NHS
Nottingham and Nottinghamshire

Integrated Care Board Meeting Agenda (Open Session)

Thursday 09 March 2023 09:00 – 11:05

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

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

Principles:

- We will work with, and put the needs of, our **people** 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: 12 January 2023	Kathy McLean	Paper	-
5.	Action log and matters arising from the meeting held on: 12 January 2023	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.	Bassetlaw Place-Based Partnership Report *(This item will be introduced with a citizen story)*	Victoria McGregor-Riley David Armiger Andria Birch	Paper	09:25
9.	Strategic approach to transforming health and care within community services	Victoria McGregor-Riley	Paper	09:50
10.	ICS Green Plan: Strategic Progress Update	Lindsey Sutherland	Paper	10:10

Assurance and system oversight

11.	Integrated Performance Report		Paper	10:25
	a) Finance	Stuart Poynor		
	b) Service Delivery	Victoria McGregor-Riley		
	c) Health Inequalities	Dave Briggs		
	d) Quality	Rosa Waddingham		
	e) Workforce	Rosa Waddingham		
12.	Committee Highlight Reports		Paper	10:50
	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

13.	Risks identified during the course of the meeting	Kathy McLean	Verbal	11:05
14.	Questions from the public relating to items on the agenda	Kathy McLean	Verbal	-
15.	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: 11 May 2023 at 9:00 (Arnold Civic Centre)

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/03/2023
Paper Title:	**Declaration and management of interests**
Paper Reference:	ICB 22 064
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 **note** 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.

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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.
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.
MAJID, Ifti	Mental Health Partner Member	NHS Confederation: BME Leaders Network	Chair		✓			07/12/2022	Present	This interest will be kept under review and specific actions determined as required.
MAJID, Ifti	Mental Health Partner Member	NHS Confederation: Mental Health Network	Board Member and Trustee		✓			07/12/2022	Present	This interest will be kept under review and specific actions determined as required.
MAJID, Ifti	Mental Health Partner Member	Ellern Mede - provider of high intensity children and young people's eating disorder services	Spouse is Managing Director				✓	07/12/2022	Present	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.

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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
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

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
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:										
HUBBER, Lucy	Director of Public Health, Nottingham City Council	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
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.

Appendix B

NHS
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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
12/01/2023 09:00-11:30
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
Ifti Majid	NHS Trust/ Foundation Trust Partner Member
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
Mel Barrett	Executive Lead, Nottingham City Place Based Partnership (item ICB 22 053)
Rich Brady	Programme Director, Nottingham City Place Based Partnership (item ICB 22 053)
Amanda Chambers	Greenspace Programme Manager (item ICB 22 054)
Andrew Fearn	Interim Digital Senior Responsible Officer (item ICB 22 056)
Lucy Hubber	Director of Public Health, Nottingham City Council (Public Health Representative)
Dr Hugh Porter	Clinical Director, Nottingham City Place Based Partnership (item ICB 22 053)
Shannon Wilkie	Corporate Governance Officer (minutes)

Cumulative Record of Members' Attendance (2022/23)

Name	Possible	Actual	Name	Possible	Actual
Kathy McLean	4	4	Caroline Maley	4	3
Marios Adamou	4	4	Stuart Poynor	4	4
John Brewin	1	0	Paul Robinson	4	3
Dave Briggs	4	4	Amanda Sullivan	4	4
Lucy Dadge	4	4	Jon Towler	4	4

Name	Possible	Actual	Name	Possible	Actual
Stephen Jackson	4	4	Catherine Underwood	4	3
Kelvin Lim	4	2	Rosa Waddingham	4	4
Ifti Majid	1	1	Melanie Williams	4	4

Introductory items

ICB 22 046 **Welcome, introductions and apologies**

Kathy McLean welcomed members to the meeting of the Board; a particular welcome was extended to Ifti Majid who had joined the Board's membership as NHS Trust/ Foundation Trust Partner Member to bring knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

Also welcomed was Lucy Hubber who will be attending the Board's meetings moving forward in an advisory capacity. It was explained this advisory role will rotate on an annual basis between the two Local Authority Directors of Public Health, with contributions to Board discussions being that of public health expertise, rather than as representatives of specific organisations or populations.

A round of introductions was undertaken and there were no apologies for absence.

ICB 22 047 **Confirmation of quoracy**

The meeting was confirmed as quorate.

ICB 22 048 **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 22 049 **Minutes from the meeting held on: 10 November 2022**

The minutes were agreed as an accurate record of the discussions held. Members noted that colleagues from 360 Assurance, the ICB's internal audit provider, had observed the November 2022 Board meeting.

ICB 22 050 **Action log and matters arising from the meeting held on: 10 November 2022**

All actions from the last meeting were confirmed as complete.

Leadership

ICB 22 051 **Chair's Report**

Kathy McLean presented the item and highlighted the following points:

a) Entering the sixth month of the Integrated Care Board's (ICB) existence and moving towards the end of the financial year, the opportunity had been taken to reflect on the ambitions of the system and the progress made since the ICB's establishment. The dedicated work of teams across the system and within the ICB itself was commended in responding to the increasing pressures on urgent and emergency care, which had resulted in recent critical incidents being called within the system.

b) A key area of focus for 2023 would be driving strategic ambitions and transformation plans. With strong foundations set in the ICB's first sixth months, attention would shift in 2023 to delivery through collaboration and integration.

c) The Integrated Care Partnership (ICP) had been established as the statutory committee jointly formed between the ICB and the two upper-tier local authorities. The ICP's focus of recent months had been the development of the Integrated Care Strategy, which had been signed-off in its initial form on 16 December 2022. This strategy would be treated as the starting point for all that must be done for the Nottingham and Nottinghamshire patient population. It set out actions to be taken in line with the four key 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).

The Board **noted** the Chair's Report.

At this point, Dave Briggs joined the meeting.

ICB 22 052 **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-19 infections, staff absence and vacancies. A critical incident had been declared on 19 December and was in place until 23

December. A further critical incident was declared on 29 December and was still in place at the time of the meeting. This was to maintain safe services for patients and to manage emergency care services.

b) As a result of the ongoing dispute between Trade Unions representing NHS staff and the Government over the 2022/23 pay award, industrial action had taken place during December 2022. Members of the Royal College of Nursing took industrial action on 15 and 20 December and members of GMB, Unite and Unison (ambulance staff) took action on 21 December, with GMB taking further action on 28 December. Planned surgery and outpatients' appointments were affected. Further industrial action for ambulance staff would take place in January 2023. A system response plan and associated structure had been developed combining input from people, operational and emergency preparedness resilience and response leads at the System Control Centre to ensure essential services were maintained. The Board was asked to consider and approve the plan.

c) The closure of the remaining dedicated vaccination centres took place on 30 December 2022. Since establishment in December 2020, the vaccination programme had delivered nearly three million vaccinations across Nottingham and Nottinghamshire. Moving forward, eligible members of the public would be able to access Covid-19 vaccinations at a number of Pharmacy and GP locations across the City and County.

d) NHS England had released its Priorities and Operational Planning Guidance for 2023/24 containing objectives which aligned to the three key objectives during 2023 (recovering core services and productivity, delivering key ambitions in the NHS Long Term Plan and transforming the NHS for the future).

e) Utilising the NHS England Targeted Investment Fund, Sherwood Forest Hospitals NHS Foundation Trust had finalised plans to expand operating theatres at Newark Hospital. This would create extra capacity in elective care for urology and ear nose and throat surgery. These areas had the largest patient backlogs at the time of reporting. An extra 2,600 procedures were expected to take place each year as a result of the expansion.

f) The Department of Health and Social Care had announced that an independent review of ICSs would be undertaken. The review would consider and make recommendations on the role of the Care Quality Commission (CQC), the scope of targets that ICBs should

be held accountable for and how to empower local leaders to focus on improving outcomes at a population level.

g) Findings from a recent local survey on racism and discrimination in primary care would be used to feed into the development of an anti-racism strategy for the ICS.

The following points were made in discussion:

h) Members welcomed the news of the planned development at Newark Hospital, which had been a topic of discussion for several years within the system.

i) Members noted press coverage surrounding the allocation of Adult Social Care Discharge Funding and queried whether the system had received its allocation. This was confirmed and members were advised that for Nottingham and Nottinghamshire, the allocation was received in November 2022 and some schemes had already been implemented. The funding had made a positive impact regarding home care capacity as well as interim care placements, particularly in acute settings.

j) Members discussed the impact of recent critical incidents when resources were diverted to support urgent and emergency care, and the effect this had on community services and the detriment to waiting lists.

k) Ifti Majid offered to support the development of the Nottingham and Nottinghamshire ICS anti-racism strategy, drawing upon his experience as Chair of the NHS Confederation Black and Minority Ethnic Leaders Group. Rosa Waddingham welcomed this support and agreed to set up a meeting to take this forward.

l) Members questioned whether further work could be done to improve awareness of the vaccination programmes (both Covid-19 and flu). It was explained that a programme of targeted communications material had been in place throughout the pandemic, and each flu season. Focus was on low uptake areas and learning would be reflected within vaccination strategies for future campaigns.

m) Members reflected on the ongoing supply issues in the workforce and the specific impact on community services. Whilst joint appointments were being progressed to manage capacity in community services, this would not tackle the overall issue.

n) Members took the opportunity to acknowledge the hard work of colleagues across the system to tackle demand and heightened pressure during the critical incidents and recognised that patients were experiencing higher than usual waiting times. Members

stressed that all options were being explored to improve the situation for the future of the system.

o) It was noted that the Incident Response Plan had been circulated to Members separately due to its confidential nature of its content.

The Board **received** the Chief Executive's Report and **approved** the ICB's Incident Response Plan.

At this point, Mel Barratt, Rich Brady and Dr Hugh Porter joined the meeting.

Health inequalities and outcomes

ICB 22 053 **Supporting the Nottingham City Place-Based Partnership to be a delivery vehicle for ICS priorities**

The Chair welcomed Mel Barrett, Rich Brady and Dr Hugh Porter from the Nottingham City Place-Based Partnership (PBP) who were in attendance at the meeting to provide an update on the work of the Nottingham city Place-Based Partnership. The following points were highlighted:

a) The PBP brings together statutory and voluntary sector organisations with communities to improve population health and wellbeing in an area that has significant challenges regarding health inequalities.

b) There had been a focus on delivering 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. This had delivered increased coherence, trust and confidence across partners.

c) The paper set out a number of initiatives and achievements, which included work with people who experience severe multiple disadvantage, improved collaboration within PCNs, and a co-designed race health inequalities maturity matrix.

d) The PBP's commitment to supporting the delivery of national and local priorities was confirmed.

The following points were made in discussion:

e) Members recognised the strengths that PBPs had at their disposal by engaging with people and communities within their populations, which enabled PBPs to bring a unique perspective and insight.

This could then feed into strategy development and workstreams whilst strengthening relationships.

f) Recognising that currently the resources within the ICB's Locality Teams were primarily primary care facing, members sought to understand how the PBP would widen participation and involvement by all statutory partners.

g) Members noted the ambitions of the PBP from an NHS perspective but welcomed further insight into the ambitions of the Local Authority. Understanding this better would enable resources to be used collectively to achieve maximum impact.

h) Members questioned whether the scale of ambition for this work had been determined by the PBP, particularly in terms of integrated teams within neighbourhoods. Once this was confirmed, work could begin to determine the level of resource and leadership required to drive engagement within communities. It was explained that the scale of the ambition encompassed housing, employment and healthcare as key levers to address deprivation within Nottingham City. A key aspect of this work would be partners working together to address fundamental issues with the health and wellbeing of the population.

i) It was acknowledged that work had taken place in recent years to improve cohesion amongst GP practices within Nottingham City. In order to successfully deliver the NHS priorities, focus would need to shift to improve cohesion with non-NHS organisations.

j) Members discussed an ambition to empower communities to drive change and give citizens agency over their own health and wellbeing.

k) The concept of treating each place as a micro-system of the ICS was discussed.

l) It was noted that there were schemes of work already underway within communities that the ICB did not have stewardship over, that were potentially progressing the goals of the ICB already.

m) Noting the progress that had already been made, it was agreed that the timing was appropriate to progress the next phase of governance arrangements for PBPs. Lucy Dadge would take this forward outside of the meeting with oversight from the Strategic Planning and Integration Committee.

n) It was agreed that colleagues from Nottingham City PBP would return to the Board meeting once the cycle of attendance for all four PBPs had run its course.

o) Mel Barrett encouraged members of the Board to reach out to colleagues within the Nottingham City PBP should they wish to learn more about ongoing work programmes.

The Board **noted** the development of the Nottingham City Place-Based Partnership and its approach to delivery

Mel Barrett, Rich Brady and Dr Hugh Porter left the meeting at this point and Amanda Chambers joined the meeting.

ICB 22 054 Citizen Story: Green Social Prescribing

Rosa Waddingham and Amanda Chambers presented the item and highlighted the following points:

a) The cross Government Green Social Prescribing Programme was developed to tackle and prevent mental ill-health. Since 2021, the programme had encouraged the increased use of, and connection to, green (outdoor) and blue (water-based) areas within communities.

b) The Nottingham and Nottinghamshire ICS had been selected as one of seven test sites in 2021 to launch the two-year pilot. In the year since its conception, over 1,200 referrals had been made.

c) Locally, the Nottingham Community and Voluntary Service had led the programme working with Framework, the Canal and River Trust and Nottingham Open Spaces Forum.

d) Patients were referred to the green social prescribing services, usually through their General Practitioner, and were linked to projects, activities and schemes within their local community with the aim of supporting their health and wellbeing.

e) A presentation which included videos detailing patients' experiences of the service was shown to the Board. Positive recollections were given, and the mental health benefits associated with time spent outdoors were described.

f) A long-term plan for green social prescribing was in development in Nottingham and Nottinghamshire with the aim of embedding the service within the local system as an intervention of choice. An opportunity to extend the national test and learn programme was being explored as this would fund the service for an additional 18 months.

g) The presentation included validated data captured by providers, evidencing either maintenance or improvement of users' mental wellbeing over the course of six weeks.

The following points were made in discussion:

h) Stephen Jackson declared his interest as Non-Executive Chair of the Nottingham Business Improvement District, who work closely with the Canal and River Trust. This was noted by the Board.

i) Members discussed the importance of reinvigorating mental health partnerships throughout the ICS. To do this, a flexible approach to funding and investment must be taken, ensuring that evidence-based initiatives, such as this one, are supported. Members agreed to explore whether any existing mental health funding could be re-purposed for social prescribing initiatives. This would be explored further outside of the meeting.

j) Members noted that this type of initiative was a prime example of changing the way in which healthcare is viewed and delivered to achieve better outcomes.

The Board **noted** the Citizen Story.

At this point, Amanda Chambers left the meeting.

ICB 22 055 Transforming Personalised Care and Co-production

Rosa Waddingham presented the item and highlighted the following points:

a) The paper outlined the collaborative approach taken towards the system development of personalised care and co-production, and their crucial role as fundamental enablers to the way in which the ICB would deliver future strategic change.

b) Personalised care and co-production were recognised as key elements to preventing health inequalities, giving citizens agency and creating services that are meaningful.

c) A Strategic Co-Production Group had formed in January 2023 with the purpose of strengthening the foundations to drive the effective strategic change required for delivery of the Personalised Care Strategy.

The following points were made in discussion:

d) Welcoming the report, Members acknowledged the role of personalised care in ensuring collaborative working across the system, striving for best practice.

e) Members recognised that a culture change would need to be encouraged for co-production and personalised care to thrive.

The Board:

- **Noted** the progress update regarding the Personalised Care Programme and the system approach to strategic co-production.
- **Endorsed** 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.

Andrew Fearn joined the meeting at this point.

ICB 22 056 Digital Transformation – Strategic Progress Update

Dave Briggs and Andrew Fearn presented the item and highlighted the following points:

a) The paper provided a delivery update against the ICS Digital Strategy. The digital health and care system, referred to locally as 'Digital Notts', had proven successful in working effectively over a long-standing digital collaborative, underpinned by strong governance arrangements.

b) Progress against the initial strategy objectives had been positive and the ICS had been viewed as an exemplar of digital, nationally. The strategy had however been updated using specific, achievable, relevant and time-bound (SMART) objectives to support further digital transformation.

c) Changes to the national digital approach over the previous twelve months had resulted in delays to the release of digitisation funds. Despite this set back, significant progress had been made. Plans for 2023 included a substantial material increase to the ICS digital eco-system to move to real time data. This would change the way in which services are delivered.

d) Further work to upgrade the digital architecture within primary care was also planned for 2023.

e) A key area of focus would be the implementation of plans to promote digital inclusion. Training and engagement would take

place with the objective of improving public access to digital resources.

f) The approach being centred around developing the people, staff and patients, rather technology, was emphasised.

The following points were made in discussion:

g) While noting the positive position of the system regarding the digital agenda, it was felt that there were still improvements to be made. Members queried whether weaker areas of the technical infrastructure within Nottingham and Nottinghamshire had caused any detriment to the quality of patient care. It was explained that resource was invested to ensure the quality of care does not suffer where the technology is lacking. This, however, was not an efficient solution.

h) Members discussed the shift away from capital expenditure to revenue when it comes to technology. Creative solutions would need to be identified to relieve pressure operationally, to release revenue funds which could then be reinvested in digital schemes.

i) The Chair commended the progress and noted that the Board would receive future updates through its annual work programme and the highlight reports from Finance and Performance Committee as the responsible committee for digital oversight.

j) In a general point relating to all items presented, the Chair asked that future presentations outlining plans/schedules of work include a timeline for outcomes.

The Board **noted** the progress update regarding digital transformation across the Nottingham and Nottinghamshire Integrated Care System.

Assurance and system oversight

ICB 22 057 **Integrated Performance Report**

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

a) At the end of month eight, the NHS System was reporting a £35.1 million deficit position, which was £17.2 million adverse to plan. The main drivers of the deficit related to Covid-19 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 was now a view that the system would not achieve its

financial plan. NHS England had been notified of this and conversations were taking place to agree a new target for the system. It was likely that this change would be reflected in the month ten position as each organisation would need to approve their element of the plan at their Board meetings, prior to sign off by the ICB. Due to the timelines, the Board was asked to delegate sign off of an amended system forecast to the ICB Finance and Performance Committee. The outcome would be reported to the Board.

b) The system was failing to meet the majority of service delivery 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) Operational Planning guidance had been published towards the end of December 2022. At present, it was not possible to determine the scale of the ask for 2023/24. Further analysis would be undertaken, and this would be discussed at the next meeting.

d) The capital works required at Sherwood Oaks were completed and the facility opened in November 2022. Patients were relocated there during December 2022. The opening of this facility would support out of area placements and the eradication of dormitory accommodation across Nottinghamshire Healthcare NHS Foundation Trust (NHFT).

e) 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 (CQC). System support mechanisms were also in place for NHFT to address concerns raised by the CQC during a recent inspection.

f) Flu and Covid vaccination programmes had commenced.

g) Infection prevention and control and hospital acquired infection rates 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 higher than planned levels.

The following points were made in discussion:

k) Members discussed the process for horizon scanning for emerging risks to the ICB's financial position. It was noted that this exercise was undertaken during the standing risk item at Finance and Performance Committee meetings. The system-wide meeting of senior leaders from all partners in December to discuss the system's financial position was also noted.

l) Members noted a discrepancy between workforce figures for the system, which had been reported as over plan for Whole Time Equivalent (WTE) staff despite evidence suggesting higher usage of agency and bank staff. Members were advised that a deep dive into workforce figures was being carried out and would be presented to the Finance and Performance Committee.

m) The recovery plan for 78-week waits was noted and members were advised that further work was required to achieve the recovery trajectory. It was agreed that inclusion of timelines for recovery actions within the IPR would be helpful.

n) Members noted that appointment numbers had increased as a result of Primary Care Extended Access, which was positive.

o) A discussion took place around an increase in excess mortality rates for younger, older adults. This could suggest that health inequalities had widened for this demographic and data suggested that this was a national trend. It was agreed that work would be completed rapidly to better understand the local drivers for this position, which will be reported to a future meeting of the Finance and Performance Committee.

The Board **noted** the Integrated Performance Report and **approved** delegation to the Finance and Performance Committee to agree the revised system financial plan for 2022/23.

Actions:

- **Stuart Poynor to ensure that future Integrated Performance Reports include timelines for recovery actions.**
- **Dave Briggs to present the outcome of a rapid review into excess mortality rates for younger, older adults to the Finance and Performance Committee.**

ICB 22 058 **Committee Highlight Reports**

The report presented an overview of the work of the Board's committees since its last meeting in November 2022; it aimed to provide assurance that the committees were effectively discharging their delegated duties and included assessments of the levels of assurance the committees had gained from their work during the period. A summary of the current high-level operational risks being oversighted by the Board's committees was also included.

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 actions undertaken to improve the financial position whilst progressing both financial and operational planning for 2023/24. Due to the worsening position, all items relating to ICB and system finances received partial assurance.

b) Quality and People Committee members had undertaken a review of its risk register revising the risks with updated language and definitions. Members had only been able to take limited assurance in response to the People and Culture Report and System Quality Assurance Reports pending further development.

c) Strategic Planning and Integration Committee members had a focused discussion surrounding the future hosting arrangements for Pharmacy, Optometry and Dental (POD) services and an extra-ordinary meeting had been scheduled to discuss this further. 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 with the exception of an item on Emergency Preparedness, Resilience and Response (EPRR) and ICB Core Standards. The item had received partial assurance as further work was required to meet the required standards of a Category One responder.

The Board **noted** the Committee Highlight Reports.

Closing items

ICB 22 059 **Risks identified during the course of the meeting**

Members reflected on the earlier conversation around a potential emerging risk relating to excess mortality rates. An action had been agreed to initiate a deep dive into this, and any risks identified as a result of this would be reflected on the Operational Risk Register.

ICB 22 060 Questions from the public relating to items on the agenda

No questions were raised.

ICB 22 061 Any other business

No other business was raised and the meeting was closed.

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

NHS
Nottingham and Nottinghamshire

ACTION LOG for the Integrated Care Board meeting held on 12/01/2023

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
Closed	12.01.23	Integrated Performance Report	To ensure that future Integrated Performance Reports include timelines for recovery actions.	Stuart Poynor	09.03.23	See agenda item 11 – timelines for recovery actions included where known.
Open – On track	12.01.23	Integrated Performance Report	To present the outcome of a rapid review into excess mortality rates for younger, older adults to the Finance and Performance Committee.	Dave Briggs	11.05.23	Scheduled for presentation at the 29 March meeting of the Finance and Performance Committee.

Key:

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

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/03/2023
Paper Title:	**Chair's Report**
Paper Reference:	ICB 22 067
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 start to head into Spring and away from the winter months, it does feel like brighter times lie ahead as we exit a period of particular challenge for the health and care system locally and nationally. The combined impact of industrial action, operational pressures of flu, Strep-A and Covid-19 have all had a considerable impact, but I am impressed and grateful to colleagues across our system for way that they have pulled together to deal with that.
2. The fact that we have experienced such high levels of pressure on the whole health and care system underlines, for me, the fact that we must accelerate our work to deliver on our Integrated Care Strategy and the transformation work that it envisions. By committing to our principles of prevention, equity and integration we have a framework for how we will make the difference we need and avoid the recent challenges being a recurrent event. The integrated way that our teams responded to those challenges does give me heart and confidence that we can achieve what the Integrated Care Strategy sets out – but it will not be easy.
3. As I described in my report to January’s Board meeting, this year’s priorities are delivery – delivery on our Integrated Care Strategy as I indicate above and below, delivery on our short-term financial sustainability and delivery on our ongoing development as a system.
4. In terms of financial performance, we are awaiting the latest announcements from the Government in the budget on 15 March but are hopeful for further clarity on capital investment through the New Hospitals Programme as one of our key priorities for the medium term. The detailed operational and financial planning for the year ahead is well underway and we will hear more on that later in the meeting today. As we move forward as a system, working together, across organisational boundaries to make sure that we are maximising all our allocated resources for our population will be critical.
5. Finally in terms of introductory matters, I am pleased once again to see that the investment of time last year in the setting up of our structures and processes is paying off. Whilst there is more to do, we are starting to reap the benefits of both the formal processes that we have set up in the ICB and the wider partnership arrangements surrounding the ICP – including the ICS Reference Group I describe below and the new forum we have established to hear from our Foundation Trust Governors. The more that we can listen to, and work with, our wider partners, the stronger and more effective our delivery will be.

Today's situation: operational and financial pressures

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

7. As I note above, the pressures that we have seen from a combination of winter illnesses (flu, Strep-A and Covid-19) and workforce challenges have started to abate in recent weeks. Executive colleagues are still closely monitoring this position but are hopeful that we are through the worst of this winter period.

8. Board members will be aware of the ongoing period of Industrial Action organised by the Trades Unions. Again, the teams within the ICB and all our providers have worked together in an impressive way to ensure that our citizens can still access timely care in an emergency wherever possible and that the maximum number of elective appointments are protected from cancellation. Pay is a matter for discussion between the Government and the Trades Unions, but I am pleased that the proposed strike by Royal College of Nursing (RCN) members on 1 to 3 March was paused during intensive talks on pay and hope that by the time of our meeting there may be an outcome from those talks.

9. Finally in terms of current operational performance, notwithstanding the impacts of the industrial action and winter pressures as described above, the system is making good progress on ensuring that citizens have access to elective operations in line with the Government's expectations. We have a trajectory to deliver zero waits over 18 months by the end of this month and have submitted our detailed plan to eliminate waits over 15 months by the end of March next year.

Developing the system for tomorrow

10. The ICS Reference Group met on 16 February and was well attended, bringing together leaders across our system to discuss and shape key system business. This session focussed on the Integrated Care Strategy, where colleagues were reminded of the strong partnership work that has happened to date, and the plans to launch the Strategy. More details on the Integrated Care Strategy can be found further on in this update.

11. On the same day, I attended the inaugural system meeting of NHS Foundation Trust Governors. I was joined by 29 colleagues, including Trust Governors, Trust Non-Executive Directors and ICB colleagues where we explored how we can work more closely together in listening to our communities and championing the implementation of our Integrated Care Strategy. I was inspired by the energy in the room – there is a clear commitment from Foundation Trust Governors to continue to work with their communities, some of whom have links to specific population groups, geographical locations and those living with

certain health conditions. The ICB Engagement Team has a role in supporting colleagues to do this and helping to close the loop if specific issues are raised. I recognise the important work that Trust Governors do to represent the voice of citizens and will continue to meet regularly with them. Many thanks to Suzy Brain England from Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust for chairing the event and for the input of Lead Governors from our Foundation Trusts.

12. The Government announced through the Chancellor's autumn statement that a new independent review would be established to examine oversight of Integrated Care Systems (ICSs) to reduce disparities and improve health outcomes across the country. The review, which is led by former Health Secretary the Rt Hon Patricia Hewitt, who is currently Chair of NHS Norfolk and Waveney ICB, will explore how to empower local leaders to focus on improving outcomes for their populations.

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

14. There are five different workstreams within the review and I am pleased to have been asked to co-chair the 'autonomy, accountability and regulation' workstream. Each workstream includes patient and service user representatives, NHS, social care, local government and the Voluntary, Community and Social Enterprise (VCSE) sector. This work is well underway and is due to report within the next few days.

Our Integrated Care Strategy

15. Our Integrated Care Partnership is the 'guiding mind' of the local health and care system and its main task in recent months has been to support the development and agreement of the Integrated Care Strategy.

16. Work has been underway to finalise the strategy for the next ICP meeting, taking place on 17 March. This has focussed making changes to the narrative following feedback from the ICP meeting in December and confirming specific targets so we are clear on what success looks like. The strategy document has also been designed into a public facing document.

17. Our next key step is supporting 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 (equity, prevention and integration).

18. A launch plan has been developed to ensure that the Integrated Care Strategy is understood and adopted into everyday working practice by staff across health and care, creating enthusiasm to deliver more joined-up care with a focus on prevention and inequalities. The launch plan also aims to ensure that there is a level of awareness of the Integrated Care Strategy amongst our population supporting existing behaviour change campaigns.
19. I am positive that we will bring the four aims of our Strategy (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) to life for citizens and stakeholders.

Transformation delivery

20. Over the past few weeks, I have continued my regular programme of visits to see services being delivered on the frontline. I am always keen to hear from anyone who might want me to visit their service, particularly if it is a great example of delivery on equity, prevention or integration.
21. In January, I attended the Trustees' Reception for the Canal and River Trust, a charity who care for a 2,000-mile long ‘green-blue ribbon’ of canals, rivers, reservoirs and docks. I heard about ‘blue’ social prescribing activities, including cycling, paddling and foraging sessions. I am looking forward to seeing one of these in action, and meeting staff, volunteers and service users.
22. Also in January, I spent some time with colleagues in South Nottinghamshire, including a meeting with the Nottingham West Care Navigation Team to learn more about their joint working with social care. I have also met with the Chief Executive of the Local Medical Committee (LMC) to find out more about their role in supporting local GPs, as well as the LMC’s role in our ICS.
23. Alongside these visits I have been pleased to be part of several events organised by NHS Confederation, network meetings nationally and regionally with other Chairs and Non-Executive leaders as well as important conversations regarding economic development opportunities in our area.

Summary and looking forward

24. Spring is a time for renewal and new hope and so I step forward from this point with a real sense of optimism and positivity that we have an excellent new Integrated Care Strategy to implement which will make a real difference to our population and a firm belief that we have the structures, processes and relationships in place to deliver on that strategy.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/03/2023
Paper Title:	**Chief Executive's Report**
Paper Reference:	ICB 22 068
Report Author:	Amanda Sullivan, Chief Executive
Report Sponsor:	Amanda Sullivan, Chief Executive
Presenter:	Amanda Sullivan, Chief Executive
Recommendation(s):	The Board is asked to **receive** this item for information and **confirm** the ICB's commitment to the Nottinghamshire County and Nottingham City Declaration on Tobacco Control.

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: Nottinghamshire County and Nottingham City Declaration on Tobacco Control

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
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 to this report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Chief Executive's Report

ICB updates and developments

Developing our Joint Forward Plan

1. Planning guidance for the Joint Forward Plan was published by NHS England on 23 December, which is available online here: B1940-guidance-on-developing-the-joint-forward-plan-december-2022.pdf (england.nhs.uk).
2. The Joint Forward Plan provides an opportunity to create a longer-term shared sense of endeavour, a realistic and ambitious view of what is achievable and a sense of hope for our teams and our public. The ICS Executive Leadership Group has discussed and agreed the scope as:
    a) Delivering the NHS Mandate, whilst also tackling the most challenging issues for the system: e.g. demand, capacity, performance, finance, sustainability.
    b) The NHS contribution to the aims of the Integrated Care Strategy.
3. Work is underway with partners to jointly develop the plan by 30 June with proposed contents which may include:
    a) Foreword from the Chair and Chief Executive to outline the mission and a call to action
    b) Executive summary
    c) Introduction including our journey to date, the context of the plan and vision set by the Integrated Care Strategy, the NHS Long Term Plan, and Joint Health and Wellbeing Strategies
    d) Our ambition and how we might address these through the Provider Collaborative at Scale and Place Based Partnerships
    e) Our approach to population health management and what the data tells us about our population
    f) Our clinical priorities, contributing to:
        - Improved navigation and flow to reduce emergency pressures
        - Proactive management of long-term conditions to avoid crises/escalations of care
        - Reduced elective waiting lists
        - Reduced illness and disease prevalence
    g) Our enablers to this work:
        - Workforce

- Estates and capital
- Digital, analytics, information and technology
- Development of specialised services
- Research

h) How we will work together, including:

- Primary care and the role of Primary Care Networks
- Place Based Partnerships
- Provider Collaboration at Scale
- Single system activity/demand/capacity plan
- Single system long term financial framework
- Social value and the role of anchor institutions
- Accountability and oversight, performance, governance and outcomes framework
- Approach to quality improvement, leadership, organisational development, education and training
- Joint Commissioning for integrated care and mental health
- Clinical and care professional leadership arrangements
- Personalisation

4. The approach set out above has been tested with partners who have welcomed the focus on both the NHS contribution to the Integrated Care Strategy and confronting our most challenging issues. The Strategic Planning and Integration Committee will oversee progress on behalf of the Board with the final version of the Joint Forward Plan being presented to a future meeting of the Board.

System resilience and response

Industrial action

5. The Royal College of Nursing has confirmed that they will pause strike action planned for March while they enter a process of intensive talks with the Government. Further updates on this will be provided when available.

6. GMB and Unite trade unions at East Midlands Ambulance Service (EMAS) have confirmed that they intend to take industrial action on 6, 7, 20 and 21 March. Due to the reduction in staff, planned surgery and outpatient appointments may be affected and it is anticipated that there will be fewer ambulances available. Military personnel will provide support to EMAS in responding to non-emergency patients during the

strike action, thus protecting the limited number of ambulances available to attend to the most seriously ill people in the region.

7. The British Medical Association (BMA) has gained a national mandate for strike action by junior doctors and has now notified Trusts and members that the first round of action will start on Monday 13 March and conclude on the morning of Thursday 16 March. They will also now be joined by members of the Hospital Consultants and Specialists Association (who had previously announced strike action on 15 March) and the British Dental Association, aligning with the dates and times of the BMA action. This will include complete cessation of labour for 72 hours. The BMA has confirmed that there will be no derogation of services negotiated at any level for the duration of the strike period, with the exception being arrangements to recall staff in event of a mass casualty incident.

8. We continue to work within a system response structure that brings together people, operational and emergency preparedness resilience and response leads in a System Control Centre to ensure that essential services are maintained.

Partner updates

Nottinghamshire County and Nottingham City Declaration on Tobacco Control

9. Smoking kills around 1,513 people in Nottinghamshire County and Nottingham City every year; it is also the biggest contributor to health inequalities (50% of the difference in life expectancy between the most affluent and the most deprived areas is due to tobacco). Smoking also costs Nottinghamshire County and Nottingham City an estimated £378 million every year through, among other things, lost productivity, treatment for smoking related diseases and social care support.

10. In August 2022, the Nottinghamshire County and Nottingham City Declaration on Tobacco Control was updated to ensure that it supported the relaunch of the national declaration and the Government's ambition for England to be smoke free by 2030. It commits to improve smoking cessation support available through NHS Long Term Plan commitments to provide all smokers in hospital, pregnant women and long-term users of mental health services with tobacco dependence treatment.

11. The Declaration has been endorsed by both the County and City Health and Wellbeing Boards. Both Boards recognised the importance of this Declaration and support the recommendation for partners to individually take this forward.

12. Signing the Declaration demonstrates the ICB's commitment to addressing tobacco related issues and improving the health of the Nottingham and Nottinghamshire population.

13. The Declaration, which can be found at **Appendix A**, sets out a single set of principles to commit to reducing smoking in our communities and includes a commitment to developing and implementing an organisational action plan. High level proposed

actions include nomination of a senior champion within the ICB; ensuring timely and accessible communications and information about local Stop Smoking Services and annual events (e.g. National No Smoking Day); ensuring commissioned services adopt smoke free workplaces; and advocating for national and local tobacco control measures.

14. The Board is asked to confirm the ICB's commitment to the Nottinghamshire County and Nottingham City Declaration on Tobacco Control and support the development of an action plan to ensure the commitments within the declaration are taken forward.

Health and Wellbeing Board updates

15. The Nottingham City Health and Wellbeing Board met on 25 January 2023. The meeting received updates from the Joint Health Protection Board and the Nottingham City Place Based Partnership. 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.

16. The Nottinghamshire County Health and Wellbeing Board met on 1 February 2023. The meeting received a report on planning requirements for the 2022/23 Better Care Fund adult social care discharge fund, a covid impact assessment on mental health and a report on taking collective action on homelessness as a health and wellbeing priority. 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.

Nottingham University Hospitals NHS Trust People First Report

17. Nottingham University Hospitals NHS Trust's Chief Executive, Anthony May, has recently published the Trust's vision for addressing the challenges it faces and to restore the confidence of the public, stakeholders and regulators. It is based on conversations Anthony has had with staff, patients, volunteers and partners and the report seeks to address three recurrent themes that came out of those conversations; specifically, pressures on emergency care and its impact on delays and waiting times, ensuring appropriate staffing levels through recruitment and retention, and the need to continue to improve leadership and culture, including responding to identified problems of racism, bullying and harassment. The report can be found here: https://www.nuh.nhs.uk/download/doc/docm93jijm4n12706.pdf?ver=29733

Mansfield Community Diagnostic Centre

18. Funding from NHS England has been approved to bring Nottinghamshire's first Community Diagnostics Centre to Mansfield. Plans for the purpose-built Community Diagnostics Centre have now been submitted by Sherwood Forest Hospitals NHS Foundation Trust to Mansfield District Council. If these are approved, the centre will run alongside the existing Mansfield Community Hospital and will become a 'one-stop shop' for patients to access the tests and investigations they need in a single visit, helping to give patients a diagnosis sooner. Checks available at the new Centre will include a host of x-rays, scans and tests for a range of other conditions, including cancer and other long-term conditions, such as heart and lung disease.

National updates

Case studies to support ICSs to adopt and spread innovation

19. The Accelerated Access Collaborative (AAC) is a unique partnership between the patient groups, government bodies, industry and NHS bodies, working together to streamline the adoption of new innovations in healthcare. It has co-developed a series of case studies with AAC partners on the implementation approaches taken in local Integrated Care Systems to promote the adoption and spread of proven innovation.

20. Ways in which ICSs can facilitate innovation are listed as including:

    a) Driving local leadership in innovation through clinical and care professionals and/or dedicated innovation roles.

    b) Working to foster a culture of innovation across local health and care organisations and partnerships.

    c) Implementing local organisational structures which support and promote the adoption of innovation.

    d) Working to tackle health inequalities through increasing equity of access to innovation or through the promotion of innovative products which reduce health disparities.

    e) Facilitating collaborative partnerships working towards the adoption and spread of innovation, including working with the voluntary, community and social enterprise (VCSE) sector.

21. The case studies seek to provide practical examples for how innovation can be implemented. The suite of case studies also aims to increase awareness of the role of innovation in tackling health inequalities across the system and promote shared learning and collaboration in the implementation, adoption and spread of proven innovation. Links to the case studies can be found here: https://www.england.nhs.uk/publication/case-studies-to-support-icss-to-adopt-and-spread-innovation/.

Appendix A

Nottinghamshire County and Nottingham City Declaration on Tobacco Control

…… ……..

NHS Nottingham and Nottinghamshire ICB acknowledges that:

- **Smoking is the single greatest cause of premature death and disease in our communities.**
- **Reducing smoking in our communities significantly increases household incomes and benefits the local economy.**
- **Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities.**
- **Smoking is an addiction largely taken up by children and young people, two thirds of smokers start before the age of 18; in Nottinghamshire County and Nottingham City approximately 1,334 11 to15-year-olds take up smoking each year.**
- **Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the approximate 1,513 people its products kill locally every year.**
- **The illegal trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.**

As local leaders with an interest in health we welcome the:

- **Opportunity for local government and partners to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence.**
- **Government's ambition to make England smoke-free by 2030 and tackle inequalities in smoking prevalence.**
- **Commitment and leadership across Nottinghamshire County and Nottingham City in recognising the importance of reducing tobacco use harm across our communities.**
- **Commitment by the Government to protect the development of public health policy from the vested interests of the tobacco industry (the World Health Organisation Framework Convention on Tobacco Control).**
- **NHS Long Term Plan commitments to provide all smokers in hospital, pregnant women and long-term users of mental health services with tobacco dependence treatment.**
- **Endorsement of this declaration by the local Health and Wellbeing Boards and partners.**

From this date, we commit to:

- **Declaring our commitment to reducing smoking in our communities.**
- **Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities.**
- **Develop individualised organisation actions plans to address the causes and impacts of tobacco use.**
- **Share actions plans and commitments with communities and partners.**
- **Support action at a local level to help reduce smoking prevalence and health inequalities in our communities.**
- **Recognise and where possible protect our tobacco control work from the commercial and vested interests of the tobacco industry.**
- **Regularly monitor the progress of our plans and commitments and share results.**
- **Publicly declare our commitment to providing strategic and/or operational input into the Nottingham and Nottinghamshire Smoking and Tobacco Alliance to reduce the harm caused by tobacco.**

Endorsed by:

Signatory:

Position:

Nottinghamshire County's Health and Wellbeing Board Chair

Nottingham City's Health and Wellbeing Board Chair

Based on the Local Government Declaration on Tobacco Control

8

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/03/2023
Paper Title:	**Bassetlaw Place-Based Partnership Report**
Paper Reference:	ICB 22 069
Report Author:	Lee Eddell, Programme Director/Deputy Locality Director
Report Sponsor:	Lucy Dadge, Director of Integration
Presenter:	Victoria McGregor Riley, Locality Director David Armiger, Chief Executive, Bassetlaw District Council Andria Birch, Chief Executive, Bassetlaw Community and Voluntary Service
Recommendation(s):	The Board is asked to **receive** this item.

Summary:

The Health and Care Act 2022 has facilitated significant opportunities for collaboration and partnership working at all levels within the health and care system. Place-Based Partnerships (PBP) are recognised as significant contributors to partnership working by bringing together key stakeholders in formal collaborative mechanisms. As such, PBPs are well placed to support Integrated Care Boards (ICBs) to deliver their core aims, priorities and objectives. By bringing local voices together, across health and care sectors as well as communities, they are ideally suited to designing and delivering transformational initiatives sensitised to the distinctive needs and characteristics of local populations at a sub-system level.

Bassetlaw PBP has a long history of collaborative working to address the population needs of its 120,000 citizens. The PBP established a 2022/23 local vision and priorities for Bassetlaw that are aligned with the Nottinghamshire Health and Wellbeing Strategy. Since July 2022, the PBP has also sought to actively engage in the delivery of the strategic priorities of NHS Nottingham and Nottinghamshire ICB following its transition from the South Yorkshire and Bassetlaw ICS. The Bassetlaw PBP comprises Executive level representation from a wide range of local statutory and Voluntary Community and Social Enterprise (VCSE) organisations. These include:

- Bassetlaw Community and Voluntary Service
- Bassetlaw District Council
- NHS Nottingham and Nottinghamshire ICB
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
- Healthwatch Nottingham and Nottinghamshire
- Nottinghamshire County Council
- Nottinghamshire Healthcare NHS Foundation Trust
- Bassetlaw Primary Care Networks
- Bassetlaw Improvement District

During 2022/23 Bassetlaw PBP agreed six priorities on which to focus our collective efforts in order to explore and deliver new ways of working to address our local challenges – finding better solutions where coming together 'added value' and achieved improved outcomes. **Note: The presentation of this paper will be introduced with a citizen story, giving an insight into the Aurora Bassetlaw service, which aims to make coping with cancer easier.**

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	Bassetlaw Place-Based Partnerships aims to improve the population health outcomes of Bassetlaw citizens through increased collaboration between partners and integrated place-based models of delivery. The PBP intends to accelerate improvement through integrated neighbour team model adoption.
Tackle inequalities in outcomes, experience and access	Bassetlaw Place Based partnership priorities align to the Nottinghamshire Health and Wellbeing Strategy which aims to reduce health inequalities across Nottinghamshire. Addressing inequalities in outcomes, experience and access is business as usual activity for Bassetlaw PBP.
Enhance productivity and value for money	By working together partners aim to reduce the burden on health care services, preventing or reducing presentation in primary, community and secondary care. This in turn should free clinicians to work with those more complex or most in need. Proactive early intervention should reduce presentation in secondary care including emergency department, prolonged length of stay in hospital or improving discharge. Partners are working together to develop a benefits table for all initiatives in 2023/24. BPBP focusses not simply on citizen cohorts but also how partners can work more effectively and cost efficiently. For example working together to maximise One Public Estates across partners offers value for money in context of wider public purse.
Help the NHS support broader social and economic development	Bassetlaw PBP brings together local government and voluntary sector partners to support the broader social and economic development agenda. Partners are currently exploring a SROI tool to ensure impact can be measured.

Appendices:

Appendices:
Appendix A – Key health and care challenges in Bassetlaw
Appendix B – Bassetlaw PBP Governance Structure
Appendix C – Bassetlaw PBP Priorities Performance Dashboard
Appendix D – Bassetlaw Place Based Partnership Achievements (Case Examples)
Appendix E – Bassetlaw Partnership Achievements (Q3 2022/3)

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 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.

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	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	Yes
Duties as to climate change	No
Duties regarding public involvement and consultation	No
Public sector equalities duties	Yes

Report Previously Received By:
Not applicable

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

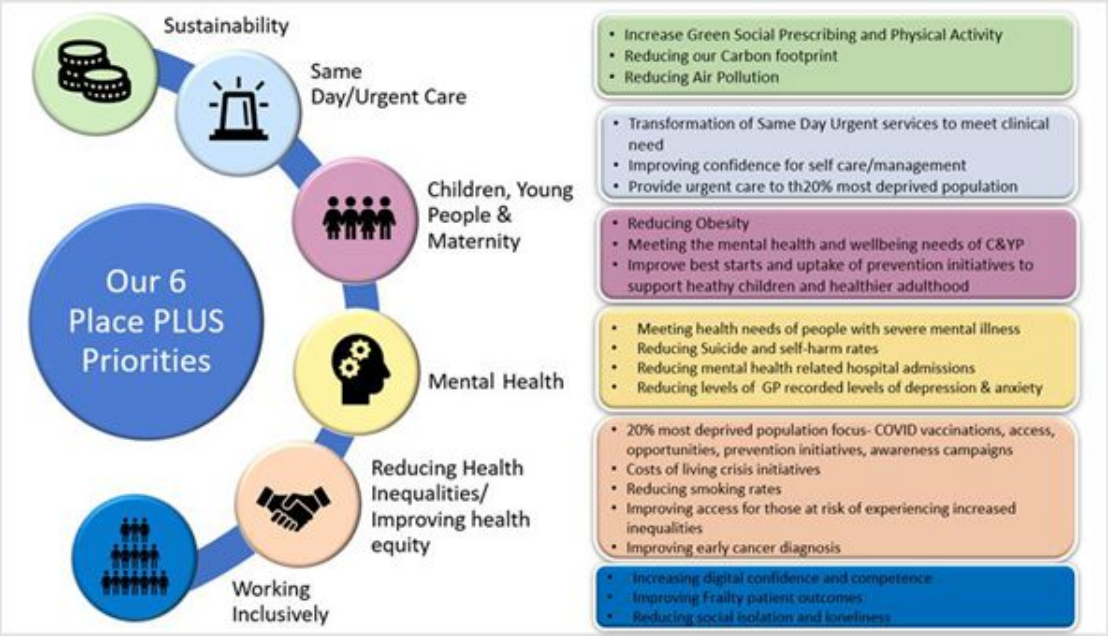
Bassetlaw Place-Based Partnership Report

Introduction

1. Bassetlaw Place-Based Partnership (PBP) is a mature partnership of key stakeholders working closely together to deliver best possible outcomes for the citizens of Bassetlaw. The maturity of the partnership fosters increased coherence, trust, and confidence across leadership and operationally focussed teams. Membership of the PBP includes the three Primary Care Networks (PCNs), Voluntary Community and Social Enterprise (VCSE) as well as public sector partners and local business via the Business Improvement District.

2. Key partners have an agreed PBP Memorandum of Understanding dated November 2021; the partnership has agreed its values and as recently as January 2023 reaffirmed them. Bassetlaw PBP has a robust operational model and governance arrangements that all partners are committed to (see Appendix A). This has been reviewed frequently throughout 2022/23 and will continue to evolve to remain fit for purpose.

3. Bassetlaw PBP partners have a clear direction of travel and are determined to mature the partnership and be a key delivery partner within the ICS. The PBP is committed to integrated working to improving population health and wellbeing outcomes, supporting the delivery of system priorities and system objectives. The PBP recognises that the six key priority areas of focus will achieve greater benefits for people and improved cost effectiveness and efficiency by joint working across partner organisations rather than organisations working in isolation. The PBP meets regularly to review the initiatives, aims and objectives that deliver on those priorities. The 2022/23 priorities are:



4. Through its six place-based priorities Bassetlaw PBP seeks to:

    a) Achieve left shift and target resources to support the further development of Place based preventive services and joined-up care based around the citizen rather than organisations or professions.

    b) Reduce health inequalities and 'level up' healthy years lived; empowering individuals, families and communities to take control over their own health and wellbeing.

    c) Improve health outcomes through working with partners to address the wider determinants of health such as employment, education, housing, lifestyle choices and early starts.

    d) Employ a population health approach to improve access to health and social care, promoting equity across the population of Bassetlaw and addressing the needs of our most vulnerable citizens.

    e) Continue our transformation of community based mental health services and achievement of parity of esteem for users of Mental Health services.

    f) Support the development of digitally enabled services that put the citizen at the heart of their own care as well as digital confidence and competence of service users.

    g) Support sustainability and social value, ensuring value for money for the place and system pound.

    h) Reduce duplication and inefficiency across the system by sharing best practice and resources to collaborate on transformation schemes aligned to our priorities.

5. The partnership reaffirmed its priorities in January 2022 in both readiness for moving geographical footprint from the South Yorkshire ICS to the Nottingham and Nottinghamshire ICS and as a consequence of the impact of the Covid-19 Omicron variant.

6. Bassetlaw PBP has recently come together again to review progress and priorities in order to develop the Bassetlaw Place Plan for 2023/24, giving due consideration and ensuring consistency with the ICS Integrated Care Strategy, Nottinghamshire Health and Wellbeing Strategy and the needs of Bassetlaw citizens. As well as delivering improved integrated care at a local level, the PBP will be the local driver for maintaining focus on these system priorities and will support the ICB to achieve its core four aims and delivery of national expectations (for example primary care resilience, PCN development and the ICB Primary Care Strategy). In order to achieve these multifarious demands on local capacity (supported by ICB programme leads and subject matter experts), the local ICB dedicated resources at Place will continue to work in a fully blended delivery model. This model is also critical as we continue to transition into a whole system approach for Bassetlaw into the wider Nottinghamshire

footprint and continue to maintain our links into South Yorkshire, which reflects local pathways of care.

