production values and principles as set out in the ICB Co-production Strategy within the ICB and wider system by having oversight of ICB co-production activities taking place, identifying areas for further development, removing barriers to co-production and holding the ICB to account for genuine co-production approaches being adopted.

    b) Provide oversight and scrutiny to the ICB and ICP to ensure that co-production activity to support the delivery of the Integrated Care Strategy is being undertaken effectively.

    c) Provide oversight and scrutiny on co-production progress within the 12 system transformation programmes.

Next Steps

Areas of focus to develop and embed co-production and personalisation

23. Co-production and personalisation approaches work hand in hand to create a significant culture change for the ICB.

24. Appendix C demonstrates the personal, project and strategic level approaches that will support this way of working, reinforcing everyone’s role in the ICB in applying these enabling approaches.

25. As one of the fundamental enablers to deliver strategic change, work will continue to strengthen the foundations to support the ICB’s co-production approach, including:

    a) Formation of the Co-production Network where lived experience groups from across the system will come together to share intelligence and support the wider co-production agenda.

    b) Continuing to strengthen and triangulate system intelligence and insights from working with people and communities to inform strategic developments.

c) Development of a co-production toolkit and training package for both staff and people with lived experience to ensure that people have the skills, confidence and tools they need to work together in partnership and coproduce effectively.

d) Wider culture change across the system to support the co-production approach, including staff induction and co-production champions in key areas/organisations.

26. Oversight of progress to embed co-production will be overseen by the Strategic Planning and Integration Committee.

27. Priority focus for the year ahead will be to support the delivery of personalised care within the delivery of the Integrated Care Strategy and the twelve system transformation programmes. Focussing on scaling up personalised care approaches in:

a) **Ageing Well** – anticipatory care and frailty, looking at personalised approaches to support high intensity users of services.

b) **Elective Care**

c) **Urgent Care**, supporting discharge PHBs to improve flow.

d) **Mental health**, including developing PHBs for people with personality disorders.

e) **Learning Disability and Autism (LDA)** support to look at personalised approaches to manage obesity (a key learning from Norfolk safeguarding reviews for people in residential settings with LDA) and annual health checks. Also looking at personal health budgets to support commissioning gaps in neuro-disability.

f) **Children and Young People** working with local authority partners to ensure personalised care and support plans and personal budgets are integrated together.

g) **Local Maternity and Neonatal services**, increasing personalised care and support plans in maternity services with bespoke training and links into wider maternity improvement programmes.

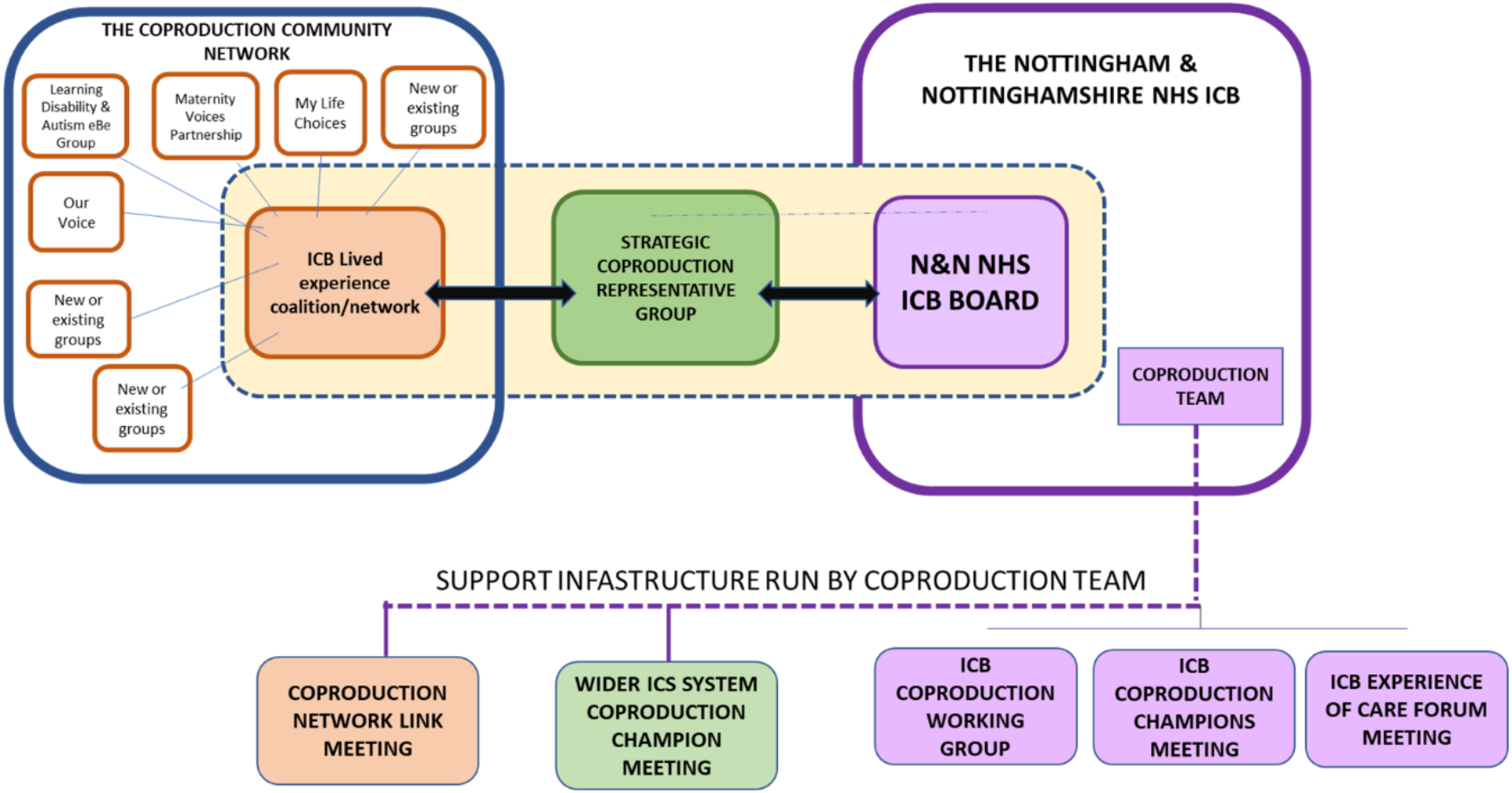
h) **Primary Care**, with a focus on proactive care at home (currently focussing on cardiovascular disease and hypertension) and end of life care.

28. A successful preventative social prescribing model relies on a strong and effective community and voluntary sector for people to access local support. Focused work with ‘Place’, particularly voluntary and community partners, will continue to support communities. Recognising the non-recurrent nature of much of the funding for this, we will continue to work with all system partners to maximise the delivery of these schemes.

Appendix A: Personalised Care Performance

	Activity Data	NHS Long Term Plan operational planning metrics (By March 2023)	Universal Personalised Care NHS Regional stretch targets (By March 2023)	Performance achieved per quarter				Year to date TOTAL	Over target / On track / Under target / Under by 20% — Track against target: Operational / Stretch
				Q1	Q2	Q3	Q4		
1	**Total number of unique people receiving Personalised Care Institute accredited eLearning training**	293	596	298	634			**932**	
2	**Personal Health Budgets (in place)**	7,250	7,250	2477	1192			**3669**	
3	**Personalised care and support plans (total new and reviewed)**	27,000	41,717	5891	4839			**10,730**	
4	**NHSE funded social prescribing link worker referrals**	13,610	22,474	2645	4180			**6825**	
4.1	**Total directed enhanced service (DES) Additional Reimbursement (AAR) funded social prescribing link workers**	68	68	68	20			**88**	
4.2	**Total Integrated Care Board (ICB) funded social prescribing link workers**	**No NHSE or NHS Regional targets set** The data is collated to gain local system wide understanding and information		12	0.5			**12.5**	**No targets**
4.3	**Total DES and ICB funded link workers:** Employed by 8 system social prescriber providers across 20 Primary Care Networks			80	20.5			**100.5**	
4.4	**Total number of onward referrals from SPLW's to community assets (NB: no target)**			4900	6540			**11,440**	
4.5	**Care Coordinators** DES ARRs funded personalised care roles			31	20			**51**	
4.6	**Health and wellbeing coaches** DES ARRs funded personalised care roles			12	5			**17**	

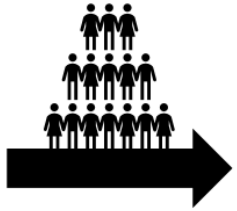
Appendix B: Co-production Governance in the ICB



Chappell Room, Arnold Civic Centre 09:00-12/01/23

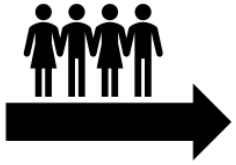
Appendix C: Co-production levels within the ICB

STRATEGIC COPRODUCTION



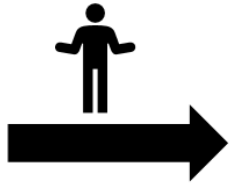
- LARGE SCALE COPRODUCTION – TOP LEVEL DECISIONS IMPACTING POPULATION OF LOCAL AREA
- EMPOWERING EXPERTS BY EXPERIENCE/LIVED EXPERIENCE WITH LEADERSHIP CAPABILITIES
- DECISIONS AFFECT ALL PEOPLE AND ALL PROTECTED CHARACTERISTICS
- COPRODUCTION PROJECTS DRIVE COLLECTIVE CHANGE WHICH AFFECTS MULTIPLE SERVICES OR APPROACHES
- FULL SYSTEM WORKING STRATEGICALLY

PROJECT LEVEL COPRODUCTION



- COPRODUCTION PROJECTSWORKING ON A SPECIFIC SMALLER TARGETED AGENDA OR HEALTH CONDITION– INCLUDING LARGE SCALE COMMISIONING , PERSONALISED CARE AND TRANSFORMATION
- OUTCOME LIKELY TO IMPACT A SPECIFIC WORK AREA, COMMISSIONED SERVICE OR APPROACH BUT NOT AFFECT WHOLE ORGANISATION
- MAY BE SOME PARTS OF THE SYSTEM WORKING TOGETHER BUT NOT ALL
- SMALLER COPRODUCTION PROJECTS

PERSONAL LEVEL COPRODUCTION



- EMPOWERMENT AND KNOWLEDGE: WORK IN PARTNERSHIP WITH PEOPLE, PROVIDING CLEAR EVIDENCE -BASED INFORMATION TO SUPPORT SHARED DECISION MAKING, ENCOURAGING THEM TO ASK QUESTIONS.
- FOCUS ON WHAT MATTERS TO PEOPLE AND THE OUTCOMES THEY WANT TO ACHIEVE.
- POWER SHARING: WALK ALONGSIDE PEOPLE, POWER SHARING AND WORKING WITH THEM.
- CONNECTION RECONNECTS PEOPLE WITH THEIR COMMUNITY AND BUILDING RESILIENCE.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/01/2023
Paper Title:	**Digital Transformation – Strategic Progress Update**
Paper Reference:	ICB 22 106
Report Authors:	Andrew Fearn, Interim Digital Senior Responsible Officer Alexis Farrow, Digital Programme Director
Report Sponsor:	Dave Briggs, Medical Director
Presenter:	Andrew Fearn, Interim Digital Senior Responsible Officer
Recommendation(s):	The Board is asked to **RECIEVE** the progress update regarding digital transformation across the Nottingham and Nottinghamshire Integrated Care System.

Summary:

The purpose of this report is to provide an update on the national digital context; share progress in delivering the ICS Digital Strategy; give insight into our future digital vision; and to share some of our challenges.

The Nottingham and Nottinghamshire Integrated Care System is well placed to be a national exemplar for digital and intelligence. Our current strategy has created an environment where real benefits are starting to be seen by the people who live in our communities, those who receive services and those who provide the services – but there is much further to go.

The revised strategy will maintain our focus on delivery and through specific, measurable, achievable, relevant and time-bound (SMART) objectives, will enable a demonstrable improvement to be identified that will support further digital transformation.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	Citizens can access and contribute to their healthcare information, taking an active role in their health and well-being.
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:

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

- Risk 12: Digital Transformation – Failure to deliver digital transformation and establish effective system intelligence solutions.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	No
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	No
Duty to obtain appropriate advice	Yes
Duty to promote innovation	Yes
Duty in respect of research	Yes
Duty to promote education and training	No
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	No
Duties as to climate change	No
Duties regarding public involvement and consultation	No
Public sector equalities duties	No

Report Previously Received By:
The ICB's Finance and Performance Committee has received papers on digital transformation in line with the committee's remit and as part of its annual work programme.

Are there any conflicts of interest requiring management?
No

Is this item confidential?
No

Digital Transformation – Strategic Progress Update

Introduction

1. The Nottingham and Nottinghamshire Integrated Care System (ICS) has a reputation as one of the most capable and progressive digital 'health and care systems' in England. We have a well-established digital health and care community (known as Digital Notts) that works together effectively through a long standing, formal Digital Collaborative; supported by strong governance in the form of an ICS Digital Executive Group and guided by a system-wide Digital Charter (available here). We have a national profile as exemplars in shared care records, intelligence led decision-making and especially in public facing digital services and inclusion.
2. The purpose of this paper is to provide an update on the national digital context; share our progress in delivering the ICS Digital Strategy; give insight into our future digital vision; and to share some of our challenges.

National and local context

3. Over the past 12 months, there have been some subtle but significant shifts in the national approach to digital and data across the NHS – including political leadership and the announced rationalisation of the national bodies sharing the agenda. NHS England, NHS Digital and NHSX digital teams will merge into a single body within NHS England during the coming year.
4. These changes, coupled with national financial challenges, have resulted in a delay in releasing funds to allow some of the planned digital transformation to come into effect. Despite these setbacks, as an ICS, we managed to secure an additional £23 million in 2021/22 and are on track for an additional £20 million this year for our system-wide digital transformation.
5. Nationally, the 'What Good Looks Like' (WGLL) framework (What Good Looks Like framework - What Good Looks Like - NHS Transformation Directorate (england.nhs.uk)) remains the over-arching digital aspiration and is measured against seven success criteria. Its goal is to '***Empower Citizens***' by creating the right infrastructure through '***Well led***' digital governance, '***Ensuring smart*** [digital] ***foundations***' and '***Safe*** [digital] ***Practice***'; so we might '***Support people***' to more effectively support our citizens; and ultimately '***Improve care***' and create '***Healthy Populations***'.
6. A Digital Maturity Assessment has been developed at a national level to measure each statutory organisation's compliance against expectations to deliver the WGLL framework. Digital Maturity Assessment results will be published nationally in the new financial year. The Digital Maturity Assessment

will allow us as a system to target digital investment and to ensure consistency for our citizens.

7. National investments this year have been focussed on the '*smart foundations*' criteria in WGLL – specifically targeting 'Frontline Digitisation' in acute care settings by investing in Electronic Patient Records. Each Trust's Electronic Patient Records status was assessed and investments targeted to deliver basic functionality.

8. Within our ICS, Sherwood Forest Hospitals NHS Foundation Trust was deemed a level 0 Trust; with Nottingham University Hospitals NHS Trust and Nottinghamshire Healthcare NHS Foundation Trust both considered to be level 2. Level 0 Trusts were to have all their funding requirements met; Level 2 Trusts were able to bid for limited funds. We await confirmation of bid success.

9. Finally, at a national level, there has been significant focus on 'at scale' data management. The national investment into Electronic Patient Records will improve the organisational data available. The ICS is at the cutting edge of an emerging concept of Federated Data Platforms, which will enable data to be curated effectively and seamlessly at a system, regional and national level for planning and population health management purposes. This will enable us to build on the superb, exemplary work undertaken in the System Analytics and Intelligence Unit (SAIU). Jointly, with our colleagues in Leicester, Leicestershire and Rutland ICS, we are leading an East Midlands wide bid to create a Sub-National Secure Data Environment. This is a tool to bring de-identified data appropriately and securely from Federated Data Platforms across the 5.1 million population for the purposes of research and development.

10. These national investments will see us using the same data sources for direct care in an Electronic Patient Record; combining that for planning and population health purposes through Federated Data Platforms; and then ultimately making that data available for research and development opportunities through a secure data environment.

11. Making data available more quickly will enable us to make significant improvements in clinical and financial efficiency and effectiveness for direct care, for planning and for research – all for the benefit of the people we serve.

Strategic Intent and Future Vision

12. The ICS has had a Digital, Analytics, Information and Technology Strategy (known as the Digital Strategy and included here) for two years.

13. The Strategy sets out five strategic initiatives:

    a) *Building Public Facing Digital Services Strategy* (included here);

    b) *Developing Population Health Management*;

c) *Digitising Provider Systems*;

d) *Deploying a Single Shared Care Record*;

e) *Improving Digital Literacy and capability in our Workforce.*

14. By securing national investment and support, whilst working closely and collaboratively with colleagues across the system, we have made significant progress against each of the strategic initiatives.

15. Our strategy articulates what our initiatives would mean for the people living in our communities; what it would mean for people receiving services in our system; and what it would mean for people working in our system.

16. As a result of the progress made, people living in Nottingham and Nottinghamshire can access health and care advice and direct support services through the NHS App. People previously considered 'digitally excluded' are being given the wherewithal and knowledge to use their information to improve their lives. People responsible for planning and population health management can make better-informed decisions through the utilisation of data available through existing digital innovations; which thanks to the SAIU is presented in dashboards and will benefit further from our involvement in national innovations. People working on the front line are benefitting from the external digital investment we have secured. People receiving care (whether in health or social care) are benefitting from their care information being shared between organisations through our Shared Care Record. People working in digital across our collaborative system are benefitting from improved training.

17. With the advent of Integrated Care Boards and the national shift in digital priorities we are currently in the process of reviewing our Digital Vision and Strategy. Our revised Strategy will be completed by April 2023.

18. The future Digital Vision Strategy will articulate through a 'Person-centric lens' how it can digitally enable the Integrated Care Strategy guiding principles of prevention, equity and integration. It will explain how we will create the digital enablers to tackle inequalities, improve outcomes, productivity and social and economic development.

19. Our vision is clear – we will develop the digital tools to enable the people of Nottingham and Nottinghamshire to have their best, healthiest lives. We are currently developing our priorities aligned with national expectations, but these are likely to be:

a) Empower our population with effective *Public Facing Digital Services.*

b) Support our population and our workforce to improve *Digital Inclusion*.

c) Give our workforce the tools they need through *Provider Digitalisation*.

d) Improve care provided by sharing data through better *Interoperability.*

e) *Support Intelligent Decision-making* to tailor resources effectively.

20. Our developing Charter, creating a system wide approach to managing digital infrastructure, workforce and finances, will underpin these priorities.
21. We will ensure our priorities – and the plans we put together to deliver the revised Strategy – are specific, measurable, achievable, relevant and time-bound (SMART).

Challenges

22. Existing funding – We will focus on ensuring best value for money at a system level with joint procurements, single solutions across multiple providers where appropriate, and best use of people resources; but inflation rises, and currency weakness are reducing the amount of technology we can buy for what we have available.
23. External funding – We have been very successful so far in attracting external funding for digital investment at a system level but will need to be creative in building partnerships in the future to keep funding sources flowing.
24. Capital versus revenue – Most external funding we receive is capital but we need revenue to make the most of cloud computing.
25. Workforce – We are carrying a significant number of specialist digital vacancies across the system and have a significant number of digital experts on fixed, temporary contracts, creating a threat to delivery of ambition. If we are to be successful in securing additional funding, we will have to demonstrate we have a history of delivery at pace.
26. People and change – the appetite for digital innovation needs fostering and building, across our society, across our service users and across our staff. They will need the time and the inclination to deliver the changes required. That will require improved communications and a different approach to what many perceive as a technological solution.

Summary

27. The ICS is well placed to be a national exemplar for digital and intelligence. Our current strategy has created an environment where real benefits are starting to be seen by the people who live in our communities, those who receive services and those who provide services – but there is much further to go. Our revised strategy will maintain our focus on delivery, and through SMART objectives, will enable a demonstrable improvement to be identified that will support further digital transformation.
28. We are aware of the challenges we face – but are keen to explore the opportunities presented.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/01/2023
Paper Title:	**Integrated Performance Report**
Paper Reference:	ICB 22 057
Report Author:	Sarah Bray, Associate Director of Performance and Assurance
Report Sponsor:	Stuart Poynor, Director of Finance
Presenter:	Stuart Poynor, Director of Finance
Recommendation(s):	The Board is asked to **RECEIVE** the Integrated Performance Report.

Summary:

The purpose of this report is to present progress against compliance and commitment targets as required for 2022/23. The report includes progress against quality, service delivery, finance, workforce and health inequalities, and provides exception reports for areas of concern. Areas of particular concern identified as low assurance and high risk for delivery include:

Finance:

- Year to date performance is off plan at month eight (page 42)
- Financial risks have been identified and are being actively managed (page 43)

Service Delivery:

- Urgent care – Length of stay over 21 days, ambulance conveyances and hospital handover delays over 60 minutes are over planned levels (pages 25-27)
- Elective care – Rising waiting lists and 52 week waits (page 29)
- Cancer – Cancer 62-day low performance and 62-day backlogs (page 32)
- Mental health – Children and young people eating disorders below plan (page 38)
- Community – High levels of community waiting lists (page 40)

Health Inequalities:

- The IPR includes a focus on smoking relevant to the Core20+5 (page 61)

Quality:

- Maternity concerns and oversight arrangements (page 17)
- Learning disability and autism, inpatient and health checks not achieving plan (page 13)
- Infection prevention and control areas of concern (page 19)

Workforce:

- Agency – High levels of agency are still being required across the system (page 47)
- Vacancies – The system is holding higher levels of vacancies than planned (page 48)
- Sickness absence – The system has higher levels of staff absence than planned (page 48)

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	Provides an overview of current performance in relation to quality and urgent care recovery across the ICB.
Tackle inequalities in outcomes, experience and access	Provides an overview of current performance in relation to elective, mental health, primary care and community care recovery, as well as an outline of current health inequalities across the ICB.
Enhance productivity and value for money	Provides an overview of current performance in relation to finance across the ICB.
Help the NHS support broader social and economic development	Provides an overview of current performance in relation to workforce across the ICB.

Appendices:
Appendix 1 – Integrated Performance Report December 2022

Board Assurance Framework:

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

- Risk 1: Health Inequalities and Outcomes – Failure to adequately address health inequalities and improve health outcomes for the population of Nottingham and Nottinghamshire.
- Risk 2: System Resilience (for Managing Today) – Working effectively across the system may fail to address the current levels of demand across primary, community and secondary care.
- Risk 6: Quality Improvement – Failure to maintain and improve the quality of services.
- Risk 7: People and Culture – Failure to ensure sufficient capacity and capability within the local workforce.
- Risk 10: Financial Sustainability – Establishing a shared culture of financial stewardship may not ensure financial sustainability across the system.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	No
Duty to promote innovation	No
Duty in respect of research	No
Duty to promote education and training	No
Duty to promote integration	No
Duty to have regard to the wider effect of decisions	Yes
Duties as to climate change	No
Duties regarding public involvement and consultation	No
Public sector equalities duties	Yes

Report Previously Received By:
Sections of the IPR are reviewed by the relevant committees of the Board.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Integrated Performance Report

Executive summary

1. An ICB Scorecard has been provided on page 4 of Appendix 1, which gives a summary of current delivery of the ICB against the various key system requirements aligned to the ICS four core aims. This highlights that the system is experiencing pressures to delivery across all areas of the ICS aims. Patients are experiencing extended waits across urgent care and elective pathways; the financial position is in a deficit position against plan at month eight; and there are challenges in recruitment in line with substantive staffing plans. There are also high vacancy and sickness absence levels, which are leading to greater agency usage than planned.

Finance (Stuart Poynor)

2. **Year to date (YTD)** – At the end of month eight, the local NHS system reported a £35.1 million deficit position, which is £17.2 million adverse to plan. The ICB and the mental health/community trust both reported a breakeven position YTD against plan and the acute provider position reported £17.2 million YTD adverse variance against plan. The main drivers of the deficit related to Covid costs, efficiency shortfalls, costs of continuing healthcare, excess costs arising from urgent care capacity and hospital discharge and interim beds.
3. **Forecast** – At month 8, all system partners continue to forecast to meet the 2022/23 planned deficit of £17.0 million. The system met with the NHS England Chief Finance Officer and national finance team on 5 December to discuss the financial position, route to improvement and impact on the year-end forecast. Given the current run rate and continuing risks to delivery, the system has entered discussions with NHS England on potentially enacting the forecast change protocol (process and conditions for a formal change to the in-year forecast).
4. **Financial risks** – The system has undertaken a full review of risks with potential impact upon the system financial forecast position. The risks and mitigations are detailed in the appendix on page 43.
5. **Capital** – The system capital envelope is underspent by £4.9 million to the end of month eight and forecasting to spend £85.3 million of the £89.6 million plan (set at 105% of allowance) by the end of the financial year.
6. **Agency** – NHS England has introduced an agency cap of £54.6 million for NHS Nottingham and Nottinghamshire ICS, current forecast is that the ICS will exceed the agency cap by £29.6 million.

Service delivery (Lucy Dadge)

7. The system is failing to meet the majority of the operational planning targets for 2022/23 across service performance (see Appendix 1, pages 6-9). The SPC charts indicate that whilst there are some areas of improvement, the position is unlikely to return to within the set control levels this year across many of the areas (see Appendix 1, Page 23). The system is taking specific actions against each area to target further improvements during the year as outlined below.

8. **Urgent care demand and pressures** continue to be high across the system. On the 19 December, the system declared a critical incident due to high numbers of patients arriving at local hospitals and has also experienced critical incidents over the Christmas period, due to increased demand and industrial action. There was high demand for all services across the system that extended waiting times to access beds with continued difficulties in discharging patients. Harm reviews are undertaken across this cohort of patients, which is overseen through the System Quality Group.

9. **System flow** is a key driver in elective and cancer performance as well as the urgent care position outlined above. This is due to difficulties in discharging patients from the acute episode of care into an alternative setting, such as community, social or home care. In turn, this leads to patients remaining in acute beds longer than is necessary, which prevents other patients from accessing the hospital. The number of discharge pathway 1, 2 and 3 patients medically safe for transfer (MSFT) for over 24 hours remains at a high level within the system. Data at week ending 18 December showed that there were 267 MSFT patients in beds within Nottingham University Hospitals NHS Trust (NUH) and Sherwood Forest Hospitals NHS Foundation Trust (SFH).

10. The Length of Stay (Appendix 1, page 26) of patients also remains an area of concern and a key challenge for the system. The number of patients within hospital for 21 days or more has increased significantly against pre-Covid levels. The revised Discharge to Assess business case is designed to improve the discharge process and reduce reliance on interim capacity. The impact is expected to increase during the final quarter of the year.

11. **Elective Care:** Urgent care demand, flow and staffing challenges have limited the volume of elective activity that providers have been able to undertake. Providers have focused on delivery of cancer treatment and high priority waiting list activity. However, this has had a significant impact on low clinical priority cases and specialties and has led to rising waiting lists and 52-week waiters.

12. The ICB is robustly managing performance for the longest waiting patients; at the end of December 2022 there were six patients waiting beyond 104 weeks for routine treatment. Providers track these patients daily to ensure that any risks that may prevent treatment are identified and mitigated. The longest waits will continue to be a focus area as the system moves to reduce the number of

patients waiting over 78 weeks. Mutual aid across the NHS acute providers and independent sector providers continues to be utilised where clinically appropriate, based on equity of waits. Any cancelled operations are being clinically reviewed daily. To increase elective capacity, building works on modular wards and theatres at City Hospital are nearing completion. The newly built ward is due to open in January 2023, which is later than the original plan of Autumn 2022.

13. **Cancer:** Demand for cancer services has been around 20% higher than pre-Covid levels since January 2021. Whilst it is a positive position for patients, in that missing cancer referrals during Covid appear to have come forward, the high level of demand is causing pressure in some services.

14. The increased levels of **two week wait referrals** continue to cause outpatient capacity challenges, especially in skin, lower gastrointestinal and head and neck tumour sites. However, additional clinics and increased levels of diagnostic activity are being undertaken, which means that some patients, whilst unfortunately waiting longer than 14 days for their initial consultation, are receiving a timely diagnosis within 28 days. Note that across all tumour sites, performance for the system against the Faster Diagnosis Standard was 77.9% in October against the 75% national standard. The Nottingham and Nottinghamshire system was one of only three systems within the region to achieve the Cancer Faster Diagnosis Standard in October.

15. The increased levels of demand are also impacting upon the volumes waiting on the **cancer pathway**, as can be seen with the increased volumes of patients waiting over 62 days against the planned level. The latest published position for the 62-day cancer backlog relates to October 2022, which highlights that there were 494 patients against a plan of 319 patients waiting beyond 62 days. The position is also tracked weekly using provisional data, which shows that at week ending 18 December, the system backlog has significantly improved to 396 patients. The Nottingham and Nottinghamshire system benchmarks well within the region for the proportion of the cancer waiting list that exceeds 62 and 104 days, which is 9% and 2% respectively.

16. **Diagnostics:** Across all modalities there is an increasing waiting list for the system. There are challenging positions for MRI, Echocardiography and Non-Obstetric Ultrasound services within the system. MRI waiting list and backlogs at NUH have increased significantly since October, due to increased staff sickness and a high number of vacancies within the service. NUH has two relocatable units in addition to two mobile units in place to provide additional capacity, which has been a key driver behind the improvements seen earlier this year. Additional revenue has recently been allocated to the system by NHS England, which will improve the system financial position as well as allow for an additional MRI machine at NUH.

17. **Echocardiography** is area of concern at SFH. SFH is working to utilise locum and insourcing providers to provide additional capacity, as well as offering weekend working to existing staff to increase capacity levels further.

18. **Non-Obstetric Ultrasound (NOU):** there has been significant growth in the waiting list and backlog of NOU at NUH. As of 4 December, the waiting list volume was 2,987 and the backlog was 650 patients. The level of administration staff vacancies was as high as 50%, which led to a reduced volume of bookings. There have also been sonographer absences caused by increased short term sickness, which led to significant cancellation of lists and reduced capacity. This has necessitated increased use of sonographer agency staff. Recruitment is currently in progress for substantive administration staff.

19. **Mental Health:** After some delays with the capital works required at Sherwood Oaks, the facility opened to patients at the end of November 2022, with patients being relocated there during November and December. This will support Out of Area Placements and the eradication of dormitory accommodation across Nottinghamshire Healthcare NHS Foundation Trust (NHT). Out of area placements increased rapidly in quarter one; however, crisis and continuity of care principles have led to subsequent reductions. The September position was 100 bed days against a plan of zero.

20. A new contract has been awarded for IAPT services and will be operational from 1 April 2023. A transition plan is in place to ensure the impact on service users is minimal, the plan is reviewed on a weekly basis.

21. **Primary Care:** The number of GP appointments was above plan in October 2022 and was 13% higher than October 2021. The majority of patients were seen the same and next day. The system continues to offer a blended model, with 71% of appointments being delivered face to face. There were 2,764 home visits delivered in October, with 150,825 appointments conducted via video or telephone. Capacity and demand pressures remain high within primary care.

Health inequalities (Dave Briggs)

22. Core20+5[1] for children has been released by NHS England and includes the clinical priorities of asthma, diabetes, epilepsy, oral health and mental health. These priorities align with transformation programmes and further work will be taken to fully outline health inequalities.

23. Following a successful bid, Nottingham and Nottinghamshire has been selected as one of seven national ‘Core20+ Collaborative’ accelerator sites. Working with the Institute for Healthcare Improvement, the collaborative programme

[1] Core20PLUS5 is a national NHS England approach to reduce healthcare inequalities https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

supports a systematic qualitative improvement approach and our bid includes a learning collaborative for system leaders.

24. Health inequalities dashboards have been provided on pages 48-49 of the Integrated Report. These have been established by the National Commissioning Data Repository and provide an overview of metrics for ethnicity and deprivation and how the indicators vary for the different patient cohorts relative to the population mean for the Nottingham and Nottinghamshire population.

Quality (Rosa Waddingham)

25. Appendix 1 provides detail in relation to delivery against quality plan requirements and trajectories across: learning disability and autism, personalisation, co-production, maternity, infection prevention and control, vaccinations and patient safety (Appendix 1 IPR; pages 12-21).

