NHS
Nottingham and Nottinghamshire

Integrated Care Board Meeting Agenda (Open Session)

Thursday 13 July 2023 09:00 – 11:10

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 *(For Assurance, Decision, Discussion or Information)*	Enc.	Time
Introductory items					
1.	Welcome, introductions and apologies	Kathy McLean	-	-	09:00
2.	Confirmation of quoracy	Kathy McLean	-	-	-
3.	Declaration and management of interests	Kathy McLean	Information	✓	-
4.	Minutes from the meeting held on: 11 May 2023	Kathy McLean	Decision	✓	-
5.	Action log and matters arising from the meeting held on: 11 May 2023	Kathy McLean	Discussion	✓	-
Leadership					
6.	Chair's Report	Kathy McLean	Information	✓	09:05
7.	Chief Executive's Report	Amanda Sullivan	Information	✓	09:15
Health inequalities and outcomes					
8.	Nottingham and Nottinghamshire NHS Joint Forward Plan	Lucy Dadge	Approve	✓	09:35
9.	Nottingham and Nottinghamshire Provider Collaborative at Scale	Claire Culverhouse/ Ifti Majid/ Paul Robinson	Discussion	✓	10:00

Assurance and system oversight

10.	Integrated Performance Report:		Assurance	✓	10:20
	a) Finance	Stuart Poynor			
	b) Service Delivery	Lucy Dadge			
	c) Health Inequalities	Dave Briggs			
	d) Quality	Rosa Waddingham			
	e) Workforce	Rosa Waddingham			
11.	Committee Highlight Reports:		Information	✓	10:45
	a) Strategic Planning and Integration	Caroline Maley /Stephen Jackson			
	b) Quality and People	Marios Adamou			
	c) Finance and Performance	Stephen Jackson			
	d) Audit and Risk	Caroline Maley			
	e) East Midlands Joint Committee	Amanda Sullivan			

Closing items

12.	Risks identified during the course of the meeting	Kathy McLean	Discussion	-	11:05
13.	Questions from the public relating to items on the agenda	Kathy McLean	-	-	-
14.	Any other business	Kathy McLean	-	-	-

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: 14 September 2023 at 9:00 (TBC)

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/07/2023
Paper Title:	**Declaration and management of interests**
Paper Reference:	ICB 23 018
Report Author:	Jo Simmonds, Head of Corporate Governance
Report Sponsor:	Lucy Branson, Associate Director of Governance
Presenter:	Kathy McLean, Chair

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

Summary:

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

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

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

Recommendation(s):

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

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

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

Board Assurance Framework:
Not applicable to this report.

Report Previously Received By:
Not applicable to this report.

Are there any conflicts of interest requiring management?
Yes – in relation to item 8 on the meeting agenda, it should be noted that Paul Robinson and Ifti Majid are both Chief Executives in organisations that are members of the Nottingham and Nottinghamshire Provider Collaborative at Scale, alongside being Partner Members of the ICB Board; however, as no decision is required by this item, they can both fully participate in discussion.

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.
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	07/04/2023	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	07/04/2023	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Nottingham Business Improvement District (BID) - a business-led,not for profit organisation helping to champion Nottingham.	Non-Executive Chair		✓			01/07/2022	Present	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.

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JACKSON, Stephen	Non-Executive Director	Portland College	Governor		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Marketing Nottingham - A not for profit business and the official place marketing organisation for Nottingham City.	Non-Executive Director		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Derbyshire Health United CIC - A not for profit community interest company providing a range of health service provisions.	Non-Executive Director	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by DHU CIC).
JACKSON, Stephen	Non-Executive Director	Imperial Business Consulting Ltd - a management consultancy business, based in Leicestershire.	Joint Owner and Chief Executive Officer	✓				01/07/2022	Present	There is no contract in place with this organisation - 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 Service (PICS) - provider of local health services in the Nottinghamshire area	Director (NB - Dr Lim has resigned from this post but will remain working for PICS until October 2023).	✓				01/07/2022	31/10/2023	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	30/06/2023	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.

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MALEY, Caroline	Non-Executive Director	Village Health Group	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	University Hospitals of Derby and Burton NHS Foundation Trust	Trust Chair	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Kathy McLean Limited - Private limited company to offer health related advice	Director	✓				01/07/2022	Present	There is no contract in place with this organisation - therefore this interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Barts Health NHS Trust (London)	Non-Executive Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS Employers	Chair of the national negotiation committee for Staff and Associate Specialists on behalf of NHS Employers		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Care Quality Commission (CQC)	Occasional Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Public Sector Consultancy	Senior Clinical Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS England/Improvement	Lay Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS Providers Board	Trustee		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
POYNOR, Stuart	Director of Finance	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
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	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.

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UNDERWOOD, Catherine	Local Authority Partner Member	Nottingham City Council	Corporate Director of People	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
UNDERWOOD, Catherine	Local Authority Partner Member	Ruddington Medical Centre	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
WADDINGHAM, Rosa	Director of Nursing	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
WILLIAMS, Melanie	Local Authority Partner Member	Nottinghamshire County Council	Corporate Director for Adult Social Care and Health	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
WILLIAMS, Melanie	Local Authority Partner Member	Orchard Surgery	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
The following individuals will be in attendance at the meeting but are not part of the Board's membership:										
HUBBER, Lucy	Director of Public Health, Nottingham City Council	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
HUNT, Philippa	Chief People Officer	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
11/05/2023 09:00-11:15
Chappell Room, Civic Centre, Arnot Hill Park

Members present:	
Dr Kathy McLean	Chair
Professor Marios Adamou	Non-Executive Director
Dr Dave Briggs	Medical Director
Lucy Dadge	Director of Integration
Stephen Jackson	Non-Executive Director
Dr Kelvin Lim	Primary Care Partner Member
Caroline Maley	Non-Executive Director
Stuart Poynor	Director of Finance
Paul Robinson	NHS Trust/Foundation Trust Partner Member
Amanda Sullivan	Chief Executive
Jon Towler	Non-Executive Director
Catherine Underwood	Local Authority Partner Member
In attendance:	
Lucy Branson	Associate Director of Governance
Diane-Kareen Charles	Deputy Director of Nursing and Director of Quality
Paul Devlin	South Nottinghamshire Place-Based Partnership Convenor and Chair of Nottinghamshire Healthcare NHS Foundation Trust (for item 8)
Lucy Hubber	Director of Public Health, Nottingham City Council
Philippa Hunt	Chief People Officer
Lance Juby	South Nottinghamshire Place-Based Partnership Board Member and Head of Communities and Leisure, Gedling Borough Council (for item 8)
Dr Jill Langridge	South Nottinghamshire Place-Based Partnership Clinical Lead (for item 8)
Maria Principe	System Analytics and Intelligence Unit Director (for item 9)
Jack Rodber	Chief Analyst (for item 9)
Sue Wass	Corporate Governance Officer (minutes)
Apologies:	
Ifti Majid	NHS Trust/Foundation Trust Partner Member
Rosa Waddingham	Director of Nursing
Melanie Williams	Local Authority Partner Member

Cumulative Record of Members' Attendance (2023/24)

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

Introductory items

ICB 23 001 Welcome, introductions and apologies

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

A particular welcome was extended to Diane-Kareen Charles, who was deputising for Rosa Waddingham.

ICB 23 002 Confirmation of quoracy

The meeting was confirmed as quorate.

ICB 23 003 Declaration and management of interests

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

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

ICB 23 004 Minutes from the meeting held on: 09 March 2023

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

ICB 23 005 Action log and matters arising from the meeting held on: 09 March 2023

One action from the previous meeting had been closed, and three remained open and on track for completion.

No further matters were raised.

Leadership

ICB 23 006 **Chair's Report**

Kathy McLean presented the item and highlighted the following points:

a) Thanks was given for the continued professionalism of all staff working across the system during challenging times.

b) The financial year 2023/24 would be one of considerable challenge in terms of finances, the recovery of services and productivity. All needed to be addressed as a matter of urgency in order to deliver the best possible service to the public and patients.

c) The focus also needed to be on the delivery of the aims of the Integrated Care Strategy in order to transform services to avoid a repeat of the current challenges in future years. The Joint Forward Plan would be the local NHS contribution to achieving the aims of the Strategy. Work continued with system partners to populate the Plan and the deadline for submission was the end of June 2023.

d) The Hewitt Review, which recommended how local leaders can best focus efforts to improve outcomes for their populations, had recently been published; and although the Government had not yet formally responded to the report, it was very much in line with the direction of travel in the local system, and its recommendations would be taken forward to help to shape how the system can come together to integrate services.

The following points were made in discussion:

e) Members queried the impact of delays to the budget allocations for the Government's New Hospital Programme, due to the election period. It was noted that this would potentially impact on Tomorrow's NUH (Nottingham University Hospitals NHS Trust); the National Rehabilitation Centre and community diagnostic centres; however, it was acknowledged that this was a national issue and not one that can be resolved locally.

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

ICB 23 007 **Chief Executive's Report**

Amanda Sullivan presented the item and highlighted the following points:

a) Several urgent decisions had been made using the Board's emergency decision-making powers since the last meeting, as listed in detail in the report, and noted as the 2023/24 Operational

and Financial Plans; the 2023/24 Joint Capital Resource Use Plan; the Delegation Agreement in relation to primary pharmacy and optometry services and primary and secondary dental services and associated joint working arrangements across the East Midlands ICBs; and Joint working arrangements with NHS England and the East Midlands ICBs for certain specialised services. All had been discussed initially at previous Board and committee meetings and were presented for formal ratification by the Board.

b) The on-going industrial action continued to absorb energy and time to ensure that essential services were maintained; however, services had inevitably been disrupted. Colleagues from across the system continued to work hard to mitigate risks. It was noted that a pay deal had now been agreed for Agenda for Change staff.

c) The Nottinghamshire Police and Crime Commissioner had recently launched a strategy aiming to reduce the prevalence of violence against women and girls. Amanda would be meeting with the Police and Crime Commissioner's Office to discuss how the ICB would be involved in the development of an action plan to underpin the aims of the strategy.

d) NHS England had recently published guidance that set out what good research practice should look like. There was a vibrant research community locally, and the Nottinghamshire Integrated Care System Research Partners Group had been referenced as a case study in the guidance.

e) The NHS England publication, NHS Delivery and Continuous Improvement Review, was also welcomed and would help shape thinking going forward.

f) Attention was drawn to the findings of the 2023 British Social Attitudes survey that found public satisfaction with the NHS was at its lowest level recorded since 1997, which reflected the current pressures on services.

g) Several other recent publications were noted, including the Government's Tacking Loneliness Annual Report and the Voluntary, Community, and Social Enterprise's Health and Wellbeing Alliance: Tackling the cost-of-living crisis and impacts on health and wellbeing.

The following points were made in discussion:

h) Each urgent decision was considered in turn and ratified.

i) Relating to the delegation of primary pharmacy and optometry services and primary and secondary dental services to ICBs, members queried how the nationally required reduction in ICB

operating costs would affect the delivery of these services. It was noted that the development of the operating model would need to ensure the best use of resources and teams would need to work in a more collaborative way. However, there was already good alignment.

j) Members queried whether the pay deal would add to the system's financial pressures. It was noted that the expectation was that it would not be funded via existing allocations.

k) Members felt unsighted on matters relating to the ICB's own workforce and requested that the ICB's staff survey results be presented to the next meeting, which was agreed.

l) Noting that the cost-of-living crisis was driving inequalities, members queried whether the system was taking into account the proposed actions in the report by the Voluntary, Community, and Social Enterprise Health and Wellbeing Alliance. It was noted that the ICB had brought together partners during 2022 to identify how the local system would work together to support people with the rising costs of living and actions had been taken, but there was always more to do. The development of a Population Health Management approach would be a useful tool to enable targeted activity and support. The Chair noted that this topic could be further discussed at a Board development session or a wider system meeting to enable a strategic view to be taken.

The Board **received** the item for information, having **ratified** the urgent decisions made during March and April 2023 using the Board's emergency powers.

Actions:

Amanda Sullivan to include the ICB's 2022 Staff Survey results within the Chief Executive's Report to the Board's 13 July 2023 meeting.

Amanda Sullivan to arrange an ICB or wider system discussion to explore the actions being taken by system partners to address the cost-of-living crisis.

Health inequalities and outcomes

ICB 23 008 South Nottinghamshire Place-Based Partnership Report

The Chair welcomed Paul Devlin, Jill Langridge and Lance Juby from the South Nottinghamshire Place-Based Partnership (PBP), who were in attendance to provide an update on the work of the PBP.

Paul, Jill, and Lance presented the item, and highlighted the following points:

a) The PBP has a strong partnership focus, with an ethos of shared responsibility to work towards the achievement of its vision through collaboration and co-production ‘to enable people in South Nottinghamshire to live healthier lives and get the care and support they need when they need it’.

b) Several practical interventions were highlighted, including the development of community groups for social prescribers to refer on to; and the delivery of falls prevention groups to reduce falls and waiting lists for therapy. Outside organisations had also been commissioned to run programmes, such as Base 51, to support the mental health and wellbeing of children and young people.

c) The key work programmes for the year ahead were highlighted: an aging well programme; the development of an integrated neighbourhood working model; and the alignment of health and prevention offers to address any gaps and avoid duplication.

d) The use of data and intelligence was key to targeting resource allocation at discrete areas of deprivation within what was predominantly an affluent area. It was hoped that joint working with the ICB and Public Health would allow for the development of a South Nottinghamshire Outcomes Framework to support decision making.

e) Collaborative work with other PBPs to share best practice was also noted, for example the embedding of social prescribers into the Emergency Department at Nottingham University Hospitals NHS Trust, which had won an NHS England-sponsored partnership award.

f) The presentation ended with a citizen story, which gave an insight into the work of Base 51 to support the mental health and wellbeing of children and young people.

The following points were made in discussion:

g) Members welcomed the presentation, commending the good progress that was being made.

h) Recognising the significant and geographically diverse pockets of deprivation within what was one of the most affluent areas in the country, members queried how the PBP was addressing their

needs. It was noted that good relationships had been built with each of the district councils to develop plans to address the wider determinants of health, building on the community assets within each of the areas, using integrated neighbourhood working.

i) Members queried whether the PBP was able to operate effectively within existing resources. It was noted that it was always a challenge; however, new resources were constantly being sourced and there was a wealth of resources within communities that were yet to be fully utilised.

j) Members welcomed the mapping of the PBP's aims to the Integrated Care Strategy, the commitment to integrated neighbourhood working, and the use of an outcomes framework.

The Board **noted** the report, having discussed the work of the PBP.

At this point, Paul Devlin, Dr Jill Langridge, and Lance Juby left the meeting and Maria Principe and Jack Rodber joined the meeting.

ICB 23 009 An integrated approach to Population Health Management Outcomes Monitoring

The Chair welcomed Maria Principe and Jack Rodber to the meeting, who went on to present the item with Dave Briggs, highlighting the following points:

a) The report presented the approach being taken to refresh and further develop the system's outcomes framework in a way that aligned with a Population Health Management (PHM) approach.

b) The ICB's System Analytics and Intelligence Unit, working with key partners, was building a comprehensive programme. This included an overarching outcomes framework that would be based on a comprehensive set of metrics, using local patient-level population data covering the full life course to understand improvements and reduce inequalities.

c) The approach used segmentation and stratification techniques to aid understanding of the local population, allowing for effective primary, secondary, and tertiary prevention interventions to improve outcomes.

d) A local secure data platform would be used to process, link, analyse, and report data from health, care, and wellness partners, and eHealthScope would be used to target individuals and offer

interventions to reduce health inequalities in disadvantaged groups.

e) The approach would take three years to complete, with an interim dashboard available by March 2024. The four phases of the programme were discussed, as detailed in the report.

The following points were made in discussion:

f) Members queried the long timescale for implementation. It was noted that one of the key challenges was to identify the missing data required to build a comprehensive outcomes framework and work with the holders of the data to reach the necessary agreements was time consuming. There was also the need to gain the support and buy-in of all partners within the system, particularly the securing of clinical engagement and ownership. It was confirmed that this would be raised at a meeting of the Provider Collaborative.

g) The importance of this piece of work in creating an evidence-based mechanism for the allocation of resources, which could be used by all organisations and PBPs within the system was discussed.

h) Its future use in the better understanding of workforce requirements was also noted.

i) The Chair commended the programme for its ambition, urged partners to support it and requested that a baseline dashboard, which reflected how as a system we are performing against our high-level strategic outcomes be brought to the September 2023 meeting.

The Board **noted** the report, having discussed and supported the programme of work and associated timeframe for developing and implementing the PHM Outcomes Framework.

Action:

Dave Briggs to present a progress update regarding the development and implementation of a PHM Outcomes Framework to the September 2023 Board meeting.

Maria Principe and Jack Rodber left the meeting at this point.

Assurance and system oversight

ICB 23 010 **Integrated Performance Report**

Stuart Poynor, Lucy Dadge, Dave Briggs, Diane-Kareen Charles and Philippa Hunt presented the item and highlighted the following points:

a) At the end at the end of the financial year 2022/23, the NHS system reported a £13.9 million deficit position, which was £3 million favourable to plan.

b) One area of concern was an overspend in the capital envelope at the end of month twelve, relating to a misclassification at one of the Trusts. There was a risk that this would lead to a reduction in the capital budget for the 2023/24 financial year, and the ICB was discussing the issue with regional and national colleagues.

c) The industrial action had led to the cancellation of many elective procedures.

d) Discharge pressures continued. Length of stay had been increasing locally, and system flow continued to be an area of focus, with targeted work taking place around admission avoidance.

e) Cancer services continued to perform well against national comparators.

f) A change of contract had impacted on Talking Therapy (previously Improving Access to Psychological Therapies); however, overall mental health services were performing well, with improvements across several areas.

g) The foundations for smoking cessation services across the NHS (inpatient, maternity, and mental health) had been put in place during April.

h) Good progress had been made by NUH in addressing the backlog of reported serious incidents and learning had been incorporated into its improvement plans.

i) There had been a recent inspection of maternity services at NUH, although findings were yet to be received.

j) There were issues regarding children and young people's services and there was a need to gain a more consistent picture of the current situation. There would be a focus on this at the next Quality and People Committee meeting.

k) The offer from the System Staff Support Hub on mental wellbeing would end in June following the loss of funding and future arrangements were being discussed by the ICS People and Culture Group.

l) Trusts were operating at staffing levels above plan on substantive staff yet were reporting increases in the use of bank and agency staff. This remained an area of focus.

m) Retention of existing staff also remained a key focus.

The following points were made in discussion:

n) Members discussed issues relating to urgent and emergency care services, noting that the investment in several initiatives to improve flow had had no discernible impact on discharge rates. As the achievement of the operational and financial plans for 2023/24 were largely predicated on the transformation of urgent and emergency care services, the Board requested a focussed update its next meeting to report on all activity in this area, covering reductions in admissions, lengths of stay and bed occupancy.

o) Noting that workforce numbers were above planned trajectories, members queried whether there were appropriate controls within the system to mitigate this. It was noted that there was a need to review the credibility of, and progress in, the delivery of existing workforce plans.

The Board **noted** the report, having discussed the latest performance in the areas of finance, service delivery, health inequalities, quality and workforce.

Action:

Lucy Dadge to present a focussed update to the July Board meeting to report on the urgent and emergency care pathway discharge and flow arrangements, covering reductions in admissions, lengths of stay and bed occupancy.

ICB 23 011 Committee Highlight Reports

The report presented an overview of the work of the Board's committees since its last meeting in March 2023; 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.

Jon Towler, Marios Adamou, Stephen Jackson and Caroline Maley, as Committee Chairs, presented the report and highlighted the following points:

a) Strategic Planning and Integration Committee members had received an update on the development of the Joint Forward Plan,

noting that the timeframe for the completion of the work by the nationally set deadline would be very challenging, and urged the Executive to give it a renewed focus.

b) Quality and People Committee members had noted limited assurance in progress towards compliance with key quality domains in respect of Looked After Children and had requested a deep dive report be brought to a future meeting. Concern had also been raised regarding the impact of the high use of agency staff and the Committee had requested a further deep dive report into this.

c) Finance and Performance Committee members had commended the achievement of the 2022/23 financial targets and had received assurance from an analysis, requested by the Board, into excess deaths, which was found to be in line with national averages.

d) Audit and Risk Committee members had received assurance of the work being undertaken to address gaps in control and assurance on the Board Assurance Framework. In preparation for the ICB's Annual Report and Accounts, a draft Head of Internal Audit Opinion of significant assurance had been received and the Committee had reviewed the ICB's draft Annual Report and unaudited accounts, commending the relevant teams for their hard work in their preparation.

The following points were made in discussion:

e) The Chair noted the need for the Quality and People Committee to maintain focus on the areas of limited assurance.

The Board **received** the report, noting the levels of assurance provided.

ICB 23 012 Board Assurance Framework

Lucy Branson presented the item and highlighted the following points:

a) The Board Assurance Framework provided a mechanism to manage strategic risks in a structured way by identifying and mapping the main sources of assurance in support of the achievement of the ICB's core aims/objectives. The report presented the latest position of the ICB's Board Assurance Framework for scrutiny and comment.

b) The Board had previously agreed that the Assurance Framework would remain in place until March 2024 in recognition of the ICB

being newly established and its core aims and strategic risks being unlikely to change over the period to March 2024.

c) The Executive Management Team had reviewed the 14 risks and confirmed their continued appropriateness.

d) Since the opening position, three risks had reached their target score, and one risk had increased in score.

e) A good level of control continued to be in place; this had been enhanced during the period with new working arrangements, strategies, plans and frameworks being established.

f) Identified gaps in control largely related to developing arrangements for delivery oversight of the newly established ICS and ICB strategies and plans.

g) There was also a continued need to ensure there was appropriate balance in 'managing today', system resilience, and 'making tomorrow better', transformation plans.

The following points were made in discussion:

h) Members queried the movement in risk ten, financial sustainability and it was noted that it reflected the achievement of the ICB's financial targets.

i) Regarding risk two, system resilience, members queried whether the control description should include an explicit reference to community services transformation, and it was agreed that the risk would be updated to reflect this.

The Board **received** this item for assurance, having reviewed the latest position of the Board Assurance Framework and confirming the continued appropriateness of the ICB's strategic risks for 2023/24.

Action:

Lucy Branson to update the control description for risk two to include explicit reference to community services transformation.