Delivery of 2022/23 priorities

7. Based on extensive review of local population health needs, the priorities for Bassetlaw PBP fit into six categories: sustainability; same day urgent care; children, young people and maternity; mental health; reducing health inequalities; and working inclusively.

8. These priorities and their supporting programmes and initiatives are based on population health management, proactive care and prevention approaches with specified metrics for delivery reported via the Bassetlaw Health Inequalities Forum (HIF). Programmes of work are overseen by the Bassetlaw HIF with multiple task and finish groups delivering specific projects to support the overall programme delivery. The HIF is made up of almost 40 partner organisations that are proactive in Bassetlaw.

9. The HIF has oversight of a performance dashboard that is reported monthly and also presented to the Bassetlaw Partnership Board for awareness and comment. The most recent HIF dashboard is included at **Appendix B**. More recently, a newly formed executive leaders group (the Bassetlaw Cabinet) has been created to enable more robust conversations with local leaders in relation to delivery of agreed ambitions. This group will have a more direct role in supporting the delivery of the Bassetlaw Place Plan for 2023/24.

10. In addition to HIF reporting and assurance to the Bassetlaw Partnership Board, the PBP provides a quarterly assurance report to the Nottinghamshire Health and Wellbeing Board reflecting Bassetlaw PBP's commitment to the delivery of the Joint Health and Wellbeing Strategy.

Place-based achievements

11. 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 local health and wellbeing outcomes (see **Appendices C and D** for more detail). Whilst not an exhaustive list, key achievements include:

    a) Developing our cost-of-living response

    b) Supporting local families in most need

    c) Collaborating to support our most vulnerable (e.g. those experiencing multiple disadvantage)

    d) Promoting primary prevention (e.g. through highly successful local vaccination campaigns led by our PCNs)

e) Creating efficiencies and promoting value for money (e.g. in promoting use of our public estates and developing local health care facilities for primary and secondary care)

f) Addressing our population health challenges (e.g. creation of a Bassetlaw Suicide Prevention Alliance)

12. The impact of work from a patient or citizen perspective can be accessed via the following link. https://healthandcarenotts.co.uk/bassetlaw-place-case-studies/

Next steps

13. Bassetlaw PBP is a mature group of organisations committed to the principle of working in partnership and is a coalition of partners with a track record of aligning resources to deliver improved outcomes through an agreed set of programmes. With the recently developed Nottingham and Nottinghamshire Integrated Care Strategy, the development of the ICB's five-year Joint Forward Plan and the recently published 2023/24 NHS Operating Framework, Bassetlaw PBP partners are keen to continue to explore opportunities for the PBP to play a more supportive role in delivering system priorities.

14. The development of the 2023/24 Bassetlaw Place Plan will provide an opportunity to outline more clearly our local ambitions for the next one to five years and how we can work within the Nottingham and Nottinghamshire ICS to achieve our shared vision to enable every person to enjoy their best possible health and wellbeing.

15. The draft Bassetlaw Place Plan will be presented to partners for consideration and adoption at the Bassetlaw Cabinet and the Partnership Board meetings in March 2023.

Conclusion

16. Bassetlaw PBP has evidenced how an integrated approach can improve the coordination of health and care support and planning, resulting in positive impacts on health and wellbeing outcomes for its local population. This approach has been, and will continue to be, built on the principle of maximising the value of the partnership's collective resource to achieve a shared ambition to improve health and wellbeing outcomes and reduce health inequalities for the people of Bassetlaw.

Appendix A – Key health and care challenges in Bassetlaw

The guiding purpose of the Bassetlaw PBP is to address issues of health inequalities in Bassetlaw. Key health and care challenges include:

- Life expectancy for both men and women is lower than the England average- with even lower rates of 8.7 years for men and 6.9 years for women in the most deprived areas compared most affluent areas of Bassetlaw.
- 8% of the population live within the 10% most deprived areas across England and 20% live in the 20% most deprived areas.
- 22% of people have a limiting long-term illness compared with 18% across England
- 28% of people have no qualifications compared with 22% across England
- 20% of households have no car, and as a rural area with poor transport links accessing services is a challenge.
- Bassetlaw has higher rates of childhood obesity at 23.7% in comparison to the England average at 21%
- Bassetlaw rates of adult obesity are higher at 67.4% in compassion to the England average at 63%
- Bassetlaw has higher rates of pregnant women smoking at time of delivery at 13.1% in compassion to the England average 9.6%
- Bassetlaw has higher rates of full-term babies with low birth weights at 3.2%, in compassion to the England average at 2.9%
- Bassetlaw has a significantly higher rates of suicide at 14.6% per 100,000 population in comparison England average 10.4%
- Recorded dementia diagnosis rates are higher in Bassetlaw 71.8% compared with the England average of 62%
- 36.3% adults with long term mental health conditions are smokers compared with the England average of 26.3%
- Bassetlaw rates of emergency hospital admissions for COPD are higher at 429.7 per 10,000 in compassion to the England average of 415.1.
- 2021 Census figures evidence that the Bassetlaw's population has increased by 4.4% between 2011-2021, with a 24.6% increase in people aged 65 years and over.
- Bassetlaw's approximate population aged 65-90+ is 22.33%, compared the England average of 19.43% and Nottingham and Nottinghamshire's average of 17.85%.

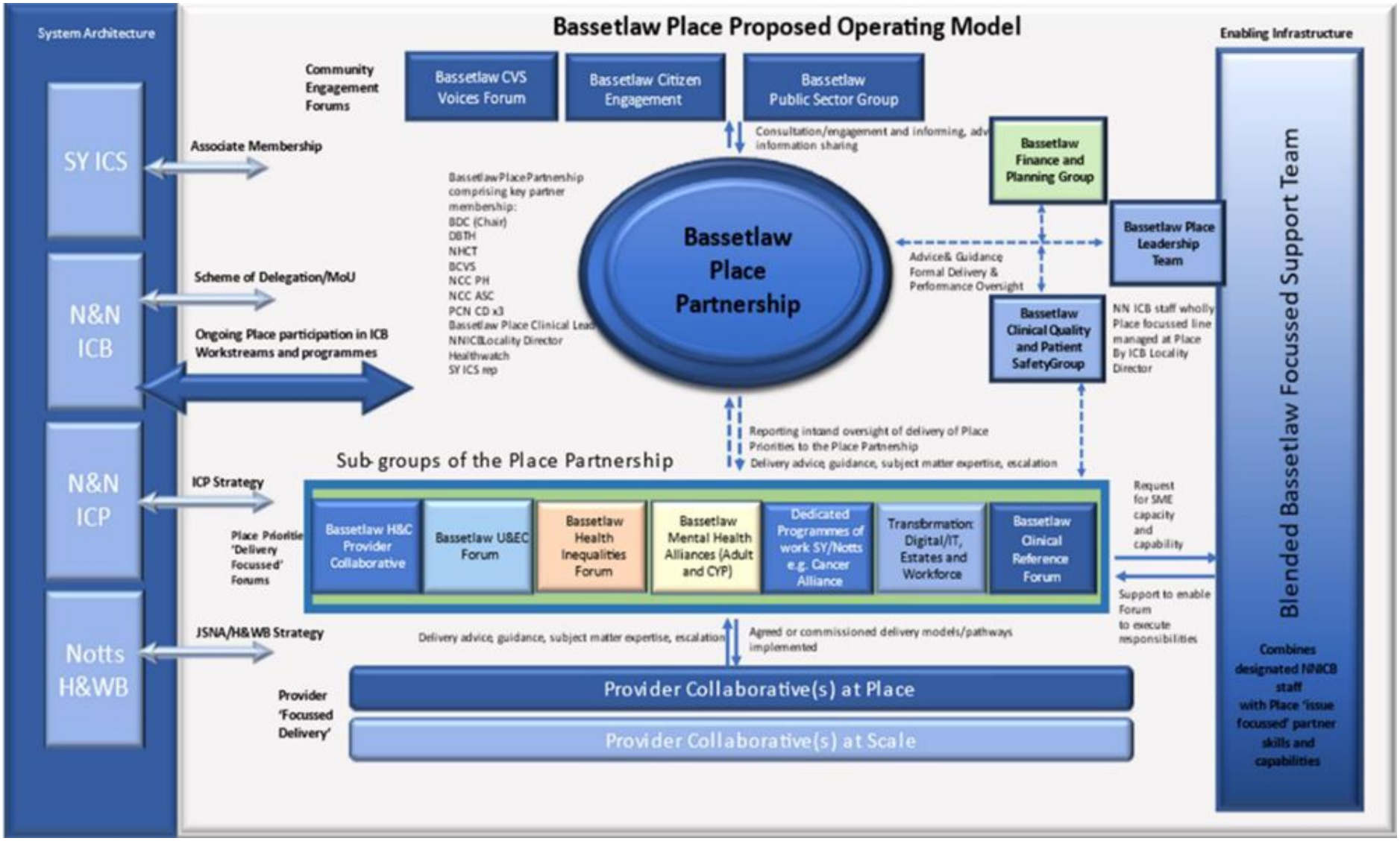
Appendix B – Bassetlaw Place Based Partnership Governance Structure

The Bassetlaw Place Based Partnership (PBP) oversees programmes of work that deliver agreed outcomes that address local population health need. Delivery of programmes and supporting initiatives are supported by the Place Delivery Team. The Place Delivery Team is comprised primarily of ICB delegated resources supplemented by additional transformation and project support from partner organisations on a flexible 'per programme/initiative' basis. Partners lead on key programmes of work where they are best placed due to their requisite skills, capacity and capability.

Governance arrangements support the principle of *subsidiarity*, ensuring that decisions at individual care pathway level are made at the most local level appropriate. This promotes maximum empowerment of local health and care teams and promotes flexibility and adaptability. It also supports consensus building at Primary Care Network level to allow services to be integrated, designed around the needs of particular communities.

The Bassetlaw Place Memorandum of Understanding (MoU) requires that where Primary Care Networks wish to make changes to services that would result in a change in how resources are deployed or managed across organisations then these must be agreed by all relevant parties directly affected by that change and a mandate for the change sought by the Partnership. The MoU also outlines agreed values and behaviours across the Partnership.

These governance arrangements are regularly reviewed to ensure they remain fit for purpose. For example the PBP has recently established a senior leaders group, the Cabinet, to provide more direct and detailed oversight of programmes of work. A Finance and Planning Group is also to be established to provide advice and guidance to the Partnership. The operating model for BPBP is below:



Appendix C - Bassetlaw PBP Priorities Performance Reporting Dashboard

Bassetlaw
Place Based Partnership

Priorities Performance Dashboard

January 2023

Integrated Care System
Nottingham & Nottinghamshire

- Increase Green Social Prescribing and Physical Activity
- Reducing our Carbon footprint
- Reducing Air Pollution

- Transformation of Same Day Urgent services to meet clinical need
- Improving confidence for self care/management
- Provide urgent care to th20% most deprived population

- Reducing Obesity
- Meeting the mental health and wellbeing needs of C&YP
- Improve best starts and uptake of prevention initiatives to support heathy children and healthier adulthood

- Meeting health needs of people with severe mental illness
- Reducing Suicide and self-harm rates
- Reducing mental health related hospital admissions
- Reducing levels of GP recorded levels of depression & anxiety

- 20% most deprived population focus- COVID vaccinations, access, opportunities, prevention initiatives, awareness campaigns
- Costs of living crisis initiatives
- Reducing smoking rates
- Improving access for those at risk of experiencing increased inequalities
- Improving early cancer diagnosis

- Increasing digital confidence and competence
- Improving Frailty patient outcomes
- Reducing social isolation and loneliness

Key outcomes and Initiatives 22/23

Promoting Sustainability

ADULTS CORE20Plus5 Key Clinical Area

CYP incorporated from March 2023

OUTCOMES				
Reducing Air Pollution	Increase green social prescribing	Reducing the Bassetlaw Carbon footprint	Achievement of ICB Efficiency targets	Achieve financial balance as a Place
KEY INITIATIVES				
Pledge from partners to develop and implement policies supporting home working and on -line meetings, where appropriate.	Increase in recreational green spaces within Bassetlaw, supported by BDC planning.	Pledge from partners to develop and implement Sustainability Policy and Action Plans, supported by BCVS for VCSE partners.	Respiratory care pathway review as part of virtual ward development.	
MONITORING METRICS				
>10% increase in green social prescribing 2022/23 through funded Green/Blue initiatives	Increased number of local residents and landlords implementing carbon neutral homes initiatives	At least 75% (average) of meetings with external partners/non -client conducted are via on-line (quarterly audit of partners)	>10% Reduction in emergency admissions related to respiratory (adults and children)	>20% increase in Third and Voluntary sector NHS funded partners having and implementing a Sustainability Policy & Action Plan	Achieve financial balance on operating costs (Bassetlaw Place ICB delegated resources)	Achieve balance on overall delegated Bassetlaw budget

Key outcomes and Initiatives 22/23

Same Day Urgent Care

ADULTS CORE20Plus5 Key Clinical Area

CYP incorporated from March 2023

OUTCOMES			
Supporting those with ill health to remain confident and supported to stay well at home	Improving estates provision for Urgent and Emergency Care at Bassetlaw Hospital site	Reducing demand for hospital provided urgent care for those with SMI and CYP and 20% most deprived population	
KEY INITIATIVES			
Bassetlaw Emergency Village- in line with UTC Standards including paediatric pathway	Implementation of 2 year pilot- Front Door model for Bassetlaw ED- mutual agreement between DBTH and NHT	Increase in crisis support for people with SMI e.g. crisis sanctuaries, safe spaces, crisis helpline, 24/7 CRT.	Increased access to advice and guidance and direct referrals to Bassetlaw Same Day Emergency Care (**SDEC**) from GPs, EMAS and NHCT (for Medicine, Surgical, Family (Paed and Gynae)-
ED streaming and redirection tool implementation	Review of pathways for geriatric, respiratory and frailty patients	Reconfiguration of GP same Day appointments via 111	
MONITORING METRICS			
10% increase in use of Healthier Together website from Bassetlaw residents (baseline 2020/21)	Progress on Bassetlaw Emergency Village (BEV)	>5% reduction in ED attendances for people on SMI register	Increase to minimum monthly average 20% of patients presenting at ED streamed into alternative pathways of care including self care. Baseline average 2019/20.
A minimum of 400 A&G calls to be received by SDEC services in 12 month period (Apr22-Mar23)	At least 50% of A&G calls to SDEC to have an outcome recorded	75% of calls 111 calls booked into a GP practice or GP access hub	
	Reduction in emergency hospital admissions for all causes	>5% reduction in emergency admissions 65yrs+ (baseline 2019/20)	5% reduction in ED emergency admissions for people on SMI register

Key outcomes and Initiatives 22/23

Children, Young People & Maternity

ADULTS CORE20Plus5 Key Clinical Area

CYP incorporated from March 2023

CORE20 20% most Deprived focus

OUTCOMES						
Improving early starts for Bassetlaw children and young people	Reducing demand for hospital provided urgent care	Increasing children and young peoples physical activity	Reducing obesity levels in school age children	Promoting employment, training and skills for younger people	Improved uptake of prevention initiatives to support heathy children and healthier adulthood	Improved mental health and wellbeing outcomes for children and young people.

KEY INITIATIVES				
Improved Maternity care services working in parentship with DBTH	Increased volunteering initiatives for younger people. POV	Childhood obesity/family weight management programmes with focus on most deprived areas	Expansion of provision of mental health & wellbeing services for C&YP including a focus on most deprived areas PCN based CYP Social Prescribing Link workers School based MHST VCSE delivered counselling and MH support Provision of crisis sanctuaries LGBT+ support Kooth	Development of Suicide Prevention Alliance & initiatives
Increased provision of outdoor green and blue initiatives- BCVS	Harworth & Bircotes Youth Hub			Improved Flu and COVID Vaccinations for eligible CYP <25 years including a focus on most deprived areas
COVID and Flu vaccination campaign	Fundamental films- sexual health education	Children & Family service for those affected by cancer Aurora & Talkzone		Re-establish place based C&YP Network and increase programmes focused on CYP and engagement of CYP
Bassetlaw Children & Young people's Mental Health Alliance	Increased access to Perinatal Mental Health Services	School Uniform Bank and ' The Boot Room'	Family Hub Networks in Nottinghamshire	

Key outcomes and Initiatives 22/23

Children, Young People & Maternity

ADULTS CORE20Plus5 Key Clinical Area

CYP incorporated from March 2023

CORE20 20% most Deprived focus

MONITORING METRICS

Improved perinatal Mental Health	70 % Flu uptake in eligible school age children	25% uptake COVID-5-15 years-Not in at risk groups	75% of CYP received support within 24 hours of referral, for crisis resolution home	80% reported improvement in mild to moderate MH outcomes measured ON54 <25yrs Social Prescribing Link workers and PCN Personalised Care Roles	
10% increase in referrals for smoking in pregnancy support	Min 65% uptake COVID 16- 17 – 29 years	70% uptake COVID-5-15 years- in at risk groups	5% increase in employment for <25yr old	75% Of CYP accessing Kooth recommend this service, showing access quality online digital support	
Reported continuity of maternity care 75% of BAME women and those from most deprived groups.	Min 65% uptake COVID 16- 17		Increased communication and awareness of Bassetlaw CYP mental health services across the Place Parentship	Increased number of CYP accessing School Uniform Bank and ' The Boot Room'	
	70% uptake COVID-5- 11 years -at risk groups	Progress on Bassetlaw Family Hub	90% of secondary schools and youth groups embedding Fundamental Films & Lesson Plans	10% increase in CYP engagement in outdoor initiatives	
75% COVID vaccination uptake in pregnant women			Increased provision for young people living in Haworth and Bircotes	Increased number of partners engaged place based C&YP Network	
		>5% reduction in obesity levels in school age children <16 years by 2025	Reduction in reported rates of self harm		
75% flu vaccination uptake in pregnancy	25% uptake COVID-5- 11 years –Not at in risk groups		80% of CYP accessing targeted provision demonstrate improved mental health and wellbeing outcomes (NHS funded initiatives)	>20% increase in volunteering opportunities	>5% reduction in childhood asthma (0-16yrs) **Baseline from April 2022 to review reduction in April 2023*

Key outcomes and Initiatives 22/23

Mental Health

ADULTS CORE20Plus5 Key Clinical Area

CYP incorporated from March 2023

CORE20 20% most Deprived focus

OUTCOMES

Increased employment for patients with SMI	Increase in overall health of people with SMI	Reduction in hospital related MH admissions	Reduced levels of GP recorded levels of depression and anxiety	Reduced levels of GP recorded social isolation and loneliness	Increasing remote/virtual access to health services and support	Increase in locally developed volunteering capacity	Reduced Suicide rates and self harm rates

KEY INITIATIVES

Increased referrals to Individual Placement Support (IPS) Employment support service for people with severe mental illness (SMI)	Completion of health Checks for people with SMI and LD, Working Win employment support	Increase in provision of MH services and roles for adults: High Intensity, Admiral Nurses and Mental Health Practitioner roles in PCN's IAPT Services Men's MH support groups Bereavement support services Street Watch Programmes VCSE MH services and projects Peer support workers- Mind BPL Health & Wellbeing Coach	Increase in support for adults at risk of social isolation: PCN Social Prescribers Community support initiatives for shopping/transport	Implementation of Comms initiatives to support public awareness of local MH services Prevention Concordat for Better Mental Health	Increased volunteering initiatives for adults Development of Suicide Prevention Alliance, local pledges and initiatives.

MONITORING METRICS

10% of people on SMI register supported into employment Increased number of people on Working Win Service	A minimum of 60% Health Checks for of people with a SMI Deployment of R;pple Suicide Prevention tool across Place Partnership	A minimum of 75% Health Checks for of people with LD Min 10% reduction in MH admissions (2019/20 baseline)	75% of people received support within 24 hours of referral, for crisis resolution home treatment.	Min 10% increase in social prescribing referrals (via PCNs) related to social isolation and loneliness 2019/20 baseline	70% of people accessing targeted provision demonstrate improved mental health and wellbeing outcomes (CCG funded initiatives)	Increase in Peer Support Worker and Mental Health related roles across Bassetlaw Place 10% reduction in number of A&E for self-harm of adults
Increase in number of adults engaging in volunteering	Increased visibility and awareness of local mental health support services via collaborative comms and citizen engagement initiatives	Development of Bassetlaw suicide prevention Action Plan Increased suicide prevention initiatives across Bassetlaw		Reduction in reported rates of self harm from Third sector providers	50% Recovery rate for adults accessing psychological therapies	10% reduction in emergency admissions for self-harm of adults

Reducing Health Inequalities/ Improving health equity

ADULTS CORE20Plus5 Key Clinical Area

CYP incorporated from March 2023

CORE20 20% most Deprived focus

Key outcomes and Initiatives 22/23

OUTCOMES					
Improved access for vulnerable communities including those in the 20% most deprived areas.	Increased uptake of vaccinations and immunisations	Reducing mortality and morbidity related to cancer	Successful implementation of monitoring standards across partnerships, supporting to identify target population and improve outcomes for people with characteristics protected by the Equality Act 2010.	Reduced risk of myocardial infections and stokes	Increased opportunities for employment, education and training
Increased number of prevention initiatives focusing on wider determinants of health across deprived and vulnerable communities	Min 85% uptake COVID booster vaccinations 20% most deprived areas	Reduced health inequalities and premature mortality related to smoking		Increasing ill health prevention	Promoting earlier access to appropriate services
KEY INITIATIVES					
Implementation of 'C the Signs' initiative across all GP practices Increased cancer Screening programmes Cancer Alliance Behavioural Science nudge techniques implementation across all GP practices Comms and public engagement cancer awareness campaigns supported by all partners	Evergreen COVID and Flu vaccination campaign Increase blood pressure check availability across the community Cancer Champions based in PCN's	Increased promotion of Health Checks for people with LD/SMI across all partners Bassetlaw food Insecurities Network	Increased collaborative Comms Strategies to support wider awareness of local services offering direct access including Bassetlaw website offering DOS for physical and MH services and self care support Substance misuse Peer Support Workers- Double Impact	Completion of Worksop Bridgecourt Place supporting local education/training/employment Increased usage of Mobile Health bus for health promotion/advice LGBT+ Partnership Forum
Implementation of Targeted Lung Health Checks - 50yrs+ ex-smoker/occupation.	Increased community engagement and prevention initiatives within Worksop South East- Thriving Communities Strategy (BDC 2021-25)	Waiting Well Initiative		
Prevention initiatives ABL- Adult weight management, Physical Activity, Alcohol reduction. Homeless Health Team-Out of Hospital support.	QUIT- Smoking Programme	Bassetlaw Health Improvement Team (HIT) focusing an annual physical health checks and follow up care	Implementation of monitoring standards across all CCG funded programmes.	Implementation of local reporting methods

Monitoring Metrics 22/23

Reducing Health Inequalities/ / Improving health equity

ADULTS CORE20Plus5 Key Clinical Area

CYP incorporated from March 2023

CORE20 20% most Deprived focus

MONITORING METRICS				
Min 85% booster vaccinations for COPD patients.	Min 80% case finding of expected prevalence of population hypertension case per PCN	0.5% reduction in in hypertension exception reporting across all practices (CHD008) (excluding where no existing exceptions)	0.5% reduction in in hypertension exception reporting across all practices (CHD009) (excluding where no existing exceptions)	Min 95% completion of ethnicity monitoring records for all providers (inc exception reporting)
Min 85% uptake COVID booster vaccinations 20% most deprived areas	Min 3% increase in COPD patients receiving Flu vaccination (COPD007)	Increase in hypertension control for recorded patients per PCN (total population and 20% most deprived) i.e. HYP003 to min 47% (CCG ave) with max exception reporting rate of 4%	Reduced unemployment rates for most deprived population	Min 10% Increase in social prescribing referrals baseline 2019/20
			75% of all cancer cases diagnosed at Stage 1 or 2 by 2028	>10% Increase in referrals to NDPP and Low Calorie Diet
Reduced smoking rates across Bassetlaw	Increased in the number of annual physical health checks and follow up ca being provided	50% increase in local providers with minimum monitoring standards for CCG funded community programmes	Increase in comms and public engagement awareness campaigns supported by all partners	Increased numbers of GP practices implementing C the Signs' initiative and Cancer Alliance Behavioural Science nudge techniques.
Increased community engagement levels and progress with prevention initiatives within Worksop South East- Thriving Communities Strategy.		Increase in availability of blood pressure checks across the community	Increase in Mobile Health bus usage for health promotion/advice	Increase in numbers of homeless people accessing support via Homeless Health Team
Increased number of affordable food hubs in Bassetlaw	70% uptake in Targeted Lung Age Health Checks Programme	Increased engagement and focus on reducing health inequalities across LGBT+ communities	20% increase in access to substance misuse support	Developing metric focused on work of Cancer Champions
				Min 10% reduction in overall unemployment

Key outcomes and Initiatives 22/23

Working Inclusively

ADULTS CORE20Plus5 Key Clinical Area

CYP incorporated from March 2023

CORE20 20% most Deprived focus

OUTCOMES					
Promotion of digital confidence and competence		Increase in virtual support for patients with health and care needs		Development of new Diabetes Framework increasing joint clinics, mentorship and education.	Increase in seamless transition of support and care for patients and carers
Increased all age frailty support		Reduction in social isolation and loneliness			
KEY INITIATIVES					
BCVS initiatives to promote digital confidence in most deprived communities	Virtual Wards for patients with Frailty and Respiratory conditions	Diabetes Community Model	Implementation of connecting initiatives to support peer support network e.g. Dementia and Mental health	Roving exercise support for rural communities and older people	End of Life and Palliative Care Integrated Pathway
MONITORING METRICS					
Min 10% increase in reported overall digital confidence 22/23 to 23/24		Increase in website hits for Bassetlaw Place supporting signposting of services	Reduction in social isolation and loneliness monitored through Min 10% increase in social prescribing referrals (via PCNs) related to social isolation and loneliness 2019/20 baseline	% of adult social care users reporting they have as much social contact as the would like.	Reduction in % of patients who have 3 or more emergency admissions during last 90 days of life
20% increase in numbers of patients engaging roving exercise support- rural communities and older people		Progress on Virtual Wards development (Frailty and Respiratory) 2022/23		Overall primary care consultations across face to face, video and telephone consultation modes above national averages	Progress on End of Life and Palliative Care Integrated Pathway

Appendix D – Bassetlaw Place Based Partnership Achievements (Case Examples)

Developing our Cost of Living Response

Bassetlaw VCSE are a vibrant and essential resource to deliver impacts for the citizens of Bassetlaw affording a proactive preventative approach to care. As a result of closer working relationships, partners have successfully aligned resources to improve efficiency of working across the partnership, positively impacting health and wellbeing outcomes. For example the development of social prescribing at Bassetlaw Hospital in ED and discharge (pre-empting this work which has now been established across the Nottinghamshire footprint). BCVS led on the development of a Bassetlaw Cost of Living Crisis Booklet (again providing a blueprint for the Nottinghamshire system).

Supporting local Families in most need

As a rural 'place' Bassetlaw have associated challenges linked to being able to access primary and secondary health care services and have a greater dependency on community service provision outside or public sector provision of services. Through partnership working with local community groups and citizen representatives, local authority leaders, health and care organisations and the Nottingham County Council public health team we have successfully launched a Family Hub in an area of specific community need. This Hub provides a wide range of support and advice to families spanning health and care needs as well as wider issues that matter most to them such as improved access to employment and debt advice.

BPBP came together as a response to the influx of Ukrainian guests following Russia's invasion of Ukraine – there is a local info pack avai :w guests detailing how to access services and support groups availa aw has a specific support group for Ukrainian people new to the area.

Collaborating to support our most vulnerable

Working alongside community and voluntary groups BPBP ensured the most vulnerable groups in the locality had access to 'warm space' 'warm packs' and 'food hubs' as well as having a community bus to reach our most rural communities. Each of these interventions ensured a MECC approach to ensure that there is signposting to support and appropriate advice. The BPBP Cost of Living leaflet and QR code, consistently used across all partner organisations communications channels, promotes this single message across all networks and communities – avoiding confusing messages for the public and creating efficiency in use of limited communications resources.

Partners have worked together to ensure that there is maximum uptake of support schemes / benefits / financial advice across the area.

BPBP organisations have come together at various events to have maximum representation to improve health prevention activities, such as vaccine uptake and access to healthcare, support to access to food banks, travel schemes and heating support.

Promoting ill health prevention: Vaccination

Through targeted work to increase Covid and 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. BPBP partners also worked alongside communities to increase covid vaccination rates in minority communities, including mobilising a community health bus to workplaces and school sites. Bassetlaw has consistently had one of the best uptake rates across the ICS and compared favourably with national rates.

Creating efficiencies and promoting value for money: Estates

BPBP have worked together to ensure that they can maximise the availability of estate across the place footprint. Maximising estates includes wherever possible reducing private landlord arrangements to maximise One Public Estate and reducing void space. This has led to, for example, relocation of Mental Health services to the BDC Queens Building, identifying areas for sexual health services to be relocated closer to Worksop centre, developing a 'Statement of Common Ground' regarding future housing developments ensuring green space availability is considered. The Bridge is a new estate resource that is being maximised and promoted by partners in the centre of Worksop. This facility has a virtual ward supporting placements for health care professionals and their training.

BPBP have supported the development and submission of the Outline Business Case (OBC) and more recently Full Business Case (FBC) for the Bassetlaw Emergency Village seeking capital investment of £16 million. In conjunction with ICB leads, BPBP is also working to support the submission of the FBC for Newgate Health and Well Being Hub. This is a Section 2 arrangement with NHS England and BDC which will see the much needed development of a health and well being hub in the centre of Worksop.

Addressing our population health challenges: Suicide Prevention Alliance

Locally, Bassetlaw has high rates of suicide making the area an outlier locally and nationally; as a consequence BPBP called a 'Suicide Prevention Launch Event'. The suicide prevention launch saw multiple partners come together to agree local priories to address the suicide rate in Bassetlaw and local pledges to take forward. In addition to this, Bassetlaw have continued to work with South Yorkshire in its approach to suicide prevention including the production of the 'Walk with Us' toolkit that has recently attracted national attention as leading practice.

Appendix E – Bassetlaw Partnership Achievements (Q3 2022/23)

2022/23

Up to Q3

Monthly group support for people with dementia and their carers within local community.

99.9% of local people accessing Bassetlaw IAPT services receive treatment within 6 weeks.
Average wait referral to assessment is 4.9 days

Talkzone – CYP Mental health Service
165 CYP in service as of Dec 2023
770 sessions counselling delivered to C&YP; 546 sessions delivered in extended access times.
Reducing increased MH needs and CAMHS referrals

BAC - SWP – 164 referrals accepted
Promoting Independence – 46 referrals accepted
Transport Programme – 6502 journeys completed
Men's Walk Talk – 23 people regularly attending sessions

Aurora: 562 people supported to access personalised care support. 277 people supported via one-to-one sessions and 37 group sessions delivered.

>30 people supported through self harm pathway
To reduce level of self harm and self care

54% SMI Physical health checks increase from 37.4%
42.2% LD Health checks (from Place Priorities Dashboard)

Oasis
Veteran's projects promoted at Oasis Circus Tent events throughout September.
Supporting bereaved veterans with cooking classes and access to subsidised meals

C the Signs adopted across all practices in 2021/22 to support decision making and early cancer diagnosis.

Health Improvement Task and Finish Team, implemented Q4 working across Bassetlaw PCN's increasing uptake of annual physical health checks and follow up care

The Edge – Men's MH Supported 75 men up to Dec 22.
Hosts in Sam's Name weekly support group.
Oasis has supported over 500 people locally

Optometry First - 4 new live services launched.
9% reduction in referral to secondary care, 33% reduction in internal C2C referrals and 70% reduction in patients waiting over 52 weeks for optometry services.

Non Urgent Community Dermatology Service protected two week cancer pathway at Trust as only patients with true two week wait referred to hospital. Maintaining care closer to home. 2,500 patient accessed community service.

CYP MH Alliance met monthly to continue shared learning and pathway improvement involves all providers, GP, NCC and education colleagues.

11 pop up holistic health and wellbeing community events with blood pressure checks, C02 monitoring, BMI checks and information support and guidance on Mental Health Services, Weight Management and Stopping Smoking in one accessible community-based venue.

BPL-finalist for HSJ NHS Partnership Award

104 new referrals to Mind #well programmes.
121 total users are accessing the various #well programmes
Community cafes in most deprived communities/under represented populations

Vaccines uptake –above ICB average :
Visited schools using vaccine bus to increase CYP uptake,
Visited workplaces to increase uptake in deprived areas.
Health bus to those communities not represented

400 new referrals to Long Term Exercise project.
186 people fully completed.
96% of users reported an improvement in their health.
100% of users continuing to exercise after the end of the programme

188 people supported through dementia connect service, reducing Isolation & sign posting to Right support first time.	22 CYP Supported by Bluebell Wood Children and Young Peoples Hospice	3401 sessions of befriending provided by BAC through peer to peer support, telephone support and group sessions reducing isolation, loneliness and depression.	77 Staying Well groups delivered by BAC supporting self care and self management of long term conditions avoiding presentation in clinical settings and reducing medication support.
227 active families on Database. Sensory service Offer. Supporting whole Family approach	people with SMI supported to employment IPS service received centre of excellence award in 2021/22 Working Win have supported 66 people with a health condition to achieve a Job outcome- 110% of profile and 56 people have sustained a job 116% of profile 202/23	CAB have supported 922 clients as of Dec 22 with some clients receiving as much as £2500 in additional benefits with over £1.5million benefit support	Doncaster and Bassetlaw Teaching Hospitals (DBTH) and Retford Oaks Academy launch landmark partnership with second 'Foundation School in Health' in UK, to develop opportunities and widen participation for pupils from the Bassetlaw area wishing to pursue a career in the health and care service Q3.
373 adults with accessed QWELL online mental health support Platform. 91.9% returning logins 98% would recommend Q4 22/23-Q4 23/24	54 people supported by BPL cardiac rehab service, care closer to home improving clinical outcome, self management and avoiding repeated cardiac attendance.	The Sleep Charity supported 77 families and provided sleep workshops in Bassetlaw Schools. Supporting improved school attendance improved resilience, positive behavioural changes and medication reduction.	You Before Two – produced 6 'Fundamental films' sexual health videos and lesson plans accredited for use within schools nationally at a cost but free to all Bassetlaw schools and CYP services
CYP Social Prescribing Link Worker within R&V PCN evaluated with 196 CYP 11 -19yrs supported within the first 10 months Q1. Expanded within R&V to x2 WTE roles Q4	64 CYP supported by Childrens Bereavement Service, avoiding longer term mental health issues, increased resilience and family support.	PIFU across 5 secondary care pathways and 8 pending 22/23 intended to reduce number of outpatient appointments.	100% completion on health inequalities monitoring and reporting implemented across commissioned services from Q2. 93% competition of ethnicity recording across PCN's Q4
Medical SDEC - Advice and Guidance and direct referral lines for EMAS to seek consultant-led advice and guidance for the management of patients on scene with the option for direct referrals of the patient to SDEC avoiding ED	Bassetlaw Provider Collaborative- partnership working to respond quicker to issues locally	Surgical SDEC and Emergency Geriatric Service Advice and Guidance lines for GPs to contact secondary care clinicians avoiding onward referral to secondary care.	Pilot launch of ED Streaming and Redirection Tool in BDGH ED for patients aged 16+.

Family Hub Network operating in Bassetlaw from January 2023 Q4.
Partner organisations offering provision from the hub on a weekly basis.

Health day in Retford providing blood pressure checks to local people.
Promotion of exercise and well being attended by multiple partners.
Defibrillator lesson.

Real Talk a series of free workshops for young women aged 14-18 that have been co-produced with young people delivered by Transform Training.

X3 WTE Mental Health Practitioners fully recruited in all 3 Bassetlaw PCN's Q3

Suicide Prevention

Small grants scheme supporting 7 VCSE suicide prevention projects Q1
Self-harm rates reported and monitored across commissioned community based mental health services Q1
Bassetlaw Suicide Prevention Alliance Launched Q2

Bassetlaw engagement within Nottinghamshire Suicide Real Time Surveillance Working Group, Nottinghamshire Healthcare Trust Suicide Prevention Strategy Group, East Midlands Regional Suicide Prevention Forum and Nottinghamshire & Nottingham Suicide Prevention Strategy Group- Q2. The Strategy group received a Excellence in parentship Awards (Q3)

Bassetlaw pledge wall and commitment from place partners to implement mandatory suicide prevention training Q3

Agreement for Zero Suicide Alliance, Suicide Prevention Training mandated for all ICB staff across Nottingham & Nottinghamshire Q3

First Suicide Prevention & Mental Health month long awareness campaign Q3
Launch of co-produced toolkit 'Walk With Us' - aimed at CYP and families bereaved by suicide- Developed in partnership with South Yorkshire and Bassetlaw Q3- shortlisted for Local Chronical Award Q4

Bassetlaw Place Parentship become joins National Suicide Prevention Alliance Q4

Mental Health First Aid and Applied Suicide Intervention Skills Training being delivered across Place at subitised costs for VCSE partners with mental health Q1-2 2023-24

R;pple –working to develop and implement bespoke version of online suicide and self harm content interception tool across Bassetlaw Place Q1-2 2023-24

New blood pressure monitors in covid vaccination clinics across Bassetlaw as part of autumn booster roll out.

LGBT+ communities

Local LGBT+ Forum feeding into Health inequalities forum Q1
Worksop Pride supported by place partners Q3

Co-development of inclusive mental health recourse packs to distribute at community events

Launch of Harworth & Bircotes 1st Pride Q3

Launch of first Place LGBT+ History Month Campaign co-produced pack developed with LGBT+ communities Q4

LGBT+ 150 new referrals
297 one-to-one counselling sessions provided
79 group sessions provided
100% of users surveyed stating that the service has had a positive impact

Point of View Project (POV) and Y-Volunteer Projects

POV- BCVS and Junction Arts are working with 9 local VCSE sector organisations to collectively provide over 100 local new volunteer opportunities for young people. Q2

Y-Volunteer BCVS consulting with over 300 on barriers to volunteering.

BCVS to run a campaign to affect changes needed with local partners

Young People Advisory Group being established

Youth Hub Development one stop support shop working collaboratively with Place Partners to deliver weekly sessions for young people within a rural area.

Expanding to all age provision within Q1 2023-24

Co-development of Adult and Children and Young People's mental health services posters- ensuring information on all local mental health services is available in one resource with QR codes to referral routes. Distributed and displayed across Place Q1	Co-development of QR code keyrings for Children and Young People's mental health services enabling access to a digital version of the mental health resource posters with interactive links to individual service information and referral options Q2	Project being developed by the CYP Mental Health Alliance to co-produce resources (digital and hard copies) with CYP, to share with CYP, parents and carers waiting to access services to support with managing CYP mental health and avoiding crisis escalation- Completing Q1 23/24	Project being developed by Adult Mental Health Alliance to co-produce a communication and engagement plans aimed at reducing stigma around mental health in the rural communities focusing on farmers and 'myth bust' some of the common misconceptions relating to accessing mental health and shotgun licencing implications. Completing Q1 23/24

Bassetlaw Cost of Living Support

Cost of Living Booklet- launched September 2022 in both digital and hard copy formats. Used as a template by other organisations across Nottinghamshire

Over 2,000 paper booklets and over 7,500 Leaflets with QR codes have been distributed across Bassetlaw by place partners
Between September to January 2023 the digital format has had the following reach:
— Online digital flipbook booklet 2,059 views
— BCVS Cost of Living landing page averages 17 views per day totaling 3,986
— 8,259 people reached with the BCVS Facebook page- this does not include information shared by partners across place

Booklets and leaflets have been shared with all GP practices and community organisations. Cost of Living Support will be distributed across Bassetlaw in March 2023 With the council Tax billing and information

Bassetlaw Food Insecurity Network (BFIN)- Launched the first Food Hub in June 2022, supported by a range of partners working with FareShare and other local food providers with surplus food, enabling local people to purchase a large bag of food for £3 that would otherwise go to landfill.

19 weekly food hubs operating across Bassetlaw open to the community with no access eligibility criteria.
Online views for the Food Hubs in Bassetlaw average 9 per day.

Warm Spaces- Bassetlaw Warms Space Directory was launched October 2022. On-line views on BCVS landing page for warms spaces in Bassetlaw average 25 per day, totaling 2,430, with BCVS Social Media post reaching 29,213 people- this does not include information shared by partners across place.

Over 50 Warm Spaces mobilized across Bassetlaw operating 7 days per week

Eastern European and Ethic Minority Group Development Officer employed within BCVS working across Place to increase engagement with local citizens of ethnic minority origins- Q2	Flooding in Bassetlaw leaflets and information produced by Bassetlaw District Council and shared by all partners in response to severe flash flooding	Healthier Together Website increase usage by 8% Q3. Being widely promoted across Place and within PCN's to support self-care	Kooth – 99 registrations as of the end of Q3 with a total of 111 service users 1486 total logins – average of 12 per service user
Targeted Lung Health Check (TLHC) Adapted programme for Bassetlaw to include: Conducting LHC virtually, increasing capacity. Trained LHC nurses in brief intervention stop smoking, resulting in 154 patients being referred into the Stop Smoking Service within 6 weeks of mobilisation Altering the 'opt out' element to the NICE guidance, further increasing referrals to the local stop smoking service. Outcomes within first 6 month of mobilization Q3-4 5,443 patients aged 55-74 years that are current or previous smokers have received a health check 450 patients referred to Stop Smoking Service 249 patients referred to MDT screening 16 cancers have been detected, 15 lung cancers 60% of cancers have been detected at Stages 2-3 (27% Stage 1- 20% % Stage 2- 13% Stage 3- 40% Stage 4) 41% of patients have had radical surgery, 6% with Chemotherapy 18 patients still awaiting investigation I can't find any data on targets I have had to find detailed info include breakdown so you can close which to use- this is what it did say- Stages 1-4 (2 patients at stage 4, rest between 1-3, meaning early intervention)		**Social Prescribing Link Workers** **3,191** patients have supported by Social Prescribing Link Workers (SPLW) across Bassetlaw during 2021/22 1,654 patients supported by Adult SPLW across all 3 Bassetlaw PCN's (4.4 FTE) 200 patients supported by Children and Young People SPLW within 1 Bassetlaw PCN (1FTE) 283 patients supported by Bassetlaw Hospital SPLW - ED and Discharge (1.7 FTE) 376 patients supported by BCVS-based SPLW /North Notts Support Partnership (1.0 FTE) 278 patients supported by Dementia Advisor - patients and carers (1.0 FTE) 3,587 Social prescriptions/ onward referrals have been made 109 Bassetlaw VCSE organisations/groups provided support from referrals 151 Volunteers have been supported as part of the SPLW model in Bassetlaw 100% of patients rated the support provided by the SPLW 5 out of 5	
Pilot Workplace Wellbeing Event- Q4 x2 Workplace Health and Wellbeing events to all shift rotations, providing language interpretation, COVID vaccinations, blood pressure and BMI checks C02 monitoring, and information support and guidance on Social Prescribing, Cost-of-Living Crisis, Food Hubs, Mental Health Services, Weight Management and Stopping Smoking. Identified large local business within the top 20% deprived area with higher rates of employees living within the area and of Eastern European ethnicity.		X3 Community One-Stop-Shop health and Wellbeing Events- focusing on the 20% most deprived areas-Q4 Providing a holistic health and wellbeing offer with access to COVID and Flu vaccinations, blood pressure checks, C02 monitoring, BMI checks and information support and guidance on Cost-of-Living Crisis, Food Hubs, Mental Health Services, Weight Management and Stopping Smoking in one accessible community-based venue.	

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/03/2023
Paper Title:	**Strategic approach to transforming health and care within community services**
Paper Reference:	ICB 22 070
Report Author:	Steven Smith, Programme Manager – Community Care Transformation (NHS Nottingham and Nottinghamshire ICB) Maxine Bunn, System Delivery Director – Mental Health and Children (NHS Nottingham and Nottinghamshire ICB) Gemma Whysall, Programme Director – Ageing Well (NHS Nottingham and Nottinghamshire ICB/ Nottinghamshire County Council) Becky Sutton – Community Care Transformation Programme Director / Executive Director of Mental Health Services (Nottinghamshire Healthcare NHS Foundation Trust)
Report Sponsor:	Lucy Dadge, Director of Integration
Presenter:	Victoria McGregor Riley, Locality Director - Bassetlaw and Mid-Nottinghamshire
Recommendation(s):	The Board is asked to **note** the progress of the Community Care Transformation Programme (CCTP) and the system approach to co-production, strategic planning and service delivery to meet the needs of the population

Summary:

This report provides an overview of the strategic approach to improve community health service provision across Nottingham and Nottinghamshire and reduce local health inequalities. Our local approach is well established through partnership working, developed in collaboration with key stakeholders.

The fundamental organising principle underpinning service transformation is a single set of system priorities and outcomes for community care transformation, which informs an integrated strategic planning approach; encompassing health, social care and third sector organisations. Managing interdependencies between services and effective utilisation of resources by working with Place, provider collaboratives and local communities to develop plans to address differentials in outcomes in each area is critical. The challenges for the system in managing the delivery of a large-scale programme within the current programme resource are described, as well as potential opportunities for the future, with delivery supported by the development of provider collaboratives and place-based partnerships and consolidating efforts with similar programmes.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	The CCTP aims to improve wellbeing and treatment, through increased and quicker access to services, by ensuring integrated planning and delivery. Service transformation plans are person focused, evidence based, utilising best practice guidelines
Tackle inequalities in outcomes, experience and access	The CCTP delivery approach ensures adaption to local population health needs. There are several examples of

How does this paper support the ICB's core aims to:	
	engagement with under-represented groups to address specific local issues relating to access to services.
Enhance productivity and value for money	Established working relationships between the Local Authorities and the ICB have increased opportunities for collaborative planning and securing integrated provision. In turn examples can be given of how this has made better use of limited resources and make sense to providers and service users.
Help the NHS support broader social and economic development	The CCTP will be supporting a place/PCN level approach to recruitment and retention, increasing employment opportunities for residents of Nottingham and Nottinghamshire.

Appendices:
Appendix A: Visual neighbourhood level health profile pack Appendix B: System wide aims/ambitions for CCTP Appendix C: Case studies from CCTP early adopters

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • 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.

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

Report Previously Received By:
Strategic Planning and Integration Committee (January 2023)

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Strategic Approach to Transforming Health and Care within Community Services

Purpose and introduction

1. Adult[1] community health services provide support across a range of needs and age groups but are most often used by older people, those living with frailty or chronic conditions and people who are near the end of their life. Community services often support people with multiple, complex health needs who depend on many health and social care services to meet those needs.

2. Community Health Services are a vital component of the system offer, however there is a need for change, driven by:

    a) The increasing level of needs and vulnerability of many of those receiving community services.

    b) Concurrent pressures on other services that support people in the community such as general practice and social care.

    c) Growing shortages in key parts of the workforce present a significant challenge to deliver community services.

    d) The structure of Community Health Services in Nottingham and Nottinghamshire ICS is complex - with varied patterns of provision due to historic commissioning arrangements and not necessarily reflecting population need.

    e) The recognition that difference in health outcomes is down to the social, economic and environmental factors that shape people's lives (wider determinants of health) and the NHS needs to work with our partners to influence and deliver these.

    f) Despite considerable diversity in their disease profile and circumstances, people with multiple conditions frequently share common problems – the care offer needs to reflect this.

    g) Our belief that local people understand better than anyone else what is needed in their communities.

3. The current community care (including non-NHS commissioned services) offer provides the building blocks of integration which will be enhanced at pace to deliver a single ICS model of care. They will be transformed to effectively utilise available resources to address local health inequalities and meet the holistic needs of the population through collaborative working with system partners. Set in the context of the system outcomes framework, the integrated planning and

[1] Please note there are separate children's and young persons' transformation programmes which covers physical needs and an all-age mental health programme.

delivery approach aims to improve the health and wellbeing of our population and improve the overall quality of care and life our service users and carers experience and receive. This will be informed and shaped through co-production with people with lived experience.

4. Due to system financial pressures, the focus is on how whole system resource can be used to deliver the best possible outcomes to our diverse population. The expectation is that this will be achieved through a shift towards prevention, removal of duplication across services and organisations, supporting the development and usage of community assets, and utilising created capacity to manage citizens with greater complexity/need in the community.

Context for community services in Nottingham and Nottinghamshire

5. A Nottingham and Nottinghamshire overview relevant to increasing demand on Community Health Services (Please see Appendix A for visual health profiles produced to aid this work):

6. 17.1% of the GP registered population have two or more long term conditions - *People with multiple conditions are more likely to have poorer health, poorer quality of life and a higher risk of dying than those in the general population.*

7. Within Nottingham and Nottinghamshire, 18 out of 27 neighbourhoods have obesity rates significantly worse than the UK average, and 13 out of 27 neighbourhoods have smoking rates significantly worse than the UK average – *associated with reduced life expectancy. These are a risk factor for a range of chronic diseases, including cardiovascular disease, type 2 diabetes, at least 12 kinds of cancer, liver and respiratory disease and impact on mental health.*

8. 1% are housebound – *with the housebound population increasing and expected to continue growing, it places increased demand on community health services.*

9. Over 106,000 people (8.7%) of people live in areas with high barriers to housing and services deprivation - t*his is a measure of the physical and financial accessibility of housing and local services*.