26. Under revised National Quality Board guidance, there is one NHS provider subject to **intensive surveillance**: Nottingham University Hospitals NHS Trust (NUH). A system-wide Improvement Oversight and Assurance Group (IOAG) is in place, which includes oversight of partnership support and mutual aid arrangements. November's IOAG meeting focused on the backlog of serious incidents, both maternity and non-maternity, with a significant challenge remaining around the reduction of these. Detail was presented around progress of the Trust's recovery plan. The ICB is working with NUH's patient safety team to support in the timescales provided.

27. One NHS provider is subject to **enhanced surveillance**: Nottinghamshire Healthcare NHS Foundation Trust (NHT). NHT has a system-wide Quality Assurance Group (QAG) and partnership support in place.

    a) The Care Quality Commission (CQC) published the Trust-wide CQC report on 25 November 2022, following its unannounced inspection of the Trust's mental health and community health services undertaken from 22 March to 28 April 2022. The Trust's overall rating remains as 'requires improvement'.

    b) The Trust is responding to written feedback following inspections at Rampton Hospital in September 2022 regarding immediate improvements required in staffing, clinical supervision, reduced patient activities, and daytime confinement.

    c) The CQC has re-inspected Priory Hospital Arnold (NHT sub-contracted mental health beds) and further escalation has been taken. The draft report is likely to be shared in the new year.

d) The Trust has opened Sherwood Oaks, a 70-bed in-patient facility providing 24/7 care to people over the age of 18 who are experiencing acute mental ill-health.

28. **Flu and COVID-19 vaccination programmes** are underway and uptake across the system is increasing, although rates are lower than anticipated for both covid and flu vaccinations. These are currently reporting lower than in 2021/22, apart from pregnant women where rates have increased in 2022/23. There continues to be a focus on ensuring that the most vulnerable are protected, with care homes now completed and housebound patients nearing completion. Plans to develop a whole system immunisation and vaccination model are underway. The programme is now also looking to deliver other vaccines, building on the success of the Covid vaccination programme, particularly in relation to managing inequalities.

29. **Care sector and home care capacity:** The system has organised a learning lab for home care and all partners have been invited. There is also a working group that has been developed to look at innovations that can be implemented in the homecare market to reduce the need for 2:1 care. Discharge personal health budgets have been approved to facilitate discharges from hospital for people who may require minimal support to facilitate their discharge. Winter monies have also been approved for a roving night service to compliment the home care sector offer.

30. System partners continue to work closely with NUH and regulators in relation to **maternity services**, in order to oversee and support improvements. A comprehensive partnership plan to reduce the serious incident backlog is in place, supported by NHS England and Lincolnshire Local Maternity and Neonatal System. A robust plan and trajectory is in place for the management of delayed serious incidents, including the establishment of an internal senior review process. Historic actions are being cross referenced to the Maternity Improvement Plan and new impactful actions are being developed where needed.

    a) A development/training session led by the Academic Health Science Network took place on 1 December, which focussed on impactful incident management, designed to support the development of meaningful actions and sustained changes in practice. A key focus for this period is around agreeing shared definitions for the status of serious incident investigations, so that appropriate resources can be applied to support recovery and key learning can continue to be identified and acted upon.

    b) The Independent Review led by Donna Ockenden commenced on 1 September; the ICB continues to provide all information requested by Donna Ockenden’s team and remain available to feed in other relevant information and data as required.

31. The **Local Maternity and Neonatal System (LMNS) programme** remains under enhanced surveillance due to capacity concerns to transform services in line with requirements given operational pressure and demands.
The Badgernet digital maternity system was rolled out across SFH and NUH in November, which represents a significant step towards integrated care pathways in maternity and neonatal services. The focus remains on action plan development in response to the East Kent report and implementation of Ockenden recommendations. NHS England has confirmed that the Single Delivery Plan (including key deliverables and funding arrangements) will not be released until Easter 2023. Locally, work is underway to identify system priorities in the meantime, but there is a risk that this delay to the national schedule means that local and national priorities may not fully align. See Appendix 1 IPR, page 17.

32. The **Learning Disability/Autism (LDA) Partnership programme** remains under enhanced surveillance due to adult inpatient numbers and increased host commissioner responsibilities (ensuring quality and safety of the increasing numbers of non-Nottinghamshire inpatients placed in Nottinghamshire settings). There were no children and young people in an inpatient environment during November, which demonstrates the impact of the dynamic support register approach to identify support needs prior to admission. This is being rolled out to adult inpatients, where the system continues to be impacted by admissions affecting performance. Annual Health Checks are on target. See Appendix 1 IPR, page 13.

33. **Infection Prevention and Control and Hospital Acquired Infections (HCAIs)** remain an area of focus, due to breaches against plan positions across a range of the new reduction targets; however, this is an issue replicated in many areas and the system is not an outlier. There is a system focus on reduction and cases are reviewed to maximise learning and provide support for ongoing reduction (Appendix 1 page 19).

Workforce (Rosa Waddingham)

34. The workforce report predominantly focuses on the three acute, community and mental health trusts within the system, reporting on the November 2022 position against the Operational Plan for 2022/23. The collective position shows the Trusts are slightly above plan (432 whole time equivalent (WTE)) with the substantive WTE, yet there is a continued use of bank and agency staff at 26% (394.38 WTE) and 18% (153.64 WTE) above plan respectively (See Appendix 1, page 47).

35. Sickness absence in the acute, community and mental health trusts saw increases in the daily position over November to 7.8% all sickness and 1.6% Covid-related sickness. The 12-month rolling average position for each Trust

has fallen to a position of 5.1% sickness, which is higher than the pre-Covid levels needed to be achieved of 4.7%. Trusts continue to review and enhance their wellbeing plans including mental health first aiders. The offer from the System Staff Support Hub on mental wellbeing is being reviewed by the ICS People and Culture Group to ensure better uptake across partners and the Group is assessing the risk of potentially no further funding to support this as an ongoing national initiative in 2023/24.

36. Retention of our existing workforce is a key focus with nursing and midwifery retention plans developed in each Trust and additional capacity of a system retention lead recruitment in progress. Turnover in both NUH and NHT is above the planned level of 11% at 12.4% and 19.1% respectively. SFH remains underneath the planned target at 9.5%. It should be noted that at a national level, NHS Employers are reflecting on higher than usual turnover rates nationwide, which they suggest is due to a delay in NHS employees leaving the service during the pandemic i.e., people have stayed on longer than they planned to in supporting the response to the pandemic. They predict national levels levelling out by the end of 2022.

37. Recruitment plans remain in place with mitigations in place where there is a national supply issue. International recruitment continues with low risk to both NUH and SFH around meeting their trajectories. The first international recruits for NHT arrived in November with the Trust on track to see 29 join by spring 2023. Joint work with finance continues in the Agency High Impact Action Group analysing agency usage, aligned to an analysis developed on understanding the substantive workforce and its deployment in delivery of the Operational Plan 2022/23 plan. A draft report has been submitted based on Trust responses to key lines of enquiry, providing recommendations on future actions required. Provider Chief People Officers/ Directors of Human Resources are informing the action plan and aligning to provider collaborative workstreams. The NHS England Regional Chief Nurse has also requested a diagnostic from the system with a meeting to be scheduled in January to support the implementation of our action plan.

38. Primary Care General Practice data, which includes the additional roles position, is a national priority for growing our general practice workforce, and is presented at a high level, showing indicative workforce numbers against the 2022/23 Operational Plan for October 2022. The general practice workforce position is collected from practices through a National Workforce Reporting Service (NWRS) support. The data collected is limited with variations in submissions linked to unclear definitions. The system is working with the national development team in NWRS to improve standardisation through clear definitions of data capture alongside consideration of local agreements to increase the utilisation of NWRS functionality.

39. The overall workforce position in general practice is being maintained with an established retention/workforce development programme in place for GPs and practice nurses. Workforce development needs to address the emerging new model of care. Engagement plans are planned at Place level to discuss the challenges of recruitment and retention as well as looking at opportunities presented through wider multi-professional working.
40. Recruitment continues into the additional roles but not to the full potential of funding allocations. Training Hub support is being provided to establish and embed roles into Primary Care Networks.
41. The Primary Care Workforce Group has completed a stocktake on the programme delivery and is looking to increase support on resilience over the winter months, ensuring wellbeing offers are clearly promoted and access into system resource made clear.
42. Following the State of Adult Social Care Sector and Workforce 2022 report, published by Skills4Care (October 2022), a presentation from Skills4Care on the Nottinghamshire position was made to the ICS People and Culture Group in October, which showed notable change in the net reduction in workforce despite increased recruitment, suggesting higher numbers of leavers added to the continual churn of turnover within the sector. A workforce planning approach is being developed with both councils. A collective approach is in development to commission work from Skills4Care.

Nottingham and Nottinghamshire

Nottingham & Nottinghamshire Integrated Care Board

Integrated Performance Report

Reporting Month: December 2022

Board Month: January 2023

Integrated Performance Report 2022/23 – Report Contents

NHS Nottingham and Nottinghamshire

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 IPR are reviewed annually and are based on the system operational plan for 2022/23, 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 60) which will support the escalation of issues to the ICB Board. This will develop and embed as an approach over the next few months.

Service Delivery and workforce areas have adopted a new reporting approach using Statistical Process Control (SPC) charts, further detail relating to SPC is included on page 61 of the report for reference to aid the review of the performance report tables included in the report. The aim of the SPC charts is to provide richer information relating to whether a service is improving or deteriorating based on trend (variation icons) and the likelihood of the system plan or target being met (assurance icons).

An ICB Scorecard has been provided on page 4 which provides a summary of the current delivery of the ICB against the various key system requirements aligned to the ICS Four Key Aims. This highlights that the system is experiencing pressures to delivery across all areas of the ICS Aims, with patients experiencing longer waits than acceptable across urgent care and elective pathways, the financial position in a deficit position against plan at month 6 and difficulties in recruitment in line with substantive staffing plans, high vacancy and sickness absence are leading to higher levels of agency usage than planned.

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 5 –11. 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 as well as an indication of whether the current process or performance levels will achieve the required level in future.

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 12 – 61.

NHS Nottingham and Nottinghamshire

1. ICB Scorecard by ICS 4 Aims – Reporting Period December 2022/23

AIM-01 Improve Outcomes in Population Health and Healthcare

ID	Key Performance Indicators	Date	Plan	Actual	In Month	Variation	Assurance
	Quality						
	LD&A Annual Health Checks	Nov-22	70%	42%	✗	-	-
	Total LD&A Inpatients	Nov-22	46	53	✗	-	-
	No. Personal Health Budgets	22-23 Q2	7250	3669	✗	-	-
	MRSA	Oct-22	0	0	✓	-	-
	CDI	Oct-22	21	24	✗	-	-
	Ecoli BSI	Oct-22	70	69	✓	-	-
	Klebseilla BSI	Oct-22	21	19	✓	-	-
	Pseudomonas BSI	Oct-22	6	6	✓	-	-
	Flu Vaccinations	tbd	-	-		-	-
	No. stillbirths per 1000 total births	Aug-22	2.5	1.7	✓	-	-
	No. neonatal deaths per 1000 live bir	Aug-22	1.5	0	✓	-	-
	Urgent Care						
	12 hour breaches	Nov-22	0	494	✗	~	?
	Handover delays > 60 minutes	Nov-22	0	313	✗	H	F
	Length of Stay > 21 days	Nov-22	265	410	✗	~	F

AIM-03 Improving the Effective Utilisation of Our Resources

ID	Key Performance Indicators	Date	Plan £m	Actual £m		Variance £m	FOT £m
	Delivery against system plan	Nov-22	-17.9	-35.1		✗ -17.2	✓ 0.0
	Efficiency Target	Nov-22	56.1	53.9		✗ -2.2	✓ 0.0
	ESRF Income	Nov-22	35.0	34.4		✗ -0.6	✓ 0.0
	Agency Spend	Nov-22	37.6	56.3		✗ -18.7	✗ -29.6
	MHIS	Nov-22	127.1	125.2		✗ -1.9	✓ 0.0
	Capital Spend	Nov-22	41.6	36.7		✓ -4.9	✓ -4.3

AIM-04 Support Broader Social and Economic Development

ID	Key Performance Indicators	Date	Plan	Actual	In Month	Variation	Assurance
	Provider Substantive Staffing	Nov-22	29,115	29,547	✓	H	F
	Provider Bank Staff	Nov-22	1,513	1,908	✗	H	?
	Provider Agency Staff	Nov-22	825	978	✗	H	?
	Provider Staff Vacancy Rate	Nov-22	8.7%	11.5%	✗	H	?
	Provider Staff Absence Rate	Nov-22	4.6%	5.8%	✗	H	F
	Primary Care Workforce	Oct-22	-	2996		H	-

AIM-02 Tackle Inequalities in Outcomes, Experience and Access

ID	Key Performance Indicators	Date	Population Plan	Population Actual	In Month	Variation	Assurance	Provider View Plan	Provider View Actual	In Month	Variation	Assurance
	Planned Care											
	Total Waiting lists	Oct-22	-	111204	-	H	-	101347	122126	✗	H	F
	Patients Waiting >104 weeks	Oct-22	-	22	-	~	-	2	19	✗	L	F
	Cancer 62 Day Backlog	Oct-22	-	-	-	-	-	319	494	✗	H	F
	Cancer Faster Diagnosis	Oct-22	75.0%	77.5%	✓	H	?	75.0%	77.9%	✓	H	?
	OP Remote Delivery	Oct-22	25.0%	20.0%	✗	~	F	25.0%	20.4%	✗	~	?
	Childrens Wheelchair Provision	Q2 22/23	91.6%	65.6%	✗	~	?	-	-		-	-
	Community											
	Community Waits - Adult	Sep-22	6240	7863	✗	H	F	-	-		-	-
	Virtual Wards	Nov-22						-	-		-	-
	Primary Care											
	GP Appointments	Oct-22	557,809	653,783	✓	H	?	-	-		-	-
	NHS App	Nov-22	60%	51%	✗	H	F	-	-		-	-
	Mental Health											
	IAPT Access	Jun-22	8984	8110	✗	H	F	-	-		-	-
	CYP Access	Jun-22	13300	17880	✓	H	P	-	-		-	-
	Out of Area Placements	Aug-22	0	70	✗	~	F	-	-		-	-
	SMI Physical Health Checks	Jul-22	3750	3424	✗	H	?	-	-		-	-
	Health Inequalities - Prevention											
	NHS Digital WM Referrals	Nov-22	1880	685	✗	-	-	-	-	-	-	-
	IP % Smokers Offered Tobacco Treatment	Jun-22	1111	1051	✗	-	-	-	-	-	-	-

NHS Nottingham and Nottinghamshire

2. Quality Scorecard

Quality Scorecard	Latest Period	Population			Variation	Assurance	Exception Report
		Plan	Actual	Variance			
Learning Disability & Autism							
LD&A Inpatients Rate Adults - ICB	Nov-22	13	18 ✗	5	-	-	Page 13
LD&A Inpatients Rate Adults - NHSE	Nov-22	30	34 ✗	4	-	-	
LD&A Inpatients Rate CYP - NHSE	Nov-22	3	1 ✓	-2	-	-	
LD&A Annual Health Checks	Nov-22	70%	42% ✗	-28.0%	-	-	
Personalisation							
No. of Personal Health Budgets	22-23 Q2	7250	3669 ✗	-3581	-	-	Page 15
No. Social prescribing referrals into link workers	22-23 Q2	13610	6825 ✗	-6785	-	-	
No. active PCSPs in place	22-23 Q2	27000	10730 ✗	-16270	-	-	
Personalised Care Institute Training	May-22	596	210 ✗	-386	-	-	
Maternity							
No. stillbirths per 1000 total births	Aug-22	2.5	1.7 ✓	-0.8	-	-	Page 17
No. neonatal deaths per 1000 live births	Aug-22	1.5	0.0 ✓	-1.5	-	-	
Hospital Acquired Infections							
MRSA	Oct-22	0	0 ✓	0	-	-	Page 19
CDI	Oct-22	21	24 ✗	3	-	-	
Ecoli BSI	Oct-22	70	69 ✓	-1	-	-	
Klebseilla BSI	Oct-22	21	19 ✓	-2	-	-	
Pseudomonas BSI	Oct-22	6	6 ✓	0	-	-	

3a. Service Delivery Scorecard - Streamline Urgent Care and Flow

NHS Nottingham and Nottinghamshire

Urgent Care Scorecard	Latest Period	Population			Variation	Assurance	Latest Period	Provider			Variation	Assurance	Exception Report
		Plan	Actual	Variance				Plan	Actual	Variance			
Urgent Care Access													
Extended Access Primary Care Appointments Booked	Sep-22	9628	11833	✔ 2205	H	?		-	-	-	-	-	
SDEC % of Total Admissions		-	-	-	-	-	Oct-22	33.0%	37.4%	✔ 4.4%		P	
Ambulance Conveyances (%)	Nov-22	55.6%	55.6%	✖ 0.1%		?		-	-	-	-	-	
Ambulance Conveyances (Vol.)	Nov-22	8007	8121	✖ 114		?		-	-	-	-	-	Page 25
A&E Attendances v 19/20 (%)	Oct-22	100%	99.9%	✖ -0.1%		?	Nov-22	100%	113.4%	✖ 13.4%		?	
% Unheralded Patients attending A&E		-	-	-	-	-	Oct-22	-	70.3%	-	H	-	
NEL Admissions v 19/20 (%)	Oct-22	100%	93.4%	✔ -6.6%		?	Oct-22	100%	95.7%	✔ -4.3%		?	
Urgent Care - Acute Discharges and Out of Hospital													
Patients medically safe to transfer from acute setting		-	-	-	-	-	Dec-22	104	279	✖ 175		F	
Length of Stay > 21 days		-	-	-	-	-	Nov-22	265	410	✖ 145		F	
No. Patients utilising Virtual Ward		-	-	-	-	-	Nov-22	-	30	-		-	Page 26
2 Hour Urgent Care Response Contacts	Oct-22	419	497	✔ 78	H	?		-	-	-	-	-	
2 Hour Urgent Care Response %	Oct-22	-	88.48%	-		-		-	-	-	-	-	
Pathway 1 - Discharge home with health and/or social care		-	-	-	-	-	Oct-22	1333	719			F	
Urgent Care - Compliance													
Ambulance (mean) Response Times Cat 1 (Notts Only)	Nov-22	0:07:00	00:08:08	✖ 00:01:08		F		-	-	-	-	-	
Ambulance (mean) Response Times Cat 2 (Notts Only)	Nov-22	0:18:00	00:53:23	✖ 00:35:23	H	F		-	-	-	-	-	
Hospital Handover Delays > 60 Minutes		-	-	-	-	-	Nov-22	0	313	✖ 313	H	F	Page 27
12 Hour Breaches ED		-	-	-	-	-	Nov-22	0	494	✖ 494		?	
12 Hour Breaches as % NEL		-	-	-	-	-	Oct-22	2%	5.6%	✖ 3.6%	H	?	

NHS Nottingham and Nottinghamshire

3b. Service Delivery Scorecard - Planned Care Recovery

Elective Scorecard	Latest Period	Population			Variation	Assurance	Latest Period	Provider			Variation	Assurance	POG Exception Report
		Plan	Actual	Variance				Plan	Actual	Variance			
Elective Recovery - Total Waiting List & Long Waits													
Total Waiting List Size	Oct-22	-	111204	-		-	Oct-22	101347	122126	20779			Page 29
Incomplete RTT pathways >52 weeks	Oct-22	-	5374	-		-	Oct-22	3677	5305	1628			
Incomplete RTT pathways >78 weeks	Oct-22	-	753	-		-	Oct-22	563	744	181			
Incomplete RTT pathways >104 weeks	Oct-22	-	22	-		-	Oct-22	2	19	17			
Elective Recovery - Activity													
Total Referrals	Oct-22	28425	25034	-3391			Oct-22	26350	23084	-3266			Page 30
Total Ordinary Electives	Oct-22	2081	1881	-200			Oct-22	2370	1888	-482			
Total Daycases	Oct-22	12931	12928	-3			Oct-22	14241	12327	-1914			
Total Outpatients - First Appointments	Oct-22	40356	24827	-15529			Oct-22	28674	22863	-5811			
Total Outpatients - Follow Ups	Oct-22	76416	59518	-16898			Oct-22	63132	57511	-5621			
Total Diagnostic Activity	Oct-22	39282	29891	-9391			Oct-22	34210	31146	-3064			
Elective Recovery - Productivity & Transformation													
Total Outpatients - Total Virtual (%) 25%	Oct-22	25%	20%	-5%			Oct-22	25%	20%	-5%			Page 31
Patient Initiated Follow ups - %	-	-	-	-	-	-	Oct-22	5.0%	4.4%	-0.6%			
Advice & Guidance - % of 1st OP	Oct-22	16	26	10			-	-	-	-	-	-	
Total Outpatient F/Up v 2019/20 Activity (%) 25% Reduction	Oct-22	75.0%	89.4%	14.4%			Oct-22	75.0%	89.0%	14.0%			
Completed admitted RTT pathways	Oct-22	5348	4573	-775			Oct-22	5085	4273	-812			
Completed non-admitted RTT pathways	Oct-22	25423	21795	-3628			Oct-22	22810	20695	-2115			
Diagnostic Recovery													
Diagnostic Activity	Oct-22	39282	29891	-9391			Oct-22	34210	31146	-3064			Page 32
Diagnostic Waiting List	Oct-22	-	25267	-		-	Oct-22	-	27292	-		-	
Diagnostic Backlog	Oct-22	-	8850	-		-	Oct-22	-	9533	-		-	
Diagnostics + 6 Weeks	Oct-22	25%	35.0%	10.0%			Oct-22	25%	34.9%	9.9%			
Cancer Recovery													
Cancer Referrals	Oct-22	-	4371	-			Oct-22	-	4478	-		-	Page 33
Cancer - Faster Diagnosis Standard 28 days	Oct-22	75.0%	77.5%	2.5%			Oct-22	75.0%	77.9%	2.9%			
Cancer - No. 1st Definitive Treatments	Oct-22	614	485	-129			Oct-22	701	591	-110			
Cancer - No. patients receiving 1st treatment < 31 days (%)	Oct-22	96%	86%	-9.6%			Oct-22	96%	88%	-7.9%			
Cancer - No. patients waiting < 62 days (%)	-	-	-	-	-	-	Oct-22	85%	55%	-30.5%			
Cancer - 62 day backlog	-	-	-	-	-	-	Oct-22	319	494	175			

NHS
Nottingham and Nottinghamshire

3c. Service Delivery - Mental Health Scorecard

Mental Health Scorecard	Latest Period	Population			Variation	Assurance	Exception Report
		Plan	Actual	Variance			
Mental Health - Improving Access to Psychological Therapies							
IAPT - Referrals	Sep-22	-	3235	-		-	Page 35
IAPT - 1st Treatment <6 Weeks	Sep-22	75%	81.6%	6.6%			
IAPT - 1st Treatment <18 Weeks	Sep-22	95%	100%	4.7%			
IAPT - Entering Treatment 3 Months	Jun-22	8984	8110	-874			
IAPT - >90 Days between 1st and 2nd Treatment	Sep-22	10%	18.0%	8.0%			
IAPT - Recovery Rate (3 months rolling)	Jun-22	50%	51.7%	1.7%			
Mental Health - Adult Mental Health							
Adult MH Inpatient Discharges - % F Up 72 hours	Jun-22	80%	85%	5.0%			Page 36
Inappropriate OAP Bed days	Sep-22	0	100	100			
Rate per 100,000 Older Adult MH LOS > 90 Days	Jun-22	11	18	7.25			
SMI Health Checks	Jul-22	3750	3424	-326			
Access SMI +2 Contacts Community MH Services	Jun-22	11854	12200	346			
Dementia Diagnosis	Sep-22	67%	68.9%	2.2%			
Mental Health - Access							
Perinatal Access % (12 month rolling)	Jun-22	10.0%	7.1%	-2.9%			Page 37
Perinatal Access - Volume	Jun-22	828	925	97			
Individual Placement Support	Jun-22	225	360	135			
Early Intervention in Psychosis (EIP)	Jun-22	60%	70%	10.0%			
Mental Health - Children & Young People							
CYP - New Referrals	Jun-22	-	1985	-		-	Page 38
CYP Eating Disorders - Routine Referral Performance (Qtr)	Jun-22	95%	71%	-23.9%			
CYP Eating Disorders - Urgent Referral Performance (Qtr)	Jun-22	95%	91%	-3.7%			
CYP Access (1+ Contact)	Jun-22	13300	17880	4580			

NHS Nottingham and Nottinghamshire

3d. Service Delivery – Primary & Community Scorecard

Primary Care and Community Scorecard	Latest Period	Population			Variation	Assurance	Exception Report
		Plan	Actual	Variance			
Primary Care and Community Recovery							
Total Appointments	Oct-22	557,809	653,783	✔ 95,974	H	?	Page 39
Percentage of Face to Face Appointments	Oct-22	-	71%	-	H		
Percentage of Same Day Appointments	Oct-22	-	38%	-	H		
Number of NHS App Registrations	Nov-22	60%	51%	✖ -9%	H	F	
Community Waiting List (Patients aged 0-17 Years)	Sep-22	529	1785	✖ 1256	H	F	
Community Waiting List (Patients aged 18+ Years)	Sep-22	6240	7863	✖ 1623	H	F	

NHS Nottingham and Nottinghamshire

4. Finance - Scorecard

		YTD Variance £m's			FOT Variance £m's			RAG	
Financial Duties	**Measure**	**Plan**	**Acts**	**Variance**	**Plan**	**FOT**	**Variance**	**YTD**	**FOT**
NHS System (Breakeven)	**(Deficit)/Surplus**	**-17.9**	**-35.1**	**-17.2**	**-16.9**	**-16.9**	**0.0**		
Capital (within Envelope)	**Spend against plan**	41.6	36.7	**4.9**	89.6	85.3	**4.3**		
MHIS (meeting target)	**Spend against plan**	127.1	125.2	**-1.9**	190.7	190.7	**0.0**		
Agency (spend within Cap)	**Spend against plan**	37.6	56.3	**-18.7**	54.6	84.2	**-29.6**		

		YTD Variance £m's			FOT Variance £m's			RAG	
Drivers of the (Deficit)/Surplus	**Measure**	**Plan**	**Acts**	**Variance**	**Plan**	**FOT**	**Variance**	**YTD**	**FOT**
COVID Spend	**Delivery against plan**	14.7	22.6	**-7.9**	17.8	28.0	**-10.2**		
NHS Efficiencies	**Delivery against plan**	56.1	53.9	**-2.2**	102.7	102.7	**0.0**		
ERF Income	**Delivery against plan**	35.0	34.4	**-0.7**	53.7	53.7	**0.0**		

- **£35.1m** deficit experienced to end of month 8, which is **£17.2m** adverse to plan.
- The adverse variance is totally experienced in the 2 acute trusts (NUH & SFH) representing **£12.4m & £4.9m** of the year to date deficit variance respectively.
- Key drivers of the adverse variance are covid (**£7.9m**), excess costs arising from urgent care capacity requirements (**£7.5m**) hospital discharge and interim beds (**£3.4m**), continuing health care (**£5.0m**) and efficiency shortfall (**£2.2m**). Adverse variances are also seen in primary care prescribing, mental health out of area beds and inter-system contracts (ESRF). Offsetting favourable variances include clinical supplies due to elective surgery performing below planned levels and primary care expenditure.
- Agency spend remains over plan and above the agency cap, with an adverse YTD variance of **£18.7m**. Drivers include covid expenditure, efficiency shortfalls, urgent care capacity requirements and shortage of substantive staff in some areas.
- The forecast remains break-even but there are significant risks to delivery, particularly relating covid, efficiency, continuing care and urgent care capacity over winter.

NHS Nottingham and Nottinghamshire

5. Workforce - Scorecard

Workforce Scorecard	Latest Period	Total Provider			Variation	Assurance	Exception Report
		Plan	Actual	Variance			
Total Provider Workforce							
Total Provider Workforce	Nov-22	31,453	32,433	980			
Total Provider Substantive	Nov-22	29,115	29,547	432			Page 47
Total Provider Bank	Nov-22	1,513	1,908	394			
Total Provider Agency	Nov-22	825	978	154			
Total Primary Care Workforce	Oct-22	-	2,996	-			Page 49
Key Workforce Performance							
Total Provider Turnover Rate % (12 month rolling)	Nov-22	11.0%	13.8%	2.8%			
Total Provider Sickness Absence Rate %	Nov-22	4.6%	5.8%	1.2%			Page 48
Total Provider In-Month Vacancy Rate %	Nov-22	8.7%	11.5%	2.8%			

NHS
Nottingham and Nottinghamshire

6: Quality

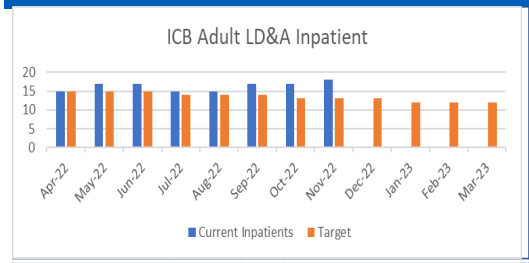
ICS Aim 1: To improve outcomes in population health and healthcare

- 6.1 - Exception Report Learning Disability & Autism
- 6.2 - Exception Report Personalisation & Co-Production
- 6.3 - Exception Report Maternity
- 6.4 - Exception Report Infection Prevention & Control
- 6.5 - Exception Report Vaccinations & Patient Safety

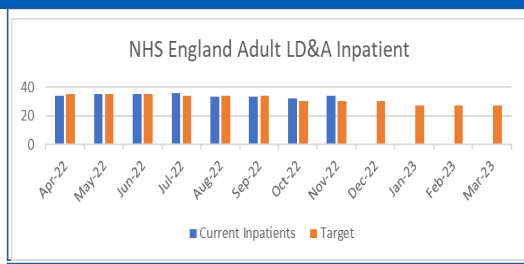
6.1 - Improving Quality of Services – Exception Report Learning Disability & Autism

NHS Nottingham and Nottinghamshire

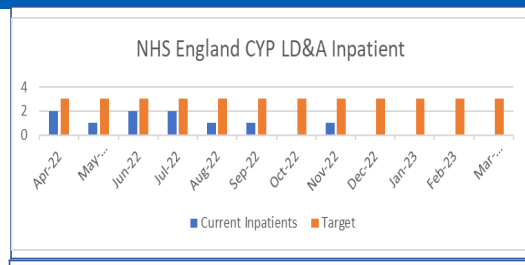
Learning Disability and Autism (LD&A)



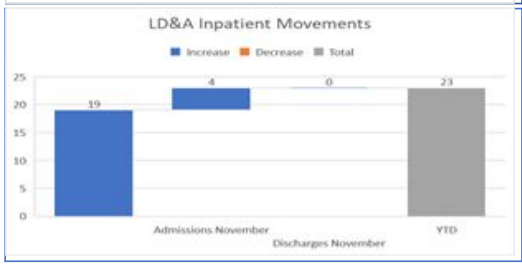
Nov-22
18
2022/23 Plan
13
Assurance
-
SPC Variation
-



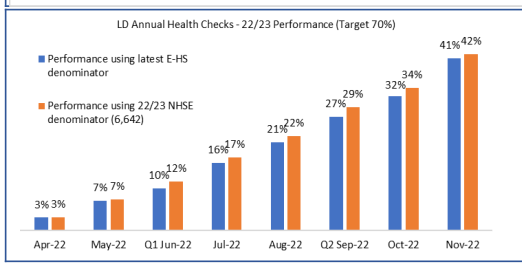
Nov-22
34
Target
30
Assurance
-
SPC Variation
-



Nov-22
1
Target
3
Assurance
-
SPC Variation
-



YTD
23
Nov-22 Admissions
4
Nov-22 Discharges
0
SPC Variation
-



Nov-22
42%
Target
70%
Assurance
-
SPC Variation
-

Apr-22
6
Target
7
Assurance
-
SPC Variation
-

Current Position

Adult Inpatients – The current adult inpatient number stands at 51, which is 8 above target for the month of November (target is 43). There were 3 admissions and no discharges within November. The total adult admissions for this financial year is 20, versus the 21 adult discharges we have had. Despite a further 5 discharges forecast by the end of March 2023, forecasts indicate there will be 46 adult inpatients by end of March 2023, missing our target by 7. Out of the 20 admissions, 16 were a result of a community placement breaking down. Nottinghamshire County Council have had 3 community placements breakdown and inherited a further 2 from other commissioner placements within their area; therefore 15 of the other community placement breakdowns are within City Council boundaries. A deep dive is planned with the Nottingham City Commissioner and a Local Authority specialist social worker to understand better the reasons for admissions, as well as a programme of work with both local authorities to strengthen community provision.