Closing items

ICB 23 013 **Risks identified during the course of the meeting**

Following on from the conversation at item ICB 23 007, regarding a loss of public confidence in NHS services, it was noted that although it was

an important issue to be kept in mind, it was outside of the ICB's direct control.

ICB 23 014 Questions from the public relating to items on the agenda

No questions had been received.

ICB 23 015 Any other business

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

Date and time of next Board meeting held in public: 13 July 2023 at 9:00 (Arnold Civic Centre)

NHS Nottingham and Nottinghamshire

ACTION LOG from the Integrated Care Board meeting held on 11/05/2023

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
Open – On track	09.03.23	ICB 22 068: Chief Executive's Report	To provide an update on proposed actions around the Declaration on Tobacco Control to a future meeting.	Dave Briggs	~~13.07.23~~ 14.09.23	A revised implementation date for this action has been agreed with the ICB's Chair. The action will now be taken forward at an extra-ordinary meeting of the Strategic Planning and Integration Committee on 3 August 2023 and reported back to the Board via the Committee's Highlight Report to the September 2023 meeting.
Closed	09.03.23	ICB 22 070: Strategic approach to transforming health and care within community services	To present a progress update to the July 2023 Strategic Planning and Integration Committee meeting, with further detail on the alignment to the Integrated Care Strategy and outcome measures.	Lucy Dadge	13.07.23	See agenda item 11 – Highlight Report from the Strategic Planning and Integration Committee.
Closed	09.03.23	ICB 22 072: Integrated Performance Report	To consider adding predicted trajectory rates on key metrics in the Integrated Performance Report.	Stuart Poynor	13.07.23	See agenda item 10 – Integrated Performance Report.
Closed	11.05.23	ICB 23 007: Chief Executive's Report	To include the ICB's 2022 Staff Survey results within the Chief Executive's Report to the Board's 13 July 2023 meeting.	Amanda Sullivan	13.07.23	See agenda item 7 – Chief Executive's Report.
Closed	11.05.23	ICB 23 007:	To arrange an ICB or wider system discussion to explore	Amanda Sullivan	13.07.23	This has been scheduled for discussion at the 6 October

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
		Chief Executive's Report	the actions being taken by system partners to address the cost-of-living crisis			2023 meeting of the Integrated Care Partnership.
Closed	11.05.23	ICB 23 009: Population Health Management Outcomes Monitoring	To present a progress update regarding the development and implementation of a PHM Outcomes Framework to the September 2023 Board meeting.	Dave Briggs	13.07.23	See agenda item 6 – Chair's Report. This includes the 2023/24 Annual Work Programme for the Board, with the next update scheduled for September 2023.
Closed	11.05.23	ICB 23 010: Integrated Performance Report	To present a focussed update on the urgent and emergency care pathway discharge and flow arrangements, covering reductions in admissions, lengths of stay and bed occupancy.	Lucy Dadge	13.07.23	Included for consideration during the Board's closed session in July 2023.
Closed	11.05.23	ICB 23 012: Board Assurance Framework	To update the control description for risk two to include explicit reference to community services transformation.	Lucy Branson	13.07.23	The control description has need updated and the latest position for risk two of the Assurance Framework will be next presented to the Board in November 2023, having been scrutinised by the Audit and Risk Committee in September 2023.

Key:

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

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/07/2023
Paper Title:	**Chair's Report**
Paper Reference:	ICB 23 021
Report Author:	Dr Kathy McLean, ICB Chair
Report Sponsor:	Dr Kathy McLean, ICB Chair
Presenter:	Dr Kathy McLean, ICB Chair

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

Summary:

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

Recommendation(s):

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

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	The 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:

A: Board Work Programme 2023/24
B: Board and Committee Etiquette

Board Assurance Framework:

Not applicable for this report.

Report Previously Received By:

Not applicable for this report.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Chair’s Report

Introduction

1. Last week we saw the celebrations of the seventy-fifth anniversary of the foundation of the NHS. Since its inception in 1948, the NHS has been the cornerstone of healthcare in the UK. It has provided universal access to high-quality care, eliminating any concerns about money when thinking about your health. This achievement alone is a testament to the values of compassion, equality and inclusivity that define the NHS. In a time where there are concerns about the cost of living, our NHS, and its founding principle of access free at the point of need are a huge comfort and support to the most vulnerable in our society.
2. I’m pleased therefore that today we are discussing our proposed NHS Joint Forward Plan. As we celebrate the NHS’s past, this is also a good time to look ahead to a future filled with possibilities and challenges. Our NHS Joint Forward Plan sets out how local NHS services will recover and be made sustainable following the pandemic. We will work with our partners to follow a joint ambition to allow every person in Nottingham and Nottinghamshire to enjoy their best possible health and wellbeing. Together, we can ensure that the NHS continues to thrive for the next seventy-five years and beyond, delivering compassionate, equitable and high-quality care to all who rely on its services.
3. Sadly, today also marks a month since the tragic murders of Ian Coates, Barnaby Webber and Grace O'Malley-Kumar in Nottingham. These senseless deaths shocked the whole country and I want to record the condolences of the Board to the families and friends of the victims. The focus rightly now has turned to supporting the communities most affected by the events of 13 June and ensuring that there is no place for division and hate in our City and County – under the ‘Nottingham Together’ banner we will move forward.
4. I know that members of the Board will support the Nottingham City Council going forward as the lead agency for this ‘recovery’ phase of the incident response and that will include both provision of mental health services and wider support as well as through partnership working more generally in our Places and communities.

Developing Our Services and System

5. Since the last Board meeting, we have seen the Government’s response to the Hewitt Review of Integrated Care Systems. Colleagues will recall that I was pleased to have co-chaired the ‘autonomy, accountability and regulation’ workstream and contributed to the overall shaping and writing of the report.

6. The Government's response supports the direction of travel that the Hewitt Review set out. This means that the basis of our developing ICB operating model and the way that we work with our partners is in line with current policy from the Government and NHS England. The response also further strengthens our direction of travel towards integration, place-based working and a focus on local health outcomes, inequalities, and prevention. Our Integrated Care Strategy is very much in line with this, so we will progress and accelerate work in these areas.

7. As part of the ongoing implementation and activation of our Integrated Care Strategy I was grateful to Lucy Hubber, Director of Public Health, Nottingham City Council, for leading a discussion at our ICS Reference Group in May on Prevention. Making sure that we all had a shared and comprehensive understanding of this key principle for our strategic work was a valuable exercise, my thanks to Lucy for that.

8. Continuing still on the theme of activating and disseminating our Strategy, I am pleased that we have now launched our first system-wide Health and Care Awards. Featuring award categories aligned to the four core aims and the three principles, these awards will be a key way that we can celebrate work which stretches across the boundaries of individual organisations. I'm also delighted that the awards will be supported by the Lord Lieutenant for Nottinghamshire, Sir John Peace. Nominations are open until 8 September and the winners will be announced at a ceremony held at Nottingham University on 24 October.

9. I am also pleased to report that following my update at the last meeting, Executive colleagues from the ICB have met their counterparts from Derby and Derbyshire and have had a very useful initial discussion about potential areas for wider collaboration and joint working across our geographic areas.

Looking Forward

10. As I described last time, we are rapidly progressing through the year – having now finished our first quarter – and I continue to be confident that we are making the progress that we need on our strategic planning and delivery. We will need to continue to pay careful attention to our financial position and the focus on elective recovery and access to services more generally will not abate.

11. On 1 July we formally welcomed to our ICB the NHS England colleagues supporting the East Midlands ICBs' work on Pharmacy, Optometry and Dentistry (POD) services. This is the first of a number of future delegations of responsibilities and staff from NHS England and signals the increasing primacy of ICBs in the delivery of our ambitions for integrated care for our population.

12. NHS England has now announced their new operating model and proposed structures and we will need to be cognisant of these as we move forward – they herald a new way of working for NHS England and also for ICBs.

13. The party-political process for selecting the candidates for the new Mayor for a Combined Authority across Nottingham, Nottinghamshire, Derby and Derbyshire is now well underway and so by May 2024 we will have a new, devolved, political leadership arrangement for our part of the East Midlands.

14. As part of this shift in the operating model of NHS England and the increasing maturation of our system working arrangements, we are taking the chance to review the Partnership Agreement that we have in place across the system. The Partnership Agreement set out our shared purpose together with some principles and ways of working that we have all agreed to sign up to. In the time since we agreed it in early 2021 there has been a considerable turnover in system leadership and also a change in our external context – so it is timely to now refresh it. That work is already underway with an initial discussion at the ICS Reference Group on 3 July.

15. Implementing our plans, in this new construct of more empowerment and autonomy from NHS England and a self-determination in the political sphere should now be our complete focus. We have the strategic direction and we have the authority and the permission to now truly shape our own destiny and that of the long-term health of our population.

Board Work Programme and Meeting Etiquette

16. A key aspect of my role as Chair of the ICB is to ensure the Board is effective, focussed on key responsibilities and delivering against statutory duties, regulations and agreed strategies. Good governance practice dictates that Boards should be supported by an annual work programme that sets out a coherent cycle of business for the next year of meetings. The annual work programme is a key mechanism to ensure the full breadth of the Board's role can be discharged, balancing agenda time appropriately between key strategic priorities and ensuring appropriately timed governance oversight, scrutiny and transparency.

17. A work programme for 2023/24 has been developed that aims to build on progress made by the Board in the ICB's initial period of operation. This will be used to steer agenda planning; however, we will keep this under review throughout the year as our arrangements continue to evolve and embed. The work programme is provided for information and feedback at Appendix A.

18. Finally, I would also like to take this opportunity to draw your attention to our recently refreshed meeting etiquette for the Board and its committees (attached as Appendix B). This will help to ensure the effectiveness of our formal meetings going forward and I would ask that you familiarise yourselves with its content.

NHS Nottingham and Nottinghamshire

Board Work Programme 2023/24

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

Core aims:

- **Improve outcomes** in population health and healthcare.
- **Tackle inequalities** in outcomes, experience and access.
- Enhance **productivity and value for money**.
- Help the NHS support broader **social and economic development**.

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.

Agenda item (and purpose)	11 May	13 Jul	14 Sep	9 Nov	11 Jan	14 Mar	28 Mar *(Extra-ordinary)*
Leadership							
Chair's Report To present a summary briefing for Board members of the Chair's reflections, actions and activities since the previous Board meeting. As appropriate, this will include updates on key governance developments, and on an annual basis this will present the Board's Annual Work Programme and include a review of the skills, knowledge and experience of Board members (when taken together) to ensure the Board can effectively carry out its functions. *Item sponsor: Kathy McLean, Chair*	✓	✓	✓	✓	✓	✓	-

Agenda item (and purpose)	11 May	13 Jul	14 Sep	9 Nov	11 Jan	14 Mar	28 Mar *(Extra-ordinary)*
Chief Executive's Report To present a summary briefing on recent local and national developments and areas of interest for Integrated Care Boards (ICBs) and the wider Integrated Care System (ICS), along with key updates from system partners, including the Integrated Care Partnership and Health and Wellbeing Boards. The report will include key updates regarding the ICB's workforce on a periodic basis, including NHS staff survey results, WRES, gender pay gap, and wider workforce indicators. As appropriate, the report may also include specific items requiring approval or for noting by Board members. *Item sponsor: Amanda Sullivan, Chief Executive*	✓	✓	✓	✓	✓	✓	-
ICS Partnership Agreement To secure Board commitment to the refreshed ICS Partnership Agreement. *Item sponsor: Amanda Sullivan, Chief Executive*	-	-	-	✓	-	-	-
Health inequalities and outcomes							
Joint Forward Plan To present the ICB's Joint Forward Plan for approval (prepared with partner NHS trusts and NHS foundation trusts) setting out how the ICB will exercise its functions over the next five years. *Note: The Joint forward Plan will be subject to an annual review and refresh, which will be factored into the Board's 2024/25 work programme.* *Item sponsor: Lucy Dadge, Director of Integration*	-	✓	-	-	-	-	-
Strategic Delivery Updates To present strategic delivery updates on the four key areas that provide the greatest opportunity to improve population health and achieve the ICS principles of principles of integration, equity and prevention, as defined within the Joint Forward Plan: • Timely access and early diagnosis for cancer and elective care • Improving navigation and flow to reduce emergency pressures	- -	- -	- -	✓ -	- ✓	- -	- -

Agenda item (and purpose)	11 May	13 Jul	14 Sep	9 Nov	11 Jan	14 Mar	28 Mar *(Extra-ordinary)*
• Proactive management of long-term conditions and frailty • Prevention: Reducing illness and disease prevalence The updates will also consider the steps the ICB has taken to implement the Joint Local Health and Wellbeing Strategies. It is proposed that the Chairs of the ICB's Citizen Intelligence Advisory Group and VCSE Alliance be invited to join the Board for these focussed sessions. Other system colleagues may also be inviting, in line with the developing ICB Operating Model. *Note: The final delivery update is shown for completeness and will be presented in May 2024.* *Item sponsors: Lucy Dadge, Director of Integration and Dave Briggs, Medical Director*	-	-	-	-	-	✓	-
	-	-	-	-	-	-	-
Delivery Plan for Recovering Access to Primary Care To present a system level primary care access recovery plan for approval. *Item sponsor: Lucy Dadge, Director of Integration*	-	-	-	✓	-	-	-
People and Culture To present a strategic update on the delivery of the ICS People Plan. *Item sponsor: Rosa Waddingham, Director of Nursing*	-	-	✓	-	-	-	-
Digital Transformation To present a strategic update on the delivery of the ICS Digital Strategy. *Item sponsor: Dave Briggs, Medical Director*	-	-	-	-	✓	-	-
Environmental Sustainability To present a strategic update on the delivery of the ICS Green Plan. *Item sponsor: Stuart Poynor, Director of Finance*	-	-	-	-	-	✓	-
HealthWatch Report To receive a report from HealthWatch Nottingham and Nottinghamshire on the views of people who use health and social care services, particularly those whose voice is not often listened to. *Item sponsor: Amanda Sullivan, Chief Executive*	-	-	-	-	-	✓	-

Agenda item (and purpose)	11 May	13 Jul	14 Sep	9 Nov	11 Jan	14 Mar	28 Mar *(Extra-ordinary)*
2024/25 Operational and Financial Plans To present the operational and financial plans for approval. *Item sponsor: Stuart Poynor, Director of Finance*	-	-	-	-	-	-	✓
2024/25 Annual Budget To present the ICB's annual budget for approval. *Item sponsor: Stuart Poynor, Director of Finance*	-	-	-	-	-	-	✓
2024/25 Joint Capital Resource Use Plan To present the Joint Capital Resource Use Plan for approval (prepared with partner NHS trusts and NHS foundation trusts). *Item sponsor: Stuart Poynor, Director of Finance*	-	-	-	-	-	-	✓
Developing our Integrated Care System To present updates on the strategic development of Place Based Partnerships and the Provider Collaborative at scale.							
• South Nottinghamshire Place-Based Partnership	✓	-	-	-	-	-	-
• Nottingham and Nottinghamshire Provider Collaborative as Scale	-	✓	-	-	-	-	-
• Mid Nottinghamshire Place-Based Partnership	-	-	✓	-	-	-	-
Future reporting requirements will be determined following receipt of the final scheduled update in September and in light of the developing ICB Operating Model. *Note: Nottingham City Place-Based Partnership and Bassetlaw Placed-Based Partnership presented during 2022/23, in January and March 2023 respectively.*							
NHS England Delegations To receive strategic updates in relation to NHS England's ongoing programme of delegating commissioning functions. This will include consideration of pre-delegation assessments and approval of associated post-delegation governance arrangements. *Note: The illustrated timeline for this work during 2023/24 is indicative and subject to change in line with NHS England requirements.* *Item sponsor: Amanda Sullivan, Chief Executive*	-	-	✓	-	-	-	✓

Agenda item (and purpose)	11 May	13 Jul	14 Sep	9 Nov	11 Jan	14 Mar	28 Mar *(Extra-ordinary)*
Assurance and system oversight							
Population Health Management (PHM) Outcomes Framework To receive strategic updates on the development and implementation of the PHM Outcomes Framework. *Item sponsor: Dave Briggs, Medical Director*	✓	-	✓	-	-	✓	-
Integrated Performance Report To present progress against the key performance targets across finance, service delivery, health inequalities, quality and workforce, and to note key developments and actions being taken to address performance issues. Delivery of the 2023/24 Operational and Financial Plans will be monitored via the Integrated Performance Reports. On a quarterly basis, the reports will also include the latest segmentation ratings under the NHS Outcomes Framework. *Item sponsors: Stuart Poynor, Director of Finance, Lucy Dadge, Director of Integration, Dave Briggs, Medical Director and Rosa Waddingham, Director of Nursing*	✓	✓	✓	✓	✓	✓	-
Highlight Reports from the Finance and Performance Committee, Quality and People Committee, Strategic Planning and Integration Committee, Audit and Risk Committee, Remuneration Committee and East Midlands Joint Committees To present an overview of the work of the Board's committees 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, and on an annual basis the outcome of a review of committee effectiveness will be included, following consideration by the Audit and Risk Committee. *Item sponsors: Stephen Jackson, Non-Executive Director, Professor Marios Adamou, Non-Executive Director, Jon Towler, Non-Executive Director, Caroline Maley, Non-Executive Director and Amanda Sullivan, Chief Executive*	✓	✓	✓	✓	✓	✓	-

Agenda item (and purpose)	11 May	13 Jul	14 Sep	9 Nov	11 Jan	14 Mar	28 Mar *(Extra-ordinary)*
Board Assurance Framework To present the opening, mid-year and year-end position of the Board Assurance Framework. This will include annual approval of the ICB's strategic risks. *Item sponsor: Rosa Waddingham, Director of Nursing*	✓	-	-	✓	-	-	-
Risk Management Policy To present the ICB's Risk Management Policy for approval, including a refreshed approach to the ICB's risk appetite following Board development discussions. *Item sponsor: Rosa Waddingham, Director of Nursing*	-	-	✓	-	-	-	-
Working with People and Communities To present an annual report on the ICB's arrangements for working with people and communities. This will be reviewed by the Strategic Planning and Integration Committee prior to presentation to Board. *Item sponsor: Amanda Sullivan, Chief Executive*	-	-	-	-	-	✓	-
Meeting the Public Sector Equality Duty To present an annual report on the ICB's arrangements for meeting the Public Sector Equality Duty. This will be reviewed by the Quality and People Committee prior to presentation to Board. *Item sponsor: Rosa Waddingham, Director of Nursing*	-	-	-	-	✓	-	-
Emergency Preparedness, Resilience and Response (EPRR) Annual Report To present an annual report on the ICB's arrangements for meeting its responsibilities as a category one responder under the Civil Contingencies Act. This will be reviewed by the Audit and Risk Committee prior to presentation to Board. *Item sponsor: Lucy Dadge, Director of Integration*	-	-	-	-	✓	-	-
Senior Information Risk Owner (SIRO) Annual Report To present an annual report on the ICB's data security and protection arrangements. This will be reviewed by the Audit and Risk Committee prior to presentation to Board. *Note: This report is shown for completeness and will be presented in May 2024.* *Item sponsor: Dave Briggs, Medical Director*	-	-	-	-	-	-	-

Development Session Work Programme

Topic	13 Apr	8 June	12 Oct	14 Dec	8 Feb
• Hewitt Review • Revised ICB Operating Model	✓	-	-	-	-
Note: 8 June session cancelled	-	-	-	-	-
• Governance and Partnership Self-Assessment • Review of Board Effectiveness	-	-	✓	-	-
• Approach to Future Strategy Development • Revised ICB Operating Model (incl. development of Place-Based Partnerships)	-	-	-	✓	-
• Leading a Pro-Equity Organisation	-	-	-	-	✓

ICS Reference Group Work Programme

Topic	18 May	3 Jul	13 Nov	15 Feb
• Prevention • Development of the Joint Forward Plan	✓	-	-	-
• ICS Partnership Agreement • Government Response to Hewitt Review	-	✓	-	-
• Adding Social and Economic Value	-	-	✓	-
• System Risk Appetite	-	-	-	✓

Appendix B – Board and Committee Etiquette

Introduction

1. As a publicly funded organisation, the Integrated Care Board (ICB) has a duty to set and maintain the highest standards of conduct and integrity and, this should be demonstrated through the appropriate behaviours of members and attendees (hereafter referred to as 'individuals') of our Board, committees and sub-committees. The purpose of this document is to provide guidance on the behaviours expected at formal meetings; regardless of whether the meeting is in open or closed session or held in person or virtually.

Prior to meetings

2. Attendance at meetings should be prioritised in diaries; however, if providing apologies, members must inform the Committee Secretary of this as soon as possible and (where terms of reference permit) arrange for a deputy to attend in their place. Members are responsible for ensuring their deputy is well-briefed and able to contribute effectively at the meeting.
3. Individuals should make sure they are fully prepared for the meeting by:
    a) Being clear as to the purpose of the meeting and the role you play at the meeting (this is particularly important for individuals deputising for absent members).
    b) Reading the agenda and papers; being clear on the purpose of items being presented (e.g. any decisions requested) and considering any questions/points that you may wish to raise.
    c) Advising the Committee Secretary of any conflicts, or potential conflicts of interest, in relation to the agenda (if these haven't been identified already).
    d) Arriving at the meeting, or joining online if being held virtually, in plenty of time. This will allow the meeting to start promptly (for example, enabling individuals time to resolve any connectivity issues).
    e) Informing the Chair if you need to leave during the meeting (however, this should be avoided if possible).
    f) For virtual meetings, ensuring that you have the corporate background on, particularly if the meeting is in open session. Position yourself so that you are close to the camera, so that your face fills most of the screen and can be clearly seen by anyone watching and make sure (as far as possible) that you/the meeting won't be disturbed by other members of your household.

g) Ensuring that you have everything you need for the meeting, such as a drink, pen and paper etc. and by ensuring that your device is fully charged or that you are quickly able to connect to a power source if needed.