10. Over 312,000 people (25%) of people live in areas with high income deprivation - *areas with more income deprivation are more likely to have a range of health conditions including serious mental illness, obesity, diabetes, and learning disabilities.*

11. 2,900 people over age 65 are living alone - *Living alone can increase a person's risk of social isolation and loneliness and have a negative impact on their health and wellbeing.*

Sources: Nottingham and Nottinghamshire Health Inequalities Plan (2022),) and eHealthscope (2022)

The future vision for community health services in Nottingham and Nottinghamshire

12. To address the challenges identified, the future vision is to ensure:

    a) Health and social care resources and workforce are aligned to implement neighbourhood /place-based Community Teams, delivering a consistent model of care across the ICS, whilst ensuring services are responsive to local population need.

    b) Levels of support and care are driven by population health data and intelligence, with a focus on delivering outcomes that reduce inequalities in health and wellbeing.

    c) Personal and community assets are fully utilised and developed to support outcomes, using a practice framework for an integrated health and social care personalised, strengths and asset-based approach that empowers individuals and communities to take control of their own health and care.

    d) Development of an organisational development approach for all community care (NHS, local authority and voluntary sector) staff to empower practitioners and to support the implementation of the new care model, irrespective of employing organisation and role.

    e) Adoption of a transparent approach across commissioners and providers to ensure we deliver best value for money, moderating costs of care and maximising value (the relationship between quality, outcomes and resources).

Working differently to improve community services

13. The Community Care Transformation Programme (CCTP) is focussed on strategic and collaborative working through a system-wide programme created in May 2021 across the Nottingham and Nottinghamshire ICB, Nottinghamshire Healthcare Foundation Trust, CityCare, Nottinghamshire County Council and Nottingham City Council.

14. A single set of system priorities and outcomes (Appendix B) has been developed via engagement with key stakeholders. These set out ambitions aligned to the System Outcomes Framework and future vision for Community Health Services. These are structured around key themes, including: improving population health and wellbeing, quality and experience of services, delivery of integrated care, and workforce considerations. These are system ambitions to have the greatest impact on health inequalities and to meet the needs of populations, delivered through a Primary Care Network (PCN)/Place level approach, which is being tested through 5 early adopter sites (PCN level).

15. Examples of how the system is working at place to deliver against our ambitions are covered within detailed case studies in Appendix C, and summarised below:

    a) *Focus on improving community services for people with dementia and their carers in Nottingham West PCN:* Engagement has been undertaken with 51 citizens to date, through attendance at relevant community assets (e.g. dementia café). The approach has been designed to ensure we can reach and engage with all the population who are impacted, through use of practice diagnosis registers to identify those not accessing services. The key themes/issues have been analysed and will now be used to co-produce solutions with citizens to improve dementia services across health, social care and community sectors.

    b) *A PCN level approach to workforce and retention in Bulwell and Top Valley:* Opportunities have been identified through community conversations and engagement with a multi-organisational workforce. Multiple stakeholders have committed to a school visiting programme to promote careers in health and social care, mentoring and shadowing opportunities across organisations and the delivery of a workforce event. This will improve recruitment and retention and has wider socio-economic benefits through supporting children and young people moving into employment.

    c) *A community resource hub in Ashfield:* Digital Notts is supporting an online Community Resource Hub for public and professionals to source information on community assets relevant to that population. This is underpinned by utilising a Strength Based Approach and aligned with Social Prescribing methodologies to promote services which will impact on relevant wider determinants of health.

    d) *Delivering integrated services across Health, Social Care and VCSE in Newark*: Focus identified through engaging with people who have lived experience, and those with local expertise. Key actions have included:

        (i) Support in accessing appointments – via digital solutions and transport solutions where face-to-face is required.

        (ii) Introduction of a community support record to improve communication between the multi-disciplinary team and across organisations/sectors.

        (iii) Community asset mapping and development – raising awareness and streamlining referral processes to improve access to a wider range of services.

Future opportunities and challenges for improving community health services

16. Transformation of care and support for people accessing community services in Nottingham and Nottinghamshire will continue to be delivered through a collaboration between system partners and people with lived experience. The foundations for this are in place and will be strengthened further through a proposed alignment of similar programmes (*Anticipatory Care (Ageing Well) and Nottinghamshire County Council Innovation sites*). Significant benefits will be delivered from this approach, including better use of limited resource (within programmes, supporting functions and PCNs/locality teams), a clearer strategy, and true system working across health, social care VCSE and people. This creative approach across partner organisations will support people to maximise their independence and remain at home for longer via a focussed effort on health inequalities and care gaps which is a common objective for all the above programmes.

17. Locality teams are integral partners in the transformation work, including the development of a single system approach to using Population Health Management (PHM) data at a PCN footprint. This approach will be utilised to identify care gaps within their geographical area, and to implement solutions via an Integrated Neighbourhood Team. All areas (based on PCNs) will be enrolled in this approach by the end of 2023/24, with a combined focus on delivering *"'Next steps for integrating primary care: Fuller stocktake report".*

18. The approach will support system planning, against which an alliance of providers will arrange services in direct response to the differential needs of their populations. Funding will be allocated based on population need and demand as determined by our well-established population health management insights. As provider collaboratives and Places continue to mature, it is anticipated their role in the development and delivery of broader aspects of care and support to community health service provision will also develop and increase.

How this adds value for our population

19. We will work in accordance with the programme principles, in collaboration with all partners and will listen to what local people want and need in designing future service provision, to add value for our people:

20. People's independence will be optimised by addressing physical and mental health and social needs proactively before a state of crisis is reached. Our people will be empowered and supported to self-care, with support from within their communities, maximising the use of community assets.

21. People with multiple conditions will in future receive greater service integration, more person-centred, holistic care, and better support for mental wellbeing. Through integrated care, and better communication between services and to

citizens - people will be cared for in the most appropriate setting for their need. There will be a reduction in avoidable and unplanned admissions to hospital and care homes.

22. Health care is only one factor contributing to health and wellbeing – others include individual behaviours, environment, including housing, poverty, education and employment. Collaborative working will extend beyond the confines of the health service to ensure this programme achieves the maximum possible impact. People will be recipients of collective action across different sectors to act on these wider determinants of health.

23. Co-production will ensure people feel heard and are more empowered. Services will be a better fit for the people that use them, delivering improvements in access, outcomes and experience.

24. Broader social and economic development will be achieved through PCN level recruitment initiatives, with a view to growing affinity/loyalty to a geographical area, rather than organisation – delivering improvements in recruitment and retention. This will lead to a more resilient workforce, and greater consistency in the person giving care. Consistency of care giver is a key enabler for holistic and personalised care.

Appendix A

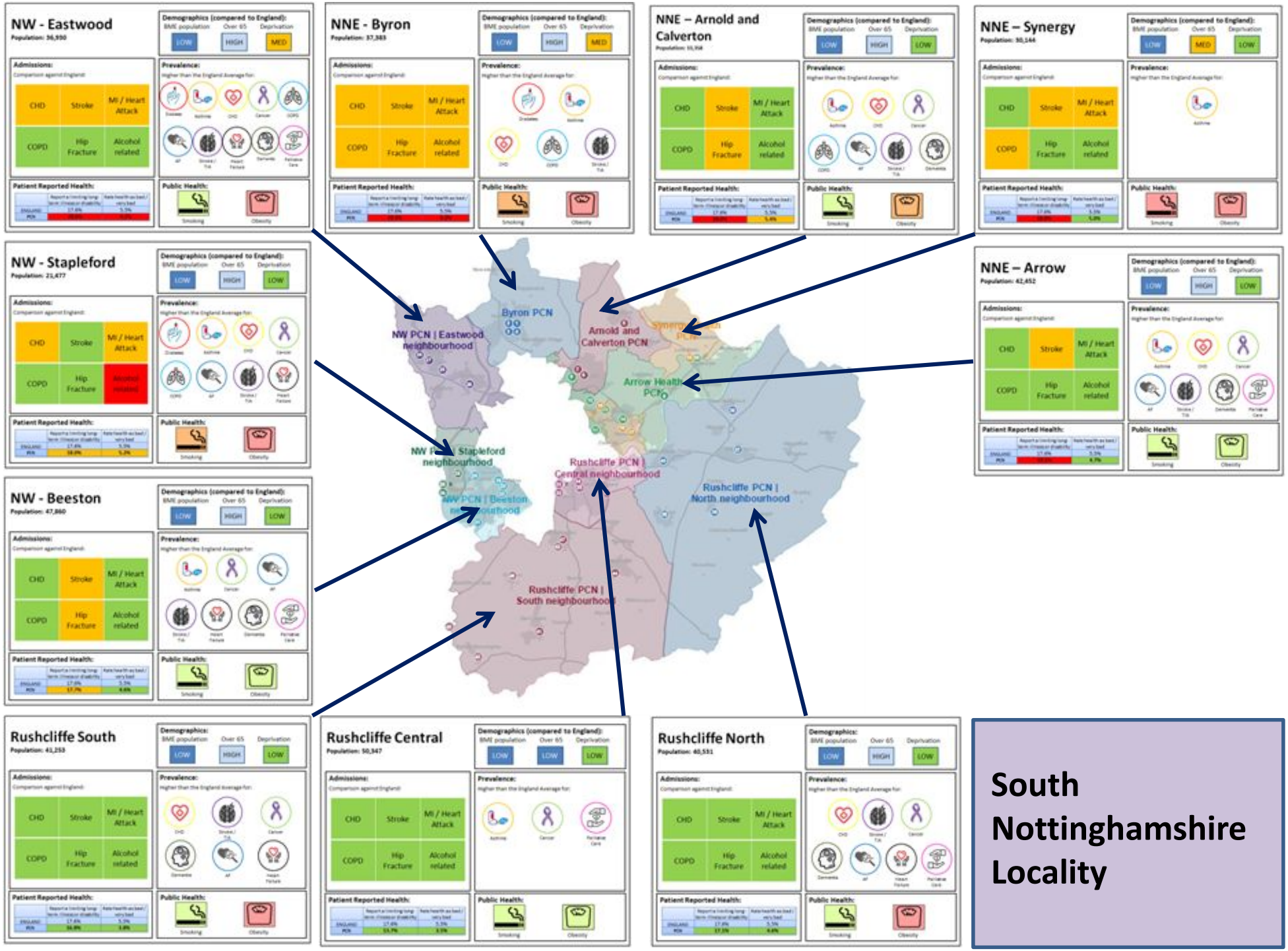
Nottingham and Nottinghamshire PCN/Neighbourhood – Health Profile Packs

- All the information is taken from the ICS Health and Care profiles – accessible from the Nottingham Insight website. https://www.nottinghaminsight.org.uk/
- There is greater information available within the profiles, however the information presented here is what is felt to be most relevant to **community services**.
- The summary tiles include information on demographics, admissions, patient reported health, prevalence of long term conditions, and smoking/obesity rates.
- There is an associated spread sheet that includes the detailed data behind the summary 'tiles' included here, and some further metrics.
- The key to the colour coded metrics are:

	Significantly BETTER than England
	Similar to England
	Significantly WORSE than England
	Significantly LOWER than England
	Significantly HIGHER than England

- The purpose of this document is to highlight differences between and within areas across Nottingham and Nottinghamshire, to stimulate discussion. Care should be taken in the interpretation of this information, and is advised that further data is sought to inform service changes.
- Any queries – please contact Steven Smith – Programme Manager: Community (steven.smith6@nhs.net)

South Nottinghamshire Locality



South Nottinghamshire Locality

Rushcliffe South

Population: 41,253

Demographics:

BME population	Over 65	Deprivation
LOW	HIGH	LOW

Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:


CHD


Stroke / TIA


Cancer


Dementia

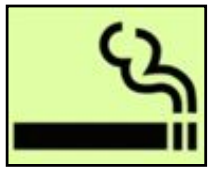

AF


Heart Failure

Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**16.8%**	**3.8%**

Public Health:


Smoking


Obesity

Rushcliffe North

Population: 40,531

Demographics:

BME population	Over 65	Deprivation
LOW	HIGH	LOW

Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:


CHD


Stroke / TIA


Cancer


Dementia


AF

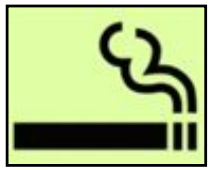

Heart Failure


Palliative Care

Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**17.1%**	**4.6%**

Public Health:


Smoking


Obesity

Rushcliffe Central

Population: 50,347

Demographics (compared to England):

BME population	Over 65	Deprivation
LOW	LOW	LOW

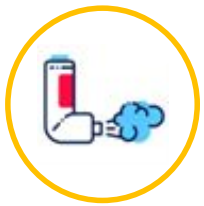
Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:



Asthma

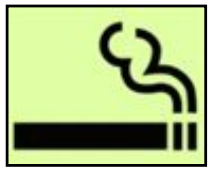
Cancer

Palliative Care

Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**13.7%**	**3.5%**

Public Health:



Smoking

Obesity

NW - Stapleford

Population: 21,477

Demographics (compared to England):

BME population	Over 65	Deprivation
LOW	HIGH	LOW

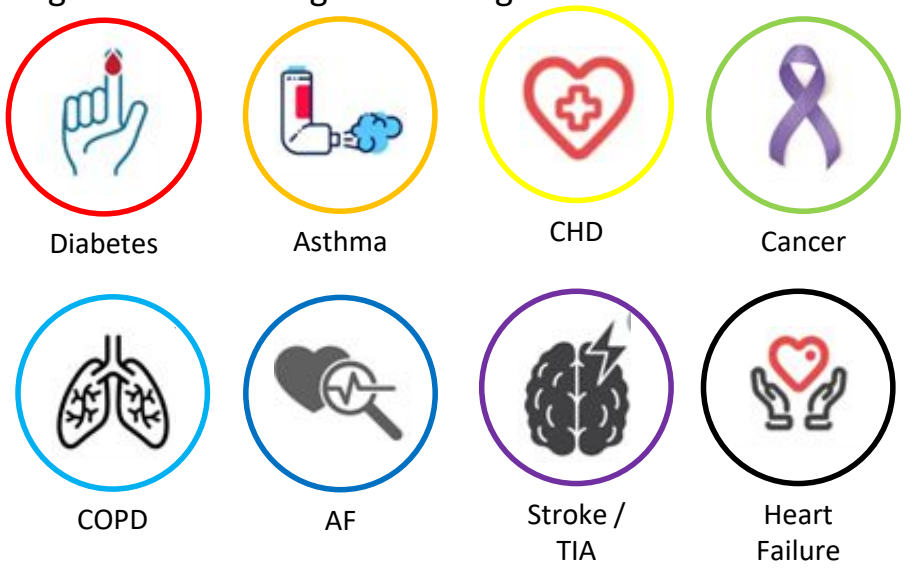
Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:



Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**18.0%**	**5.2%**

Public Health:

NW - Beeston

Population: 47,860

Demographics (compared to England):

BME population	Over 65	Deprivation
LOW	HIGH	LOW

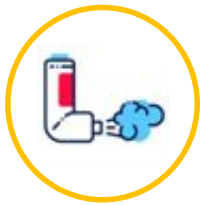
Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:



Asthma

Cancer

AF

Stroke / TIA

Heart Failure

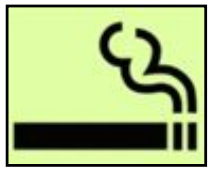
Dementia

Palliative Care

Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**17.7%**	**4.6%**

Public Health:



Smoking

Obesity

NW - Eastwood

Population: 36,930

Demographics (compared to England):

BME population	Over 65	Deprivation
LOW	HIGH	MED

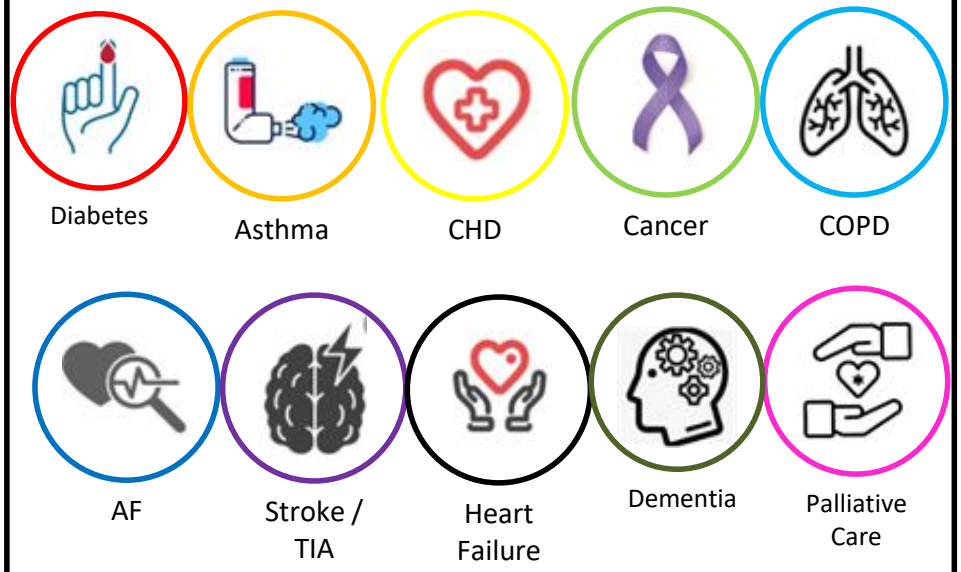
Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

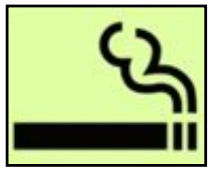
Higher than the England Average for:



Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**20.6%**	**6.2%**

Public Health:


Smoking


Obesity

NNE - Byron

Population: 37,383

Demographics (compared to England):

BME population	Over 65	Deprivation
LOW	HIGH	MED

Admissions:

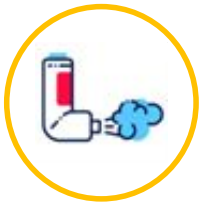
Comparison against England:

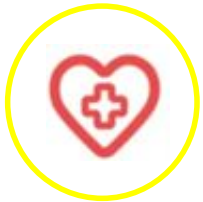
CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:


Diabetes


Asthma


CHD


COPD


Stroke / TIA

Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**20.3%**	**6.2%**

Public Health:


Smoking


Obesity

NNE – Arnold and Calverton

Population: 33,358

Demographics (compared to England):

BME population	Over 65	Deprivation
LOW	HIGH	LOW

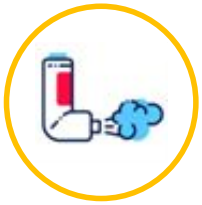
Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:


Asthma


CHD


Cancer


COPD


AF


Stroke / TIA


Dementia

Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**19.9%**	**5.4%**

Public Health:


Smoking


Obesity

NNE – Arrow

Population: 42,452

Demographics (compared to England):

BME population	Over 65	Deprivation
LOW	HIGH	LOW

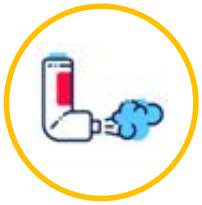
Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:


Asthma


CHD


Cancer


AF


Stroke / TIA

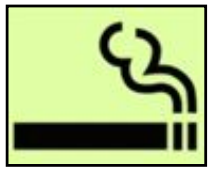

Dementia


Palliative Care

Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**19.1%**	**4.7%**

Public Health:


Smoking


Obesity

NNE – Synergy

Population: 30,144

Demographics (compared to England):

BME population	Over 65	Deprivation
LOW	MED	LOW

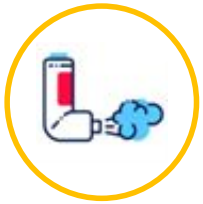
Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:



Asthma

Patient Reported Health:

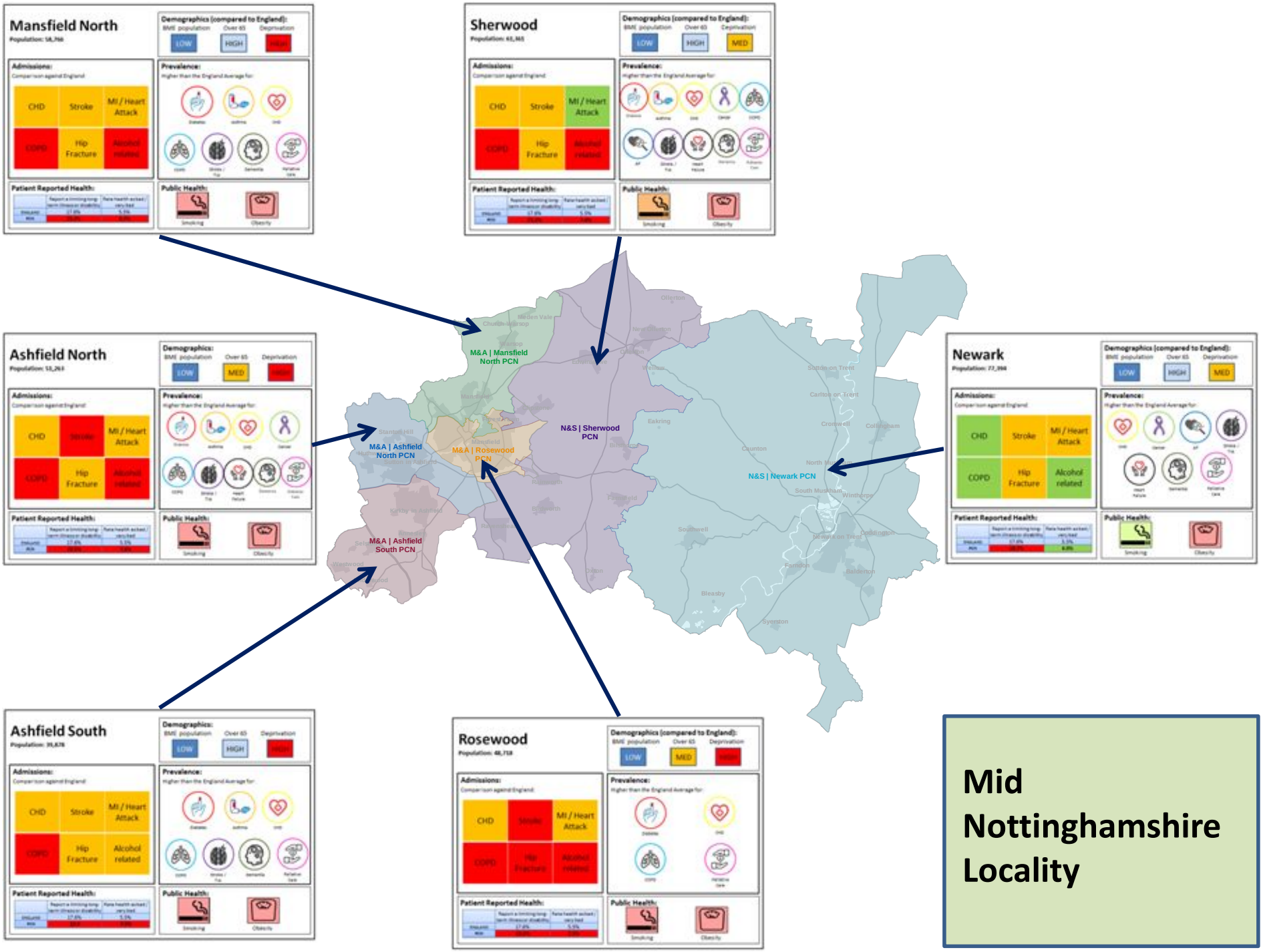
	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**18.8%**	**5.0%**

Public Health:

Smoking

Obesity

Mid Nottinghamshire Locality


Mansfield North
Sherwood
Ashfield North
Newark
Ashfield South
Rosewood
M&A | Mansfield North PCN
N&S | Sherwood PCN
M&A | Ashfield North PCN
M&A | Rosewood PCN
N&S | Newark PCN
M&A | Ashfield South PCN
Mid Nottinghamshire Locality

Ashfield North

Population: 51,263

Demographics:

BME population	Over 65	Deprivation
LOW	MED	HIGH

Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:


Diabetes


Asthma


CHD

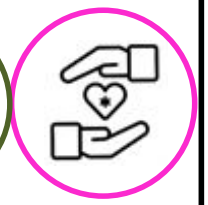

Cancer


COPD


Stroke / TIA


Heart Failure


Dementia


Palliative Care

Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**23.5%**	**7.6%**

Public Health:


Smoking


Obesity

Ashfield South

Population: 39,878

Demographics:

BME population	Over 65	Deprivation
LOW	HIGH	HIGH

Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:


Diabetes


Asthma


CHD


COPD


Stroke / TIA


Dementia


Palliative Care

Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**22.9**	**7.5%**

Public Health:


Smoking


Obesity

Mansfield North

Population: 58,766

Demographics (compared to England):

BME population	Over 65	Deprivation
LOW	HIGH	HIGH

Admissions:

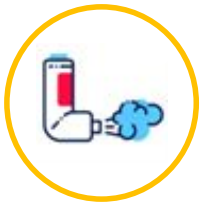
Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:


Diabetes


Asthma


CHD


COPD


Stroke / TIA


Dementia


Palliative Care

Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**25.3%**	**8.7%**

Public Health:


Smoking


Obesity

Newark

Population: 77,394

Demographics (compared to England):

BME population	Over 65	Deprivation
LOW	HIGH	MED

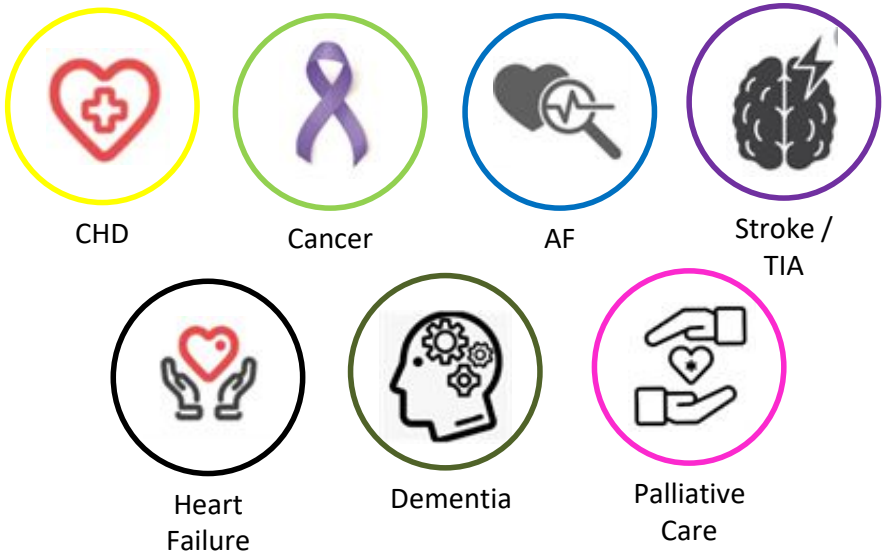
Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

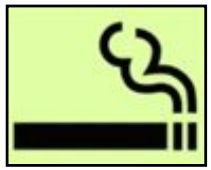
Higher than the England Average for:



Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**18.7%**	**4.9%**

Public Health:


Smoking


Obesity

Rosewood

Population: 48,718

Demographics (compared to England):

BME population	Over 65	Deprivation
LOW	MED	HIGH

Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:

Diabetes

CHD

COPD

Palliative Care

Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**22.5%**	**7.5%**

Public Health:

Smoking

Obesity

Sherwood

Population: 61,361

Demographics (compared to England):

BME population	Over 65	Deprivation
LOW	HIGH	MED

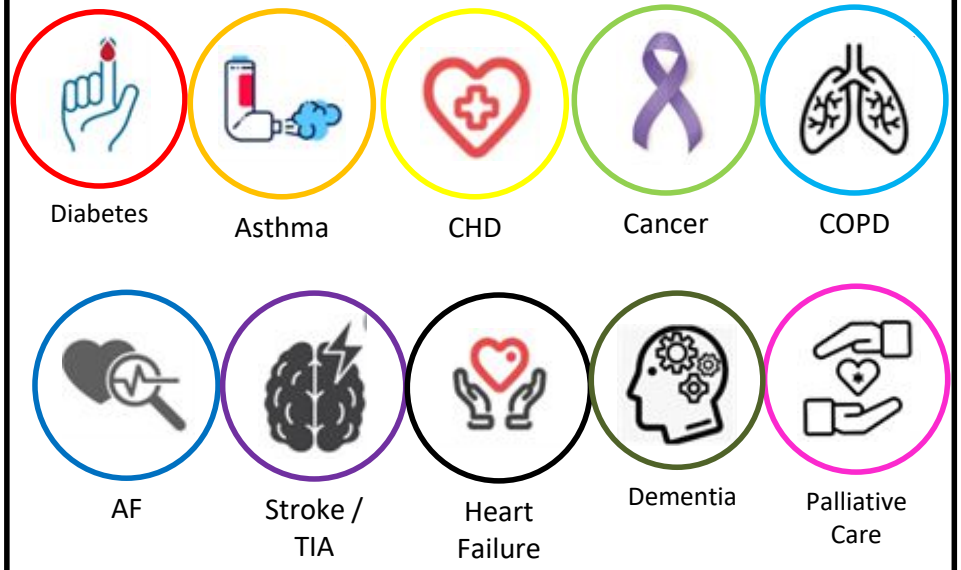
Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:



Patient Reported Health:

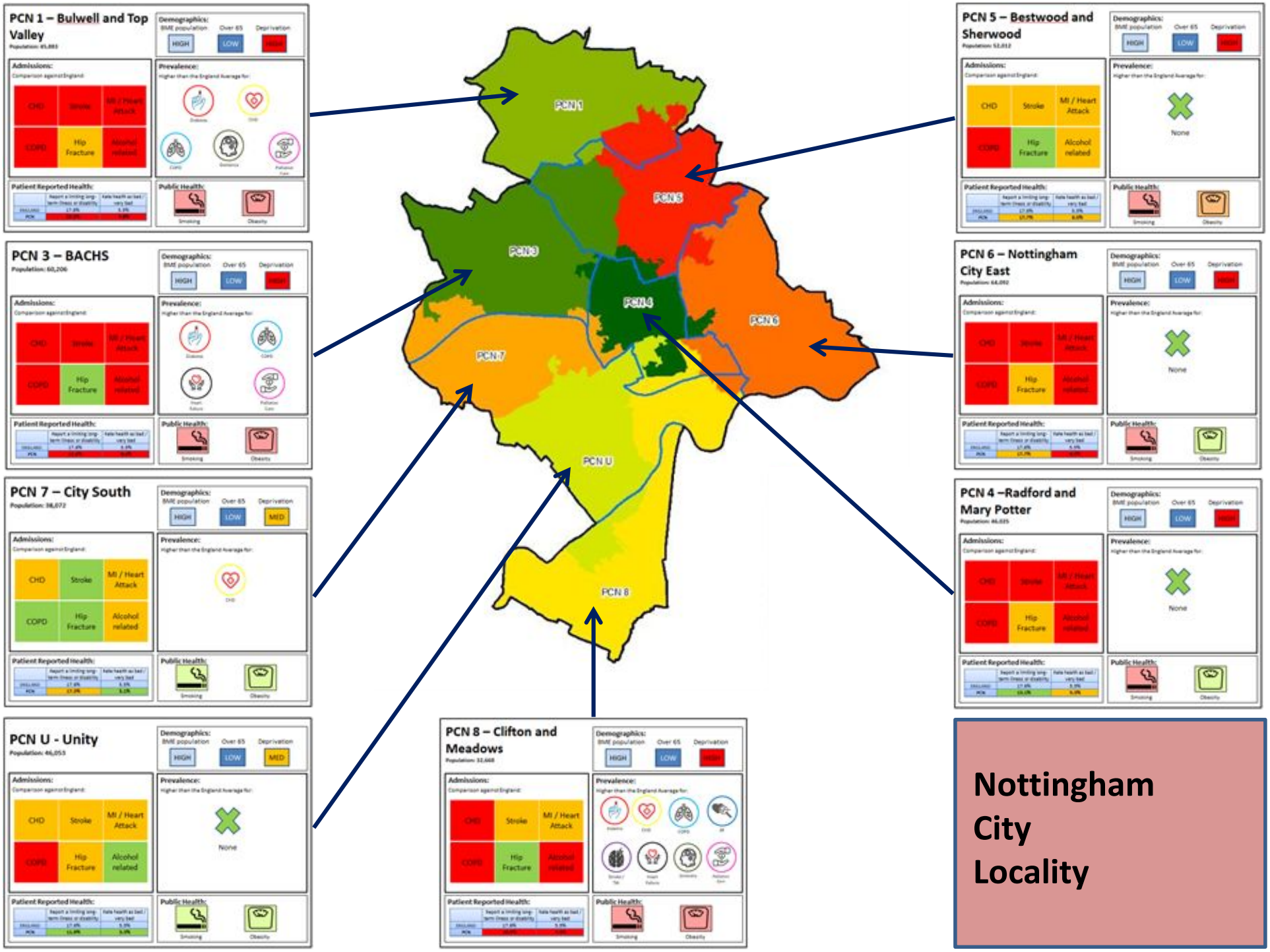
	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**23.2%**	**7.4%**

Public Health:


Smoking


Obesity

Nottingham City Locality


PCN 1 – Bulwell and Top Valley
PCN 5 – Bestwood and Sherwood
PCN 3 – BACHS
PCN 6 – Nottingham City East
PCN 7 – City South
PCN 4 –Radford and Mary Potter
PCN U - Unity
PCN 8 – Clifton and Meadows
PCN 1
PCN 5
PCN 3
PCN 4
PCN 6
PCN 7
PCN U
PCN 8
Nottingham City Locality

PCN 1 – Bulwell and Top Valley

Population: 45,883

Demographics:

BME population	Over 65	Deprivation
HIGH	LOW	HIGH

Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:

Diabetes

CHD

COPD

Dementia

Palliative Care

Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**22.2%**	**7.8%**

Public Health:

Smoking

Obesity

PCN U - Unity

Population: 46,053

Demographics:

BME population	Over 65	Deprivation
HIGH	LOW	MED

Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:

None

Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**11.9%**	**3.3%**

Public Health:

Smoking

Obesity

PCN 3 – BACHS

Population: 60,206

Demographics:

BME population	Over 65	Deprivation
HIGH	LOW	HIGH

Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:

Diabetes

COPD

Heart Failure

Palliative Care

Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**21.6%**	**8.2%**

Public Health:

Smoking

Obesity

PCN 4 –Radford and Mary Potter

Population: 46,025

Demographics:

BME population	Over 65	Deprivation
HIGH	LOW	HIGH

Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:

None

Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**13.1%**	**5.3%**

Public Health:

Smoking

Obesity

PCN 5 – Bestwood and Sherwood

Population: 52,012

Demographics:

BME population	Over 65	Deprivation
HIGH	LOW	HIGH

Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:

None

Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**17.7%**	**6.0%**

Public Health:

Smoking

Obesity

PCN 6 – Nottingham City East

Population: 64,092

Demographics:

BME population	Over 65	Deprivation
HIGH	LOW	HIGH

Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:

None

Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**17.7%**	**6.7%**

Public Health:

Smoking

Obesity

PCN 7 – City South

Population: 38,072

Demographics:

BME population	Over 65	Deprivation
HIGH	LOW	MED

Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:

CHD

Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**17.3%**	**5.1%**

Public Health:

Smoking

Obesity

PCN 8 – Clifton and Meadows

Population: 32,668

Demographics:

BME population	Over 65	Deprivation
HIGH	LOW	HIGH

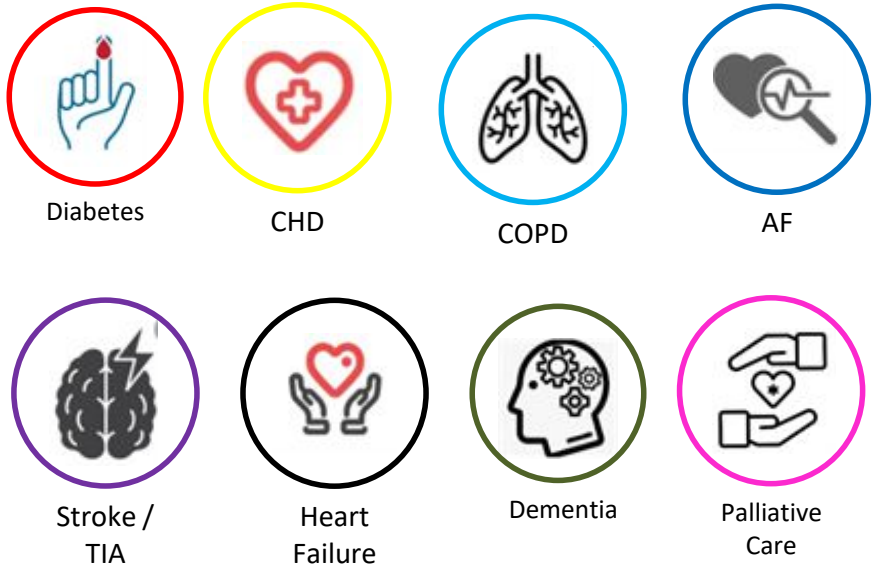
Admissions:

Comparison against England:

CHD	Stroke	MI / Heart Attack
COPD	Hip Fracture	Alcohol related

Prevalence:

Higher than the England Average for:



Patient Reported Health:

	Report a limiting long-term illness or disability	Rate health as bad / very bad
ENGLAND	17.6%	5.5%
PCN	**20.5%**	**7.3%**

Public Health:

All PCNs/Neighbourhoods

Integrated Care System
Nottingham & Nottinghamshire

Appendix B

Improve citizen experience and outcomes

Components and Principles

Build services **around citizens** - make patients the 'customer'

Acknowledge and build on **existing work** within PCN/ neighbourhoods/ ICPs

Build on **current strengths and assets** across the community

Better **co-ordination** throughout care to reduce 'hand offs' causing duplication and barriers.

Give staff permission to do right thing, ie. look at holistic care.

Build links into community leaders / groups - e.g. Social Prescribing, disseminating health messages

Need to tailor service to **population needs**.

Move away from performance management culture – need to **focus on outcomes, wider determinants**

Increased use of **technology**

Promote and allow for **self care/self management**

Integrated Care System
Nottingham & Nottinghamshire

Focus on health and wellbeing

Components and Principles

Make things simpler:
- Simplify access into services
- Care co-ordination
- No acronyms or jargon
- Consider self referral

Patient centred approach:
- Shared Decision Making
- 'what is going to make a difference to you'
- Listening

Shift the focus towards **prevention** and away from managing crisis.

Need to consider **wider provision** within community* and how they can impact on wider determinants of health

Consideration of an **asset based approach** - Community groups can have a big impact with very little resource.

Proactive identification of issues prior to arising - crisis prevention and disease management.

Workforce education:
- holistic working
- motivational training
- knowledge of assets available

Consideration of **specialist vs generalist**. Everyone working at top of their licence.

Consider **health literacy** – what can person and community do for themselves?

* e.g. Community Pharmacy/ Third Sector/ Education/ Fire Service/ Housing/ Public Health

Integrated Care System
Nottingham & Nottinghamshire

Deliver integrated care

Components and Principles

Removal of barriers:
- Shared notes / data sharing
- Work within PCN
-Join workforce together
- Shared documents/ guidelines/ policies

Resources / funding may need to move across the system as required.

Give staff the time and empower and permission – to do the right thing:
- Look after the whole person
- Think family not just citizens

Support the capacity and infrastructure of **Community Voluntary Services (CVS)** – to develop some consistency of offer

Develop **consistency** of service offer across ICS

Integrated Care System
Nottingham & Nottinghamshire

Work with our communities

Components and Principles

Staff to have time to learn more about **the community / culture** within the area they work.

Empowering and understanding communities:
- Communities drive the discussion
- Connect to our partners with community knowledge

People / communities need to know how and **where to access support**

Take services to communities
- Consider employers and how we can take services to them
- Community bus – library / benefits/ health

Consider that health **definition of community** may differ from that of citizens. Community should be defined by the citizens.

Engagement considerations:
- Go to our residents – don't expect them to come to us.
- Work with trusted leaders.
- engage people who don't access services
- Link to HealthWatch and ICS

Whilst focus may be on communities, **mutual aid across PCNs** needs to be considered.

Asset development:
- Work with community strengths and develop assets
- Look at all assets – the people / workforce / building

Involve the citizens in re-design of services and governance

Can't do to communities, need to work with communities.

Integrated Care System
Nottingham & Nottinghamshire

Good communication

Components and Principles

IT Considerations:
- Access to IT systems must be broadened
- We must work with the multiple IT systems and be sensible about overcoming barriers

Governance/Data Sharing Considerations:
- Data sharing agreements with non- health partners
- Information governance teams to support
- Remove the red tape

Workforce considerations:
- Use of technology
- Teams to co-locate, engage, work together and build trust
- Move away from organisational barriers
– culture change

What we communicate to citizens:
- Need to ensure its pertinent information, not sharing everything

Why we communicate to citizens:
- Making every conversation count!
- Right info, right time, right person, right decision making!

How we communicate to citizens:
- Comms at appropriate geographical level
– understand the community the person lives in
- Personalisation agenda
- telling your story once

Considerations when we communicate:
- Don't assume everyone is digital-savvy
- No jargon and acronyms
- English isn't always a first language

Integrated Care System
Nottingham & Nottinghamshire

A healthy and happy workforce

Components and Principles

Training:
-Need to approach training, policy and development as one system and not individually
-Access to supervision and coaching to deal with high levels of deprivation and safeguarding.

Loyalty/belonging/culture:
-Consider Culture and how we support individuals to feel part of organisation and system
-Shared vision and values across partnership need to be created and we can then work together to achieve
-Get the geographical team right in size and consider how we do this to encourage loyalty

The voice of the workforce:
-Open culture and freedom to speak up
-Ask the workforce what they need and want

Recruitment and retention:
-Need a strategy around retention
-Attractive recruitment campaign across system
-Consider new approaches to flexible working
-consider how we become inclusive and recognise diversity
-consider recruitment from within local population and work in creating opportunities
-Celebration of what we achieve

Appendix C

Integrated Care System
Nottingham & Nottinghamshire

Nottingham and Nottinghamshire ICS
Community Transformation Programme

Case Studies from Community Care Transformation:

1. Working together across organisations, workforce and people to co-produce solutions to improve the integration and experience of services (Newark PCN).
2. Demonstration of the Community Care Transformation principles in action: Community Assets, Strength based approaches and holistic care (Ashfield North PCN).
3. Improving Dementia services in Broxtowe – Using health inequalities and Co-production (Nottingham West PCN).

Working together across organisations, workforce and people to co-produce solutions to improve the integration and experience of services.

Case Study Summary

"Wouldn't it be great if there was a way to share details about all the community contacts and friends and family supporting me in my care – everything in one place."

This is the view of 39 year old 'Andy' who has complex health conditions. These views were shared after an asthma attack, and the ambulance team did not have access to vital information about maintaining his airway (positioning). This therefore deteriorated into a crisis situation and he was admitted to hospital.

The local design team engaged with workforce and people to co-produce a solution based on comments like these and developed the 'Community Support Record'. This is a document held in the person's home and holds key information about them and the services involved in their care (with key contact information).

Organisation – Newark PCN – Community Care Transformation Local Design Team

The aim – To improve the integration between health and care services, to better the experience and outcomes for people. This should be achieved through co-production.

The solution – The local design team worked with workforce and people to design a solution based on comments like:

- *"Wouldn't it be great if there was a way to share details about all the community contacts and friends and family supporting me in my care – everything in one place."*
- *"As professionals we could save time searching for information and reducing pressure on the person to provide information" - so they are not having to repeat their story every time*
- *"Wouldn't it be great if multiple professionals throughout week all focussed on me as a person not a single intervention"*

The outcome was a 'Community Support Record' which is a short document held in the person's own home.

Challenges – There was consideration that the document should be digital, so it could be accessed remotely by wider services. However, this was resisted as it was agreed that it should be easily accessible, and people commented that having a physical document they owned and could easily view provided reassurance.

Results – The initiative is in its early stages, and formal evaluation is being completed, however early feedback from people and workforce has been:

- People felt more confident that services had the right information to support their needs for both physical health and emotional wellbeing
- Contact details in one place saving time spent in an emergency searching for information, eg vital information for maintaining Andy's airway - crisis management reduced
- Reduces the amount of repetitive direction people give to teams from Health and Social Care
- Reduces the time professionals spend in handover/chasing information giving more time to support people with their care needs and making a real connection
- Gave professionals (and family) a snapshot of interventions that are in place and key points of contact

Key learning point – Engagement and co-production with people and workforce can develop simple and meaningful solutions that have a significant impact on care service experience and outcomes.

Demonstration of the Community Care Transformation principles in action: Community assets, strength-based approaches and holistic care.

Case Study Summary

Mrs Smith is severely deaf, partially sighted, diabetic with heart problems and has multiple other health issues. She was also beginning to experience low mood. Her daughter is her main carer.

Mrs Smith was discussed during a MDT meeting. The GP requested a referral to social services to arrange respite care (daughter needed a break from her caring role) and to avoid hospital admission.

Utilising a strength-based approach, the social worker made an assessment and considered the holistic needs of both Mrs Smith and her daughter. The negative impact of respite on Mrs Smith was explained, and an option for Mrs Smith to remain at home with a good level of visiting support was suggested.

The new option was agreed and Carers HUB services for respite at home, befriending services was put in place. A plan to address some of the other challenges identified (eg communication aids) was also agreed. The plan has been so successful, that support was maintained following the daughter's holiday and improved outcomes have been delivered for Mrs Smith and her daughter.

Organisation – Ashfield North PCN – Community Care Transformation Local Design Team (example from Nottinghamshire County Council)

The aim – To consider the holistic needs of a person (and their family) rather than focus solely on delivery of tasks/interventions.

The solution – Nottinghamshire County Council has developed a scheme called a strengths-based approach. This type of approach helps to encourage people to become more independent by gradually withdrawing support once the carer can see the person has the skill or strength required to carry out certain tasks independently. This has the benefits of support still being in place as long as the person needs it, while allowing the cared-for person to become increasingly independent and self-sufficient.

It is built on the assumption that if you collaborate with and allow people to be co-designers of their support then their positive outcomes go up, and their use of health and social care resources goes down.

In this scenario, there was a need to resist the requested intervention and consider what the person could do with support from commissioned services as well as community assets. The solution delivered was not only better for the respite period but is also delivering longer lasting improved outcomes.

Challenges – The Community Care Transformation programme is working collaboration with Nottinghamshire County Council, to embed this approach within health care services. One of the key challenges quoted is the perceived additional time that this takes.

Results – Quote from the Social Worker involved:

"Things went so well that the care was left in place when Mrs Smith's daughter returned from her holiday. We also worked to maximise communication aids. When I visited weeks later Mrs Smith looked fabulous. She presented as more confident and happier and had even started engaging more with her peers who had been isolating her. I felt really pleased that the right course of action had been taken as did her daughter."

Key learning point – Sharing best practice across health, social care and community and voluntary sector services is of great benefit. Having aligned values and behaviours will deliver improved experience and outcomes for our population.

Improving Dementia services in Broxtowe – Using health inequalities and Co-production.

Case Study Summary

Nottingham West PCN wished to create an approach in which citizens are not merely the target of consultation, but in which the process is co-led by people, allow them to define both the problems they face and co-produce the solutions to those problems: "We do not aspire to citizen engagement. We aspire to people partnership".

They actively sought the input of people living with dementia through the Memory Cafés and other dementia services that exist in parts of the PCN. They already knew the leaders of these services and knew that they will co-ordinate and advocate on behalf of the target groups or, even more desirably, encourage them to become part of the leadership team directly.

To date, the Nottingham West PCN team have had community conversations with over 50 people either living with dementia or caring for someone with dementia. To address health inequalities, they have developed a robust approach to ensuring the views of those not currently accessing services are also captured. They have implemented solutions to a number of key issues identified.

Organisation – Nottingham West PCN – Community Care Transformation Local Design Team

The aim – NW PCN decided early on when working with the Community Care Transformation Programme to look at the care provided to "Carers and those they care for". Health inequalities data identified a more defined focus on Dementia was required. This fits with previously identified place priorities and a consistent workstream of improving the identification of carers, and the support offer made to them both directly and indirectly through appropriate supportive care for those they care for.

The solution – The Local Design Team designed a robust co-production and improvement process including:

- Mapping of dementia related community assets and stakeholders.
- An extended local design team was developed to include community and voluntary sector partners
- Development of questions to allow natural flow of conversation and not led by professionals
- Identification and training of volunteers to hold 'community conversations'.
- Going to where people are, to hold conversations, and not expecting them to come to us
- Theming of key findings, and priority setting with those with lived experience
- Solutions to key issues, are being co-produced with people.

Challenges – The Local Design Team also acknowledged that many of the responses were from white British people. They also recognised that there are people with dementia not accessing services. The team have worked with primary care to review diagnosis registers and have targeted further efforts at engaging with those not yet heard from.

Results – The work to date has identified a number of key issues for those living with dementia or caring for someone with dementia in Broxtowe. Through co-production, and a growing network of partners, the Nottingham West PCN team have implemented initiatives focussed on:

- information available for people during and after a dementia diagnosis
- the development of a dementia 'single point of access' through the dementia connect service
- improved referral processes between relevant services
- the development of 2 key forums: a co-production group, and a carers champions forum.