During November, there were **0 children and young people in an inpatient environment**. This was largely due to a system approach to maximising community wraparound provision and the impact of the Dynamic Support Register (DSR) panel in identifying CYP with behaviours of concern earlier. We currently have **1 CYP inpatient** within the system (target is 3) due to a planned short term admission to support with eating.

The adult DSR was launched on 21st November, utilising learning from the CYP DSR. Work is progressing through the admission avoidance workstream, with the ongoing recruitment process for the Quality Manager post progressing. Work also continues in relation to the development of community wraparound proposals, as well as the development of a task and finish group to review adult Unplanned Care Bed provision and procurement.

System Quality Group Assurance – Limited Assurance

Enhanced Surveillance: Due to Adult Inpatient numbers and increased Host Commissioner responsibilities.

6.1 (continued) - Improving Quality of Services – Exception Report Learning Disability & Autism

NHS Nottingham and Nottinghamshire

Learning Disability and Autism (LD&A)

Current Position (Continued)

Quality Improvement – The strengthening of the case management/commissioning process has supported effective discharge planning across the ICS, with greater risks now being managed within the community. Between September and November 2022, the ICB established, chaired and administrated the Cygnet Cedar Vale Closure programme, alongside colleagues at Cygnet and NHSE regional and national teams. This involved ensuring that all placing systems attended key meetings to drive action towards effective and safe discharges within a tight timescale. All patients were moved out of the service a day before the closure deadline. Of the 7 placed inpatients, the closure resulted in 2 being transferred to alternative hospital beds and 5 people being discharged into the community. Regional and National colleagues fed back positively regarding the support that the ICB gave and suggested this should be shared as an example of good practice.

As part of **workforce** development, the five new Advanced Clinical Practitioner (ACP) posts across NHT and NUH have been recruited to. An LDA Consultant role has been appointed by region within the local system and priorities have been agreed.

Dashboard development: Work is underway with the SAIU to develop an LDA dashboard that will contain key LDA performance reporting. This will include key KPI's and outcome measures to demonstrate impact. Work is underway to explore automation of the current inpatient reporting, which is currently undertaken manually. A Project Initiation Document (PID) has been developed with the aim of having the dashboard in place by March 2023.

Sustainable Finance Plan: NHSE have confirmed that two funding streams (FTA and three-year road map) will become recurrent in 2023. A review of schemes has taken place and recommendations around non-recurrent and recurrent schemes were agreed at the LDA Executive Board in November. This provides stability and sustainability for the system to achieve improved outcomes for people with a learning disability and autism.

Learning Disabilities Mortality Review (LeDeR) – The LeDeR annual review report has been published. The learning from the reviews is being implemented through transformation and quality improvement activity.

Annual Health Checks (AHC) – As of 1st December 2022, 2,800 health checks have been completed. This equates to 41% of checks completed across the ICS based on the latest GP LD register figures (E-Healthscope) and 42% based on the NHSE denominator set at the start of 22/23 (using previous year's QOF GP LD register), keeping the ICS on trajectory to meet our Q3 target (2,856 checks), as well as the end of March 23 target of 70%.

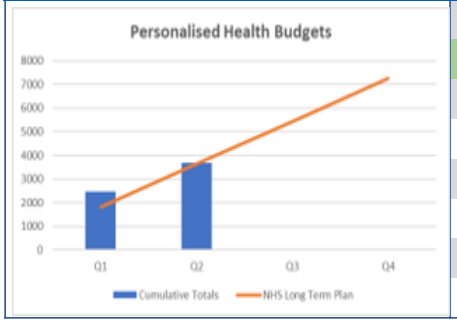
The **NHSE Winter Summit** on LDA has been postponed from December to 24th January 2023 and will include key system representation.

Chappell Room, Arnold Civic Centre 09:00-12/01/23

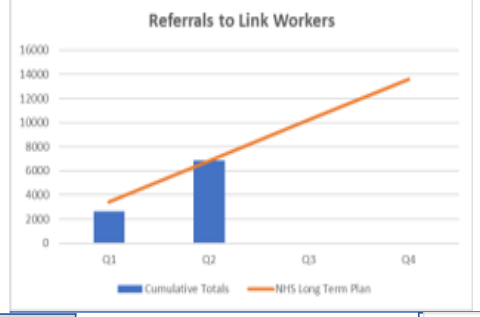
6.2- Improving Quality of Services – Exception Report Personalisation & Co-Production

NHS Nottingham and Nottinghamshire

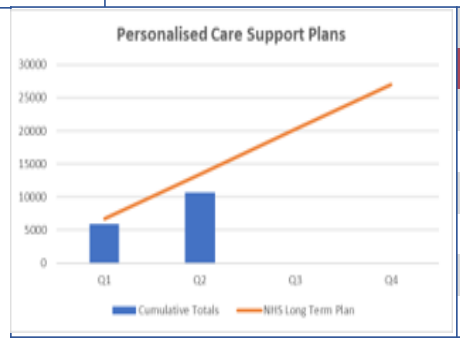
Personalisation



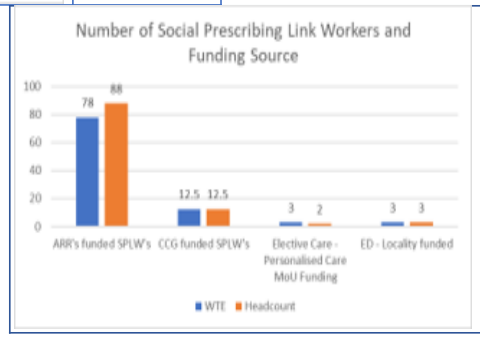
Q2 22-23
3669
2022-23 Plan
7250
Assurance
SPC Variation



Q2 22-23
6825
2022-23 Plan
13610
Assurance
SPC Variation



Q2 22-23
10730
2022-23 Plan
27000
Assurance
SPC Variation



Q2 22-23
105.5
2022-23 Plan
N/A
Assurance
SPC Variation

System Quality Group Assurance – Partial Assurance

- In November, NHSE sent a letter of congratulations to the ICB for the continued delivery and implementation of personalised care, with the system ranking as one of the top performing systems in the country across personalised care measurements. This includes being ranked out of all 42 ICB's as 1st for Shared Decision-Making; 10th for personal health budgets; 14th for personalised care and support plans and 19th for social prescribing referrals. It was also noted that the system has overachieved on the trajectory to train the workforce in personalised care by 25%.
- Work is underway to embed personalisation in Anticipatory Care work, including the development of paperwork and prompts to support personalised conversations and the measurement of personalised approaches. This will be incorporated into a specification for an evaluation, alongside collating quantitative data from the SAIU team.
- Extensive work is underway in the Children and Young People transformation programme to embed personalised approaches, personalised care and support plans for asthma, as well as co-production and scaling up of 'About Me' via a digital patient-facing app, in conjunction with Digital Notts. This is with the aim of ensuring that the functionality talks to all providers' systems.
- A review will be undertaken in the New Year of the Personalised Care Strategic Oversight Group, with a focus on the relationship and ownership between system and Place to deliver personalised care.
- Personalisation is one of the key system approaches to delivering the Integrated Care Strategy and work has commenced to identify priority areas for delivery support.

Chappell Room, Arnold Civic Centre 09:00-12/01/23

6.2 (continued) - Improving Quality of Services – Exception Report Personalisation & Co-Production

NHS Nottingham and Nottinghamshire

Personalisation (continued)

System Quality Group Assurance – Partial Assurance

Social Prescribing

- In total there are over 90 Social Prescribing Link Workers (SPLWs) employed by 12 provider organisations across the 23 PCNs, with additional link worker resource in secondary care (Emergency Departments, Elective Care, prehabilitation cancer pathway and hospital discharge).
- The total number of referrals to PCN Social Prescribing Link Workers for Quarter 1 and Quarter 2 was 6825, meaning we remain on track for the original 22/23 referral to Social Prescribing target.
- PCN now have 43 WTE Care Coordinators and 17 Health & Wellbeing Coaches, funded through the Personalised Care Additional Reimbursement Roles scheme
- All PCNs have created Proactive Social Prescribing plans, identifying specific patient cohorts that have unmet needs and addressing health inequalities
- A Social Prescribing & Community Development Project Manager has been recruited; this role will complement the social prescribing principals work across all sectors and embed the learning from the Green Space programme.
- The Social Prescribing Programme funding comes to an end in April 2023 and focus will be on developing a sustainability plan to embed green social prescribing into health pathways.
- The Green Social Prescribing evaluation is due to be released, while the mental health toolkit (co-designed locally) will be used as a national model. The Big Green Book digital resource provides safe referral pathway to 'trusted providers' for SPLWs and health teams.
- Nottingham City is one of the 11 areas to secure pilot programme funding for the Active Travel Social Prescribing (ATSP) programme, with an award of £1,588,426 revenue grant in three annual instalments from 2022/23 to 2024/25. The ATSP project is specifically targeted to Beechdale/Aspley, St Ann's/Sneinton and Bulwell. The Nottingham City GP Alliance will receive funding to expand the link worker provision and Nottingham CVS will receive funding for a community coordinator to work alongside the link workers and support patients to become involved in active travel; this is due to start in April 2023.

Data

- We currently we do not have a system-wide approach to capturing referrals into social prescribing data, though work is in progress with the SAIU to look at solutions to this.

Co-Production

System Quality Group Assurance – Full Assurance

Co-production has been included within the Integrated Care Strategy as the step change approach for how we will work as a system to identify solutions to challenges together. The Co-production Working Group were involved in providing feedback on the final draft.

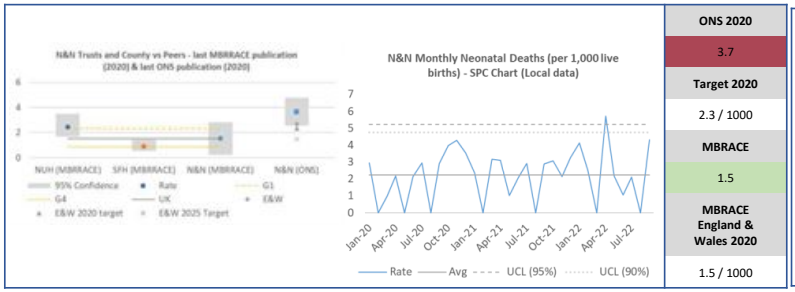
The new Strategic Co-production Group will launch in January 2023. This group will be responsible for oversight and assurance of all co-production activity across the ICB. It's initial focus will be on the oversight of progress of co-production within the Integrated Care Strategy and the twelve system transformation programmes.

Recruitment to the newly formed Coproduction Team roles continue to be a challenge; however a refreshed recruitment approach, with partner support, means there is confidence that the current activity will result in appointments.

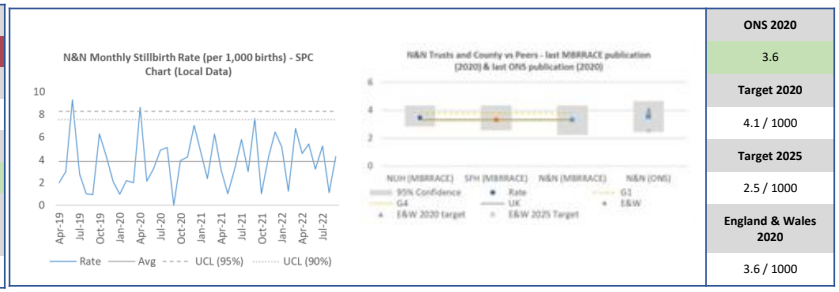
6.3 - Improving Quality of Services – Exception Report Maternity

NHS Nottingham and Nottinghamshire

Local Maternity & Neonatal System (LMNS)



ONS 2020
3.7
Target 2020
2.3 / 1000
MBRACE
1.5
MBRACE England & Wales 2020
1.5 / 1000



ONS 2020
3.6
Target 2020
4.1 / 1000
Target 2025
2.5 / 1000
England & Wales 2020
3.6 / 1000

Ockenden	NUH			SFH		
	Jan-22	Apr-22	Sep-22	Jan-22	Apr-22	Sep-22
IEA1 Enhanced Safety	56%	100%	100%	100%	100%	100%
IEA2 Listening to women and families	88%	99%	100%	88%	100%	100%
IEA3 Staff training and working together	56%	63%	96%	100%	100%	100%
IEA4 Managing complex pregnancy	79%	89%	100%	100%	100%	100%
IEA5 Risk assessment throughout pregnancy	67%	70%	98%	100%	100%	100%
IEA6 Monitoring fetal well being	67%	94%	97%	100%	100%	100%
IEA7 Informed consent	50%	57%	93%	71%	71%	93%
Workforce	70%	80%	95%	100%	100%	100%

Current Position and Summary of Activity

Digital: The Badgernet digital maternity system has been rolled out across SFH and NUH in November, which represents a significant step towards integrated care pathways across Nottingham and Nottinghamshire's maternity services. It is anticipated that Badgernet will support communication between teams and specialities, support patient safety, allow for personalised care pathways to be developed and maintained, and provide access to key audit data to support the continuous improvement of services. The first Badgernet babies have been born at each Trust.

Maternity and neonatal services in East Kent: 'Reading the signals' report: System recommendations are being reviewed locally and agreed next steps will be developed with LMNS partners; this will be reviewed by the LMNS Executive Partnership and the ICB Board in January 2023.

Nottingham University Hospitals (NUH) maternity: The ICB continue to work closely with NUH, Care Quality Commission (CQC), and NHS England (NHSE) to oversee improvements in maternity services. The Independent Review led by Donna Ockenden commenced on 1st September 2022.

Ockenden Oversight: The next Quarterly Ockenden Assurance Panel is taking place on 14th December to scrutinise and assure compliance and progress against the Immediate and Essential Actions (IEAs). A system approach to the East Kent 'Reading the Signals' Report will also be agreed at the meeting. A public-facing progress infographic is being developed with Maternity Voices Partnership (MVP) partners and will be agreed at the December assurance panel, to update the public on progress.

Perinatal Quality Surveillance: Focus remains on CNST compliance, as progress continues at both Trusts in relation to **Saving Babies Lives Care Bundle** (SBLCBv2). A key focus for this period is to agree shared definitions for the status of serious incident investigations, so that appropriate resources can be applied to support recovery and key learning can continue to be identified and acted upon. The NHSE regional maternity team have offered Board-level support and will be observing the LMNS Transformation Board in December and LMNS Executive Partnership in January to provide recommendations regarding oversight and assurance. This is part of a regional offer to all systems.

System Quality Group Assurance – Limited Assurance

Enhanced Surveillance due to comprehensive programme of improvement at NUH, plus limited capacity across providers to transform services in line with LTP requirements, owing to continued operational pressures and workforce challenges. Focus includes action plan development in response to the East Kent report, implementing Ockenden recommendations, developing our Maternity Voices Partnership (MVP) & Neonatal Voices, and implementing Equity Strategy plans.

Chappell Room, Arnold Civic Centre 09:00-12/01/23

6.3 (continued) - Improving Quality of Services – Exception Report Maternity

NHS Nottingham and Nottinghamshire

Local Maternity & Neonatal System (LMNS)

Current Position and Summary of Activity (Continued)

Coproduction: The Maternity Voices Partnership (MVP) development work is underway. The MVP Chair has recruited 9 new volunteers. Over time these volunteers will support programme priorities and ensure people with lived experience are involved as equal partners.

Workforce: A system workforce plan for maternity services is being developed with NUH and SFH. This will be presented to the People and Culture Board before submission to NHSE on 31st December.

Equity Strategy: The Equity Strategy was submitted to NHSE and published on the ICB website in September. Feedback has been received from the regional team, and throughout December and January the Midlands Perinatal Team will be meeting with LMNSs to support further development of plans. Work is ongoing to look at potential options to provide antenatal education in different languages. The PMO team are developing an approach to roll out a Cultural Competency & Safety Workshop to embed equity within culture.

Perinatal Mental Health – the LMNS PMO is working with stakeholders to develop a single referral form to be uploaded into Badgernet for all referrals to IAPT and or/ Community mental health team to simplify the process and increase referrals from midwifery, rather than rely on self-referrals. Following a tender process, a provider for IAPT has been agreed from 1st April 2022.

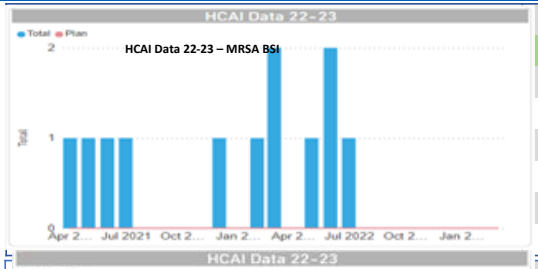
Development of a co-produced LMNS website to communicate with women and families effectively (LMNS): Work is ongoing to identify key information priorities, a developed co-production work plan and the broadening of tailored information. Work with the MVP seeks to broaden the diversity of representation and service user representation is being identified to develop understanding on how best to share information with women, birthing people and families.

NHSE have confirmed that the Single Delivery Plan (including key deliverables and funding arrangements) will not be released until Easter 2023. Locally, work is underway to identify system priorities in the meantime, but there is a risk that this delay to the national schedule means that local and national priorities may not fully align.

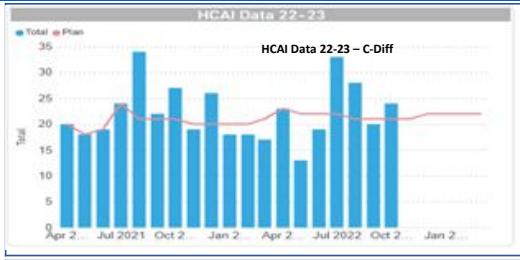
6.4 - Improving Quality of Services – Exception Report Infection Prevention & Control

NHS Nottingham and Nottinghamshire

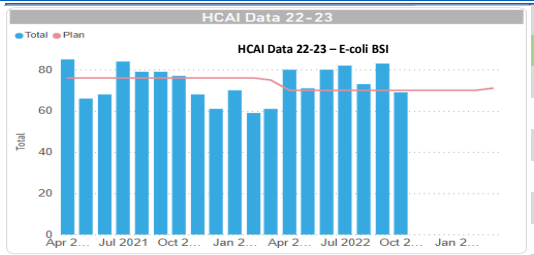
Infection Prevention and Control



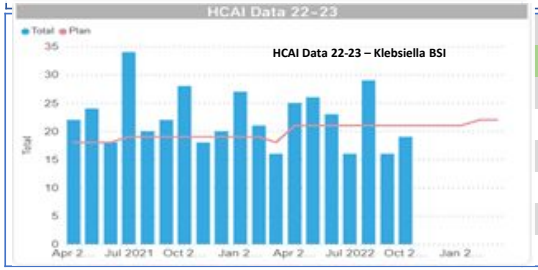
Oct-22
0
Plan
0
Assurance
Variation



Oct-22
24
Plan
21
Assurance
Variation



Oct-22
69
Plan
70
Assurance
Variation



Oct-22
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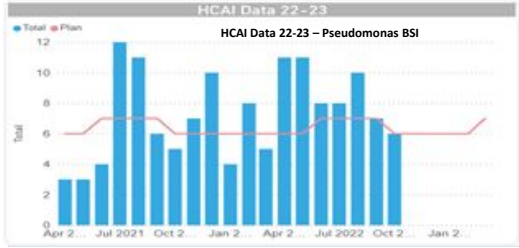
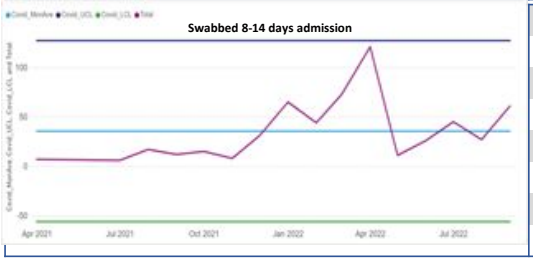
Plan
21
Assurance
Variation



Oct-22
6
Plan
6
Assurance
Variation



Oct-22
59
Mean
36
Assurance
Variation

Current Position

Current

- COVID-19 cases have stabilized, with a plateau in related admissions noted. There are no new themes from COVID-19 Outbreaks/SI cases. Locally and regionally there has been a reported increase in COVID-19 related mortality in the recent wave; reasons for this are under review.
- Cases of influenza A at both a national, regional and local level have significantly increased, which has led to an associated rise in those requiring ITU admission. We are officially 'in' flu season.
- Paediatric cases of Respiratory Syncytial Virus (RSV) and group A streptococcal (GAS) infection are rising, resulting in an increase in related admissions.
- Point of care testing in ED remains in place for COVID-19, RSV and flu A/B.
- The continued increase in bed occupancy and inability to deep clean wards is considered to be a contributory factor in the rise in some healthcare associated infections.
- HCAI cases have increased both regionally and locally; this rise is likely to be multifactorial and includes a reported increase in the complexity of patients accessing healthcare.

November 22 HCAI data (Bassetlaw data and targets remain separate to ICB)

•MRSA BSI: ICB, NUHT and SFHT met month plan, Bassetlaw breached month plan 1/0

•CDI: ICB, NUHT and SFHT met month plan, Bassetlaw breached month plan 3/2 and year end plan 21/19. Individual case reviews are in place to identify lapses in care. System-wide and regional NHSEI meetings are in place to support with reduction actions. Nationally and regionally cases are increasing. Increased bed occupancy and reduced deep cleaning programmes are considered to be contributory factors.

•*E.coli* BSI: ICB breached month plan 82/70, Bassetlaw breached month plan 8/7, SFHT breached month plan 9/8, NUHT breached month plan 25/23 . System-wide and regional NHSEI meetings are in place, but NHSEI meetings are often cancelled due to capacity pressures.

•*Klebsiella* BSI: ICB, NUHT and SFHT met month plan. Bassetlaw breached month plan 2/1. System-wide and regional NHSEI meetings are in place to review and plan reduction actions.

•*Pseudomonas* BSI: ICB breached month plan 7/6, Bassetlaw breached month plan 1/0. SFHT and NUHT met month plan. System-wide and regional NHSEI meetings are in place to review and plan reduction actions

System Quality Group Assurance – Partial Assurance

Further information required: due to breaches against plan positions across a range of the new reduction targets, further information has been requested which will be reviewed at the system meetings that have been established

Chappell Room, Arnold Civic Centre 09:00-12/01/23

6.4 (continued) - Improving Quality of Services – Exception Report Infection Prevention & Control

NHS Nottingham and Nottinghamshire

Infection Prevention and Control (continued)

Healthcare System Infection Prevention and Control Assurance Group (HSIPCAG)

Actions

- IPC teams continue to update BAF/plans in line with new IPC guidance and the NHSE principles.
- IPC teams' focus is on going back to IPC basics, training and compliance with guidance
- The IPC derogation process has been revised to include other infections and this has been approved. This process aims to support discharge and flow but is dependent on effective discharge arrangements.
- Work to progress system workforce planning is in place and progressing slowly; IPC recruitment remains challenging across the system. A NHSE project funding application was successful for system IPC development posts - details are awaited
- HCAI reduction meetings are in place (CDI, urinary source gram negative BSI) along with planned regional NHSE meetings.
- Work continues with Public Health teams to promote vaccination uptake
- The devolvement of Pharmacy, Optometry and Dental (PODS) to the ICB in 2023

Concerns:

- Regarding winter pressures, with the current levels of COVID-19 cases & the increase in Flu A locally
- Regarding IPC resilience, recruitment and retention of staff
- Regarding constant high bed occupancy and the impact on general and 'deep' cleaning at both NUH/SFH.
- The lack of 'deep' cleaning and inability to use a decant facility due to high admission rates are considered to be contributory factors in the rise in trust acquired HCAI locally and regionally.
- Old NHS estate and ventilation requirements
- Lack of IPC resource to undertake work with PODs

6.5 - Improving Quality of Services – Exception Report Vaccinations, Patient Safety & Safeguarding

NHS Nottingham and Nottinghamshire

Vaccinations

System Quality Group Assurance – Partial Assurance

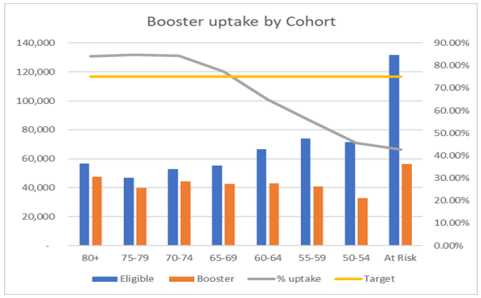
Programme delivery of Covid vaccine & flu oversight - as at 27th November 2022

COVID

- Autumn Plan (Phase 5) began on 5th September 2022
  - Eligible Population – 545,000
  - Booster Vaccination – 330,705 **(60%)**
  - Target 75% uptake based on financial planning assumptions

Delivery Model and Actions:

- 2 Vaccination Centres are delivering vaccinations and supporting the Roving Team to deliver to Care Homes and "At Home" citizens
- 9 Place-Based Community Satellite clinics are operating
- Rapid Response Pop Up clinics being offered for hard-to-reach communities
- This Medivan offer is outreaching into homeless and asylum/refugee sites & shelters
- Close working continues with Public Health to address inequalities and maximise equity in the vaccine offer
- The Programme Outreach Team is delivering vaccination services to the NHFT forensic and mental health inpatient population
- The Hospital Hub at Kings Mill Hospital is offering vaccinations to staff, other health and social care workers, and the general population
- The Hospital Hub at NUH is offering vaccinations to their own staff, paediatric completion of primary course and allergy clinics
- There are 37 Community Pharmacies offering vaccinations to the general population
- There are 14 PCNs delivering vaccinations to care homes, "at home" citizens, immunosuppressed citizens and their PCN population.



- Programme planning continues for the community outreach Monkeypox offer, in partnership with sexual health services at SFHT and NUH
- Additional satellite clinics are planned in areas of low uptake/poor coverage
- Place-based vaccination groups have been established to identify sites for pop-up activity, with significant community engagement
- There is a comprehensive targeted communications programme in place

Risks:

- There continues to be low uptake of autumn boosters, being mitigated by an agile workforce model to reduce financial risk
- The national level planning is unclear for 2023/24 programme (evergreen offer and possible spring or autumn programme)

FLU

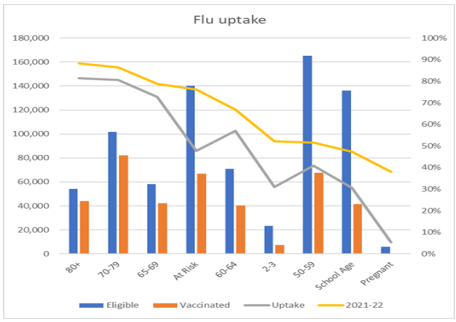
- Eligible Population – 764,000
- Booster Vaccination – 365,000 **(48%)**
- Target to achieve same or increase uptake as 2021-22 programme

Actions being taken

- Work continues with locality teams to establish the actions being taken to increase uptake in all cohorts
- Data packs are reviewed with the SIAU, with weekly updates now being produced and shared with localities and other providers.

Risks:

- There continues to be low uptake of the flu vaccination



Patient Safety

The ICS PSN has further refined its approach, building on the revised Terms of Reference and incorporating the ICS PSIRF implementation work. In November 2022 the group evaluated its progress against the PSIRF implementation workplan, identified key priorities for the next reporting period, and proposed areas for shared working in the day-to-day management of patient safety incidents and in future planning around specialist training.

Phase two of the PSIRF plan runs from December to April - '*Diagnostic and Discovery.*' - this includes some transformational objectives and will depend upon executive engagement.

Chappell Room, Arnold Civic Centre 09:00-12/01/23

NHS
Nottingham and Nottinghamshire

7: 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

7.1 - ICB Service Delivery Metrics Insights – Reporting Period December 2022/23

December 2022		Assurance: Pass	Assurance: Hit & Miss	Assurance: Falling Below
Variation	Special Cause - Improvement	IAPT <6 weeks IAPT < 18 weeks Adult SMI +2 Contacts Community CYP Access (1+ Contact)	Primary Care Extended Access Total Referrals (Prov) Total Diagnostic Activity (Prov) RTT Admitted (Pop) RTT Non-Admitted (Prov) Op Plan Diagnostic Activity (Prov) Cancer FDS (Pop & Prov) Cancer 1st Treatments (Pop & Prov) 2 Hour Urgent Care Response Adult MH - 72 Hour Follow Ups Perinatal Access Volume Primary Care Appointments	104 Week Waits (Prov) Total Referrals (Pop) Daycases (Prov) Outpatient 1st (Pop) PIFU (Prov) RTT Non-Admitted (Pop) Cancer 1st <31 days % (Pop & Prov) IAPT Treatments (Access) SMI Physical Health Checks CYP Eating Disorders - Urgent Perinatal Access % NHS App Registrations
	Common Cause - Random	Advice & Guidance (Pop)	NEL Admissions vs 19/20 (Pop & Prov) Ordinary Electives (Pop & Prov) Daycases (Pop) Outpatient Fups (Prov) OP Virtual (Prov) Ambulance Conveyances Volumes & % A&E Attendances vs 19/20 (Pop & Prov) Length of Stay >21 days OP Fup 25% Reduction (Pop & Prov) RTT Admitted (Prov) Individual Placement Support	SDEC % of Total Admissions MSFT Pathway1 - Discharge Home (Prov) Ambulance Response Cat 1 Length of Stay >21 days 78 Week Waits (Prov) Outpatient 1st (Pop) Outpatient Fups (Pop) Total Diagnostic Activity (Pop) OP Virtual (Pop) Op Plan Diagnostic Activity (Pop) Diagnostic 6 Weeks % (Pop & Prov) Cancer 62 Day % (Prov) Inappropriate OAP Bed Days
	Special Cause - Concern	IAPT Recovery Rate Dementia Diagnosis Early Intervention Psychosis	12 Hour Breaches % NEL IAPT <90 days 1st to 2nd Older Adult MH >90 day LOS	Ambulance Response Cat 2 Hospital Handover Delays > 60 minutes Total Waiting List (Prov) 52 Week Waits (Prov) Cancer 62 Backlog (Prov) CYP Eating Disorders - Routine Community Waiting Lists Aged 0-17 Community Waiting Lists Aged 18+

Items for escalation based on the indicators Falling short of the target and showing Special Cause for concern are as follows:

Electives:
- Patient Waiting List & Long Waits - Page 29
- Cancer 62 Day Backlog - Page 32

Mental Health:
- CYP Eating Disorders - Page 38

Community:
- Community Waiting Lists - Page 40

Urgent Care:
- Ambulance Response Category 2 - Page 27
- Hospital Handover Delays > 60 minutes - Page 27

The Matrix supports the Board to identify 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.