During the meeting

4. During meetings, individuals should:

a) Stay fully engaged and dedicate your attention to the purpose of the meeting, refraining from performing other duties that will distract you (or could appear to distract you), for example, by responding to emails.

b) For virtual meetings, ensure that your video function is on throughout the duration of the meeting so that other members/attendees can always see you. You should also ensure that your microphone is always muted (unless you are speaking) to reduce background noise interference and minimise the risks of people speaking over one another.

c) Turn off your mobile phone/electronic communications device. When an electronic device must be kept on, turn to silent/vibrate and excuse yourself from the meeting should you need to answer an urgent call. Excusing yourself means leaving the room if the meeting is in person or temporarily turning your camera off if the meeting is virtual. During your absence, you will not be included in the meeting quorum.

d) Raise your hand to indicate that you wish to speak. For virtual meetings, this can be done by pressing the 'Raise Hand' button on the Participants Panel. In both cases, wait until the Chair states that you may speak to avoid interrupting a fellow Board/committee member. When invited to speak, do so clearly, concisely and at a volume that all attendees can hear (especially the minute-taker).

e) Refrain from private conversations with other members, even if this is considered relevant to the meeting discussion (in which case, it should be raised as described above). This also applies during virtual meetings, where the 'Chat' function can be considered the equivalent of talking directly/privately with other members. This can be distracting and comments made in this way will not be recorded in the meeting minutes. As such, this function should only be used when you need to speak directly to the Chair or Committee Secretary (e.g. if you need to leave the meeting).

f) Listen attentively and respectfully to others and be constructive and professional when providing critique and/or challenge.

g) Speak up if you disagree. Silence will be taken by the Chair as your agreement/approval and the members in attendance have collective responsibility of any decisions made or actions agreed.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/07/2023
Paper Title:	**Chief Executive's Report**
Paper Reference:	ICB 23 022
Report Author:	Amanda Sullivan, Chief Executive
Report Sponsor:	Amanda Sullivan, Chief Executive
Presenter:	Amanda Sullivan, Chief Executive

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

Summary:

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

Recommendation(s):

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

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

Appendices:

None.

Board Assurance Framework:

Not applicable to this report.

Report Previously Received By:

Not applicable to this report.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Chief Executive's Report

ICB updates and developments

2022 Staff Survey Results

1. The ICB took part in the 2022 NHS Staff Survey, achieving a 77% response rate. The full results of the survey can be found here: https://cms.nhsstaffsurveys.com/app/reports/2022/QT1-benchmark-2022.pdf, and although the ICB benchmarks favourably in comparison to other ICBs, there is still work to be done. A working group of the ICB's Staff Engagement Group has been established in response to the findings, which has highlighted the following:

    a) The need to look at the results in the context of system changes and cost pressures.

    b) To keep a focus on what good looks like and for actions to be pragmatic and manageable.

    c) To ensure checks are put in place to monitor progress

    d) To have senior leadership sponsorship to ensure delivery of the actions.

2. The working group has developed a staff survey action plan, which has been considered and approved by the Board's Human Resources Sub-Committee and its progress will be monitored and scrutinised by the Remuneration Committee. Key actions include reviewing mechanisms for raising concerns; review of resources in support of line managers and their development; and finalisation of the ICB's Wellbeing Strategy.

Getting to Equity – Building Equitable Systems

3. This is a development programme for System Executive Leaders. Integrated Care Boards have been charged with leading the integration of services which improve outcomes in population health and healthcare, tackle inequalities in outcomes, experiences, and access, enhance productivity and drive broader social and economic development.

4. The Getting to Equity Programme is designed for leaders who recognise the need to embed systemic race equity into their leadership team in order to create a system where there is equity in access, experience and outcomes for the workforce and population. The programme focuses on making anti-racism the rule and promoting race equity as a vital component of closing the gap on inequality. A key aspect of the programme is the engagement between ICB and System Executives which, embeds co-production as a fundamental principle of the partnership for improvement. Adopting a whole system

approach offers an opportunity for systems to grow equitable leadership capability which exposes how racism is showing up across the system and coproduce an approach which is expert driven and addresses racism and the causes of racism within a framework of transparent accountability and improvement.

5. Nottingham and Nottinghamshire ICB is one of two East Midlands Systems that will be early implementers of the programme. 15 places, funded by NHS England are available to the ICB. Board members are invited to participate in the programme, which is due to commence during September 2023. The commitment includes 55 hours over a seven month period. The ICB Director of Nursing has completed the programme and is available to answer any questions related to participation.

Publication of the ICB's first Annual Report and Accounts

6. The ICB's first Annual Report and Accounts for the period 1 July 2022 to 31 March 2023 has been published following approval by the Audit and Risk Committee. On establishment, the ICB also assumed responsibility for approving the Annual Reports and Accounts of the former NHS Bassetlaw Clinical Commissioning Group (CCG) and NHS Nottingham and Nottinghamshire CCG for their final three months of operation (1 April to 30 June 2022). These Annual reports and Accounts have also now been approved and published.

7. The reports provide key organisational details and the audited financial statements in line with the Department of Health and Social Care reporting requirements. The requirements include an assessment of performance during the reporting period, details as to how key statutory duties have been discharged and a governance statement that describes how governance, risk management and decision-making arrangements have operated over the year.

8. The ICB and both former CCGs reported achievement of their statutory financial duties, received Head of Internal Audit Opinions providing significant assurance and had no significant control issues to report. The reports can be found here: https://notts.icb.nhs.uk/about-us/our-priorities/annual-reports-and-accounts/.

9. The ICB will be holding its Annual Public Meeting during September 2023 and further details will be shared once available.

NHS England's annual assessment of ICB performance

10. NHS England has recently published guidance relating to how the performance of ICBs will be assessed for the nine-month period 1 July 2022 to 31 March 2023.

11. The assessment approach has been developed in collaboration with ICB leaders and subject matter experts and will consider how effectively the ICB has led its system, as well as its contribution to the four fundamental purposes of an ICS. The approach has been designed to minimise additional burden, and as such, will draw on three main existing sources of evidence:
    a) The ICB's own reflections and evidence set out in its 2022/23 Annual Report and Accounts.
    b) The outcomes of conversations held between the ICB and NHS England over the course of the year.
    c) Feedback from key system stakeholders.
12. For this first year, the outcome of the assessment will be a letter highlighting areas where the ICB has performed strongly as well as any areas of challenge, including those where NHS England is providing direct support. Assessments will be completed by the end of July.
13. The full guidance can be accessed here: NHS England » Annual assessment of integrated care boards 2022-23: supporting guidance.

Integrated Care System/Partner updates

Industrial action

14. Junior doctors undertook a further bout of industrial action between 14 and 17 June. We issued a warning of potential disruption to the public and asked for their support by using services appropriately. The system response structure, which brings together people, operational and emergency preparedness resilience and response leads in a System Control Centre, continued to ensure that essential services were maintained.
15. A further round of industrial action is planned for 13 to 18 July by junior doctors across all services; and, for the first time, consultants have agreed a 48 hour walk out on 20 and 21 July, with only emergency care to be provided.
16. It should be noted that industrial action by nurses at the Royal College of Nursing will not continue after the union's ballot of its members in England failed to reach the required threshold to secure a mandate for further action, and that the Government's pay settlement for Agenda for Change staff has now been implemented.
17. NHS England data indicates that nationally over half a million appointments have been affected over the past six months. The cumulative effect will have implications for tacking the backlog of operations as a result of the Covid 19 pandemic.

Prime Minister visits Nottingham to announce the roll out of Lung Cancer Screening

18. The Prime Minister Rishi Sunak and the Secretary of State for Health and Social Care Steve Barclay visited Nottingham on 26 June to announce a national extension of the targeted lung cancer screening programme, which is designed to catch cancer sooner or prevent it altogether. The rollout follows a successful opening phase where approximately 70% of the screening took place in mobile units parked in convenient places – such as supermarket car parks – to ensure easy access and focused on more deprived areas where people are four times more likely to smoke. The programme, backed by a recommendation from the UK National Screening Committee, will use patients' GP records for those aged 55 to 74 to identify current or former smokers. Patients will have their risk of cancer assessed based on their smoking history and other factors and those considered high risk will be invited for specialist scans every two years.

Area SEND Inspection of Nottinghamshire Local Area Partnership

19. In February 2023, a Special Educational Needs and Disabilities (SEND) local area inspection by Ofsted and the Care Quality Commission took place, which highlighted significant concerns about the experiences and outcomes of children and young people with SEND in Nottinghamshire. The report, published on 16 May, identified two priority actions that Nottinghamshire Local Area Partnership is required to address urgently:

    a) The need to identify, assess and provide for the needs of children and young people with SEND. This includes an assessment of needs, timely issuing of Education and Health and Care plans and holistic oversight of these plans through annual reviews.

    b) The need to act urgently to identify and address the delays and gaps in access to some health services, particularly speech and language therapy, neuro-developmental pathways and equipment services. NHS Leaders are also required to work together better to use available performance data to identify where gaps exist and whether actions taken to address these are effective.

20. We accept the findings of the report, and we are committed to working across the partnership to improve the experience of children and young people with SEND. We are sorry that the experiences and outcomes of children and young people with special educational needs and disabilities are not as good as they should be.

21. A Nottinghamshire SEND Partnership Improvement Board has been established to oversee the improvement actions needed. This Board will be chaired independently by a recognised sector expert, Dame Christine Lenehan,

Director of the Council for Disabled Children. We are working with the Nottinghamshire Parent Carer Forum and children and young people with SEND and their families to develop and agree the improvement plan to make sure their views will directly influence the actions.

22. Our progress with this work will be overseen within the ICB by the Quality and People Committee, which will report to the Board through its Highlight Reports.

East Midlands Ambulance Services Strategy for 2023 to 2028

23. Following a period of extensive consultation, East Midlands Ambulance Services NHS Trust has recently launched a refreshed strategy for 2023 to 2028, which rests on five new strategic ambitions:

    a) To deliver outstanding patient care

    b) To be an attractive employer

    c) To deliver improved outcomes for patients

    d) To deliver safe, effective, compassionate care

    e) To work in partnership to reduce health inequalities

24. Much of the service delivery model is around achieving the most appropriate and suitable care for patients within the best location. To achieve this, the importance of working with teams across the whole health and social care system was acknowledged, whilst understanding that each of the divisions were unique in both the physical environment and the needs of patients and service users. The full strategy can be found here: https://www.emas.nhs.uk/about-us/our-values/.

Award for Nottinghamshire County Council's Children's Centre Service

25. The Council's Children's Centre Service has received a UNICEF Baby Friendly Gold Award for the third year running. The scheme ensures public services give new families the best possible support, including with infant feeding and developing nurturing relationships. Nottinghamshire continues to be one of only a handful of areas within the UK where both Children's Centre Service and Healthy Families teams are accredited to this level. The Children's Centre Service supports those who are expecting a baby and new parents in Nottinghamshire.

Nottinghamshire's partnership approach wins national Integrated Health Award

26. The Nottingham and Nottinghamshire Community Care Transformation Programme has won a national Integrated Health Award. The transformation

programme was developed with partners from across the Nottingham and Nottinghamshire Integrated Care System. It aims to plan and deliver sustainable community care services that help local people be as independent as possible by supporting their physical, mental and social needs. The programme won the Best Initiative Supporting Integrated Care Systems category. It was also shortlisted in the Most Promising Pilot and Transformation Programme of the Year categories.

Awards in the King's Birthday Honours List

27. Dr Andy Haynes has been awarded an MBE. Dr Haynes worked across the county's NHS for over 35 years, including for 25 years at Nottingham University Hospitals NHS Trust (NUH) before he became Executive Medical Director and Deputy Chief Executive at Sherwood Forest Hospitals NHS Foundation Trust between 2014 and 2019. He became Cancer Lead in Nottingham and shaped how cancer services are provided in the county. He also helped to establish the Nottingham and Nottinghamshire Integrated Care System (ICS), initially as Clinical Lead then later as Executive Lead until his retirement in 2021. Andy is now Specialist Non-Executive Advisor to the Board of Sherwood Forest Hospitals NHS Foundation Trust.

28. Anthony May, Chief Executive of NUH has been awarded an OBE. Anthony, who was Chief Executive of Nottinghamshire County Council before taking up his post at NUH in September 2022, has been recognised for his services to local government.

Health and Wellbeing Board updates

29. The Nottingham City Health and Wellbeing Board met on 31 May 2023. The meeting received a report on the Nottingham and Nottinghamshire Joint Forward Plan, a report on the findings of the Hewitt Review, an update report on the Nottingham City Place-Based Partnership and updates on Joint Needs Assessments and the Joint Health Protection Board. 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

30. The Nottinghamshire County Health and Wellbeing Board met on 24 May 2023. The meeting received a report on Better Care Fund governance arrangements, and use of the Nottinghamshire County National Discharge Grant. 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.

National updates

NHS response to Covid-19: Stepping down from NHS level 3 incident

31. On 19 May 2022 NHS England announced a stepping down from a Level 4 (national) to a Level 3 (regional) incident level. At the time of making this announcement, the NHS England Board took the opportunity to thank teams for the outstanding efforts to deal with the impact of this extraordinary health emergency; and the next stage of Covid 19 response was outlined, which included changes to data collection and reporting arrangements.

32. In stepping down the incident, it was acknowledged that Covid 19 as a health issue itself, as well as the wider long-term impact of the pandemic, will continue to be significant for years to come. New waves and novel variants will continue to impact on patient numbers, as well as staff absences, and services will also need to continue for those suffering the effects of ‘long Covid’.

Government response to the Health and Social Care Committee’s report and the Hewitt Review on integrated care systems

33. In June, the Government published its formal response to the Hewitt Review and the Health and Social Care Select Committee’s report on integrated care system (ICS) autonomy and accountability.

34. The Government’s response sets out a commitment to supporting the success of ICSs, and recognises that the challenges faced by the NHS, local authorities and other partners, and the implications of these for the future of health and care, are significant and shared.

35. The Government response also recognises the essential role that ICBs are playing as a point of coordination and management across the system, and includes some specific responses to particular recommendations, which include:

    a) Targets and priorities have been reduced in this year’s planning guidance, with a balance between access and longer-term metrics, which allows for local priorities to be determined through Integrated Care Strategies and Joint Forward Plans.

    b) The Department of Health and Social Care and NHS England will work together to look at leadership development requirements for system working.

    c) NHS England will discharge its provider oversight arrangements in conjunction with ICBs unless enforcement action is required.

    d) Peer review will be developed, building on learning from the Local Government Association approach and consideration will be given to how best to monitor ICS development and maturity.

e) There is support for a shift towards prevention and early detection.

f) There is support for greater health and care integration and potentially greater pooled budgets.

36. The full response can be found here: Government response to the House of Commons Health and Social Care Committee's seventh report of session 2022 to 2023 on 'Integrated care systems: autonomy and accountability' - GOV.UK (www.gov.uk).

The Government's 2023 Mandate to NHS England

37. This month sees the first anniversary of the constitution of ICBs on 1 July 2022. To acknowledge the importance of allowing systems the freedom to deliver, the 2023 Mandate is a much different document, responding to the health system's request for fewer targets. The Mandate, which has been developed in consultation with Healthwatch England, applies from 15 June 2023 until such time as another Mandate is published. The overriding priority is to cut NHS waiting lists and recover performance, with the focus on delivering the plan for tackling the backlog of elective care; improving cancer outcomes; improving accident and emergency and ambulance performance; and improving access to GP surgeries. Other priorities are to support the workforce through training, retention and modernising the way staff work; deliver recovery through the use of data and technology; and to continue to deliver the Long-Term Plan to transform services.

38. NHS England has a duty to seek to achieve the objectives in the Mandate and the Secretary of State for Health and Social Care keeps progress against the Mandate under review, setting out his views in an annual assessment which is laid in Parliament and published.

39. The full document can be found here: The government's 2023 mandate to NHS England - GOV.UK (www.gov.uk).

NHS Long Term Workforce Plan

40. On 30 June, NHS England published the NHS Long Term Workforce Plan. Developed in collaboration with staff groups and wider experts, with the support of the government, this is the first time that the NHS has produced a comprehensive long term workforce plan, and it represents a once-in-a-generation opportunity to put staffing on a sustainable footing for the future. The plan, which builds on the valuable work in both the NHS People Plan and the NHS People Promise, sets out a clear direction for the long term and provides certainty of confirmed funding up to 2028, allowing actions to be taken locally, regionally, and nationally to address the gaps in the current workforce

and meet the challenge of a growing and ageing population. These actions fall into three priority areas:

a) **Train**: significantly increasing education and training to record levels, as well as increasing apprenticeships and alternative routes into professional roles, to deliver more doctors and dentists, more nurses and midwives, and more of other professional groups, including new roles designed to better meet the changing needs of patients and support the ongoing transformation of care.

b) **Retain**: ensuring that we keep more of the staff we have within the health service by better supporting people throughout their careers, boosting the flexibilities we offer our staff to work in ways that suit them and work for patients, and continuing to improve the culture and leadership across NHS organisations.

c) **Reform**: improving productivity by working and training in different ways, building broader teams with flexible skills, changing education and training to deliver more staff in roles and services where they are needed most, and ensuring staff have the right skills to take advantage of new technology that frees up clinicians' time to care, increases flexibility in deployment, and provides the care patients need more effectively and efficiently.

41. In the coming weeks and months, NHS England will work with us to co-design the delivery of system-level NHS Long Term Workforce Plan actions.

42. The full plan can be found here: NHS Long Term Workforce Plan (england.nhs.uk).

National Audit Office value for money report: Access to unplanned or urgent care

43. The National Audit Office has recently published a report that provides an overview of NHS services that may be used when people need rapid access to urgent, emergency, or other non-routine health services, and whether such services are meeting performance standards. Its key conclusion is that "More people than ever before are receiving unplanned and urgent NHS care every day. To support these services, the NHS is spending increasing amounts of public money and employing record numbers of people. Nevertheless, patients' satisfaction and access to services have been worsening, suggesting there is no single, straightforward solution to improving what is a complex and interdependent system. NHS England's recovery plan for urgent and emergency care aims to improve services by March 2024. The long-term trends in workforce, activity, spending and performance indicate this will be a significant challenge."

44. The full report can be found here: https://www.nao.org.uk/wp-content/uploads/2023/06/access-to-unplanned-or-urgent-care-summary.pdf.

Chancellor Jeremy Hunt's speech at the Centre for Policy Studies

45. The Chancellor recently made a speech about improving productivity growth across the public and private sectors, with a renewed focus on public sector reform. Of note were references to the NHS: "in the NHS, we count the number of hospital treatments but not the value of preventative care, even though that saves lives and reduces cost". He trailed his instigation of a review on how to improve the way public sector productivity is measured, noting "Patricia Hewitt's review into how we significantly reduce the number of top down-targets in the NHS made a series of recommendations to help empower local leaders, something I am pleased the NHS has already started to take forward." The full speech can be found here: https://www.gov.uk/government/speeches/chancellor-jeremy-hunts-speech-at-the-centre-for-policy-studies.

NHS England Appointments

21. NHS England has appointed a new Chief Information Officer to oversee digital technology across the health service. John Quinn's key responsibilities will include running and evolving the NHS's critical technical infrastructure and managing cyber security for national services. John has been filling the role on a temporary basis since February and was previously the Executive Director of IT Operations and Enterprise Services at NHS Digital.

22. Kate Brintworth has been appointed to the role of Chief Midwifery Officer for England. Kate has been a midwife for 26 years. She was previously the Chief Midwife for NHS England in the London region. She has worked strategically across many parts of the maternity system.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/07/2023
Paper Title:	**Nottingham and Nottinghamshire NHS Joint Forward Plan**
Paper Reference:	ICB 23 023
Report Author:	Joanna Cooper, Assistant Director of Strategy
Report Sponsor:	Lucy Dadge, Director of Integration
Presenter:	Lucy Dadge, Director of Integration Mark Wightman, Director of Strategy and Reconfiguration Victoria McGregor-Riley, Locality Director, Bassetlaw and Mid-Nottinghamshire

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

Summary:

NHS England (NHSE) guidance for the development of Joint Forward Plans (JFP) was published on 23 December 2022. The JFP sets out the NHS's contribution to delivery of the Nottingham and Nottinghamshire Integrated Care Strategy and how NHS core services will be recovered and made sustainable over the five-year period 2023-2027.

Our aim is to articulate an ambitious approach in the JFP that provides the detail of how we will deliver the Integrated Care Strategy and the specific interventions, programmes and projects that we will implement to meet our collective ambition.

The plan has been co-produced with system partners and citizens during May and June to ensure there is system support for the JFP as our collective plan.

The final draft plan was published online on 30 June to meet NHSE requirements and is presented to the ICB Board meeting on 13 July for approval.

Recommendation(s):

The Board is asked to:

- **Approve** the NHS Joint Forward Plan and supporting documents, indicating the preferred design for a formal launch of the plan by end of July 2023.
- **Discuss** the proposed approach to inform the development of future system strategies, and for the future governance and oversight arrangements of delivery to provide assurance of, and confidence in, the achievement of the ambition of the JFP.

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

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

Appendices:

Appendix 1: Final draft NHS Joint Forward Plan
Appendix 2: Final draft Executive Summary NHS Joint Forward Plan
Appendix 3: Final draft public facing summary NHS Joint Forward Plan
Appendix 4: Proposed design options for the final NHS Joint Forward Plan
Appendix 5: Summary engagement plan for JFP development

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 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.

Report Previously Received By:

Reports have been provided to the Board in closed session and with the Strategic Planning and Integration Committee at its previous meetings.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No

Nottingham and Nottinghamshire NHS Joint Forward Plan

Background

1. The Nottingham and Nottinghamshire NHS Joint Forward Plan (JFP) responds to the requirement for ICBs and their partner NHS trusts and foundation trusts to develop five-year joint delivery plans following the publication of Integrated Care Partnership (ICP) Integrated Care Strategies.
2. The NHS Act 2006 (as amended by the Health and Care Act 2022) requires ICBs and their partner trusts to prepare their JFP before the start of each financial year. Given this is the first year of publication, 2023/4 JFPs must be published for 30 June 2023.
3. Whilst national guidance has been provided in respect to the content of the JFP the ICB Board and the ICS Executive Leadership Group have agreed the scope of the Nottingham and Nottinghamshire JFP should contain specific reference to:
    a) The recovery of NHS core services and making them sustainable
    b) Show how the NHS will support the delivery of the Integrated Care Strategy by shifting resource from treatment to prevention, focusing on those communities where need is greatest and integrating services around people and their communities.
4. The final draft JFP was published online on 30 June to meet NHS England requirements and is being presented to the ICB Board meeting on 13 July for formal approval (Appendix 1).
5. To compliment the published document an Executive Summary (Appendix 2) and public facing summary (Appendix 3) have been produced. The intended audience of the JFP is primarily health and care professionals. The document includes an extended Glossary of Terms to encourage a wider breadth of professional access and understanding. The Executive Summary and public facing summary are intended to be more accessible to the general public.
6. It is proposed that the JFP is formally launched by the end of July 2023. Worked examples for the professional design of the JFP are shown in Appendix 4 for Board members to discuss and approve their preferred option.