Key learning point – Success has been achieved through a focus on identified health inequalities priorities, and then within that work assessing how those people experiencing health inequalities can be engaged with.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/03/2023
Paper Title:	**Nottingham and Nottinghamshire ICS Green Plan – Progress Update**
Paper Reference:	ICB 22 071
Report Author:	Lindsey Sutherland, Head of System PMO and Programme Director for Greener ICS
Report Sponsor:	Stuart Poynor, Chief Finance Officer
Presenter:	Lindsey Sutherland, Head of System PMO and Programme Director for Greener ICS
Recommendation(s):	The Board is asked to **receive** this item for assurance

Summary:

The Nottingham and Nottinghamshire Integrated Care System (ICS) Green Plan 2022 to 2025 was approved by the outgoing ICS Partnership Board in May 2022. The plan describes how we will work across the NHS and local authorities to achieve carbon net zero by 2040 and deliver against the NHS target of 80% carbon net zero by 2028. This paper outlines our approach and progress made to date against our ICS Green Plan.

NHS England assess our progress towards delivery of key priorities monthly, supplemented by an in-depth quarterly review. Feedback received through this governance process has been very good; our system is classed as one of the most advanced in our approach, system working and delivery.

The Board is asked to receive this paper for assurance and note the approach, delivery progress and feedback from our external regulators.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	Climate change and air pollution disproportionately effect those that are more deprived. The Green Plan will support reducing climate change and air pollution.
Tackle inequalities in outcomes, experience and access	
Enhance productivity and value for money	Waste contributes significantly to carbon emissions. Reducing waste will also save money.
Help the NHS support broader social and economic development	The Green Plan centres on improving lives for those that live in Nottingham and Nottinghamshire, and contributes to a more sustainable future for the planet

Appendices:

Appendix A: Status of key areas by organisation as of December 2022

Board Assurance Framework:

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

- Risk 13: Environment Sustainability – Failure to effectively deliver on the green plan.

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	Yes
Duty to promote involvement of each patient	No
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	No
Duties as to climate change	Yes
Duties regarding public involvement and consultation	No
Public sector equalities duties	No

Report Previously Received By:
Finance and Performance Committee (October 2022)

Are there any conflicts of interest requiring management?
No

Is this item confidential?
No

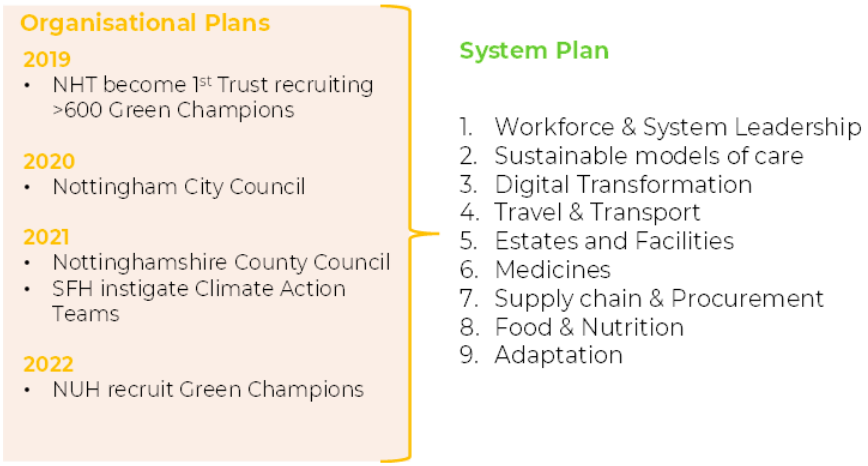
Nottingham and Nottinghamshire ICS Green Plan – Progress Update

Introduction

1. The NHS is responsible for nearly five percent of all carbon emissions in the UK. Air pollution is a factor in one in 20 deaths in the UK, and the impact of global warming and air pollution disproportionately effects the poorest and most vulnerable of our citizens. In July 2022, the Health and Care Act formalised the NHS commitment to becoming carbon net zero by 2040. The NHS is the first health care system in the world to legislate this.
2. This paper outlines our approach and progress made to date against our ICS Green Plan.

How our system is working towards reaching carbon net zero

3. Our Integrated Care System (ICS) Green Plan was approved by the outgoing ICS Partnership Board in May 2022. The plan describes how we will work across NHS and local authorities to achieve carbon net zero by 2040 and deliver against the NHS target of 80% carbon net zero by 2028.
4. Our Green Plan consolidates the commitments made in each organisation's Green Plans or Strategies and is arranged into nine delivery 'chapters' or workstreams.



5. In January 2022, the national NHS England Green Programme created a dashboard of 15 key areas that will move us to carbon net zero. All NHS organisations and Integrated Care Boards (ICBs) are required to complete submissions of their status for these 15 areas. The dashboard collates submissions and some limited data designed to support planning and delivery. As a system, we also collect where our local authorities are against these 15

key areas. The 15 key areas form the basis of our delivery plan. Appendix A shows the status of each by organisation in December 2022.

6. In June 2022, the NHS England Midlands Green Programme Team issued a Memorandum of Understanding (MoU) outlining their priorities for 2022/23 and expectations of what each ICB should achieve towards these priorities.
7. Each of the nine Green Plan chapters/workstreams have a designated lead who acts to facilitate delivery across the system. Each chapter has a 'hopper' and 'pipeline' of initiatives that include the national key areas, MoU priorities and locally identified opportunities.
8. There is a programme director (Lindsey Sutherland), and programme manager (Sarah Markin) who support each chapter as required and maintain an overarching view of delivery. An ICS Green Programme Board is held monthly.
9. Chapters report through monthly highlight reports which are reviewed by the Programme Board, as well as being sent on to the NHS England Midlands Green Programme Team.
10. Given the number and complexity of national, regional and local priorities, each chapter/workstream has a particular focus and target to deliver every three months.

Key achievements

- ✓ Our agreed plan covers both NHS and local authorities rather than concentrating on NHS legislative requirements only.
- ✓ Our system has exceeded the target for Desflurane[1] use. We aim to be the first system to be Desflurane zero in 2023.
- ✓ We have secured two Health Education England funded fellows to provide much needed clinical capacity for planning and delivery of our Green Plan, and we aim to go further securing medical and other health professionals who are required to take a research module during their professional training.
- ✓ All our organisations now purchase 100 percent of their electricity from renewable sources.
- ✓ All applicable organisations in our system now have a digital meal ordering system for patients installed to enable more accurate meal planning and reduce food waste.
- ✓ All our organisations work closely with local transport partners; this is a continuing area for growth.

[1] Desflurane is more than 2,500 times more potent as a greenhouse gas than carbon dioxide (CO_2)
Target: less than 5% of all volatile anesthetic gases used in surgery

- ✓ All our organisations now have facilities in place to encourage and support people who arrive by a mode of active travel (e.g. walking, bicycle); this is a continuing area for growth.

Areas for further attention

11. Food and nutrition chapter – there are several MoU priorities within this chapter where work has not yet started. A new clinical lead started work in February and initiatives are now being scoped and prioritised; delivery is expected to commence from late March.
12. Adaptation chapter – this chapter is centred on how we become more resilient in the face of global warming, ensure greater business continuity when adverse weather hits, and provide the best services for our citizens through our estate. We have not been able to find an appropriate lead with capacity to progress this chapter. We therefore plan to consolidate this with the Estates and Facilities chapter.

External regulation

13. Monthly highlight reports are issued documenting progress against priorities outlined in our MoU with the NHS England Midlands Green Programme Team. These are also reviewed at our monthly ICS Green Programme Board, on which an NHS England Midlands representative sits. Quarterly review meetings are held between NHS England Midlands and our SRO and/or Programme Manager.
14. Feedback received through this governance process is very good; our system is classed as one of the most advanced in our approach, system working and delivery success.
15. A new NHS England Midlands Green Programme MoU is expected, which will outline priorities for 2023/24. We do not expect this will need a significant change in our approach or delivery plans.

Appendix A: Status of key areas by organisation as of December 2022

Focus Area	Applicable to...	NHT	SFH	NUH	County Council	City Council	ICB
1. Does your organisation purchase 100% of its electricity from renewable sources?	Providers - all						
2. Have you (a) undertaken the piped nitrous oxide waste audit, (b) identified wasted nitrous oxide by comparing clinical use of nitrous oxide and procurement data and (c) acted on the findings?	Providers - NHS						
3. Does your organisation purchase or lease solely vehicles (under 3.5 tonnes) that are Ultra-Low Emission vehicles (ULEVs) or Zero Emission Vehicles (ZEVs)?	All ICS						
4. Does your organisation's salary sacrifice scheme for vehicles allow for the purchase of only ULEVs or ZEVs?	All ICS						
5. What travel-related schemes do you operate across your organisation?	Providers - all						
6. Which local transport partners does your organisation work closely with?	All ICS						
7. What facilities does your organisation offer for people who arrive by a mode of active travel?	Providers - all						
8. At the site where you have the largest food service, how does your organisation measure the total amount of food waste produced?	Providers - NHS						
9. Does your organisation have a digital meal ordering system for patients installed, as recommended by the Independent Review of NHS Hospital Food, to enable more accurate meal planning and reduce food waste?	Providers - NHS						
10.In your food service, have you identified opportunities to make menu options healthier and lower carbon by increasing the proportion of fruit, vegetables, beans, pulses or other low carbon ingredients/proteins?	Providers - NHS						
11.Have you identified a list of suppliers that will be impacted by the April 2023 Carbon Reduction Plan requirement (PPN 06/21)?	All ICS						
12.How are you managing the inclusion of the minimum of 10% on Net Zero and Social Value in every tender?	All ICS						
13.Do you participate in a walking aids return and reuse scheme?	Providers - NHS						
14.Does your organisation have a nominated lead who is accountable for adaptation planning and management?	All ICS						
15. Does your organisation have a long-term climate change adaptation plan separate from your business continuity plan?	All ICS						

Appendix A: Status of key areas by organisation as of December 2022

Status update for areas in progress:

Focus area	Schedule of work	Estimated timeline for completion
2. Piped Nitrous Oxide Waste Audit	SFH audit commenced February and ends in March, owned by the medical gases committee. SFH lead is working with NUH to formulate a plan. NUH has completed an audit and is working on an action plan to reduce.	June 2023 (to action implementation)
3. Low emission vehicle leases	Data being collected on fleet numbers and emissions. Contract variations will be considered in each organisation.	March 2023
4. Schemes for the purchase of ULEVs/ZEVs	Salary sacrifice contracts being reviewed by NHS organisations. Contract variations will be done (where possible) to comply with NHS standard contract. Nottingham County Council to consider same action as NHS organisations.	March 2023 (for contract assessment)
8. Measurement of food waste	Lead for food and nutrition chapter to formulate a comprehensive food waste audit.	September 2023 (next review)
9. Digital meal ordering	Our secondary care providers have digital ordering in place. Our community and mental health provider does not; this is unlikely to be financially viable at this time. This will be periodically assessed.	September 2023 (next review)
11. Identification of suppliers impacted by Carbon Reduction Plan requirements	City Council to identify all suppliers impacted by requirements i.e. contracts above £5 million in value.	April 2023
12. Minimum of 10% on net zero and social value in every tender	Procurement workstream are using the TOMS (Themes, Outcomes and Measures) framework to move towards this priority. The completion timeline to reach the 10% target is 2025	2024-2025
13. Walking aids return and reuse scheme	SFH pilot is now halfway though and data showing positive benefits. Pilot to complete and evaluation to be done before planning wider roll out	Mid-April 2023

Appendix A: Status of key areas by organisation as of December 2022

Focus area	Schedule of work	Estimated timeline for completion
14. Nominal lead for adaptation planning	Subsume the opportunities and initiatives in this chapter into Estates and Facilities chapter. The ICS Strategic Estates Group will then become responsible for deliver.	10 March 2023
16. Long term climate change adaptation plan	As per number 14. ICS Estates strategy will incorporate requirements to have a long-term adaptation plan. Each organisation will develop their own adaptation plan with the support of Emergency Planning colleagues.	September 2023

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/03/2023
Paper Title:	**Integrated Performance Report**
Paper Reference:	ICB 22 072
Report Author:	Sarah Bray, Associate Director of Performance and Assurance
Report Sponsor:	Stuart Poynor, Director of Finance
Presenter:	Stuart Poynor, Director of Finance Victoria McGregor-Riley, Locality Director Dave Briggs, Medical Director Rosa Waddingham, Director of Nursing
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 10 (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 long waiters (page 29)
- Cancer – Cancer 62-day low performance and 62-day backlogs (page 33)
- Mental health – Perinatal and children and young people eating disorders (routine) are below plan (page 38-39)
- Community – High levels of community waiting lists (page 41)

Health Inequalities:

- The IPR includes a focus on the Core20+5 (page 59).

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 – the underlying cause of agency use/cost is the impact of increased demand (critical incidents), higher than planned levels of turnover and sickness absence driving a need to expand the workforce through temporary staffing. Despite this the focused work of the agency high impact reduction group is resulting in a downward trend due to greater application of control processes (pages 51-52).

- Vacancies – The system is holding higher levels of vacancies than planned (page 49)
- Sickness absence – The system has higher levels of staff absence than planned (page 49)

A table has been provided at the end of this report (pages 13-14) outlining the actions and recovery timeframes being worked towards for the areas of most significant concern.

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 March 2023

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

Applicable Statutory Duties:	
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 provides 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 continues to experience pressures on delivery across all areas of the ICS aims. The data reported relates to the winter period, where patients were experiencing extended waits across urgent care and elective pathways due to higher levels of activity due to covid and flu and the impact of the industrial action. Challenges in recruitment, as well as high vacancy and sickness absence levels, have led to greater agency usage than planned. Local data for January into February report some improvements across staffing and elective activity, however the urgent care system and flow remains challenging. The financial position remains in a deficit position against plan as at month 10, however the in-month position reported a small surplus.

Finance

2. **Year to date (YTD):** at the end of month ten, the NHS system reported a £36.4 million deficit position, which is £16.8 million adverse to plan. The ICB reported a breakeven position YTD against plan, with the adverse variance mainly experienced in the two acute Trusts (Nottingham University Hospitals NHS Trust (NUH) and Sherwood Forest Hospitals NHS Foundation Trust (SFH)), representing £36.2 million of the year-to-date deficit with a small £0.2 million over-spend at Nottinghamshire Healthcare NHS Foundation Trust (NHT). The main drivers of the deficit relate to Covid costs, efficiency shortfalls, continuing healthcare, excess costs arising from urgent care capacity, and hospital discharge and interim beds.
3. **Forecast:** At month 10, all system partners continue to forecast to meet the 2022/23 planned deficit of £16.9 million. As the final outturn position will be a deficit, the system will still need to enact the NHS England protocol for changes to in-year revenue financial forecast. The ICS has already enacted the majority of the components of the protocol through the year and continues to liaise with NHS England over any further actions required.
4. **Financial risks:** The system has undertaken a full review of risks with potential impact upon the system financial forecast position. Although risk remains, there are expected to be sufficient mitigations to offset these. Note that all mitigations are non-recurrent.

5. **Capital:** The system capital envelope is underspent by £11.1 million to the end of month 10 and is forecasting to spend the £85.3 million capital envelope in full.

6. **Agency:** NHS England has introduced an agency cap of £54.6 million for Nottingham and Nottinghamshire ICS, current forecast is that the ICS will exceed the agency cap by £30.7 million. The breach relates to the areas of overspend described above (covid, efficiency shortfall, urgent care capacity requirements).

Service delivery

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 within the year across many of the areas (see Appendix 1, Page 24). The system is taking specific actions against each area to target further improvements as outlined below.

8. **Urgent care demand and pressures** continue to be high across the system. The system continues to have high levels of MSFT (medically safe for transfer). Volumes remain too high for an efficient flow through the system and need to reduce significantly to aim for the national target of 50% of the December 2021 position. Data at week ending 20 February showed that there were 296 MSFT patients in beds within NUH and SFH, which is 126 more than the forecast level.

9. Long lengths of stay have been increasing locally over the past 12 months and this was the focus in the February meeting of the Discharge Steering Group. The system position has been increasing for ambulance handover delays and 12-hour breaches. Significant work has been undertaken across the front of the pathway to avoid admission and transfers into the hospitals and reducing conveyances. This continues to be a focus across the system. Harm reviews are undertaken across this cohort of patients, which is overseen through the System Quality Group.

10. The Length of Stay (Appendix 1, page 27) of patients also remains an area of concern and a key challenge for the system, as the number of patients within hospital for 21 days or more has increased significantly against pre Covid levels. The Discharge to Assess business case has been implemented during the winter period with some positive impacts being made to the volumes of discharges. Specific ‘task force’ approaches are being undertaken within Trusts to focus on reducing the longer lengths of stay, with specific patient focused reviews on the longest stay patients. Senior review panels are being held across three areas identified as having patients stay in hospital longer:

medicine, orthopaedics and older people wards. This is expected to start to impact reductions in long lengths of stay from February onwards.

11. **Elective Care:** Urgent care demand, flow, staffing challenges and industrial action have limited the volume of elective activity that providers have been able to undertake. Providers have focused on the 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. At the end of January 2023 there were 13 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 reduces the volume 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. The Jubilee Unit at the City Hospital in Nottingham opened at the end of January, which will support patients who have undergone colorectal or simple case hepatobiliary surgery. These patients can now be treated at the City Hospital, rather than Queen's Medical Centre, releasing beds to help ease emergency pressures.

13. A new modular theatre building, incorporating three theatres and an Enhanced Perioperative Care Unit where patients who require a higher level of monitoring post-operatively can be cared for, is also under construction at City Hospital and is due to open in late Spring 2023.

14. **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, as missing cancer referrals during Covid appear to have come forward, the high level of demand is causing pressure in some services.

15. 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. Although, additional waiting list initiatives have been used, aligning capacity to high levels of demand remains challenging. 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 (FDS) was 76.56% in December against the 75% national standard. The Nottingham and Nottinghamshire system was one of only two systems within the region to achieve the Cancer FDS in December.

16. The increased levels of demand for cancer services, as well as the impact of the critical incident and strike action, impacted upon the volume of patients waiting on the cancer pathway. This caused the volume of patients waiting

beyond 62 days to increase within the system in December and into January to a high of 478 patients. The position is tracked weekly using provisional data, which shows that by week ending 12 February, the system backlog had improved to 419 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 13% and 3% respectively.

17. **Diagnostics:** Across all modalities, the waiting list volume exceeds the planned levels for the system. There are challenging positions for MRI, Echocardiography and Non-Obstetric Ultrasound services within the system, with some improvements beginning to be seen. At the end of January, the MRI waiting list was 6,074 patients, which is a reduction of 546 patients from the position reported in November 2022. NUH has two relocatable units in addition to two mobile units in place to provide additional capacity. Additional revenue has been allocated to the system by NHS England, which enabled a third mobile MRI machine to be sited at NUH from the 30 January. This will further improve the level of capacity that can be delivered. Plans have been submitted to NHS England, which show that the volume of patients waiting over 13 weeks is forecast to fall from 2,996 at January 2023 to 411 by March 2024. A large reduction in the volume of 6-week waiters is also planned from 4,341 in January 2023 to 596 by March 2024.

18. Echocardiography is area of significant concern at SFH. The Trust 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. By March 2024, the total backlog is planned to reduce to 135 patients from the current level of 3,656 in January 2023.

19. Non-Obstetric Ultrasound has significant growth in the waiting list and backlog at NUH. The waiting list volume has increased during the year from 2,473 patients in April 2022 to 4,236 patients by January 2023. The level of administration staff vacancies has been 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. Plans recently submitted to NHS England show the volume of 6-week waiters is forecast to reduce from 1,170 to 572 between January 2023 and March 2024.

20. **Mental Health:** Staffing levels continue to be a concern; however, some local recruitment approaches have proven successful. The Sherwood Oaks facility is fully operational, which increases the number of acute beds by 14, which has supported improvements in out of area placements through December to February. This will support plans to reduce the reliance on sub-contracted beds and eradication of dormitories. Out of area placements reductions are also

supported with the on-going implementation and review of the crisis and urgent mental health pathways, as well as internal flow improvements.

21. Early Intervention Psychosis (EIP): the areas of compliance against the NICE standards have been reviewed locally and the system is able to report delivery against the compliance standards, which is for all to be at level 3 or above. Improvements were made across Family Interventions and Outcomes measures to secure this position. Two standards have reduced to level 3 from level 4, which are being reviewed by NHT to determine actions required to improve.

22. Access to Children and Young People Eating Disorder services are improving. However, performance relating to routine services remain challenged. Detailed reviews are undertaken relating to any young person who is not seen within required timescales, and it has been ascertained that the primary reason relates to patients choosing to attend for dates later than those offered within the timescales.

23. **Primary Care:** The number of GP appointments were above plan in December 2022 by 8.6%, which is 18% higher than the volume delivered in December 2021. The system continues to offer a blended model, with 68% of appointments being delivered face to face. There were 2,600 home visits delivered in December, with 155,177 appointments conducted via video or telephone during the month.

Health inequalities

24. 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.

25. 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 supports a systematic Qualitative Improvement approach, and our bid includes a learning collaborative for system leaders.

26. 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 Nottingham and Nottinghamshire population.

[1] An approach to reducing health inequalities for children and young people NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people

Quality

27. 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, patient safety and safeguarding (Appendix 1, pages 12-22).

28. **Intensive Surveillance:** Under revised National Quality Board guidance, there is one NHS provider subject to intensive surveillance: NUH. A system-wide Improvement Oversight and Assurance Group (IOAG) is in place, which includes oversight of partnership support and mutual aid arrangements. January's IOAG meeting focused on the approaches that are been taken towards staff retention. An update on serious incidents received appropriate recognition, particularly the progress around recognising and responding to incidents, the robustness of the investigations and, significantly, how themes and learning are being identified and embedded.

29. **Enhance Surveillance:** One NHS provider is subject to enhanced surveillance: NHT. The Trust has a system-wide Quality Assurance Group (QAG), which meets quarterly; the latest QAG meeting was held in January 2023. The QAG Terms of Reference are being amended to facilitate the sustained delivery of required actions, aligned to the findings of the Care Quality Commission (CQC) following inspections carried out in 2022. The Trust has increased their levels of quality oversight of their subcontracted beds using an established quality monitoring framework. This has been extended to include all contracts over the value of £250,000. The Trust is also actively working with the Priory Hospital Arnold, following a further inadequate CQC rating (January 2023), and New Care Nottingham (Ruddington Manor) around discharge pathway beds, in order to address quality and safety concerns identified leading to a temporary suspension of contract. Improvements are required within 28 days.

30. **Care Sector and Home Care Capacity:** There have been some contractual changes with our local authority colleagues in both City and County for domiciliary packages of care. The ICB is currently supporting one care home closure; weekly operational meetings are in place, as well as daily Safety Huddles and regular face-to-face visits are in place. Workforce continues to be an area of concern for most providers, which can impact on the quality-of-service delivery. However, there have been no recent reports of nursing homes without a nurse on duty. The Social Care Nursing Task and Finish Group are currently focussing on recruitment and retention of the current workforce; links have been made with NHS England, who are looking to develop a preceptorship framework for social care. Local training offers to social care nurses are being mapped, with a view to completing a gap analysis of what is required and how this training will be funded. A webinar is planned regarding apprenticeships (including Trainee Nurse Associates) to inform and support providers to develop their own future nursing workforce.

31. **Maternity Services:** System partners continue to work closely with NUH and regulators to oversee and support improvements. The Perinatal Quality Surveillance workstream continues to focus on the response to learning from serious incidents. The latest bi-monthly meeting was held in January; good progress was noted towards a standardisation of approach across NUH and SFH, with the establishment of the BadgerNet maternity records system, the launch of the shared guidelines group, the adoption of a regional pathway around competency assessment for foetal monitoring, and a proposed review of the NUH maternity dashboard to enable benchmarking. Key appointments have been made into the senior midwifery team, with new starters in post from January 2023.

32. 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.

33. 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. Focus remains on action plan development in response to the East Kent report and implementation of Ockenden recommendations. East Kent system recommendations and next steps have been agreed with LMNS partners and endorsed by the LMNS Executive Partnership. Key messages are being developed into a public facing format for wider sharing. This quarter has seen a significant improvement in quality, which reflects the introduction and embedding of an additional executive-led -internal review at NUH. (Appendix 1, pages 17-18)

34. Learning Disability/Autism (LDA) Partnership programme: the 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). Adult inpatient performance remains a challenge and forecasts indicate non-compliance against the 2023/24 long term plan trajectories. Revised forecasts have been agreed with the ICS LDA Board and discussions are taking place with the NHS England regional team to review and refine the 2023/24 trajectory, given the changing context. The NHS England Winter Summit on LDA took place on 24 January 2023 and positive work was recognised (especially in relation to Learning Disability Mortality Reviews), but inpatient performance remains a focus (Appendix 1, pages 13-14).

35. **Infection Prevention and Control and Hospital Acquired Infections (HCAIs):** HCAIs remain an area of focus, due to breaches against plan positions across a range of the new reduction targets. Covid 19 and Flu related admissions are reducing following the peak in late December and outbreaks

are starting to subside across services including care homes. HCAI targets remain challenging against a backdrop of high bed occupancy and an inability to deep clean ward areas. This remains a regional and local concern. (Appendix 1, page 19-20).

36. **Personalised Care:** Both the Personalised Care and Coproduction strategies were endorsed by the ICB Board in January; these set out the fundamental approaches the ICB will take to work effectively with people in the delivery of system priorities. (Appendix 1, page 15-16).

37. **Children and Young Peoples Service Transformation** has been subject of increased focus due to concerns about access and the ability to deliver integrated services. Partners are reviewing the impact of plans around transforming services and have instigated recovery plans to focus on improving access in key areas such as health checks for looked after children (LAC), children with special educational needs (SEND) and access to therapies including CAMHS (children and young people's mental health services) (reported on Appendix 1, page 36). Key performance and quality metrics are being compiled, which will bring together reporting on these areas into a clearer format in the next IPR. This quarter has seen a significant focus on LAC health check performance, and a joint SEND Ofsted/CQC inspection in Nottinghamshire.

Workforce

38. The workforce report predominantly focuses on the three acute, community and mental health trusts within the system, reporting on the January 2023 position against the Operational Plan for 2022/23. The collective position shows the Trusts are above plan (780.7 wte (whole time equivalent)) with the substantive wte yet seeing a continued use of bank and agency at 8% (441 wte) and 15% (157 wte) above plan respectively (Appendix 1, page 48)

39. Sickness absence in the acute, community and mental health trusts saw increases in the daily position over the month of January to 7.2% (all sickness) and 1.5% Covid related sickness. The 12-month rolling average position for each Trust has maintained at a position of 5.7% sickness, which is higher than the pre-Covid level target needing 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 People and Culture Group to assess the risk of no further funding to support this intervention as an ongoing national initiative in 2023/24.

40. Retention of our existing workforce is a key focus with Nursing and Midwifery. Retention plans have been developed in each Trust and additional capacity of a system retention lead recruitment is in progress. Turnover in two trusts remains higher than plan of 10.5%. NUH is at 12.2%, NHT is at 18.6% and SFH

is at 9.3%. 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 support the response to the pandemic.

41. 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. NHT is on track to see 29 further posts join the Trust by spring 2023. Work continues in the Agency High Impact Action Group to analyse agency usage, aligned to an analysis developed on understanding the substantive workforce and its deployment in the delivery of the Operational Plan 2022/23. The NHS England regional Chief Nurse received a diagnostic from the system in December 2022 resulting in a meeting in early February resulting in an actions to develop a collaborative action plan. Greater pace and impact will be needed to address the Operational planning guidance to reduce the cost of the pay bill by 3.7%, which currently stands at 5%. The ICB Chief People Officer will act as joint SRO on this High Impact Action along with the Chief Finance Officer from SFH.

42. Primary Care General Practice data, which includes the additional roles position, which is a national priority for growing our general practice workforce, is presented at a high level, showing indicative workforce numbers against the 2022/23 Operational Plan for December 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 (Appendix 1, Page 50).

43. The overall workforce position in general practice is being maintained with an established retention/workforce development programme in place for General Practitioners 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. 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. The Primary Care Workforce Group is aligning workforce development plans to match the Primary Care Strategic objectives.

44. Following the State of Adult Social Care Sector and Workforce 2022 report, published by Skills4Care (October 2022) and presentation from Skills4Care on the Nottinghamshire position at 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.

45. **Table 1: Non-Compliant Performance Areas – Recovery Overview**

Programme Area	Performance Metric	Latest Performance	Recovery Trajectory
Quality	LD&A Inpatients	Adult commissioned by ICB is 17 against a plan of 12 inpatients. Adult commissioned by NHSE is 33 against a plan of 27 inpatients. CYP commissioned by NHSE is 1 against a plan of 3 inpatients. Further detail is shown in Appendix 1: IPR Page 13-14.	Despite good levels of adult inpatient discharge activity (23 discharges this year), admission rates remain consistent (20 this year), so the net effect is small (a reduction in total number of 3 people). Significant forecasting work has been undertaken with all partners (NHT, IMPACT and both local authorities) to confirm a realistic inpatient trajectory for 2023/24 given local challenges (market development lead times and individuals subject to legal frameworks) and development work in place that requires time to mature and impact performance. The system has a robust grip on all inpatients, what their needs are and where they are at on their 12-point discharge plan by bed type and local authority area. The definition of the population requiring support has changed (with changes to diagnosis) and the Building the Right Support figures and trajectories set at the beginning of the programme demonstrate a different population to the one we are now working with. A revised system forecast has been agreed with ICS LDA Board members and discussions are being undertaken with NHSE Regional team to gain NHSE agreement on final trajectories for 2023/24.
	Personal Health Budgets	5,860 Personal Health Budgets YTD to Dec against a plan of 5,707.	The ICB are on track with the monthly trajectory, as reported at Personalised Care SOG, and are expected to deliver the end of year target position.
Urgent Care	12 Hour Breaches	1,109 in Jan 23 against a target of zero.	Providers are forecasting to achieve the 4-hour standard for A&E (Types 1, 2 and 3), which is 76% by March 2024. Improvements in process and flow will be required which will also reduce the volume of 12-hour breaches.

Programme Area	Performance Metric	Latest Performance	Recovery Trajectory
	Ambulance Handover Delays > 60 minutes	448 in Jan 23 against a target of zero.	Operational plans are under development by Derbyshire ICB as lead for the EMAS contract and will be included when received.
	Length of Stay > 21 days	470 in Jan 23 against a plan of 314.	Trajectories submitted to NHSE show that this is planned to reduce to 395 by April 2023. Increases are predicted in September and October to 465 and 450 respectively. However, December and January are forecast to be 404 and 415, which is below historical levels.
Planned Care	Long Waits +104 & +78 weeks	104ww - 13 patients @ end of Jan 2023 78ww – 760 patients @ end of Jan 2023	104 week-waits are forecast to be zero for March 2023. 78 weeks-waits are forecast at zero for March 2023. However, there is a risk of up to 150 patients which is being managed across NUH and SFT.
	Cancer 62-day backlogs	478 @ Jan 2023 v 313 target.	The system is working to achieve a backlog volume at the end of March that is equivalent to the position at the end of March 2022, which was 417 patients. This is in line with the request from NHSE.
Mental Health	NHS Talking Therapies	7,225 patients against a plan of 9427 at Nov 22 (3 month rolling position).	The system is working to achieve the NHS Talking Therapies Entering Treatment by the end of March 2023.
	Out of Area Placements	85 @ Nov 22 against a zero national target	Performance has continued to improve with zero patients being in inappropriate out of area beds at the end of January.
	SMI Physical Health Checks	4,377 @ Jan 23, 2022/23, against a plan of 6237.	The position continues to increase however not at the rate required. As in previous years, the performance is expected to increase in Q4 as primary care focus on the LES element of the checks, however this is not expected to be sufficient to deliver to target. A performance trajectory is being confirmed as part of the planning for 2023/23.

NHS
Nottingham and Nottinghamshire

Nottingham & Nottinghamshire Integrated Care Board

Integrated Performance Report

Reporting Month: January 2023

Board Month: March 2023

Integrated Performance Report 2022/23 – Report Contents

NHS Nottingham and Nottinghamshire

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 continue to 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 66 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 10 and despite improvements in recruitment in line with substantive staffing plans, high vacancy and sickness absence are leading to higher levels of bank and agency usage than planned.

It is important to note the context for the performance in December was against rising demand due to increasing covid and flu presentations, which led to critical incidents being declared by both acute trusts on the 29th December, which were stepped down by NUH on the 6th January and SFHT on the 9th January. These pressures resulted in reductions in the volumes of elective activity being undertaken at the end of December and through January. In addition, there was the impact of the industrial action being undertaken through December and January.

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 (variation) as well as an indication of whether the current process or performance levels will achieve the required level in future (assurance).

Exception reports by functional area, detailing the areas of concern, actions being taken to address the current issues, and assurance as to whether these actions will impact upon and improve the position, are provided on pages 12 – 63.

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1. ICB Scorecard by ICS 4 Aims – Reporting Period January 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	Dec-22	5707	5860	✓	-	-
	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	Jan-23	0	1109	✗		
	Handover delays > 60 minutes	Jan-23	0	448	✗		
	Length of Stay > 21 days	Jan-23	314	470	✗		

AIM-03 Improving the Effective Utilisation of Our Resources

ID	Key Performance Indicators	Date	Plan £m	Actual £m		Variance £m	FOT Var £m
	Delivery against system plan	Jan-23	-19.7	-36.4		✗ -16.7	✓ 0.0
	Efficiency Target	Jan-23	75.4	72.9		✗ -2.5	✓ 0.0
	ESRF Income	Jan-23	45.6	45.6		✓ 0.0	✓ 0.0
	Agency Spend	Jan-23	46.3	70.9		✗ -24.6	✗ -30.7
	MHIS	Jan-23	158.9	178.2		✓ 19.3	✓ 0.0
	Capital Spend	Jan-23	58.0	46.9		✓ 11.1	✓ -4.3

AIM-04 Support Broader Social and Economic Development

ID	Key Performance Indicators	Date	Plan	Actual	In Month	Variation	Assurance
	Provider Substantive Staffing	Jan-23	29,115	29,936	✓		
	Provider Bank Staff	Jan-23	1,537	1,978	✗		
	Provider Agency Staff	Jan-23	853	1,010	✗		
	Provider Staff Vacancy Rate	Jan-23	8.7%	12.1%	✗		
	Provider Staff Absence Rate	Jan-23	4.6%	5.7%	✗		
	Primary Care Workforce	Dec-22	-	3200			-

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	Dec-22	-	111712	-		-	102197	123751	✗		
	Patients Waiting >104 weeks	Dec-22	-	6	-		-	1	6	✗		
	Cancer 62 Day Backlog	Dec-22	-	-	-	-	-	314	439	✗		
	Cancer Faster Diagnosis	Dec-22	75.0%	76.6%	✓			75.0%	76.6%	✓		
	OP Remote Delivery	Dec-22	25.0%	20.5%	✗			25.0%	21.0%	✗		
	Childrens Wheelchair Provision	Q2 22/23	91.6%	65.6%	✗			-	-		-	-
	Community											
	Community Waits - Adult	Dec-22	5337	8209	✗			-	-		-	-
	Virtual Wards	Nov-22						-	-		-	-
	Primary Care											
	GP Appointments	Dec-22	528,346	573,880	✓			-	-		-	-
	NHS App	Jan-23	60%	51%	✗			-	-		-	-
	Mental Health											
	IAPT Access	Nov-22	9427	7225	✗			-	-		-	-
	CYP Access	Nov-22	13450	18400	✓			-	-		-	-
	Out of Area Placements	Nov-22	0	85	✗			-	-		-	-
	SMI Physical Health Checks	Jan-23	6237	4377	✗			-	-		-	-
	Health Inequalities - Prevention											
	NHS Digital WM Referrals	Nov-22	1880	685	✗	-	-	-	-	-	-	-
	IP % Smokers Offered Tobacco Treatment	Jun-22	1111	1051	✗	-	-	-	-	-	-	-

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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	Dec-22	5707	5860 ✓	153	-	-	Page 15
No. Social prescribing referrals into link workers	Dec-22	13610	9316 ✗	-4294	-	-	
No. active PCSPs in place	Sep-22	27000	10730 ✗	-16270	-	-	
Maternity							
No. stillbirths per 1000 total births	Oct-22	4.1	3.6 ✓	-0.5	-	-	Page 17
No. neonatal deaths per 1000 live births	Oct-22	2.3	3.7 ✗	1.4	-	-	
Hospital Acquired Infections							
MRSA	Dec-22	0	0 ✓	0	-	-	Page 19
C-Diff	Dec-22	22	22 !	0	-	-	
Ecoli BSI	Dec-22	70	68 ✓	-2	-	-	
Klebseilla BSI	Dec-22	21	22 ✗	1	-	-	
Pseudomonas BSI	Dec-22	6	6 ✓	0	-	-	

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

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Urgent Care Scorecard	Latest Period	Population			Variation	Assurance	Latest Period	Provider			Variation	Assurance	Exception Report
		Plan	Actual	Variance				Plan	Actual	Variance			
Urgent Care Access													
SDEC % of Total Admissions		-	-	-	-	-	Nov-22	33.0%	28.5%	✗ -4.5%			Page 26
Ambulance Conveyances (%)	Dec-22	54.4%	47.1%	✓ -7.3%				-	-	-	-	-	
Ambulance Conveyances (Vol.)	Dec-22	8035	7609	✓ -426				-	-	-	-	-	
A&E Attendances v 19/20 (%)	Dec-22	100%	107.1%	✗ 7.1%			Jan-23	100%	96.9%	✓ -3.1%			
% Unheralded Patients attending A&E		-	-	-	-	-	Nov-22	-	72.2%	-		-	
NEL Admissions v 19/20 (%)	Dec-22	100%	95.2%	✓ -4.8%			Dec-22	100%	98.8%	✓ -1.2%			
Urgent Care - Acute Discharges and Out of Hospital													
Patients medically safe to transfer from acute setting		-	-	-	-	-	Jan-23	104	285	✗ 181			Page 27
Length of Stay > 21 days		-	-	-	-	-	Jan-23	314	470	✗ 156			
No. Patients utilising Virtual Ward		-	-	-	-	-	Jan-23	-	35	-		-	
2 Hour Urgent Care Response Contacts	Dec-22	430	681	✓ 251				-	-	-	-	-	
2 Hour Urgent Care Response %	Dec-22	-	88.50%	-		-		-	-	-	-	-	
Pathway 1 - Discharge home with health and/or social care		-	-	-	-	-	Jan-23	1460	824	✗ -636			
Urgent Care - Compliance													
Ambulance (mean) Response Times Cat 1 (Notts Only)	Dec-22	0:07:00	00:09:38	✗ 00:02:38				-	-	-	-	-	Page 28
Ambulance (mean) Response Times Cat 2 (Notts Only)	Dec-22	0:18:00	01:46:51	✗ 01:28:51				-	-	-	-	-	
Ambulance (mean) Response Times Cat 3 (Notts Only)	Dec-22	2:00:00	13:27:53	✗ 11:27:53									
% Cat 2 waits below 40 minutes (Notts Only)	Dec-22	90.0%	23.1%	✗ -66.9%									
Hospital Handover Delays > 60 Minutes		-	-	-	-	-	Jan-23	0	448	✗ 448			
12 Hour Breaches ED		-	-	-	-	-	Jan-23	0	1109	✗ 1109			
12 Hour Breaches as % NEL		-	-	-	-	-	Dec-22	2%	9.0%	✗ 7.0%			

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3b. Service Delivery Scorecard - Planned Care Recovery

Elective Scorecard	Latest Period	Population			Variation	Assurance	Latest Period	Provider			Variation	Assurance	Exception Report
		Plan	Actual	Variance				Plan	Actual	Variance			
Elective Recovery - Total Waiting List & Long Waits													
Total Waiting List Size	Dec-22	-	111712	-		-	Dec-22	102197	123751	✖ 21554			Page 30
Incomplete RTT pathways >52 weeks	Dec-22	-	4929	-		-	Dec-22	3732	5395	✖ 1663			
Incomplete RTT pathways >78 weeks	Dec-22	-	692	-		-	Dec-22	328	791	✖ 463			
Incomplete RTT pathways >104 weeks	Dec-22	-	6	-		-	Dec-22	1	6	✖ 5			
Elective Recovery - Activity													
Total Referrals	Dec-22	24661	21016	✖ -3645			Dec-22	23342	19507	✖ -3835			Page 31
Total Ordinary Electives	Dec-22	1746	1714	✖ -32			Dec-22	1980	1712	✖ -268			
Total Daycases	Dec-22	11781	11895	✔ 114			Dec-22	12988	11034	✖ -1954			
Total Outpatients - First Appointments	Dec-22	34942	22635	✖ -12307			Dec-22	25994	20883	✖ -5111			
Total Outpatients - Follow Ups	Dec-22	73499	55330	✖ -18169			Dec-22	58625	53791	✖ -4834			
Total Diagnostic Activity	Dec-22	39000	28772	✖ -10228			Dec-22	34004	30199	✖ -3805			
Elective Recovery - Productivity & Transformation													
Total Outpatients - Total Virtual (%) 25%	Dec-22	25%	20%	✖ -5%			Dec-22	25%	21%	✖ -4%			Page 32
Patient Initiated Follow ups - %	-	-	-	-	-	-	Dec-22	5.0%	3.9%	✖ -1.1%			
Advice & Guidance - % of 1st OP	Dec-22	16	18	✔ 2			-	-	-	-	-	-	
Total Outpatient F/Up v 2019/20 Activity (%) 25% Reduction	Dec-22	75.0%	100.7%	✖ 25.7%			Dec-22	75.0%	101.8%	✖ 26.8%			
Completed admitted RTT pathways	Dec-22	4593	4345	✖ -248			Dec-22	4450	3795	✖ -655			
Completed non-admitted RTT pathways	Dec-22	21085	22562	✔ 1477			Dec-22	19324	22127	✔ 2803			
Diagnostic Recovery													
Diagnostic Activity	Dec-22	39000	28772	✖ -10228			Dec-22	34004	30199	✖ -3805			Page 34
Diagnostic Waiting List	Dec-22	-	25220	-		-	Dec-22	-	27315	-		-	
Diagnostic Backlog	Dec-22	-	10309	-		-	Dec-22	-	11652	-		-	
Diagnostics + 6 Weeks	Dec-22	25%	40.9%	✖ 15.9%			Dec-22	25%	42.7%	✖ 17.7%			
Cancer Recovery													
Cancer Referrals	Dec-22	-	3550	-			Dec-22	-	3958	-		-	Page 33
Cancer - Faster Diagnosis Standard 28 days	Dec-22	75.0%	76.6%	✔ 1.6%			Dec-22	75.0%	76.6%	✔ 1.6%			
Cancer - No. 1st Definitive Treatments	Dec-22	525	430	✖ -95			Dec-22	657	528	✖ -129			
Cancer - No. patients receiving 1st treatment < 31 days (%)	Dec-22	96%	87%	✖ -8.6%			Dec-22	96%	87%	✖ -8.9%			
Cancer - No. patients waiting < 62 days (%)	-	-	-	-	-	-	Dec-22	85%	62%	✖ -23.2%			
Cancer - 62 day backlog	-	-	-	-	-	-	Dec-22	314	439	✖ 125			

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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	Nov-22	-	3590	-		-	Page 36
IAPT - 1st Treatment <6 Weeks	Nov-22	75%	88.5%	✔ 13.5%			
IAPT - 1st Treatment <18 Weeks	Nov-22	95%	100%	✔ 4.7%			
IAPT - Entering Treatment 3 Months	Nov-22	9427	7225	✖ -2202			
IAPT - >90 Days between 1st and 2nd Treatment	Nov-22	10%	16.1%	✖ 6.1%			
IAPT - Recovery Rate (3 months rolling)	Nov-22	50%	50.6%	! 0.6%			
Mental Health - Adult Mental Health							
Adult MH Inpatient Discharges - % F Up 72 hours	Oct-22	80%	81%	✔ 1.0%			Page 37
Inappropriate OAP Bed days	Nov-22	0	85	✖ 85			
Rate per 100,000 Older Adult MH LOS > 90 Days	Oct-22	11	8	✔ -2.35			
SMI Health Checks	Jan-23	6237	4377	✖ -1860			
Access SMI +2 Contacts Community MH Services	Nov-22	14101	13605	✖ -496			
Dementia Diagnosis	Dec-22	67%	68.9%	✔ 2.2%			
Mental Health - Access							
Perinatal Access % (12 month rolling)	Nov-22	10.0%	8.1%	✖ -1.9%			Page 38
Perinatal Access - Volume	Nov-22	1175	1045	✖ -130			
Individual Placement Support	Dec-22	675	706	✔ 31			
Early Intervention in Psychosis (EIP)	Nov-22	60%	86%	✔ 26.4%			
Mental Health - Children & Young People							
CYP - New Referrals	Jun-22	-	1985	-		-	Page 39
CYP Eating Disorders - Routine Referral Performance (Qtr)	Sep-22	95%	83%	✖ -11.7%			
CYP Eating Disorders - Urgent Referral Performance (Qtr)	Sep-22	95%	100%	✔ 5.0%			
CYP Access (1+ Contact)	Nov-22	13450	18400	✔ 4950			

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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	Dec-22	528,346	573,880	✔ 45,534	H	?	Page 41
Percentage of Face to Face Appointments	Dec-22	-	68%	-	H		
Percentage of Same Day Appointments	Dec-22	-	47%	-	H		
Number of NHS App Registrations	Jan-23	60%	51%	✖ -9%	H	F	
Community Waiting List (Patients aged 0-17 Years)	Dec-22	497	1949	✖ 1452	H	F	
Community Waiting List (Patients aged 18+ Years)	Dec-22	5337	8209	✖ 2872	H	F	

4. Finance - Scorecard

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		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**	**-19.7**	**-36.4**	**-16.8**	**-16.9**	**-16.9**	**0.0**		
Capital (within Envelope)	**Spend against plan**	58.0	46.9	**11.1**	89.6	85.3	**4.3**		
MHIS (meeting target)	**Spend against plan**	158.9	178.2	**19.3**	190.7	190.9	**0.3**		
Agency (spend within Cap)	**Spend against plan**	46.3	70.9	**-24.6**	54.6	85.3	**-30.7**		

		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**	16.6	26.7	**-10.1**	17.8	30.2	**-12.4**		
NHS Efficiencies	**Delivery against plan**	75.4	72.9	**-2.5**	102.7	102.7	**0.0**		
ERF Income	**Delivery against plan**	45.6	45.6	**0.0**	53.7	53.7	**0.0**		

- **£36.4m** deficit experienced to end of month 10, which is **£16.8m** adverse to plan.
- The adverse variance is mainly experienced in the 2 acute Trusts (NUH & SFH) representing **£25.8m** of the **£10.5m** year to date deficit with a small **£0.2m** over-spend at the mental health & community Trust (NHT).
- Key drivers of the adverse variance are covid (**£10.1m**), continuing care spend **(£8m**) and efficiency shortfall (**£2.5m**). There are also pressures relating to excess costs arising from urgent care capacity requirements greater than plan. Offsetting favourable variance include all primary care expenditure (£5.4m) and clinical supplies (£2.3m).
- Agency spend remains over plan and above the agency cap, with an adverse YTD variance of **£24.6m**. 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 relating to the continuation of over-spending areas.

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5. Workforce - Scorecard

Workforce Scorecard	Latest Period	Total Provider			Variation	Assurance	Exception Report
		Plan	Actual	Variance			
Total Provider Workforce							
Total Provider Workforce	Jan-23	31,453	32,925	1471			
Total Provider Substantive	Jan-23	29,115	29,936	821			Page 47
Total Provider Bank	Jan-23	1,537	1,978	441			
Total Provider Agency	Jan-23	853	1,010	157			
Total Primary Care Workforce	Dec-22	-	3,200	-			Page 49
Key Workforce Performance							
Total Provider Turnover Rate % (12 month rolling)	Jan-23	11.0%	13.5%	2.5%			
Total Provider Sickness Absence Rate %	Jan-23	4.6%	5.7%	1.1%			Page 48
Total Provider In-Month Vacancy Rate %	Jan-23	8.7%	12.1%	3.4%			

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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 & Safeguarding

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

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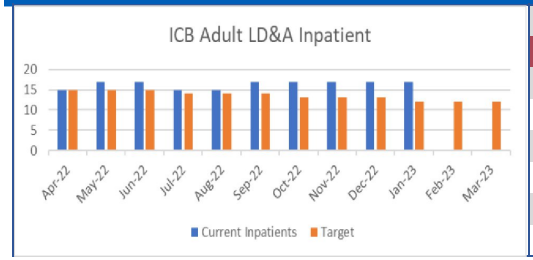
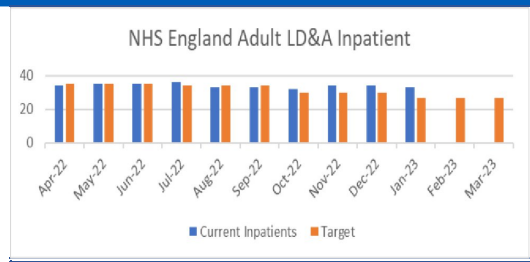
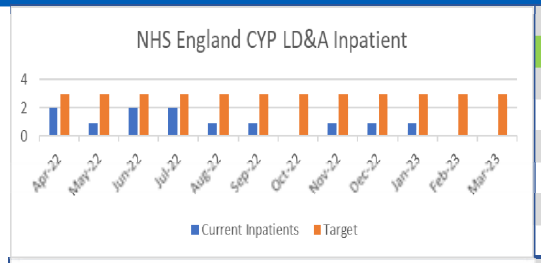
Learning Disability and Autism (LD&A)



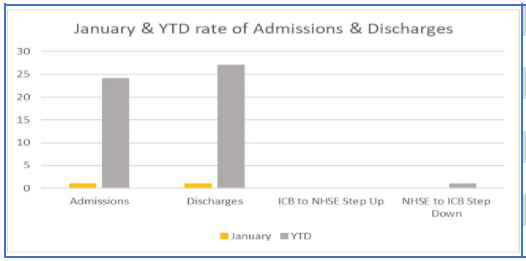
Jan-23
17
2022/23 Plan
12
Assurance
-
SPC Variation
-



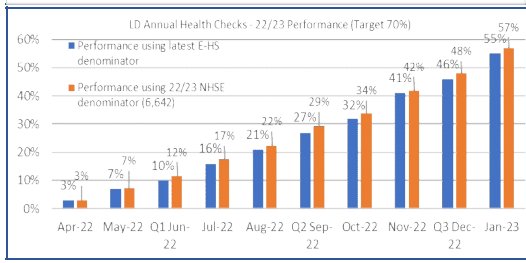
Jan-23
33
Target
27
Assurance
-
SPC Variation
-



Jan-23
1
Target
3
Assurance
-
SPC Variation
-



YTD
24
Admissions
1
Discharges
-1
-



Jan-23
55%
Target
70%
Assurance
-
SPC Variation
-

Jul-22
1
Target
6
Assurance
-
SPC Variation
-

Current Position

Adult Inpatients: Our current adult inpatient number stands at 50 people, missing the target for January (39) by 11 people. There was 1 admission into non-secure setting and 1 discharge within non-secure setting. Despite a significant system-wide approach to discharges, resulting in 27 discharges this financial year, 24 adult admissions during the same period means we have only achieved a net reduction of 3 people within an adult setting. Forecasts indicate 2 discharges within this financial period and an end of year position of 49 people in an adult inpatient setting, missing our target by 10 people.