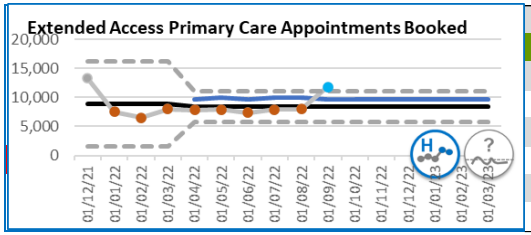
7.2 Service Delivery
Urgent Care Performance

7.2a – Urgent Care Access Exception Report
7.2b – Discharges and Out of Hospital Exception Report
7.2c – Urgent Care Compliance Exception Report

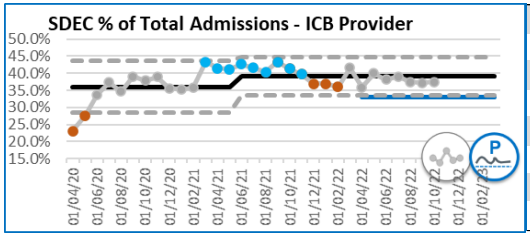
7.2a- Streamline Urgent Care – Exception Report : Access

NHS Nottingham and Nottinghamshire

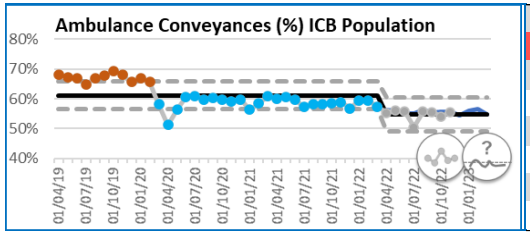
Urgent Care - Access



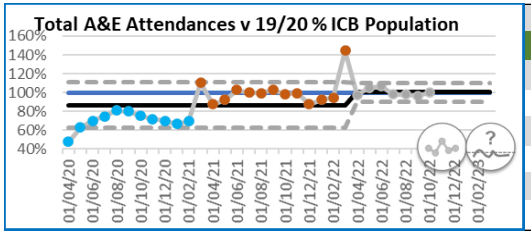
Sep-22
11833
2022-23 Plan
9628
Assurance
Flip
SPC Variation
Improving - High



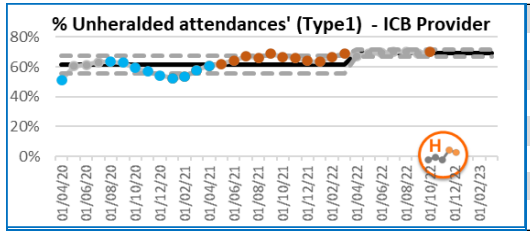
Oct-22
37.4%
2022-23 Plan
33.0%
Assurance
Pass
SPC Variation
Common Cause



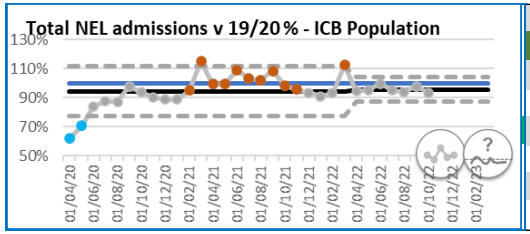
Nov-22
55.6%
2022-23 Plan
55.6%
Assurance
Flip
SPC Variation
Common Cause



Oct-22
99.9%
2022-23 Plan
100%
Assurance
Flip
SPC Variation
Common Cause



Oct-22
70.31%
Target
-
Assurance
-
SPC Variation
Concerning - High



Oct-22
93.4%
2022-23 Plan
100%
Assurance
Flip
SPC Variation
Common Cause

Summary

GP Extended Access - The Extended Access service has now been replaced with Enhanced Access, which came into effect on 1st October 2022. Enhanced Access is part of the Network Contract Direct Enhanced Service contract specification 2022/23, and is delivered by all PCNs across the ICB. This requires PCNs to provide Enhanced Access to their registered patient population in 'Network Standard Hours', which is between 6.30pm and 8pm Monday to Friday, and 9am and 5pm on Saturdays. One PCN within the ICB area is also providing Sunday access as per their approved PCN Enhanced Access plan. Each PCN must deliver 60 minutes per 1000 registered population, per week.

Ambulance Conveyances - Calls which result in an emergency response arriving at the scene, followed by ambulance conveyance to a healthcare facility as % of incidents continue to reduce and are now at planned levels, following sustained improvements since pre-covid levels meaning common cause alert and flip assurance.

A&E and NEL activity plans The system is operating at increased levels compared to the planning assumptions, which is continuing to cause added pressure on the acute urgent care system.

Unheralded Attendances have reduced marginally for October, which keeps the SPC alert as common cause variation. These are patients that have attended A&E without accessing 111 or their GP practice in advance.

Actions

A&E - High Intensity Service User posts have been recruited who will work with specific patients to identify suitable alternative health and care settings and support if appropriate, which will impact upon **unheralded attendances**.

The System **Reducing Conveyance** lead role has been extended until March 2023, which will progress delivery of the logic model and plans on a page actions.

A&E Flow - SDEC Services - A review of streaming within the ED has been completed by ECIST, with recommendations agreed.

The national ambition is to increase the proportion of Same Day Emergency Care (SDEC) from a fifth of acute admissions to a third as defined within the long term plan. This is tracked closely within the Right Place First Time Board. Data for October shows that 37.4% of total admissions are SDEC. Performance can be seen to be above the 33% target in the chart.

Wound care follow up pathway pilot has been agreed with community providers and GP practice nurse leads. An Acute Respiratory Care Unit proposal at NUH sites is progressing through the system.

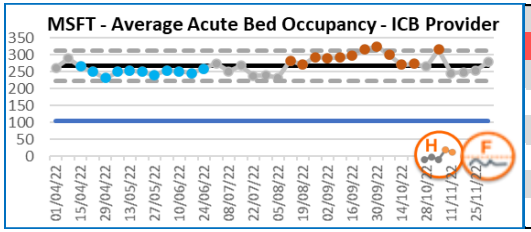
POG Assurance - Limited Assurance

Activity levels for A&E and Non-Elective admissions is below the operational plan in October, however challenges in length of stay, MSFT and discharge remain.

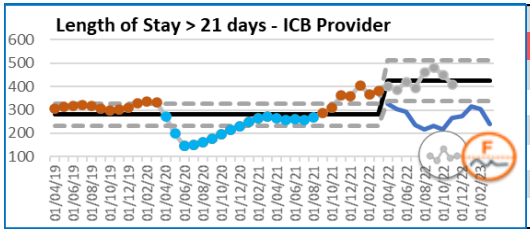
7.2b - Streamline Urgent Care – Exception Report: Discharges and Out of Hospital Provision

NHS Nottingham and Nottinghamshire

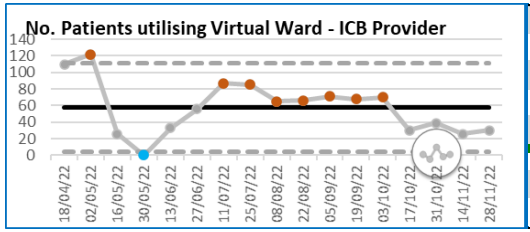
Urgent Care - Acute Discharges & out of hospital provision



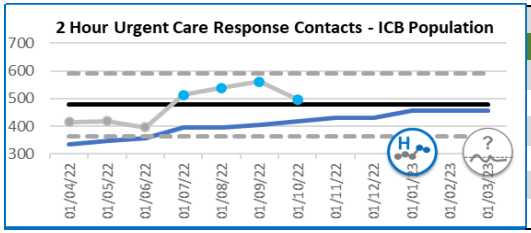
Dec-22
279
2022-23 Plan
104
Assurance
Fail
SPC Variation
Concerning - High



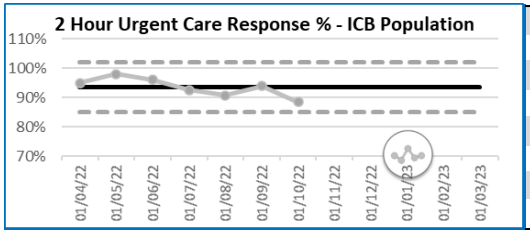
Nov-22
410
2022-23 Plan
265
Assurance
Fail
SPC Variation
Coomon Cause



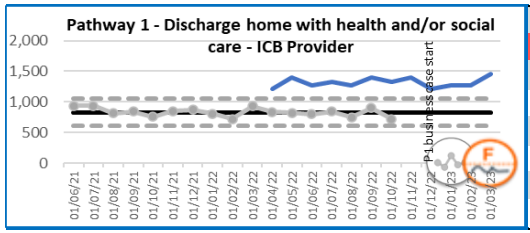
Nov-22
30
2022-23 Plan
-
Assurance
SPC Variation
Common Cause



Oct-22
497
2022-23 Plan
419
Assurance
Flip
SPC Variation
Improving - High



Oct-22
88%
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause



Oct-22
719
2022-23 Plan
1333
Assurance
Fail
SPC Variation
Common Cause

Summary

Patients Medically Safe to transfer from acute episode of care are significantly higher than the acute baselines, and also significantly higher than the modelling assumptions within the operational plans for 2022/23.

LOS >21 days has a Special Cause High Alert as there are significantly more patients in acute hospitals with lengths of stay of over 21 days than planned and pre-covid levels. Within the system, 17% of all available acute beds are currently occupied by +21 day patients as at 13th December 2022. As well as the impact from the issues of flow out of the hospitals, patients are entering the system with increased acuity for emergency presentation and deconditioned presentations for elective care which lengthens recovery time and therefore extends the period to discharge.

The systems inability to provide sufficient homecare packages and care home placements to meet current demand continues to be the main reason for patients experiencing long delays and remaining in hospital beyond their determined safe transfer decision date.

Urgent Community Response - Provides urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Performance monitoring is in place. The volume of UCR contacts is currently above the operational plan level, which is shown above.

Actions

100 Day Challenge - Key awareness points include that LA P1 referral data is lower than modelled. The local authorities have reported that there are low levels of referrals. There are some discrepancies in provider reporting on P1 activity which are being addressed. Planned actions include Acute Therapy resource for P1 Community Discharge during Critical Incidents/Opel 4 to be agreed by acute trusts. There is meeting to agree a standardised operating procedure for Transfer of Care Hubs. All providers have been asked to capture the reasons for lower than planned activity and share these with the ICB team.

Virtual Wards - NUH experiencing issues with reporting, which includes newly established virtual wards that are not being reported as well as older pre-existing wards relating to covid maternity that should not be included within the submission. NHSE/I are liaising with NUH around the submission. SFHFT and NHT have also been asked to ensure reporting is accurate and valid. Work is being undertaken with provider colleagues to agree a local weekly reporting dataset is underway, which will provide further detail beyond that captured within the mandated submission. A meeting is taking place with acute and community colleagues to discuss potential opportunities to increase virtual ward bed numbers. SFHFT Acute Respiratory Infection (ARI) Virtual Ward paused whilst data flow issues are resolved. NUH ARI Virtual Ward deferred due to strike action and will now go live on 3rd January 2023. Discussions happening between NUH and community to progress a virtual ward for EoL and vascular VW.

POG Assurance - Low Assurance

The additional capacity being planned for within the Discharge to Assess business case will be implemented later than planned due to delays in finalising the business case.

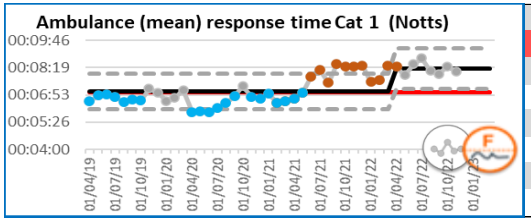
Data for week ending 20/11/22 shows that the volume of pathway 1 discharges was below the system trajectory (132 against a plan of 257). Please note NUH are currently having reporting challenges regard P1 data capture, work is underway to resolve. The volume of MSFT patients was higher than the planned number at 279 against a plan of 89. There is a risk that the system pressures, such as the critical incident and consistent OPEL level 4 levels will impact on the capacity levels for the 100 Day Plan Challenge. However, providers are investigating accelerating existing discharge workstreams that feed into the 100 Day Plan Challenge. Some of the learning from the response to the Critical Incident may inform changes in process and practice to support achievement of the planned targets.

On 19/12/22, the Nottingham and Nottinghamshire system declared a critical incident due to the high numbers of patients arriving at local hospitals, high demand for all services across the system, extended waiting times to access beds within hospitals and difficulties in discharging patients.

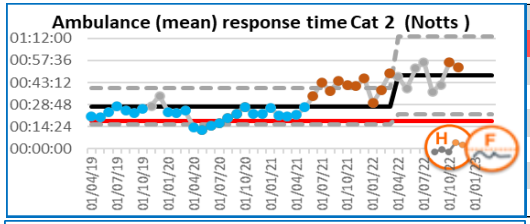
7.2c - Streamline Urgent Care – Exception Report : Compliance

NHS Nottingham and Nottinghamshire

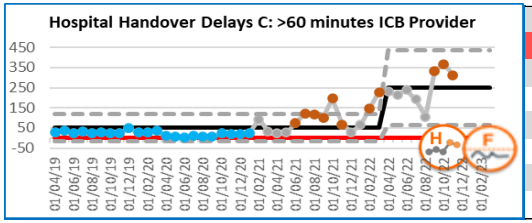
Urgent Care - Performance Compliance



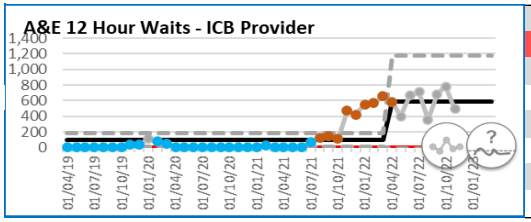
Nov-22
00:08:08
Target
0:07:00
Assurance
Fail
SPC Variation
Common Cause



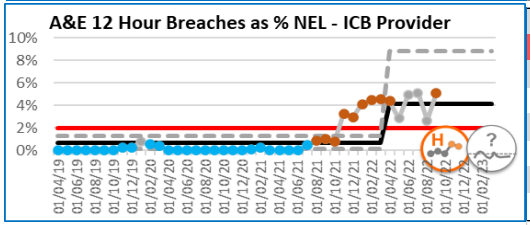
Nov-22
00:53:23
Target
0:18:00
Assurance
Fail
SPC Variation
Concerning - High



Nov-22
313
Target
0
Assurance
Fail
SPC Variation
Concerning - High



Nov-22
494
Target
0
Assurance
Flip
SPC Variation
Common Cause



Oct-22
5.6%
Target
2%
Assurance
Flip
SPC Variation
Concerning - High

Date
2022-23 Plan
Assurance
SPC Variation

Summary

Ambulance Handover Delays >60 minutes: There is a special cause alert for this metric due to high values. The volume of delays have reduced marginally from the October position, but remain high at 313 for November 2022.

Ambulance Response Times: Category 1 and 2 response times have remained at high levels since June 2021 but have decreased in the past month, with common and special cause variation. The category 1 responses are where an immediate response is required due to a life threatening condition, such as cardiac or respiratory arrest. Category 2 responses relate to serious conditions, such as a stroke or chest pain which may require rapid assessment and/or urgent transport. Ambulance trusts should respond to Category 2 calls within 18 minutes on average and respond to 90% of Category 2 calls within 40 minutes. Nottinghamshire achieved 42.8% performance against the 40 minute target for November, which is an improvement of 2.5% compared to the previous month.

12-Hour Breaches: Common cause alerts as volumes of patients waiting more than 12 hours from a clinical decision to admit have decreased in month below the mean.

Actions

Ambulance Delays - the system advocates a total system partner response to delays with ambulances and aims to release ambulances at the earliest opportunity. Despite the current failure to achieve handover targets, the data for November indicated that Nottingham and Nottinghamshire ICB preforms better than its neighbouring systems, with NUH having fewer delays than peer tertiary hospitals and SFHT the fewest in the region. Actions being taken include EMAS recruiting mental health nurses to be based in ambulance call centres, additional training to navigate patients to alternative appropriate services, increased early system awareness of pressures within the ambulance service and making progress with the ICS Ambulance Improvement Plan.

12 Hour Breaches - actions include targeted work through admission avoidance initiatives to reduce footfall into ED, maximising discharge profiles for simple and supported discharges to improve hospital flow, with a focus on pre-noon discharges, thematic review of long waits to identify specific high impact actions.

POG Assurance - Low Assurance

12 Hour waits - Harm reviews are being undertaken and thematic reviews being addressed through the System Quality Group.

ED Quality Metrics – an NUH quality group has been established to implement a set of quality metrics for use in ED for long waiting patients. These metrics will be regularly reviewed going forward and will be discussed through the A&E Board.

Chappell Room, Arnold Civic Centre 09:00-12/01/23

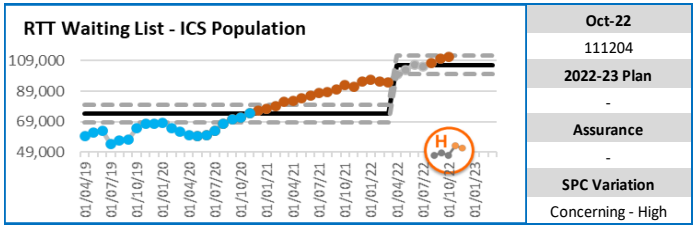
7.3 Service Delivery
Elective Care Performance

7.3a – Elective Waits Exception Report
7.3b – Elective Activity Exception Report
7.3c – Productivity and Transformation Exception Report
7.3d – Cancer Exception Report
7.3e – Diagnostics Exception Report

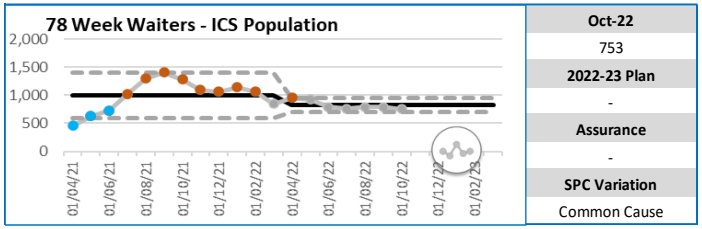
7.3a - Recover Services and Address Backlogs – Exception Report : Elective Waits

NHS Nottingham and Nottinghamshire

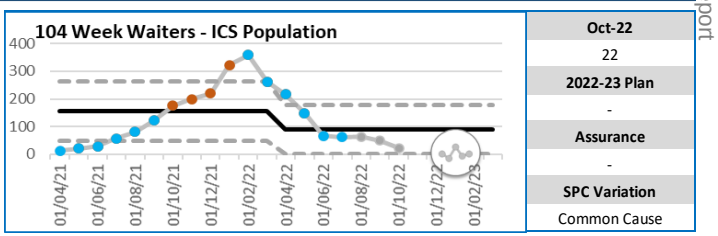
Elective Waits - Total Waiting List and Long Waits



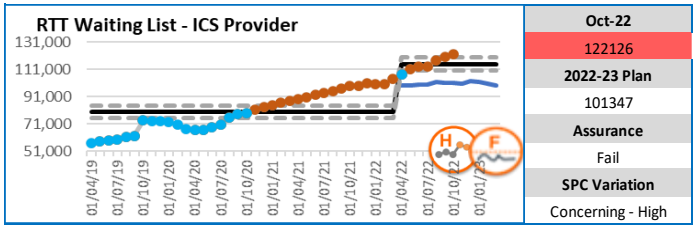
Oct-22
111204
2022-23 Plan
-
Assurance
-
SPC Variation
Concerning - High



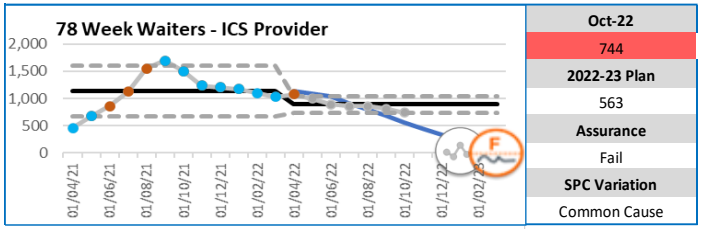
Oct-22
753
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause



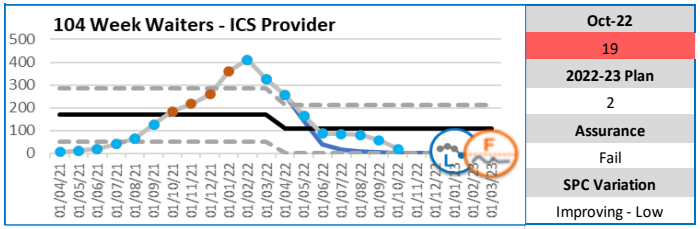
Oct-22
22
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause



Oct-22
122126
2022-23 Plan
101347
Assurance
Fail
SPC Variation
Concerning - High



Oct-22
744
2022-23 Plan
563
Assurance
Fail
SPC Variation
Common Cause



Oct-22
19
2022-23 Plan
2
Assurance
Fail
SPC Variation
Improving - Low

Summary

Waiting List - ***showing concerning-high variation due to continual deterioration of the position and failure to deliver against the plan*** . A reduction of 20,779 patients is needed to return to plan.

78 Week Waits - ***showing common cause variation as the position is moving around the mean*** . The volume of 78ww is higher than the planned level at October 2022. There are 181 more patients than planned waiting over 78 weeks for NUH and SFH combined. Note that the plan is to eliminate waits of 78 weeks or more by March 2023.

104 Week Waits - **showing special *cause low variation as the position remains below the mean*** . The national target was zero 104 week waits by the end of June 2022 except where patients choose to wait beyond the date offered. At the end of October, there were 19 patients waiting 104 weeks or more at NUH and SFH. . Of the 19 patients at the end of October, 8 were due to complexity, 0 were due to capacity and 11 to patient choice. Weekly data highlights that the position improved further during November and into December.

Actions

Elective Hub - the system operates a system wide elective hub which reviews the current waits of patients across the local NHS trusts as well as commissioned Independent Sector providers. The aim being to ensure equity of waits across the system and that the various providers review patients on assessment of clinical need and prioritisation, and align capacity resource through mutual aid as required. Specialty reviews are also undertaken to provide organisational support where specific issues have arisen. This has been successful with over 700 patients moving between providers since summer 2021.

104 week waits - all patients at risk of breaching 104 week waits are individually contacted by the relevant provider, offered dates for the future and are actively supported while waiting. Interim guidance around the management of patients on the waiting list choosing to decline offered treatment dates has been released by NHSE, which provides clear guidance on the management of choice for the longest waiting patients. The volume of 104ww has reduced from the latest published data (October). The latest provisional data as at week ending 11/12/22 shows there were 10 patients waiting 104 weeks or more for treatment at NUH and 1 patient waiting at SFH.

POG Assurance - Limited Assurance

Internal Oversight of the 104 position continues to take place on a daily basis by providers. Weekly meetings with NHSE/I continue to enable a granular discussion around specialty level risks and mitigations. This also includes a review of the current volume of patients breaching the 78 week standard as well as reviewing progress against the volume of patients that will breach the standard by the end of March 2023 if not treated. This is known as the 78 week patient cohort.

The system position for 78 week waiters is 687 patients against a plan of 328 at week ending 11/12/22. The 78 week and over cohort is being fully validated and reviewed with analysis being undertaken across admitted and non-admitted pathways. NUH specialties have forecast that there will be 838 patients waiting 78 weeks or more by the end of March 2023. The forecast takes into account staffing challenges as well as planned adjustments to elective capacity due to winter pressures. The equivalent forecast for SFH is that there will be zero breaches by March 2023.

The total waiting list increase is a cause for concern. The system needs to undertake a review to fully determine the forecast waiting list position and potential forecast ranges for the 'peak' position and timeframe.

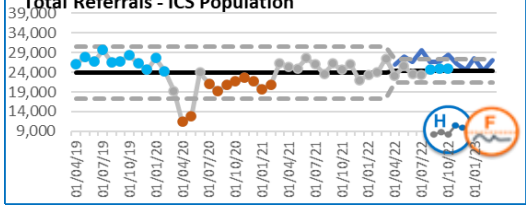
Chappell Room, Arnold Civic Centre 09:00-12/01/23

7.3b - Recover Services and Address Backlogs – Exception Report Elective Activity

NHS Nottingham and Nottinghamshire

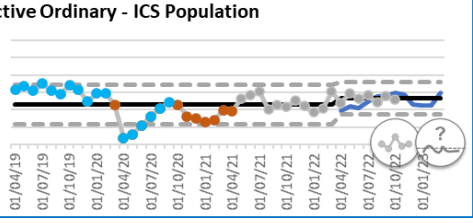
Elective Recovery - Activity

Total Referrals - ICS Population



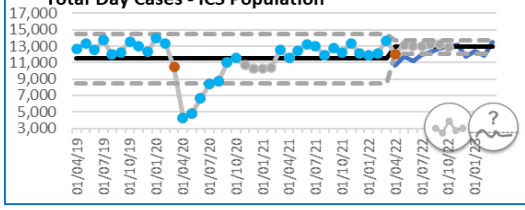
Oct-22
25034
2022/23 Plan
28425
Assurance
Fail
Variation
Improving - High

Elective Ordinary - ICS Population



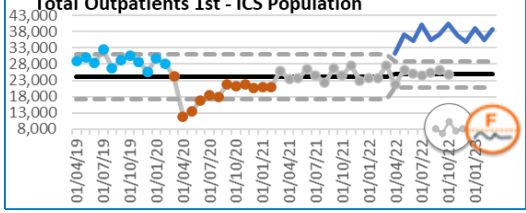
Oct-22
1881
2022/23 Plan
2081
Assurance
Flip
Variation
Common Cause

Total Day Cases - ICS Population



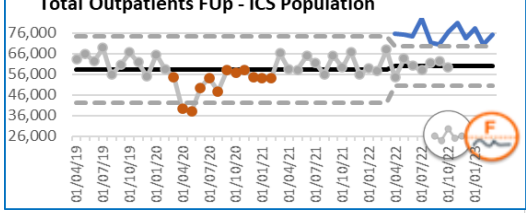
Oct-22
12928
2022/23 Plan
12931
Assurance
Flip
Variation
Common Cause

Total Outpatients 1st - ICS Population



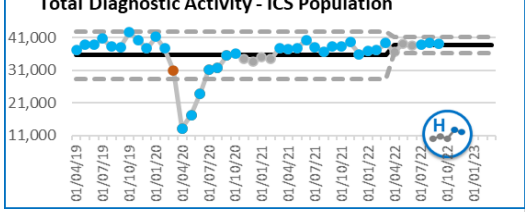
Oct-22
24827
2022/23 Plan
40356
Assurance
Fail
Variation
Common Cause

Total Outpatients FUp - ICS Population



Oct-22
59518
2022/23 Plan
76416
Assurance
Fail
Variation
Common Cause

Total Diagnostic Activity - ICS Population



Oct-22
39668
2022/23 Plan
-
Assurance
-
Variation
Improving - High

Summary

These charts compare the October activity level to the operational plan. The charts include activity for the whole ICB population and at all providers (NHS and IS).

Two of the charts (Total Referrals and Total Diagnostic activity) are showing Improving - High variation, which indicates a period of sustained activity above the mean (the black line). The remaining charts are showing common cause variation.

However, consistent fail alerts are shown for referrals and outpatients which illustrate that the current run rate of activity varies significantly from the planned level and that future failure of the plan is likely unless effective action is taken.
Referrals have increased significantly since April 2020, which has been driven by additional demand for urgent cancer services (2ww referrals). 2ww referral volumes are between 20% and 30% higher than pre-pandemic levels.

Actions

Elective Capacity - Staffing challenges through staff vacancies or sickness remain a key challenge for the system. The system continues to have levels of staff absence between 7% to 8% of the acute provider workforce. This has resulted in increased utilisation of agency staff, which is above the planned level.

Sourcing Additional Capacity -Fully utilising Independent Sector capacity and identifying mutual aid potential across NHS Providers where clinically appropriate. Around 700 patients have already transferred between NUH and SFHT to support treatment.

Infection Prevention and Control (IPC) restrictions have been eased in line with national guidance, which will support more productive and flexible use of capacity.

POG Assurance - Limited Assurance

Day Case activity, Referrals and outpatients remain below planned levels for October. However, Day Cases were only 3 spells below plan. A task and finish group has been set up within the system to examine system productivity in more detail, which will begin by reviewing benchmarking analysis produced by the NHSE/I National Team. This work will bring together activity and finance analysis to generate a shared understanding of the key drivers behind the productivity benchmark position for the system.

The pressures for hospital bed capacity are not fully resolved with delayed discharges remaining high, while this is the case there continues to be risk to delivery of the elective activity.

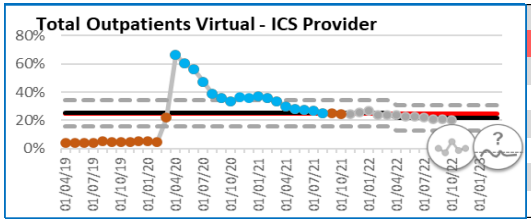
System needs to determine the most appropriate way to protect elective activity wherever possible.

The system needs to remain focused on transformation areas such as A&G, PIFU and virtual outpatients to support patients on the waiting list. (see Productivity & Transformation section of the report).

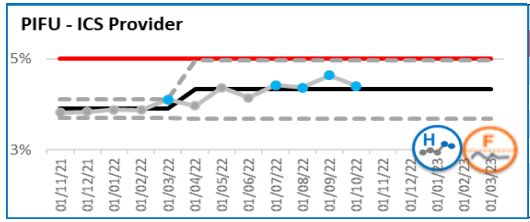
7.3c - Recover Services and Address Backlogs – Productivity & Transformation

NHS Nottingham and Nottinghamshire

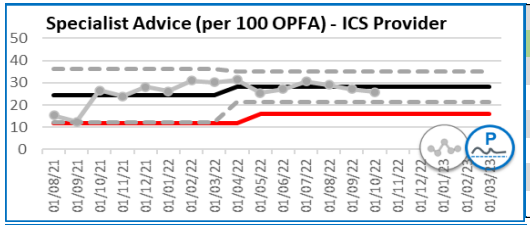
Elective Recovery - Productivity & Transformation



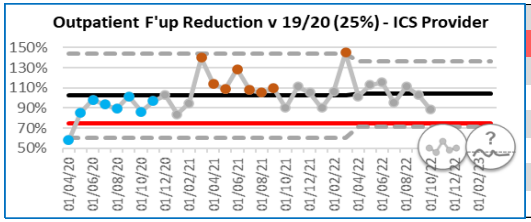
Oct-22
20.4%
Target
25.0%
Assurance
Flip
Variation
Common Cause



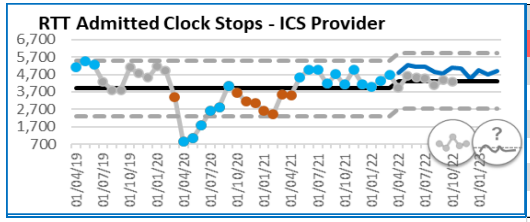
Oct-22
4.4%
March 2023 Target
5.0%
Assurance
Fail
Variation
Improving - High



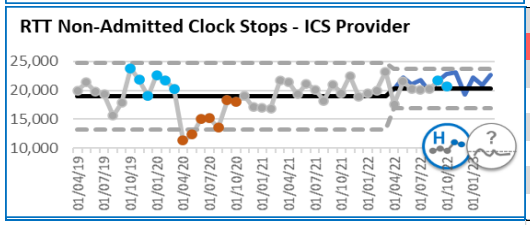
Oct-22
26
March 2023 Target
16
Assurance
Pass
Variation
Common Cause



Oct-22
89%
Target
75%
Assurance
Flip
Variation
Common Cause



Oct-22
4273
2022-23 Plan
5085
Assurance
Flip
Variation
Common Cause



Oct-22
20695
2022-23 Plan
22810
Assurance
Flip
Variation
Improving - High

Summary

Outpatient Virtual: Common cause variation, 'flip' target delivery as the target is near the mean. The latest position for the system is 20.4%, which is below the national standard of 25%. Since April 2022, the position for the system has reduced from 24% to the 20.4% reported in October.

Outpatient Follow-up 25% Reduction: The ICS plan did not deliver the 25% reduction due to c32,000 patients at SFH and NUH who have an overdue follow up review. Reducing follow up appointments by 25% would result in patients waiting longer putting them at increased clinical risk and potentially increasing backlogs.

Advice & Guidance Target: minimum of 12 A&G requests delivered per 100 first outpatient attendance, rising to 16 by March 2023. The ICS plan exceeds this standard throughout 22/23. The utilisation rate in October 2022 was 26. The stepped increase in October 2021 related to definitional changes from NHSEI, which enabled a larger volume of activity to be captured within the target.

Patient Initiated Follow Up (PIFU): **Improving-High variation** position towards, but not as yet delivering, the year end target of 5% with current performance of 4.4%.

Admitted and Non-Admitted Clock Stops: These charts show high-improving variation, with activity being delivered above the mean. However for the system to be successful in tackling waiting lists, the activity levels need to shift above the planned levels.

Actions

Outpatient Virtual: NUH and SFH submitted trajectories which show delivery of the 25% national standard by March 2023. SFH have developed an implementation plan, which outlines four workstreams to increase virtual attendances. These are data, admin processes, governance and safeguarding. The specialties being focused upon initially are: Rheumatology, Diabetes and Clinical Haematology, which are highlighted as opportunities within regional benchmarking. NUH are reliant upon a digital solution to increase utilisation of virtual appointments within the Trust.

Advice & Guidance: PCN level analysis was made available on Friday 11th November within the national dashboard and a supporting pack has been received by the ICB from NHSEI. This highlights variation at PCN level and suggests opportunities to increase utilisation of Advice and Guidance at specialty level. This was discussed at the Referral Optimisation Group in November and will be progressed through the group.

Patient Initiated Follow Up (PIFU): Providers are expanding the uptake of PIFU to all major outpatient specialties, with the ambition of moving or discharging 5% of outpatient attendances to PIFU pathways by March 2023.