Developing our plan

7. The JFP and its supporting documents have been developed with system partners and citizens during May and June to ensure there is system support for the JFP as our collective plan for the next five years.

8. Partners have been engaged through system groups and within organisations. A summary of the system partners and groups engaged is included in Appendix 5.

9. To date, formal feedback on the JFP has been recorded from 104 sources (meetings or correspondence). A record of the feedback received and how this has been reflected in the plan is available on request. Key themes from the feedback include:

    a) The plan has been generally well received by partners with agreement on the clear read across to the Integrated Care Strategy aims, principles and strategic priorities for the system.

    b) Support expressed for the ‘all age’ approach with parity between physical and mental health.

    c) Further consideration of pace in delivery of the JFP commitments with the need to instil a sense of urgency to address the issues that system partners collectively face.

    d) Ensuring that the Plan is underpinned by strong governance, oversight and assurance mechanisms to ensure collective delivery.

10. All feedback has been reviewed and incorporated as appropriate by subject matter or editorial leads. This has necessitated maintaining a balance between content detail and maintaining focus/brevity within the document.

11. To further support co-production a survey was developed and shared with broader stakeholders including citizens on 5 June 2023 to give them opportunity to share their thoughts on the emerging content of the JPF. The survey closed on 18 June 2023 and received 168 responses.

12. There was support for the four areas of focus described in the survey:

    a) Helping people to manage their long-term health conditions by diagnosing them earlier and supporting them to avoid getting worse

    b) Reducing illness and disease prevalence by focussing on prevention

    c) Reducing pressures on emergency services

    d) Ensuring timely access and early diagnosis for cancer and elective care

13. A number of themes arose from the qualitative data, including a need for specific focus in the JFP on the following:

    a) Recruitment and retention of NHS staff

    b) Discharge pathways that feel seamless to patients

    c) Personalisation of care

    d) Equity, integration and prevention

14. Again, feedback was incorporated into the main body of the document or specifically within Summary workplan slides by subject matter leads as appropriate.

15. A version of the draft plan was submitted to NHS England on 22 May in line with their expectations. This is not a formal assurance process; however, NHS England indicated confidence that all national requirements have been addressed and the draft plan received positive feedback.

Evaluation of the approach to inform future strategy development

16. To inform the development of future iterations of the JFP and other system strategies (e.g. Integrated Care Strategy) it is proposed to undertake an evaluation of the approach used for this initial JFP. The purpose of this evaluation will be to agree with system partners our collective approach to strategy development going forward.

17. The Director of Integration will agree a scoping proposal for the evaluation with key stakeholders during July 2023. It is likely that a mixed method approach will be used, combining a short survey with follow up interviews with key stakeholders. This will be broad in nature with quantitative and qualitative questions which could test:

    a) How engaged stakeholders felt in the development of the JFP.

    b) How stakeholders felt that their feedback was reflected in the final version of the plan.

    c) In the future refresh of the plan, what would stakeholders keep / change / strengthen about the process.

    d) How could these insights be used in the co-production of future system strategies more generally across Nottingham and Nottinghamshire ICS and ensure shared ownership and responsibility for delivery across partner organisations.

18. System partners will have the opportunity to endorse the outcome of the evaluation, and proposed future approach, prior to further consideration by the Strategic Planning and Integration Committee. It is important that whilst this is a targeted and focussed piece of work, the outcome is co-owned and co-produced.

19. The outcome of this engagement will be provided to the Strategic Planning and Integration Committee in September for discussion. Following further feedback from this consideration a Board workshop will be undertaken in the Autumn.

Oversight and delivery of the Joint Forward Plan

20. Our system is complex and dynamic, comprising multiple stakeholders and communities of interest. Our JFP fully embraces this wide array of both NHS and non-NHS partners recognising the high level of interdependency across all those who serve the health and wellbeing interests of the people of Nottingham and Nottinghamshire.
21. Our JFP specifically provides detailed expectations in relation to the delivery of NHS programmes and initiatives over the next five years that will, in combination, transform the way we work together and how/where we focus our collective efforts and resources. Work will be undertaken to refine key deliverables and milestones across programme areas as part of agreed governance and oversight mechanisms.
22. As a system we will embed a programmatic approach to monitoring delivery of programmes and initiatives – combining our resources to ensure appropriate oversight and further support to teams where delivery fails to meet our agreed expectations.
23. We provide a high-level summary of system step changes that will be made over the next five years in slides 10-11 of the JFP in order to implement our three strategic principles. Slide 12 outlines critical success factors we will use to assess our ongoing achievement of implementing these principles.
24. We provide a high-level summary of interventions that specifically address the four NHS focus areas identified by system population data as providing the greatest opportunity to improve outcomes, address current demand and prepare us better to meet the needs of tomorrow (see slides 28-29 of the JFP). We provide further detail of key deliverables in 20 areas of focus in slides 35-55.
25. Our programmatic approach will lock into established system governance arrangements and provide clarity of oversight to all system partners.
26. Oversight will be supported by more in-depth intervention/action commitments identified across key areas within Appendix 2.
27. Further work will be undertaken with system partners, including our statutory NHS providers, to confirm specific responsibilities for individuals, teams, partnerships and organisations associated with these Action Plans.
28. It is expected that the JFP be reviewed annually to maintain its alignment with national policy expectations as well as focus on ICS priorities. Any review will be proportionate to the need to maintain focus on delivery. As indicated above, the mechanism for future co-production of the JFP will be agreed with system partners and aligned to the programme oversight process.

Appendix 1

DRAFT document

Version Final DRAFT
30 June 2023

To be approved at the ICB Board meeting on 13 July 2023

Nottingham and Nottinghamshire NHS Joint Forward Plan

DRAFT

2023-27

NHS
Nottingham and Nottinghamshire

Our statutory partners

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

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

NHS Nottingham University Hospitals NHS Trust

NHS Sherwood Forest Hospitals NHS Foundation Trust

NHS Nottinghamshire Healthcare NHS Foundation Trust

NHS East Midlands Ambulance Service NHS Trust

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

Bassetlaw Place-Based Partnership

Mid-Nottinghamshire Place-Based Partnership

Nottingham City Place-Based Partnership

South Nottinghamshire Place-Based Partnership

Nottingham City Council

Nottinghamshire County Council

NHS England

Nottinghamshire Health & Wellbeing Board

CityCare

NEMS Community Benefit Services

NICE National Institute for Health and Care Excellence

DHU Healthcare

pics Primary Integrated Community Services Ltd

BCVS Bassetlaw Community and Voluntary Service

DementiaUK Helping families face dementia

healthwatch Nottingham & Nottinghamshire

Plan contents

This plan sets out how we will work differently, where we want to be in five years and how we will get there

Foreword from our Chief Executives

We have a collective ambition to improve the health and wellbeing of our local population. Our Integrated Care Partnership, acting as the 'guiding mind' of the Nottingham and Nottinghamshire Integrated Care System, published its Integrated Care Strategy 2023-27 in March 2023.

This Strategy describes our ambition, challenges and intended achievements to ensure that ***every person will enjoy their best possible health and wellbeing***.

This ambition is testament to the hard work and dedication of our staff who continue to work tirelessly across all our NHS and partner organisations to deliver safe and high quality health and care services to the people of Nottingham and Nottinghamshire and beyond.

We face multiple challenges in converting this ambition into action. Recruitment and retention of staff remains a priority and demand for services continues to rise. We continue to seek to recover services following the pandemic. Covid-19 highlighted underlying health inequalities across our communities and clear opportunities to improve healthy life expectancy and life chances for those who are most disadvantaged.

This five-year Joint Forward Plan has two specific and interlinked aims:

1. To recover NHS core services and make them sustainable.
2. To show how the NHS will support the delivery of our Strategy by shifting resources from treatment to prevention, focusing on those communities where need is greatest and integrating services around people and their communities.

This Joint Forward Plan demonstrates our determination to stay on course to deliver the ambitions of the Strategy. The Plan provides more detail as to 'how' we will deliver the Strategy, the approach we will take and the specific interventions that we will implement in order to meet our collective ambition over the next five years.

In delivering the Strategy we will retain the three strategic principles of:

PREVENTION, EQUITY and INTEGRATION.

Over the next five years, our collective focus will be on preventing people becoming ill, reducing the impact of ill health and empowering people to manage their illness themselves. We will reduce health inequalities across our population and we will promote equity.

We will do this in partnership with our local authorities, public and voluntary sector organisations, our population and communities. We will build on the momentum of our Joint Health and Wellbeing Strategies to tackle the wider determinants of health and support people to live healthier lives.

We will not simply rely on large-scale change programmes to achieve this. Our commitment to reducing health inequalities, promoting equity and prevention will simply become 'the way we work'. Our teams will be empowered to ensure every contact counts and encourage all voices to be heard in how we respond to our current challenges, as well as co-create our health and care services of the future.

We recognise that achieving our collective ambition will require us to accelerate our collaborative working at neighbourhood, Place, system and regional level. Our teams will be more integrated, developing proactive care to prevent ill health and helping people stay healthier at home for longer. We will rapidly scale up personalised care planning, working with those with lived experience and local communities to co-create solutions that build on personal strengths as well as community assets. We will actively seek out voices that are seldom heard so that all may contribute to building our transformed system.

We will redeploy investment and resources into services to support prevention, earlier detection and interventions that impact on population health. We will seek to reduce inequity across our system, in areas such as improving healthy lifestyles and promoting the building blocks of good health in employment, education and housing.

Over the next five years, these changes will result in a significant cultural shift in the way we work together and a radical overall transformation of the system in which we work.

This Joint Forward Plan commits our NHS organisations to delivery of key national expectations and will be a primary reference point for future strategic and planning decision making. It provides detail on how we will continue to improve and meet or exceed national standards in relation to elective care recovery, patient waiting times, access to primary care and other services. Nottingham and Nottinghamshire performs well compared to certain national indicators and this Plan demonstrates our commitment to remain one of the best performing systems in the East Midlands region, if not nationally.

We know we will not achieve the improvement in our population's health and wellbeing without thinking creatively, acting bravely and maintaining focus. We commend this Joint Forward Plan as a clear statement of our determination to do just that.

NHS Nottinghamshire Healthcare NHS Foundation Trust
NHS East Midlands Ambulance Service NHS Trust
NHS Nottingham and Nottinghamshire
NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
NHS Sherwood Forest Hospitals NHS Foundation Trust
NHS Nottingham University Hospitals NHS Trust

Section 1. Our approach

Introduction

Our Nottingham and Nottinghamshire Integrated Care Partnership has developed an integrated care strategy for our system, with the expectation that collaboration across all partners will deliver four core aims, and that delivery of these will be guided by three underlying principles:

We now have to translate this intent into action – encouraging local people, neighbourhoods, communities, staff, Place Based Partnerships and system partners to all play their part. This Joint Forward Plan acts as the NHS delivery commitment for all NHS organisations within the Nottingham and Nottinghamshire Integrated Care System (ICS), with intentions in line with our two Joint Health and Wellbeing Board Strategies for the city and county.

This Plan sets out the role that NHS partners will play in collaboration with our wider system partners in delivering our Strategy as well as the national expectations set out by NHS England. We want to be ambitious – we trust the passion, experience and commitment of our staff to enable us to be brave in the changes we intend to introduce or accelerate. We recognise that our communities face huge challenges and that we need to ensure every public pound, and all our combined effort, is focused on helping every person within Nottingham and Nottinghamshire to enjoy their best possible health and wellbeing.

We want to emphasise in this Plan how, by acting as an NHS team within our ICS, we will address the challenges of today as well as tomorrow. We outline the changes that our system will take over the next five years to ensure we have sustainable services by working differently, co-producing these changes with children, young people and adults, and being courageous in our approach. Our delivery plan responds directly to the priorities identified within our Strategy.

Our agreed 11 Integrated Care Strategy priorities

We will support children and young people to have the best start in life with their health, development, education and preparation for adulthood.
We will support frail older people with underlying conditions to maintain their independence and health.
We will 'Make Every Contact Count' for traditional areas of health, for example, mental health and healthy lifestyles, and incorporate signposting to other services.
We will support children and young people and adults with the greatest needs (the 20% most deprived areas nationally, those in vulnerable or inclusion groups and those experiencing severe multiple disadvantage).
We will focus and invest in prevention priorities, like tobacco, alcohol, healthy weight, oral health and mental health, to support independence, prevent illness, poor birth outcomes and premature death from heart attack, stroke, cancer, chronic obstructive pulmonary disease (COPD), asthma and suicide.
We will establish a single health and care recruitment hub.
We will adopt a single system-wide approach to quality and continuous service improvement.
We will review our Better Care Fund programme.
We will bring our collective data, intelligence and insight together.
We will make it easier for our staff to work across the system.
We will add social value as major institutions in our area.

Underlying principles guiding our delivery

Prevention is better than cure
Equity in everything
Integration by default

Building our integrated approach

Working and behaving differently to deliver maximum impact

We want to transform the way our system works, to improve the lives of the people it serves. In line with the national Hewitt Review and the Fuller Review, our integration approach is widespread, taking in all levels, including colleagues within existing NHS organisations and the development of our four Place Based Partnerships (PBPs), working alongside system-level transformational programmes. Our PBPs will be characterised by empowered local teams working together across upper and lower tier councils. PBPs will be supported to work with our Primary Care Networks (PCNs) and develop integrated neighbourhood working (sometimes in the form of multi-disciplinary teams). Focus for these teams will be where population health intelligence suggests it would be most impactful, either in terms of improving health and wellbeing outcomes and/or improving cost-effective use of our collective resources. Ongoing evaluation and system level assurance mechanisms will enable us to refine and adapt these approaches as well as rapidly spread good practice and learning.

Our system model (see Figure 1) shows how our various partners 'lock' into our shared integrated system approach. The triangle of inter-dependency is strong, with all partners and elements of our system playing their role in delivering change based on the platform of the Integrated Care Partnership and the Integrated Care Strategy. The three strategic principles of Prevention, Equity and Integration remain the basis for this platform.

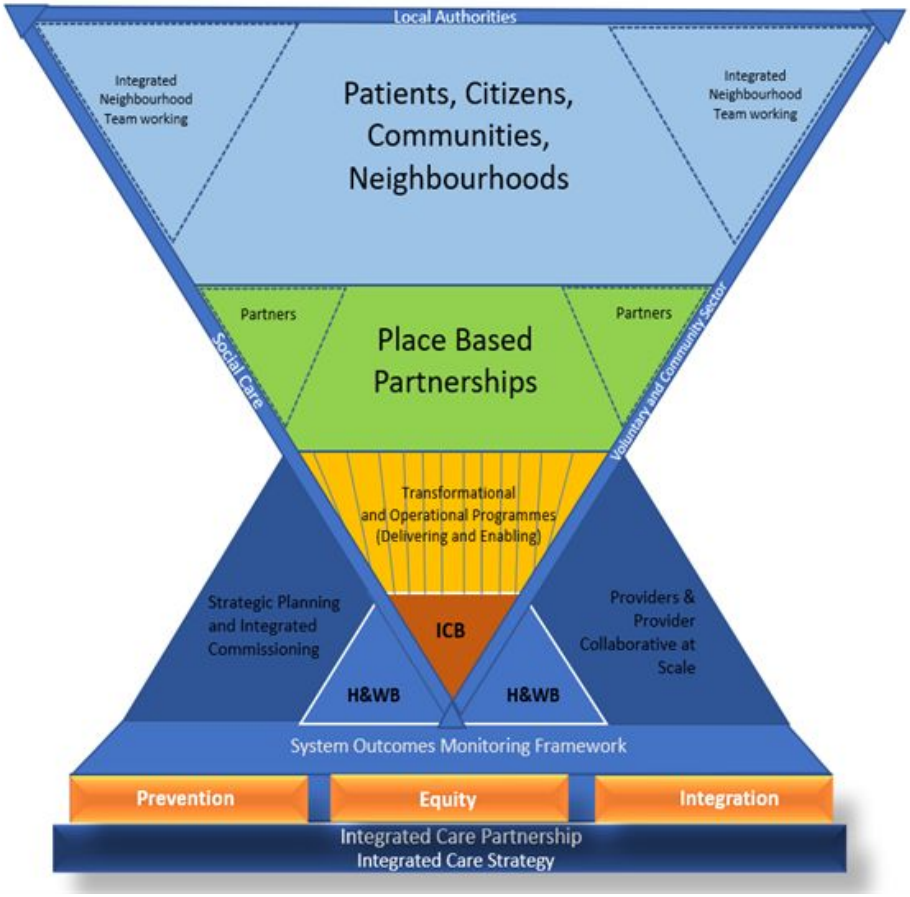
The benefits of this approach will be:

- Transformational change driven and owned by people closer to where people live
- Interventions co-designed with a better understanding of the context within which people live – interventions more sensitive to local need and therefore more impactful and cost efficient
- Relationships across partners and with communities are stronger and better able to use local resources – for example, creating innovation through integration/combined posts/shared knowledge and skills transfer
- More direct communication channels – professionals get to the right person/organisation more quickly to resolve the problem. Informal and formal mechanisms of engagement expand opportunities to make appropriate professional connections
- PBPs offering a way to drive local transformational change initiatives working in collaboration with system level experts, in areas such as public health, clinical and social care.

We will review our ICB operating model to further support this integrated system approach (see page 54).

Figure 1.

Evolving our integrated working model



Building our integrated approach

Delivering through improved prevention, reducing health inequalities and promoting equity

Our Plan is built on the shared commitment of all local NHS leaders to create conditions for success. We value our staff and recognise the significant contribution they can bring to finding creative solutions to the challenges we face. The NHS partner organisations, with local people and our communities, are well placed to ensure a sustainable health and care system that improves the long-term health and wellbeing of the people we serve. We share this motivation with our partners across our local authorities, wider public sector and our voluntary and community services.

We will achieve our future system by creating incentives for change. These areas include changes in focus, funding, structure, process and culture across our organisations, teams and individual staff members.

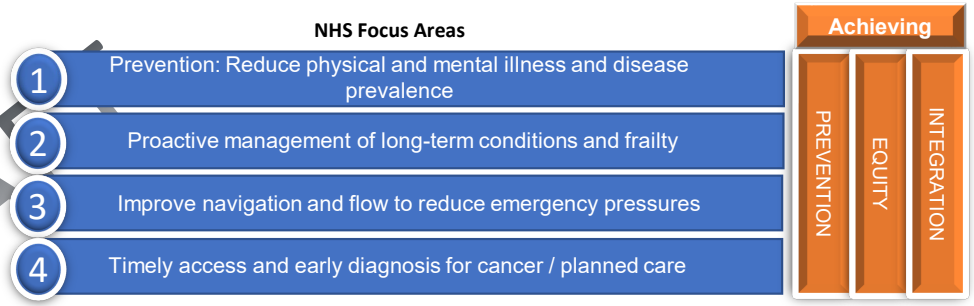
We will continue to deliver on national performance and delivery standards, as outlined within the NHS England 2023-24 Priorities and Operational Planning Guidance (Appendix F).

Delivering today while preparing to meet the challenges of tomorrow

"Prevention, population health management and reducing health inequalities are not a distraction from the immediate priorities: indeed, they are the key to sustainable solutions to those immediate performance challenges." Hewitt Report 2023.

In Nottingham and Nottinghamshire, we know that in a decade there will be a 38% increase in people aged over-85 years living in poor health (see Section 4). By seeking to reduce the growth in demand for costly hospital and specialist skills, unnecessary duplication across services and reducing inappropriate use of all services, we can shift resources into prevention initiatives that reduce demand in later years. We will do this while still maintaining safe and effective support for people when they need it. Alongside this, we recognise that babies, children and young people (aged up to 18 years) make up 20% of our population but 100% of our future. By investing in our services for all ages, across physical and mental health, using evidence and population health intelligence to prioritise where we can make the greatest impact, we will accelerate prevention of future ill health, reduce health inequalities and achieve improvement in health inequity.

Data tells us there are four areas which will significantly contribute to sustaining services today and create the conditions for meeting demand tomorrow. Making the significant impact required needs all NHS organisations to consolidate our collective effort over the next five years.



In pages 10-11 we have summarised NHS transformational expectations in line with our strategic principles. Critical success factors are highlighted on page 12. We have included proposed changes to our financial regime and the way we reinvest our resources. This will ensure a financially sustainable system, now and in the future. These commitments recognise that by focusing more on prevention we will generate longer term cost efficiencies that will enable future reinvestment. By promoting equity, we will provide everyone with the opportunity to have improved health and wellbeing (physical and mental). By promoting integration, we will significantly reduce waste and inefficiencies, creating future opportunities for reinvestment.

Developing detailed programme delivery plans and accountability

Our Joint Forward Plan (JFP) recognises the high level of inter-dependency across all those who serve the health and wellbeing interests of the people of Nottingham and Nottinghamshire. It show how we will deliver NHS programmes and initiatives over the next five years and how/where we will place our collective efforts and resources. The principles of oversight of the JFP for partners will be:

- Build on existing and maturing governance frameworks where this works well
- Ensure accountabilities and responsibilities are clearly identified
- Provide clarity of oversight for system partners and ongoing system level awareness of delivery, impact, risks and risk management
- Support ongoing collaboration and commitment to the delivery of agreed activities/programmes of work over the five years as well as an annual Plan re-fresh.

As a system, we will embed a programme approach to monitoring delivery of these initiatives. We will combine our resources to ensure appropriate collaborative oversight and further support to teams where delivery fails to meet our agreed expectations. While this approach will mature, current NHS oversight arrangements are in place to ensure all partners are able to co-produce this emergent approach (see Figure 2).

A high level summary of interventions that specifically address our focus areas is provided on pages 28-29. We provide additional detail of key deliverables in 20 key transformation areas on pages 35-55. Further detailed delivery plans have been developed by subject matter leads across our system which will be used to inform our understanding of progress on delivery of our JFP.

Figure 2.