Focused work has been undertaken with all system partners to forecast adult inpatient performance for 2023/24 to ensure compliance against the long-term plan trajectories. Revised forecasts have been agreed with the ICS LDA Board and discussions are taking place with Region to review and refine the 2023/24 trajectory, given the changing context. The definition of the population requiring support has changed (with changes to diagnosis) and the Building The Right Support figures and trajectories, which were set at the beginning of the programme, demonstrate a different population to the one we are now working with. Planning leads are fully briefed.

Children and Young People (CYP) Inpatients: Our current CYP inpatient number remains low at 1, which is within our end of year target of no more than 3. We have had three admissions, three discharges and one transfer into adult provision this financial year. Our Dynamic Support Register (DSR) panel is helping to identify CYP with behaviours of concern earlier. This continues to be an area of strong performance for the ICS. Figures show that there are a high number of CYP (61) who are currently being supported effectively within the community. Since the inception of the CYP DSR we have had only one child who has been on the DSR being admitted into an inpatient setting.

System Quality Group Assurance – Limited Assurance

Enhanced Surveillance: Due to Adult Inpatient numbers, rapid response to the Five Eyes recommendations, and increased Host Commissioner responsibilities.

Content Author: Natasha Wrzesinski | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

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)

Workforce Development: The overall scope of the LDA workforce deep dive exercise has been agreed (this is part of the wider ICS Care Workforce Group exploration into the external workforce in social care). The purpose of this work is to understand specific barriers and challenges to recruiting and retaining the LDA workforce, so as to improve quality of services and patient care.

Coproduction: An action plan for increased coproduction activity has been developed by the Expert by Experience group. There is a need to widen membership of the Expert By Experience group and a plan is in place to address this.

Dashboard development: Work continues with the SAIU to develop an LDA dashboard that will contain key LDA performance reporting. The development of the dashboard will be undertaken in phases, with phase 1 being completed by March 2023 and phases 2 and 3 undertaken over the next 6-9 months.

Annual Health Checks (AHC): As at 01 February 2023 there have been 3,767 health checks completed in 2022/23 across the ICS, putting performance against this year's denominator set by NHSE at the start of the year (based on the previous all age QOF GP LD register) at 57% and 55% against the current GP LD register on E-Healthscope (14 years and over). This is an increase of 14% and 12% respectively against last year's end of January position and 367 health checks above target (3,400). The BAME exemplar pilot in City for 14–25-year-olds has resulted in increased take-up within BAME communities. Current uptake is at 85%; before the pilot take up was 52%.

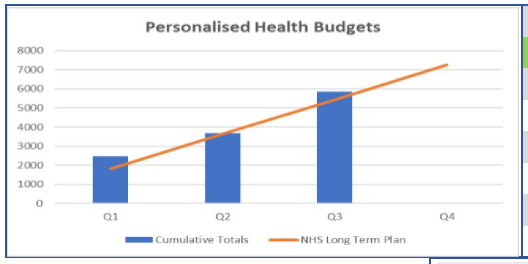
The **NHSE Winter Summit** on LDA took place on 24th January 2023. Positive work was recognised, particularly in relation to crisis management, prevention activity (especially in CYP services), reduction of inequalities in Annual Health Checks and LeDeR, where we have achieved 99% performance nationally. However, inpatient performance needs to be addressed.

	Key Performance Indicator	Date	Plan	Actual	Variance
LD&A	Adult Inpatient Care Rate per million – commissioned by ICB	Jan-23	12	17	+5
	Adult Inpatient Care Rate per million – commissioned by NHSE	Jan-23	27	33	+6
	CYP Inpatient Care Rate per million – commissioned by NHSE	Jan-23	3	1	-2
	Annual Health Checks by GPs on Learning Disability Register	Jan-23	3767	3400	367

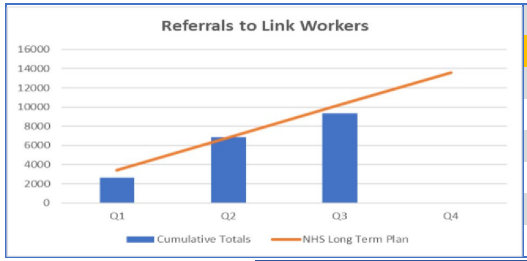
6.2- Improving Quality of Services – Exception Report Personalisation & Co-Production

NHS Nottingham and Nottinghamshire

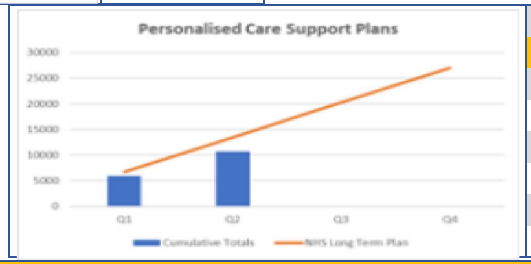
Personalisation



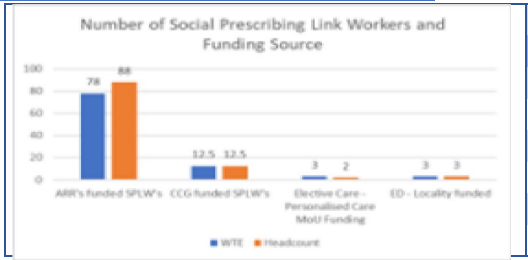
Q3 22-23
5860
2022-23 Plan
7250
Assurance
SPC Variation



Q3 22-23
9316
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

- The Personalised Care Strategy was endorsed by the ICB Board in January 2023; this sets out 8 key system actions to embed personalised care.
- NHSE have confirmed that there will no longer be a Personalised MOU for the system, as this embeds as part of business as usual. This means there will be no formal trajectories set for 2023/24 and no additional funding for the system. The team are developing a series of options for how best to embed personalised care within existing resources.
- A review of the ICS Personalised Care Strategic Oversight Group is underway to ensure clarity on focus for 2023/24, given the changing context of the programme. Focus will be on ensuring alignment between strategic system priorities and Place priorities.
- Quarter 3 UPC data demonstrates that the system is on target, or over-target, for each trajectory. This includes achieving 80% of the personal health budget target of 7,500 to date and achieving over-target for the number of personalised care and support plans.
- The Personalised Care workforce hub pages are in development; this will be in place for our system workforce to find out what training, tools, information and resources are available to support the system to deliver personalised care.
- Work is underway in partnership with Digital Notts to develop a people-facing, digital 'About Me' form that has interoperability with all providers IT systems. Working with Digital Notts will ensure the capabilities and requirements are implemented. An interoperability request has been submitted and is going through the digital governance process.
- 4 options were approved for a range of system partners to embed personalised care approaches with people experiencing health inequalities and are obese/severely obese. They include a project in the City with children and young people; secondary care to support people waiting for elective care; three Primary Care Networks in the City; and Mid Notts Place-Based-Partnership.

Content Author: Natasha Wrzesinski | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

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

- Green Social Prescribing Service: NHSE have confirmed there will be no extension of national financial investment into this area - despite initial plans for this - with current funding ending in April 2023. An options paper for future delivery is being developed.
- Referrals to Social Prescribing are below expected the target, due to waiting lists in several PCN's. Mitigations are in place.
- Work is in progress with the SAIU, NHS England and National Data Standards to establish a system-wide approach to capturing referrals into social prescribing, so that the system can be assured on actual performance.
- Work is underway with Nottinghamshire County Council regarding the challenges of the Maximising Independence Service waiting list and lack of access to Link Workers; this includes exploring data system alignment to support flow.
- PCN's now have 60 WTE Care Coordinators and 26 Health & Wellbeing Coaches, funded through the Personalised Care Additional Reimbursement Roles scheme

Co-Production

System Quality Group Assurance – Full Assurance

The ICB Coproduction Strategy was endorsed by the ICB Board in January, setting out the strategic direction to embed coproduction throughout the organisation and the key next steps to achieve this; this includes the development of the Strategic Coproduction Representative Group, development of the system Coproduction Network, and the creation of a coproduction toolkit/training for people with lived experience and staff.

The first meeting of the new Strategic Coproduction Representative Group successfully took place on 19 January 2023. This group will be responsible for oversight and assurance of all co-production activity across the ICB. The group are meeting in person in February 2023. The group is at the start of their journey and together will coproduce all aspects of strategic coproduction – this includes coproducing the group itself and how it will run, as well as aligning the group to ICB governance, the Coproduction Network (once established) and wider system.

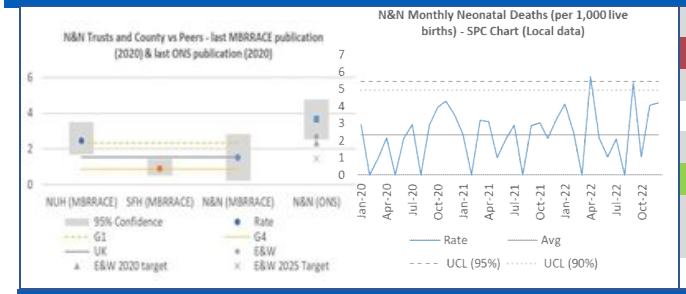
Collaboration with the ICB Finance and Governance teams is taking place to agree the standard procedures for different methods of reimbursement for coproduction, in line with the agreed policy.

Recruitment to the newly formed Coproduction Team Band 4 role continues to be a challenge; options of support are being explored in light of the current pause to recruitment.

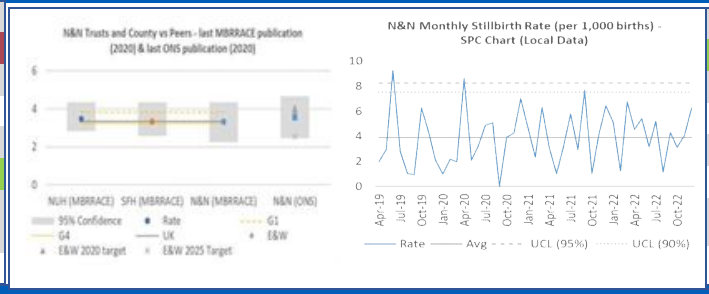
6.3 - Improving Quality of Services – Exception Report Maternity

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

Current Position and Summary of Activity

Single Delivery Plan: NHSE have confirmed that the Single Delivery Plan (combining all LMNS deliverables with Ockenden and East Kent recommendations) will be available at the end of March 2023. Work progresses in line with the local plans and priorities to drive work forward while we await the plan. There is a risk that there may be disconnect when the single delivery plan is published in March.

Maternity and neonatal services in East Kent: 'Reading the signals' report - System recommendations and next steps have been agreed with LMNS partners and the LMNS Executive Partnership. Key messages are being developed into a public facing format for wider sharing.

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.

Ockenden Oversight: The December Assurance Panel compliance report has been signed off by the LMNS Executive Partnership. The system is declaring full compliance for IEA1 Enhanced Safety, IEA2 Listening to women and IEA5, Risk Assessment Throughout Pregnancy, with all other domains at or above 93% compliance. Insight visits are being planned for NUH in June and SFH in October – focus will remain on Ockenden 1, as Trusts will not be in a position to report compliance against Ockenden 2 until direction is given by NHSE via the single delivery plan. Funding has been allocated by the national team to support implementation of Ockenden Immediate and Essential actions through team coaching for the LMNS programme team. It has been agreed that this will focus on IEA 2 – listening to women and families – and the PMO will work with the MVP to support MVP and Trusts to work together. The system have been asked to present at a national Ockenden learning event in March, with a focus on showcasing local governance arrangements and MVP development.

Coproduction: The Maternity Voices Partnership (MVP) development continues with the MVP Chair and its Lived Experience members as equal partners. An Independent Senior Advocate role has been recruited on a part time basis, two days per week. This is an NHSE funded pilot role for 6-months to support women, birthing people and families ensuring their voices are heard by their maternity and neonatal care providers. The post is currently back out to advert for the remaining three days per week. The PMO team will update at MVP Board and ask for service user input into the shaping and development of the role and to establish clear links between the role and MVP. The first coproduction working group for redesigning MVP locally was well attended and there was a huge appetite to support both the process and the need for a new model. The MVP are planning coffee mornings to support volunteers in their role. The recruitment of new volunteers continues.

System Quality Group Assurance – Limited Assurance

Enhanced Surveillance due to capacity concerns to transform services in line with requirements, given operational pressures and workforce challenges. The focus remains on implementing Ockenden recommendations, developing our Maternity Voices Partnership (MVP) & Neonatal Voices, and implementing Equity Strategy plans.

Content Author: Natasha Wrzesinski | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

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)

Perinatal Quality Surveillance: This quarter has seen a significant improvement in quality and number of investigation reports submitted for the LMNS panel review, which reflects the introduction and embedding of an additional executive-led internal review at NUH (with ICB attendance). A trajectory for completion for outstanding SIs is anticipated to be the end March 2023. Submissions to the Maternity Incentive Scheme have closed, with considerable variance in compliance; SFH are proposing full compliance, while NUH acknowledge gaps but will have a better understanding when declaration has been completed. NUH continue to work with the Regional Perinatal Team to update compliance with SVBLCBV2 every other month and this is showing a steady improvement, with training being the area requiring most focused support. SFH have 2 agreed divergences and self-assess as fully compliant.

Workforce: Work has started on translating the system workforce plan into action and agreeing the top three priorities over the next six months. This includes more robust workforce data feeding into the LMNS dashboard. A successful visit from NUH to South Africa, to support the international recruitment programme, saw strong candidates being seen. The Care4Notts career events are being held in March in Nottingham City and Mansfield, and a system approach to recruitment and internal secondments is being developed with Care4Notts. SFH and NUH are in receipt of Birthrate+ reports; the trusts are updating these and will share them once finalised. Progress is being made in both Trusts within the Maternity Support Worker (MSW) workforce, including alignment to the HEE framework.

Equity Strategy: The ICB have planned an engagement session on maternity & wellbeing for Kemet FM to take place on 01 March 2023. An approach for the show has been agreed and NUH have agreed to have a representative on the talk show panel. Cultural Competency training is being piloted within the ICB ahead of further roll out, with the ICB Chief Nurse and Head of Equality, Diversity and Inclusion in attendance. Work is progressing to align the NUH inclusion agenda with the system equity strategy for maternity.

Perinatal Mental Health: The pilot Trauma and Bereavement Speciality Midwife role will end later this month. The PMO are working with ICB colleagues and the Perinatal Community Mental Health teams to consider how to assess the impact and secure ongoing funding to keep this role going.

Continuity of Carer (CoC): Written feedback on the local system CoC plan has been received from the regional team. Focus will be on translating the feedback into actions across the system.

Personalisation: The NUH Homebirth Whoseshoes event was held on 27 January 2023, with 60 stakeholders - including service-users - in attendance. This was a positive event and will inform NUH home birth services. The SFH Birthing Outside of Guidance Service is seeing a steady increase in referrals; birthing people decisions are upheld following risk discussion.

Better Postnatal Care: The NUH Postnatal Working Group has been established and SFH colleagues have been invited to join. The Group is focussing on processes around discharging women after having a baby. The PMO have obtained service user feedback on a discharge video idea, to support NUH in their development of a new discharge video to be watched before families go home from hospital.

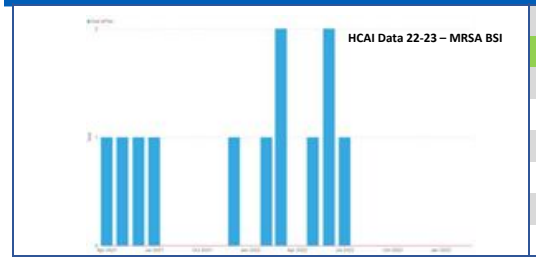
Population Health: The SFH in-house tobacco dependency service continues successfully with month-on-month improvements in smoking cessation rates. The NUH in-house tobacco-dependency service has not yet been established, with contracting issues halting the TUPE of CityCare advisors. A business case has been developed for targeted winter vaccine messaging, for communities who have lower-than-average vaccine uptake.

Family Hub: The LMNS PMO are engaged in Family Hub formation discussions in the City. All partners are keen to align priorities.

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

NHS Nottingham and Nottinghamshire

Infection Prevention and Control



Dec-22
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Plan
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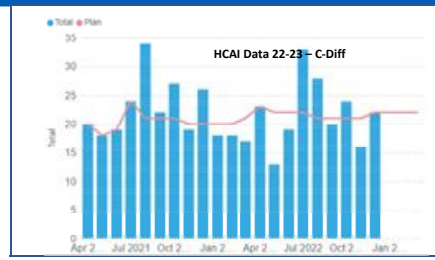
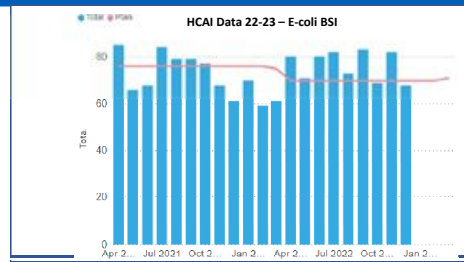
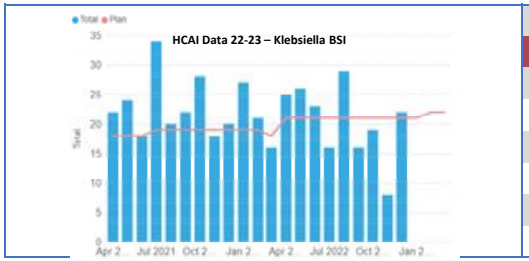
Assurance
Variation



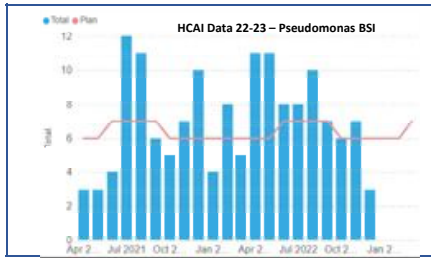
Dec-22
22
Plan
22
Assurance
Variation



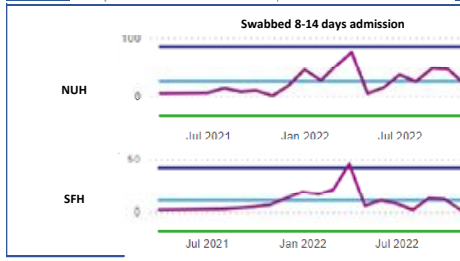
Dec-22
68
Plan
70
Assurance
Variation



Dec-22
22
Plan
21
Assurance
Variation



Dec-22
3
Plan
6
Assurance
Variation



Dec-22
NUH: 27 / SFH: 10
Mean
NUH: 26 / SFH: 11
Assurance
Variation

Current Position

January 2023

- COVID-19 and Flu A related admissions are reducing following the peak in late December. There has been a decrease in Strep A related admissions.
- COVID-19 and Flu A outbreaks are starting to subside across services including care homes.
- No IPC derogations have been requested during January
- IPC measures to reduce HCAI in secondary care continue to be impacted by winter pressures including high bed occupancy. Implementing measures such as 'one over' on wards reduces the opportunity for thorough cleaning between patients. Concerns remain regarding environmental cleanliness, due to an inability to deep clean wards and use HPV.
- HCAI targets remain challenging against a backdrop of high bed occupancy and an inability to deep clean ward areas. This remains a regional and local concern.
- There are no new themes from COVID-19 Outbreaks/SI cases.
- Updated BAF are in place across all providers
- Work to progress HCAI reduction plans has been impacted by winter pressures both locally and regionally

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

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

NHS Nottingham and Nottinghamshire

Infection Prevention and Control (continued)

Current Position and Summary of Activity (Continued)

January 23 HCAI data (Bassetlaw data and targets remain separate to ICB)

- MRSA BSI: 1 case reported through NUHT breach to month plan ICB 1/0. Post infection review investigation underway as a possible contaminant/community case. ICB, NUHT, SFHT and Bassetlaw have all breached year end plan of zero cases. ICB 5/0 Bassetlaw 4/0
- CDI: SFHT met month plan. NUHT breached month plan 14/9 and year end-target 126/105, Bassetlaw breached month plan 2/1 and year-end target 24/19. ICB breached month plan 29/22 and remain over plan 227/217. Individual case reviews are in place to identify lapses in care. Nationally and regionally cases are increasing. Increased bed occupancy and reduced deep cleaning programmes are considered to be contributory factors as are high acuity patients.
- E.coli BSI NUHT and Bassetlaw met month plan. SFHT and ICB breached month plan 12/8, 75/70. ICB remains over plan 763/700. System-wide and regional NHSEI meetings are planned but many are being cancelled due to sustained winter pressures HCAI cases are reviewed to identify learning. Few new themes are being identified.
- Klebsiella BSI: Bassetlaw breached month plan 1/0. ICB, NUHT and SFHT met month plan. Bassetlaw breached year–end target 24/15.System-wide and regional NHSEI meetings are planned to determine reduction actions, but many are cancelled due to winter pressures.
- Pseudomonas BSI: Bassetlaw breached month plan 1/0 and year–end target 9/7. ICB, SFHT and NUHT met month plan. System-wide and regional NHSEI meetings are planned to review system actions but are often cancelled due to winter pressures.

Healthcare System Infection Prevention and Control Assurance Group (HSIPCAG)

Actions

- Limited progress to report since last month's update; this has been escalated at regional level
- IPC teams continue to update BAF/plans in line with new IPC guidance and the NHSE principles. NHS guidance and DHSC guidance regarding COVID-19/PPE is not aligned, increasing the challenge to maintain compliance in relation to mask use in care homes.
- IPC collectively support with the derogation process and support needed to increase hospital discharges.
- IPC recruitment across the system remains a challenge and progress to implement the IPC development posts has been limited.
- HCAI reduction work continues to be impacted by winter pressures and industrial action. Planned local and regional meetings have been cancelled (CDI, urinary source gram negative BSI, regional updates).
- Meetings with Public Health teams to secure funding for community IPC services beyond September 2023 are in place
- Detailed information is still awaited from NHSE in relation to the IPC expectations, following devolvement of dentistry/POD's to the ICB from April 2023.

System IPC Concerns:

- Lack of IPC resource to undertake work with PODs post March 23
- Instability regarding community IPC funding from Local Authorities
- Lack of progress against IPC actions due to winter pressures. Continued high bed occupancy is impacting the ability to 'general' and 'deep' clean between patients 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.
- National COVID-19 PPE guidance does not support IPC teams to reduce risks of transmission in care homes, after universal mask use was withdrawn in December 2022.
- Concerns regarding IPC resilience, recruitment and retention of staff
- Old NHS estate and ventilation requirements

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

NHS Nottingham and Nottinghamshire

Vaccinations

System Quality Group Assurance – Partial Assurance

Overview: Programme delivery of Covid vaccine & flu oversight - as at **29 January 2023**

COVID

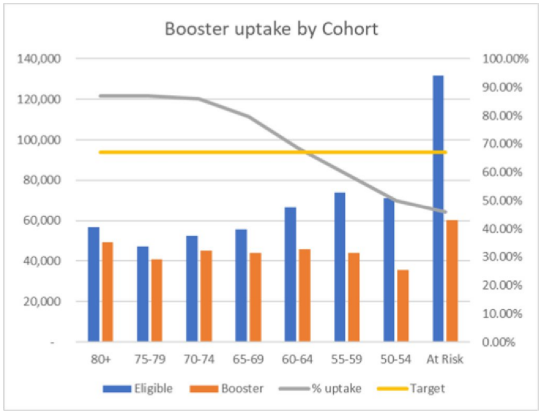
- Autumn Plan (Phase 5) began on 5th September 2022
  - Eligible Population – 545,000
  - Booster Vaccination – 351,000 **(64%)**
  - Target 67% uptake based on financial planning assumptions

Delivery Model and Actions:

- 2 Vaccination Centres are now closed to appointments/walk-ins and continue to support satellite, pop-up and mobile (van) activity
- 9 Place-Based Community Satellite clinics are operating
- Rapid Response Pop Up clinics are being offered for hard-to-reach communities
- Close working continues with Public Health to address inequalities and maximise equity in the vaccine offer
- The workforce is being 'right-sized' to meet the reduction in uptake and impending slow-down in programme activity
- 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
- 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 a low uptake of autumn boosters, being mitigated by an agile workforce model to reduce financial risk
- JCVI recommendations published for the Spring Booster and Autumn booster in 2023-24



FLU

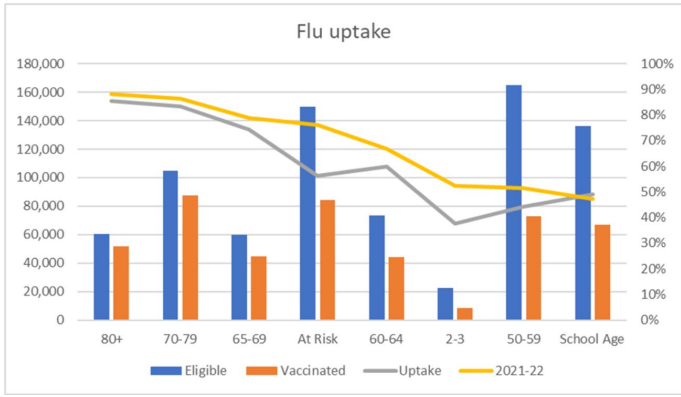
- Eligible Population – 766,000
- Booster Vaccination – 424,000 **(55%)**
- Target to achieve same or increase uptake as per the 2021-22 programme

Actions being taken

- School Aged Immunisation Service (SAIS) started visiting secondary schools on 12th December
- 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
- There is a significantly low uptake for 'at risk' citizens and 2-3 year olds.



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

NHS Nottingham and Nottinghamshire

Patient Safety

ICS Patient Safety Network (PSN): The January 23 meeting received a presentation from a colleague at SFH around a QI initiative to support smoking cessation in pregnancy, with reflections on the QSIR training and application in practice. There are links now establishing between the PSN and the new system QI collaborative; the February meeting will focus on proposals for a system-wide tissue viability community of practice, facilitated by the ICB.

Progress continues against the PSIRF workplan, with acknowledged challenges at national level relating to the launch of the patient safety events platform. The workplan is currently in phase two - 'Diagnostic & Discovery' – until April 2023.

DIAGNOSTIC & DISCOVERY PHASE – December 22 to April 23

#	Activity	Progress	NOTES
2.1	What is being done to support open & transparent reporting?		Active system engagement with development of LFPSE taxonomy in order to reduce barriers to reporting. Good reporting cultures embedded.
2.2	How do you engage and involve those affected by patient safety incidents?		All partners broadly compliant with Duty of Candour requirements. Some recruitment underway at system and provider level for family liaison leads. PNA/PMA programmes in place for staff support.
2.3	What is being done to support the development of a just culture?		Applied learning from patient safety specialists when supporting development of KLOEs and learning outcomes – focus on system approach rather than RCA.
2.4	What is your incident response capacity and what are your training needs?		Training needs are a key focus in line with move towards professionalising patient safety investigators. Some challenges at organisational level – practical and cultural issues.
2.5	How do you use learning from incidents to inform improvement?		Strong focus at this meeting on the inclusion of quality improvement activity as a key function of this group and moving forward. ICS Design Collaborative will be launched in January 2023.
2.6	What do you need to do next?		Retain a focus on future phases of the workplan, particularly to apply a more accelerated approach to roll out. Acknowledge executive support and approval will be required to progress this.

ICS Safeguarding & Public Protection Assurance Group

The role of the ICS Safeguarding & Public Protection Assurance Group is to identify and highlight intelligence from all system partners, to inform the shared view of safeguarding & public protection risks to children and adults in Nottingham & Nottinghamshire. It provides us with the opportunity to coordinate actions to drive improvements and, where appropriate, to escalate to the ICS System Quality Group. Shared learning is developed, and good practice shared amongst all safeguarding teams. Current membership includes: Nottingham & Nottinghamshire ICB Designated Professionals (Chair & Secretariat), NUH, NHCFT, City Care Partnership, DBHT, SAB Board Managers, Children's Safeguarding Partnerships, Spire Health Care Park Hospital.

February 2022:

- We have already seen an impact within the full Safeguarding Team as a result of the vacancy pause; some of these roles were identified as critical during the response to the COVID pandemic and one is a statutory post.
- The Nottinghamshire County Council Ofsted and CQC SEND inspection has been completed and there will be some immediate actions to take forward. This is currently being planned looked at with our partners in the County Council.
- The reported position of both the statutory initial & review health assessments for Looked After Children are showing significant increase in the time to achieve these; this has been escalated as an exception report to the ICB Quality & People Committee for February 2023.

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 February 2022/23

February 2023		Assurance: Pass	Assurance: Hit & Miss	Assurance: Falling Below
Variation	Special Cause - Improvement	IAPT <6 weeks CYP Access (1+ Contact) Early Intervention Psychosis CYP Eating Disorders - Urgent	2 Hour Urgent Care Response RTT Non-Admitted (Pop) Adult MH - 72 Hour Follow Ups Primary Care Appointments	104 Week Waits (Prov) Cancer 1st <31 days % (Pop & Prov) IAPT Treatments (Access) SMI Physical Health Checks Adult SMI +2 Contacts Community Perinatal Access % Perinatal Access Volume CYP Eating Disorders - Routine NHS App Registrations Individual Placement Support
	Common Cause - Random	IAPT < 18 weeks Dementia Diagnosis Advice & Guidance (Pop)	Ambulance Conveyances Volumes & % A&E Attendances vs 19/20 (Pop & Prov) NEL Admissions vs 19/20 (Pop & Prov) Ambulance Response Cat 1 Hospital Handover Delays > 60 minutes 12 Hour Breaches Actual 12 Hour Breaches % NEL Total Referrals (Pop & Prov) Ordinary Electives (Pop & Prov) Daycases (Pop & Prov) Outpatient 1st (Prov) Outpatient Fups (Pop & Prov) Total Diagnostic Activity (Prov) OP Virtual (Prov) PIFU OP Fup 25% Reduction (Pop & Prov) RTT Admitted (Pop & Prov) RTT Non-Admitted (Prov) Op Plan Diagnostic Activity (Prov) Cancer FDS (Pop & Prov) Cancer 1st Treatments (Pop & Prov)	SDEC % of Total Admissions MSFT Length of Stay >21 days Pathway1 - Discharge Home (Prov) 78 Week Waits (Prov) Outpatient 1st (Pop) Total Diagnostic Activity (Pop) OP Virtual (Pop) Op Plan Diagnostic Activity (Pop) Diagnostic 6 Weeks % (Pop & Prov) Cancer 62 Day % (Prov) Cancer 62 Backlog (Prov) Inappropriate OAP Bed Days
	Special Cause - Concern	IAPT Recovery Rate	Ambulance Response Cat 2 IAPT <90 days 1st to 2nd Older Adult MH >90 day LOS	Total Waiting List (Prov) 52 Week Waits (Prov) 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 (Provider) - Page 30
- 52 Week Waits (Provider) - Page 30

Community:
- Community Waiting Lists Aged 0-17 - Page 41
- Community Waiting Lists Aged 18+ - Page 41

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.

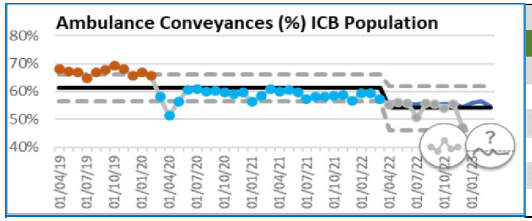
7.2 Service Delivery
Urgent Care Performance

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

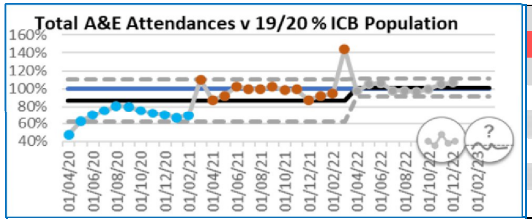
7.2a- Streamline Urgent Care – Exception Report : Access

NHS Nottingham and Nottinghamshire

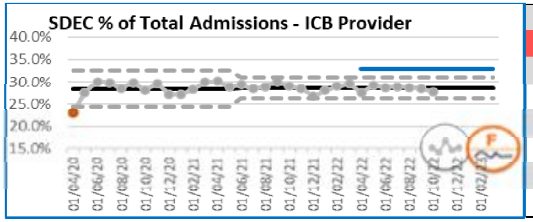
Urgent Care - Access



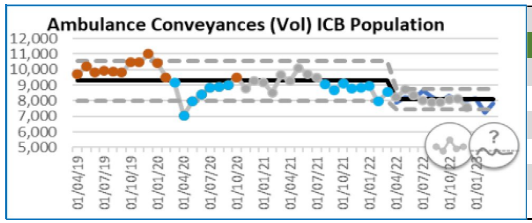
Dec-22
47.1%
2022-23 Plan
54.4%
Assurance
Flip
SPC Variation
Common Cause



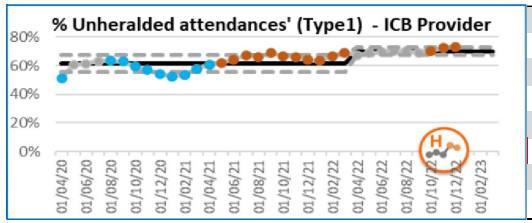
Dec-22
107.1%
2022-23 Plan
100%
Assurance
Flip
SPC Variation
Common Cause



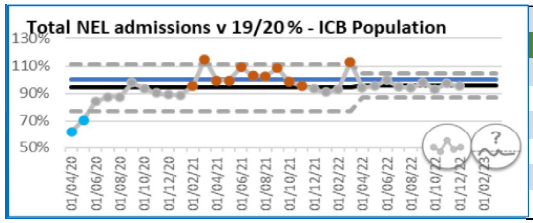
Nov-22
28.5%
2022-23 Plan
33.0%
Assurance
Fail
SPC Variation
Common Cause



Dec-22
7609
2022-23 Plan
8035
Assurance
Flip
SPC Variation
Common Cause



Nov-22
72.24%
Target
-
Assurance
-
SPC Variation
Concerning - High



Dec-22
95.2%
2022-23 Plan
100%
Assurance
Flip
SPC Variation
Common Cause

Summary

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 below 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 increased marginally for December, which keeps the SPC alert as concerning. 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 November shows that 28.5% of total admissions are SDEC. Performance has been consistently under the 33% target in the above chart.

The SFH Medical TF group that was due to take place in December was stood down due to the system-wide critical incident. This has been rescheduled and we are awaiting the outcome. Planned review of metrics to monitor for the SFH Medical SDEC project with the SAIU is to take place as well as finalise the SDEC Project Initiation Document and SDEC Milestones Plan.

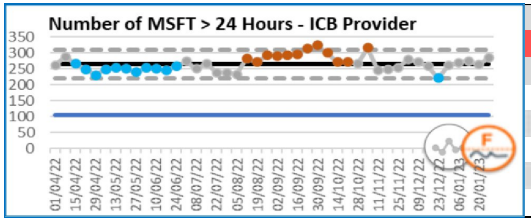
POG Assurance - Limited Assurance

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

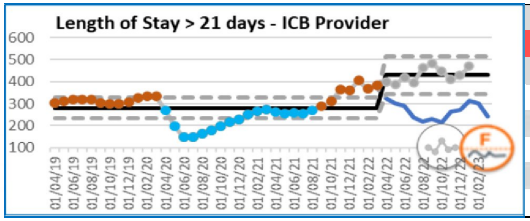
7.2b - Streamline Urgent Care – Exception Report: Discharges and Out of Hospital Provision

NHS Nottingham and Nottinghamshire

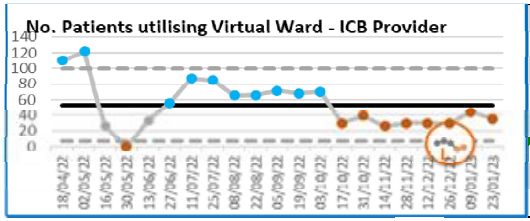
Urgent Care - Acute Discharges & out of hospital provision



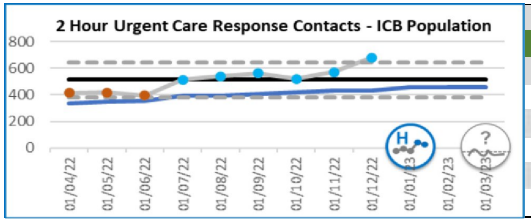
Jan-23
285
2022-23 Plan
104
Assurance
Fail
SPC Variation
Common Cause



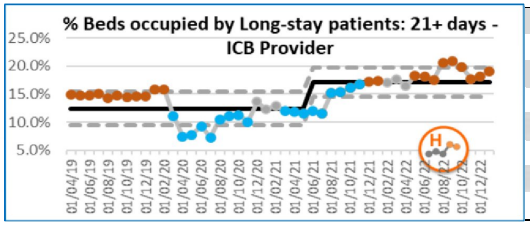
Jan-23
470
2022-23 Plan
314
Assurance
Fail
SPC Variation
Common Cause



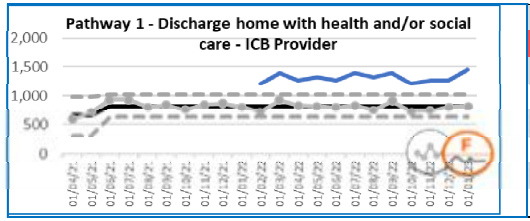
Jan-23
35
2022-23 Plan
-
Assurance
SPC Variation
Concerning - Low



Dec-22
681
2022-23 Plan
430
Assurance
Flip
SPC Variation
Improving - High



Jan-23
19.0%
2022-23 Plan
Assurance
SPC Variation
Concerning - High



Jan-23
824
2022-23 Plan
1460
Assurance
Fail
SPC Variation
Common Cause

Summary

Patients Medically Safe to transfer from acute episode of care continue to be significantly higher than the acute baselines, and also significantly higher than the modelling assumptions within the operational plans for 2022/23. The above chart shows a snapshot of the final day of each week. for the number of patients who have been medically safe for transfer for greater than 24 hours.

LOS >21 days has a Common Cause High Alert as although there are significantly more patients in acute hospitals with lengths of stay of over 21 days than planned and pre-covid levels, the number had lowered over recent months before increasing over winter. Within the system, 18% of all available acute beds are currently occupied by +21 day patients as at 8th February 2023. 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 and continuing to improve.

Actions

Long length of Stay There was a focus on LLOS in the February Discharge steering group which included system data, detailed plans from all trusts on next steps for LLOS actions and reviewed shared learning.
NUH: Phase one trial (weekly LLOS review of longest stay patients with panel of senior leaders from system) in medicine completed and to continue, it appears to show a reduction of LOS 21 days plus some evidence of a reduction in 14 to 20 days LOS band suggesting there is longer term benefit.
Phase 2 in Orthopaedics rolled was rolled out in February.
In addition a bespoke deep dive and insight group being set up in HCOP LLOS due to HCOP having the greatest number of LLOS patients.
SFH: LLOS process delayed due to pressure over January
Plan to start a LLOS twice weekly review from next week, with internal senior leaders reviewing top 20 patients with longest length of stay who no longer meet the criteria to reside (10 acute and 10 community beds).
BGH: Commencement of walk round Wednesday where a panel go to each ward and review all patients with a LOS over 14 days, Early indication is that this is having an impact on LOS, but need to review data over a longer period. Following Walk round Wednesday a system call is in place for last 4 week to review Top 10 patients on site to try to unblock/resolve issues. NHC: Weekly onsite MADE with system MDT ran throughout January, this involved every patient in a NHC bed regardless of LOS.

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.

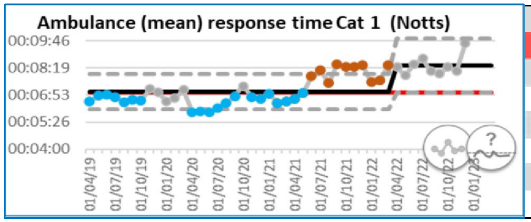
Data for week ending 29/01/23 shows that the volume of pathway 1 discharges was below the system trajectory (199 against a plan of 268). The volume of MSFT patients was higher than the planned number at 279 against a plan of 60. Providers are investigating accelerating existing discharge workstreams 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. Through system working, a reduction in admissions was seen along with an increase in discharge levels, which enabled the incident to be stood down on the 12th January. In the following weeks there have been several days of industrial action amongst both RCN and EMAS.

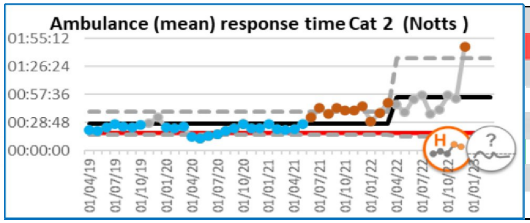
7.2c - Streamline Urgent Care – Exception Report : Compliance

NHS Nottingham and Nottinghamshire

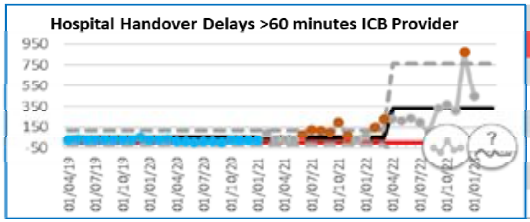
Urgent Care - Performance Compliance



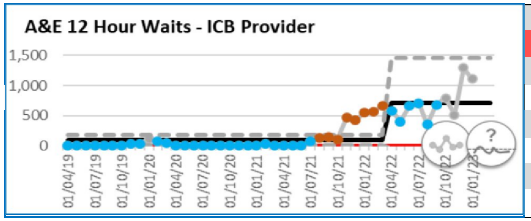
Dec-22
00:09:38
Target
0:07:00
Assurance
Flip
SPC Variation
Common Cause



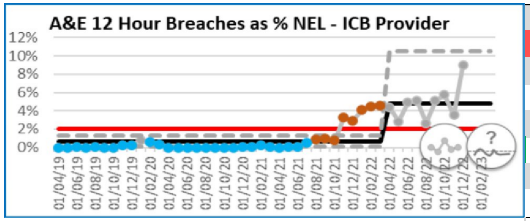
Dec-22
01:46:51
Target
0:18:00
Assurance
Flip
SPC Variation
Concerning - High



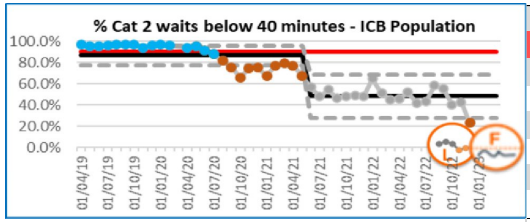
Jan-23
448
Target
0
Assurance
Flip
SPC Variation
Common Cause



Jan-23
1109
Target
0
Assurance
Flip
SPC Variation
Common Cause



Dec-22
9.0%
Target
2%
Assurance
Flip
SPC Variation
Common Cause



Dec-22
23.1%
Target
90.0%
Assurance
Fail
SPC Variation
Concerning - Low

Summary

Ambulance Handover Delays >60 minutes: There is a common cause alert for this metric due to high values. The volume of delays have reduced from the peak of December but remain higher than previous positions.

Ambulance Response Times: Category 1 and 2 response times showed signs of reduction in previous months but spiked for December 2022, with special cause High alert flagging for Category 2 responses . 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 23.1% performance against the 40 minute target for December, which is a deterioration of 19.7% compared to the previous month. The average response time for Cat 1 has increased from 8 to 9.5 minutes (17%) in December, with Cat 2 increasing from 53 to 146 minutes (175%).

12-Hour Breaches: Common cause alerts as volumes of patients waiting more than 12 hours from clinical decision to admit have reduced from December.

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 December indicated that neighbouring systems averaged an increase of between 62 minutes and 120 minutes for December (compared to Notts 57 mins) and all reported a higher average response time. December performance was impacted by two days of strike action for EMAS. January also included one day of strike action which will impact on the performance figures, once they are available. 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.

Ambulance Delays - Remains an area of concern and is not a position that is acceptable to the ICB. Work continues to focus on conveyance and the flow through to ED. A focus report on ambulance delays will be taken to a future Urgent and Emergency Care Board to discuss approaches to improving the position.

7.3 Service Delivery
Elective Care Performance

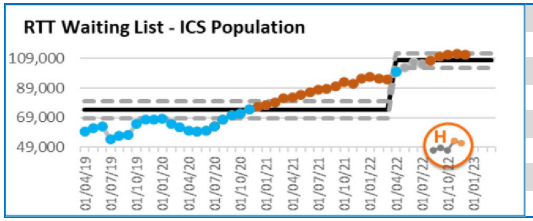
7.3a – Elective Waits Exception Report
7.3b – Elective Activity Exception Report
7.3c – Productivity and Transformation Exception Report
7.3d – Cancer Exception Report
7.3e – Diagnostics Exception Report

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

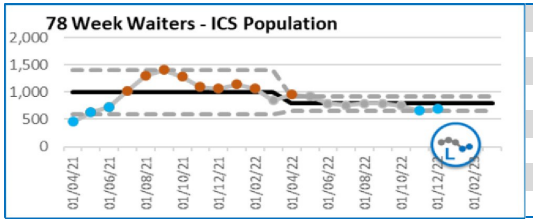
NHS Nottingham and

Planned Care

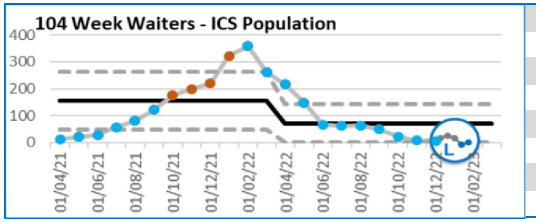
Elective Waits - Total Waiting List and Long Waits



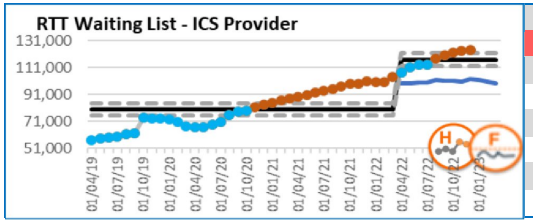
Dec-22
111712
2022-23 Plan
-
Assurance
-
SPC Variation
Concerning - High



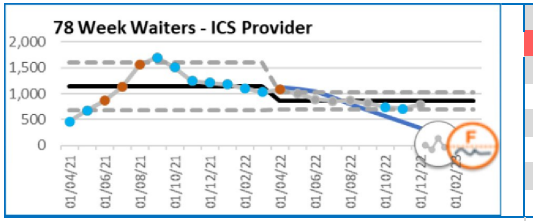
Dec-22
692
2022-23 Plan
-
Assurance
-
SPC Variation
Improving - Low



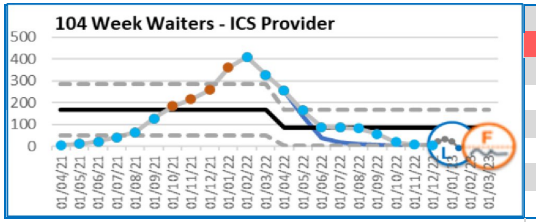
Dec-22
6
2022-23 Plan
-
Assurance
-
SPC Variation
Improving - Low



Dec-22
123751
2022-23 Plan
102197
Assurance
Fail
SPC Variation
Concerning - High



Dec-22
791
2022-23 Plan
328
Assurance
Fail
SPC Variation
Common Cause



Dec-22
6
2022-23 Plan
1
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 21,554 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 December 2022. The forecast for the system is zero 78 weeks by March 2023. However, there is a level of risk for 25 patients at SFH with ongoing mutual aid. The forecast at NUH represents a higher risk. Action is being taken to improve the position each week, supported bby additional NHS funding.

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 December, there were 6 patients waiting 104 weeks or more at NUH. Of the 6 patients at the end of December, 6 were due to complexity, 0 were due to capacity and 0 to patient choice. Weekly data highlights that the position deteriorated during January but is improving in February.

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.

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 increased from the latest published data (December). The latest provisional data for the end of January shows that there were 13 patients waiting 104 weeks or more for treatment at NUH and 0 patients waiting at SFH. The number of patients waiting over 104 weeks at NUH is forecast to reduce to 1 for the end of February, this patient has surgery scheduled in March. The SFH position is forecast to remain at 0.

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.