Admitted and Non-Admitted Clock Stops: Over the past few months, there have been a number of inter-related factors which have limited the volume of elective activity and therefore clock stops - See activity section for further detail on actions.

POG Assurance - Limited Assurance

Outpatient Virtual attendance volumes at SFH remain significantly lower than the national standard. However, the trust are working to improve virtual utilisation in specialties with low benchmarks.

Outpatient Follow-up 25% Reduction: the national 25% reduction will not be delivered as the providers concentrate on treating patients on their current lists. Future service change plans will focus on safely progressing the reductions required. Utilisation of **Advice and Guidance** remains high and the system continues to consistently achieve the national standard. There is confidence that this performance level will continue during the financial year.

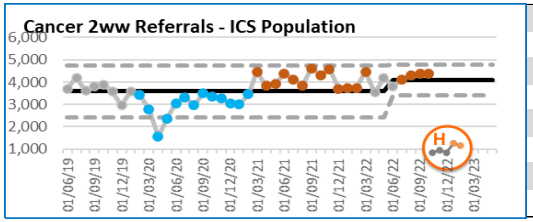
PIFU - The current system performance level in October 2022 is 4.4%. The October position for NUH is 3.7% and 6.1% for SFH.

Admitted and Non-Admitted Clock Stops. There continues to be challenges around the level of staff sickness, which will impact the volume of activity that can be delivered.

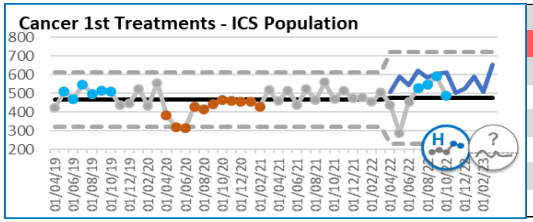
7.3d - Recover Services and Address Backlogs – Exception Report : Cancer

NHS Nottingham and Nottinghamshire

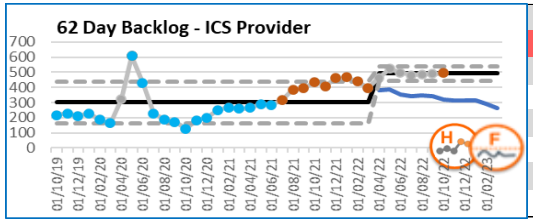
Cancer Recovery - Total Provider View



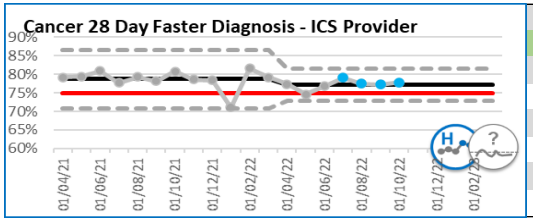
Oct-22
4478
2022/23 Plan
-
Assurance
-
Variation
Concerning - High



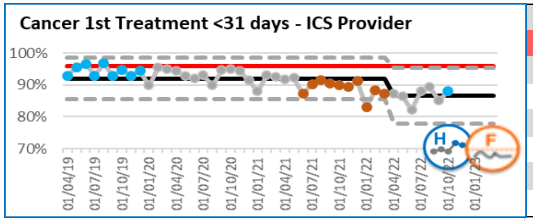
Oct-22
591
2022/23 Plan
701
Assurance
Flip
Variation
Improving - High



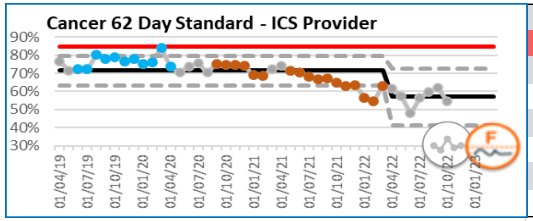
Oct-22
494
2022/23 Plan
319
Assurance
Fail
Variation
Concerning - High



Oct-22
77.9%
Target
75.0%
Assurance
Flip
Variation
Improving - High



Oct-22
88%
Target
96%
Assurance
Fail
Variation
Improving - High



Oct-22
55%
Target
85%
Assurance
Fail
Variation
Common Cause

Summary

2ww Referrals: ***Concerning-High variation as the referrals are above the mean,*** with **g**rowth in demand being at c120% of pre-pandemic levels since March 2021. This is across all tumour sites and continues to lead to pressures on services, and impacts all other measures. Work is taking place between the ICB and SFH to review and optimise GP referrals to ensure that each patient pathway is as efficient as possible.

28 Day Faster Diagnosis*: common cause and 'flip' assurance indicate activity remains around the mean and will therefore hit or miss the target* . Despite increased demand the 28 day FDS continues to be achieved. The latest benchmarking data relates to October and shows that the N&N system is one of only three systems within the region that achieved the 28 day FDS standard in that month.

31 Day & 62 Day Performance: ***Special cause alert due to high values, which demonstrates an improving position.*** The continued high level of two-week wait referrals has placed pressure on outpatient capacity in some areas, especially Gynae, Urology and LGI, impacting on the 62-day pathway.

62 Day Backlog: ***Concerning high alert although having reduced in August, volumes are still above the mean.*** The majority of patients waiting +62-days are in Lower GI, Urology, Gynae, Lung, Upper GI and Skin.

Actions

NUH hold the majority of the cancer backlogs for the system, due to the scale and specialist services it provides.

During the development of the operational plans, NUH specialties each developed plans that would support achievement of the ***organisational level plan, which is a backlog of 198 patients by March 2023. The equivalent plan for SFH is to achieve a backlog of 67 patients.***

To address the 62 day backlog, NUH have held Internal meetings with all tumour site leads and clinical leads which have enabled discussion around reviewing approaches to follow ups. Joint discussions are also held across NUH and SFHT to progress mutual aid wherever possible. The 62 day backlog for NUH and SFH is discussed at tumour site level on a weekly basis. This includes the volume of patients removed from the list as well as potential and confirmed additions.

Workforce issues are a key factor impacting the capacity of histology and radiology as well as the oncology appointment capacity. The increased waiting times for PET scans and subsequent reporting continue to impact lung and LGI tumour sites. Histology reporting also remains a concern due to ongoing workforce challenges at NUH.

POG Assurance - Limited Assurance

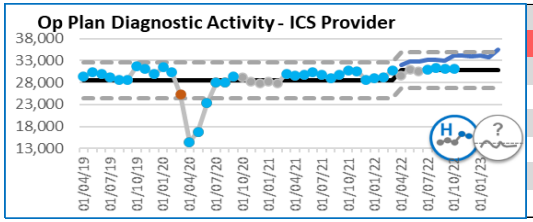
Following development of the NUH specialty level plans, the underlying assumptions which were linked to system level conditions fundamentally changed. As an example, the impact of COVID was more material than planned, the sickness levels of staff were greater than forecast and the impact of non-elective pressures were more severe than expected. Therefore, the backlog increased materially during April and May 2022, with reductions seen in October and November. ***The latest weekly data for week ending 11/12/22 is 388 patients against a plan of 314 patients. NUH have 314 patients against a plan of 240 and SFH have 74 patients against a plan of 74.*** NUH and SFH benchmark well nationally for the proportion of the waiting list that are waiting 62 days or more (11.62% and 5.31% respectively at 04/12/22). The 104 week waiter meetings that take place with NHSE have been expanded to cover cancer performance on a fortnightly basis. This enables a granular discussion to take place around plans to reduce the 62 day cancer backlog.

62 day standard performance is expected to remain at lower levels during the time period that longer waiting patients are progressed through to treatment. The target is a measure of the point at which treatments are undertaken.

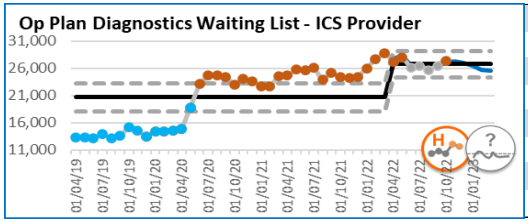
7.3e - Recover Services and Address Backlogs – Exception Report: Diagnostics

NHS Nottingham and Nottinghamshire

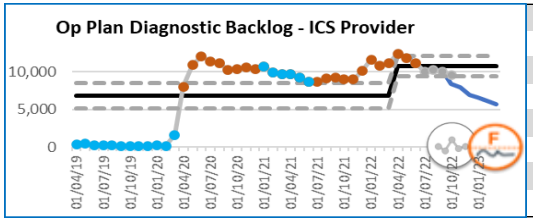
Diagnostics Recovery - Total Provider View



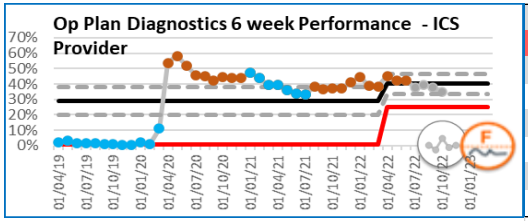
Oct-22
31146
2022-23 Plan
34210
Assurance
Flip
Variation
Improving - High



Oct-22
27292
2022-23 Plan
27158
Assurance
Fail
Variation
Concerning - High



Oct-22
9533
2022-23 Plan
8334
Assurance
Fail
Variation
Common Cause



Oct-22
34.9%
2022-23 Plan
25.0%
Assurance
Fail
Variation
Common Cause

Diagnostic Modality - Highlighted Modalities are included in the OP Plan

Variances achieving the 25% standard are highlighted green

ICS Provider	Waiting List	Backlog	%
MRI	7,370	3,512	47.7%
Computed Tomography	4,203	696	16.6%
Non-obstetric ultrasound	6,856	621	9.1%
Echocardiography	6,340	3,546	55.9%
Colonoscopy	1,018	468	46.0%
Flexi sigmoidoscopy	426	257	60.3%
Gastroscopy	1,079	433	40.1%
Total - Plan Modalities	**27,292**	**9,533**	**34.9%**
Barium Enema	0	0	
DEXA Scan	1,848	494	26.7%
Audiology	753	482	64.0%
Cardiology - Electrophysiology	0	0	
Neurophysiology	227	15	6.6%
Sleep studies	1,435	750	52.3%
Urodynamics	171	30	17.5%
Cystoscopy	385	70	18.2%
Total - All Modalities	**32,111**	**11,374**	**35.4%**

Summary

These charts display the latest position for MRI, CT, NOUS, Colonoscopy, Flexi-Sigmoidoscopy, Gastroscopy and Echocardiography, which were included in the Operational Plan (OP plan) for 2022/23. **Diagnostic activity: is showing an improving position** with activity levels above the mean, but the position does vary by modality and provider. However, activity remains below the planned level.

Diagnostics backlog & waiting list: ***showing common cause variation*** due to values moving below the mean between June and October.

Diagnostic 6 week performance for plan modalities: October at 34.9% with the 6 week backlog decreasing to 9,533 from 9,973 patients in September.

MRI: challenging at NUH, however the position has improved substantially since January 2022. The MRI waiting list and backlog have decreased by around 1000 patients. Mutual aid has been provided by SFHT during this time. However, the backlog remains high for the system at 3487 patients at the end of October 2022.

Echocardiography: The data for October shows that Echo is performing at 55.9% for SFH and NUH. After a period of rapid increase, the backlog and waiting list are now showing signs of reduction at NUH. However, pressures remain at SFH.

Actions

MRI - The data captured nationally within the DM01 return is limited to the acquisition of images. However, NUH have focused on reducing the waiting times for reporting of images through dedicating a significant amount of capacity during the first week of November to reporting of images. This generated a significant reduction in the reporting backlogs. MRI backlog reduced by 50% and the CT reporting backlog reduced by 60% after the week had concluded. Focusing almost all capacity on reporting will have a negative impact on acquisition, so performance will be impacted. However, achieving balance between acquisition and reporting is key to providing an effective service.

Echocardiography (ECHO) at NUH has seen an improved position, this has been achieved using additional sessions and improved staffing levels, these efforts have supported the backlog to stabilise and begin to reduce. However, the echocardiography position at SFH continues to be very challenging. The service is exploring securing additional capacity through utilising locum staff as well as investigating insourcing possibilities, which will stabilise the waiting list and backlog. Longer term solutions around recruitment and the development of the CDC are required to support the service in future. The service are working to forecast the waiting list and backlog position, which will be included within the next version of this report.

POG Assurance - Limited Assurance

The backlog improved between September and October however it is yet to trigger an SPC alert. A sustained increase in activity is required in order deliver the planned backlog and waiting list levels.

The system has submitted a Diagnostic Improvement Plan for Diagnostic Performance to NHSE, to improve current performance from 35% failing to be seen within 6 weeks, to 25% (ie to move from 60% being seen within the 6 weeks requirement to 75% by the end of March 2023, then 85% by March 2024 and 95% by March 2025).

The system was required to submit recovery trajectories to NHSE/I on the 20th October for CT, MRI, NOUS, Echocardiography and Endoscopy. All the trajectories showed improving positions, however Echocardiography and MRI are forecast to be below the 75% ambition by the end of March 2023 (52.9% and 58.1% respectively).

Chappell Room, Arnold Civic Centre 09:00-12/01/23

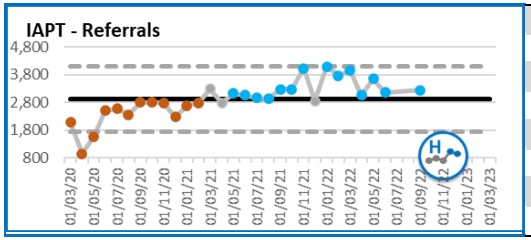
7.4 Service Delivery Mental Health Performance

7.4a – Exception Reports Mental Health IAPT
7.4b – Exception Reports Mental Health Adult Services
7.4c – Exception Reports Mental Health Access
7.4d – Exception Reports Mental Health CYP

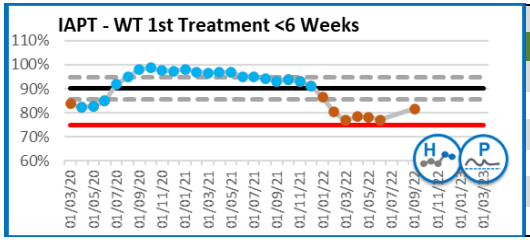
7.4a - Recover Services and Address Backlogs – Exception Report : Mental Health - IAPT

NHS Nottingham and Nottinghamshire

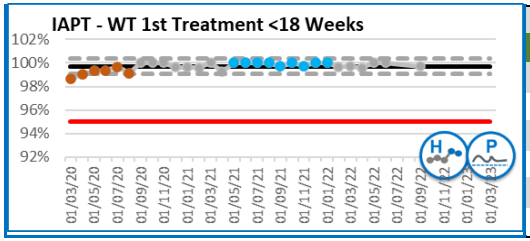
Mental Health - Improving Access to Psychological Therapies



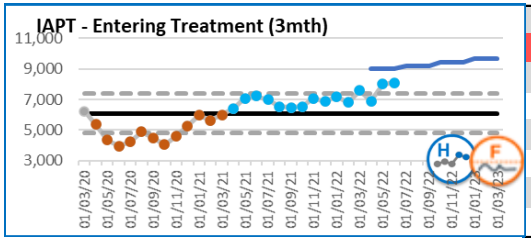
Sep-22
3235
2022-23 Plan
-
Assurance
-
SPC Variation
Improving - High



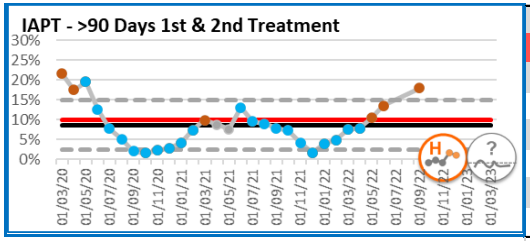
Sep-22
82%
Target
75%
Assurance
Pass
SPC Variation
Concerning - Low



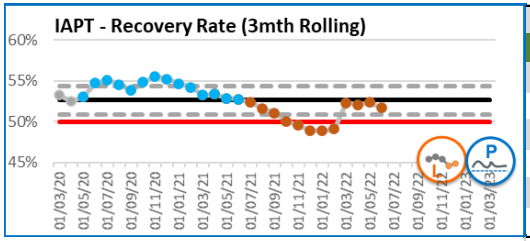
Sep-22
100%
Target
95%
Assurance
Pass
SPC Variation
Improving - High



Jun-22
8110
2022-23 Plan
8984
Assurance
Fail
SPC Variation
Improving - High



Sep-22
18%
Target
10%
Assurance
Flip
SPC Variation
Concerning - High



Jun-22
52%
Target
50%
Assurance
Pass
SPC Variation
Concerning - Low

Summary

Please be aware that due to an issue with an ONS source file that NHSD use in their processing they have been as yet unable to publish ICB level data for some data for September.

- IAPT referrals are above the mean showing an improving - high variation.
-Treatment numbers (3-month) rolling average are above the mean but still below planned levels, 8110 against 8984 plan, however it is the highest recorded for the ICB.

The service continues to achieve and exceed **waiting time standards**. There had been a sustained reduction in treatments within 6 weeks, followed by performance below the mean, changing to concerning low variation. This is largely due to a 16% increase in referrals between Q3 and Q4, which resulted in reduced appointments available, and doubled appointment cancellations across that provider.

Patients **waiting over 90 days** between 1st and 2nd treatments have also risen over the past 4 months, causing a special cause alert in month, due to the issues described above.

Actions

Key actions to increase performance over the next quarter include:
Access - Focus on service promotion, community advertising and engagement and strengthening links with localities and PCNs. This includes continuing with service promotion and awareness raising through social media animations, videos and blogs, monthly newsletters, community advertising and attendance at community events.
Waiting Times - A continued focus on staff wellbeing, supervision and caseload management including training and drop-in support sessions.
- The wider roll out of NHS Limbic will improve online access, support appropriate signposting ensuring that clinical capacity is used most appropriately and additional support to patients while they are waiting to reduce drop-out rates, and thus supporting the access and recovery standards.
Recovery - targeted support for staff with lower recovery rates including refresher training, review of case suitability and data quality and processes.
Inequalities - A continued focus on inequalities to include the roll out of online offers in different languages and the commencement of community engagement workers, with a primary focus on BAME communities and older adults.

POG Assurance - Partial Assurance

An established monthly steering group with IAPT providers is in place, with focussed monitoring of targeted actions to assess impact of improvement actions and delivery of spending review investments.

The revised trajectory for IAPT Access - Entering Treatment is for the system to achieve by the end of March 2023.

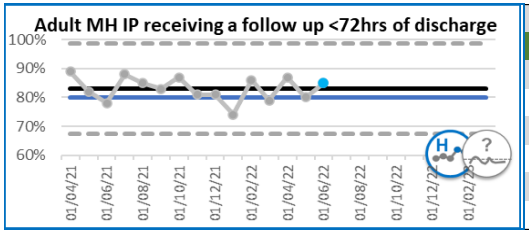
Local data is utilised to identify and address performance issues with providers and agree actions to improve capacity and service delivery, including workforce issues.

A procurement is underway for IAPT services across the ICB, a new contract will be in place from 1 April 2023. A transition plan is in place to ensure the impact on service users is minimal, the plan is reviewed on a weekly basis.

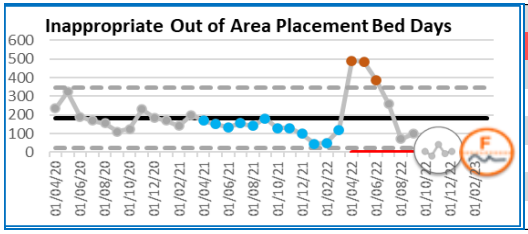
7.4b - Recover Services and Address Backlogs – Exception Report: Mental Health - Adult Services

NHS Nottingham and Nottinghamshire

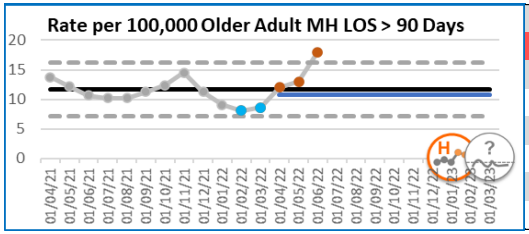
Mental Health - Adult Mental Health



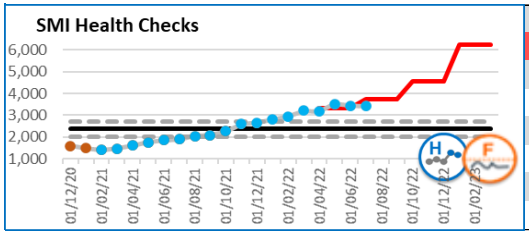
Jun-22
85%
Target
80%
Assurance
Flip
SPC Variation
Improving - High



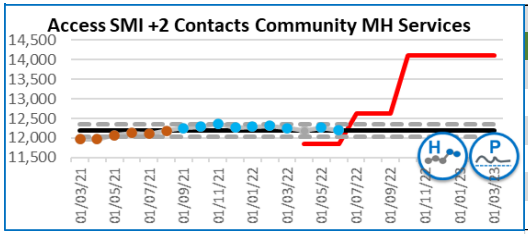
Sep-22
100
2022-23 Plan
0
Assurance
Fail
SPC Variation
Common Cause



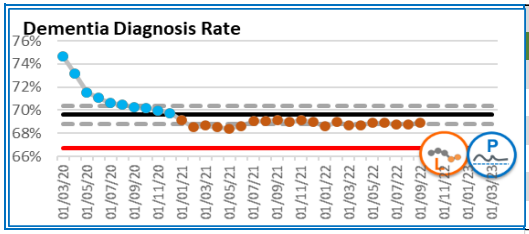
Jun-22
18
Target
11
Assurance
Flip
SPC Variation
Concerning - High



Jul-22
3424
2022-23 Plan
3750
Assurance
Fail
SPC Variation
Improving - High



Jun-22
12200
2022-23 Plan
11854
Assurance
Pass
SPC Variation
Improving - High



Sep-22
68.9%
Target
66.7%
Assurance
Pass
SPC Variation
Concerning - Low

Summary

Please be aware that due to an issue with an ONS source file that NHSD use in their processing they have been as yet unable to publish ICB level data for September.

72 Hour Follow Ups - this target is near the mean level of performance, therefore is likely to hit and miss the target due to normal variation in performance.

OAPs - Placements out of area have significantly decreased from April 2022, local data reports 100 as at September 2022. The number of OAPS has been driven by increased demand for inpatient admissions, acuity and complex patient delays in discharge from the acute setting.

Older Adult +90 days - the performance is near the mean therefore is likely to hit and miss the target. The recent increases have triggered a concerning-high alert.

SMI Physical Health Checks - There had been continued improvement in 2021/22 however this has plateaued since July, 41.3% (3,424 checks). The target for 2022/23 increases to 5,592 (6,237 including Bassetlaw).

Dementia - continues to deliver to standard. Memory Assessment Services increased capacity and has significantly reduced waiting times following additional investment.

Actions

OAPS - A new Crisis and Urgent Mental Health Transformation Lead commenced in post in Q3 to continue to transform and integrate the Crisis pathway developments and ensure services are delivering to fidelity standards and best practice. NHT opened a new acute mental health inpatient unit in November 2022/23. The unit increases the number of acute beds by 14, with plans to reduce the reliance on sub-contracted beds.

SMI Health Checks - The PHSMI LES continued into 2022/23 with 100% of practices signed up. An additional 481 checks and follow ups have been delivered in Q2 2022/23, compared to 226 in Q2 2021/22, representing a 113% increase. Work is underway to review the LES and plan for 2023/24. An SMI Health Check training package is being promoted to Primary Care, to support practices in skills promoting, communicating, and delivering the check and follow up in a personalised way. The training is available to all Primary Care staff and is available from Q3 22/23, uptake will be monitored.

Dementia - Further modelling has been undertaken as new roles have been embedded into the service, to enable the service to apply for the Memory Services National Accreditation Programme (MSNAP). The application process commenced in July 2022 with participation in the MSNAP development programme confirmed in November 2022. The self-review will take place in January 2023.

POG Assurance - Partial Assurance

OAPS - The Mental health Crisis and Urgent Care Steering Group, meets monthly to reviews actions. Partnership meetings are also in place to identify actions that can be taken to alleviate system pressures. The level of additional capacity available from the new facility will be dependent upon the ability to successfully recruit and open all beds.

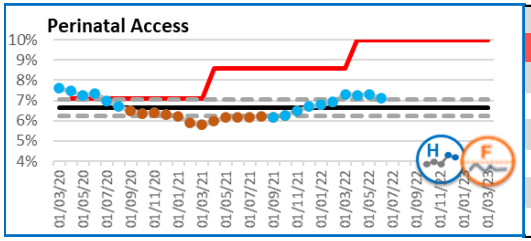
SMI Health Checks - Oversight of delivery of the standard has been integrated into the Community Mental Health Transformation Programme. This ensures coordination with all service developments, including the development and expansion of Local Mental Health Teams and introduction of Mental Health Practitioners in PCNs.

Dementia - The Memory Assessment Service (MAS) has reduced waiting times significantly since its reinstatement in September 2020 from 18 weeks to 7.1 in November 2022.
A waiting time recovery trajectory was agreed to ensure the historical backlog is cleared and to monitor the 6-week waiting time to diagnosis target; this is monitored, and progress is reviewed monthly with MAS service leads.

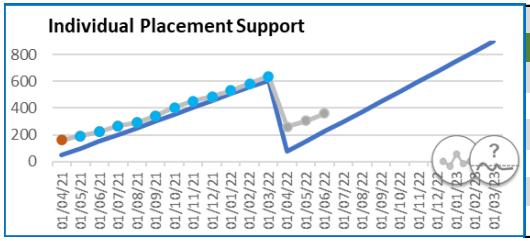
7.4c - Recover Services and Address Backlogs – Exception Report : Mental Health – Access

NHS Nottingham and Nottinghamshire

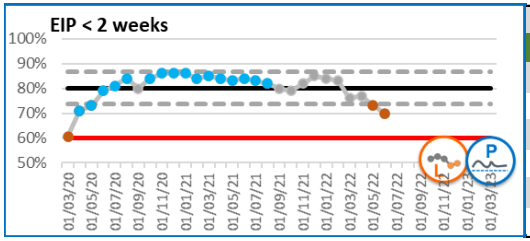
Mental Health - Access



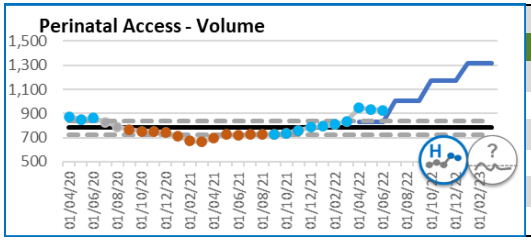
Jun-22
7.1%
Target
10.0%
Assurance
Fail
SPC Variation
Improving - High



Jun-22
360
Plan
225
Assurance
Flip
SPC Variation
Common Cause



Jun-22
70%
Target
60%
Assurance
Pass
SPC Variation
Concerning - Low



Jun-22
925
2022-23 Plan
828
Assurance
Flip
SPC Variation
Improving - High

Early Intervention Psychosis (EIP) Compliance Levels

NICE standard	Current performance	Rating
Access	Level 4	Top Performer
CBTp	Level 3	Performing Well
Family Interventions	Level 2	Needs Improvement
Supported employment and education	Level 4	Top Performer
Physical Health Checks	Level 4	Top Performer
Carer Focussed education	Level 4	Top Performer
Outcome measures	Level 2	Needs Improvement

Summary

Please be aware that due to an issue with an ONS source file that NHSD use in their processing they have been as yet unable to publish ICB level data for September.

Perinatal - Rolling 3-month performance in June shows a reduction in performance from 7.2% to 7.1%. Performance continues to remain below the 2022/23 10% end of year access target. National data is not available this month, but rolling YTD shows increased access. Local data suggests the ICS is approximately 100 contacts under the recovery plan trajectory.

IPS - The ICS meet and exceeded the 2021/22 IPS access standard. Month 3 is ahead of trajectory and track to achieve the 2022-23 year-end target of 899.

EIP - The access standard has been consistently exceeded at an ICS level. Due to some ongoing issues with NHS Digital, national data for ICB level data for August, September and October is not available, however, local data for October shows an improvement in performance at 83.2%

Actions

Perinatal

•Continuous ICS wide communications campaign including the sharing of service promotion videos developed with referrers and service users to be undertaken to promote awareness of the service.

•Work to be undertaken with the Clinical Network to undertake system pathway mapping, to ensure right care at the right time by local services - Jan 2023.

•Continuous targeted work within areas where there is underrepresentation (BME groups) to understand reasons and increase engagement.

•Implementing self-referral and expanding who can refer into the service -Jan 2023.

EIP - The focus remains on maintaining a level 3 NICE compliant service and ensuring the access standard is met.

In October 2022, NHSE have approved funding to support improvement in Family Interventions. An updated service model, which includes testing of an 'At Risk Mental State' (ARMS) pathway, has been developed and built into Community Mental Health Transformation Plans.

An ARMS pilot model is currently being recruited to in Q3 and will be implemented during Q4 as the new roles commence. This will be tested with the North EIP Team and across the CYP Head 2 Head service, before evaluation and rollout across the ICB in 23/24.

POG Assurance - Partial Assurance

Perinatal - The team is commissioned to meet the LTP ambition.

An ICS Perinatal Recovery Action Plan has been developed. The recovery improvement trajectory is March 2023 (12 months rolling performance). ***The access target is to achieve 10% by the end of March 2023.***

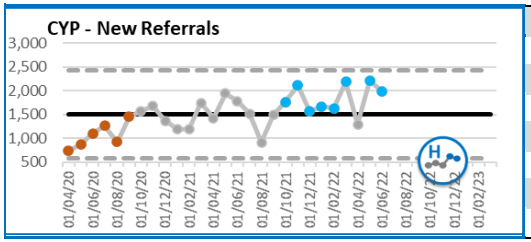
EIP Transformation meetings are in place to review progress against agreed actions, variations across teams and progression through compliance levels.

IPS - Additional investment has been agreed for 2022/23 to enable sufficient capacity to deliver the increased target, with 5 roles currently out to advert. This will ensure equity of offer across the ICS. A fidelity review of the Mid-Notts element of the service has been undertaken by IPS Grow, with the service assessed as a ***Centre of Excellence.*** The year end target of 899 is expected to be achieved.

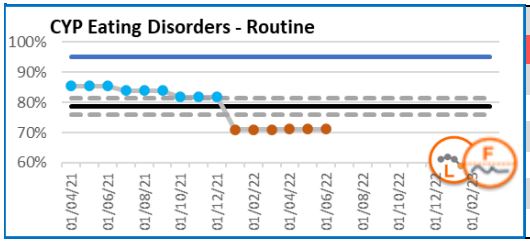
7.4d - Recover Services and Address Backlogs – Exception Report : Mental Health – Children & Young People

NHS Nottingham and Nottinghamshire

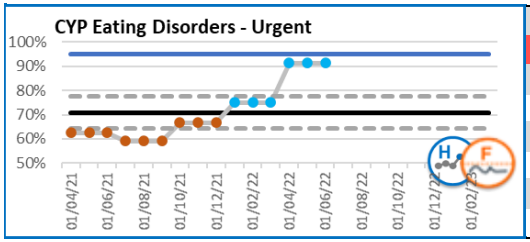
Mental Health - Children & Young People (CYP)



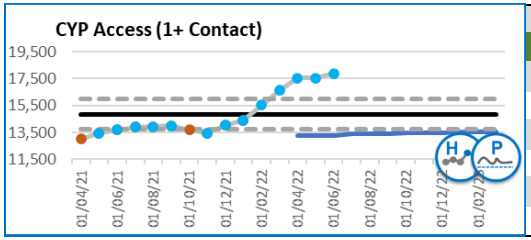
Jun-22
1985
2022-23 Plan
-
Assurance
-
SPC Variation
Improving - High



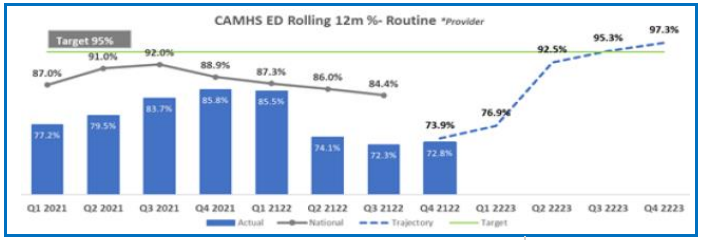
Jun-22
71%
Target
95%
Assurance
Fail
SPC Variation
Concerning - Low

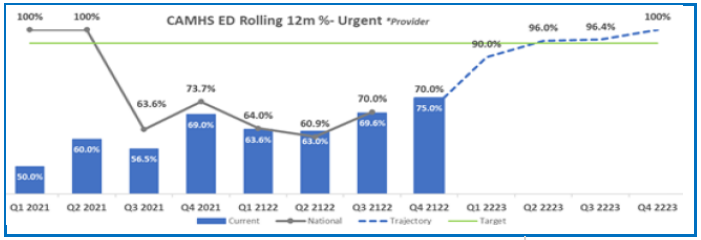


Jun-22
91%
Target
95%
Assurance
Fail
SPC Variation
Improving - High



Jun-22
17880
2022-23 Plan
13300
Assurance
Pass
SPC Variation
Improving - High





Summary

Please be aware that due to an issue with an ONS source file that NHSD use in their processing they have been as yet unable to publish ICB level data for September.