System changes aligned to our three principles are:

PRINCIPLES	Year 1	Year 2	Year 3	Year 4	Year 5
Prevention	Refining our approach and commitment to primary and secondary prevention, building on the contributions and strength of all partners. PBPs will implement a minimum of one Joint Health and Wellbeing Strategy prevention priority, dependent on population needs. PBPs will do more where Place resources support this. Focus will be on key priorities such as smoking, obesity, frailty, mental health, best starts and long-term condition management. Development of care pathways that support people to stay well at home for longer. Development of 'virtual wards' to enable people to be cared for at home/within their communities safely.	Collective focus across our system on a minimum of two Joint Health and Wellbeing Strategy prevention priorities, dependent upon population needs (one of these addressing healthy behaviour choices). Population health intelligence will guide collaboration with our communities and across partners to maximise this impact, for example, including consideration of wider determinants of health, as well as inter-relationship with promoting equity.	PBPs will implement a minimum of three Joint Health and Wellbeing Strategy prevention priorities, dependent upon population needs and Place resources.	PBPs will implement a minimum of four Joint Health and Wellbeing Strategy prevention priorities, dependent upon population needs and Place resources.	PBPs will implement a minimum of four Joint Health and Wellbeing Strategy prevention priorities, dependent upon population needs and Place resources.
	Building on existing Joint Health and Wellbeing Strategy and delivery plans, to agree prevention approaches across health and care pathways. Improving children and young people outcomes and mental health needs will be evident in all Plans over the five years. Through integration and using the skills and resources across the system and Place, and in particular with the support of the VCSE sector and communities, we will gradually accelerate action that moves population need away from treatment. Impact on equity considered for all prevention initiatives.				
Equity	The ICB will continue to provide a dedicated fund to support improvements in health inequalities and equity. This fund will be a minimum of £4.5m.	This fund will increase by 0.2% from baseline year one.	This fund will increase by 0.2% from baseline year two.	This fund will increase by 0.4% from baseline year three.	This fund will increase by 0.4% from baseline year four. This accumulates to circa £30-35m.
	All system partners will improve data quality for ethnicity and disability for all patients and local people to support future analysis. Consideration of 'proportionate universalism' as part of strategic decision-making processes.	Enacting the principle of 'proportional universalism', partners will commit to target resources to higher levels of need informed by system data and intelligence. Solutions co-produced inclusively with local communities, engaging with and listening to those whose voices are seldom heard. We recognise that a whole population approach is required and that our opportunities relate to the sum of all the parts of the system. Each partner has a role to play in impacting on equity.			
	All partners will commit to a Population Health Framework.	Ongoing oversight of delivery of our agreed transformation initiatives/commitments across Places, primary care, community and acute sectors.			
	Embed parity of esteem for physical and mental health needs across all policy areas (including maintaining a focus on dementia).				
	Development of a Strategic Co-production Representative Group. Creation of co-production toolkit and network.	Ongoing oversight of co-production approach as part of Integrated Care Strategy commitments. Roll-out of training offer.			Co-production embedded as default within system.

System changes aligned to our three principles are:

<table>
<tr><th>PRINCIPLES</th><th>Year 1</th><th>Year 2</th><th>Year 3</th><th>Year 4</th><th>Year 5</th></tr>
<tr><td rowspan="4">Integration</td><td>PBPs will develop a Place plan outlining delivery of interventions to address key priorities, including Core 20+5 (adults and children and young people) and Joint Health and Wellbeing Strategies. Based on local priorities identified by the System Analytics and Intelligence Unit and public health teams, PBPs will develop integrated neighbourhood team working to curb demand growth, focusing on keeping people out of hospital wherever possible. Delivery will build on the success of our community transformation programme.</td><td>Based on identified local and system priorities, PBPs will develop integrated neighbourhood teams to curb demand growth, focusing on keeping people out of hospital wherever possible.</td><td colspan="3">Based on local and system priorities identified by the System Analytics and Intelligence Unit, PBPs will develop integrated neighbourhood teams to curb demand growth, focusing on the prevention agenda.</td></tr>
<tr><td>Development of a system monitoring and delivery assurance framework for the ICP Strategy and JFP. Development of an agreed inclusive approach to annual JFP refresh.</td><td colspan="4">Ongoing system level assurance and delivery oversight of the ICS Integrated Care Strategy and Joint Forward Plan.</td></tr>
<tr><td colspan="5">Developing multi-disciplinary personalised care plans and active case finding for those at greatest need to support their health, care and independence needs.</td></tr>
<tr><td>System transformation programmes will develop strategic plans across the partnership to address key strategic priorities to be delivered at a system level.</td><td colspan="4">Ongoing system level leadership, assurance and delivery oversight with governance that reflects system working. Development of a system level project management office to support oversight.</td></tr>
<tr><td rowspan="4">How we will use our resources differently</td><td>Agreement on system funding and resources for sustainable Place delivery teams and PBPs.

Approach based on agreed Place plans and responsibilities, supporting development of integrated neighbourhood team working, delivery of Primary Care Strategy and wider integration approaches supporting delivery of JFP.</td><td>Reprioritisation of funding/resources on prevention, moving from treatment services to prevention services to address system priorities, for example, smoking, obesity, alcohol.</td><td colspan="3">Recurrent investment in prevention where it will have the greatest value, recognising the valuable contribution across all partners (NHS, statutory and non-statutory) and through our structures (with an annual investment uplift dependent upon affordability and return-on-investment assessment).</td></tr>
<tr><td>Review of Better Care Fund with specific reference to supporting PBP plan delivery and delivery of the three guiding principles.</td><td>Application of Better Care Fund review outcomes to support initiatives aligned to the three guiding principles.</td><td colspan="3">Ongoing assurance of use of Better Care Fund to maximise investment to achieve delivery of the ICP Integrated Care Strategy, Joint Forward Plan and Joint Health and Wellbeing strategies.</td></tr>
<tr><td colspan="2">Development of equity framework that demonstrates the opportunity to impact on access across interventions including the re-distribution of resources. Testing out on a small scale (years one-to-two) moving resources to population need.</td><td>Development of equity framework that demonstrates the opportunity to impact on patient experience and outcomes.</td><td>Equity framework refined and model tested in relation to the distribution of financial resources.</td><td>Equity frameworks embedded across all activities that provide a strong universal approach with resources targeted to need.</td></tr>
<tr><td colspan="5">Ongoing system review of opportunities for reinvestment based on invest to save and value-for-money principles. Redistribution of efficiency savings and/or growth funds to those areas of greatest prevention and equity opportunity, to shift health and wellbeing outcomes at a population level. Anchor organisations continue to progress with development of opportunities to advance social value, leveraging the NHS opportunity to contribute to wider social and economic development.</td></tr>
</table>

Critical success factors for our transformational journey will include:

PRINCIPLES	Year 1	Year 2	Year 3	Year 4	Year 5
Prevention	• Health Inequalities Investment Fund to tackle to priorities, for example, tobacco, weight, alcohol and mental health • Evidence-based review of system prevention offer to reshape and integrate services • Commit to increasing percentage spend on prevention • 0.2% of revenue invested in prevention • Develop our Population Health Management approach through the identification of metrics and a system-level reporting framework for NHS as well as Joint Health and Wellbeing outcomes. The ongoing development of detailed analysis to inform future investment decisions • Develop our focus on children and young people across all Places, including progression of UNICEF child friendly status	• System plan for people's first 1,001 days and implement Ockenden recommendations • Review smoking cessation support in antenatal and maternity • Scope multi-disciplinary team family hubs • 0.4% invested in prevention	• All new starters to complete Make Every Contact Count training as part of induction by March 2026 • 0.6% invested in prevention	• 1% invested in prevention	• 90% of frontline care staff completed Make Every Contact Count training • An improvement in healthy life expectancy and life expectancy from birth from 2018-20 baselines • 1.4% invested in prevention • 80% carbon net zero by 2028-32
Equity	• Adoption of 'proportionate universalism' and plan for resource deployment based on need rather than historic allocations: examples of approach provided through commissioning decision-making processes • Improve data quality for ethnicity and disability across primary, community and acute data sets • Review waiting lists and access criteria against deprivation level criteria across acute and community services (including physical and mental health services) • Delivery plan for Core 20Plus5 developed in line with JFP • Identify and address 'care gaps' in anticipatory care and tertiary/secondary prevention across a minimum of the top five high-impact long-term condition areas • Agreement of a collective procurement social value strategy for ICS partners, gaining efficiencies from our combined purchasing power, and supporting sustainability and social value in our communities by March 2024 • Confirm scope of mental health waiting list recovery programme	• At least 75% of people aged 14-years-plus with learning disabilities will have an annual health check • Annual operating plan 2024-25 resource allocation reflects resource deployment review findings • Ethnicity and disability data and waiting list review findings converted into 2024-25 action plan • Core 20Plus5 plan enacted • Identify and address 'care gaps' in anticipatory care and tertiary/secondary prevention across a minimum of the top 10 high-impact long-term condition areas • Development of an ICS all-age mental health strategy, incorporating mental health waiting list recovery	• Core 20Plus5 plan enacted • Partnership working with all major suppliers that identifies opportunities for local apprentice schemes, supports disadvantaged groups and engages with local providers by March 2026	• Core 20Plus5 plan enacted	• Core 20Plus5 plan enacted • A reduction in the life expectancy gap (measured in years) between those living in the most and least deprived areas from the 2018-20 baseline
Integration	• Create a common view of outcomes/quality and performance across system • Develop 'one version of the truth' dashboard to monitor key system priorities and identify actions • Rotation scheme for allied health professionals by April 2023 and review of opportunities to roll-out to other professions by March 2024 • Recruited head of commissioning posts for Ageing Well and Living Well, and head of quality and market management • Scope and vision for provider collaboration agreed: delegation principles and responsibilities commencing 2024-25 confirmed • System assurance, governance and monitoring arrangements established for key system actions, for example, role of ICB, ICP and health and wellbeing boards • Integrated approach to system-wide acute transformation opportunities scoped and agreed, for example, outpatients • Strategic aims and principles embedded into staff induction by March 2024 • Mobilise implementation of the Primary Care Strategy. Establishment of the Primary Care Strategy Delivery Group	• Develop a collaborative, virtual intelligence system across the ICS • Integrated commissioning function and a quality and market management function established across ICS • Integrated discharge hubs implemented	• Strategic aims and principles embedded into all staff performance development reviews by March 2026		• An increase of 10% in the number of jointly employed health and care posts

Section 2. Our ambition

Securing our ambition for our population

What our Joint Forward Plan will mean for us, our patients and our partners

Our key programmes of work, implemented via leaders at all levels within organisations, will reinforce our commitment to support integrated working throughout NHS organisations and system partners. We have already embarked on novel ways of working across teams, sharing skills and resources in order to create efficiencies and maximise impact for patients. These approaches will be accelerated and scaled up over the next five years. Case studies of existing initiatives are shown in Appendix E.

We will change the way we engage with our patients, service users and communities. Our working ethos across all NHS partners will be founded on personalised care and care planning, supporting individuals to feel treated as a person rather than a diagnosis. Through the development of social prescribing, care navigation and 'making every contact count', we will generate a new approach to supporting people to achieve their self-identified outcomes.

This ethos will extend to working more closely with people and communities, including those with lived experience and their carers, to co-create and design services to ensure they remain accessible, relevant, effective and value for money. We will build on and take learning from the embedded co-production and engagement arrangements already in place for children and young people so that all voices are heard across the system.

Co-production will ensure more effective commissioning decisions and more efficient use of available resources across a community. By adopting an asset-based approach and supporting increased community resilience, often through the expansion of voluntary and community sector services, we can realise our aim of improving socio-economic development. All NHS organisations will contribute, developing collaboration into genuine integration to create new delivery forms – either in relation to direct patient care or in terms of the services that enable that care.

Figure 3 outlines what these changes will mean for our system.

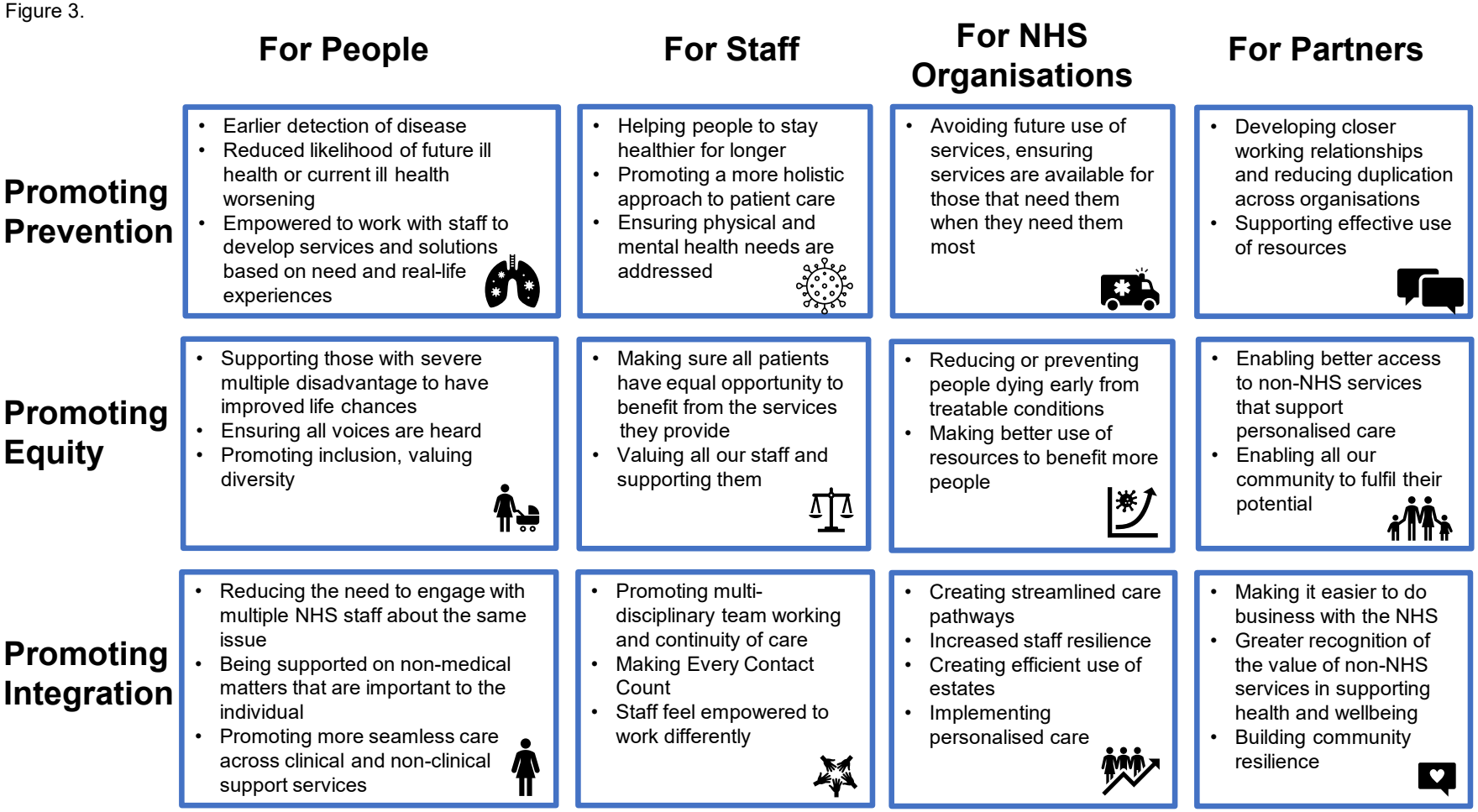
Ensuring delivery and managing risks

Delivery of our Joint Forward Plan will be monitored through agreed governance and oversight arrangements (see page 9). The development of an outcomes framework for providing oversight and monitoring of delivery will require the engagement of all partners. This will include the reporting and collection of high quality data. Our approach to risk management associated with the JFP will remain complementary to organisational and system risk management arrangements. Key risks for the JFP are:

RISK	MITIGATION
Delivery of the JFP and key commitments	System level governance and control mechanisms, supported by clear metrics/milestone reporting, to enable the ICB and partner organisations to monitor, support and be accountable for the implementation of the JFP from 2023-24.
System financial balance impacting on re-investment in prevention	By signing off the JFP, ICB and partners commit to stated investment in health inequalities and prevention. Investment will remain protected across the five years. All partners deliver improvements in the recurrent financial position to secure overall system financial balance.
Cultural and structural changes fail to materialise and achieve anticipated benefits	Development of system-wide communications and engagement to help staff/public commitment. Workforce initiatives, combined with system leadership across partners, create the conditions for change. Data-informed decision-making, ongoing maturity of PBPs, Provider Collaborative, joint working across all partners and integrated neighbourhood teams supports embedded and sustainable change.
Individual partner resilience including workforce	Development of collaborative workforce initiatives, greater integration of teams, ongoing support for voluntary and community sector investment, collaboration on estates and digital, and focus on health inequalities, equity and prevention creates opportunities for more efficient use of system resources. All underpinned by continued focus on quality improvement.

What will delivery of our Joint Forward Plan mean for our community?

Figure 3.



What will the Joint Forward Plan mean for our Integrated Care System?

Success in delivering our five-year plan will mean our ICS will:

- ❑ Enable every person, young and old, to achieve their best possible health and wellbeing. This includes their physical and mental health.
- ❑ Be able to evidence positive impact for our communities in each of our Places and across the system, in terms of both physical and mental health outcomes.
- ❑ Demonstrate positive impacts on reducing health inequalities and inequity. Impact will be linked to targeted interventions, tracked through local and national outcomes metrics.
- ❑ Urgently make a real shift of NHS resources to prevention related initiatives over the next five years, reflected in how resources are allocated to key priorities and by developing new roles and ways of working.
- ❑ Have an inclusive, diverse and innovative culture across the NHS, with a sustainable workforce, local skills pipeline, developing and retaining local talent.
- ❑ Recover services fairly from the pandemic – achieve target waiting times with a focus on equity and close the mental and physical health gap for children and young people affected by the pandemic. We will meet quality and national performance metrics while continuing to adopt a more personalised and proactive approach to care. Care in hospital will be complemented by personalised care planning to maximise patient outcomes and help people to stay well at home for longer.
- ❑ Consistently make the best possible collective use of our resources and be ambitious to gain the best outcomes for local people – working collaboratively to maximise our impact on both physical and mental health and wellbeing during people's lives.
- ❑ Achieve financial balance within a safe health and care system, with high quality, high performing services.
- ❑ Be highly visible and relevant in communities, creating effective partnerships with local organisations that drive change and contribute to social justice, community resilience and economic development in our area.
- ❑ Use community assets, strengths-based approaches and digital tools to support people to take control of their health and wellbeing, with place-based inclusion strategies to promote health equity.
- ❑ Accelerate our research programmes, including service evaluation and audit. We will use population health data, best practice guidance and research evidence to inform the choices and decisions we make. We will work together with our population, Nottingham's universities and our local National Institute for Health and Care Research infrastructure to inform this approach.
- ❑ Use data and intelligence to help us understand issues better, like smoking and obesity, and to allocate resources on this basis. We will tailor and personalise support for people, so that they feel empowered to make healthy changes in areas that are important to them and their carers and families.

In order to deliver this future, we will commit to the key system changes outlined on pages 10-12 which affect the way we work with partners and the communities and how we reinvest our funding. Alongside this, we will develop more detailed change programmes across a wide range of services (as outlined in Section 6).

Section 3. Our system

Our Integrated Care System

How we work together

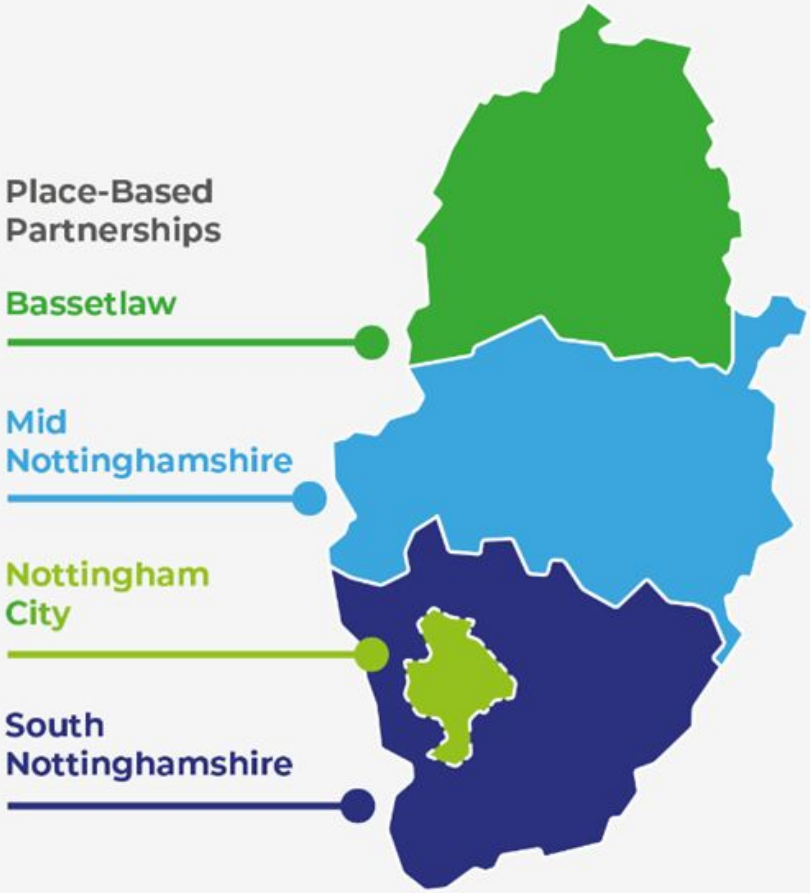
Our Integrated Care System (ICS) has two statutory elements:

- Integrated Care Board (ICB) – a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services. The ICB works to deliver the ICS outcomes with partners from across our system.

- Integrated Care Partnership (ICP) - a statutory committee formed between the NHS Integrated Care Board and upper-tier local authorities. The ICP brings together a broad alliance of partners concerned with improving the care, health and wellbeing of the population.