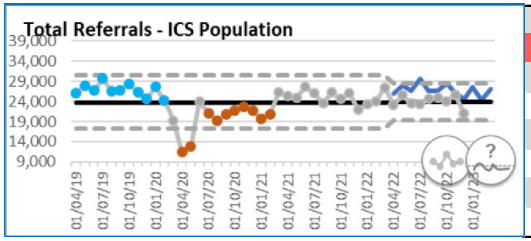
Provisional data shows that the system position for 78 week waiters is 707 patients against a plan of 109 as at week ending 05/02/23. The 78 week and over cohort is being fully validated and reviewed with analysis being undertaken across admitted and non-admitted pathways. NUH specialties have forecast (as at 3rd February) that there will be 179 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 29 breaches by March 2023.

Granular plans to deliver zero 65 week waiters by March 2024 were submitted to NHSEI on Friday 10th February. The forecast position is expected to improve further during the planning process. Monitoring against this plan will be included in future reports.

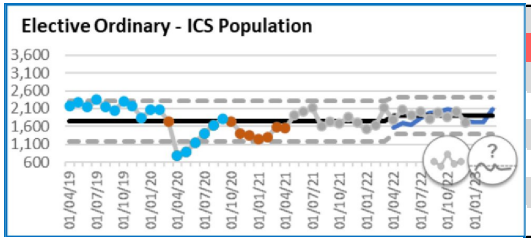
7.3b - Recover Services and Address Backlogs – Exception Report Elective Activity

NHS Nottingham and Nottinghamshire

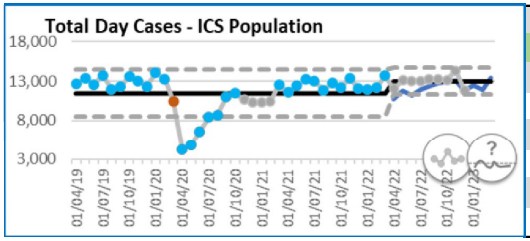
Elective Recovery - Activity



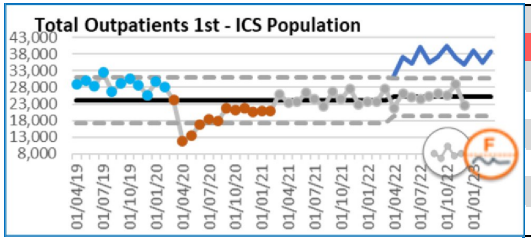
Dec-22
21016
2022/23 Plan
24661
Assurance
Flip
Variation
Common Cause



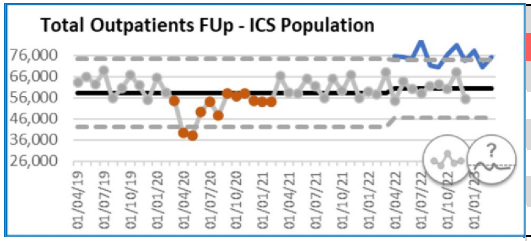
Dec-22
1714
2022/23 Plan
1746
Assurance
Flip
Variation
Common Cause



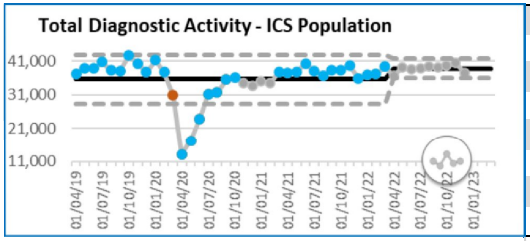
Dec-22
11895
2022/23 Plan
11781
Assurance
Flip
Variation
Common Cause



Dec-22
22635
2022/23 Plan
34942
Assurance
Fail
Variation
Common Cause



Dec-22
55330
2022/23 Plan
73499
Assurance
Flip
Variation
Common Cause



Dec-22
37581
2022/23 Plan
-
Assurance
-
Variation
Common Cause

Summary

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

All charts are showing common cause variation, which indicates a period of sustained activity around the mean (the black line).

However, consistent fail alerts are shown for outpatients 1st attendances 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 and 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

Referrals and outpatients remain below planned levels for December. 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.

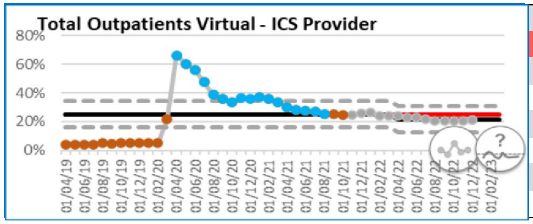
System needs to determine the most appropriate way to protect elective activity wherever possible.

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).

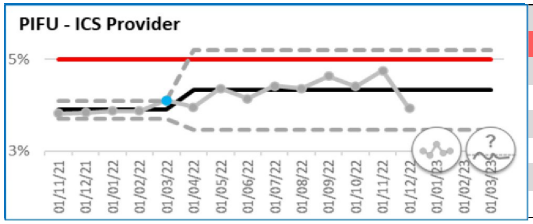
7.3c - Recover Services and Address Backlogs – Productivity & Transformation

NHS Nottingham and Nottinghamshire

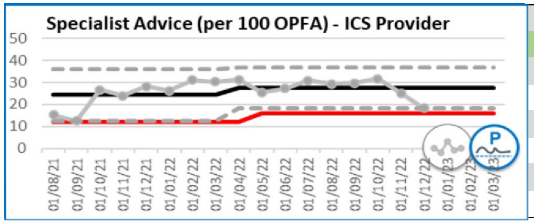
Elective Recovery - Productivity & Transformation



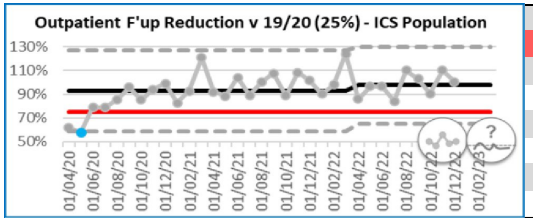
Dec-22
21.0%
Target
25.0%
Assurance
Flip
Variation
Common Cause



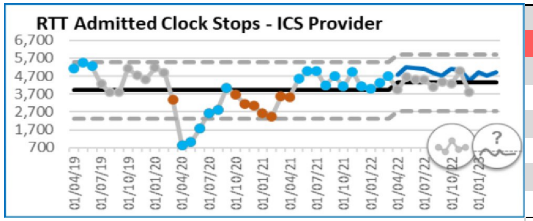
Dec-22
3.9%
March 2023 Target
5.0%
Assurance
Flip
Variation
Common Cause



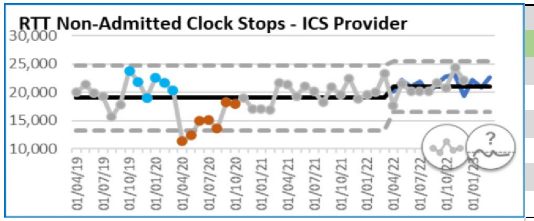
Dec-22
18
March 2023 Target
16
Assurance
Pass
Variation
Common Cause



Dec-22
102%
Target
75%
Assurance
Flip
Variation
Common Cause



Dec-22
3795
2022-23 Plan
4450
Assurance
Flip
Variation
Common Cause



Dec-22
22127
2022-23 Plan
19324
Assurance
Flip
Variation
Common Cause

Summary

Outpatient Virtual: Common cause variation, 'flip' target delivery as the target is near the mean. The latest position for the system is 21.0%, which is below the national standard of 25%. Since April 2022, the position for the system has reduced from 24% to the 21.0% reported in December.

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 2022/23. The utilisation rate in December 2022 was 18. 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.

Admitted and Non-Admitted Clock Stops: These charts show common cause variation, with activity being delivered on or above the mean. Non admitted clock stops exceded plan for December by 2,803. However admitted clock stops continue to be below 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.

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.

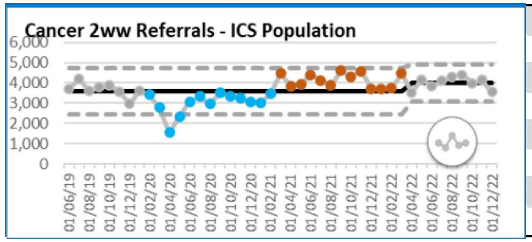
PIFU - The current system performance level in December 2022 is 3.9%. The November position for NUH is 3.4% and 5.3% for SFH.

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.

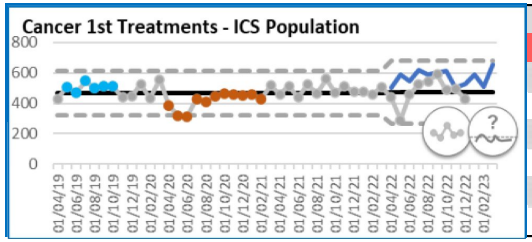
7.3d - Recover Services and Address Backlogs – Exception Report : Cancer

NHS Nottingham and Nottinghamshire

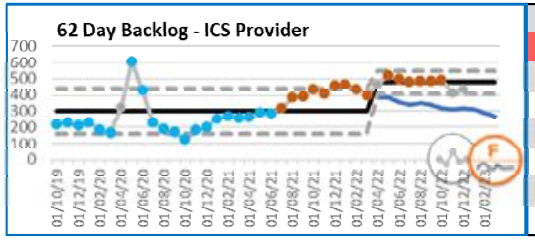
Cancer Recovery - Total Provider View



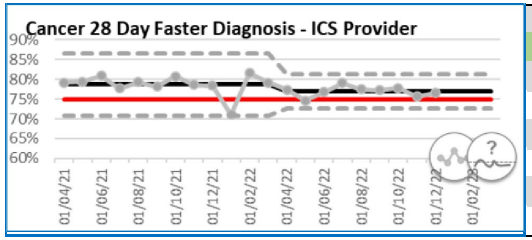
Dec-22
3958
2022/23 Plan
-
Assurance
-
Variation
Common Cause



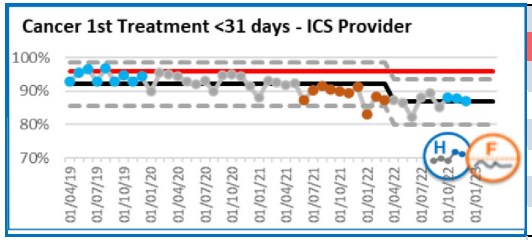
Dec-22
528
2022/23 Plan
657
Assurance
Flip
Variation
Common Cause



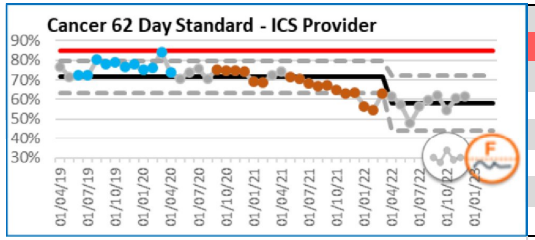
Dec-22
439
2022/23 Plan
314
Assurance
Fail
Variation
Common Cause



Dec-22
76.6%
Target
75.0%
Assurance
Flip
Variation
Common Cause



Dec-22
87%
Target
96%
Assurance
Fail
Variation
Improving - High



Dec-22
62%
Target
85%
Assurance
Fail
Variation
Common Cause

Summary

2ww Referrals: ***Common Cause variation as the referrals are around the mean,*** with growth 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 November and shows that the N&N system is one of only two 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 05/02/23 is 440 patients against a plan of 313 patients. NUH have 383 patients against a plan of 233 and SFH have 57 patients against a plan of 80.*** NUH and SFH benchmark well nationally for the proportion of the waiting list that are waiting 62 days or more (14.5% and 4.1% respectively at 05/02/23).

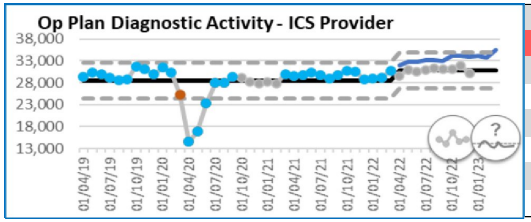
The 104 week waiter meetings that take place with NHSE have been expanded to cover cancer performance on a fortnightly basis. This enables a granular discussion to take place around plans to reduce the 62 day cancer backlog.

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. 62 day backlogs have increased due to strike action and the Christmas period.

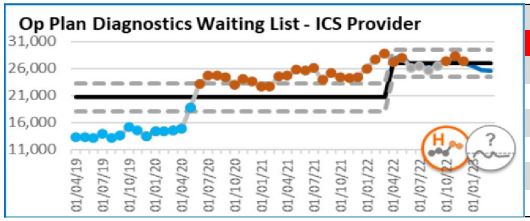
7.3e - Recover Services and Address Backlogs – Exception Report: Diagnostics

NHS Nottingham and Nottinghamshire

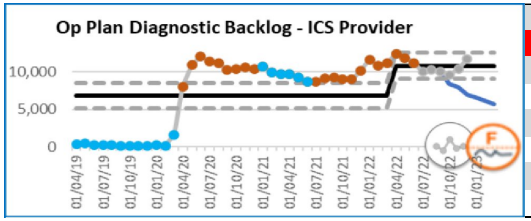
Diagnostics Recovery - Total Provider View



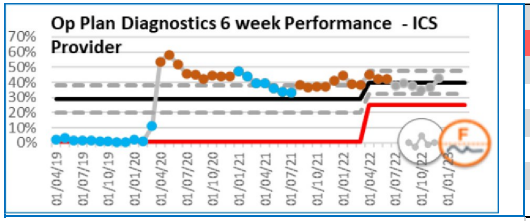
Dec-22
30199
2022-23 Plan
34004
Assurance
Flip
Variation
Common Cause



Dec-22
27315
2022-23 Plan
26950
Assurance
Flip
Variation
Concerning - High



Dec-22
11652
2022-23 Plan
6865
Assurance
Fail
Variation
Common Cause



Dec-22
42.7%
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	7,926	4,410	55.6%
Computed Tomography	4,352	1,088	25.0%
Non-obstetric ultrasound	6,078	897	14.8%
Echocardiography	6,289	3,926	62.4%
Colonoscopy	992	486	49.0%
Flexi sigmoidoscopy	456	280	61.4%
Gastroscopy	1,222	565	46.2%
Total - Plan Modalities	**27,315**	**11,652**	**42.7%**
Barium Enema	0	0	
DEXA Scan	1,406	519	36.9%
Audiology	884	356	40.3%
Cardiology - Electrophysiology	0	0	
Neurophysiology	272	5	1.8%
Sleep studies	1,510	906	60.0%
Urodynamics	174	49	28.2%
Cystoscopy	439	115	26.2%
Total - All Modalities	**32,000**	**13,602**	**42.5%**

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 and backlog: showing as common cause variation with activity levels around the mean, but the position does vary by modality and provider. However, activity remains below the planned level.

Diagnostics waiting list: showing concerning high variation due to a sustained period above the mean (the black line).

Diagnostic 6 week performance for plan modalities: December at 42.7% with the 6 week backlog increasing to 11,652 from 10,366 patients in November.

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 4,410 patients at the end of December 2022.

Echocardiography: The data for December shows that Echo is performing at 62.4% 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 - NUH have 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 this year. Additional revenue has recently been allocated to the system by NHSE, which will improve the system financial position as well as allow for an additional MRI machine at NUH.

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 increased between November and December however it is yet to trigger an SPC variation alert. A sustained increase in activity is required in order deliver the planned backlog and waiting list levels.

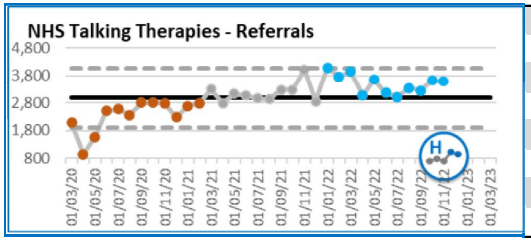
Overall the diagnostics position for the system remains challenging. Modality level performance for December is shown above and highlights that MRI and Echocardiography are key drivers of the current performance challenges. Forecasts for the waiting list volume, over 6 week and over 13 week waiters by modality were submitted to NHSE/I on 10/01/23. Equivalent forecasts are being developed for 2023/24, which will be submitted to NHSE/I as part of the planning process.

7.4 Service Delivery
Mental Health Performance

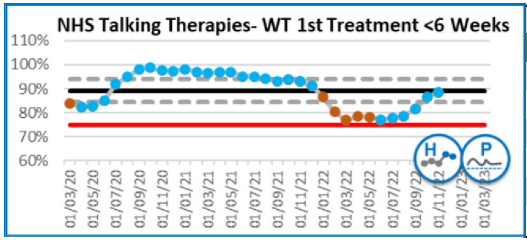
7.4a - Recover Services and Address Backlogs – Exception Report : Mental Health – NHS Talking Therapies (formerly IAPT)

NHS Nottingham and Nottinghamshire

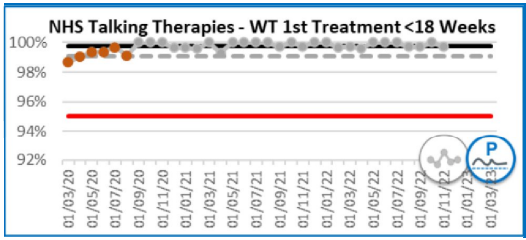
Mental Health - NHS Talking Therapies



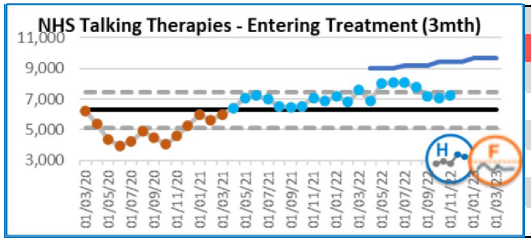
Nov-22
3590
2022-23 Plan
-
Assurance
-
SPC Variation
Improving - High



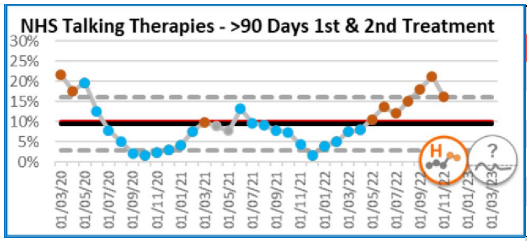
Nov-22
89%
Target
75%
Assurance
Pass
SPC Variation
Concerning - Low



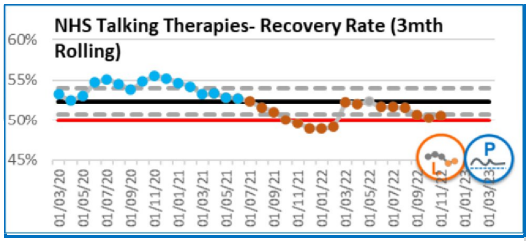
Nov-22
100%
Target
95%
Assurance
Pass
SPC Variation
Improving - High



Nov-22
7225
2022-23 Plan
9427
Assurance
Fail
SPC Variation
Improving - High



Nov-22
16%
Target
10%
Assurance
Flip
SPC Variation
Concerning - High



Nov-22
51%
Target
50%
Assurance
Pass
SPC Variation
Concerning - Low

Summary

- NHS Talking Therapies (formerly 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, 7225 against 9427 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 NHS Talking Therapies 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 NHS Talking Therapies Access - Entering Treatment is for the system to achieve by the end of March 2023.

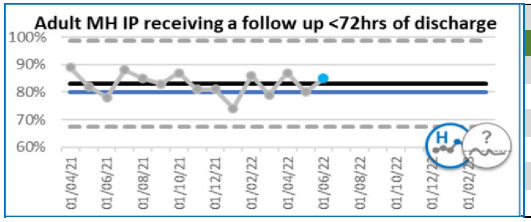
Local data is utilised to identify and address performance issues with providers and agree actions to improve capacity and service delivery, including workforce issues.

A new contract has been awarded for NHS Talking Therapies 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.

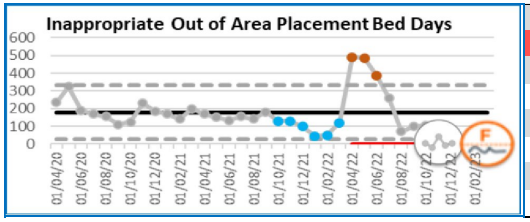
7.4b - Recover Services and Address Backlogs – Exception Report: Mental Health - Adult Services

NHS Nottingham and Nottinghamshire

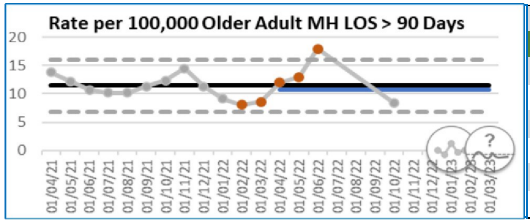
Mental Health - Adult Mental Health



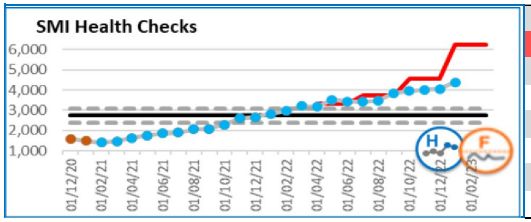
Oct-22
81%
Target
80%
Assurance
Flip
SPC Variation
Improving - High



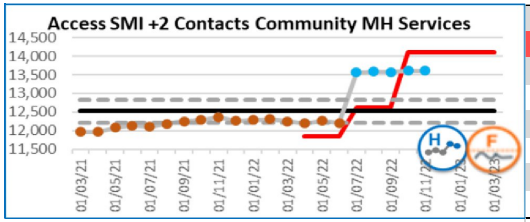
Nov-22
85
2022-23 Plan
0
Assurance
Fail
SPC Variation
Common Cause



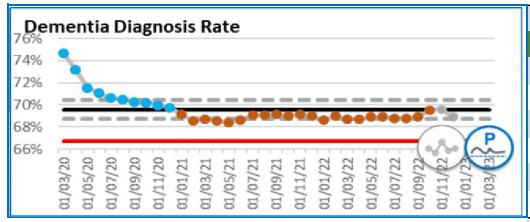
Oct-22
8
Target
11
Assurance
Flip
SPC Variation
Common Cause



Jan-23
4377
2022-23 Plan
6237
Assurance
Fail
SPC Variation
Improving - High



Nov-22
13605
2022-23 Plan
14101
Assurance
Fail
SPC Variation
Improving - High



Dec-22
68.9%
Target
66.7%
Assurance
Pass
SPC Variation
Common Cause

Summary

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 85 as at November 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 reduction has brought this back to common cause variation.
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.

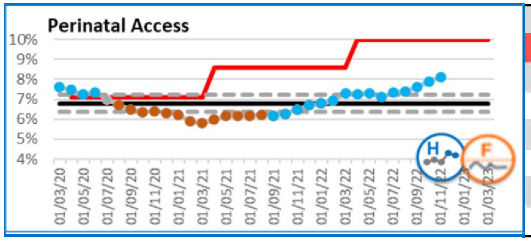
SMI Health Checks - Oversight of delivery of the standard has been integrated into the Community Mental Health Transformation Programme. This ensures coordination with all service developments, including the development and expansion of Local Mental Health Teams and introduction of Mental Health Practitioners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

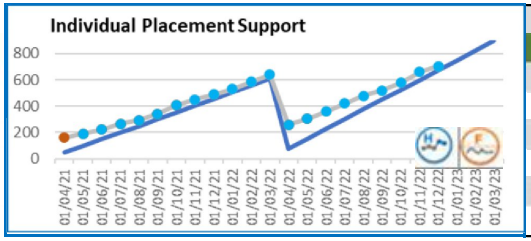
7.4c - Recover Services and Address Backlogs – Exception Report : Mental Health – Access

NHS Nottingham and Nottinghamshire

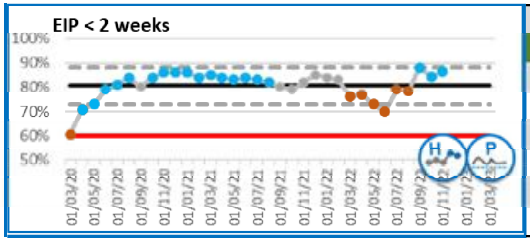
Mental Health - Access



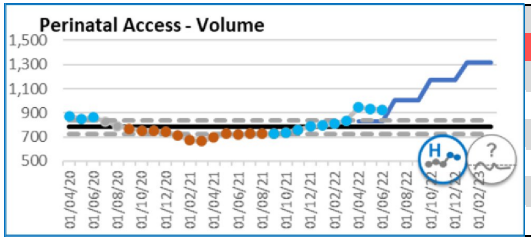
Nov-22
8.1%
Target
10.0%
Assurance
Fail
SPC Variation
Improving - High



Dec-22
706
Plan
675
Assurance
Fail
SPC Variation
Improving - High



Nov-22
86%
Target
60%
Assurance
Pass
SPC Variation
Improving - High



Nov-22
1045
2022-23 Plan
1175
Assurance
Fail
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 3	Performing Well
Supported employment and education	Level 4	Top Performer
Physical Health Checks	Level 3	Performing Well
Carer Focussed education	Level 3	Performing Well
Outcome measures	Level 3	Performing Well

Summary

Perinatal - Rolling 3-month performance in November shows an increase in performance to 8.2%. 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. Data for November shows an improvement in performance at 86.4%

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.***

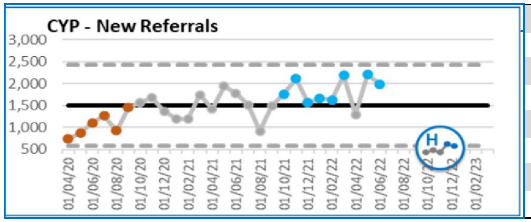
EIP Transformation meetings are in place to review progress against agreed actions, variations across teams and progression through compliance levels.

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.

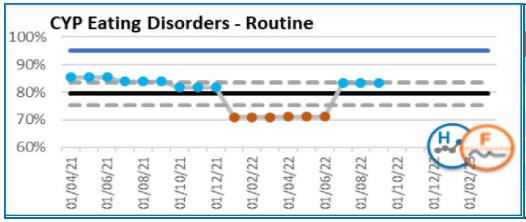
7.4d - Recover Services and Address Backlogs – Exception Report : Mental Health – Children & Young People

NHS Nottingham and Nottinghamshire

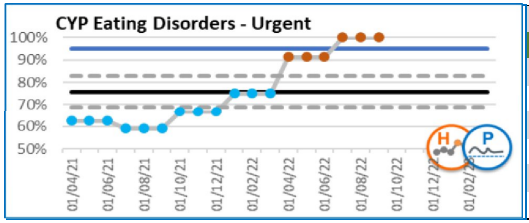
Mental Health - Children & Young People (CYP)



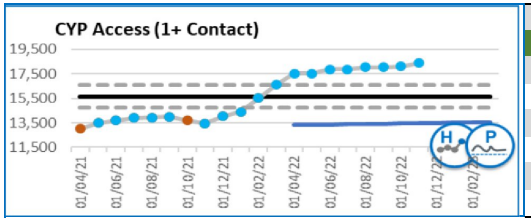
Jun-22
1985
2022-23 Plan
-
Assurance
-
SPC Variation
Improving - High



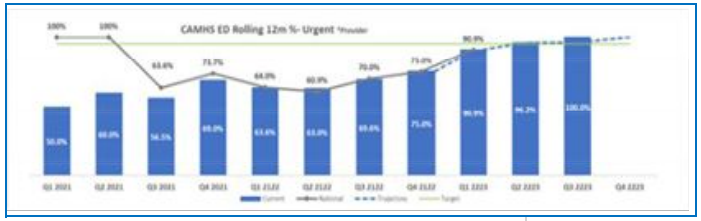
Sep-22
83%
Target
95%
Assurance
Fail
SPC Variation
Improving - High



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



Nov-22
18400
2022-23 Plan
13450
Assurance
Pass
SPC Variation
Improving - High



Summary

CYP Referrals - have been increasing and have triggered a special cause High alert.
CYP Access (1+ Contact) - The ICS is exceeding the access target of number of children and young people (CYP) receiving support (1-contact); 18,400 CYP were recorded as having at least 1 contact in the rolling 12 months ending November 2022, exceeding the annual plan of 13,450
CYP ED Routine (< 4 weeks) - Improving - High variation due to theimprovement 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.

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. CYP ED volumes are very small and will have large impacts on the position for any patient who does not meet the timeframes required. Each patient missing target is reviewed each month and it has been identified that each current breach relates to patients choosing to wait for an appointment post the required target date.

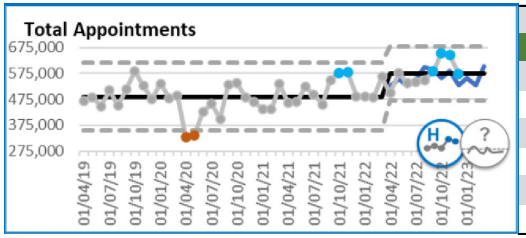
7.5 Service Delivery Primary & Community Performance

7.5a – Exception Reports Primary & Community

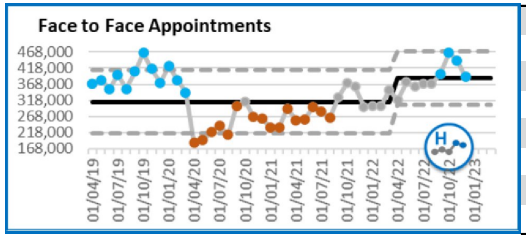
7.5a - Recover Services and Address Backlogs – Exception Report: Primary and Community Recovery

NHS Nottingham and Nottinghamshire

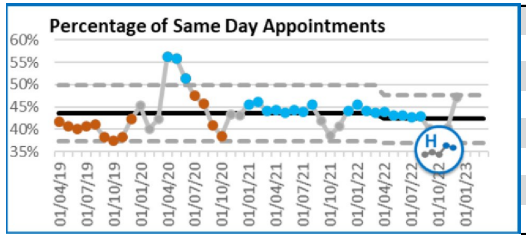
Primary Care and Community Recovery



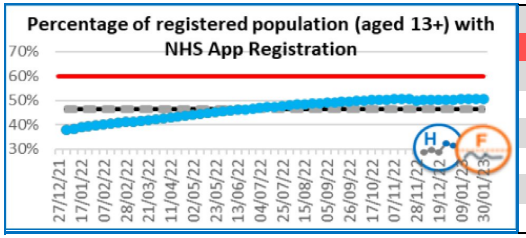
Dec-22
573880
Max Lmit / Target
528346
Assurance
Flip
SPC Variation
Improving - High



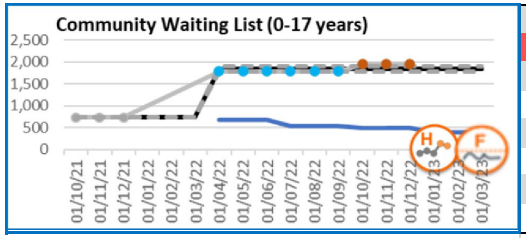
Dec-22
68%
Max Lmit / Target
-
Assurance
-
SPC Variation
Improving - High



Dec-22
47%
Max Lmit / Target
-
Assurance
-
SPC Variation
Improving - High



Jan-23
51%
Max Lmit / Target
60%
Assurance
Fail
60% by March 2023
Improving - High



Dec-22
1949
Max Lmit / Target
497
Assurance
Fail
SPC Variation
Concerning - High

Dec-22
8209
Max Lmit / Target
5337
Assurance
Fail
SPC Variation
Concerning - High

Summary

Total GP Appointments in December were 8.6% above plan. The percentage of appointments held face to face remains consistent with previous months at 68%. Appointments delivered on the same day has a special cause alert due to high values, which illustrates an improving position. There has been a stepped increase in home visits since March 2022 as the average number per month is 2842 in 2022/23 compared to an average of 2033 per month in 2021/22.

GP Appointments within two weeks data shows that 85% of appointments were offered within two weeks in December 2022.

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 3 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

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 of patients exceeds the planned levels at quarter 3 2022/23. The waiting list volume has increased between quarter 2 and quarter 3 by 510 patients across all ages, which equates to 9.2% for paediatrics and 4.4% for adults.

Operational planning for 2023/24 is underway at present. The initial iteration of the plan shows that the waiting list volume is forecast to reduce by 602 patients in aggregate for community services when compared to the current level. The forecast reductions are 118 patients for paediatrics and 484 for adults by March 2024.

NHS
Nottingham and Nottinghamshire

8.0 Finance

ICS Aim 3: Enhance productivity and VFM

- 8.1 – Month 10 2022/23 Financial Position – Key Metrics
- 8.2 – System Financial Performance – Key Messages
- 8.3 – Organisational Analysis
- 8.4 – System Response – Recovery Plan

NHS Nottingham and Nottinghamshire

8.1 - Finance Position Month 10 2022/23 – Key Metrics

		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**	**-19.7**	**-36.4**	**-16.8**	**-16.9**	**-16.9**	**0.0**		
Capital (within Envelope)	**Spend against plan**	58.0	46.9	**11.1**	89.6	85.3	**4.3**		
MHIS (meeting target)	**Spend against plan**	158.9	178.2	**19.3**	190.7	190.9	**0.3**		
Agency (spend within Cap)	**Spend against plan**	46.3	70.9	**-24.6**	54.6	85.3	**-30.7**		

		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**	16.6	26.7	**-10.1**	17.8	30.2	**-12.4**		
NHS Efficiencies	**Delivery against plan**	75.4	72.9	**-2.5**	102.7	102.7	**0.0**		
ERF Income	**Delivery against plan**	45.6	45.6	**0.0**	53.7	53.7	**0.0**		

- **£36.4m** deficit experienced to end of month 10, which is **£16.8m** adverse to plan.
- The adverse variance is mainly experienced in the 2 acute Trusts (NUH & SFH) representing **£25.8m** of the **£10.5m** year to date deficit with a small **£0.2m** over-spend at the mental health & community Trust (NHT).
- Key drivers of the adverse variance are covid (**£10.1m**), continuing care spend (**£8m**) and efficiency shortfall (**£2.5m**). There are also pressures relating to excess costs arising from urgent care capacity requirements greater than plan. Offsetting favourable variance include all primary care expenditure (£5.4m) and clinical supplies (£2.3m).
- Agency spend remains over plan and above the agency cap, with an adverse YTD variance of **£24.6m**. 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 relating to the continuation of over-spending areas.

8.2 - Finance Position Month 10 2022/23 – System Financial Performance – Key Messages

NHS Nottingham and Nottinghamshire

- The Nottingham & Nottinghamshire ICS has reported a £36.4m deficit at month 10, which is £16.8m adverse to plan. Month 10 has seen a £1.5m in-month surplus, which is £0.8m favourable to plan.
- The in-month run rate expenditure has been similar to previous months and is mitigated by a number of non-recurrent measures e.g., reduced Annual Leave accrual.
- The difficult operating environment currently seen across the system continues to impact on expenditure, particularly in the acute sector with continuing agency costs due to higher than planned levels of sickness and urgent and emergency care capacity requirements.
- Monthly covid costs continue to reduce but as the original plan was to operate under a low covid environment, even small amounts of covid related backfill lead to an overspend.
- The main drivers of the £36.4m year to date adverse variance remain as in M10 covid related sickness, excess costs arising from urgent care capacity, hospital discharge and interim bed capacity, and continuing health care. Adverse variances are also seen in primary care prescribing due to increasing No Cheaper Stock Obtainable (NCSO) costs, efficiency shortfall, mental health out of area beds and inter-system contracts agreements. These are partially offset by favourable variances in clinical supplies and primary care.
- In January NUH received a fine of £0.8m in January after the CQC brought charges due to a failure in care in the maternity department. This is a one-off cost recognised in full in month 10.
- Although meeting the plan deficit of £17m is a significant stretch, NHSE have informed the ICS that if we are able to deliver a target of a £20m deficit, this would result in additional revenue of £6m (used to further reduce the deficit) and additional system capital in 2023/24 of £4.6m.
- System partners are working to meet this goal. Although focus remains on recurrent transformational change the improvement needed in the position at this stage of the year will primarily come from non-recurrent benefits. 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.
- As the final outturn position will be a deficit the system is required to enact the NHSE protocol for changes to in-year revenue financial forecast. The ICS has already enacted the majority of the components of the protocol through the year and continues to liaise with NHSE over any further actions required.

8.3 - Finance Position Month 10 2022/23 – Organisational Analysis

NUH

- Year to date position of £25.8m deficit, which is £11.6m adverse to plan. This is driven by covid expenditure £8.7m above plan, £1.6m excess costs arising from urgent care capacity requirements, maternity services fine £0.8m and efficiencies £0.6m adverse to plan.
- In month 10 alone NUH finances are £1.3m worse than plan.

SFH

- The YTD position is driven by efficiency shortfall of £1.3m, covid spend above planned levels of £2.3m, excess costs arising from urgent care capacity requirements £3.7m, offset by £1.6m Non-recurrent benefit.
- In month deterioration of £2.1m driven by covid related costs (sickness absence) and urgent care capacity costs.

NHT

- Year to date position of £0.2m deficit, which is £0.4m favourable to plan.
- The main area of risk remains out of area bed spend, which is £3.3m adverse to plan. This is offset by substantive staff being below plan due to recruitment difficulties.

M10 Financial Position						
Orgn £'ms	YTD plan	Actuals	Variance	Plan	FOT	Variance
NUH	-14.2	-25.8	-11.6	-12.3	-12.3	0.0
SFH	-4.9	-10.5	-5.6	-4.7	-4.7	0.0
NHT	-0.6	-0.2	0.4	0.0	0.0	0.0
N&N ICB	0.0	0.0	0.0	0.0	0.0	0.0
Total System	**-19.7**	**-36.4**	**-16.8**	**-16.9**	**-16.9**	**0.0**

ICB

- Breakeven position including the impact of CCG spend (N&N and Bassetlaw) to month 10.
- Adverse variances seen in continuing healthcare £8m, and hospital discharge costs (interim beds supporting urgent care) £4.6m.
- There is also a growing pressure relating to primary care prescribing, due to pricing pressures of no cheaper stock obtainable (NCSO) items.
- Partly offset by total primary care costs below planned levels £5.4m and other non-recurrent benefits.

8.4 - Finance Position Month 10 2022/23 – System Response – Recovery Plan

- 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. The ICS Finance Director's Group has developed a working model that is expected to deliver the financial plan 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 is extremely challenging and to aid delivery the system will need to focus on transformation and efficiency so that change is embedded before the start of the financial year.
- To support this the Clinical & Care Professional Leaders Group (CCPL) have agreed an approach to clinical prioritisation . 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 will 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)
- This framework, alongside a focus on productivity improvement and organisational cost improvement will form the 2023/24 efficiency plans (and future years) with benefit expected from April 2023.

NHS
Nottingham and Nottinghamshire

9.0 System Workforce

ICS Aims: All 4 (Outcomes, inequalities, productivity and social and economic development)

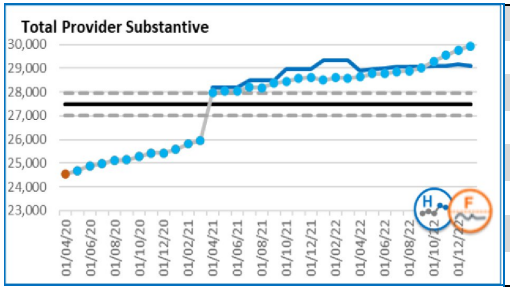
- 9.1 – Exception Report Provider Workforce
- 9.2– Exception Report Provider Vacancies, Turnover & Sickness
- 9.3 – Exception Report Primary Care Workforce
- 9.4 – Exception Report Agency Cost
- 9.5 – Exception Report Agency Usage
- 9.6 – Social Care Workforce
- 9.7 – Social Care Employment Overview
- 9.8 – Social Care Projections
- 9.9 – Care Homes Workforce

9.1 - Workforce – Exception Report Provider Workforce

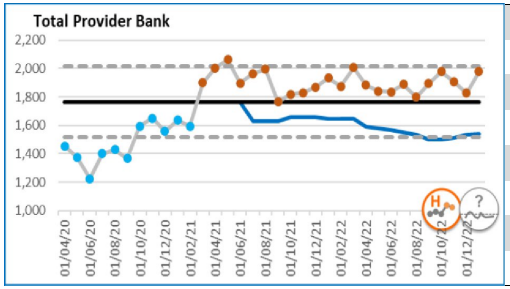
NHS Nottingham and Nottinghamshire

Workforce

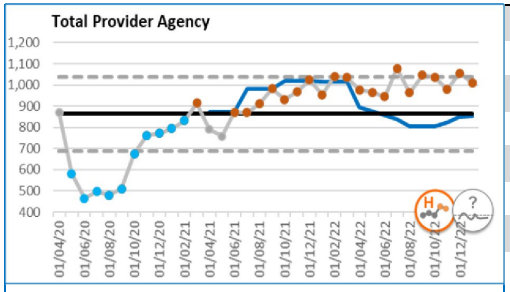
Total ICB Provider Workforce - Operational Plan v Actual 2022/23



Jan-23
29936
2022-23 Plan
29115
Assurance
Fail
SPC Variation
Improving - High

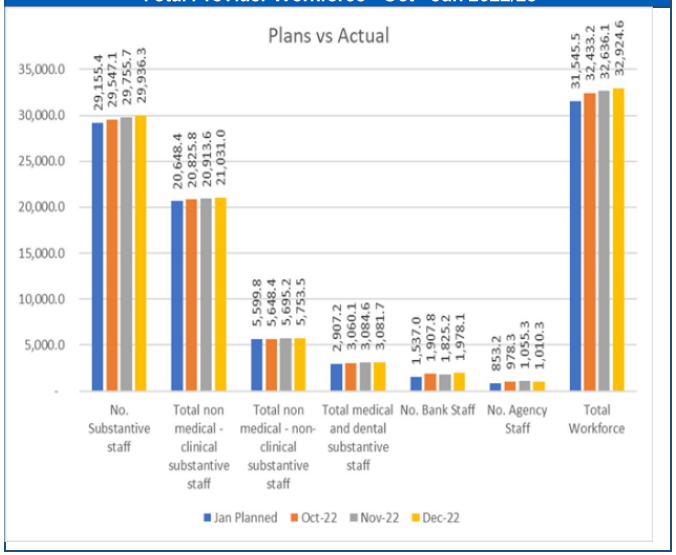


Jan-23
1978
Target
1537
Assurance
Fail
SPC Variation
Concerning - High



Jan-23
1010
2022-23 Plan
853
Assurance
Fail
SPC Variation
Concerning - High

Total Provider Workforce - Oct - Jan 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.

A review of baseline workforce assumption informing the 23-24 operational plan are in train with Trust workforce planning leads to assure that the workforce reflects financial assumptions linked to productivity and efficiencies.

Total Provider Current position:

Growth in substantive workforce seen above plan for two trusts as a result of in-year increase in capacity. NHT remain below plan with signifcant reliance on bank and agency to support. Agency and Bank usage remains variable, with related increase in bank usage.
NHT vacancies in HCSW and resulting use of agency to mitigate remains the key concern. High use of agency also reflects the shortage of the skilled workforce needed to deliver the Mental Health Investment Plan which mapped workforce to service and activity changes expected.
Increase in staffing above substantive plan have been as a result of in-year funding to increase capacity.

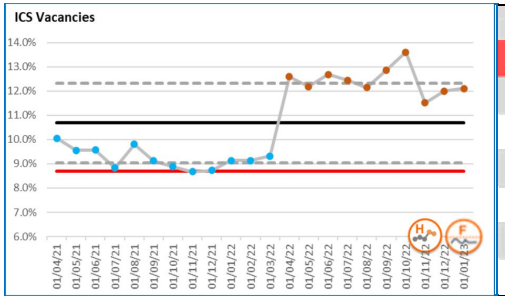
P&C Group Assurance -Enhanced Assurance Level

Total Providers:
Plans are in place but needs improved monitoring to evidence impact of each intervention and whether additional interventions are needed

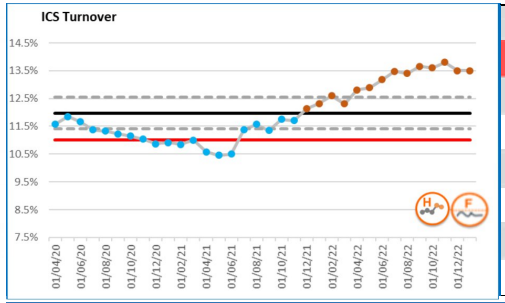
9.2 - Workforce – Exception Report Provider Vacancies, Turnover & Sickness

NHS Nottingham and Nottinghamshire

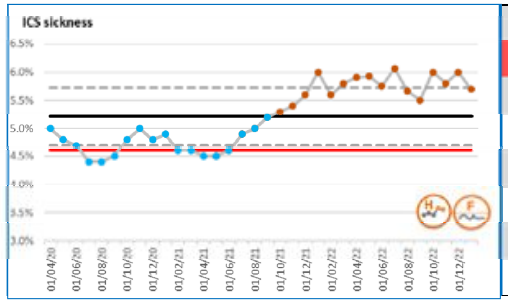
Workforce - Vacancies, Turnover & Sickness Absence



Jan-23
12.1%
Target
8.7%
Assurance
Flip
SPC Variation
Concerning - High



Jan-23
13.5%
Target
10.5%
Assurance
Fail
SPC Variation
Concerning - High



Jan-23
5.7%
Target
5.2%
Assurance
Fail
SPC Variation
Concerning - High

KPI	Latest Period	Target	Actual	Variance	Variation	Assurance
ICS Vacancies	Jan-23	8.7%	12.1%	3.4%		
NHC Vacancies	Jan-23	8.7%	11.8%	3.1%		
NUH Vacancies	Jan-23	8.7%	14.1%	5.4%		
SFH Vacancies	Jan-23	8.7%	3.9%	-4.8%		

KPI	Latest Period	Target	Actual	Variance	Variation	Assurance
ICS Turnover (12 mth)	Jan-23	10.5%	13.5%	3.0%		
NHC Turnover (12 mth)	Jan-23	11.0%	18.6%	7.6%		
NUH Turnover (12 mth)	Jan-23	11.0%	12.2%	1.2%		
SFH Turnover (12 mth)	Jan-23	8.0%	9.3%	1.3%		

KPI	Latest Period	Target	Actual	Variance	Variation	Assurance
ICS Sickness Absence	Jan-23	4.6%	5.7%	1.1%		
NHC Sickness Absence	Jan-23	4.6%	6.8%	2.2%		
NUH Sickness Absence	Jan-23	4.6%	5.4%	0.8%		
SFH Sickness Absence	Jan-23	4.6%	5.0%	0.4%		

Summary

Vacancies have increased in Total Providers since April 22 following changes to establishments . There is a wide variation in performance across providers: 3.9%-14.1%

Turnover - continues to see a higher turnover than plan across all providers. This is in line with national trends post Covid

Sickness levels remain higher than pre covid levels across the Total Providers with a reduction seen in month. It is unlikely that the sickness levels will return to pre-covid levels that we were asked to set as a target from teh 22-23 planning guidance, reflected in changed guidance for 23-24 to refelct experience of last 12 months.

Actions

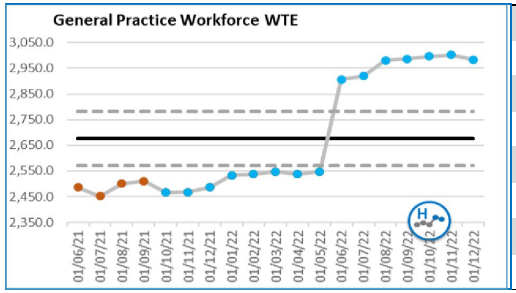
Trusts are seeing variation in levels of vacancies across the different staff and professional groups, nursing and clinical support remain the highest but are linked to establishment changes made as a result of agreed investments in year. Trusts are also reviewing recruitment capacity to support the 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 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



Dec-22
3200
Target
Assurance
SPC Variation
Improving - High

Total ICB Primary Care Workforce - Operational Plan v Actual 2022/23

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 Dec-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	3200	3194	3228
GPs excluding registrars	581	584	584	577	583	578
Nurses	323	362	372	350	378	383
Direct Patient Care roles (ARRS funded)	333	384	406	459*	424	434
Direct Patient Care roles (not ARRS funded)	260	265	267	272	269	284
Other – admin and non-clinical	1537	1538	1539	1542	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 aligning workforce development plans to match the Primary Care Strategic objectives.

P&C Group Assurance -Enhanced Assurance Level

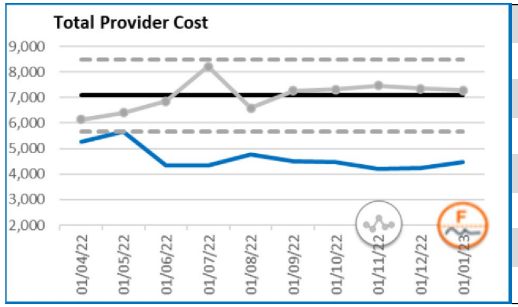
Primary Care - General Practice:
Plans are in place and are effective but more needs to be done to make general practice an attractive offer supporting staff, offering flexibility in working and cultural shift to integrated working.

Leads from the Primary care Workforce group are engaging with PCN leads to determine nest steps in supporting retention and recruitment challenges being experienced.