CYP Referrals - have been increasing and have triggered a special cause High alert.

CYP Access (1+ Contact) - National data is not available this month, but the ICS is forecast to continue to increase access. The ICS is exceeding the access target of number of children and young people (CYP) receiving support (1-contact); 17,880 CYP were recorded as having at least 1 contact in the rolling 12 months ending June 2022, exceeding the annual plan of 13,559.

CYP ED Routine (< 4 weeks) - Special Cause Low variation due to the deterioration of performance. It is not expected that the service will meet the required standard.

CYP ED Urgent (<2 weeks) - Special Cause High variation due to the improvement in performance over the past 2 quarters. However the service remains below the required standard and is unlikely to consistently meet the required standard.

Actions

CYP Access - Due to increased demand investment has been agreed to deliver the Long Term Plan objectives for 2022/23 which enable service expansion and transformation across a range of services; schemes are being implemented throughout the current financial year and next. Regular multi-agency transformation meetings are scheduled which support the areas of transformation and ensure partnership working.

CYP Eating Disorder Service - 2022/23 investment plans have been agreed to increase capacity in line with current referral levels and to achieve the waiting time standards.
Recruitment is ongoing but is challenging.

POG Assurance - Partial Assurance

CYP Access - It not expected that referral levels will plateau. Referral trends have continued largely above the mean and the national team at NHS England advise areas to plan for a sustained response to the current level of referrals.

Investment has been agreed to deliver the Long Term Plan objectives for 2022/23 which will enable service expansion and transformation across a range of services.

Regular multi-agency transformation meetings are scheduled which support transformation plans and ensure partnership working.

Work is now being undertaken to ensure all eligible services within Bassetlaw are contributing and submitting successfully to the MHSDS.

CYP Eating Disorder - Investment plans have been agreed in line with increasing and sustained service demand. Assumptions about referral trends have been endorsed by the regional Clinical Network.

All-age transformation meetings continue, attended by commissioners, providers and primary care leads, which address any performance issues and agree required remedial actions. Actions are reviewed on a monthly basis.

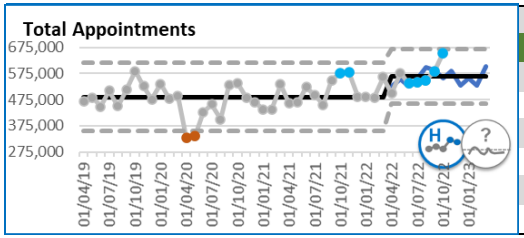
7.5 Service Delivery Primary & Community Performance

7.5a – Exception Reports Primary & Community

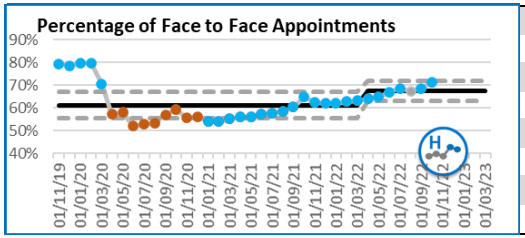
7.5a - Recover Services and Address Backlogs – Exception Report: Primary and Community Recovery

NHS Nottingham and Nottinghamshire

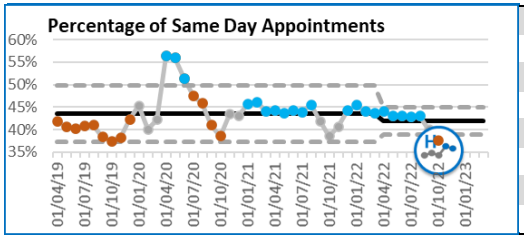
Primary Care and Community Recovery



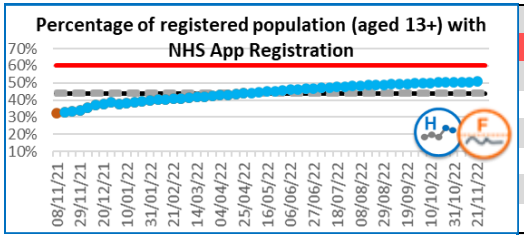
Oct-22
653783
Max Lmit / Target
557809
Assurance
Flip
SPC Variation
Improving - High



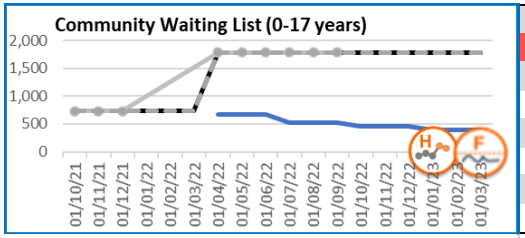
Oct-22
71%
Max Lmit / Target
-
Assurance
-
SPC Variation
Improving - High



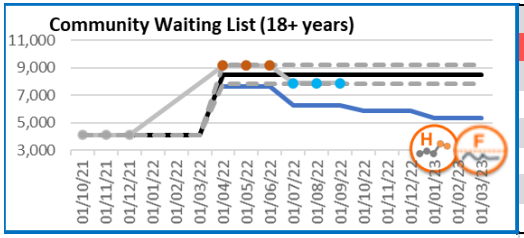
Oct-22
38%
Max Lmit / Target
-
Assurance
-
SPC Variation
Improving - High



Nov-22
51%
Max Lmit / Target
60%
Assurance
Fail
60% by March 2023
Improving - High



Sep-22
1785
Max Lmit / Target
529
Assurance
Fail
SPC Variation
Concerning - High



Sep-22
7863
Max Lmit / Target
6240
Assurance
Fail
SPC Variation
Concerning - High

Summary

Total GP Appointments in October were more than 17% above plan. The percentage of appointments held face to face continues to increase at 71%, which is a small increase from 69% reported for September. Appointments delivered on the same day continues to perform around the mean at 38%. There has been a stepped increase in home visits since March 2022 as the average number per month is 2834 in 2022/23 compared to an average of 2033 per month in 2021/22.

GP Appointments within two weeks data is now being received, data for October 2022 shows that 75.7% of appointments were offered within two weeks.

NHS App - registrations onto the NHS App have continued to increase over the past few years. The end of March 2023 target is to achieve 60% registration.

Community Waiting Lists are significantly over the planned level for patients aged 0-17 as well as those aged 18 and over. Analysis of more detailed data for quarter 2 shows that the waiting lists exceed plan at CityCare as well as Nottinghamshire Healthcare NHS Trust for all ages of patients. The plan for NHCT was set at a low level as it incorrectly excluded waits for Nursing services. However, there remains a high level of demand for community services within the system.

Actions

GPs continue to respond to increasing demand, as well as the impact of the recent wave of covid. In addition they are moving to address the hidden waits of Long Term Condition reviews.

NHS App - Ensuring consistent promotion of the NHS App is being picked up via the redmoor review and part of the excellence in PCIT programme; this is also a direct target for us as part of our PFDS programme as the strategic direction is NHS App as the single front door. Within the DDAT team we have been supporting GP practices to promote the NHS App via specific target comms activities such as social media, radio ads and bus and tram advertisement.

POG Assurance - Limited Assurance

Work has taken place to understand the services that were excluded from the original baseline period that was used to set the plan for 2022/23, which improves clarity around the position. However, in both age categories, the volume patients exceeds the planned levels. Collaborative work is required between ICB and providers to break the position down by constituent service and identify a range of actions that can be taken to increase capacity, reduce waiting times and improve the position.

NHS
Nottingham and Nottinghamshire

8.0 Finance

ICS Aim 3: Enhance productivity and VFM

- 8.1 – Month 8 2022/23 Financial Position – Key Metrics
- 8.2 – System Financial Performance – Key Messages
- 8.3 – Organisational Analysis
- 8.4 – System Response – Recovery Plan

8.1 - Finance Position Month 8 2022/23 – Key Metrics

NHS Nottingham and Nottinghamshire

		YTD Variance £m's			FOT Variance £m's			RAG	
Financial Duties	**Measure**	**Plan**	**Acts**	**Variance**	**Plan**	**FOT**	**Variance**	**YTD**	**FOT**
NHS System (Breakeven)	**(Deficit)/Surplus**	**-17.9**	**-35.1**	**-17.2**	**-16.9**	**-16.9**	**0.0**		
Capital (within Envelope)	**Spend against plan**	41.6	36.7	**4.9**	89.6	85.3	**4.3**		
MHIS (meeting target)	**Spend against plan**	127.1	125.2	**-1.9**	190.7	190.7	**0.0**		
Agency (spend within Cap)	**Spend against plan**	37.6	56.3	**-18.7**	54.6	84.2	**-29.6**		

		YTD Variance £m's			FOT Variance £m's			RAG	
Drivers of the (Deficit)/Surplus	**Measure**	**Plan**	**Acts**	**Variance**	**Plan**	**FOT**	**Variance**	**YTD**	**FOT**
COVID Spend	**Delivery against plan**	14.7	22.6	**-7.9**	17.8	28.0	**-10.2**		
NHS Efficiencies	**Delivery against plan**	56.1	53.9	**-2.2**	102.7	102.7	**0.0**		
ERF Income	**Delivery against plan**	35.0	34.4	**-0.7**	53.7	53.7	**0.0**		

- **£35.1m** deficit experienced to end of month 8, which is **£17.2m** adverse to plan.
- The adverse variance is totally experienced in the 2 acute trusts (NUH & SFH) representing **£12.4m & £4.9m** of the year to date deficit variance respectively.
- Key drivers of the adverse variance are covid (**£7.9m**), excess costs arising from urgent care capacity requirements (**£7.5m**) hospital discharge and interim beds (**£3.4m**), continuing health care (**£5.0m**) and efficiency shortfall (**£2.2m**). Adverse variances are also seen in primary care prescribing, mental health out of area beds and inter-system contracts (ESRF). Offsetting favourable variances include clinical supplies due to elective surgery performing below planned levels and primary care expenditure.
- Agency spend remains over plan and above the agency cap, with an adverse YTD variance of **£18.7m**. Drivers include covid expenditure, efficiency shortfalls, urgent care capacity requirements and shortage of substantive staff in some areas.
- The forecast remains break-even but there are significant risks to delivery, particularly relating covid, efficiency, continuing care and urgent care capacity over winter.

Chappell Room, Arnold Civic Centre 09:00-12/01/23

8.2 - Finance Position Month 8 2022/23 – System Financial Performance – Key Messages

NHS Nottingham and Nottinghamshire

Month 8 Position

- The Nottingham & Nottinghamshire ICS has a £35.1m deficit at month 8, which is £17.2m adverse to plan. Month 8 has seen a £2.8m in-month surplus which is £0.4m favourable to plan.
- The main driver of this improvement is an increase in Community Diagnostic Hub income. NHSE have advised that £8.5m will be provided non-recurrently in 2022/23. This has led to a £5.0m improvement in month. Discounting this one off gain, the system has seen a £2.2m deficit (£4.6m adverse to plan)
- The main drivers of the year to date adverse variance are covid above planned levels (£7.9m), excess costs arising from urgent care capacity (£7.5m), continuing health care (£5.0m) and hospital discharge and interim beds (£3.4m) . Adverse variances are also seen in primary care prescribing (due to a national pricing), efficiency shortfall, and mental health out of area beds. These are partially offset by favourable variances in clinical supplies and primary care.
- Monthly covid costs continue to reduce but as the plan was for a low covid environment even small amounts of covid related backfill lead to an overspend. Covid, urgent care and recruitment difficulties are all contributing to agency spend above the agency cap.
- Efficiency delivery is £2.2m off plan to month 8. Plans are in place to recover this and the ICS continues to forecast delivery of the full £102.7m by the end of the year. However, delivery is highly dependent on non-recurrent action with £47.7m (£22.6m higher than plan) expected to be non-recurrent in the forecast position

Risks & Mitigations

- Delivery of the forecast requires a significant change in existing run rates. There is a particular risk to continuing agency costs over winter given operational pressures, high levels of workforce sickness requiring backfill and recruitment difficulties in some specialisms.
- In addition, there is a risk in relation to out of area contract agreements, where other systems are withholding ESRF payable. The total value of the risk is approximately £3m within the forecast position.
- There is also an emerging risk in relation to primary care prescribing price concessions (also referred to as no cheaper stock obtainable). Year to date costs are £1.8m higher than 2021/22 with a forecast position of £3.6m higher than 21/22. There is a further risk that this could increase to £4.5m.
- Mitigations continue to be developed and will need to be a mixture of recurrent run rate change based on the locally agreed High Impact Areas and non-recurrent benefits as we approach year-end. The FD Group continues to oversee the collective position with a live assessment of risks and mitigations as we approach the end of the financial year.

Forecast Change Protocol

- NHSE have released a forecast change protocol. This describes the process and conditions for a formal change to the in-year forecast. Systems will need to describe actions taken to minimise the deficit and the recovery plan to return to a sustainable position.
- At month 8, all system partners continue to forecast to meet the 2022/23 planned deficit of £17.0m. The system met with the NHSE CFO and national finance team on 5 December to discuss the financial position, route to improvement and impact on the year-end forecast. Given the current run rate and continuing risks to delivery the system has entered discussions with NHSE on potentially enacting the forecast change protocol.

Chappell Room, Arnold Civic Centre 09:00-12/01/23

8.3 - Finance Position Month 8 2022/23 – Organisational Analysis

NUH

- Year to date position of £24.9m deficit, £12.4m adverse to plan is driven by in envelope covid expenditure £6.5m above plan, £5.2m excess costs arising from urgent care capacity requirements and efficiencies £0.5m adverse to plan.
- ESRF income is now assumed to be on plan following NHSE advice. Clinical supplies costs are £1.6m favourable to plan due to lower than planned elective activity levels.

SFH

- The YTD position is driven by efficiency shortfall of £1.1m, in envelope covid spend above planned levels of £1.2m, excess costs arising from urgent care capacity requirements £2.3m and ESRF not received from outside the N&N system £0.5m.

NHT

- Currently on plan at £1.0m year to date deficit.
- The YTD position is mainly driven by £0.3m in envelope COVID above planned levels & £0.6m efficiencies below plan.
- Out of area bed spend is £2.4m YTD adverse to plan alongside agency staff which is being offset by substantive staff being below plan.

M8 Financial Position						
Orgn £'ms	YTD plan	YTD Actuals	Variance	Annual Plan	FOT	Variance
NUH	-12.5	-24.9	-12.4	-12.3	-12.3	0.0
SFH	-4.4	-9.2	-4.9	-4.7	-4.7	0.0
NHT	-1.0	-1.0	0.0	0.0	0.0	0.0
N&N ICB	0.0	0.0	0.0	0.0	0.0	0.0
Total System	-17.9	-35.1	-17.2	-16.9	-16.9	0.0

ICB

- Breakeven position including the impact of CCG spend (N&N and Bassetlaw) to month 3.
- Adverse variances seen in continuing healthcare £5.0m, and hospital discharge costs (interim beds supporting urgent care).
- Offset by primary care costs below planned levels and non-recurrent benefits.
- The ICB also holds a system risk of £6.3m. £1.2m of this has been covered within the year to date position.

Chappell Room, Arnold Civic Centre 09:00-12/01/23

Chappell Room, Arnold Civic Centre 09:00-12/01/23

8.4 - Finance Position Month 8 2022/23 – System Response – Recovery Plan

NHS Nottingham and Nottinghamshire

- The system continues to focus on financial recovery through the system-wide high impact approach. Programmes areas as follows:
  - Reductions in covid expenditure
  - Reduce acute urgent care capacity requirements to within planned levels
  - Productivity actions to increase ESRF within existing resources
  - Delivery of 22/23 cash-releasing efficiency programmes
  - Actions to reduce agency expenditure
  - Investment review principles and processes
  - System wide transformation programme development
- Demonstrable financial improvement has been seen in covid and efficiency with improving trends in agency price cap compliance, although this is not yet mirrored in expenditure run rate trajectories. Monthly progress reports continue to be reported through the ICS Finance Director's Group.
- Given the year to date deficit experienced within the system and with little time to see the impact of further implemented change, delivery of the 2022/23 plan will need to be supplemented by further non-recurrent benefits. Full mitigations against risks have not yet been identified but a number of options are being explored. The process is being overseen through the ICS Finance Director's Group with a near real-time assessment of the risk to delivery.
- Alongside the process of managing this financial year, the ICS is continuing to focus on reducing recurrent expenditure run rates. 2023/24 financial settlement is expected to be extremely challenging and to aid delivery the system will need to focus on transformation and efficiency into quarter 4 so that change is embedded before the start of the financial year.
- Senior Leadership including Chairs and Chief Executives from across the system met on 16 December to explore this in more detail, agreeing a commitment to system-wide change through clinically led transformation. This will require full engagement and collaboration of system partners at all levels to come up with new ways of working across boundaries.
- To support this there is an emerging approach to clinical prioritisation under development through the Clinical Design Authority. The focus is on delivering better value through better outcomes (particularly in areas of high inequality) at lower cost (through reduced acute demand). The approach is clinically led and looks to address the following 4 priority areas:
  - Reduction in avoidable and unplanned admissions to hospital and care homes (navigation and flow)
  - Increase in number of people being cared for in an appropriate care setting (anticipatory care)
  - Increase in healthy life expectancy (maintaining wellness for longer)
  - Access to the right primary and community based health and care services first time (Referral optimisation)
- The approach will be further developed and quantified into quarter 4 with an expectation that this will form part of 2023/24 plans (and future years) with benefit seen from April 2023.11

NHS
Nottingham and Nottinghamshire

9.0 System Workforce

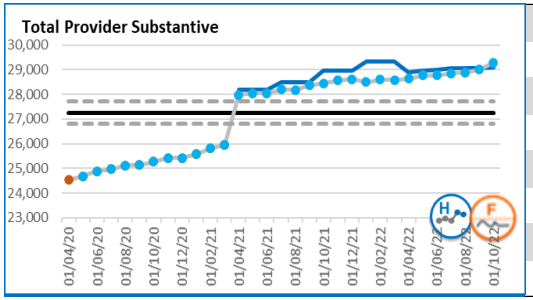
ICS Aims: All 4 (Outcomes, inequalities, productivity and social and economic development)

- 9.1 – Exception Report Provider Workforce
- 9.2– Exception Report Provider Vacancies, Turnover & Sickness
- 9.3 – Exception Report Primary Care Workforce
- 9.4 – Exception Report Agency Cost
- 9.5 – Exception Report Agency Usage
- 9.6 – Social Care Workforce
- 9.7 – Employment Overview
- 9.8 – Projections
- 9.9 – Care Homes Workforce

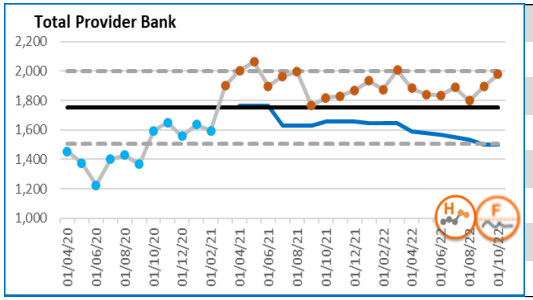
9.1 - Workforce – Exception Report Provider Workforce

NHS Nottingham and Nottinghamshire

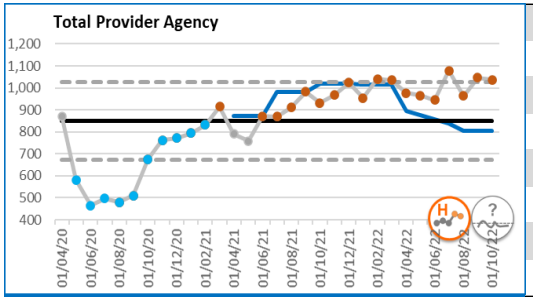
Total ICB Provider Workforce - Operational Plan v Actual 2022/23



Nov-22
29547
2022-23 Plan
29115
Assurance
Fail
SPC Variation
Improving - High

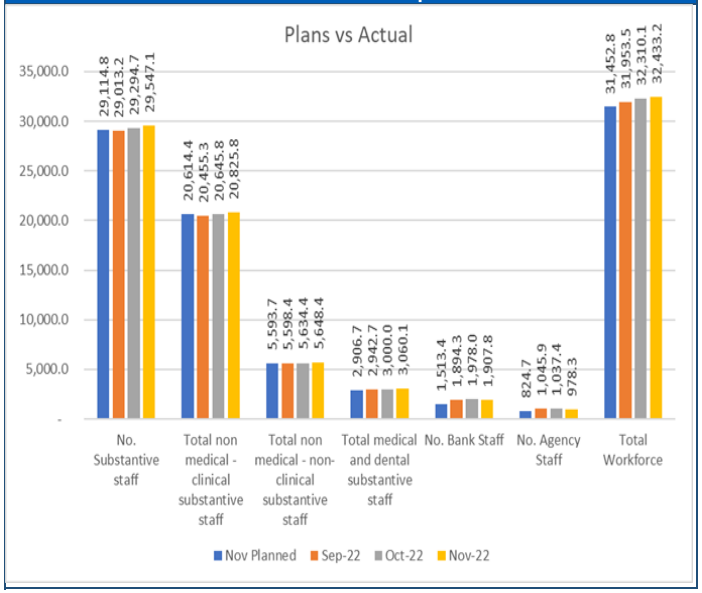


Nov-22
1908
Target
1513
Assurance
Fail
SPC Variation
Concerning - High



Nov-22
978
2022-23 Plan
825
Assurance
Fail
SPC Variation
Concerning - High

Total Provider Workforce - Sep - Nov 2022/23



Actions

Recruitment and retention plans are being monitored to ensure planned growth in staff groups seen is following the plan, with variances explained to inform on future workforce needs and supply.

Winter plan actions are being implemented, contributing to some of the increase in bank staff. Risks around any recruitment needed for winter plan have been assessed through the People & Culture Group with low/medium risks identified.

Total Provider Current position:

Growth in substantive workforce seen on track with plan.
Agency usage has reduced during October, with related increase in bank usage.

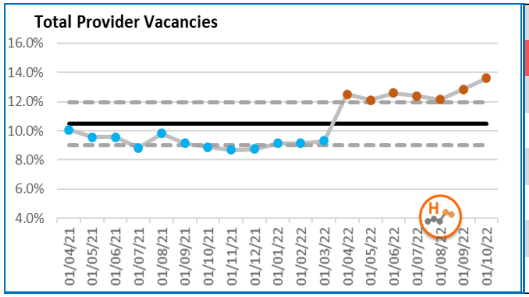
P&C Group Assurance -Enhanced Assurance Level

Total Providers:
Plans are in place but needs improved monitoring to evidence impact of each intervention and whether additional interventions are needed

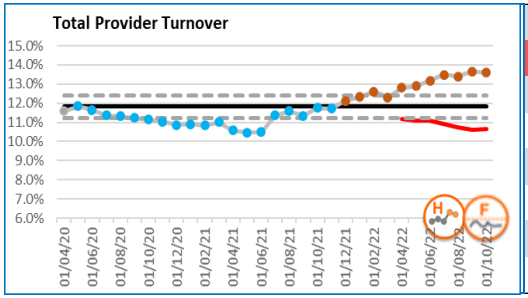
9.2 - Workforce – Exception Report Provider Vacancies, Turnover & Sickness

NHS Nottingham and Nottinghamshire

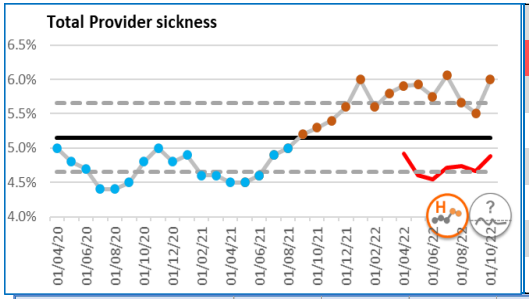
Workforce - Vacancies, Turnover & Sickness Absence



Nov-22
11.5%
Target
8.7%
Assurance
Flip
SPC Variation
Concerning - High



Nov-22
13.8%
Target
11.0%
Assurance
Fail
SPC Variation
Concerning - High



Nov-22
5.8%
Target
8.7%
Assurance
Fail
SPC Variation
Concerning - High

KPI	Latest Period	Target	Actual	Variance	Variation	Assurance
ICS Vacancies	Nov-22	8.7%	11.5%	2.8%	H	F
NHC Vacancies	Nov-22	8.7%	12.4%	3.7%	H	?
NUH Vacancies	Nov-22	8.7%	12.8%	4.1%	H	F
SFH Vacancies	Nov-22	8.7%	4.5%	-4.2%		P

KPI	Latest Period	Target	Actual	Variance	Variation	Assurance
ICS Turnover (12 mth)	Nov-22	11.0%	13.8%	2.8%	H	F
NHC Turnover (12 mth)	Nov-22	11.0%	19.1%	8.1%	H	F
NUH Turnover (12 mth)	Nov-22	11.0%	12.4%	1.4%	H	?
SFH Turnover (12 mth)	Nov-22	11.0%	9.5%	-1.5%	H	P

KPI	Latest Period	Target	Actual	Variance	Variation	Assurance
ICS Sickness Absence	Nov-22	4.6%	5.8%	1.2%	H	F
NHC Sickness Absence	Nov-22	4.6%	7.0%	2.4%		F
NUH Sickness Absence	Nov-22	4.6%	5.4%	0.8%	H	?
SFH Sickness Absence	Nov-22	4.6%	5.1%	0.5%	H	?

Summary

Vacancies have increased in Total Providers since April 22 following changes to establishments . There is a wide variation in performance across providers: 5.5%-12.8% with reductions in vacancies seen in all three trusts

Turnover - continues to see a higher turnover than plan across all providers with the exception of SFH. This is in line with national trends

Sickness levels remain higher than pre covid levels across the Total Providers with a upturn seen in month. This was an expected position predicted through workforce availability modelling based on the experiences seen in the last year.

Actions

Trusts are seeing variation in levels of vacancies across the different staff and professional groups, nursing and clinical support remain the highest but are linked to establishment changes made as a result of agreed investments in year. Trusts are also reviewing recruitment capacity to support the recruitment intentions, targeting those services where higher vacancies are being seen.
Exit interviews are being conducted and will be linked to staff survey responses.
Workforce development such as leadership training, growing new roles and increased capacity to support recruitment areas are in place or being enhanced in Trusts.
Increased options around flexible working being piloted.
Turnover seen in the Total Providers reflects the national position with Nursing contributing in both registered and Health Care Workers categories. Each Trust has completed a retention assessment and are developing action plans working with regional leads on targeted areas. Promotion and work life balance continue to be common reasons for leaving. Flexible working remains a key area of development. A review of this years Staff Survey outcomes will inform system decisions.
Trusts continue to review and enhance their wellbeing plans including mental health First aiders. The offer from the System Staff support Hub on mental wellbeing is being reviewed by the People & Culture Group to ensure better uptake across partners and are assessing the risk of potentially no further funding to support this as an ongoing national initiative in 2023-24.

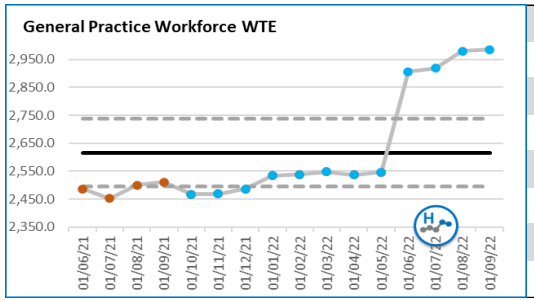
People & Culture Group Assurance - Further Information Required

Plans are in place but more detail is needed to determine if targeted interventions are required.

9.3 - Workforce – Exception Report Primary Care Workforce

NHS Nottingham and Nottinghamshire

Total ICB Primary Care Workforce - Operational Plan v Actual 2022/23



Oct-22
2996
Target
Assurance
SPC Variation
Improving - High

Primary Care	Baseline	Plan	Plan	Actual	Plan	Plan
	Staff in post outturn	Q1	Q2		Q3	Q4
Nottingham And Nottinghamshire Health And Care STP	Year End (31-Mar-22)	As at the end of Jun-22	As at the end of Sep-22	As at the end of Oct-22	As at the end of Dec-22	As at the end of Mar-23
Workforce (WTE)	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE
Total Workforce	3034	3133	3168	3178	3194	3228
GPs excluding registrars	581	584	584	581	583	578
Nurses	323	362	372	359	378	383
Direct Patient Care roles (ARRS funded)	333	384	406	408*	424	434
Direct Patient Care roles (not ARRS funded)	260	265	267	273	269	284
Other – admin and non-clinical	1537	1538	1539	1589	1540	1549

Total Primary Care Current position:

Data collection at practice level shows variation due to unclear definitions on the workforce detail to be recorded. Members of the primary care team are working with the national development team to determine standardisation through clear definitions. The workforce data is therefore indicative data.

Actions

The overall workforce position is being maintained with an established retention/workforce development programme in place for General Practitioners and Practice nurses.
Recruitment continues in to the additional roles but not to the full potential of funding allocations. Training Hub support is being provided to establish and embed roles into PCNs.
Primary Care Workforce Group stocktake on the programme delivery and looking to support resilience over the winter months, ensuring wellbeing offers are clearly promoted and access into system resource made clear.

P&C Group Assurance -Enhanced Assurance Level

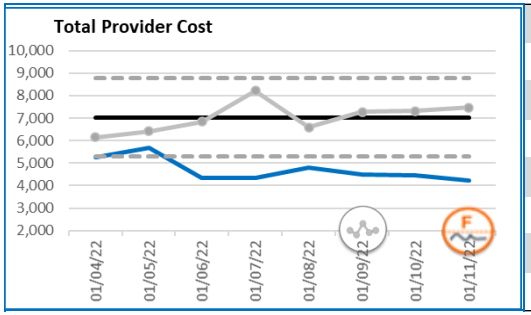
Primary Care - General Practice:
Plans are in place and are effective but more needs to be done to make general practice an attractive offer supporting staff, offering flexibility in working and cultural shift to integrated working.

Leads from the Primary care Workforce group are engaging with PCN leads to determine nest steps in supporting retention and recruitment challenges being experienced.

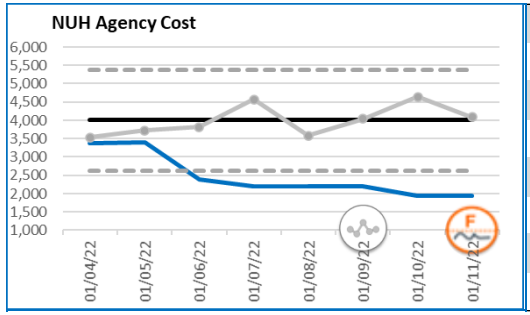
9.4 – Workforce – Exception Report Agency Cost

NHS Nottingham and Nottinghamshire

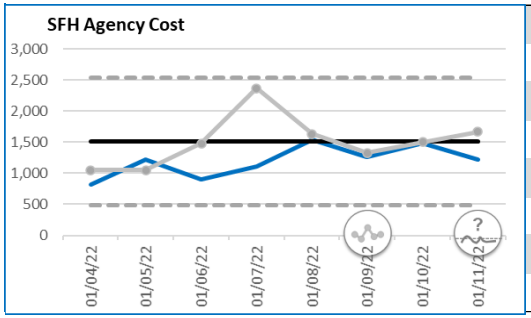
Total Provider Agency Cost



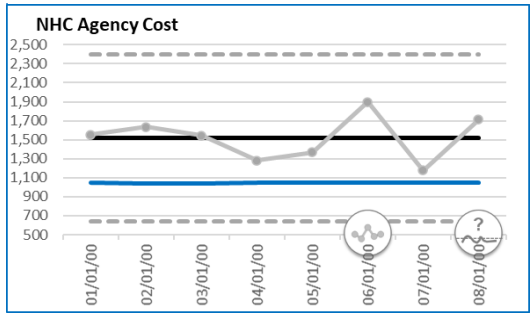
Nov-22
£7,471
2022-23 Plan
£4,207
Assurance
Fail
SPC Variation
Common Cause



Nov-22
£4,088
2022-23 Plan
£1,946
Assurance
Fail
SPC Variation
Common Cause



Nov-22
£1,669
2022-23 Plan
£1,215
Assurance
Flip
SPC Variation
Common Cause



Nov-22
£1,714
2022-23 Plan
£1,046
Assurance
Fail
SPC Variation
Common Cause

Summary

Agency usage has continued above plan, with reductions seen in 2 of 3 providers. SFH and NHT have reduced agency spend to be within plan this month. However, increases in bank usage have also been seen hence the HIA working group is looking at Temporary staffing as a whole.