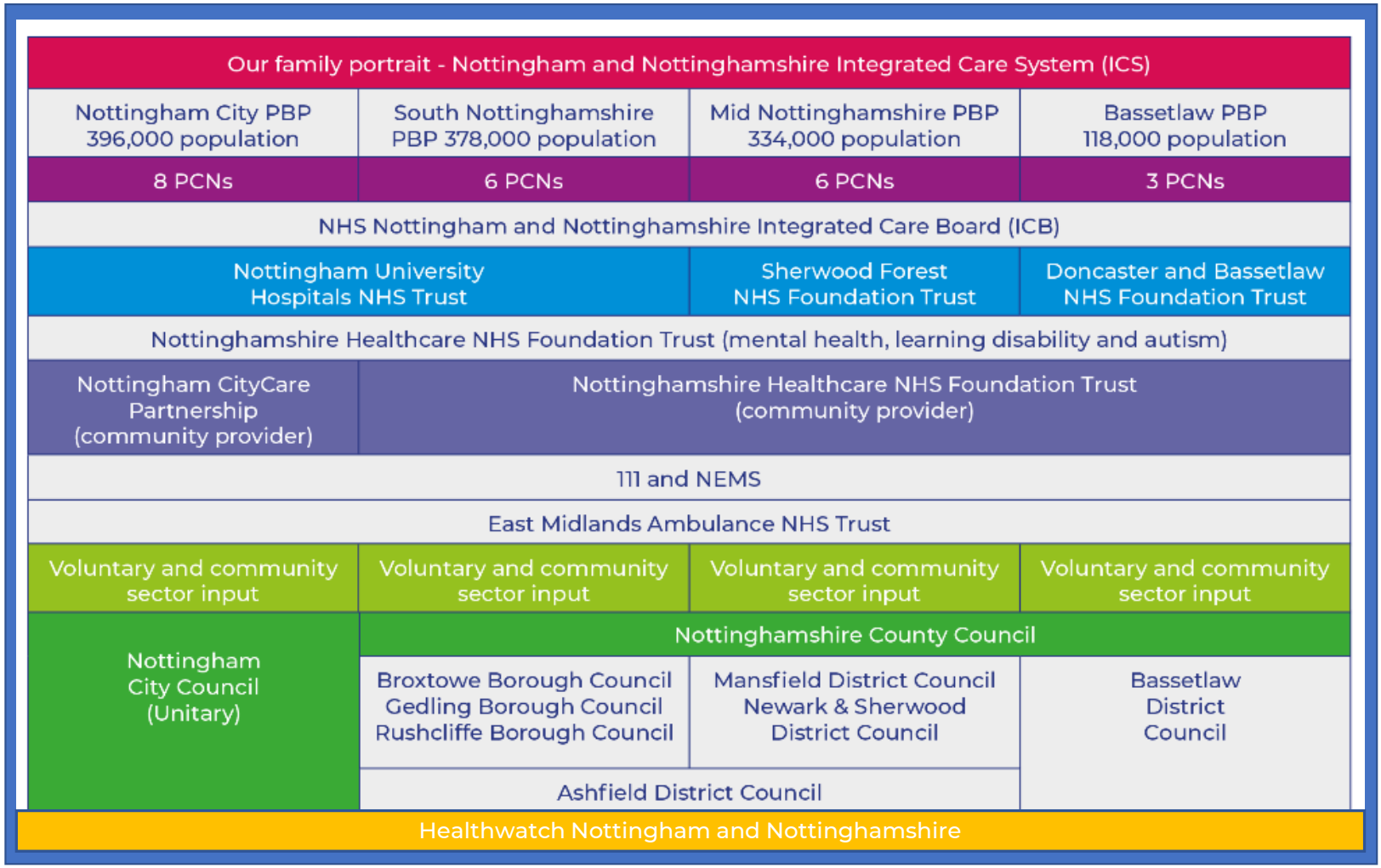
With a combined annual budget of £3.6 billion for the commissioning and provision of health and care services, the partners collaborate at:

- A 'neighbourhood level' through 23 primary care networks (PCNs) covering populations between 30,000 and 50,000
- At a 'place level' through four Place-Based Partnerships (PBPs): Bassetlaw, Mid Nottinghamshire, Nottingham City, and South Nottinghamshire. Each PBP serves a population of about 120,000 to 350,000 people and leads the detailed design and delivery of integrated services across their localities and neighbourhoods. These involve the NHS, local councils, community and voluntary organisations, local residents, people who use services, their carers and representatives and other community partners
- Through 'provider collaboratives at scale' which produce benefits of NHS providers working together, across multiple places to improve quality, efficiency and outcomes, and reduce inequalities in access and experience
- At a whole 'system' (ICS) level



23 Primary Care Networks (PCNs) will operate across the healthcare system, and will be aligned with the four Place Based Partnerships.

Our places and partners



The Voluntary, Community and Social Enterprise (VCSE) Alliance will be an essential part of how the system operates at all levels. This will include involving the sector in how we govern and run the system, how we use data and insights to better understand our population, and how we intend to re-design services. The VCSE sector is a critical partner in the ICS and at a Place level.

Section 4. Our health needs

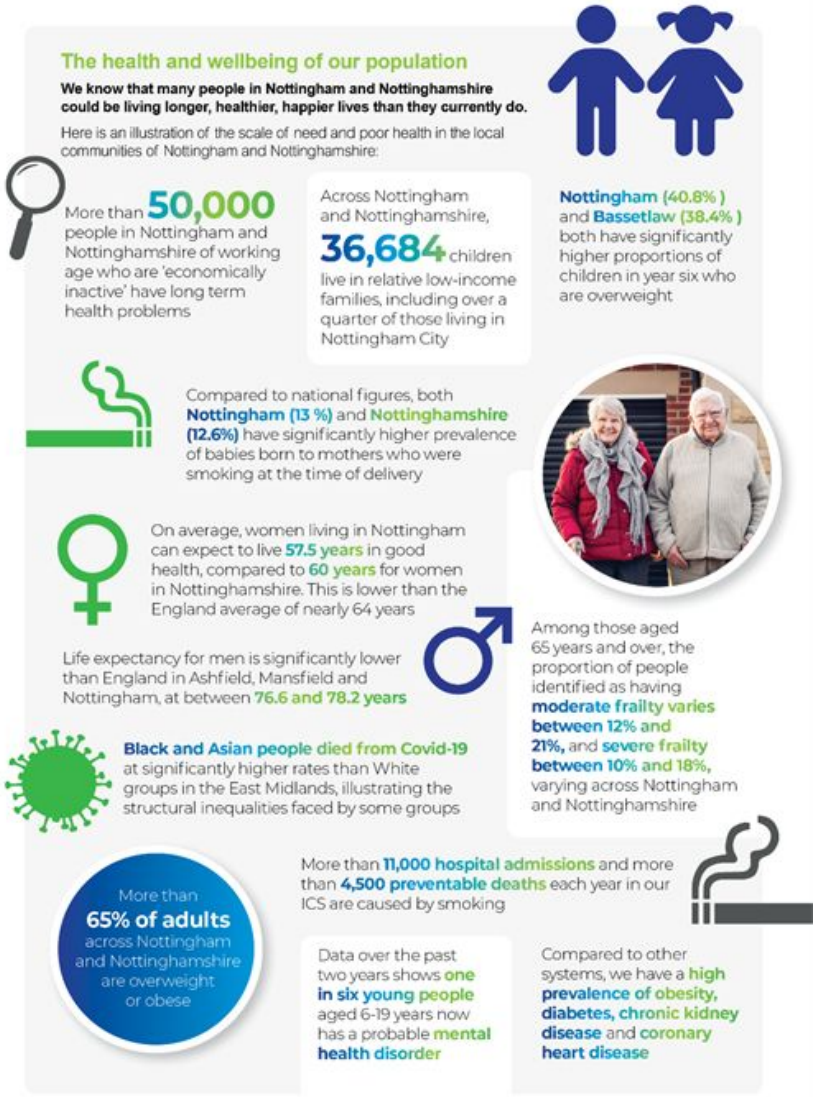
Our population

Local health challenges

We know that many people in Nottingham and Nottinghamshire could be living longer, healthier, happier lives than they currently do – as explained in our Integrated Care Strategy and Joint Health and Wellbeing Strategies for Nottingham and Nottinghamshire.

Our population health management experts have looked at what the future might hold in terms of our population's needs and the anticipated demand and capacity required to meet those needs over the next five to 10 years. The outcome of this modelling underlines how we must fundamentally shift our model of care. Overall, the population of Nottingham and Nottinghamshire will grow by 5% over the next 10 years. However, this figure masks very significant growth in our older population with a 38% increase in people over the age of 85 during the same period. We know that age and illness are closely linked. Currently 70% of emergency beds and 54% of emergency admissions in Nottingham and Nottinghamshire are occupied by people over 65 years old despite that age group comprising just 18% of the population. Of the people currently in Nottingham and Nottinghamshire aged over 65, 81% have a long-term condition and/or a diagnosis related to frailty - just 12% are considered 'healthy'.

Frailty, circulatory and respiratory conditions are more prevalent in older people, and as our older population grows, we can expect more people with moderate and severe frailty, heart failure, stroke, congestive heart disease, chronic obstructive pulmonary disease (COPD), cancer, hypertension and diabetes. 15,000 (or 5.5%) of children and young people (aged up to 19 years) have asthma in Nottingham and Nottinghamshire. This indicates significant under-diagnosing, as the national rate is around 10%. Only 53% have a recorded annual review.



Our population

Local health challenges

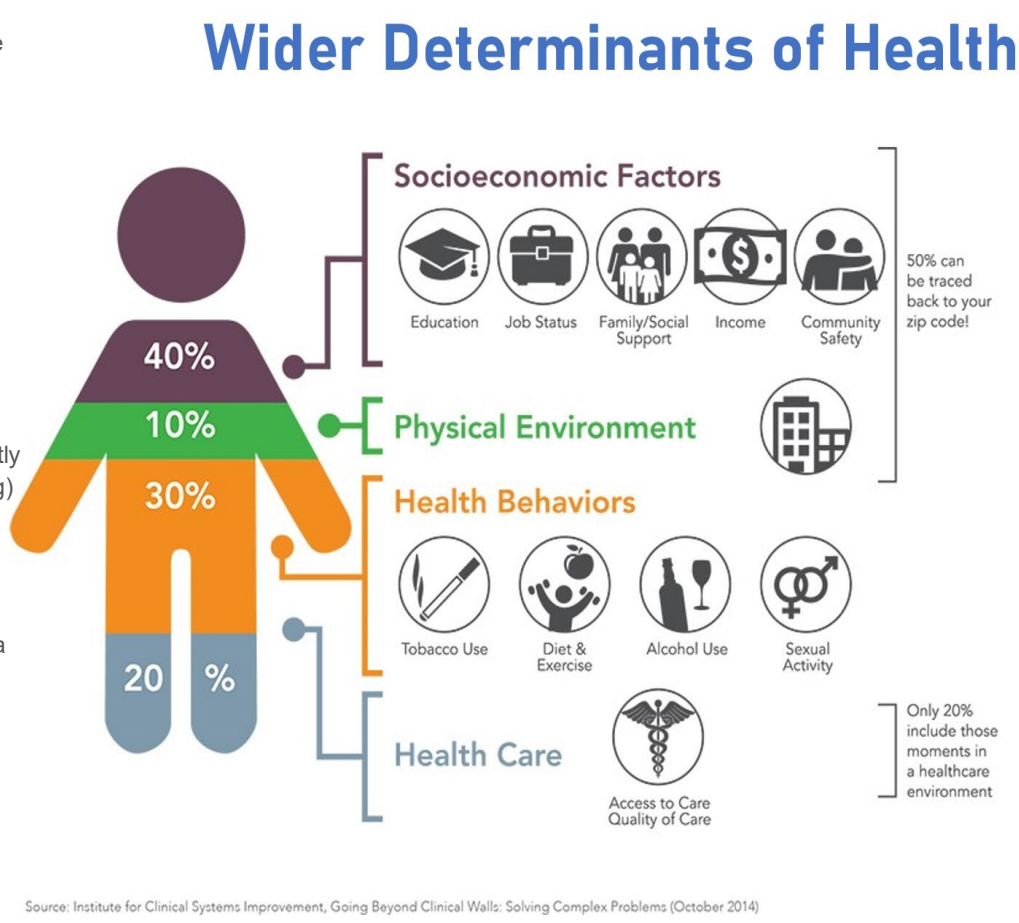
Nearly one in three people with a long-term physical condition also has a common mental health disorder, most commonly depression and anxiety. Across Nottingham and Nottinghamshire, there are 8,880 adults, children and young people aged 15 years-plus on the GP severe mental illness register. These people are:

- At higher risk of emergency admissions compared to the general population
- 4.5 times more likely to die prematurely than those who do not have severe mental illness
- 37% of people identified with severe mental illness are smokers, 34% of obese
- The prevalence of severe mental illness is higher in black and mixed ethnicity groups and in socio-economic deprived areas.

The impact of wider determinants of health on people's physical and mental health, from birth through to end-of-life and the importance of prevention cannot be under-estimated. For example, smoking has consistently remained the greatest contributor to death and disease across Nottingham and Nottinghamshire for the past 30 years. This combination of age and illness (greatly impacted by wider determinants such as healthy behaviours, education, employment and housing) is likely to overwhelm our services in the near future if we continue with the same approach.

We must recognise the continued impact of Covid-19 on our children and young people, with a particular focus on emotional health and wellbeing and school readiness, including speech and language support. A national survey reported that one in six young people (to age 19) now have a probable mental health disorder. This is strongly reflected locally in increased referrals for self-harm, child and adolescent mental health services and school health services.

The high level of relevance of the wider determinants of health on overall health and wellbeing outcomes is reflected in the illustration opposite.



The impact on activity, demand and costs

Population health management data clearly illustrates how demand will increase without action towards greater ill health over the next five years.

For example, mental health services for older people are predicted to see an 11% increase in activity over five years and a 23% increase over 10 years. This is similar to the predicted growth for district nursing services. For primary care, the growth over 10 years is 9%, requiring an extra 600,000 appointments each year.

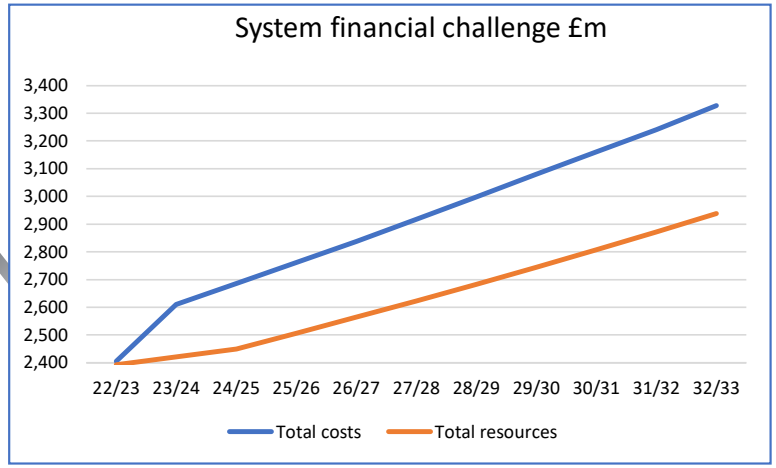
Over five and 10 years, we can expect an 8% and 16% increase in ambulance conveyances and linked to that, a need for a 19% increase in emergency beds (360 beds or about 15 wards).

This modelling does not account for any of the other contributory factors, for example the impact of the current cost of living crisis on both physical and mental health.

The impact of this demand will increase costs within the system. A conservative estimate is that in five years' time (based *only* on demographic growth in our older population and inflation) and the current underlying deficit, the gap will be £650m, rising to just over £1 billion in 10 years.

Public health analysis clearly identifies the opportunity to mitigate this risk of disease burden for our population and increased service demand and costs, through the development of our approach towards prevention, reducing health inequalities and equity.

Without focused action today, to mitigate the rise in demand currently experienced by health and care services and associated funding, the population is likely to be burdened with poorer health and wellbeing outcomes tomorrow. Our desire to shift significant resource from treatment to prevention, and from acute to community based services, will continue to be severely compromised.



POD	POD2	5 yr growth	10 year growth	5 yr growth	10 year growth
CHC (patients - snapshot)	Fast Track (Palliative)	111%	124%	21	46
Mental Health	MHSOP	111%	123%	7,036	14,238
Community & Primary Care	District Nursing	111%	123%	82,701	178,932
Beds	Emergency	109%	119%	157	332
EMAS	See Treat & Conveyed	108%	116%	5,894	12,290
EMAS	See & Treat	107%	115%	2,874	6,108
Community & Primary Care	GP Appointments	105%	109%	317,763	606,594

How the data defines our clinical priorities

Our clinical prioritisation model, based on a population health management approach, informs the Joint Forward Plan in identifying where our efforts are best placed to reduce demand. This analysis builds on high-level demand predictions and focuses on disease prevalence and associated health conditions that are driving demand across our communities.

The table opposite shows which conditions are driving activity in emergency admissions. The ten most common conditions account for 85% of acute bed days. This data enables us to better identify those cohorts of people that need more targeted support outside of hospital. Our approach signals the importance of reducing health inequalities in order to drive system efficiencies. The graph below shows that people living in the most deprived neighbourhoods have healthcare costs (represented by hospital emergency admissions) which are more than double those in the least deprived. The stark differences in disease burden across Nottingham and Nottinghamshire is illustrated in the chart on page 25. This depicts our Primary Care Networks and the variable health and wellbeing challenges their communities are experiencing.

Our Joint Forward Plan will address these challenges. We will develop integrated neighbourhood team working to improve the management of long-term conditions and promoting active case finding, earlier intervention and wider holistic support through signposting into appropriate non-clinical community-based services. This approach, enabling us to better prioritise secondary and tertiary prevention in the early years of our Plan, will achieve resource efficiencies so we can redeploy funding into additional primary prevention initiatives in later years.

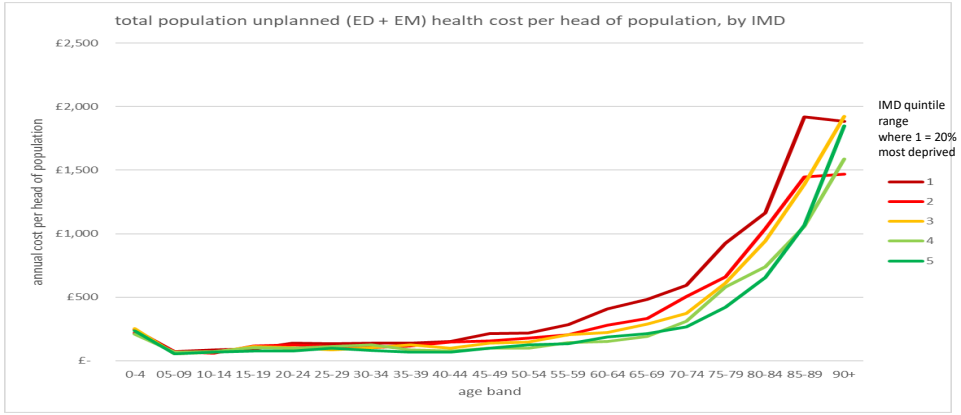
By working collaboratively, with partners, communities and our people, we can co-design and implement changes, that work alongside existing community assets, to reduce health inequalities and help achieve our Integrated Care Strategy priorities.

2019

Age_Band	(Multiple Items)	65+
LoS	(Multiple Items)	1+
Activity_Month_D	(Multiple Items)	2019
Provider_Group	(Multiple Items)	Exclude NHFT

Diagnosis group	Emergency admx	Bed days	Av LOS	Beds	Beds %	Beds cum %
Respiratory	9,680	77,059	8.0	211	18%	18%
Circulatory	7,819	64,233	8.2	176	15%	34%
Fractures and other injuries	4,307	51,993	12.1	142	12%	46%
Digestive	5,639	40,922	7.3	112	10%	56%
Sepsis	2,790	31,762	11.4	87	8%	64%
Mobility	2,769	24,915	9.0	68	6%	70%
Urinary	2,972	22,455	7.6	62	5%	75%
Musculosketelal	1,803	17,149	9.5	47	4%	79%
Dementia, delirium and cognitive problems	1,322	14,075	10.6	39	3%	82%
Cancer	1,176	12,945	11.0	35	3%	85%
Skin conditions	1,123	10,876	9.7	30	3%	88%
Other	1,626	10,654	6.6	29	3%	91%
Anaemia and other blood disorders	635	9,695	15.3	27	2%	93%
Neurological	1,156	8,067	7.0	22	2%	95%
Post-procedural complications	909	6,688	7.4	18	2%	96%
Metabolism	783	5,929	7.6	16	1%	98%
Diabetes	400	3,822	9.6	10	1%	99%
Other infections	295	2,890	9.8	8	1%	100%
Other mental health conditions	160	1,041	6.5	3	0%	100%
Poisoning and toxic effects	133	683	5.1	2	0%	100%
Burns and corrosions	20	295	14.8	1		
Grand Total	**47,517**	**418,148**	**8.8**	**1,146**		