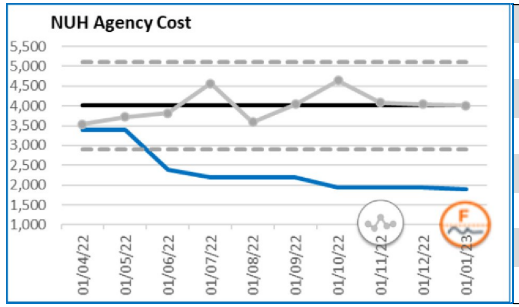
9.4 – Workforce – Exception Report Agency Cost

NHS Nottingham and Nottinghamshire

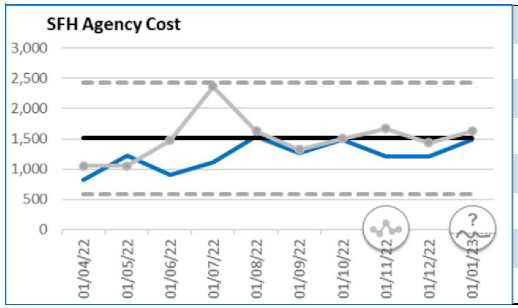
Total Provider Agency Cost



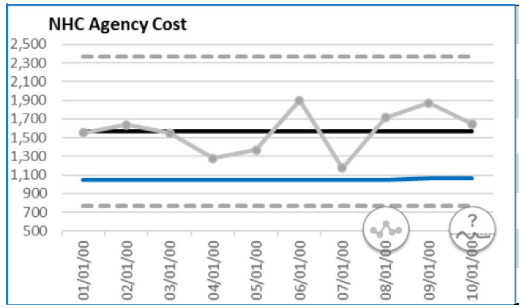
Jan-23
£7,286
2022-23 Plan
£4,229
Assurance
Fail
SPC Variation
Common Cause



Jan-23
£4,012
2022-23 Plan
£1,905
Assurance
Fail
SPC Variation
Common Cause



Jan-23
£1,626
2022-23 Plan
£1,490
Assurance
Flip
SPC Variation
Common Cause



Jan-23
£1,648
2022-23 Plan
£1,067
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

Following submission of system diagnostic in December 2022 a regional Agency Reduction Programme meeting has been held wit hRegioal CNO and Service Improvemet leads. Although positive feedback on understanding the issues implementation of good practice there is a lack of pace around teh effectiveness of these measures.

Joint SROs in Finance (CFO SFH) and People (CPO ICB) are now taking forward actions to build on the evidence collated to date, actions taken within individual Trusts to look at collaborative actions. The required reduction in the metric of percentage of pay bill, currently at 5% down to 3.7% in 23-24 Operational Plan Guidance requires a clear action plan be developed to achieve this reduction.

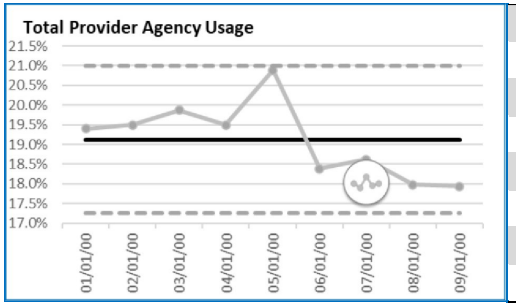
People & Culture Group Assurance - Further Information Required

Plans are in place but more detail is needed to determine if further targeted interventions are required.

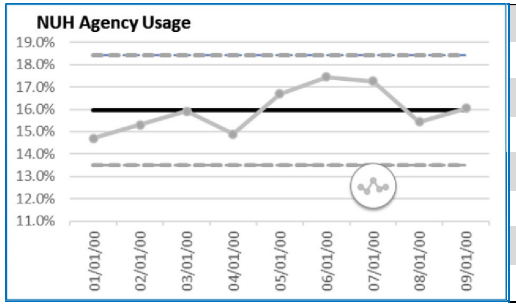
9.5 – Workforce – Exception Report Agency Usage

NHS Nottingham and Nottinghamshire

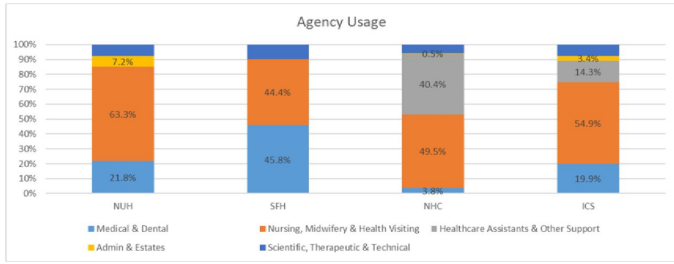
Total Provider Agency Usage

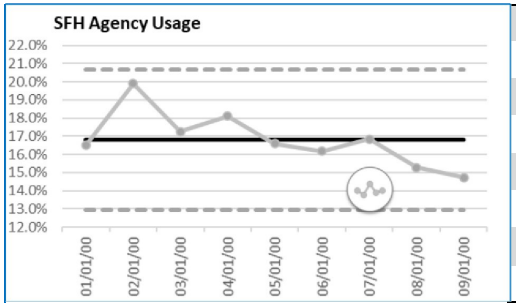


Jan-23
17.94%
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause

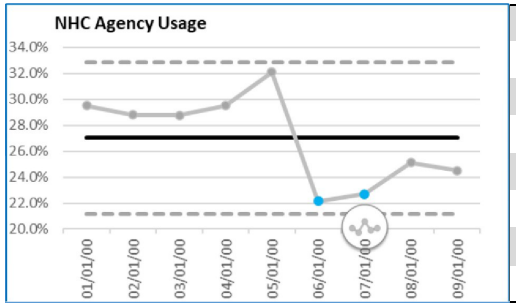


Jan-23
16.05%
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause



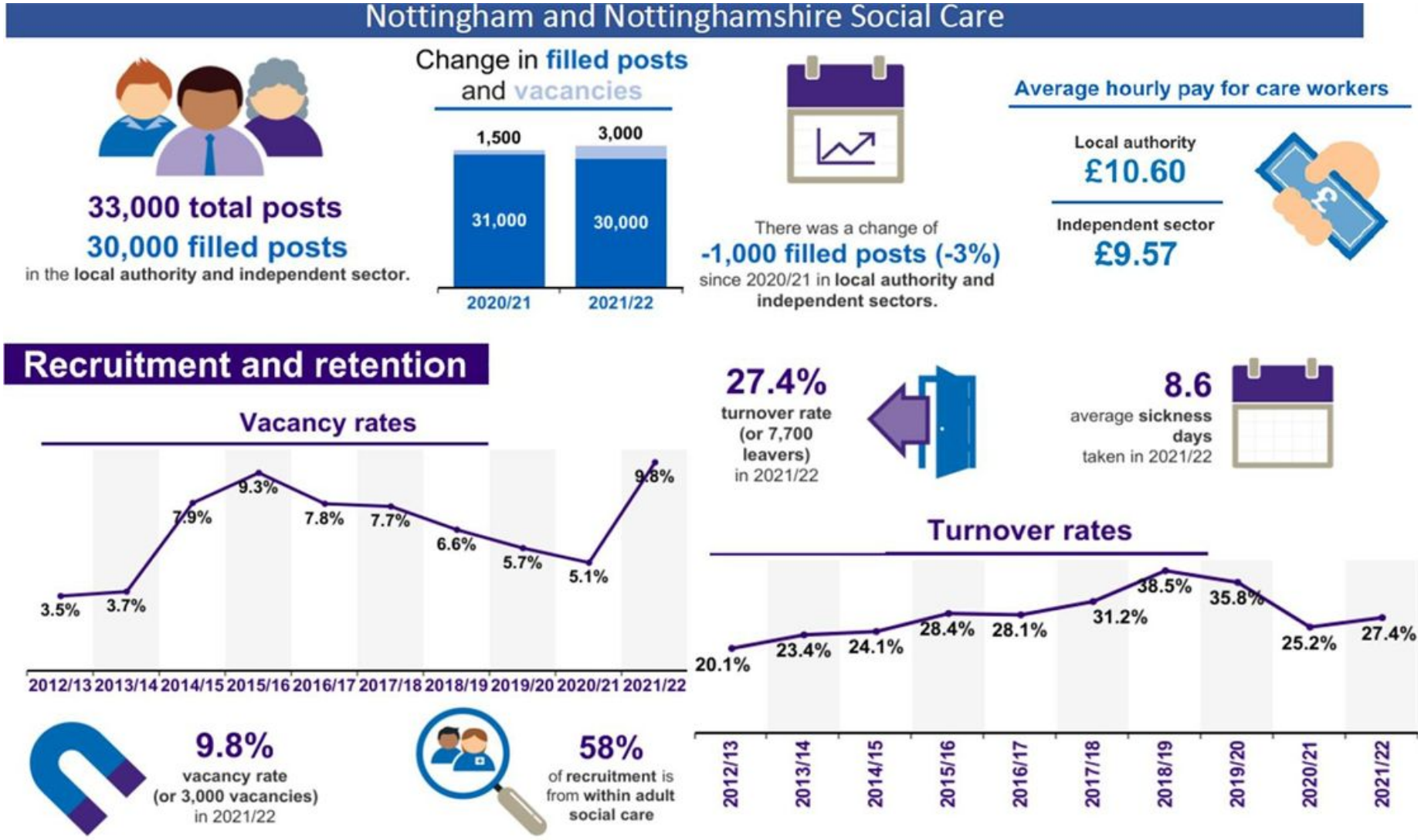


Jan-23
14.74%
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause



Jan-23
24.51%
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause

9.6 – Workforce – Social Care Workforce



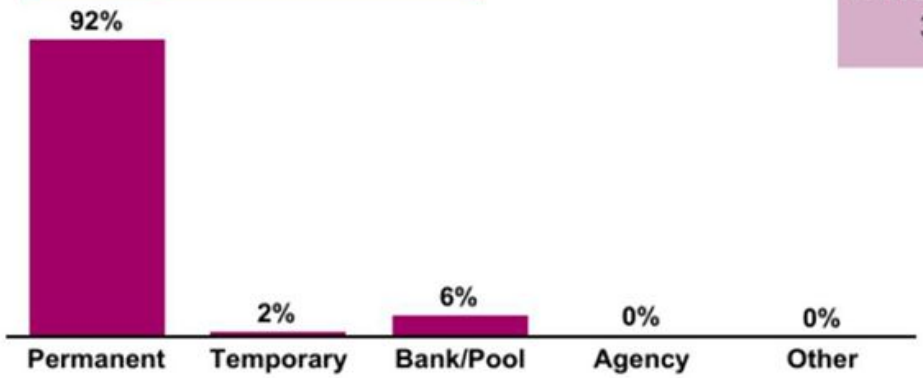
9.7 – Workforce – Social Care Employment Overview

NHS Nottingham and amshire

Employment overview

Key:
Full-time
Part-time

Employment status



Filled posts:
30,000

19%
of filled posts were **zero-hours contracts** (or **5,900 filled posts**)

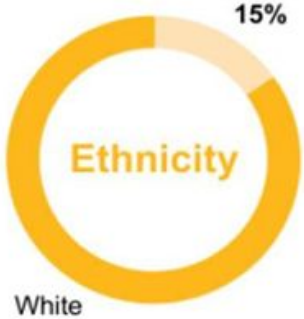
Demographics

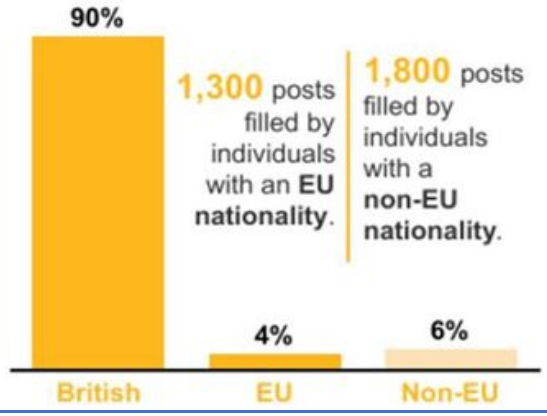
Gender

83%
of the workforce were **female**.

17%
of the workforce were **male**.

Ethnicity and nationality



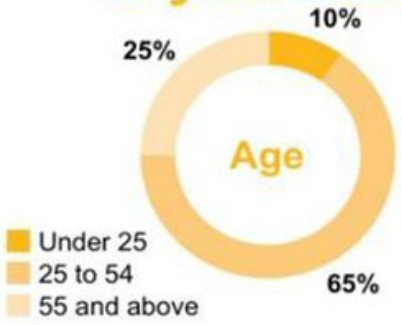


1,300 posts filled by individuals with an **EU nationality**.

1,800 posts filled by individuals with a **non-EU nationality**.

Age

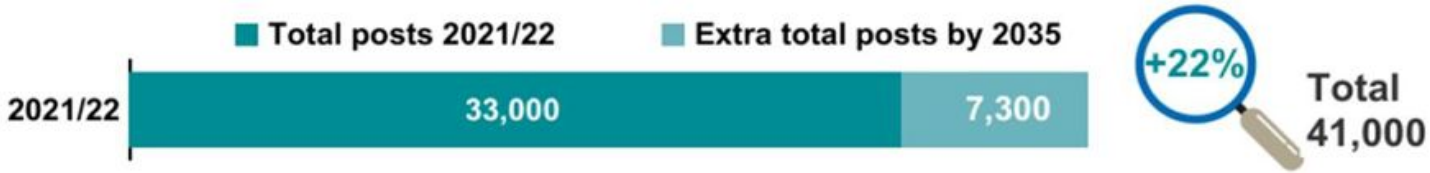
The average **age** was
43 years old



9.8 – Workforce – Social Care 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.

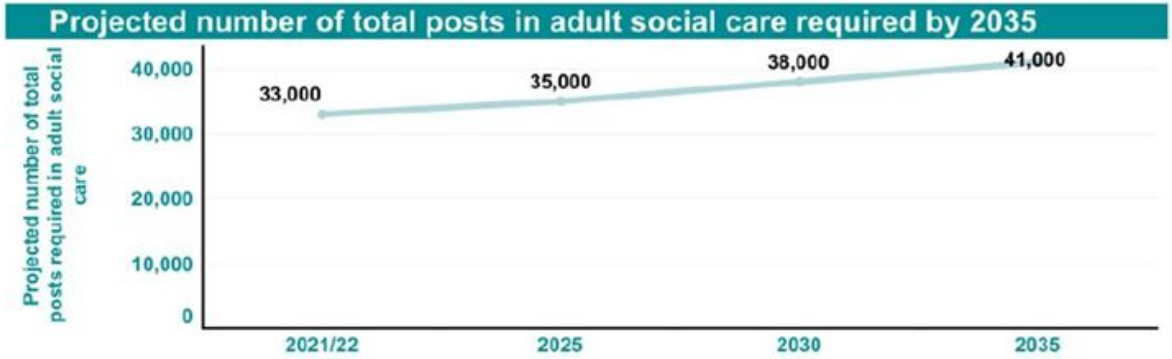


If the adult social care workforce grows proportionally to the projected number of people aged **65 and over** in the population then the number of adult social care filled posts will...

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



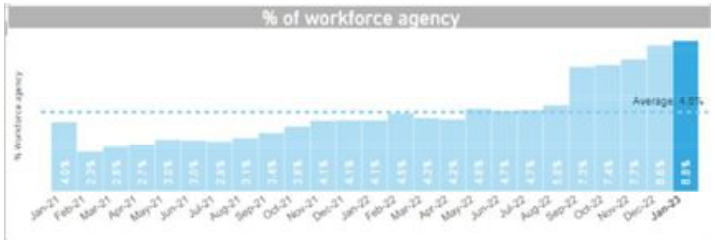
9.9 – Workforce – Care Homes

Care Homes Workforce

Workforce absence and agency staff

Monthly staff trend: All staff

Aligned PBP	Employed	Absence	%	Agency	%
Bassetlaw	1,532	31	2.0%	177	10.4%
Mid Notts	4,213	167	4.0%	436	9.4%
Nottm City	2,528	95	3.8%	221	8.0%
South Notts	4,327	177	4.1%	387	8.2%
Total	12,600	470	3.7%	1221	8.8%



Care Home workforce absence is a currently 3.7% across all staff groups. This is much lower than the percentage during Jan 21 and Jan 22 which were both in the region of 7%. During Jan 2023, nursing staff have the lowest absence reporting with 2.4%, non care workers are reporting 3.2% absence. Care Workers are the largest staff group and are reporting the highest 4% absence

Agency staff percentages has increased significantly in the latest 5 months, however this is possibly due to CHs incorrectly reporting agency staff on the National Capacity Tracker. This has been raised in the Care Home and Home Care Data Streams - Operational Meeting. Work is ongoing to contact these services reporting higher numbers of agency staff to ensure correct reporting.

SAIU SYSTEM ANALYTICS INTELLIGENCE UNIT

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

10.1.1 Detailed analysis on emergency admissions has been carried out by the SAIU in order to inform clinical priorities of the ICS. The analysis highlights the disparities in access and experience and therefore the opportunity to embed equity as a core principle by targeting resources to need in relation to prevention and treatment. In relation to the analysis, 54% of emergency admissions and 70% of emergency bed days (average of 1,665 emergency beds) relate to the over 65s, despite only being 18% of the ICS population. 71% of those over 65 have a long-term condition with a high incidence of multi-morbidity. The highest incidence of long-term conditions is in the most deprived areas of our ICS with variations which may be impacted differently depending on factors including ethnicity, age, gender. The prevalence of COPD is roughly double in the most deprived quintile of our population compared to the least. Stroke, heart failure, heart disease, diabetes and asthma prevalence are all higher in the most deprived quintile. When we look at this in relation to emergency admissions, people aged 40-84 living in in the most deprived national quintile on average cost more than double in emergency hospital costs than those in the least deprived. The clinical priorities have been approved by the Clinical and Care Professional Leadership Group and these will form the work programme of the Clinical Design Authority with a focus on impactful interventions relevant to the population needs.

10.1.2 A Stroke workshop was held with clinicians from across the ICS to revisit the Clinical Services Strategy and establish priorities for the short and longer term. The workshop discussions and outcomes were informed by PHM data which highlighted the following: After adjusting for age and sex, the risk of Stroke increases with deprivation and it's highest for those living in the most deprived quintile (1) compared to those living in the least deprived quintile (5). Despite having a lower age population, Nottingham City has the highest rates per 100,000 population. 89% of the patients diagnosed with Stroke have at least one other long term condition, whilst only 11% have just Stroke. Once we adjust for age, sex, deprivation and comorbidities, minority ethnic groups have a significant lower risk of stroke compared to the white ethnic group (between 10% and 30% lower according to local analysis. Of those diagnosed with Stroke, 27.4% are living alone and 12.7% are housebound. At least 65% of the total population diagnosed with Stroke are either ex-smokers or current smokers.

10.1.3 Within Nottingham and Nottinghamshire here is a much higher risk of pre-diabetes in males in areas of higher deprivation in Mansfield along with a much lower uptake in the Diabetes Prevention Programme. Work has been undertaken to understand the barriers and experiences in relation to the Diabetes Prevention Programme in order that we could increase uptake. In order to reach the target audience and allow for ongoing promotion of the Diabetes Prevention Programme, Mansfield Town Football Club were approached and with the ICB have developed a campaign that ensures that messaging can be seen by as many supporters as possible. The outcome has been an increase in referrals to NDPP, access to other forums to promote the messages, as well as an overall recognition of the risks of diabetes. Michael Bradley, the Commercial Manager at Mansfield Town Football Club, also believes the partnership brings many benefits.
"Mansfield Town Football Club are really pleased to be able to help the NHS and Living Well Take Control to promote the Diabetes Prevention Programme. Diabetes is a very serious health condition and there is potentially a huge amount of people across the UK that may be suffering from this condition without knowing it. When I was approached about supporting this campaign it was a no brainer, as a football club we have a connection with thousands of people in Mansfield and beyond and it is a privilege to be able to help raise awareness of Diabetes and point people in the right direction to seek help and advice."

10.1.4 Through NHS Long Term Plan funding, Sherwood Forest Hospitals NHS Trust has established an in-house smoking in pregnancy service, that includes an incentive scheme for young mothers and partners. Sherwood Forest Hospitals are an accelerator site for the national evidence based NHS model. The service has been operational for a year and during that time it has helped 101 women to stop smoking.

NHS Nottingham and Nottinghamshire

10.2 Tackling Health Inequalities – The 5 in the 'Core20Plus5' – Adults

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach identifies '5' clinical areas linked to premature mortality and therefore requiring accelerated improvement. The below table provides an overview of performance to targets.

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
Continuity of care for 75% of women from BAME communities and from the most deprived groups.	Jan 23	0%	75%			0%	0%	0%
Annual health checks for 60% of those living with SMI	Feb 23	4565	6237			4160	3726	4594
Uptake of Covid and Flu Vaccine in people with COPD	Jan 23	65%	100%			65%	65%	65%
Reduction of emergency admissions in people with COPD	Jan 23	4%	0%			4%	4%	4%
75% of cancer cases diagnosed at stage 1 or 2 by 2028	Jan 20	50%	75%			53%	50%	56%
Reach 80% of expected hypertension diagnoses by 2029	Jan 23	72%	80%			66%	57%	74%
Optimal treatment for 80% of hypertension patients by 2029.	Jan 23	77%	80%			74%	70%	78%

Each of the five clinical areas have accompanying workstreams and plans. Plans are at a system level and are supported by action being taken at a neighbourhood and place level.

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 Access & Experience – Waiting Lists

The following tables show a breakdown of the total waiting list by deprivation, ethnicity and Place. Previous analysis has shown that the factors that contribute most significantly to longer waiting times and waiting times over 52 weeks are clinical priority and treatment function. Action is being taken to improve the recording of ethnicity data, therefore decreasing the number of unknowns.

Total Waiting List

Previous analysis showed that there is a higher proportion of the population in more deprived areas entering the surgical pathways through an urgent or emergency route.

There are significant differences in referral rates across PCNs, however there is low correlation with deprivation – this is at odds with what would expect based on prevalence.

The PBP elements are more aligned to the patient flows into the main acute hospitals and tend to have strong correlation to the performance of their main acute trust.

10.3 Access & Experience – Waiting Lists

NHS Nottingham and Nottinghamshire

52 week waits

104 week waits

78 week waits

Understanding and impacting on disparities in access and experience in relation to waiting lists extends across six stages of the pathway including identification and referral, pre-treatment, assessment and management, decision to treat, waiting list prioritisation and treatment accessibility. Programmes of work include understanding and impacting on DNAs with a particular focus on the point of referral, waiting well and earlier identification of high risk factors that will impact on surgery and structure pre-op programmes.

Tables are taken from the ICS Health Inequalities Dashboard

10.4a - 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. The indicators highlight key areas of inequity including differences in relation to avoidable mortality and morbidity. Avoidable deaths occur in those aged under 75 that are caused by diseases or injury that either: can be mainly **prevented** through effective interventions to stop disease or injury occurring or are **treatable** and can be mainly avoided through timely health care intervention

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.*

NHS Nottingham and Nottinghamshire

10.4b - Health Inequalities Dashboard – Nottingham and Nottinghamshire Health Inequalities Metrics by Deprivation

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.

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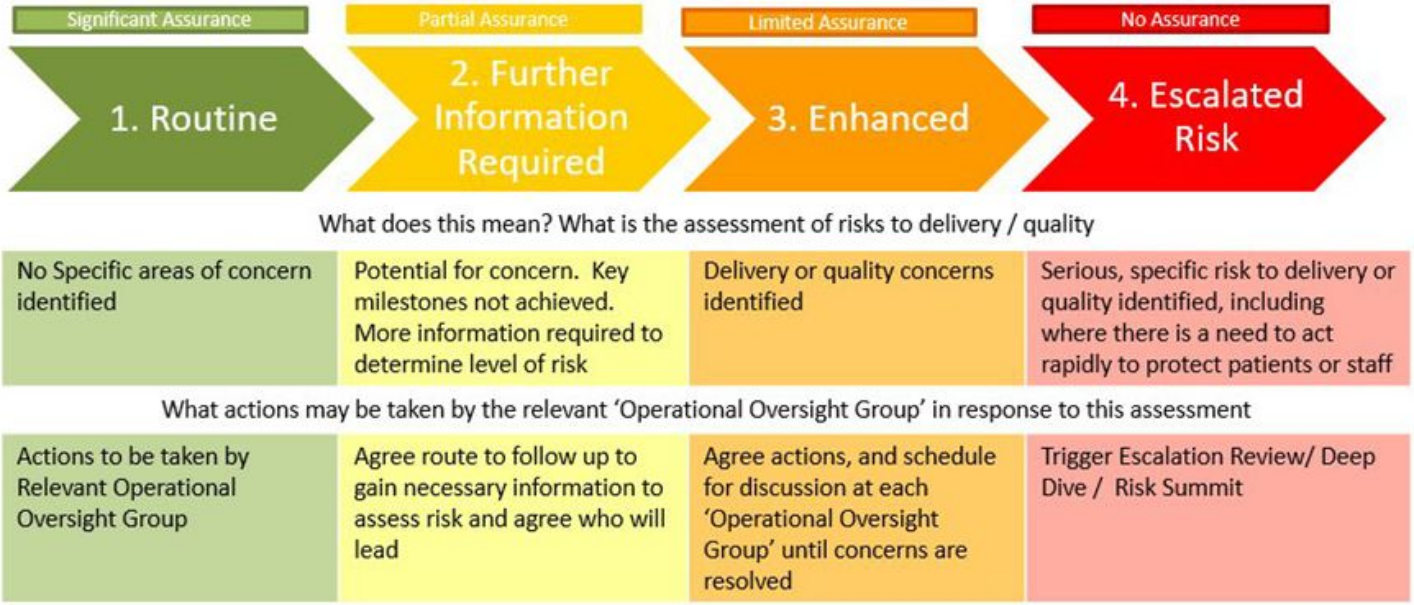
Appendices

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:



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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

iii – Glossary of Terms

NHS Nottingham and Nottinghamshire

Acronym	Meaning	Acronym	Meaning	Acronym	Meaning	Acronym	Meaning
A&E	Accident & Emergency	FD	Finance Director	NEMS	Nottinghamshire Emergency Medical Services	SEG	System Executive Group
A&E	Accident & Emergency Delivery Board	FOT	Forecast Out-Turn	NHP	New Hospitals Programme	SFH	Sherwood Forest Hospitals Foundation Trust
AMH	Anit-Mullerian Hormone	G&A	General & Acute	NHSE	NHS England	SLA	Service Level Agreement
BAU	Business as Usual	GI	Gastro-intestinal (often referred to as Upper GI or Lower GI)	NHT / NHC	Nottinghamshire Healthcare NHS Trust	SMI	Severe Mental Illness
Blaw	Bassetlaw	HEE	Health Education England	NICE	National Institute for Health & Care Excellence	SOF	System Oversight Framework
BLM	Back-log Maintenance	HFID	Hospital First Integrated Discharge	NNICB	Nottingham & Nottinghamshire ICB	SOP	Standard Operating Procedure
CAMHS	Child & Adolescent Mental Health Services	HLE	Healthy Life Expectancy	NRC	National Rehabilitation Centre	SPC	Statistical Process Control
CCG	Clinical Commissioning Group	IAPT	Improving Access to Psychological Therapies	NUH	Nottingham University Hospitals	SRO	Senior Responsible Officer
CDC	Community Diagnostic Centre	IBN	Information Breach Notice	OAPs	Out of Area Placements	TIF	Targeted Investment Fund
CDEL	Capital Departmental Expenditure Limits	ICATT	Intensive Community Assessment & Treatment Teams	OBD	Occupied Bed Days	UEC	Urgent & Emergency Care
CDU	Clinical Decision Making Unit	ICB	Integrated Care Board	OOA	Out of Area	UTC	Urgent Treatment Centre
CHC	Continuing Health Care	ICP	Integrated Care Partnership	OP	Out Patients	WTE	Whole Time Equivalents
CoP	Court of Protection	ICS	Integrated Care System	PBP	Place Based Partnerships	YOC	Year of Care
CT	Computed Tomography	IPC	Infection prevention control	PCIT	Primary Care Information Technology	YTD	Year to Date
CV	Contract Variation	IR	Identification Rules	PCN	Primary Care Networks		
CYP	Children & Younger People	IS	Independent Sector	PFDS	Public Facing Digital Services		
D2A	Discharge to Assess	JSNA	Joint Strategic Needs Assessment	PFI	Private Finance Initiative		
DC	Day Case	KMH	Kings Mill Hospital	PHM	Population Health Management		
DDAT	Digital, Data, Analytics and Technology	LD	Learning Disabilities	PHSMI	Physical Health check for Severe Mental Ill patients		
DHSC	Department of Health and Social Care	LD&A	Learning Disabilities & Autism	PICU	Psychiatric Intensive Care Unit		
DST	Decision Support Tool	LINAC	Linear Accelerator	PID	Project Initiation Document		
DTT	Diagnosis to Treatment Time	LoS	Length of Stay	PIFU	Patient Initiated Follow Ups		
EBUS	Endobronchial Ultrasound	MAS	Memory Assessment Service	POD	Prescription Ordering Direct		
ED	Emergency Department	MHIS	Mental Health Investment Standard	PoD	Point of Delivery		
EIP	Early Intervention Psychosis	MHST	Mental Health Support Team	PTL	Patient Targeted List		
EL	Electives	MNR	Maternity & Neonatal Redesign	QDCU	Queens Day Case Unit		
EMAS	East Midlands Ambulance Service NHS Trust	MOU	Memorandum of Understanding	QMC	Queens Medical Centre		
EMCA	East Midlands Cancer Alliance	MRI	Magnetic Resonance Imaging	R&D	Research & Development		
EMNNODN	East Midlands Neonatal Operational Delivery Network	MSFT	Medically Safe for Transfer	R&I	Research & Innovation		
EOL	End of Life	N&N	Nottingham & Nottinghamshire	RAG	Red, Amber & Green		
ERF	Elective Recovery Funding	NCSO	No Cheaper Stock Obtainable (prescribing)	RTT	Referral to Treatment Times		
ESRF	Elective Services Recovery Funding	NEL	Non-Electives	SDMF	Strategic Decision Making Framework		

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/03/2023
Paper Title:	**Committee Highlight Reports**
Paper Reference:	ICB 22 073
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 January 2023. 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.

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
F: Annual Equality Assurance Report

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:	**13 January 2023, 02 February 2023 and 02 March 2023**
Committee Chair:	**Jon Towler, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance
1. Joint Forward Plan	The Committee has been oversighting progress with development of the Joint Forward Plan (JFP). The guidance published in December 2022 was noted, which provided some flexibility in relation to timescales, with the JFP to now be finalised for publication by 30 June 2023. However, the timeframe for delivery was still considered to be challenging.	-
2. NHS England Delegation of Commissioning Functions relating to Pharmacy, Optometry and Dental (POD) Services and Specialised Services	The Committee has received monthly progress updates on the delegation of commissioning functions relating to pharmacy, optometry and dental (POD) services from 1 April 2023 and specialised services from April 2024. This has included oversight of the developing operating model, governance structure and staff transfer arrangements from NHS England to enable the five East Midlands ICBs to deliver the delegated functions.	-
3. System development update: Approach to delivering community and primary care transformation through thriving places and provider collaboration	The Committee received a presentation on the evolving arrangements for delivering primary and community care transformation through Place-Based Partnerships (PBP) and Primary Care Networks through new, integrated ways of working. A draft 'Blueprint' for PBP delivery of system health and wellbeing ambitions, along with a system development roadmap, were discussed in detail. Whilst the Committee was encouraged by the progress to date, Members sought an increased pace of delivery. A further update would be received in May to further understand the programme milestones and deliverables.	-

Item	Summary	Level of assurance
4. Alignment of commissioning policies	In February and March, the Committee was updated on the ongoing work to align the commissioning policies of the former CCGs. Members were supportive of the approach being taken but noted that the agreed timeframe for policy alignment had been extended. As such, the differential policy position would remain in relation to policies that relate to restricted services and access to fertility treatments for longer than originally anticipated. The Committee encouraged completion of this work at the earliest opportunity.	-
5. Research and Use of Evidence Assurance Report	An assurance report regarding the ICB's arrangements for meeting its statutory duty to facilitate and promote research was considered in February. Members recognised that research is essential for understanding the needs of the population, tackling inequalities and improving citizen health and wellbeing. Proposed actions to further develop arrangements were endorsed; these included the development of a research strategy, contributing to the development of the JFP and exploring opportunities for the ICB Board and the ICS Clinical and Care Professional Leadership Group to discuss research activity and culture across the ICS. It was agreed that there would be a focus on research within a future ICS newsletter, to promote the work of system partners and the contribution of research to the ICS aims.	**Reasonable**
6. Working with People and Communities	The Committee discussed progress to date in implementing the Citizen Intelligence Strategy and the Coproduction Strategy. Good progress was recognised at a system level, but Members felt there was more to be done to fully embed arrangements at place and neighbourhood levels.	-

Other considerations:

Decisions made:
The Committee ratified an urgent decision made in December 2022 using the Committee's emergency powers to approve investment of £799,000 to establish Acute Respiratory Infection (ARI) hubs to manage the response to invasive Group A streptococcal infections (iGAS) and winter pressures. The Committee approved a number of contract awards, including contracts for the Gynaecology Core Plus Service, termination of pregnancy services and community ophthalmology services. Procurement arrangements relating to NHS 111 telephony services and GP practice interpreter and translation services were also discussed and agreed.
Matters of interest:
The Committee also: • Endorsed the Tomorrow's NUH Pre-Consultation Business Case and recommend this for approval by the Board for onward submission to NHS England's stage two assurance panel. • Endorsed the progress of the Community Care Transformation Programme and the system approach to co-production, strategic planning and service delivery to meet the needs of the population. • Received highlight reports from the Primary Care Contracting Sub-Committee, where it had been noted that routine Care Quality Commission inspections had been paused for General Practice until April 2023 in response to the pressures being faced in primary care. • Noted the mechanisms established to monitor the activity delivered by the Acute Respiratory Infection hubs.

Appendix B: Quality and People Committee Highlight Report

Meeting Dates:	**18 January and 15 February 2023**
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 January 2023 System Quality Update included the developing quality dashboard and quality risk profiles for the four main providers. The report provided a high-level summary of system issues, risks/mitigations and improvements across the system. Concern was raised that despite a very high level of scrutiny over several months, the NUH maternity position indicated that most of the eleven key performance indicators were off track. There was recognition that the pressures on urgent and emergency services are having an impact on resilience. However, the Committee requested a review of assurance and support around maternity services in March 2023. Emerging quality concerns related the British Pregnancy Advisory Service and a system insight report from the care homes dashboard were provided in February 2023. Members focused discussion on the availability of care home beds to patients who are medically fit for discharge. It was agreed that this would be a future deep dive focus and the Joint Health and Social Care Lead would be invited to attend. In February the Committee received an integrated performance report for system quality in a revised format. The report format was welcomed and would be expanded to cover all areas of quality reporting in order to provide a heat map. Breaches in relation to infection prevention and control (IPC) were highlighted. Increased bed usage was cited as a key contributor to the position, alongside a gap in IPC resource. The position is receiving regional and national focus.	-

Item	Summary	Level of assurance
	The Nursing and Quality Statutory Duties Report provided assurance in relation to the quarter three position in respect of the ICB's statutory duties in relation to quality. Medicines optimisation was included in the report for the first time. Members challenged actions to improve performance in a number of areas, including Looked After Children initial health assessments, the completion of Education Health and Care Plans, Continuing healthcare reviews and back logs of serious incidents requiring review and sign off by the ICB.	
2. System Quality Improvement • Transformation report • LDA Deep Dive	For the first time members received highlight reports from the two system groups, Partner Quality Assurance and Improvement Group (PQAIG) and Transformation Quality Assurance and Improvement Group (TQAIG). The System Quality Group (SQG) highlight report was also included for information and provided an overview of providers and system quality programmes under intensive and enhanced surveillance. Members received a deep dive presentation into Learning Disabilities and Autism (LDA). This covered the key areas of the LDA programme including workstreams, governance arrangements and key performance indicators. Members were informed about what is working well and where there are system challenges to be addressed. Over the past two years the average length of stay in Assessment Treatment Unit provision has reduced from 14 months to six months. Care and Treatment Review and Local Area Emergency Placement processes are working well and have avoided unnecessary admissions. Despite good levels of adult inpatient discharge activity admission rates remain consistent which is compromising the work on discharges, leading to a risk in meeting the end of year position for adult inpatient numbers.	-
3. Looked After Children (LAC)	LAC is a statutory duty of the ICB. Members received detail of the position in respect of initial health reviews (IHRs) and review health assessments (RHAs), this included each provider's performance and action plan and a system wide action plan for improvement. Establishment of a LAC Integrated Assurance Group was considered key to improving scrutiny and assurance.	-

Item	Summary	Level of assurance
4. People: Performance and actions update	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 system approach e.g. connectivity around actions on recruitment, retention, wellbeing and career development continue to be priority and an update was provided against the key actions identified in November 2022. An immediate priority continues to be planning for impending industrial action. With the transfer of further functions to ICBs commencing with (Pharmacy, Optometry and Dental services (PODs) from April 2023, followed by specialised commissioning in April 2024, ICBs will have accountability for the totally of the workforce which has not been the case before. In February 2023 members received an integrated performance report focused on people for the first time. The report format was welcomed and provided assurance on delivery of the system workforce plan. Members noted that staff sickness, absence remains stable, although above target and turnover remains above plan. The general practice section of the report included workforce recruited to Primary Care Networks (PCNs) under the Additional Roles Reimbursement Scheme (ARRS) and represents success in this area. There was no growth seen or expected in General Practitioners, which mirrors the national position. System wide spending on agency and bank staff was being reduced, although remains challenging because of critical incidents and industrial action. Recruitment to mental health roles is particularly challenged. Initiatives to work differently to encourage and simplify system working across interfaces were discussed along with the need for other enablers such as the digital strategy to be aligned.	-
5. Development of the People Plan	At the February 2023 meeting the Chief People Officer who took up her role on 1 February 2023 provided an update on development of the People Plan. Immediate focus is on understanding and assimilating data that had been used to complete the diagnostic. Alongside this, relationships are being established with the three key NHS provider Chief People Officers to ensure co-production of the ICS People Plan. Staff	-

Item	Summary	Level of assurance
	are at the centre of the ICB ambition to deliver better care and support to local people. Work is underway across the ICS to take a 'one workforce' approach, inclusive of all staff and carers involved in supporting local people's health and wellbeing. This provides the opportunity to do things differently to ensure every person enjoys their best possible health and wellbeing, including the workforce who are largely members of the ICS communities. The ICS People Plan will cover all ten elements of the System Workforce Improvement Model (SWIM) and have strong delivery links with the Integrated Care Strategy.	
6. ICB Equality duties	The Public Sector Equality Duty (PSED) of the Equality Act 2010 requires the ICB to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations. Members received the annual equality assurance report setting out the ICB's responsibilities and commitment to equality, diversity, inclusion, and human rights. The paper included the ICB's objectives, which are: • Improve equality of access to health services and health outcomes of the diverse populations we serve. • Build and maintain a diverse, culturally competent workforce, supported by an inclusive leadership team. • Create and maintain an environment where dignity, understanding and mutual respect, free from prejudice and discrimination, is experienced by all, and where patients and staff feel able to challenge discrimination and unacceptable behaviours. An action plan is being developed through the Equity, Inclusion and Human Rights (EIHR) Steering Group and will be brought to and monitored through the Quality and People Committee. Members noted the report for assurance and would receive further detail and action plan at the April 2023 meeting.	-

Item	Summary	Level of assurance
	It is a national requirement that ICBs annually publish equality information that demonstrates how they are considering equality across the services they commission and in the employment of staff. The report, provided at **Appendix F**, will therefore be published by the deadline of 30 March 2023.	

Other considerations:

Decisions made:
In January 2023, members approved the Co-production Strategy and Policy with the caveat that the appropriate approval route for payments would take place in the appropriate forum. At the February 2023 meeting the Committee approved the ICB inserts into Partner Quality Accounts noting that any material changes to the inserts would be shared with members for further consideration and approval. Partner members were excluded from the discussion and decision-making related to this item, due to their conflict of interests.
Matters of interest:
The Committee received a presentation on the ICB approach to Health Inequalities in February 2023. The ICS approved an ICS Health Inequalities Strategy in October 2020 which included the five NHS priorities in addressing health inequalities. Since the ICS strategy was approved, the national NHS Core20+5 frameworks for adults and children and young people had been launched and the ICS had adopted equity as a core principle. To support delivery of the plan and to ensure it is driven at a system level, the ICS has a Health Inequalities Oversight Group attended by Place and partner representatives. The Group reports into the System Oversight Group and the Clinical and Care Professional Leadership Group. Impact is also monitored through the ICB's Finance and Performance Committee and Board. Members suggested that there remains a gap in reporting inequalities by deprivation. It was agreed that duplication should be avoided but that it may be appropriate for the Quality and People Committee to consider how health inequalities metrics relate to areas of quality via periodic reports. It was agreed that the health inequalities section of the Integrated Performance Report would routinely be provided to members via the reading room on Diligent.

Appendix C: Finance and Performance Committee Highlight Report

Meeting Dates:	**25 January 2023 and 22 February 2023**
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 and learning from this work was being applied to other areas. Discussion at the January meeting focused on recovery trajectories for diagnostics, planned care and improving timely discharge. A potential emerging risk around excess mortality rates was highlighted at the January ICB Board meeting and an action was agreed for this to be investigated further and presented to the Finance and Performance Committee. Dave Briggs tabled slides detailing initial analysis into the excess mortality rates position at the January meeting and agreed to bring back more detailed work to the March meeting.	**Partial**
2. Urgent Care Programme Focused Review	The Urgent Care Focused Review was presented to the Committee at its January meeting. It provided an overview of the governance, oversight, and operational arrangements in place across the urgent 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.	**Partial**

Item	Summary	Level of assurance
	Discussion focused on the progress of implementation of virtual wards, which had been slower than hoped. Members were advised that the scope of virtual wards was to be broadened to include elderly care and agreed to monitor progress of this in future meetings.	
3. Mental Health Programme Focused Review	The Mental Health Focused Review was presented to the Committee at its February meeting. This followed the same format as previous focused reviews. Members discussed the role of the various meetings outlined in the mapping document, which detailed reporting arrangements for mental health within the system and took assurance that there was rigorous oversight of the programme.	**Reasonable**
4. System Finance Report	The reports included detailed analysis of the financial performance for the system for months nine and ten. Key drivers of the deficit 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 spend and efficiency shortfalls. The difficult operating environment across the NHS during the Winter period has further impacted on expenditure, particularly in the acute sector. A discussion took place regarding the process to escalate worsening financial positions to NHS England. As a system with a deficit plan, engagement with the escalation process was required.	**Limited**
5. ICB Finance Report	The reports included detailed analysis of the financial position for months five and six of the ICB's operation. The ICB was working towards a breakeven plan for the full financial year, which combined the position of the former clinical commissioning groups and the ICB. There were significant risks to the in-year position and balance sheet flexibilities were being used to offset these. The key areas of pressure were continuing healthcare 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.	**Substantial**

Other considerations:

Decisions made:
No decisions were made.

Matters of interest:
The Committee received an overview of the progress to date in developing the ICS Digital Strategy. A strategic discussion took place regarding the future digital aspirations of the ICS and how success will be measured against the strategy, once finalised. Members fed back that the strategy needed to be more pragmatic and focus on fundamental matters as drivers of wider success, such as addressing basic connectivity issues. The Committee received updates at both meetings on the actions being taken by the ICB in preparation of the anticipated operational planning guidance. Guidance, including financial allocations, had been published in December 2022. Discussion focused on ensuring resource was not over-allocated for 2023/24 as it had been in 2022/23. Members also stressed the importance of agreeing to targets that were realistically achievable, yet ambitious.

Appendix D: Audit and Risk Committee Highlight Report

Meeting Dates:	**19 January 2023**
Committee Chair:	**Caroline Maley, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance
1. Board Assurance Framework – Targeted Assurance Report • Integration Directorate • Nursing and Quality Directorate	A key role of the Committee is to review the rigour of the Board Assurance Framework (BAF). This was the first of two reports that will provide a detailed review of all strategic risks across the ICB's four directorates. Members had an in-depth discussion with the Director and Integration and Director of Nursing regarding the control environment and the work being undertaken to address any gaps in control or assurance. While the Committee concluded that good progress was being made, it was recognised that further work was required to move the risks to their target scores, which was felt to be indicative of the longer timeframe agreed for the BAF. A similar review of the risks held by the Finance Directorate and Medical Directorate will be undertaken at the Committee's March meeting.	**Partial**
2. Tender Waiver Register	A routine assurance report containing details of all instances where competitive tendering requirements had been waived during the period 1 July to 31 December 2022 was examined and members were assured that all waivers had been appropriately applied.	**Substantial**
3. Use of Emergency Powers	The Committee reviewed the one urgent decision that had been undertaken since the last meeting and confirmed that the use of emergency powers had been appropriate.	**Substantial**
4. Annual Fraud Risk Assessment	Members received a report on the outcome of the annual fraud risk assessment. This was a process driven by the requirements set out by the NHS Counter Fraud Authority. It provided a list of the ICB's potential fraud risks, their ratings, potential impact, and the controls and mitigations in place to prevent each potential risk from	**Substantial**

Item	Summary	Level of assurance
	materialising. The outcome of this piece of work would in turn help to inform the ICB's annual Counter Fraud Plan for 2023/24.	

Other considerations:

Decisions made:
The Committee approved an amendment to the Internal Audit Plan for 2022/23 to move two audits into the 2023/24 plan.
Matters of interest:
• An update on evolving system risk management arrangements was provided. • Members received an update on progress of the Internal Audit Plan 2022/23. Stage one of the Head of Internal Audit Opinion work had concluded, and no issues had been identified. Five reviews were in progress, the draft terms of reference for one review had been issued and the three remaining reviews were at the planning stage. Members sought and received assurance that all reviews within the current plan would be completed by the set timescales. The External Audit Plans for the final three-month period of the former Bassetlaw CCG and Nottingham and Nottinghamshire CCG were presented for noting.

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** 20 (I4 x L5)	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 23	If Nottingham University Hospitals NHS Trust (NUH) do not have the capability to make improvements in a timely manner following CQC recommendations, the quality of maternity services will result in poor patient experience, adverse clinical outcomes and/or patient safety issues for the population of Nottingham and Nottinghamshire.	**High** 20 (I5 x L4)	Quality and People Committee
ORR 69	If the system does not have sufficient workforce to supply high-quality maternity services at across the three NHS providers, there may be 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.	**High** 20 (I5 x L4)	Quality and People Committee
ORR 06	If demand and capacity constraints for non-elective (urgent and emergency care) activity stay at their current level or increase further, there is a risk that incidents of actual harm may continue to occur across the non-elective (emergency) pathway. This 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

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

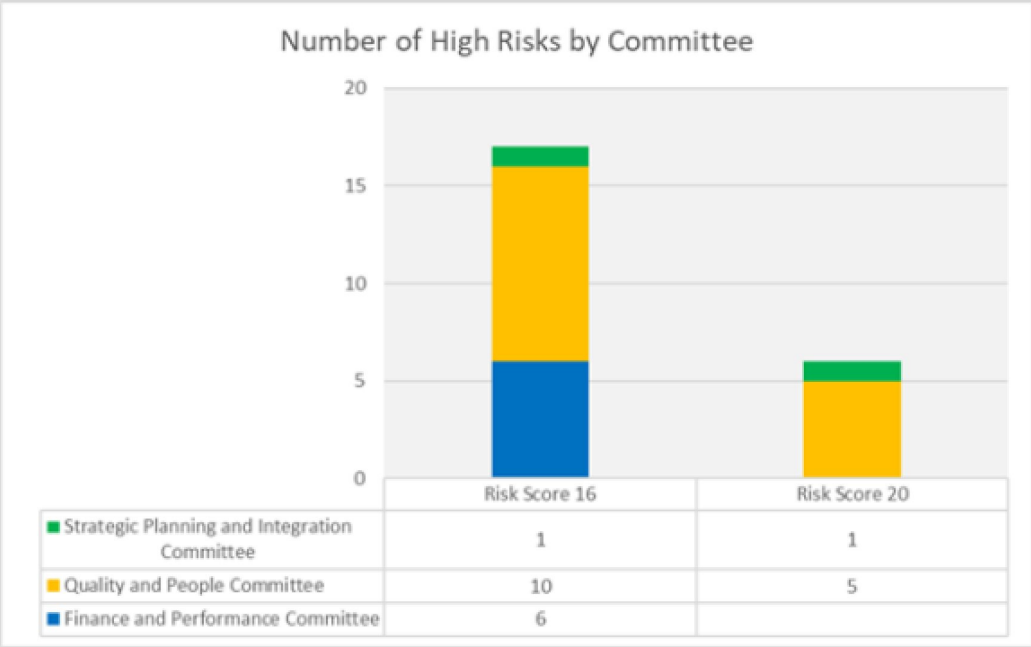
Risk Ref.	Risk Description	Current Score	Responsible Committee
ORR 03	If sustained levels of significant pressure on primary care continues due to high levels of demand for services there is risk of staff sickness, exhaustion and 'burn out'. This may also impact workforce retention.	**High** 16 (I4 x 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 may also impact the system's ability to meet national performance requirements to; eliminate waits of over 104 weeks by July 2022, eliminate waits of over 78 weeks by the end of March 2023 and sustain an improving position through 23/24.	**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 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** 16 (I4 x L4)	Quality and People Committee
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

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

Risk Ref.	Risk Description	Current Score	Responsible 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 within the 2022/23 financial plan, there is risk that the system will come under further regulation by NHSE. 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.	**High** 16 (I4 x L4)	Finance and Performance Committee
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

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

Risk Ref.	Risk Description	Current Score	Responsible 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



NHS
Nottingham and Nottinghamshire
Integrated Care Board

Annual Equality Assurance Report

February 2023

Contents

This document can be made available in:

- Large print
- Other languages

Please contact the ICB's Communications and Engagement Team.

Website: http://notts.icb.nhs.uk

Email: nnicb-nn.comms@nhs.net

1. Welcome

NHS Nottingham and Nottinghamshire Integrated Care Board (the ICB), was established on 1 July 2022, replacing the previous Clinical Commissioning Groups (CCG) Nottingham and Nottinghamshire CCG and Bassetlaw CCG. This is our first report of the ICB in relation to our Public Sector Equality Duty (PSED).