Actions

KLOE have been completed by all three Trusts with individual actions being taken through respective Trust governance. Trends and themes will be pulled together to inform a set of recommendations on improvement in management of temporary staffing. A draft report and recommendations has been received and will be reviewed in early January 2023. A submission sharing a system diagnostic and database has been submitted to the regional Agency Reduction Programme with a meeting to be scheduled to discuss targeted support in our implementation plans in January.
Development of integrated reporting on Temporary Staffing is in progress with a task & finish group finalising a Power BI format supported by SAIU
AGEM are enabling connections around local procurement initiatives and getting best

People & Culture Group Assurance - Further Information Required

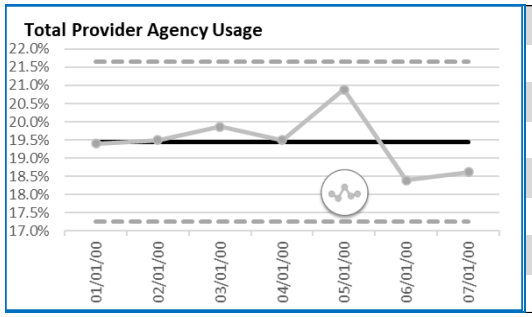
Plans are in place but more detail is needed to determine if further targeted interventions are required.

Chappell Room, Arnold Civic Centre 09:00-12/01/23

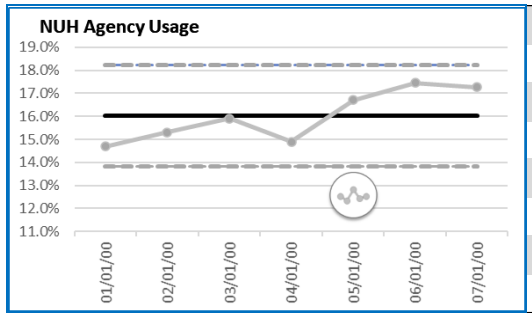
9.5 – Workforce – Exception Report Agency Usage

NHS Nottingham and Nottinghamshire

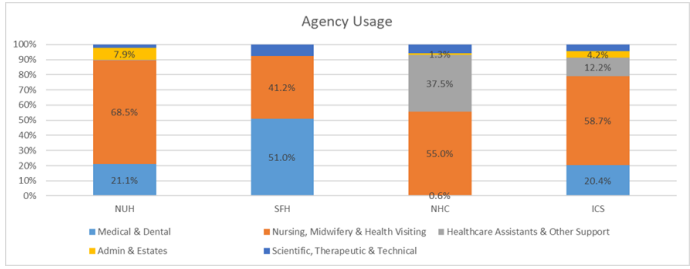
Total Provider Agency Usage

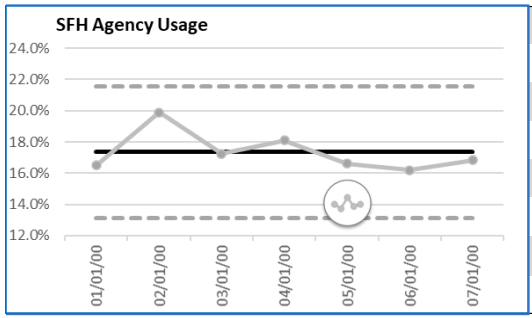


Nov-22
18.62%
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause

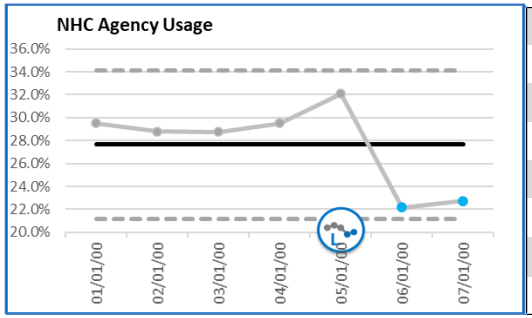


Nov-22
17.26%
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause





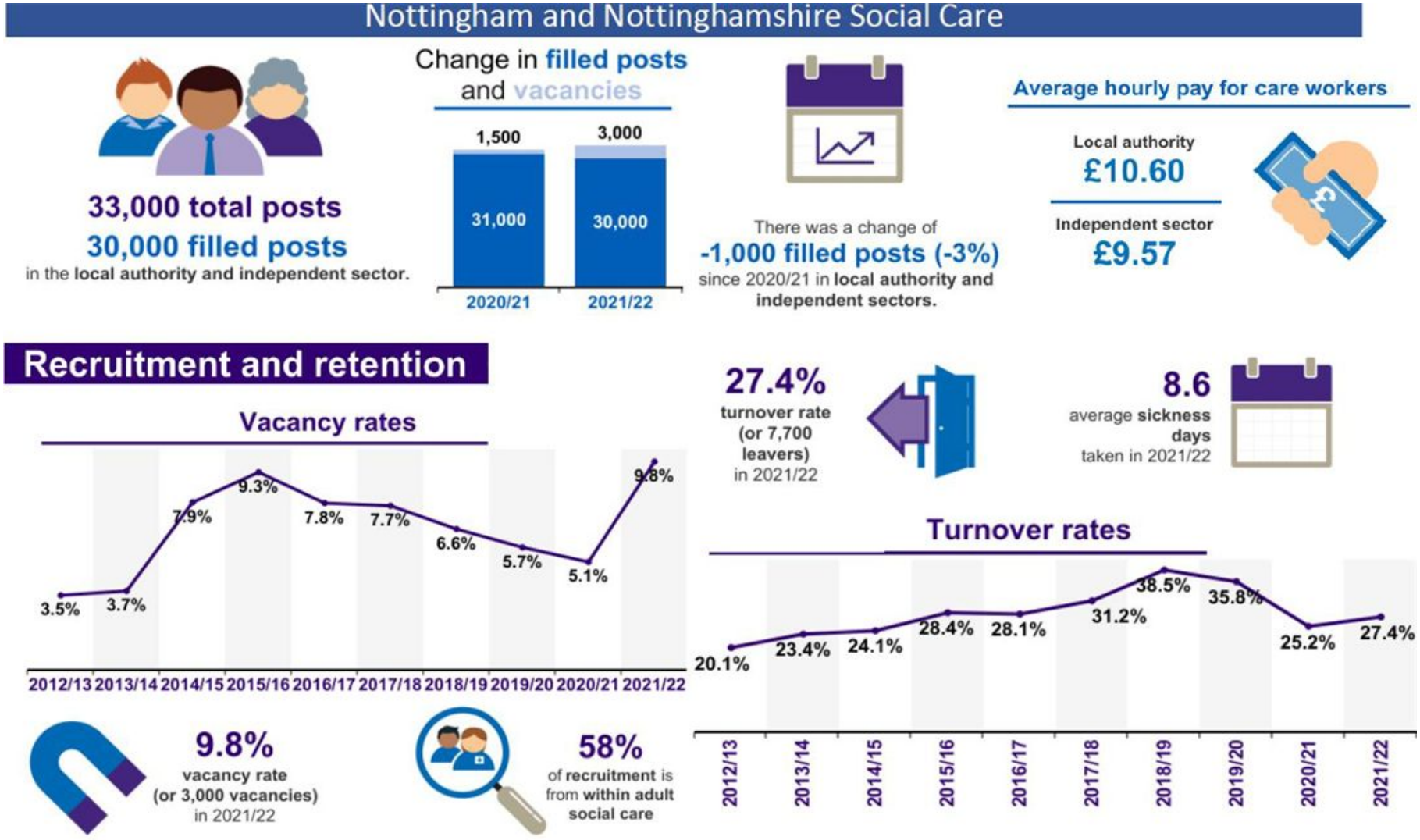
Nov-22
16.84%
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause



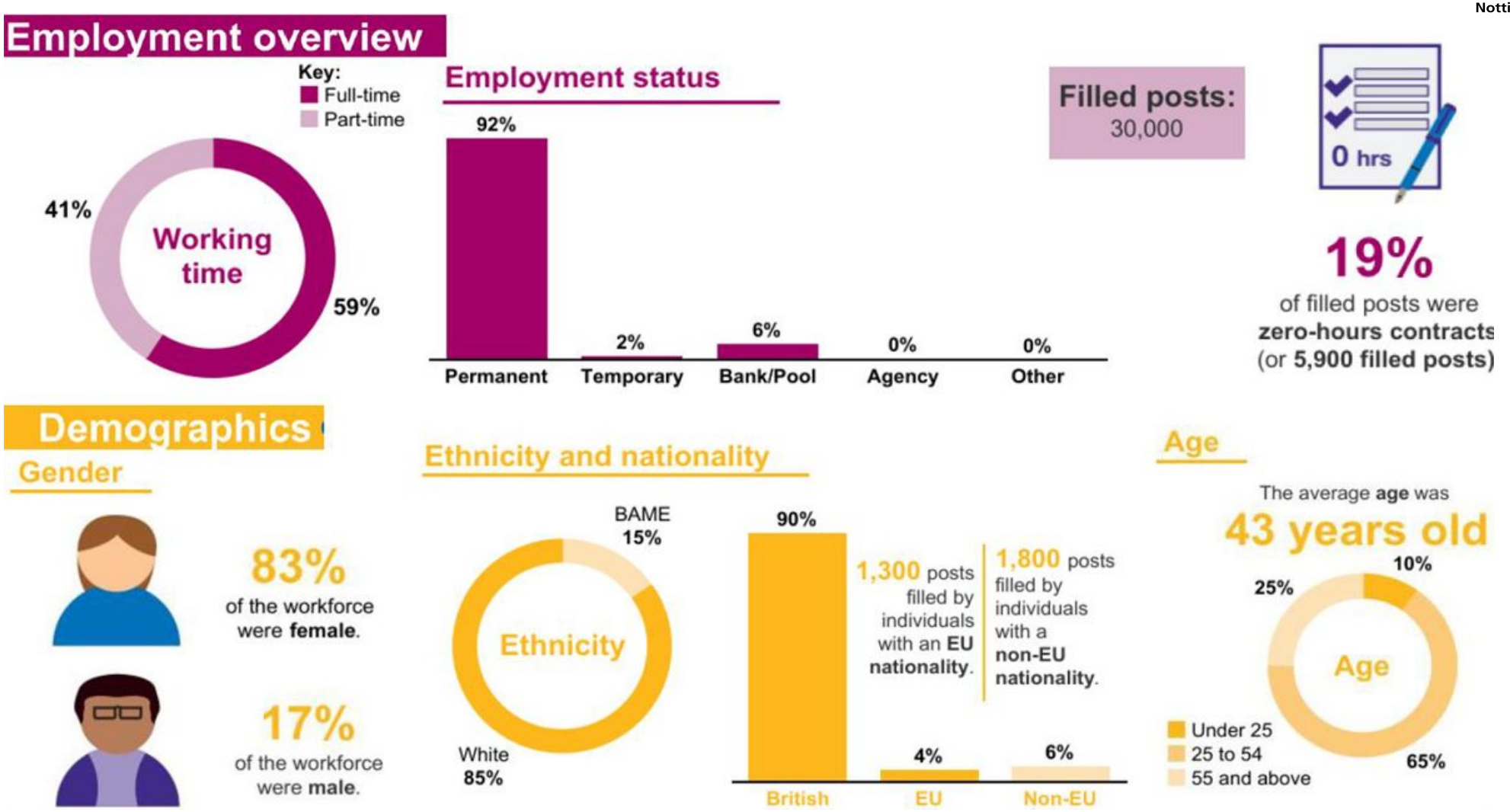
Nov-22
22.71%
2022-23 Plan
-
Assurance
-
SPC Variation
Improving - Low

Chappell Room, Arnold Civic Centre 09:00-12/01/23

9.6 – Workforce – Social Care Workforce



9.7 – Workforce – Employment Overview



9.8 – Workforce – Projections

Workforce projections

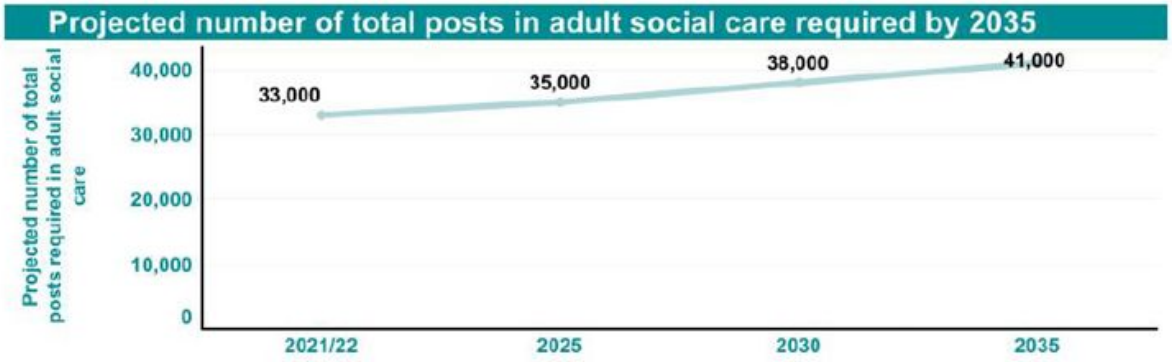
This model projects the size of the workforce if it grows proportionally to the number of people aged 65 and over in the population. This workforce includes adult social care total posts employed by local authorities and the independent sector only. Posts employed by direct payment recipients and those in the NHS are not included.
Please note that demand due to replacing leavers will be in addition to the figures shown below.

If the adult social care workforce grows proportionally to the projected number of people aged 65 and over in the population then the number of adult social care filled posts will...

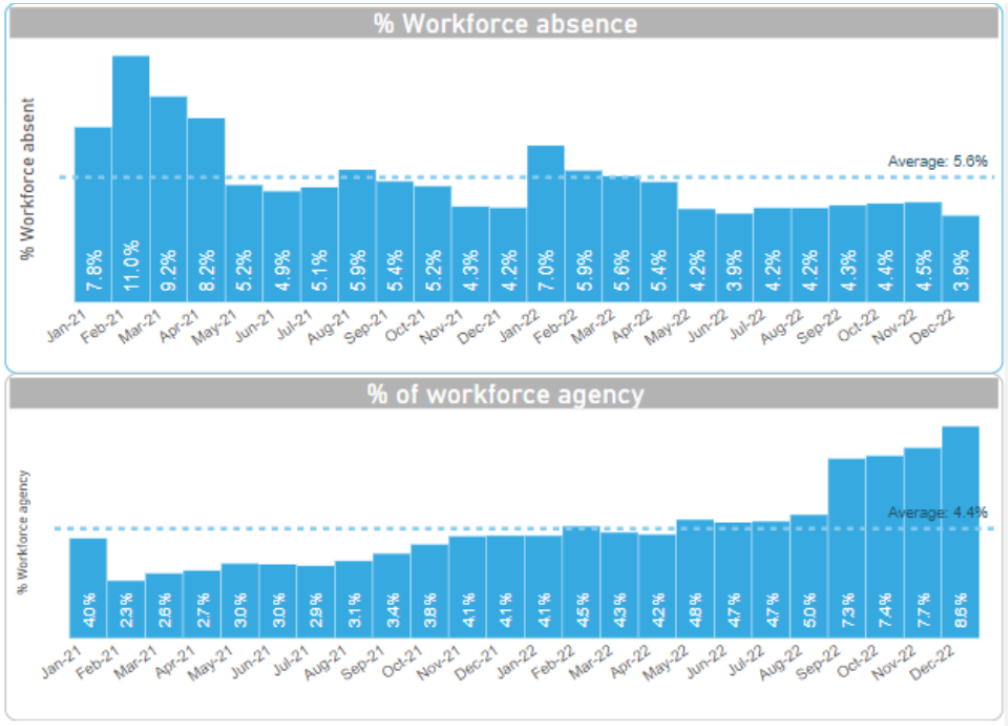
increase by 22% (7,300 total posts)

...to around 41,000 total posts by 2035

...equal to around 600 extra total posts per year up to 2035



9.9 – Workforce – Care Homes Workforce



Monthly staff trend: All staff

Aligned PBP	Employed	Absence	%	Agency	%
Bassetlaw	37,543	1,876	5.0%	1581	4.0%
Mid Notts	106,828	5,499	5.1%	5004	4.5%
Nottm City	62,085	3,522	5.7%	3175	4.9%
South Notts	102,951	6,420	6.2%	4592	4.3%
Total	**309,407**	**17,317**	**5.6%**	**14352**	**4.4%**

November workforce absence is 3.9% over all staff groups. The average absence from Jan 2021-Dec 2022 is 5.6%.

Agency staff levels have continued to rise since Feb 2021 and have been above the 4.4% average for the latest 7 months.

Data and visuals taken from the Care Home & Home Care Dashboard at 13th December on the SAIU Portal

NHS
Nottingham and Nottinghamshire

10.0 Health Inequalities

ICS Aim 2: Tackle inequalities in outcomes, experience and access

- 10.1 – Embed PHM approach
- 10.2a – Health inequalities dashboard – Metrics by Ethnicity
- 10.2b – Health inequalities dashboard – Metrics by Deprivation
- 10.3 – The 5 in the 'Core20plus5'
- 10.4 – Impact on the CORE20Plus5: Smoking

10.1 - Embed PHM Approach and Reduce Health Inequalities

NHS Nottingham and Nottinghamshire

10.1.1 The ICS Health Inequalities Group continues to consider and develop equity as a core principle which will be central to the final version of the ICS Health Inequalities Plan alongside the Core20+5 approach. Equity as a core principle will inform the ICS strategy. The Health Inequalities plan has been approved.

10.1.2 NHSE have released the Core20+5 approach for children. Five clinical areas include asthma, diabetes, oral health, mental health and epilepsy. These areas align with transformation programmes. The national Core20+5 approach supports the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. Through Place Based Partnership plans, inclusion health groups (PLUS) are identified. Actions are being taken across each of the five clinical areas and in relation to smoking cessation which is across all due to the impact on health inequalities.

10.1.3 Place Based Partnership plans to impact on health inequalities are central to the ICS approach. This includes community champion and engagement programmes which continue to develop following the learning from targeted work to increase the uptake of COVID vaccinations. The community champion and engagement programmes are fundamental and strengthen working with the voluntary sector. are being implemented across and through PBPs are fundamental to the ICS approach to impacting on health inequalities.

10.1.4 The ICS has been selected as one of five sites nationally to accelerate the Core20+ Collaborative Programme. The Core20PLUS Collaborative programme is one of a number of funded initiatives that support focused action across Integrated Care Systems (ICSs) to narrow healthcare inequalities across the five clinical areas of priority outlined in the Core20PLUS5 approach and contribute to work to address the wider determinants of health.

10.1.5 Equity as a core principle and the Core20+5 approach will be embedded within transformation programmes, supported by clinical and community engagement providing the intelligence required for a targeted approach. The ICS Diabetes Transformation Programme is trialling an equity payment in primary care to support uptake of care processes and treatment targets.

10.1.6 The system continues to progress **prevention programmes**:

- ***ICS Tobacco Dependency Steering Group*** – Work programmes are underway across maternity, mental health and NHS inpatient services. Through funding from NHSE, a pilot smoking cessation programme has been implemented specifically for NHS staff, targeting staff groups with higher smoking prevalence.
- ***Nottingham and Nottinghamshire Alcohol Pathways*** A priorities work plan has been confirmed which includes alcohol related brain injury as a pathway development. Work has commenced with NUH and Public Health to plan a review of Alcohol Care Teams and pathways to community based substance misuse treatment.
- ***Joint Weight Management*** Commissioners meetings between the ICB and Councils have been established and are producing a 2-year roadmap to integrate and align all tiers of commissioning. Service improvements are planned to address long waits for Tier 3 adult service. A proposal has been implemented for personal health budgets in relation to weight management. Children and Young People service development is progressing with consideration of aligning service offers for the whole family approach. Education with PCNs is ongoing to increase the uptake of NHS Digital Weight Management as referrals are below target.

10.2a - Health Inequalities Dashboard – Nottingham and Nottinghamshire Health Inequalities Metrics by Ethnicity

NHS Nottingham and Nottinghamshire

		Ethnicity		
Topic	Metric	Relative Difference in Mean	Trend (2017 - 2021)	Description
Cancer	Cancer morbidity in adults (percent)	0.84	Narrowing	Cancer morbidity in adults is lower in the Black and Asian population compared to the White population. The differences between populations are narrowing overtime.
	Cancer mortality age <75 (per 100,000 pop')	0.72	Steady	Cancer mortality under 75 is lower in the Black and Asian population compared to the White population.
Elderly persons	A&E Attendances age 75+ (per 100,000 pop')	0.91	Widening	A&E attendances over 75 are similar between ethnicity groups.
	Hip fracture NE Admissions age 75+ (per 100,000 pop')	0.51	Narrowing	Hip fracture NE admissions are half as frequent in the Black and Asian population as the White population. The difference between populations is narrowing over time.
H&J Spec Com	Renal morbidity in adults (percent)	1.39	Steady	Renal morbidity in adults is higher in the Black and Asian population compared to the White population,
Healthy people	A&E Attendances in adults (per 100,000 pop')	1.03	Steady	A&E attendances in adults is similar between ethnicity groups.
	All-cause mortality age <75 (per 100,000 pop')	1.10	Narrowing	All cause mortality under 75 is similar between ethnicity groups, differences between groups has narrowed overtime.
	CVD morbidity in adults (percent)	1.11	Steady	CVD morbidity in adults is similar between ethnicity groups.
	Diabetes morbidity in adults (percent)	2.39	Steady	Diabetes morbidity is 2.39 times higher in the Black and Asian population compared to the White population.
	Mortality within 60 days of a stroke (per 100,000 pop')	1.31	Widening	Mortality within 60 days of a stroke is 1.31 times higher in the Black and Asian population compared to the White population. The difference between groups is widening over time.
	Respiratory morbidity in adults (percent)	0.91	Steady	Respiratory morbidity in adults is similar between ethnicity groups.
	T&O Outpatient App. in adults (per 100,000 pop')	0.86	Steady	T&O outpatient appointments in adults are lower in the Black and Asian population compared to the White population.
Maternity & Child	Maternal C-section (per 100,000 pop')	1.65	Widening	Maternal C-section is 1.65 times higher in the Black and Asian population compared to the White population. This difference is widening overtime.
	Maternal post-partum haemorrhage (per 100,000 pop')	1.31	Steady	Maternal post-partum haemorrhage is 1.31 times higher in Black and Asian population compared to the White population.
	Mortality rate for infants aged 0-4 (per 100,000 pop')	9.73	Widening	Mortality rate for infants aged 0-4 is 9.73 times higher in the Black and Asian population compared to the White population. The difference between groups is widening over time.
Mental health	Alcohol related Admissions in adults (per 100,000 pop')	0.31	Widening	Alcohol related admissions are higher in the White population compared to the Black and Asian population. The difference between groups is widening over time.
	IAPT referrals in adults (per 100,000 pop')	0.91	Narrowing	IAPT referrals in adults are similar between ethnicity groups.
	NE Admissions for self-harm age 12+ (per 100,000 pop')	0.43	Widening	Non-elective admissions for self harm aged 12+ are higher in the White population compared to the Black and Asian population. The difference between ethnicity groups is widening over time.
Primary Care	Number of GPs in registered practice (per 1,000 pop')	0.95	Steady	Number of GPs in registered practice are similar between ethnicity groups.
	Number of nurses in registered practice (per 1,000 pop')	0.85	Widening	Number of nurses in registered practice is higher in the White population compared to the Black and Asian population. The difference between groups is widening over time.
	Received first dose of Covid-19 vaccine by 18/07/21 (%)	0.82	N/A	Covid vaccination rates are lower in the Black and Asian population compared to the White population.

The indicators here have been established by the National Commissioning Data Repository (NCDR) which utilises a number of different data sources from across the Healthcare system.

Alongside this data, the ICS local health inequalities dashboard was launched in July 2022. This dashboard presents key metrics aligned to the CORE20Plus5 as well as providing an inequality profile for each area of the ICS.
This information sits alongside the JSNA and other regional and national dashboards. Sub-groups have been established as part of the transformation programme to look at health gain value alongside financial value.

List of ICB Ambitions can be found on the next slide

	Higher Health Inequality in White population
	Higher Health Inequality in Black and Asian population

Data source: *calculations and metrics are from the 'Midlands Health Inequalities Dashboard' available in the 'National Commissioning Data Repository (NCDR)' developed by Arden and Gem. Data sets are obtained from SUS, IAPT, General Practice Workforce and Maternity Services Data Set.*

10.2b - Health Inequalities Dashboard – Nottingham and Nottinghamshire Health Inequalities Metrics by Deprivation

NHS Nottingham and Nottinghamshire

Health Inequalities Metrics				
		Deprivation		
Topic	Metric	RII	Trend (2017 - 2021)	Description
Cancer	Cancer morbidity in adults (percent)	0.97	Steady	Cancer morbidity in adults is similar between most and least deprived populations.
	Cancer mortality age <75 (per 100,000 pop')	2.53	Widening	Cancer mortality under 75 is 2.5 times higher in the most deprived population, and the inequality between groups has been widening over time.
Elderly persons	A&E Attendances age 75+ (per 100,000 pop')	1.86	Steady	A&E attendances over 75 are 1.86 times higher in the most deprived population.
	Hip fracture NE Admissions age 75+ (per 100,000 pop')	1.78	Widening	Hip fracture NE admissions are 1.78 times higher in the most deprived population. The difference between groups has been widening over time.
H&J Spec Com	Renal morbidity in adults (percent)	1.53	Steady	Renal morbidity in adults is higher in the most deprived areas.
Healthy people	A&E Attendances in adults (per 100,000 pop')	1.97	Widening	A&E attendances in adults is higher in more deprived areas and the inequality by deprivation has been widening over time.
	All-cause mortality age <75 (per 100,000 pop')	3.59	Widening	All-case mortality under 75 is 3.59 times greater in more deprived areas, and this inequality is widening over time.
	CVD morbidity in adults (percent)	1.64	Steady	CVD morbidity is 1.64 times greater in more higher areas.
	Diabetes morbidity in adults (percent)	2.37	Steady	Diabetes morbidity is 2.37 times higher in more deprived areas.
	Mortality within 60 days of a stroke (per 100,000 pop')	1.31	Narrowing	Mortality within 60 days of a stroke is 1.31 times higher in the most deprived areas, but the difference between areas has been narrowing over time.
	Respiratory morbidity in adults (percent)	1.76	Steady	Respiratory morbidity in adults is 1.76 times higher in the most deprived areas.
	T&O Outpatient App. in adults (per 100,000 pop')	1.04	Steady	T&O outpatient appointments are similar by deprivations
Maternity & Child	Maternal C-section (per 100,000 pop')	0.97	Steady	Maternal C-section rates are similar by deprivation.
	Maternal post-partum haemorrhage (per 100,000 pop')	0.80	Steady	Maternal post-partum haemorrhage is lower in more deprived population.
Mental health	Alcohol related Admissions in adults (per 100,000 pop')	6.26	Narrowing	Alcohol related admissions are 6.26 times higher in the most deprived populations, but this difference is narrowing over time.
	IAPT referrals in adults (per 100,000 pop')	0.88	Steady	IAPT referrals in adults are lower in more deprived areas.
	NE Admissions for self-harm age 12+ (per 100,000 pop')	3.15	Narrowing	Non-elective admissions for self harm aged 12+ are 3.15 times higher in more deprived areas. The difference between areas is narrowing over time.
Primary Care	Number of GPs in registered practice (per 1,000 pop')	0.86	Steady	Number of GPs in registered practices are higher in less deprived areas.
	Number of nurses in registered practice (per 1,000 pop')	0.94	Steady	Number of nurses in registered practice is similar by deprivation
	Received first dose of Covid-19 vaccine by 18/07/21 (%)	0.78	N/A	Covid vaccination rates are lower in more deprived areas.

Higher Health Inequality in Least Deprived population

Higher Health Inequality in Most Deprived Population

Calculations and metrics are from the 'Midlands Health Inequalities Dashboard' available in the 'National Commissioning Data Repository (NCDR)' developed by Arden and Gem. Data sets are obtained from SUS, IAPT, General Practice Workforce and Maternity Services Data Set.

10.3 Tackling Health Inequalities – The 5 in the 'Core20Plus5'

NHS Nottingham and Nottinghamshire

ICS Smoking Rates: City: 20.6% (2018) County: 14.4% (2019)

	Maternity Ensuring continuity of carer for 75% of women from BAME communities and the most deprived groups		**Severe Mental Illness (SMI)** Ensuring annual health checks for 60% of those living with SMI		**Respiratory** A clear focus on COPD driving uptake of flu, COVID and pneumonia vaccs		**Cancer** 75% of cases diagnosed at stage 1 or 2 by 2028		**Hypertension** To allow for interventions to optimise BP and minimise the risk of M.I. and stroke	
Key Stats	• Maternal mortality is more than 4x higher in black women, 2x higher for mixed ethnicity women and 2x as high for Asian women. Stillbirths and infant mortality are highest amongst Pakistani and Black ethnicities. NUH has a high percentage of BAME mothers. • A higher proportion than the national average of mothers are from the most deprived areas • 15.6% mother present as smokers at time of booking across the ICS, 12.8% self report as smokers at time of delivery - worse than the England average across every district in the ICS.		• People with a SMI on avg have 15 to 20 years shorter life expectancy • Premature mortality in adults with SMI is much higher in Nottingham than the England Average. • Smoking prevalence is 24.5% in Nottingham and 20.7% in Notts. • The ICS is targeted to undertake 6,237 SMI health checks for 2022/23. 12 month performance currently sits at 41% of this target. Although performance has increased since 2021/22, it has plateaued in Q1 2022/23, this is now similar to the regional average but slightly below national average.		• 2% of the total ICS population have a diagnosis of COPD. The highest rates are in Bassetlaw and Mid-Notts. • Nottingham City has the lowest prevalence of COPD but has higher COPD emergency hospital admissions than the rest of the ICS and is higher than the regional and national averages. • Uptake of the flu and covid vaccines is lower in the most deprived areas but also amongst BAME communities, regardless of deprivation quintile. • 33% of COPD patients across the ICS are smokers, 41% of COPD patients in Nottingham City are smokers.		• 20/21 saw an improvement with approx 30% of cancers diagnosed at an early stage. • In Nottinghamshire as whole, under 75s mortality rate from cancer is similar to the England average, however in Mansfield and Ashfield it is significantly worse. • Under 75 mortality rates from cancer in Nottingham City is also significantly worse than the England average and the worst in the East Midlands Region.		• Approximately 14.4% of the N&N population have a hypertension diagnosis. • 64.2% of expected cases have been diagnosed. Target is 80% by 2029. • 71.5% of hypertension cases are treated optimally. Target is 80% by 2029. • Hypertension is more prevalent in areas of higher deprivation in the ICS. Those from Black backgrounds are twice as likely to be diagnosed with hypertension than those from White backgrounds.	
Metrics	1. Continuity of carer for BAME communities. Target 75% by 2022/23 2. Smoking status at time of delivery. Target 6%, England average 9%. 3. Pre-term births. Target 6% by 2025.	**System Level Outcomes** SLO-16 SLO-14 SLO-04 SLO-06 SLO-07 SLO-03	1. Number of Physical health checks completed for people with SMI. Target 6,237 checks for 2022/23. 2. Covid vaccinations given to people with SMI 3. % of patients admitted to hospital under mental health offered tobacco treatment	**System Level Outcomes** SLO-01 SLO-02 SLO-10 SLO-07 SLO-12 SLO-14 SLO-19	1. Number of self management plans in place for COPD Patients 2. Number of referrals to Pulmonary Rehab & number of programmes completed 3. Covid vaccine uptake, Flu Vaccine uptake, Pneumonia vaccine uptake	**System Level Outcomes** SLO-01 SLO-02 SLO-18 SLO-10 SLO-09 SLO-11 SLO-13 SLO-07	1. Lung Health Checks	**System Level Outcomes** SLO-01 SLO-11 SLO-12	1. Expected no. of people to be diagnosed with hypertension. Target 80% by 2029 2. Patients with hypertension optimally treated. Target 80% by 2029 3. Stroke admissions	**System Level Outcomes** SLO-01 SLO-02 SLO-09 SLO-12 SLO-14
Current Attainment	1. 14.4% (3months end of Aug. 21 - Discontinued) 2. 12.8% (May 21 –May 22) 3. 7.6% (March 21 – March 22)		1. 3,435 completed June 21 – June 22 2. 1st Dose: 80.47%, 2nd Dose: 77.42%, Booster: 62.53% 3. N/A – not yet available		1. 73% Self management plans. 66% received annual review 2. 51.2% offered PR. Completion rates in City: 65% County: 65% 3. C: 71.2% (BAME communities low), F: 57.9%, Pn: City: 70.3% / County: 74.2%		1. N/A – Data not yet available		1. 64.2% 2. 71.5% 3. N/A – Data not yet available	

Impact on the CORE20Plus5: Smoking

England Average Smoking Rates 12.1%, Nottinghamshire: 11.4%, Nottingham City 13.4%

Smoking is the leading risk factor for ill health in Nottingham City and the second in Nottinghamshire County.
Annually smoking causes approx. 11,492 hospital admissions and 4,540 premature deaths across the ICS.
The cost of smoking to the NHS and social care each year is millions locally and £2.4b nationally.