Graph showing emergency admission increase by age and deprivation



The stark differences between our PCN/neighbourhoods

		Deprivation	Risk factors (age-adjusted)			Long term conditions (age-adjusted prevalence)								System outcomes		
PCN Neighbourhood	No of patients	IMD decile	Obesity	Current smoker	Hyper-tension	Diabetes Type 2	COPD	Heart Failure	Stroke	CHD	Cancer	Serious Mental Illness	Moderate/ Severe Frailty	Emergency admissions 1+ length of stay (age-adjusted)	Avoidable deaths (age-adjusted)	Median age of death
BACHS	61,680	2.4	21.5%	16.9%	16.8%	7.9%	3.1%	1.6%	1.6%	3.6%	3.9%	1.0%	3.9%	8,004	355	78
Clifton & Meadows	34,203	2.5	21.6%	17.2%	16.7%	7.2%	3.0%	1.4%	1.7%	3.6%	3.7%	0.9%	2.1%	8,400	329	83
Bulwell & Top Valley	45,878	2.6	22.8%	18.6%	16.4%	7.1%	3.0%	1.3%	1.6%	3.5%	4.1%	0.9%	1.5%	8,227	349	80
Radford & Mary Potter	47,166	2.7	17.5%	17.0%	16.9%	10.4%	2.2%	0.9%	1.4%	4.2%	3.2%	1.5%	4.0%	8,869	429	74
Nottingham City East	65,793	3.0	17.7%	16.9%	14.7%	7.3%	2.7%	1.3%	1.5%	3.3%	3.8%	1.4%	3.4%	7,730	380	76
Bestwood & Sherwood	54,040	3.5	18.7%	13.9%	13.9%	6.2%	1.9%	1.2%	1.5%	3.3%	3.8%	1.0%	2.0%	7,076	296	81
Ashfield North	51,540	3.9	24.6%	15.0%	14.8%	6.4%	2.4%	1.5%	1.4%	3.5%	4.4%	0.7%	1.7%	7,586	323	80
Mansfield North	59,164	4.1	22.9%	13.9%	15.4%	6.3%	2.3%	0.9%	1.3%	3.4%	4.0%	0.6%	2.2%	7,295	326	79
Rosewood	50,717	4.1	20.6%	16.7%	13.6%	6.2%	2.4%	1.1%	1.3%	3.5%	3.8%	0.8%	2.0%	7,291	294	81
Ashfield South	40,460	4.3	24.4%	14.3%	14.0%	6.4%	2.4%	1.0%	1.3%	3.2%	4.0%	0.7%	1.9%	7,312	294	79
Byron	38,408	4.5	21.4%	13.1%	13.9%	6.0%	2.2%	1.0%	1.4%	3.1%	4.3%	0.5%	1.7%	7,496	278	81
Newgate Medical Group	30,076	4.6	21.5%	16.3%	11.6%	6.0%	3.3%	1.1%	1.2%	2.8%	4.0%	0.7%	1.6%	5,917	300	80
Larwood & Bawtry	40,191	5.1	22.3%	13.1%	14.3%	6.6%	3.2%	1.3%	1.4%	3.6%	4.1%	0.7%	3.6%	6,427	251	81
Sherwood	62,794	5.3	22.3%	12.6%	14.8%	6.0%	2.2%	1.0%	1.4%	3.5%	4.2%	0.6%	2.5%	6,726	221	81
Retford And Villages	53,960	5.3	21.7%	11.7%	13.1%	5.4%	1.9%	0.9%	1.1%	2.7%	4.1%	0.5%	2.0%	5,246	207	82
City South	38,198	5.6	15.9%	9.8%	13.9%	5.4%	1.8%	0.8%	1.2%	3.3%	4.0%	0.7%	2.6%	6,975	228	82
Eastwood/Kimberley	37,549	5.9	21.4%	10.9%	13.3%	5.6%	1.9%	1.4%	1.3%	3.1%	4.3%	0.6%	1.8%	6,991	240	81
Synergy Health	30,275	5.9	20.0%	13.0%	13.3%	5.1%	1.7%	0.9%	1.4%	2.9%	4.4%	0.7%	5.5%	6,653	274	81
Newark	78,719	6.0	18.2%	12.5%	13.1%	4.8%	1.4%	1.0%	1.1%	2.8%	4.5%	0.5%	1.7%	5,698	235	81
Stapleford	22,086	6.1	21.7%	12.5%	14.8%	5.8%	1.9%	1.2%	1.0%	3.0%	4.2%	0.6%	1.9%	6,637	233	80
Arnold & Calverton	33,759	6.5	19.0%	11.0%	12.9%	4.9%	1.6%	0.7%	1.4%	2.8%	4.3%	0.7%	2.0%	6,453	203	83
Arrow Health	44,875	6.6	17.9%	11.0%	13.2%	4.8%	1.4%	0.9%	1.2%	2.7%	4.2%	0.6%	1.3%	6,400	219	83
Beeston	49,501	7.4	16.7%	9.9%	13.2%	5.0%	1.5%	1.1%	1.2%	2.7%	4.4%	0.7%	2.4%	6,141	235	84
Rushcliffe North	41,925	8.5	17.5%	8.8%	12.1%	4.0%	1.3%	0.8%	1.2%	2.6%	4.3%	0.3%	1.7%	5,811	163	83
Rushcliffe Central	52,570	8.8	12.9%	6.0%	12.0%	4.2%	1.0%	0.8%	1.1%	2.6%	4.4%	0.6%	1.2%	5,126	171	84
Rushcliffe South	42,646	9.0	16.4%	7.7%	12.2%	4.0%	1.0%	0.9%	1.1%	2.4%	4.2%	0.4%	1.0%	5,169	165	84
Unity	53,068	5.3	9.1%	6.6%	12.9%	3.7%	1.0%	0.7%	1.0%	2.0%	3.6%	0.4%	0.8%	4,182	178	n/a

Key and notes

- Bassetlaw Place
- Nottingham City Place
- South Nottinghamshire Place
- Mid Nottinghamshire Place

Unity's population is almost entirely university students and is presented separately due to its atypical population demographics.

IMD value is the index of multiple deprivation (calculated based on weighted average of registered patients' Lower Super Output Areas deciles as per GP Repository for Clinical Care).

- Most deprived PCN neighbourhood
- Least deprived PCN neighbourhood

COPD = Chronic obstructive pulmonary disease
CHD = Congestive heart disease

Risk factors and prevalence data from GP Repository for Clinical Care April 2023
Emergency admissions data from Secondary Uses Service January – December 2022
Avoidable deaths from Office for National Statistics (ONS) January 2020 – December 2022
Median age of death from ONS January 2020 – December 2022

Section 5. Our care delivery

Delivering the right care at the right time

Our opportunities for targeting joint efforts to achieve maximum impact

The population health profile of Nottingham and Nottinghamshire highlights the need to prioritise certain actions within the health and care system to address our collective challenges. Prevention measures are crucial as the area faces a higher prevalence of long-term medical conditions, particularly in the most deprived areas. Conditions such as COPD, stroke, heart failure, heart disease, diabetes, asthma and mental health conditions have higher prevalence rates among the most deprived parts of the population. Avoidable deaths in the under-75 age group are primarily attributed to cancer, circulatory, and respiratory conditions, with heart disease, lung cancer, COPD, and stroke being the leading causes.

Emergency pressures are significant within the healthcare system, as evidenced by the high percentage of emergency admissions and bed days relating to the over-65 age group. Issues with management of patient flow in and out of hospitals contribute to longer stays for patients once admitted, despite stable emergency department activity.

The relationship between deprivation and healthcare resource utilization is evident, with individuals in the most deprived areas generally incurring higher healthcare costs per head of population. This has been shown for both in-hospital emergency costs and out-of-hospital spending. Given the clear correlation between age and use of healthcare resources, the projected increase in the older age group by 2033 creates an urgency to take action now.

Reducing planned care waiting list times is critical and we must address the disproportionate impact of waits on children and young people. Long waits before accessing planned care can have life-long consequences on the development of children and young people, impacting their ability to access education and lead full and active lives.

The table below shows the key targeted interventions that will be delivered over the next five years through our Place Based Partnerships, Provider Collaborative and via greater integrated team working.

These interventions focus on the need to reduce illness and disease prevalence, encourage proactive management of long-term conditions to avoid crises/escalation of care, improve navigation and flow to reduce emergency pressures, and reduce planned care waiting lists.

The contribution of 'enabling' interventions is further outlined on pages 35-55.

The overall impact on our four aims will be to:

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Enable people to stay well, safe and independent at home for longer. Providing the right care in the right place in the right time.	Ensure services are co-designed and targeted based on shared understanding of health and care needs.
Enhance productivity and value for money	**Support broader social and economic development**
Ensure more efficient use of services and funding by reducing duplication, avoiding waste and addressing inefficient pathways and interventions. Early detection and effective management in order to reduce disease progression/severity and subsequently save resources.	Invest in our community assets and promote more non-clinical support for local people. Enable people to better manage their own health and wellbeing and access support to remain or access work, training and education and make sustainable healthy behaviour changes.

Delivering the right care at the right time

Our opportunities for working differently to achieve maximum impact: high level **delivery commitments**

System interventions	Year 1	Year 2	Year 3	Year 4	Year 5
Prevention: reduce physical and mental illness and disease prevalence	Increase in early case finding. Develop models for future opportunistic case finding. Targeted support for priority cohort linked to prevention, for example, smoking, obesity in children and young people. Embed Make Every Contact Count across NHS organisations.	Development of targeted case finding specifically focused on population health needs across Places and system priorities, for example, frailty, severe multiple deprivation, obesity.	People with multiple long-term conditions receive targeted support in a co-ordinated way with personalisation of care and individualisation of targets. Programme of universal interventions to promote prevention, for example, alcohol, ongoing smoking cessation, obesity (adults and children).		
	Expand self-care/self-management support using approaches sensitive to local and cohort needs. Implement structured education programmes.	System-wide approach to personalised care planning across all sectors (acute, community and primary).	Embed personalised care for all. Expand structured education and learning events consistently across Places and long-term conditions. Development of shared learning opportunities across primary/community and secondary care.		
Proactive management of long-term conditions and frailty to support early identification and avoid unnecessary escalation	Frailty Strategy refresh. Frailty same-day emergency care mobilised/implemented. Frailty data analysis. Focus on diagnostic pathway for children and young people with signs of asthma at an earlier stage. Increase immunisation and screening uptake for 'at risk' groups.	Frailty same-day emergency care embedded. Asthma diagnosis tools embedded within primary care for children and young people.	Working with PBPs to implement joined up frailty pathways across the system. Embed personalised care and advanced care planning for all. Achieve Clinical Design Authority frailty ambitions. Increase rates of annual reviews for children and young people with asthma to support self management plans.		
	Continued identification of physical health issues in people with a serious mental illness thorough physical health checks to ensure proactive management in this group who do not routinely access physical health services. PBPs will support integrated Place plans which address people's physical, mental and social needs (noting that 30% of people with a long-term condition also have a common mental health disorder).				
Improve navigation and flow to reduce emergency pressures in physical and mental health settings	Development of integrated neighbourhood team working across secondary, community and primary care, including the voluntary sector. Establish routine engagement opportunities for clinical interface secondary/primary clinicians.	Embedded integrated neighbourhood team working across community teams. Prioritise those cohorts/pathway development where data indicates there is greatest opportunity for impact at both Place and system level, for example, frailty, respiratory, hypertension, CVD.			
	Develop social prescribing model across all Places/care navigation across primary care, aligned with Make Every Contact Count approach.	Ongoing development of communications and information resources to support awareness of service offers to local people and staff – resources co-designed with users of services, focusing on achieving improved equity across the population.			
	Virtual wards fully established and meeting target activity levels.	Integrated care pathways linked to surgery established for specific cohorts.			
	Embed P1 pathway and the transfer of care hubs.	Develop a co-located urgent treatment centre at QMC.	Urgent treatment centre fully implemented.		
	Expand our same-day emergency care offer across hospitals.				
	Agree model for P2/P3 beds: initiate mobilisation.	Transform our P2 and P3 offer to improve patient flow for patients who are medically safe for transfer.			
		Develop an urgent care coordination hub.			
Timely access and early diagnosis for cancer and elective care	Establish elective hubs and clinical diagnostic centre (Newark, City, Mansfield). Expansion of targeted lung health programme. Implementing community-based breast screening in areas of low uptake. Implementing community-based clinics with high incidence of prostate cancer, for example, Afro-Caribbean communities.	City elective hub (phase two). City clinical diagnostic centre complete. Mansfield clinical diagnostic centre complete.	City elective hub (phase 3). City clinical diagnostic centre complete. Expansion of targeted lung health programme complete.	Ongoing delivery and development of prevention initiatives.	

Delivering the right care at the right time

Our opportunities for working differently to achieve maximum impact: high level **success factors**

System Interventions	Year 1	Year 2	Year 3	Year 4	Year 5
Prevention: Reduce physical and mental illness and disease prevalence	See pages 10 and 12 for success factors related to our focus on prevention initiatives.				
Proactive management of long term conditions and frailty to support early identification and avoid unnecessary escalation	• Using risk stratification to identify, screen and categorise those people at greatest risk of frailty and admission to hospital for PBPs / integrated neighbourhood teams. • Developing multi-disciplinary personalised care plans. • Prioritise tertiary / secondary prevention to delay disease progression. • Reflect the need for system working in all new specialist job plans (for example, geriatricians/orthogeriatricians). • Development of surgical care as part of integrated care pathways across community/acute based teams.	• Established resourced integrated neighbourhood team multi-disciplinary teams to provide holistic care for people at risk of unplanned admission. • Using system intelligence to prioritise specialty areas where non-elective admissions are high, (COPD, frailty, flu, heart disease, stroke, dementia). • Early identification, pulse checks, lung screening, blood pressure, hypertension, cancer screening. • Reflect the need for system working in all job plans. • Target coverage of anticipatory care plans. Roll forwards for years three to five.	Ongoing implementation of years one and two.		
Improve navigation and flow to reduce emergency pressures in physical and mental health settings	• System review of hospital discharge and implementing the Local Government Association recommendations on transfer of care, one shared data set and culture. • System review of Better Care Fund. • Develop and implement management/admission avoidance plan for care homes. • Deliver medically safe for transfer plan target and develop trajectory for years two to five. • Establish elective hubs and clinical diagnostic centres (Newark, City, Mansfield).	• A co-located urgent treatment centre as the first access point and reducing demand on emergency department. • Broadening the same day emergency care offer and ensuring direct access for this from the ambulance service. • Discharge to Assess – additional investment and resource in P1 capacity to reduce people's length of stay • Creation of up to 500 step up/down virtual beds • City elective hub (phase 2). City community diagnostic centre complete. Mansfield community diagnostic centre complete.	Ongoing implementation of years one and two.		
Timely access and early diagnosis for cancer and elective care	• Increase opportunities for virtual appointments/advice and guidance for GPs from secondary care/patient-initiated follow-ups beyond national targets, set trajectories. • Design and test approaches to optimise referrals across primary and secondary care with an initial focus on ear, nose and throat and gynaecology. • Delivery plan for community diagnostic centres. • System-wide ICB-supported approach to productivity improvement using mental health/'getting it right first time' data and ambition for top decile performance. • Analyse current waiting lists and anticipated demand and decide final recovery trajectory beyond plan criteria. • Review procedures of limited clinical value and agree system approach	• Deliver musculoskeletal transformation programme. • Support the Index of Multiple Deprivation waiting list review and access audit. • Work with the Provider Collaborative to scope feasibility of at scale cold site given 'Tomorrow's NUH' delay. • Implement plan for procedures of limited clinical value (with necessary consultation). • Deliver 25% reduction in follow-ups. • Spread and adopt learning from the referral optimisation workstream in other specialities	Fully deliver eye transformation programme. Ongoing implementation of years one and two.	City elective hub (phase 3). City community diagnostic centre complete.	

What will delivery of our Joint Forward Plan mean for patient care?

1 Prevention: reduce physical and mental illness and disease prevalence

- Prioritise prevention and early intervention to effectively reduce the incidence and impact of diseases and costly treatments (including planned care) on our health and care system, leading to long-term cost savings and enhanced health outcomes for our population.
- People supported to lead healthy behaviours and maintain good health from birth and for as long as possible, including education to support self-care.
- Services are commissioned in an integrated way across health, education, social care, public health and housing, improving the experience of care for the population and optimising outcomes.
- Achieve an efficient and effective healthcare system, that optimises the workforce available to us, directing resources to where they are most needed.
- Embracing technology and innovation to enhance the tools available increasing productivity for our workforce.
- Adopting digital solutions in an inclusive way (primary care and community) to improve efficiency, accessibility and patient outcomes.

2 Proactive management of long-term conditions and frailty

- Case finding and screening programmes will target population groups where there are inequalities in uptake to support early detection of long-term conditions in line with our Core20PLUS5 approach.
- Priority for those cohorts where population health management data indicates there is greatest opportunity for impact at both Place and system level, for example, frailty, respiratory, hypertension, CVD.
- People with multiple long-term conditions will be supported in a co-ordinated way with personalisation of care and individualisation of targets.
- Staff will be trained to support the complexity of needs of people with long-term conditions and to manage different diseases providing an opportunity to up-skill staff across specialisms.
- We will make every contact count ensuring people are supported for both their physical and mental health needs.
- Integrated neighbourhood team working will promote proactive care co-ordination for the management of long-term conditions – creating a 'team of teams' that wraps care around people.
- We have services and pathways in place that allow people to receive the care they require in the right place, first time.
- System working and collaboration with system partners to transform medicines use to improve the health and wellbeing of our population.

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

Flow into the hospital

- People know how and when to access urgent and emergency care services when they need it.
- We have services in place to support people who have urgent care needs to be cared for at home for both their physical and mental health needs.
- People who need to use 999 or our hospitals in an emergency are transferred to the hospital and seen in a timely manner.
- We have services and pathways in place that allow people to receive the care they require in the right place, first time.

Flow through the hospital

- People are treated and supported in hospital to a point when they are medically stable. They will be transferred to a place suitable to their ongoing care/rehab needs and plan for longer term support if required.
- Discharge planning starts on admission (or pre-admission where possible).
- Discharge teams are integrated and work seven days-a-week.
- People are assessed for their longer term needs once they are discharged and not before.
- Only those that need hospital care that cannot be provided at home are admitted into a hospital bed, with the remainder going home the same day on same day/community/virtual ward pathways.
- Physical and mental health services are integrated.

Flow out of the hospital

- Multi-disciplinary transfer of care hubs are established at each hospital and operational seven days-a-week.
- People go home, or to a place that is suitable for the support they require, on the day they are medically safe to do so.
- A culture of trusted assessment is embedded across all organisations.
- Virtual wards are established and embedded across the ICS.
- For people in an acute mental health bed, community provision, appropriate housing and supported living will support prevention of admission and timely discharge.
- Community rehabilitation supports people to maximise their recovery in their own homes.

Preventing readmissions

- Integrated Neighbourhood Teams support people to remain at home and manage their health and wellbeing.
- Our population health management approach supports us to identify those most in need.
- Comprehensive care planning for our most vulnerable patients to keep them well and/or at home in a crisis.

4 Timely access and early diagnosis for cancer / planned care

- Cancer and planned care waiting times are within national performance requirements.
- Patients have equitable access based on need with appropriate choice of provider.
- Shared decision making, patients offered options to avoid unnecessary procedures and acute intervention with conservative treatment considered at an early stage closer to home.
- Prioritisation of waiting lists includes clinical risk, health equity, population need. Consideration of the specific needs of children and young people and ensuring parity of esteem for physical and mental health.
- Elective hubs are in place, underpinned by best practice in productivity.
- Shared workforce plans and staff retention, support in place.
- Community diagnostic hubs established and GP direct access enabled.
- Expansion of targeted lung health programme starting this year and completed in 2025-26.
- Breast cancer – implementing community-based breast screening in areas of low uptake.
- Prostate cancer – implementing community-based clinics with high incidence – Afro-Caribbean communities.

Section 6. Our delivery commitments

Place Based Partnerships, provider collaboration and system programmes

How we will do things differently: our delivery methods

We are seeking to make big changes in the way we operate as a system. There are three main transformational ways that will enable this over the next five years and beyond. These are Place Based Partnerships (PBPs), our Provider Collaborative(s) and ICS programmes. These will work in harmony with our partners to achieve both the delivery of the Joint Forward Plan and national policy expectations.

By encouraging and supporting our PBPs and Provider Collaboratives to be radical, we have the opportunity to empower local frontline health and care professionals, working within statutory and non-statutory bodies, to implement transformational change which both supports system priorities and the things which matter most to their local communities. Our system programmes will continue to ensure high-level implementation of change where this makes sense in order to achieve population and system-level outcomes.

At a Place level, Integrated Neighbourhood Teams (INTs) and the integrated neighbourhood working approach (INW) will be integral to this transformation. Our PCNs will play a key role in the design and development of these approaches, aligned to the ethos and approach of the Community Transformation Programme. This will enable focus on population health management-identified specific disease/condition cohorts within a Place footprint (for example, diabetes, COPD) as well as cohorts that are geographically focused (such as those living in the most deprived communities/neighbourhoods). PBPs are able to map existing assets, understand their relative importance to local communities, engage with their populations with greater reach and develop co-designed opportunities sensitive to local community characteristics. Front-line coordination, relationship building, local knowledge and direct understanding of patient need can all combine to create a highly effective coalition able to make better use of our scarce resources.

PBPs will develop Place plans aligned to the Integrated Care Strategy priorities and which address identified opportunities to address the wider determinants of health and the Core20+5 heath inequality priorities for both children and adults. Place Plans will also support delivery of NHS priorities, such as urgent/same day care demand and long-term condition management with a focus on specific cohorts and neighbourhoods, based on system intelligence.

The ICB will support overall system maturity by developing and enabling PBPs and the provider collaborative at scale to accelerate towards greater maturity; to 'pull' for greater levels of responsibility and appropriate and proportionate levels of resources, and provide assurance of delivery of agreed commitments. The development of resourcing and assurance frameworks will be accelerated in year one.

Our Provider Collaboratives will continue to mature in a way that enables our provider organisations to work more intimately and collaboratively on key areas such as workforce, 'back office' functions and care pathways in order to secure sustainable local services.

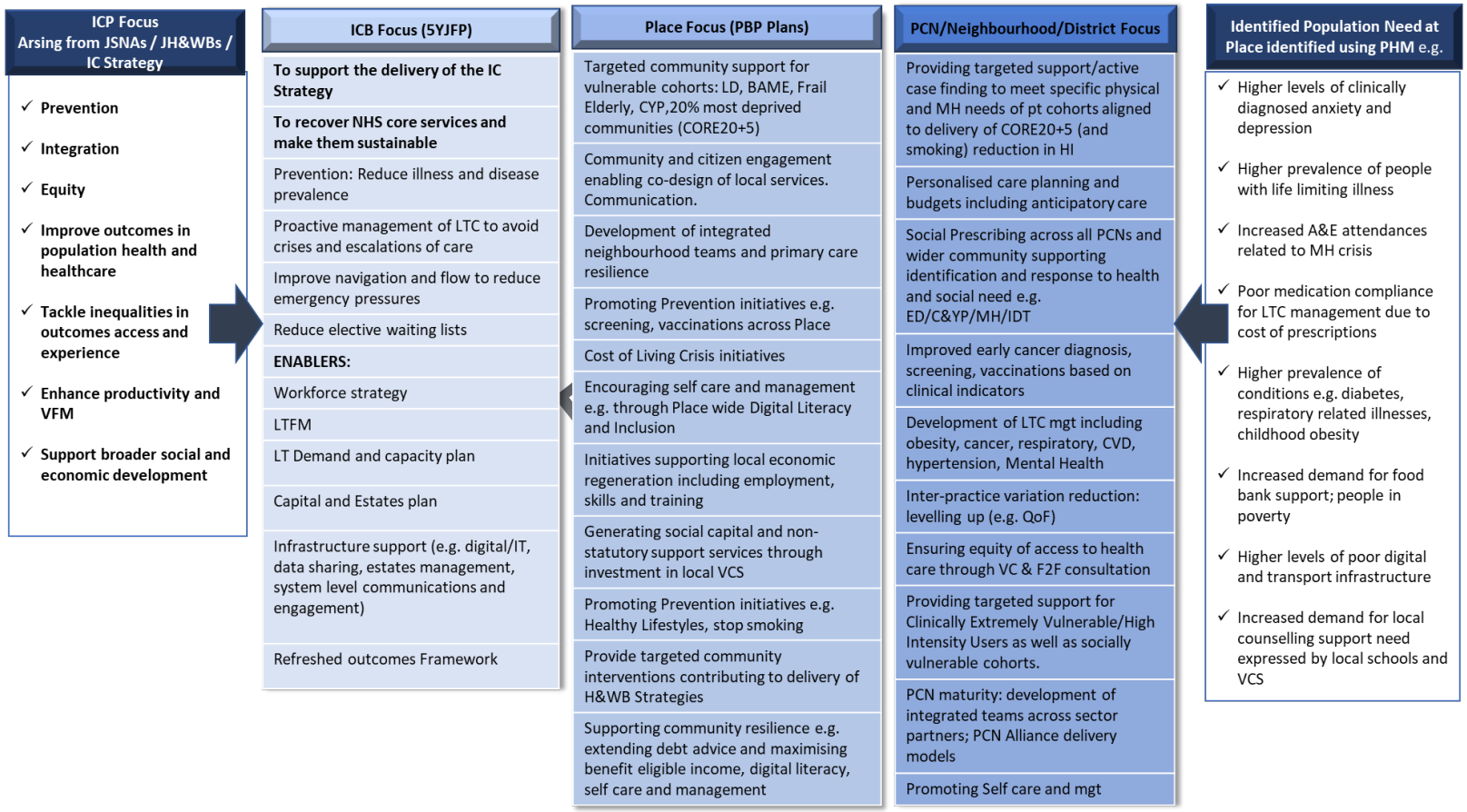
While the Provider Collaborative will provide an 'umbrella' arrangement for NHS statutory partners, it will not be the sole vehicle for driving performance and outcome improvement through provider collaboration. Provider collaboratives may form organically to address specific needs, such as local collaboration between primary and community organisations and general wellbeing support within our Places.