The ICB recognises and values the diverse needs of the population we serve, and we are committed to embedding equality, inclusion, and human rights considerations into all aspects of our work, including policy development, commissioning processes and employment practices.

Our Equality, Diversity and Inclusion Policy has been reviewed and updated and the fundamental aims of the ICB around equality, diversity, inclusion, and human rights are:

- Improve equality of access to health services and health outcomes of the diverse populations we serve.
- Build and maintain a diverse, culturally competent workforce, supported by an inclusive leadership team.
- Create and maintain an environment where dignity, understanding and mutual respect, free from prejudice and discrimination, is experienced by all, and where patients and staff feel able to challenge discrimination and unacceptable behaviours.

We understand the following regarding equality, diversity, and inclusion:

Equality: ensuring equitable access to opportunities for all, and that no-one should have poor life chances because of the way they were born, where they come from, what they believe, or whether they have a disability.

Diversity: recognition of difference, and the important role difference plays in a culturally competent, respectful, and dynamic organisation.

Inclusion: a feeling of belonging, purpose and being valued as part of the ICB's team. A diverse team doesn't automatically create an inclusive team.

This report sets out the ICB's commitment to equality, diversity, inclusion, and human rights.

In it we will summarise:

- The ICB Equality Duties.
- The Role of ICB as an integral part of the wider Integrated Care System
- How the ICB has embedded equality, diversity, inclusion, human rights, and health inequality considerations in its governance arrangements.
- How the ICB's policy development, commissioning processes and employment practices have due regard to equality.
- How the ICB supports its staff to work in culturally competent ways.
- How the ICB measures and plans to improve our equality performance.

The ICB is making progress in improving our equality performance, and this report demonstrates some specific examples of that progress. It is clear, however, there is still much more that we can do, and we will continue to listen and learn from our diverse communities and workforce.

Amanda Sullivan (she/her)

Chief Executive

Rosa Waddingham (she/her)

Director of Nursing and Executive Lead for EDI

2. Our Organisation

Nottingham and Nottinghamshire Integrated Care Board is responsible for allocating public money as well as planning and delivering a wide range of health and care services the 1.1 million people in Nottingham and Nottinghamshire.

We use our combined resources to tackle some of the biggest health issues affecting local people across Nottingham and Nottinghamshire.

We aim to provide continuing healthcare to keep people well, prevent ill-health and support people to thrive and live healthier lives.

Our ambition – over the next few years – is to make a real difference to citizens' health and wellbeing, quality of service delivery and use of resources, building on what is working well and to act as one system, rather than a collection of organisations.

3. Our Equality Duties

The Equality Act 2010 provides a single legal framework to protect people from discrimination, harassment, and victimisation in the workplace and in wider society. The Public Sector Equality Duty (PSED) – Section 149 of the Equality Act 2010 – applies to public authorities, which includes the ICB, and it consists of a general equality duty supported by specific duties that are imposed by secondary legislation. The general equality duty requires public bodies to have "due regard" to the following three aims:

1. To eliminate discrimination, harassment, victimisation, and any other conduct prohibited by the Equality Act 2010.
2. To advance equality of opportunity between people who share a relevant protected characteristic and those who do not.
3. To foster good relations between people who share a relevant protected characteristic and those who do not.

Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 require relevant public bodies to:

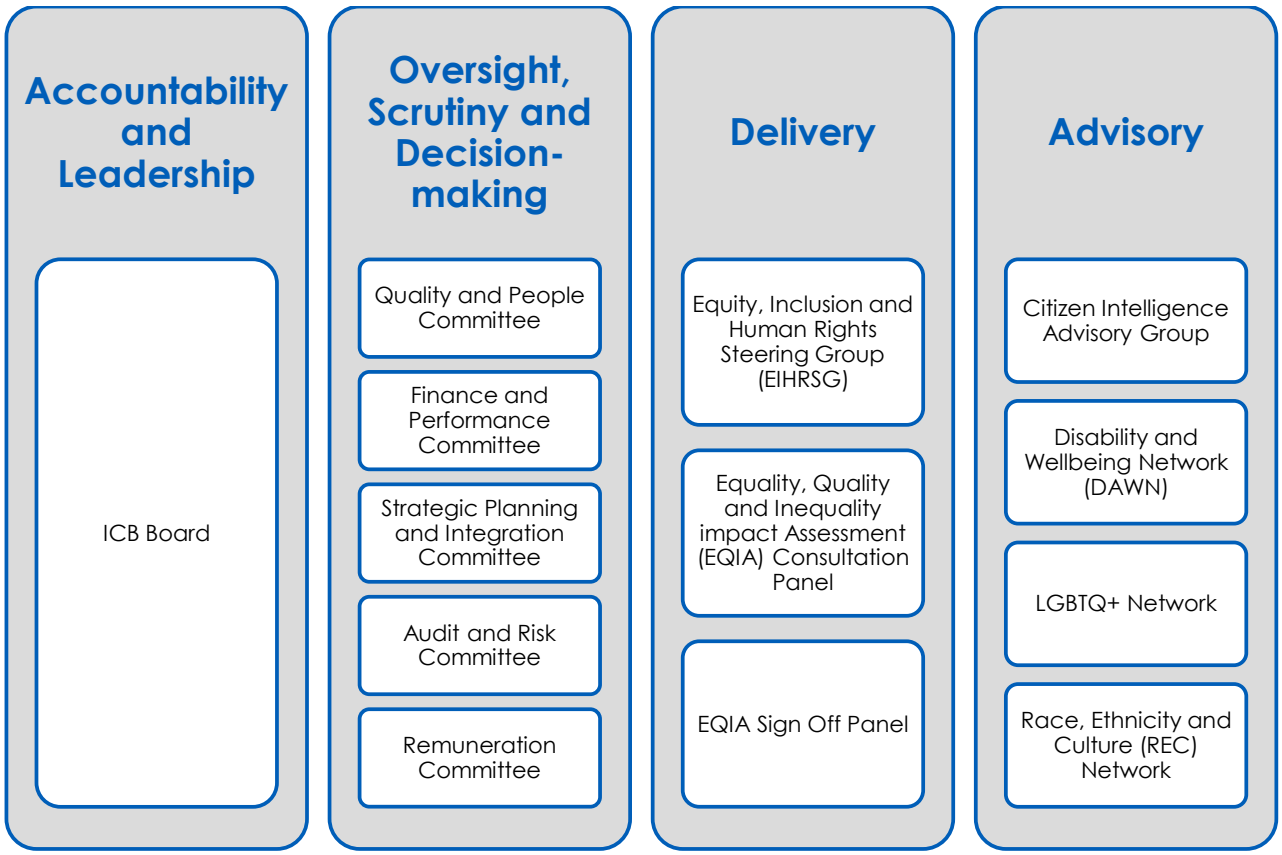
- Publish equality information annually to demonstrate compliance with the general equality duty.
- Prepare and publish one or more equality objectives at least every four years. The ICB has objectives that are incorporated into the EDI workplan.
- Publish information to demonstrate how large the pay gap is between their male and
- female employees (for organisations with 250 or more employees).

The ICB has a duty to not only consider the impact health services have on the nine protected characteristics in the Equality Act 2010, but also on a broader number of disadvantaged groups. The ICB also considers groups and communities that face particular challenges, often linked to intersectional disadvantage.

More detail on the legislative framework for equality is provided in Appendix A.

4. Our infrastructure for equality, diversity, inclusion, and human rights

As a newly formed ICB, much of the early part of 2022/2023 was focussed on establishing an appropriate infrastructure for equality, diversity, inclusion and human rights within the organisation. This infrastructure is illustrated and described below.



All ICB Board members have a collective and individual responsibility for ensuring compliance with the PSED. This secures the delivery of successful equality outcomes for the organisation, both as a commissioner and an employer. The Board is required to provide strategic leadership to the equality, diversity and inclusion programme of work. In part this is achieved through the ICB's Equality, Diversity and Inclusion Policy, and through the agreed objectives and plans for improving its equality performance. The Board will ensure equality, diversity, inclusion, and human rights considerations are a core consideration in the Board's and committees' discussions and decision making.

The **Quality and People Committee** is responsible for monitoring the ICB's equality performance in relation to its role as a commission of health services. This includes monitoring the delivery of the ICB's equality improvement plans.

The **Human Resources Sub-Committee** is responsible for monitoring the ICB's quality performance in relation to its role as an employer. This includes monitoring the delivery of the ICB's equality improvement plan in relation to recruitment, training and development, cultural competence, and staff experience.

The **Strategic Planning and Integration Committee** is responsible for making investment, disinvestment, and resource allocation decision. As part of this responsibility, the Committee ensures that appropriate equality impact assessments have been completed and their findings considered. This includes consideration of the collective impact of previous decisions and current and future proposals.

The **Remuneration Committee** is responsible for overseeing compliance with the gender pay gap requirements set out in the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017. This Committee also oversees the executive-led Human Resources Sub-committee which focusses on our role as an employer of around 550 people.

The ICB **Equity, Inclusion and Human Rights Steering Group (EIHRSG)** oversees the development and delivery of the equality, diversity, inclusion and human rights programme within the ICB. The EIHRSG embeds equality, diversity, inclusion and human rights considerations into the ICB's key business activities, assesses the ICB's equality performance, develops and implements equality improvement plans, develops the ICB's equality objectives, and prepares the ICB's annual Equality Assurance Report. The EIHRSG is Chaired by the ICB's Chief Nurse, as Executive Lead for EDI. Its membership includes senior representatives from all key business activities, the Chairs of the ICB's Staff Equality Networks, and Patient Experience teams.

Staff Networks have been established within the ICB:

- Disability And Wellbeing Network (DAWN)
- LGBTQ+ Network
- Race, Ethnicity and Culture (REC) Network

The networks are staff-led and formulate their own agendas. Networks provide a safe space for staff to discuss their lived experiences, or those of their family, friends or wider communities and networks, with the aim of ensuring an inclusive and diverse working environment for all staff, free from discrimination, judgement and disrespect. The ICB sees the network's as:

- Key advisory forums to support the wider work of the ICB as an employer, and as a commission of health services through the provision of shared insights
- Constructive challengers to existing ways of working
- Coproducers of equality initiatives and improvement plans

The Chairperson from each network is a member of the Equity, Inclusion and Human Rights Steering Group, and meets monthly as a group of Chairs with the Chair of the EIHRSG. This is the escalation route for concerns, challenge and feedback from the networks to senior leaders in the ICB.

The **Citizen Intelligence Advisory Group** acts in an advisory capacity to the Board, its committees, and other operational delivery forums within the ICB. Its membership comprises of people with lived experience and third sector representation to help bring the voice of specific population groups to the work of the ICB. The Committee provides advice and guidance on approaches to patient and public engagement, and reviews how engagement has been used to influence decisions made by the ICB. The Committee supports the ICB's equality, diversity, inclusion and human rights programme of work through the provision of shared insights and the codesign of equality initiatives and improvement plans.

5. Having “due regard” to Equality

The Public Sector Equality Duty (PSED) – Section 149 of the Equality Act 2010 –requires public bodies to have “due regard” to three aims, and broad purpose of the general equality duty is to integrate consideration of equality and good relations into the day-to-day business of public authorities recognising that not doing so can contribute to greater inequality and poorer outcomes for people. The general equality duty therefore requires organisations like the ICB to consider how they can proactively contribute to the advancement of equality and good relations. It requires equality considerations to be reflected into the design of policies and the delivery of services.

The ICB must give proper consideration – or “due regard” – to removing or minimising disadvantage, tackling prejudice and promoting understanding, and taking steps to meet people’s needs. The then CCG undertook an assessment in 2020/21 of their functions, both as a commissioner of health services and as an employer. Focussing on these key business activities has allowed us to prioritise efforts to ensure compliance with the general equality duty.

Assessing the health needs of our population

For the ICB to make the best decision for our population and communities, we must understand the health and care needs of people living across Nottingham and Nottinghamshire. Joint Strategic Needs Assessments (JSNAs) provide the ICB with key information about the health and wellbeing of our local populations. These demographics vary significantly between the City and County districts, including by age, race, disability and levels of social and economic deprivation. The ICB uses this information to help make decisions about what services we should commission, and who should provide them, to:

- Benefit the widest number of people.
- Reduces health inequalities.
- Increase healthy life expectancy (the number of years people live in ‘good health’)
- Support our communities to live as fulfilled life as they want

The ICB works closely with its partners across the ICS, and in particular the City and Country Councils, and the Local Authority Public Health colleagues, to ensure that JSNA chapters consider all protected characteristics and other disadvantaged groups to accurately inform equality considerations in the ICBs commissioning intentions.

Equity has been adopted as the core principle in the ICS Health Inequalities Plan, this provides an approach that recognises that a “one size fits all” method for services can exclude certain groups of people and recognises that we need to use our resources in different ways to help include those who may experience barriers to accessing services.

Promoting research and use of research evidence

Research is a core function of health and care and is essential for continual improvement in health, wellbeing, high quality joined up care and reducing tackling health inequalities. As an ICB, we have a statutory duty to facilitate or otherwise promote research and to promote the use of evidence obtained from research. In delivering these duties, we are focussing our efforts on equity of access to research opportunities, promoting research being delivered in locations where patient

need is greatest and in involving patients and the public from more diverse and underserved communities.

During the year the ICB funded with partners, an exploratory research study relating to the experience of Severe and Multiple Disadvantage (SMD) in ethnically diverse communities in Nottingham City. There is currently a gap in evidence relating to inequalities in outcome and access to services for this underserved population. The research study will report in the Autumn of 2023 and will inform the Changing Futures Programme in Nottingham City and strategic planning for personalised and integrated models of care for this population.

Equality, Quality and Inequality impact Assessments (EQIA)

The completion of Equality, Quality and Inequality impact Assessments (EQIA) is central to the ICB being transparent and accountable in its decisions. Equality analysis ensures the ICB do not disadvantage people from protected characteristic groups, and other disadvantaged communities, by the way it commissions and changes health services, or through our employment practices. The EQIA process is also a way of ensuring that any negative impacts or consequences are minimised or eliminated, and opportunities for promoting equity, inclusion and human rights are maximised.

The ICB has two versions of EQIAs:

1. Equality, Quality and Inequality impact Assessments (EQIA) – these are completed for all commissioning decisions.
2. Equality Impact Assessments (EIA) – these are completed for internal decisions within the ICB, for example, policy, procedure and strategy decisions, or organisational redesign)

EQIAs and EIAs incorporate wide considerations outside of protected characteristics. This includes:

- Safeguarding
- Community cohesion and social inclusion
- Human rights
- Other communities and groups at risk of significant disadvantage, for example, people who are homeless, care leavers and victims and survivors of domestic violence

Equality, Quality and Inequality impact Assessments also include elements linked to the quality of services and how services will address health inequalities. These include:

- Patient safety
- Clinical effectiveness
- Patient experience
- Impacted neighbourhoods, places and communities
- Data Protection Impact Assessment
- The positive or negative impacts of the current provision versus the proposed provision

EQIAs and EIAs are treated as ‘live documents’ and are revisited throughout the development and decision-making process, and afterwards to assess ongoing effectiveness. EQIAs and EIAs should always be revisited following any public, patient or staff consultation to ensure the views of these groups are reflected and considered.

One of the key objectives for the ICB is to review the EQIA and EIA processes, taking into consideration the following aspects:

- Ensure the information gathered is beneficial to the decision-making process.
- Ensure information is gathered consistently, cohesively, and concisely to support the decision-making process.
- The EQIA and EIA processes are as simple and streamlined as possible to reduce the impact on teams' time needed to complete them.
- The EQIA process is reflective of the services being commissioned, for example, adult services, children and young people's services, or service for all age ranges.
- EQIAs and EIAs reflect wider considerations outside of protected characteristics of the Equality Act 2010.

The ICB has two check points for Equality, Quality and Inequality impact Assessments (EQIA). The first is the **EQIA Consultation Panel**, and finally the **EQIA Sign Off Panel**. Both are designed to ensure that commissioning decisions do not negatively impact or disadvantage people from protected characteristic communities or other groups at risk of disadvantage.

The EQIA Consultation Panel is Chaired by the ICB's Head of Equality Diversity and Inclusion, and has a membership consisting of colleagues from quality, health inequalities and safeguarding teams. The role of the EQIA Consultation Panel is to provide constructive challenge to colleagues around the commissioning of services and ensure that services do not deliberately or inadvertently disadvantage a group of people.

The EQIA Sign Off Panel is Chaired by the Assistant Director of Nursing for Safeguarding, and its membership consists of the Head of Equality Diversity and Inclusion, plus Assistant and Deputy Directors of Nursing. The remit of the Sign Off Panel is to ensure the required changes have been made following Consultation Panel, and to provide a final sign off before service change. The Sign Off Panel also has a role in assessing the overall quality of EQIAs, and to provide report on the quality to the Equity, Inclusion and Human Rights Steering Group.

Public engagement and communications

We want to have a real understanding of what matters to our population and are committed to ensuring that the views of patients, carers, stakeholders, partner organisations and the wider community are represented in decisions about how services are proposed, planned and delivered, and how they can be improved.

We involve patients and the public in our work in several ways which include:

- Targeted programmes of engagement
- Formal public consultations when there is a substantial variation or development in a service

- Patient Participation Groups which involve patients about the range and quality of services provided by their GP practice and how commissioners plan services
- Annual general meetings (AGMs)
- Community engagement events
- Conversations via our social media channels.
- Citizen's Panel
- Co-production programmes

We engage with people from all protected characteristic groups (and other disadvantaged groups) in our population, particularly those whose voices may not be routinely heard, through a range of different mechanisms to ensure that we have the right information to commission the right health services that can be accessed by the people who need them. We publish reports from all our engagement and consultation activities on our website.[1]

We engage with people from all protected characteristic groups (and other disadvantaged groups) in our population, particularly those whose voices may not be routinely heard, through a range of different mechanisms to ensure that we have the right information to commission the right health services that can be accessed by the people who need them. The ICB uses three main forums to do this

1. Citizen Intelligence Advisory Group- ensures that all proposals to change and improve healthcare services in Nottingham and Nottinghamshire are developed with appropriate and sufficient citizen and service user involvement and citizen intelligence and insights from patients, staff, carers and public that tell us what matters to them are taken on board and have influenced decision making.
2. Engagement Practitioners Forum - provides 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.
3. Voluntary and Community and Social Enterprise Alliance - who have strong links with groups and communities, including those who are underserved and experiencing the greatest health inequalities. The VCSE Alliance are a group of VCSE organisations across Nottingham and Nottinghamshire that can act as a single point of contact to enable the generation of citizen intelligence from the groups and communities that they work with.

Safeguarding adults and children

We have a statutory responsibility to safeguard the welfare of adults at risk across Nottingham and Nottinghamshire. This means protecting an adult's right to live in safety, free from abuse and neglect. We also have a statutory duty to promote the safety and welfare of children.

Safeguarding has a very broad remit and much has been achieved to ensure that adults and children/young people in Nottingham and Nottinghamshire are safe and protected from harm.

[1] https://notts.icb.nhs.uk/get-involved/current-and-previous-engagement-consultations/

We continue to be committed to maintaining safe and effective safeguarding services and strengthening safeguarding arrangements across Nottingham and Nottinghamshire, working in partnership with colleagues across health and social care. Further information on our work to safeguard adults and children can be found on our website[2].

The ICB is also committed to working in partnership across the system to reduce health inequalities and improve outcomes for children and young people (0–25-year-olds) with Special Educational Needs and Disabilities (SEND) who access services. We work collaboratively as part of an integrated system to commission services to support the needs of children and young people and their families with SEND and to meet the statutory duties under the Children and Families Act 2014. More information on our work in relation to SEND is available on our website[3].

Whilst the ICB does not meet the requirements for producing an annual Slavery and Human Trafficking Statement (as set out in the Modern Slavery Act 2015), our Board fully supports the Government's objectives to eradicate modern slavery and human trafficking. As such, the Board has agreed to demonstrate its commitment to the Act and has produced a position statement, which is published on our website[4].

Learning Disabilities Mortality Review (LeDeR) Programme

People with a learning disability often have poorer physical and mental health than other people and may face barriers to accessing health and care to keep them healthy. Too many people with a learning disability are dying earlier than they should, many from things that could have been treated or prevented.

By finding out more about why people died we can understand what needs to be changed to make a difference to people's lives. We do this by;

- Delivering local service improvement, learning from LeDeR reviews about good quality care and areas requiring improvement.
- Driving local service improvements based on themes emerging from LeDeR reviews
- Influencing national service improvements by linking in with partners around themes commonly arising from the analysis of LeDeR reviews.

We work with partners to ensure that LeDeR reviews are completed, and actions are implemented to improve the quality of services for people with a learning disability and autistic people to reduce health inequalities and premature mortality. Details about this are published in the LeDeR annual report[5].

Procurement and contract management

[2] Safeguarding - NHS Nottingham and Nottinghamshire ICB
[3] Special Education Needs and/or Disability (SEND) - NHS Nottingham and Nottinghamshire ICB
[4] https://notts.icb.nhs.uk/about-us/safeguarding/equality-inclusion-and-human-rights/
[5] https://notts.icb.nhs.uk/about-us/our-priorities/annual-reports-and-accounts/

An assessment of compliance with equality legislation is required as a routine aspect of all procurement exercises. The NHS Standard Contract, in its full-length version, mandates providers of NHS services implement the following:

- The **NHS Equality Delivery System (EDS)** – the NHS Equality and Diversity Council development the EDS as a tool to enable NHS organisations to review and rate their equality performance. The EDS has been through various updates and iterations, with the latest being EDS 2022.
- The **Accessible Information Standard (AIS)** – AIS is an approach to identifying, recording, sharing, and meeting the information and communications needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.
- The **Workforce Race Equality Standard (WRES)** – WRES requires NHS services to demonstrate progress against nine indicators of workforce equality for the black, Asian and minority ethnic people. This includes recruitment, trainings opportunities, harassment and bullying, and levels of Board representation.
- The **Workplace Disability Equality Standard (WDES)** – WDES sets out 10 specific metrics that enable NHS services to compare the workplace and career experiences of disabled and non-disabled staff.
- The **Gender Pay Gap** All public sector organisations with over 250 people are required under the Equality Act 2010 to publish Gender Pay Gap information on an annual basis (in March of each year).

A range of assurances on compliance with the above requirements are incorporated within the ICB's quality monitoring processes.

Recruitment, staff development and the working environment

We are committed to being a fair and inclusive employer, as well as maintaining a working environment that promotes the health and wellbeing of our employees.

We have therefore taken positive steps to ensure that our policies deal with equality implications relating to recruitment and selection, pay and benefits, flexible working hours, training and development, and that we have policies around managing employees and protecting employees from harassment, victimisation and discrimination. This includes working to the requirements of the NHS Workforce Race Equality Standard (WRES) and the NHS Workforce Disability Equality Standard (WDES), which aim to ensure that employees from black, Asian and minority ethnic (BAME) backgrounds and those that identify as disabled have equal access to career opportunities and receive fair treatment in the workplace.

We are working towards accreditation as part of the Disability Confident employer scheme, which encourages us to think differently about disability and take action to improve how we recruit, retain and develop disabled people. As part of this, we operate a Guaranteed Interview Scheme, which ensures an interview for any candidate with a disclosed disability whose application meets all the essential criteria for the post.

We are reviewing our recruitment practices in line with the 'No More Tick Boxes' report, with a view to changes policy and processes to support the recruitment of a more diverse workforce.

All ICB staff are responsible for treating everyone with dignity and respect and must not discriminate or encourage others to discriminate.

A library of information, and support, has also been made available to our staff via our Employee Assistance Programme. Early actions arising from our Staff Networks during the year have included:

- The development of an Equality Champions Framework (including Cultural Ambassadors, aimed at reducing inequalities in disciplinary and recruitment processes, and Equality Advocates, aimed at improving staff experience and access to support, and increasing confidence in challenging discrimination)
- The introduction of Mental Health First Aiders.

Key areas of progress and action

The ICB is committed to the journey of being a system exemplar as to what an equitable, inclusive, and human rights driven organisation looks like.

The ICB now has an established EDI lead that supports the organisation to deliver on its statutory duties as well as participating as an active stakeholder within the ICS. The Staff networks continue to develop and be embedded within the organisation.

The EQIA processes is now a well-established process within commissioning and quality teams providing a consistent structure to assess the quality and inclusivity of service provision.

We are working towards developing the ICB's first Anti-racism Strategy during 2023/2024. This will provide the ICB with clear and achievable actions to move from its current position of being 'not racist' to being truly 'anti-racist', and work with system partners to become an anti-racist system.

We are working closely with the ICS's Sexual Orientation and Gender Identify (SOGI) Steering Group to develop an ICS-wide standard for gender inclusivity. This work will start in 2023/2024 and will likely take several years to develop, implement, and review the impact, but will be a key part of being an inclusive organisation and system.

In addition, work is ongoing on multiple other areas linked to equality, inclusion, and human rights to help the ICB achieve its equality objectives. Some of these areas include:

- Creating a **Disability Inclusion Strategy** for the ICB.
- Reviewing support for colleagues experiencing **menopause**.
- Ensure fair and equitable opportunities for **disabled people** within the ICB.
- Developing a more robust **recruitment process** with equity, inclusion, and human rights at its centre.
- Reviewing the **accessibility of our workspaces for neurodivergent people**.
- The **development of Toolkits** to support all colleagues around multiple areas of EDI and human rights.
- Supporting with key **ICS-wide projects and reviews**, for example, Tomorrow's NUH, Maternity Reviews, and Fertility Treatment Policy Review.

6. Meeting specific equity duties

Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 require relevant public bodies to:

- **Publish equality information annually to demonstrate compliance with the general equality duty.**

  This information is published on the ICB Website annually.

- **Prepare and publish one or more equality objectives at least every four years.**

The ICB has objectives that are incorporated into the EDI workplan. This is monitored by the Equity Inclusion and Human Rights Steering Group (EIHRSG) which reports to the Quality & People Committee.

- **Publish information to demonstrate how large the pay gap is between their male and female employees (for organisations with 250 or more employees).**

All public sector organisations with over 250 people are required under the Equality Act 2010 to publish Gender Pay Gap information on an annual basis (in March of each year). The ICB will publish its first return in March 2023 for the year April 2022 to March 2023. Previously, the CCG has published Gender Pay Gap information.

The data as submitted for the 2021/22 year is included in Appendix B, however Bassetlaw staff are not included in these figures, and 2022/23 data is which would reflect the ICBs position as a new organisation, is not available at the time of this report.

The ICB recognises that there is further work to do to ensure a more equitable representation (compared to the overall workforce) in all Pay Quarters and is committed to doing this and to closing the Gender Pay Gap between in the ICB.

7. Our equality objectives

Equality Duties require the ICB to publish equality objectives. These are needed to help the ICB focus on the priority equality issues, and deliver improvements in policymaking, service delivery and employment practices.

The ICB has the following three Equality Objectives, which have been adopted from those developed previously through an extensive baseline review.

1. Improve access and outcomes for patients and communities who experience disadvantage and inequalities.
2. Improve workforce diversity at all levels within the ICB to be reflective of the communities we serve, with a specific focus on ethnicity, disability and sexual orientation.
3. Improve the cultural competence of our workforce and empower our staff to support us in improving equality, acceptance, and inclusion in our organisation.

To ensure that the ICB continues to progress and achieve the Equality Objectives named here, an Action Plan is being developed through the EIHR Steering Group and will be brought to and monitored through the Quality and People Committee.

Appendix A – Summary of the legislative framework for equality

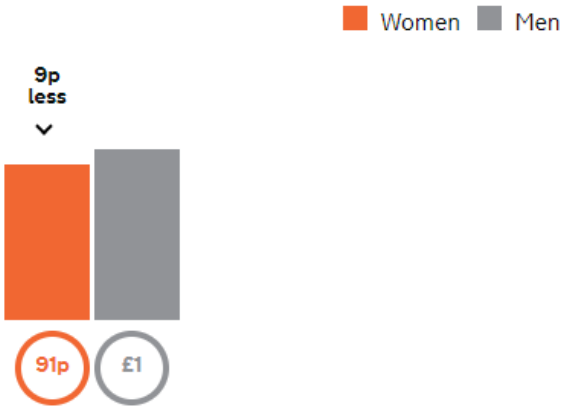
Equality Act 2010 – Nine protected characteristics:	**Age**	**Disability**	**Gender reassignment**
	Marriage and civil partnership	**Pregnancy and maternity**	**Race**
	Religion or belief	**Sex**	**Sexual orientation**
Equality Act 2010 – Types of discrimination:	**Direct discrimination** – treating someone with a protected characteristic less favourably than others		
	Indirect discrimination – putting rules or arrangements in place that apply to everyone, but that put someone with a protected characteristic at an unfair disadvantage		
	Harassment – unwanted behaviour linked to a protected characteristic that violates someone's dignity or creates an offensive environment for them		
	Victimisation – treating someone unfairly because they've complained about discrimination or harassment		
Equality Act 2010 – Further considerations	Within each protected characteristic group, the **risk of discrimination** is greater for some people than others.		
	Intersectionality – different types of 'identity' overlap for some people, which can shape unique experiences of discrimination.		
	The protected characteristic of **disability** includes a wide range of physical and sensory impairments, learning disabilities, mental health conditions and long-term conditions.		
	The needs of people from **other disadvantaged groups** (or 'Inclusion Health' groups) also need to be considered (e.g. vulnerable migrants, homeless people).		
General Equality Duty – Requires public bodies to have 'due regard' to the following three aims:	To **eliminate discrimination**, harassment, victimisation and any other conduct prohibited by the Act.		
	To **advance equality of opportunity** between people who share a relevant protected characteristic and those who don't.		
	To **foster good relations** between people who share a relevant protected characteristic and those who do not.		
Having '**due regard**' involves:	Removing or minimising disadvantages suffered by people due to their protected characteristics.		
	Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.		
	Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.		
Fostering good relations is described as:	Tackling prejudice and promoting understanding between people from different groups.		
Specific Equality Duties – Require public bodies to:	**Publish information** demonstrating compliance with the general equality duty – on an annual basis.		
	Prepare and publish one or more **equality objectives** – at least every four years.		

	Publish information to demonstrate how large the **pay gap** is between their male and female employees – on an annual basis.

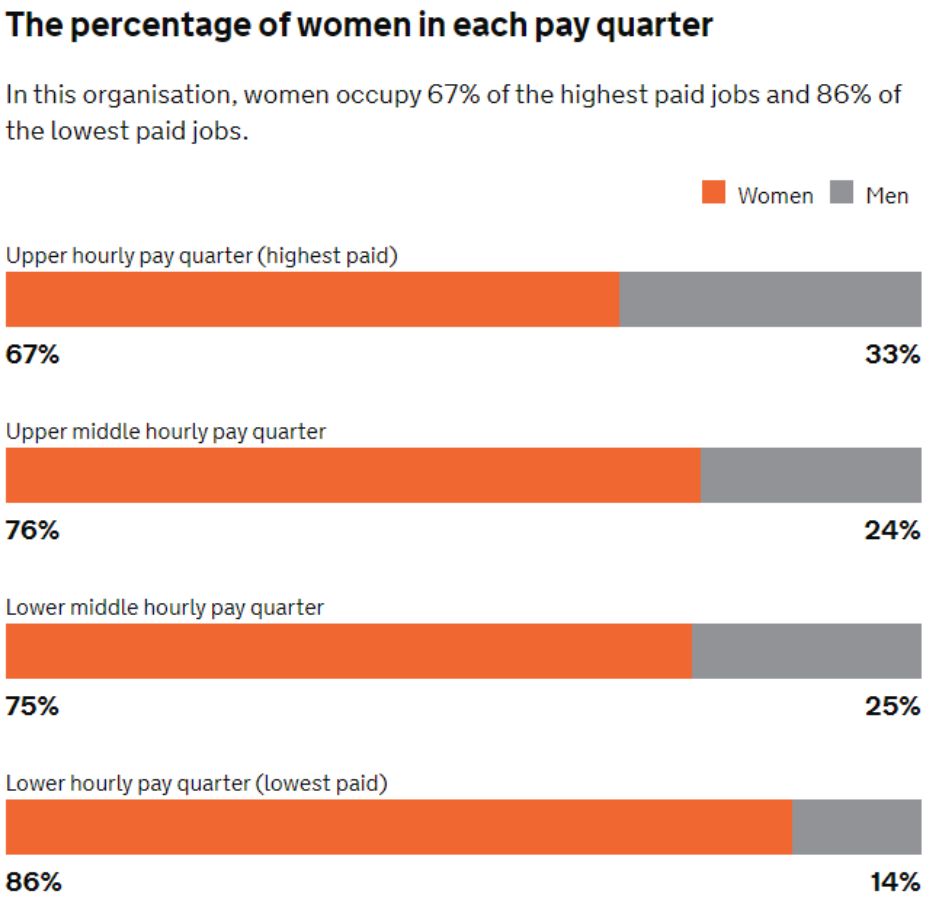
Appendix B – Gender Pay Gap

Hourly pay gap

In this organisation, women earn 91p for every £1 that men earn when comparing median hourly pay. Their median hourly pay is 9% lower than men's.



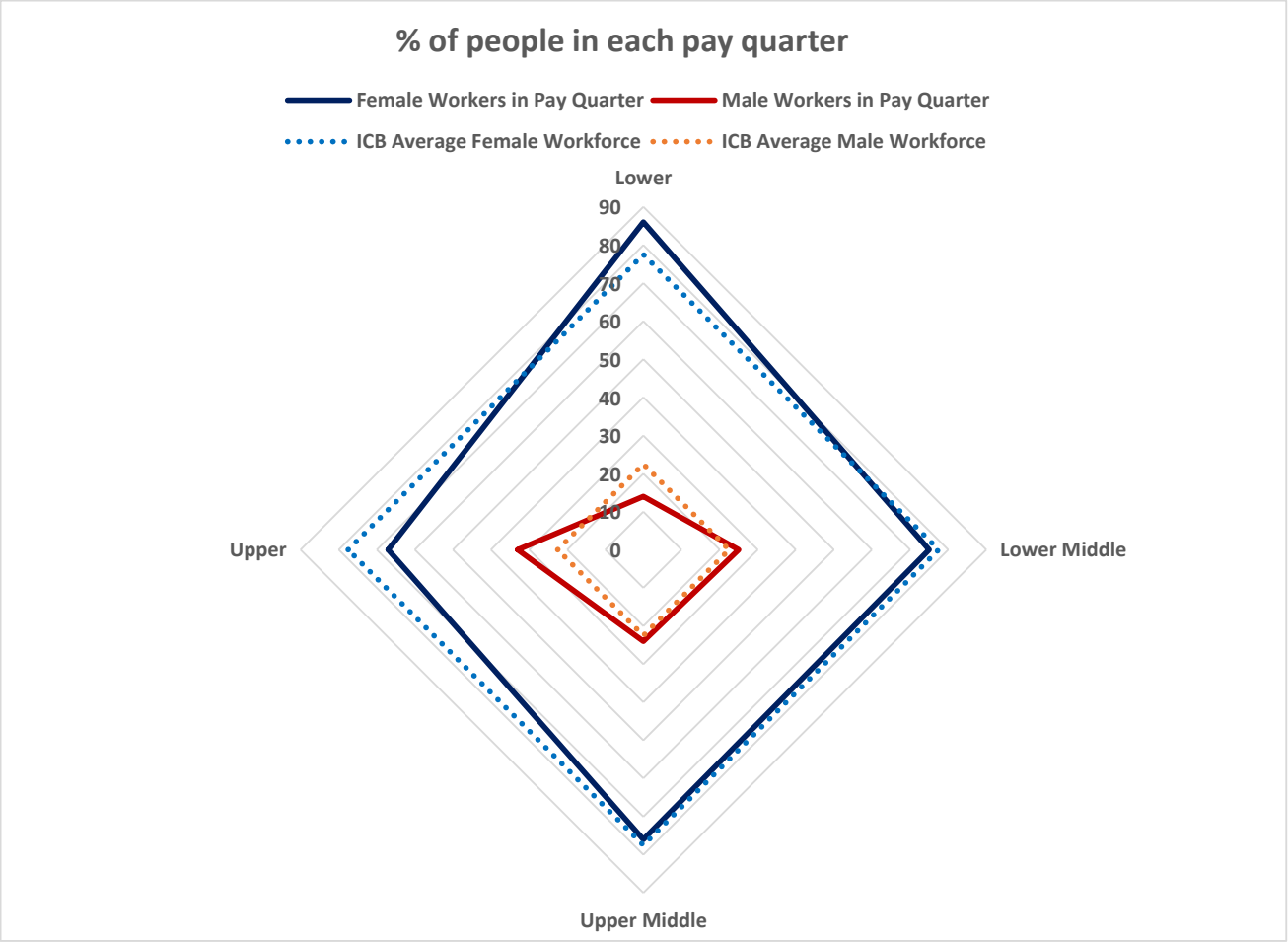
When comparing mean (average) hourly pay, women's mean hourly pay is 26% lower than men's.



The ICB workforce – as detailed in Appendix C – shows that 77.5% of the workforce is female, and 22.5% are male. Within the Lower Middle and Upper Middle Pay Quarters, the ICB has a good representation of women and men, compared to the overall workforce demographics.

In the Lower Pay Quarter, there is an over representation of women by 11.5 percentage points. In the Upper Pay Quarter, there is an under representation of women by 10.5 percentage points.

The ICB has further work to do to ensure a more equitable representation (compared to the overall workforce) in all Pay Quarters. In turn this will help to close the Gender Pay Gap between female and male employees at the ICB.


% of people in each pay quarter
Female Workers in Pay Quarter
Male Workers in Pay Quarter
ICB Average Female Workforce
ICB Average Male Workforce
Lower
90
80
70
60
50
40
30
20
10
0
Upper
Lower Middle
Upper Middle

Description	21-30	31-40	41-50	51-64	Comparator (ICB Overall)
Compassionate Culture sub-score	7.4 ↑	6.9 →	6.9 →	7.1 →	**7**
Compassionate Leadership sub-score	8.3 ↑	7.7 →	7.9 →	7.8 →	**7.8**
Diversity and Equality sub-score	8.9 →	8.4 →	8.5 →	8.8 →	**8.6**
Inclusion sub-score	7.6 →	7.1 →	7.5 →	7.6 →	**7.4**
We are compassionate and inclusive score	**8.1** ↑	**7.5** →	**7.7** →	**7.8** →	**7.7**

Appendix C – Workforce Demographics

Trend Key

- ↑ >3ppt increase
- ↗ 1ppt to 3ppt increase
- → Same or change of +1ppt to -1ppt
- ↘ 1ppt to 3ppt decrease
- ↓ >3ppt decrease

- → Green Arrow = Positive trend
- → Yellow Arrow = Positive trend, but still considerably outside the average
- → Red Arrow = Negative trend
- → Grey Arrow = Neither positive nor negative

Nottinghamshire Comparison Key

<1% of average	Within 1% and 3% of average	>3% difference from average	N/A or No Average

Averages taken from 2021 Census data for Nottingham and Nottinghamshire. Disability data taken from 2018/2019 data set and is a national comparison.

Protected Characteristic		Headcount as at 01/04/2020	Headcount as at 31/03/2021	Headcount as at 31/12/2022	Trend 03/2021 to 12/2022	Notts. Comparison
Age	**16-30** (~18% average in Notts)	8.2%	9.3%	9%	→	
	31-40 (~13% average in Notts)	26.4%	25.5%	23.8%	↘	
	41-50 (~12% average in Notts)	34.3%	31.4%	33.1%	↗	
	51-60 (~14% average in Notts)	26.3%	29.4%	29.3%	→	
	>60 (~25% average in Notts)	4.8%	4.4%	4.8%	→	
Sex	**Male**	23.8%	24.1%	22.5%	↘	-

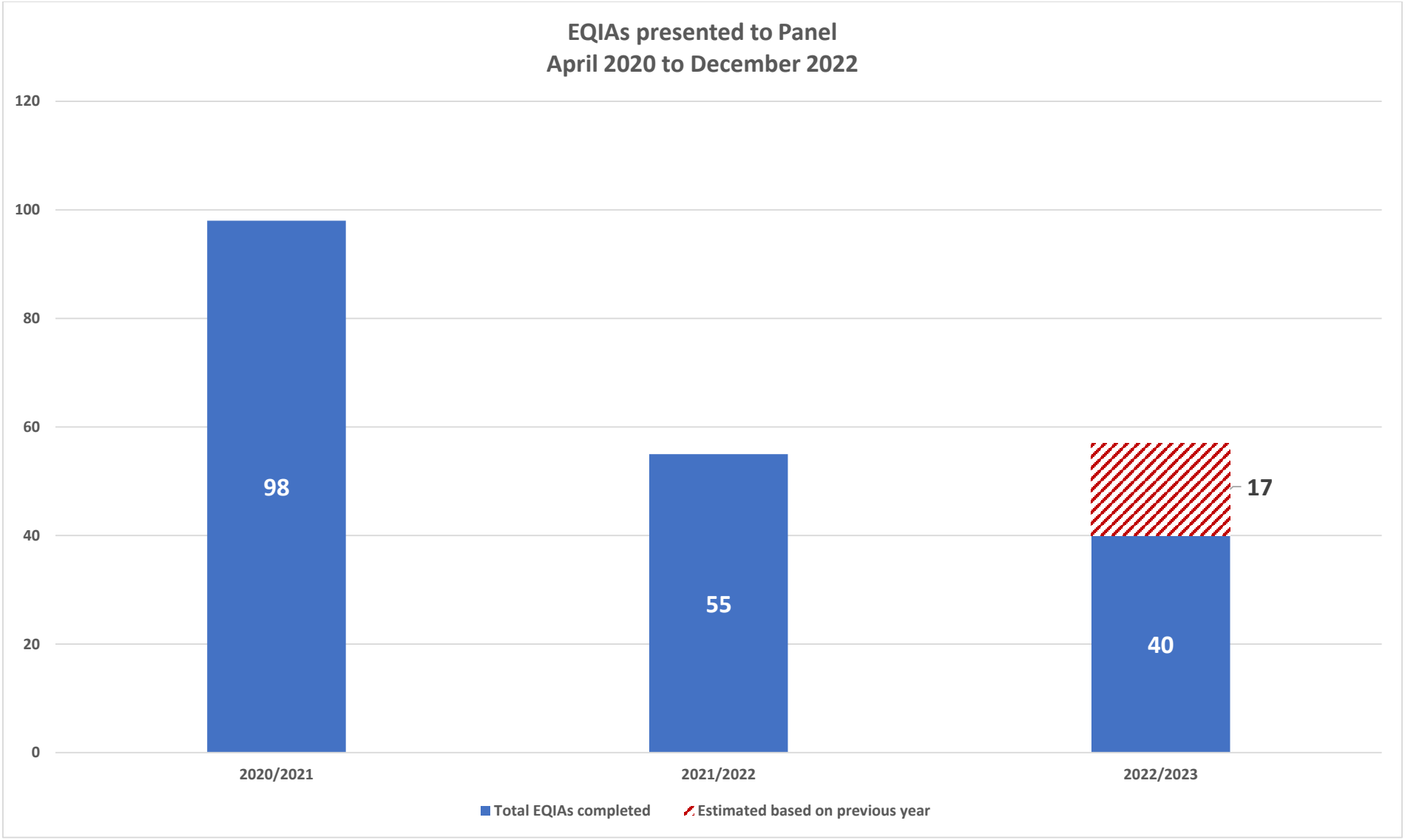
	Female	76.2%	75.9%	77.5%	↗	-
Ethnicity	**White: English, Welsh, Scottish, Northern Irish or British** (~84% average in Notts)	88.6%	89.7%	89.5%	→	
	BME (~16% average in Notts)	8.6%	8.9%	8.9%	→	
	Not declared/stated	2.8%	1.4%	1.6%	→	-
Disability	**Yes** (~23% average for Great Britain)	4.4%	5.2%	5.3%	→	
	No (~77% average for Great Britain)	80.8%	81.1%	84.3%	↑	
	Not declared/stated	14.8%	13.7%	10.4%	↓	-
Sexual Orientation	**Heterosexual** (~90% average in Notts)	70.9%	73.1%	76.7%	↑	*
	Lesbian / Gay / Bisexual / Other (~3% average in Notts)	2.2%	2.4%	3.8%	↗	*
	Not declared/stated (~7% average in Notts)	26.9%	24.5%	19.5%	↓	
Religion and Belief	**Atheism** (~44% average in Notts)	17.0%	18.5%	22.2%	↑	**
	Christianity (~45% average in Notts)	40.7%	40.7%	40%	→	
	Hinduism (~1% average in Notts)	1.0%	1.0%	1.2%	→	
	Islam (~2.7% average in Notts)	1.8%	2.0%	2.3%	→	
	Other (~1.5% average in Notts)	6.0%	6.0%	7%	↗	**
	Not declared/stated (~6% average in Notts)	33.5%	31.8%	27.3%	↓	

* The Heterosexual comparison is RED; however, this is due to a lower number of people declaring their sexual orientation as “straight” or “heterosexual”. Therefore, although RAG rated RED, this isn’t a negative.

** The Atheism comparison is RED; however, this is due to a significantly lower number of people within the ICB declaring their religion as Atheism compared the Nottinghamshire average. Therefore, although RAG rated RED, this isn’t a negative. Additionally, the number of people within the ICB declaring their religion as “other” is significantly higher than the Nottinghamshire average. Therefore, although RAG rated RED, a more diverse workforce is a positive.

Appendix D– Equality Impact Assessments 2021 to 2023

Below is a graph showing the number of EQIAs reported in 2020/21, 2021/22 and 2022/23.



April 2021 to March 2022

Month and Year	EQIA Title
April 2021	Giltbrook Surgery Boundary Change
	Leen View Boundary Change
	Emotional Wellbeing Early Support Training and Consultation Service
June 2021	Arden Tool
	Community Dermatology Service
	Interpretation and Translation Service
	Increasing threshold Faecal Immunochemical Test pts under 40 years
July 2021	Palliative and End of Life Support services and short breaks for CYP
	Emmanuel Horse Direct Award
	Faecal Immunochemical Test (FIT)
	Wheelchair service - Ross Care extension
	Rise Park Surgery Boundary Change
August 2021	Springfield Medical Centre merger with St Albans Practice

Month and Year	EQIA Title
	Continuing Healthcare at Home
	ICELS SCCPO Procurement
	Fernwood Ward Closure
	Acute Home Visiting Service
	Bull Farm Bch of Oakwood Surgery
	Diab Foot Protection Team
	Latent TB service
	Proposed Governance Process MH & LD funding requests
	Options appraisal for Queens Bower Surgery
October 2021	De-escalation of Nottingham City Clinical Management Centre
	E-Cigarettes
	N & N PLT review
	Sherrington Park Medical Practice
	2 Hour urgent care response

Month and Year	EQIA Title
	Post COVID-19 Syndrome Assessment clinics
	Notts Deaf Society - Sign language interpretation service
December 2021	Provision of surgical podiatry
	Greater Nottingham Community gynaecology service
	Pics Gynae Service
	AQP NOUS Non-Obstetric Ultrasound Service
	Newark and Mansfield GP Hubs - GP winter access fund
	Community Ophthalmology and Orthopaedic service
	Hospital Alcohol liaison team
	Newark UTC
	EOL Together Mid Nottinghamshire Alliance
January 2022	Follow up Provision Woodthorpe Hospital Pre-Op contract patients
	MidNotts Micro-suction
	NUES Ophthalmology Pilot at NUH

Month and Year	EQIA Title
	St Albans Boundary change
	Falls Equipment Pilot
	ICS D2A Pathway 1 recurrent funding
	CYP Overnight Short breaks
	The NHS-Galleri Research trial
February 2022	Children's continuing care at home
	N&N NHS Diabetes Prevention Programme Project
March 2022	N&N Diabetes Enhanced Service Specification
	SS Ending Children's Neurodevelopment Support
	Rapid movement Event - D2A pathway move
	SFHT & NUH Post OP Cataract F.Ups
	South Notts PC support to care homes - service continuation
	Friary Enhanced Homelessness Service
	Admiral Nurse pilot

April 2022 to March 2023

Month and Year	EQIA Title
April 2022	CYP Neuro developmental support
	Peri-Diagnostic Dementia support service
	Suicide crisis and self-harm support service across the ICS
	Locked rehabilitation
	Procurement of special allocation scheme for N&N
	Lung cancer hotline pilot
	CHC home care fast track
May 2022	CYP neurodevelopment support
	TeamNet
July 2022	Colorectal HPB
	Staff tobacco dependency offer
	Interpreter and translation review
	Virtual ward

	Sleep Studies (improved referrals)
August 2022	PBSC Care, ED and treatment reviews (CTRs) and LeDeR PBSC
	B1 Temporary closure of ward
	5-year Pulmonary Rehab Plan
	Lower limb wound referral
	Pre-operative diabetes service pilot
	Community Fibro-scan project
	Manor surgery, Beeston - proposed new build
	NHSEI LTP Tobacco reduction schemes
	Joint commissioning of carers services
	Merger of Riverlyn medical centre and Leen View surgery
	Nottingham City TLHC Programme
	CYP Behavioural intensive community support (BICS)
September 2022	Prostitute Outreach workers (POW)
	ARCU - advanced respiratory care unit

October 2022	TIF Elective Hub at NUH city hospital
	Homeless health team
	VHG reduction in branch opening hours
November 2022	Bassetlaw SAS
	Cripps reviewed by QT
December 2022	Social prescribing in ED
	Cripps boundary change
	Rainworth boundary change
	THMP list closure
	IAPT re-procurement
	Red Thread
	Hydration Pilot