Area	Smoking Status (2020)
Mansfield	21.40%
Gedling	14.20%
City	13.40%
Broxtowe	12.60%
Newark & Sherwood	10%
Ashfield	9%
Bassetlaw	8.30%
Rushcliffe	5.30%

What the ICS is doing:

LTP Projects for opt out smoking cessation in in-patient, maternity and mental health pathways in Trusts are being implemented across the ICS.

Mid-Notts PBP have also trialled inpatient smoking cessation services in line with the LTP, offering financial incentives for pregnant smokers.

NHS Staff Smoking Cessation pilot is underway.

10 PCN projects make reference to reducing smoking rates, improving cessation uptake and impacting smoking related illnesses and affected population groups.

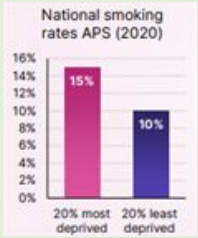
Bassetlaw PBP are working in partnership with the QUIT programme which aims to offer stop smoking support to everyone seeking treatment at 8 trusts across South Yorkshire & Bassetlaw.
Exploration of Advanced Community Pharmacy Schemes is underway, linking to maternity pathways, mental health pathways and in patients (as per the LTP).

The Core20: Higher smoking rates in the most drives inequality in life expectancy and increases NHS Pressures.

Mansfield has the 4th Highest smoking rates in the country (21.4%) and is within the 20% most deprived districts nationally.

Around 23% of people in manual and routine occupation smoke across the ICS. Smoking rates are also higher in those who are unemployed or have lower educational attainment.

Across England those in the 20% most deprived have higher hospital admissions and higher mortality than the least deprived areas.



Plus Populations: The most deprived groups have the highest smoking rates

Nationally:
Homeless populations smoking rates are around 77%.
80% of people entering prison are smokers.
22% of 11-16 yr olds with a mental illness are smokers.
26% of those in social housing smoke
Those from LGBT+ groups have higher smoking rates
Across the ICS:
75% of those entering treatment for opioid addiction and 51% of those entering alcohol addiction smoke.
Mixed and White ethnicities have higher smoking rates.

Maternity	Severe Mental Illness	Respiratory	Early Cancer Diagnosis	Hypertension
Smoking status at time of delivery is similar across the whole ICS with an average rate of 13.7%. Rates are worse than the England average across every district in the ICS. Smoking during pregnancy can increase risk of poor birth outcomes and infant mortality.	Smoking prevalence in people with SMI is 24.5% in Nottingham and 20.7% in Nottinghamshire. Smoking is one of the leading causes of the 10-15 year life expectancy gap in people with SMI.	Current smokers are 15x more likely to be diagnosed with COPD. 33% of people with COPD are smokers, the highest rates are in the most deprived areas. Smoking has a negative impact on the management of respiratory conditions.	Smoking is linked to cause of at least 15 types of cancer. Smoking causes more than 7 in 10 lung cancer cases. Lung cancer is the most common cause of cancer death in the UK and is a cancer frequently diagnosed at a later stage. Around 669 people a year in the ICS die of cancer caused by smoking	Smoking can negatively impact on people with high blood pressure, increasing the risk of heart and lung problems. Around 11% of people with hypertension in the ICS are current smokers. 221 people a year die of CVD caused by smoking.

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Appendices

i – ICS Assurance Escalation Framework

ii - Key to Variation and Assurance Icons (SPC)

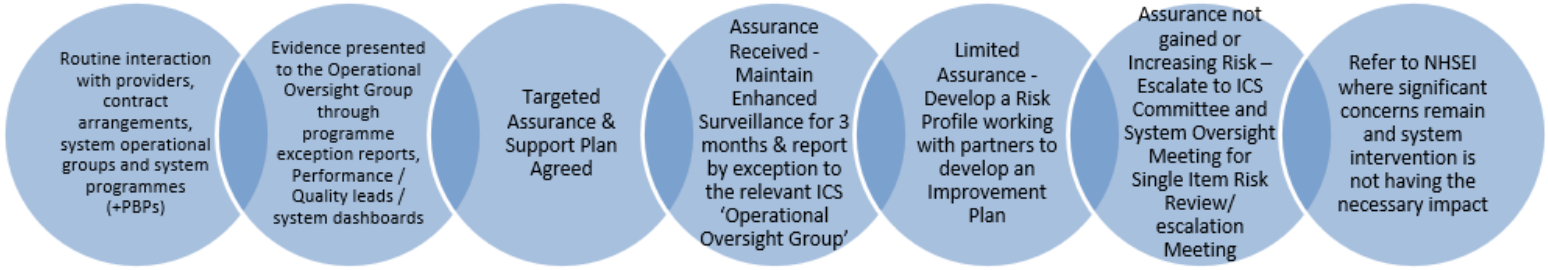
iii - Glossary of Terms

i – ICS Assurance Escalation Framework

Each key deliverable programme or oversight group will propose a level of assurance, aligned to **the assurance 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:

Significant Assurance	Partial Assurance	Limited Assurance	No Assurance
1. Routine	2. Further Information Required	3. Enhanced	4. Escalated Risk
What does this mean? What is the assessment of risks to delivery / quality			
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 actions may be taken by the relevant 'Operational Oversight Group' in response to this assessment			
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 are resolved	Trigger Escalation Review/ Deep Dive / Risk Summit

Evidence Based Assurance Process



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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	NHSE	NHS England	SLA	Service Level Agreement
A&E	Accident & Emergency Delivery Board	FOT	Forecast Out-Turn	NHT / NHC	Nottinghamshire Healthcare NHS Trust	SMI	Severe Mental Illness
AMH	Anit-Mullerian Hormone	G&A	General & Acute	NICE	National Institute for Health & Care Excellence	SOF	System Oversight Framework
BAU	Business as Usual	GI	Gastro-intestinal (referred to as Upper GI or Lower GI)	NNICB	Nottingham & Nottinghamshire ICB	SOP	Standard Operating Procedure
Blaw	Bassetlaw	HEE	Health Education England	NRC	National Rehabilitation Centre	SPC	Statistical Process Control
BLM	Back-log Maintenance	HFID	Hospital First Integrated Discharge	NUH	Nottingham University Hospitals	SRO	Senior Responsible Officer
CAMHS	Child & Adolescent Mental Health Services	HLE	Healthy Life Expectancy	OAPs	Out of Area Placements	TIF	Targeted Investment Fund
CCG	Clinical Commissioning Group	IAPT	Improving Access to Psychological Therapies	OBD	Occupied Bed Days	UEC	Urgent & Emergency Care
CDC	Community Diagnostic Centre	IBN	Information Breach Notice	OOA	Out of Area	UTC	Urgent Treatment Centre
CDEL	Capital Departmental Expenditure Limits	ICATT	Intensive Community Assessment & Treatment Teams	OP	Out Patients	WTE	Whole Time Equivalents
CDU	Clinical Decision Making Unit	ICB	Integrated Care Board	PBP	Place Based Partnerships	YOC	Year of Care
CHC	Continuing Health Care	ICP	Integrated Care Partnership	PCIT	Primary Care Information Technology	YTD	Year to Date
CoP	Court of Protection	ICS	Integrated Care System	PCN	Primary Care Networks		
CT	Computed Tomography	IPC	Infection prevention control	PFDS	Public Facing Digital Services		
CV	Contract Variation	IR	Identification Rules	PFI	Private Finance Initiative		
CYP	Children & Younger People	IS	Independent Sector	PHM	Population Health Management		
D2A	Discharge to Assess	JSNA	Joint Strategic Needs Assessment	PHSMI	Physical Health check for Severe Mental Ill patients		
DC	Day Case	KMH	Kings Mill Hospital	PICU	Psychiatric Intensive Care Unit		
DDAT	Digital, Data, Analytics and Technology	LD	Learning Disabilities	PID	Project Initiation Document		
DHSC	Department of Health and Social Care	LD&A	Learning Disabilities & Autism	PIFU	Patient Initiated Follow Ups		
DST	Decision Support Tool	LINAC	Linear Accelerator	POD	Prescription Ordering Direct		
DTT	Diagnosis to Treatment Time	LoS	Length of Stay	PoD	Point of Delivery		
EBUS	Endobronchial Ultrasound	MHIS	Mental Health Investment Standard	PTL	Patient Targeted List		
ED	Emergency Department	MHST	Mental Health Support Team	QDCU	Queens Day Case Unit		
EIP	Early Intervention Psychosis	MNR	Maternity & Neonatal Redesign	QMC	Queens Medical Centre		
EL	Electives	MOU	Memorandum of Understanding	R&D	Research & Development		
EMAS	East Midlands Ambulance Service NHS Trust	MRI	Magnetic Resonance Imaging	R&I	Research & Innovation		
EMCA	East Midlands Cancer Alliance	MSFT	Medically Safe for Transfer	RAG	Red, Amber & Green		
EMNNODN	East Midlands Neonatal Operational Delivery Network	N&N	Nottingham & Nottinghamshire	RTT	Referral to Treatment Times		
EOL	End of Life	NEL	Non-Electives	SDMF	Strategic Decision Making Framework		
ERF	Elective Recovery Funding	NEMS	Nottinghamshire Emergency Medical Services	SEG	System Executive Group		
ESRF	Elective Services Recovery Funding	NHP	New Hospitals Programme	SFH	Sherwood Forest Hospitals Foundation Trust		

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Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/01/2023
Paper Title:	**Committee Highlight Reports**
Paper Reference:	ICB 22 058
Report Author:	Committee Secretariat
Report Sponsor:	Chairs of the ICB's Committees
Presenter:	Chairs of the ICB's Committees
Recommendation(s):	The Board is asked to **NOTE** the report.

Summary:

This report presents an overview of the work of the Board's committees since its last meeting in November 2022. 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. 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. All ICB committees have a responsibility to oversee risks relating to their remit, ensuring that their discussions are reflective of the risks identified and that robust management actions are being taken in response. As such, all committee meetings have risk as a standing agenda item.

The minutes of Committee meetings will be published on the ICB's website once ratified.

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

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

Levels of assurance:	
Substantial Assurance	Reports received by the committees highlighted robust controls, designed to address the relevant risks with controls being consistently applied. Highly unlikely to impair the achievement of strategic objectives and system priorities. No remedial action required.
Reasonable Assurance	Reports received by the committees did not highlight any material weaknesses in control and risks identified can be managed effectively. Unlikely to impair the achievement of strategic objectives and system priorities. Minor remedial action is required.
Partial Assurance	Reports received by the committees highlighted some material weaknesses in control that could present material risks to the achievement of system objectives and system priorities. Some moderate remedial action is required.
Limited Assurance	Reports received by the committees highlighted significant material weaknesses in control and/or material risks to the achievement of strategic objectives and system priorities. Immediate and fundamental remedial action is required.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	Yes
Duty to promote innovation	Yes
Duty in respect of research	Yes
Duty to promote education and training	Yes
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	Yes
Duties as to climate change	Yes
Duties regarding public involvement and consultation	Yes
Public sector equalities duties	Yes

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Appendix A: Strategic Planning and Integration Committee Highlight Report

Meeting Dates:	**01 December 2022**
Committee Chair:	**Jon Towler, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance
1. Joint Forward Plan	An update was provided on progress with development of the Joint Forward Plan (JFP). The plan is an NHS England (NHSE) requirement to be published by March 2023. Discussion focused on the duty to consult on the JFP with its population and Health and Wellbeing Boards and the need for sight of the communications and engagement plan. Final guidance on the JFP had not been received from NHSE at the time of the meeting. Members acknowledged the significant amount of work required to develop the JFP within the timeframe. The Committee will receive further monthly updates as the JFP develops.	**Partial**
2. NHS England Delegation of Pharmacy, Optometry and Dental (POD) Services and Specialised Services	A report on progress with the delegation of POD services (from April 2023) and Specialised Commissioning Services (from April 2024) was received. The Pre-Delegation Assessment Framework (PDAF) for POD services has been signed off by NHSE at both a regional and national level for the East Midlands ICBs. The PDAF for specialised services has been signed off by the regional NHSE team and submitted for national moderation, the outcome of which is awaited. For the POD services delegation, there remains significant work to undertake in relation to governance and financial alignment and discussion continues regarding hosting arrangements and understanding the impact of delegation at ICB and Place/ Primary Care Network level.	**Partial**

Other considerations:

Decisions made:
The Committee approved funding of £700k for 12 months for the ICS Anticipatory Care Primary Care Network (PCN) Pilots. Anticipatory Care is the newest priority in terms of the Ageing Well Programme. The Ageing Well Anticipatory Care Framework aims to provide proactive, and personalised health and care for individuals living with multimorbidity and/or frailty at home who would benefit most from multidisciplinary interventions provided in their local community. Five Primary Care Networks (PCNs) have volunteered to be pilot sites.
Matters of interest:
The Committee also: • Discussed strategic commissioning proposals in relation to locked rehabilitation services. • Reviewed the options appraisal process for the Tomorrow's NUH (TNUH) Programme, with further information on this to be presented in January. • Received a highlight report from the Primary Care Contracting Sub-Committee noting their support for the establishment of an ICS Primary Care Transformation Group to provide an operational/delivery oversight forum. The report also highlighted the change in emphasis following recent CQC inspections in primary care resulting in a national decline in CQC ratings. Local action will include analysis to predict the practices most likely to be scheduled for an inspection, with support targeted. CQC inspection preparation will also be a focus at the Local Medical Committee (LMC) conference in February 2023.

Appendix B: Quality and People Committee Highlight Report

Meeting Dates:	**16 November 2022**
Committee Chair:	**Marios Adamou, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance
1. System Quality Assurance Reports and Nursing and Quality Statutory Duties Report	The System Quality Report included the dashboard, which continues to develop, and early sight of quality risk profiles. The report provided a high-level summary of system issues, risks/mitigations and improvements across the system. Future reports to the Committee will be in the form of a system quality assurance highlight report from the Partner Quality Assurance and Improvement Group (PQAIG). Nottingham University Hospitals NHS Trust (NUH) continues to be subject to intensive surveillance and Nottinghamshire Healthcare NHS Foundation Trust (NHT) remains under enhanced surveillance. Sherwood Forest Hospitals NHS Foundation Trust and CityCare are subject to routine surveillance. The system quality dashboard is progressing and there is now good confidence levels in terms of some of the metrics reported, although others require further work. Data sharing across organisations was a focus for discussion. System wide workforce issues were highlighted as a particular risk, specifically, the ability to recruit and retain staff in the care sector. Members discussed the impact this is having on flow through the acute settings and the management of winter pressures. The Nursing and Quality Statutory Duties Report provided assurance in relation to the quarter two position in respect of the ICB's statutory duties in relation to quality. The report format continues to develop and the following key areas of focus were highlighted:	Partial

Item	Summary	Level of assurance
	• Specialist providers are consistently unable to deliver against the 20-day time frame for Looked After Children initial health assessments. • Special Education Needs and/or Disabilities (SEND) responsibilities, specifically completion of Education Health and Care Plans (EHCPs) within the 20-week statutory timescale and completion of EHCP annual reviews are not being achieved. • Continuing healthcare (CHC) reviews are off track and contributing to an increasing financial deficit. • Challenges in achieving the national Healthcare Associated Infections (HCAIs) targets across the system are being reported. • There are increasing back logs of serious incidents requiring review and sign off by the ICB. Alongside this a new approach to serious incidents is underway with the implementation of the Patient Safety Incident Response Framework (PSIRF). Members noted the limited availability of recent data for looked after children and raised concern regarding performance in this area. Members were advised that the position has been escalated and an action plan/recovery plan is under development and will be covered in the statutory duties report to the committee in January 2023. Members noted that Liberty Protection Safeguards (LPS) will become a capacity risk when it comes online at a future date and the implementation of PSIRF is considered a risk given the backlog of serious incidents. The evolving nature of the report was noted and it was agreed that progress of actions will be documented in future reports.	
2. Children at the Heart of Improvement, City Safeguarding Children's Work and System Quality Strategy Delivery Plan 2022/23	Members were informed that Ofsted carried out an inspection of children's services across Nottingham City Council in July 2022. Their report, published in September 2022, deemed Nottingham City Council to be 'Inadequate' with seven key areas of concern identified. Nottingham City Council has developed and action plan with partners (including the ICB) detailing their responses and timelines to address the issues identified. The improvement plan will be monitored via the Children at the Heart	**Reasonable**

Item	Summary	Level of assurance
	of Improvement Board, which has an independent chair selected by the Department of Education. Following the launch of the Nottingham and Nottinghamshire System Quality Strategy 2022/23 in July 2022, a Delivery Plan has been co-developed with system partners against the ICS strategic quality priorities. The Delivery Plan outlines how these priorities will be delivered during the 2022/23 financial year. The Strategy aligns with the refreshed National Quality Board (NQB) shared commitment to quality and represents the first phase of transition to a quality governance framework. A progress report will be provided in March 2023.	
3. People and Culture: Workforce Challenges and Actions	The report continues to evolve, reflecting the newness of the ICB's responsibilities in this area and the prolonged period of pressure on the health and social care workforce. The November report began to articulate the workforce elements that are coming together to develop a system approach e.g. connectivity around actions on recruitment, retention, wellbeing and career development. Detail was provided of key actions agreed by the system to address workforce issues. The actions were defined within six-week, six-month and 18-month timeframes and are set against the ten outcome-based people functions. An immediate priority is to plan for impending industrial action. The workforce plan for 2022/23 recognised risks around having sufficient capacity to deliver services, the key one being national shortages across a range of professional roles, particularly nursing and midwifery and the significant challenge in the home care market. Members welcomed the actions presented by time frame and focused discussion on outcomes and added value, highlighting the need for further assurance regarding progress and meeting outcomes. Primary care workforce data was spotlighted as an area for future development. Members asked for a workforce heatmap to be developed to include the four ICB aims, ten workforce outcomes and actions identified to achieve them.	**Partial**

Other considerations:

Decisions made:
No items were presented for approval at the November 2022 meeting.
Matters of interest:
The Committee received a presentation on the system organisational development (OD) and culture approach. The principles for OD, culture, talent and improvement were shared along with recommendations for action. Next steps include the development of a system OD plan, a system wide leadership development offer, alongside other developments to address training and education, equality, diversity and inclusion and capability and capacity. Nottingham and Nottinghamshire are to be the second test system for the NHS Primary Care staff survey, the results of which will provide a greater insight for incorporation in the development of plans and targeting of resources. Members highlighted the need for greater citizen engagement in plans and the development of civic partnerships/integrated neighbourhood teams. The ambition was described as ‘creating an environment in Nottingham and Nottinghamshire which people are proud to work in’. When reviewing the Operational Risk Register (ORR) relevant to the Committee’s remit, members identified a further risk in relation to looked after children and Special Education Needs and/or Disabilities (SEND) for inclusion in the ORR.

Appendix C: Finance and Performance Committee Highlight Report

Meeting Dates:	**30 November 2022**
Committee Chair:	**Stephen Jackson, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance
1. Service Delivery Performance Report	Members welcomed a refreshed version of the report, which included a one-page summary of the main issues faced for the reporting period. Discussion centred around waiting lists and Length of Stay and the actions being taken within the system to reduce these. A significant system effort had reduced the 78- and 104-week waiting lists down and learning from this work was being applied to other areas. Discussion focused on what support the Committee, and wider ICB, could provide the system during operational planning. As the underlying patient waiting list was likely to continue to grow, members were cautious that this must be carefully considered during operational planning rounds for 2023/24.	**Partial**
2. Planned Care Focused Review	As per actions agreed at the October Committee meeting, further work had been undertaken to improve the Service Delivery Performance report to enable the Committee to discharge its responsibilities regarding performance oversight and to provide onward assurance to the Board. Part of this work involved introducing a rota of 'deep dives' into poorly performing areas within the Service Delivery Performance Report. The Planned Care Focused Review was the first of these to be presented to the Committee. It provided an overview of the governance, oversight, and operational arrangements in place across the planned care programme, as well as further detail in relation to performance risks and mitigating actions being taken across the system to address current risks. The report also included a mapping document which outlined reporting arrangements for performance within the Integrated Care System, which members found informative.	**Reasonable**

Item	Summary	Level of assurance
3. System Finance Report	The report included detailed analysis of the financial performance for the system for month seven, a worsening position from month six. Key drivers of the position were urgent care capacity and subsequent costs over and above those defined in the plan, Covid-19 costs, community diagnostic hub funding shortfall, continuing healthcare (CHC) spend and efficiency shortfalls. A discussion took place regarding the protocols that organisations would be required to follow, as set out by NHS England, should a change be required to be made to in-year revenue financial forecast. Focused pieces of work were underway to determine any underlying issues which had caused Nottingham University Hospitals NHS Trust (NUH) to be an outlier of Covid-19 spend in the system.	Partial
4. ICB Finance Report	The ICB financial position for month four of its operation was presented. The ICB was working towards a breakeven plan for the full financial year, which combined the position of the former Clinical Commissioning Groups (CCGs) and the ICB. The key areas of pressure were continuing healthcare (CHC) and interim beds costs. Offsetting these overspending areas was an underspend in primary care, as well as a surplus in reserves which represented an over delivery of efficiency targets mainly relating to slippage on spend. A focused piece of work was ongoing to determine the base levels of ICB staff since its establishment.	Partial

Other considerations:

Decisions made:
The Committee approved the expansion of the Jubilee Medical Partnership at the Lowdham Medical Centre. The move would increase capacity at the Centre, allowing the Practice to offer a wider range of services.

Matters of interest:
The Committee received an introductory overview of the ICS Digital Landscape. The overview was brief and high level, covering the responsibilities of the ICS in relation to digital services. An action was agreed for the Committee to receive and Information Management and Technology assurance report in early 2023. The Committee received an update on the actions being taken by the ICB in preparation of the anticipated operational planning guidance. Guidance, including financial allocations, is expected to be published in December 2022, and it is anticipated that this will require submission of interim operational plans in February 2023 and final operational plans in April 2023. The Committee received an update in relation to the System Capital Resource Plan which was approved by the ICB Board at its September 2022 meeting. The update outlined changes to the plan since then, namely, to funding and expenditure of the Community Diagnostic Centre Programme.

Appendix D: Audit and Risk Committee Highlight Report

Meeting Dates:	**17 November 2022**
Committee Chair:	**Caroline Maley, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance
1. Emergency Preparedness, Resilience and Response (EPRR) and ICB Core Standards Assurance	The Committee received an update on this year's activities in relation to Emergency Preparedness Resilience and Response (EPRR) and the ICB's compliance with core standards. On establishment, the ICB became a Category One responder, with the requirement to meet the full responsibilities of the Civil Contingencies Act 2004. As the former CCGs had been Category Two responders, additional work has been required to meet the national core EPRR standards, and an action plan has been put in place to move the ICB towards compliance. Areas of partial compliance were examined, and the Committee was assured by progress to date, with further updates to be provided to a future meeting.	**Partial**
2. Health and Safety Assurance Report	An assurance report on the embedment of arrangements across the ICB to meet health and safety requirements was received by the Committee. As the ICB is classified as a 'low risk' organisation, with staff being predominantly office or home based, focus in this area related to the health, safety, and welfare of its workforce. Members considered the governance in this area to be proportionate to the level of risk and gave a rating of substantial assurance.	**Substantial**
3. Statutory and Mandatory Training Compliance	The Committee reviewed ICB's current statutory and mandatory training compliance figures and the processes in place to monitor and improve compliance rates. Whilst overall compliance was high, there were pockets where compliance was relatively low and members urged the ICB to ensure full compliance with statutory and mandatory training requirements and asked the ICB's Executive Team to lead by example. The	**Reasonable**

Item	Summary	Level of assurance
	Committee was assured there were robust processes in place to monitor training compliance.	
4. Use of Emergency Powers	The Committee reviewed the one urgent decision that had been undertaken since the last meeting using emergency powers, as set out in the ICB's Standing Orders or committee terms of reference and considered it to have been appropriate.	**Substantial**
5. Procurement Card Usage	Members were assured of the continuing focus to ensure that the use of the ICB's procurement card was appropriate.	**Substantial**
6. Information Governance Assurance Report	The Committee received an assurance report in relation to the arrangements established within the ICB to ensure compliance with the requirements of the Data Security and Protection Toolkit. Members were assured there were robust processes in place to ensure that the ICB would meet all requirements by the 30 June 2023 submission date.	**Reasonable**

Other considerations:

Decisions made:
The Committee approved an amendment to the Internal Audit Plan for 2022/23 to utilise ten days from contingency to undertake a review on the integrity of the ICB's general ledger, as discussed at the previous meeting.
Matters of interest:
• Members noted key findings of the NHS England-mandated HfMA Sustainability Audit self-assessment, which had been conducted during September; and noted actions to address the one identified area, cost improvement/efficiency, which required action planning. A system working group is being established to bring together outputs and propose system actions for areas scoring level three or under. • Members received an update on progress of the Internal Audit Plan 2022/23, which included the issuing of terms of reference for five reviews and the commencement of the Stage One Head of Internal Opinion. Members also received a report on the proposed External Audit timeline.

- Following on from discussions at the previous meeting and the presentation of the Board Assurance Framework to the Board at its meeting on 10 November 2022, members received a report detailing the roles and responsibilities in relation to the Framework and noted the timetable for the Targeted Assurance Reports to the Committee.

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

Risk Ref.	Risk Description	Current Score	Responsible Committee
ORR 42	If levels of demand continue to outstrip urgent and emergency care capacity, this is likely to result in increased Ambulance handover delays, overcrowding within Accident and Emergency Departments and extended lengths of stay in inappropriate health care settings.	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee
ORR 43	Lack of capacity across care homes and home care provision may adversely impact system partners' ability to promptly discharge patients from Acute and Community settings.	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee
ORR 02	Increasing levels of demand on healthcare services, combined with capacity constraints across providers, may widen health inequalities across the population of Nottingham and Nottinghamshire. This risk relates to both elective and non-elective care.	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee / Quality and People Committee
ORR 69	If the system do not have sufficient workforce to supply high-quality maternity services at across the three NHS providers, there is a risk that the quality of maternity services will deteriorate for the population of Nottingham and Nottinghamshire. This may, in turn, result in poor patient experience, adverse clinical outcomes and/or patient safety issues for women and their families.	**Extreme** 25 (I5 x L5)	Quality and People Committee
ORR 06	If actual harm continues to occur across the non-elective (emergency) pathway, due to the current levels of demand and capacity constraints, staff may be demoralised and leave the service. Further reduction in workforce may lead to worsening healthcare outcomes, increased ambulance response times/handover delays, extended waits within ED (front door) and delays to discharge (back door).	**High** 20 (I4 x L5)	Quality and People Committee

Risk Ref.	Risk Description	Current Score	Responsible Committee
ORR 24	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 may deteriorate. This may lead to poor patient experience, adverse clinical outcomes and/or patient safety issues for the population of Nottingham and Nottinghamshire.	**High** 20 (I4 x L5)	Quality and People Committee
ORR 41	Workforce capacity issues across the Nottingham and Nottinghamshire system health and care partners may present a significant risk to the delivery of urgent and emergency care to the population of Nottingham and Nottinghamshire. This includes, but is not limited to, workforce shortages in relation to medical and nursing staff (acute and community); social care staff (adult and children's); and the home care workforce.	**High** 20 (I5 x L4)	Quality and People Committee
ORR 03	Sustained levels of significant pressure on primary care workforce presents a potential risk in relation to primary care staff resilience, exhaustion and 'burn out'.	**High** 16 (I4 x L4)	Quality and People Committee
ORR 04	If elective activity is reduced due to capacity constraints and non-elective demand, there is a significant risk that planned care waiting times will continue to increase which may lead to poor patient outcomes and/or experiences. This includes cancer treatments, diagnostics and other key specialties.	**High** 16 (I4 x L4)	Quality and People Committee
ORR 05	If mental health activity reduces due to capacity constraints, there is potential risk of increased mental health waiting times, leading to poor patient experience and outcomes. There is an increased risk to children and young people given the level of demand for this particular demographic.	**High** 16 (I4 x L4)	Quality and People Committee
ORR 22	If Nottinghamshire Healthcare NHS Foundation Trust (NHCT) do not have the capacity to make improvements in a timely manner (following CQC visits), the quality of mental health and community services may deteriorate.	**High** 16 (I4 x L4)	Quality and People Committee

Risk Ref.	Risk Description	Current Score	Responsible Committee
	This may lead to poor patient experience, adverse clinical outcomes and/or patient safety issues for the population of Nottingham and Nottinghamshire.		
ORR 26	If there continues to be adverse national and local media reports, there may be lack of public confidence in accessing appropriate services in a timely manner. This may, in turn, result in increased demand for urgent and emergency services.	**High** 16 (I4 x L4)	Quality and People Committee
ORR 44	Sustained levels of significant pressure on health and social care workforce presents a significant risk of moral injury, staff sickness, exhaustion and 'burn out'. This, in turn, may adversely impact workforce retention.	**High** 16 (I4 x L4)	Quality and People Committee
ORR 49	If there is inadequate capacity of workforce to supply theatres across the system, fewer procedures may be undertaken. This could lead to further increased waits for planned care, poor patient outcomes and/or experience.	**High** 16 (I4 x L4)	Quality and People Committee
ORR 51	If staffing levels are reduced due to workforce industrial action, this may result in significant risk to the delivery of services across the system.	**High** 16 (I4 x L4)	Quality and People Committee
ORR 53	If the flow of patients who are medically safety for transfer does not improve due to issues around the discharge pathway, this may result in increased lengths of stay, leading to patient harm (deconditioning, exposure to infection, social isolation) and continued pressure on access to secondary care.	**High** 16 (I4 x L4)	Quality and People Committee
ORR 15	Over-reliance on non-recurrent (one-off) funds / mitigations by the ICB to temporarily offset recurring (year on year) pressures may result in continued deterioration in the ICB’s recurrent underlying financial position for 2022/23.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR 16	If Nottingham and Nottinghamshire Integrated Care System (ICS) do not, as a collective, meet the year-end position outlined with the 2022/23 financial plan, there is risk that the system will come under further regulation by NHS England.	**High** 16 (I4 x L4)	Finance and Performance Committee

Risk Ref.	Risk Description	Current Score	Responsible Committee
	As well as potential reputational risks for the ICS, this may significantly impact the extent to which the system is able to create financial 'headroom' to focus on the transformation of services.		
ORR 45	Non-delivery of the financial efficiency programme presents a significant risk to the delivery of the 2022/23 system financial position.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR 47	Increasing levels of COVID may present a risk to the delivery of the 2022/23 system financial plan.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR 58	Over-reliance on non-recurrent mitigations to manage the system's 2022/23 financial position may result in continued deterioration in the system's underlying financial position (UDL).	**High** 16 (I4 x L4)	Finance and Performance Committee