Nottingham and Nottinghamshire ICS health partners will work with existing provider collaboratives across the Midlands to optimise local benefits for local people. For example, opportunities for further collaboration at scale with other ICBs will be considered such as elective recovery and urgent care networks. In appraising options, particular importance will be placed on those with faster and improved access to care, incorporating consideration of health inequalities and equity.

We believe that genuine and meaningful integration of our services and collaboration between all partners will be transformational if we are prepared to collectively create the conditions, and culture for co-operation to become the norm.

How our Places take forward ICS / ICB priorities

How the ambitions of the Integrated Care Partnership, expressed through the Integrated Care Strategy, are supported by the Integrated Care Board's priorities and translated into delivery at Place)



Productivity and efficiency

Achieving more within our resource constraints

Through the pandemic, efficiency schemes and expectations were stood down as we focused on maintaining high quality services that met the changing needs of our population. Ongoing challenges in respect to workforce, industrial action and the impact on population health has meant we have struggled to regain the performance and productivity required.

The system has seen a 12.5% increase of staff in post since March 2020 without a commensurate increase in activity levels. To achieve the best outcomes for our population, we need to use existing resources in the most effective way, regaining our collective focus on reducing waste and increasing productivity.

Our Joint Forward Plan commits us to achieving this, with an accelerated focus on driving cost effectiveness and efficiency over the next five years to ensure all our collective resources are focused on achieving the maximum health and wellbeing gains for our population.

Our productivity and efficiency framework comprises three elements:

- **Clinical transformation** – our population health management approach of prioritising prevention and improving proactive management of long-term conditions, improving navigation and flow, and reducing planned care waiting lists will ease the operational burden on our hospitals. This will reduce the need for additional capacity in busy periods and excess premium staffing costs.
- **Workforce productivity** – our workforce and associated costs have increased significantly in recent years, while activity levels have remained broadly flat. We will look to develop a deeper understanding of loss in productivity through the pandemic, which will enable decisions on how we can increase future activity and improve outcomes within existing workforce levels. Alongside this, our integrated approach to recruitment and retention will place less reliance on expensive agency costs.
- **Operational efficiency** – a single system approach to exploring and delivering efficiency opportunities. We will use benchmarking analysis and national tools (such as Get It Right First Time) to implement best practice. There is a particular focus on areas of collaboration and integration between partners - more efficient use of our collective estate, back office functions, procurement and medicines management.

In our approach we will make use of relevant productivity guidance and recommendations from NICE.

Oversight of delivery of this framework will be supported by the establishment of a system programme management office. Its function will be to ensure routine monitoring and reporting of progress into the ICB Board and associated oversight mechanisms.

Our summary delivery plans

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

Finance

Current state: Our challenges

- **Underlying financial deficit –** all NHS partners within the system carry underlying deficits, annually managed through non-recurrent means. At March 2023, this deficit is recognised as £143m in total.
- **Productivity and efficiency** – through the pandemic, efficiency schemes and expectations were stood down and since then system partners have struggled to get the same efficiency as we have had previously. The system has seen a 12.5% increase of staff in post since March 2020 without a commensurate increase in activity. The plan needs to reflect how we use these increased staffing levels to deliver improved performance and higher levels of productivity.
- **Shape of spend** – the system strategy is based on shifting costs by investing in preventative services and providing care closer to home. This has not been seen in reality with continuing growth in acute hospital services due to continuing urgent care pressures.
- **Capital availability** – system capital funds are scarce and have historically been used to support business as usual maintenance and replacement, relying on national funds to support larger strategic priorities. This has led to some local priorities remining unfunded for some years.

Future state: Our ambition

- **Financial sustainability –** achieve recurrent financial balance by end of year three through improved productivity and efficiency, and transformation of services to ease the burden on urgent care services. This will provide improved services for patients and staff and allow for future investment in ICS priorities.
- **Productivity and efficiency framework** – we will implement a framework that will ensure delivery of productivity and efficiency opportunities. The framework looks at clinical transformation, workforce productivity and operational efficiency. Further detail can be found on page 34.
- **Investment in prevention and tackling health inequalities** – year-on-year increased investment in prevention and reducing inequalities with a step change once recurrent financial balance is achieved.
- **Capital resources used to support strategic aims** – ensure a considerable proportion of the system capital envelope is used to support agreed strategic priorities, improving services and providing better outcomes, access and experience for staff and patients.

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

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Financial sustainability	Deliver in year balance Improving recurrent underlying deficit			Deliver recurrent financial balance. Create headroom to provide resilience.		✓		✓
Investment priorities	Increasing in investment in prevention and equity 0.2% cumulative	0.4% cumulative	0.6% cumulative	1.0% cumulative	1.4% cumulative	✓	✓	✓
Capital investment	Deliver capital plan within notified system envelope Capital prioritisation to support strategy	Increasing capital usage to support strategic aims Min. 10%	Min. 15%	Min. 20%	Min. 25%		✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Financial balance will be achieved by greater investment in prevention, providing care closer to home and less pressure on our urgent care services. Ultimately leading to improved outcomes, access and experience.	Explicit focus on investment to drive equity in our most deprived communities through the Health Inequalities and Innovation Fund.
Enhance productivity and value for money	**Support broader social and economic development**
Through improved service productivity and using our resources more effectively.	Targeted investment, alongside system partners, in prevention and wider determinants of health to keep people well for longer.

Place Based Partnerships

Current state: Our challenges

- Low healthy life expectancy has significant consequences for individuals, communities and services.
- Pressures of 'day job' across all partners, with low capacity and resilience in the primary and community workforce promotes focus on transactional, not transformational change.
- 'Today' challenges consume capability to develop and implement 'tomorrow' solutions relating to prevention and ill health avoidance.
- Pressures on primary care limit the capacity for PCNs to deliver population health management identified opportunities.
- Voluntary sector infrastructure, capacity and resilience is significantly reduced.
- Balancing NHS national/regional/ICB priorities and those generated by non-NHS PBP partners within current Place based resource constraints.
- The ability to create a cultural shift from a paternalistic approach to one where communities are empowered to make the changes themselves.
- Lack of trust in services by our communities; particularly in areas of high deprivation and among minority communities.
- Historical commissioning decisions which impact on service delivery do not always reflect current population health needs post-pandemic and due to cost of living crisis.
- Lack of system clarity on the vision and opportunities for the delegation of responsibilities to Place.
- Need for recurrent funding streams to facilitate sustainable Place-based transformation activities beyond existing ICB investment in place-based teams.
- Organisational silos inhibit progress on integrated public sector estates solutions.

Future state: Our ambition

- We will see a reduction in health inequalities through transformation of services informed through community insight, co-production and sensitive to local population health needs.
- We will have coordinated communications. We will move from community engagement to community empowerment and asset-based approaches in all we do.
- Our community and voluntary sector will be strong and sizeable, maximising community assets to create resilient communities which can support self care.
- We will maximise our social value capacity to address wider determinants of health.
- The 'Place focused' workforce will have shared purpose/values and feel supported working in the PBP, professional pride and enthusiasm in all they do, built around a unified focus on population health management, strength-based approaches and genuine co-production working alongside the people we serve.
- We will have truly integrated teams following a successful roll-out of integrated neighbourhood working across voluntary and statutory services including primary, community and secondary care services, maximising our skill sets.
- PBPs will hold increased level of delegated responsibility for delivery with appropriate resources.
- We will maximise joint commissioning opportunities, particularly around primary and secondary prevention and with our local authority partners.
- Our transformation of services will be sustained through long term investment in evidenced based services with reduced reliance on short-term funding and pilots.
- Our service delivery will maximise use of community buildings and assets.

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

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Implementation of Partnership Place Plans and PBP maturity.	Implementation of the INT approach. Focus aligned to strategy and PHM identified impact on health inequalities and equity. Support for primary care and PCN development.	Collaborative leadership of neighbourhood model embedded. PCN active participation in INTs, maximising skills and capabilities across PCNs and partners.	Place focused individuals from across partners identifying as 'one team'.	Ongoing development and rollout - review of Place impact and spread of learning. Evaluation in partnership with Academic Health Science Network/ universities.	Neighbourhood working fully embedded. Ongoing review and development of PBP role, function and impact.	✓	✓	✓
Delivery of transformation and prevention programmes through a population health approach.	Continue to deliver existing programmes and identify new areas; formalise governance with PBP partners.	Joint commissioning arrangements in place including budget and agreed outcomes, such as voluntary sector commissioning.	Prevention budget allocated and embedded at Place, maximising influence on social and economic factors that affect health and wellbeing.	Community empowerment fully embedded at Place as a prevention approach.	Fully resourced prevention approach embedded across the PBPs.	✓	✓	✓
Development and maturity of Place to enable functions to be delivered at Place and neighbourhood level.	Co-create with ICB the future ICB operating model to inform future place functions. Place resource model and funding agreed.	Place responsibilities and assurance models established. Recurrent transformational resources established.	Fully delegated responsibilities and performance oversight/assurance arrangements embedded.	Ongoing review and development of PBP role, function and impact.	Ongoing review and development of PBP role, function and impact.		✓	✓

How this will address the aims of the Integrated Care Strategy

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

Primary Care Networks

Current state: Our challenges

- Pressures on primary care limit the capacity for PCNs to deliver population health management identified opportunities.
- Capacity and demand in primary care are challenging.
- Workforce pressures growing across primary care, impacting on resilience across the PCNs.
- Estates for the growing workforce and community-based delivery of care is restricting delivery.
- In order to manage current challenges, different models of care are being tested by developing new roles through the national Additional Roles Reimbursement Scheme (ARRS) and through system clinical transformation programmes.
- A review of current estate and needs for future delivery is being undertaken as part of the system estates strategy.

Future state: Our ambition

- Delivery of our Primary Care Strategy supporting resilient/vibrant primary care practices as part of PCNs.
- PCNs across Nottingham and Nottinghamshire are working towards stage three of their PCN maturity by March 2024, allowing them to be in a positive position for leading the implementation of Integrated Neighbourhood Teams (INTs).
- 'Team of teams' to evolve from PCNs with a sense of shared ownership for improving the health and wellbeing of the population with our partners across the system, thus strengthening outcomes for patients, workforce resilience and productivity.
- Integrated Neighbourhood Teams and INT working will deliver a model of care that takes a holistic approach to supporting the health and wellbeing of a community (re-aligning the wider health and care system to a population-based approach, including aligning secondary care specialists to neighbourhood teams). This approach will see a reduction in health inequalities through transformation of services informed through community insight and co-production.

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

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
PCN maturity to support INTs.	PCN at stage 3 of maturity.	System leadership development.	Opportunities and cultural change	Continuous development.		✓	✓	✓
'Team of Teams': common purpose and shared endeavour.	Partners agreement of model. Supportive of change across the workforce.	PCN active participation in INTs maximising skills and capabilities across PCNs and partners.	Implement process improvement. Development of continuous improvement cycles.	Embed INT working.	Development opportunities.	✓	✓	✓
Integration of secondary care into INTs.	Identify opportunities in line with population needs.	Secondary care working within INTs.	Wider system roll-out based on needs of population and secondary care support.	Embed INTs.	Development opportunities.	✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Targeted approach based on community needs making every contact count through integrated working.	Enhanced services in the community with a focus of those in greatest need, delivered within the community closer to where people live.
Enhance productivity and value for money	**Support broader social and economic development**
Working together to enhance productivity and resilience across the system and its communities reducing duplication.	Wider system working that will maximise opportunities across partners and deliver sustainable health and care services.

Primary Care

Current state: Our challenges

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

Future state: Our ambition

- Our ICB will be a national exemplar in new models of working between the ICB, Place Based Partnerships and primary care providers.
- To improve on-the-day triage demand and signposting to most appropriate professional.
- Evolve contracting model where relevant to encourage / reward innovation while also delivering national contract requirements.
- Multi-disciplinary team with wider participation of roles working as part of integrated neighbourhood team working approach.
- Improved recruitment and retention and increase in new roles.
- Improved understanding among public / patients about roles and capability of primary care professionals.
- Resource allocation based on a deeper understanding of assessed need, 'proportional universalism' where discretionary funding allows.
- Real time access to advice and guidance, enabled by technology and decision support mechanisms.
- Full implementation of improved access plans and associated GPIT schemes.
- Future primary care provision across all providers remains high quality and sensitive to local population needs.
- 'One public estates' approach becomes business as usual at a Place and system level to meet needs of providers and their communities.

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

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Implementation of primary care strategy. Delivery primarily through Place-based teams working with subject leads at a system level.	Implementation of INT approach – supported by PBPs and local transformational teams. Fuller Stocktake expectations met or plans to achieve within two years. Establishment of a primary care strategy delivery group to ensure ongoing oversight/support to achievement of key deliverables.	Promote learning and sharing of new ways of working, such as care navigation and social prescribing, additional roles, prescribing and working with pharmacists. ICB primary care estates strategy completed.	Implementation of estates strategy. Evolving development of primary care workforce modelling and response. Promote primary care research.			✓	✓	✓
Improve primary care access.	All practices achieve NHSE Delivery Plan for Recovering Access expectations. Acceleration of secondary/primary care interface working to support long-term conditions management, promote referral optimisation, and pathway efficiencies. Identify practices for specific targeted support based on patient feedback/access concerns/self reported. Further development of INT working to promote streamlined access to alternative services like self referrals/referrals to wider practice teams/avoiding GP where appropriate, for example, pharmacists and physio. Improve patient communications to support awareness of local service offer/new ways of working.		Ongoing delivery of NHSE PCN directed enhanced service/delivery plan expectations.			✓	✓	✓
Supporting primary care resilience.	Promoting opportunities for PCN investment, for example, care navigation training, funding for additional roles, online consultation, cloud based telephony. Place teams working with practices to understand specific resilience challenges.	Review locally enhanced services to promote focus on reduced health inequalities and equity/promote practice. Place resources allocation proportionate to practices within highest areas of deprivation/need.	Ongoing review of primary care opportunities for collaborative working. Development of integrated team approaches to prevention programmes, for example, vaccinations.			✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
A resilient and vibrant primary care is fundamental to population health management.	Primary care is fundamental to addressing health inequalities and equity.
Enhance productivity and value for money	**Support broader social and economic development**
Technology as well as pathway reviews will realise value-for-money.	Primary care workforce is a significant contributor to our local economic development in terms of staff, as well as enabling communities and people to remain economically active.

Mental health

Current state: Our challenges

- Waiting times remain too long for access to assessment with hidden waits between services where specific mental health services/organisations operate in silos.
- Pathways are not always clear, do not provide local early support and intervention to reduce escalation, maintain independence in the community and reduce the need for acute services.
- Mental and physical health and wellbeing and social needs are inextricably linked, however services operate in silos and do not recognise interdependencies which support the whole person.
- In addition to meeting and improving performance on all national standards (business as usual).

Future state: Our ambition

- Sustainable local community care model of delivery that aims to optimise people's independence by holistically addressing their physical, mental health and social needs and intervening before people reach crisis point.
- Through integrated care, and better communication between services and those receiving services, 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 for people with mental health needs, through partners working collaboratively to meet people's needs.
- Through workforce education, we will make every contact count for areas which have been traditionally health focused, incorporating signposting to other services such as financial advice, employment advisors, housing advice and social prescribers to enable people to improve their overall health and wellbeing.
- People will be empowered and supported to self-care, with support from within their communities, maximising the use of community assets.

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

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Prevention, inpatient, discharge joint working. Seamless pathways and provision from increased community provision through to acute and social care, addressing physical and mental health needs.	Development of a system-wide mental health inpatient strategy incorporating admission prevention and discharge and associated implementation plan. Develop Place-based prevention models aligned to community transformation. Implementation of phase one priorities.	Review of phase one implementation. Develop and agree timescale for phase two implementation. Develop plan for years three-to-five transformation.	Review phase two actions. Deliver plans for phase three priorities.			✓	✓	✓
		Review pilot area and learning, agree roll-out and implementation for years two-to-five.	Implement year three priorities and associated monitoring and review process.	Ongoing review and refinement ensuring a continuous quality improvement approach.		✓	✓	✓
Reviewing waiting times and building on workforce models to utilise all sectors including the voluntary sector.	Review of all waits, 'hidden waits', hand-offs and transfers across adult and children and young people services.	Develop strategy to reduce waiting times with clear timescales and actions, supported by a revised system workforce model.	Implementation of improvement plan, monitoring impact and ensuring infrastructure to enable continuous quality improvement.	Ongoing review and refinement ensuring principles embedded in all new pathway development.		✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
PCN and Place-level support and early intervention to reduce escalation. Develop joint and seamless pathways of care which support the whole person, both physical and mental health issues. Support building resilient communities and people to prevent mental health illness in the first place.	Tailored local support developed utilising information on population needs. Improving life expectancy of people with severe mental illness through improvements in mental health/physical health integration and support. Improving the mental wellbeing of patients with physical health needs including long-term conditions.
Enhance productivity and value for money	**Support broader social and economic development**
Maximising investment that has been made into mental health services over last five years, ensuring services are delivering to meet people's needs. Develop more local integrated provision with services provided in the least acute setting aligning health and social care provision, with acute mental health services only accessed by those who need it. Prevent acute mental health admissions and reduce length-of-stay where admission is appropriate through increased fit for purpose community support.	Increase the number of people with severe mental illness in employment. Increase ability of people with severe mental illness to live independently in the community through appropriate housing and wraparound support.

Maternity, babies, children and young people

Current state: Our challenges

- Covid-19 pandemic has disproportionally affected the development, physical and mental health of babies, children and young people.
- Rates of obesity are rising in childhood, increasing short-term and lifelong negative impact on health outcomes.
- Significant health inequalities exist in maternity & neonatal care meaning worse outcomes for women & babies from minority ethnic groups.
- Access to health services for the most vulnerable groups of babies, children and young people is disjointed and inequitable.
- Numbers of children and young people experiencing signs of mental disorders are increasing.
- Children and young people (aged 0-25) with Special Educational Needs and Disabilities (SEND) are not always identified, assessed or able to access services in a timely way.
- Engagement of children and young people in decisions about their needs and health care is not systematised.
- Transitions between children and young people services and adult services are improving but remain difficult for many.

Future state: Our ambition

- Children, young people and their families continue to co-produce service improvement and transformation across the system and participate in decision-making about their individual plans and support.
- All health service planning incorporates prevention for under-25s, where there are modifiable factors
- Be child friendly. Children and young people's needs are identified accurately and assessed in a timely and effective way. Achievement of UNICEF child friendly recognition.
- Children and young people are well prepared for their next steps, achieve desired outcomes, have supportive and successful transitions into adulthood.
- Children and young people are valued, involved in decision-making about their lives, visible and included in their communities.
- Every woman and birthing person from minority ethnic groups has a safe and positive birthing experience in the place of their choosing.
- Optimise opportunities for laying a firm foundation for good mental health of children and young people through evidence-based support in the first 1001 days of a child's life.
- Families, babies, children and young people are able to access seamlessly delivered support including those at end of life, children in care, those who are neurodiverse, risk of obesity, require sleep support, meeting speech language and communication needs.
- Outcomes are improved over people's life course by focussing on children and young people at earliest stage of prevention and enabling earlier identification and provision of support for emotional health and wellbeing as well as physical.

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

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Focus on the under-fives to have the maximum preventative impact.	Review emerging local evidence base for improving mental health and reducing obesity for under-fives.	Co-design new pathways with system partners.	Focus on early identification with PCNs and at Place.	New pathways embedded. Costs saved reviewed and outcome measures refined.		✓	✓	✓
Reduce inequity of services in maternity and for children and young people.	Seek to understand and co-produce solutions for children and young people with health needs and those who are looked after.	New models of care negotiated and commence. Single points of contact explored and increase skill mix teams.	Maintain and review impact of service.			✓	✓	✓
	Delivery of the system maternity equity action plan. Delivery of the children and young people Core20+5 framework. Implementation of multi-agency models of care embedding thrive model for children and young people with mental health outcomes.					✓	✓	✓
Achieving improved outcomes for vulnerable children and young people, including those who are looked after or with SEND.	• Deep dive into health outcomes for children informed by improvement priorities with children, carers and system partners. • Co-produce new ways of thinking and working with parents/carers and children and young people with SEND or looked after to achieve more timely and meaningful support to address identified challenges. • Streamline approach and improve timeliness to achieve national standards. • Understanding needs of children and adolescents with complex needs and develop a personalised care approach.		Work with children and system partners to reduce inequity of outcomes from baseline set in year two.	Maintain and review impact of service.		✓	✓	✓
	Co-produced SEND strategy alongside review of joint children and young people commissioning plan.					✓	✓	✓
Improved outcomes for women and babies.	Implementation of the three-year maternity and neonatal delivery plan, including the embedding of Ockenden recommendations, with all system partners.					✓	✓	✓
	Development of a new maternity and neonatal voices partnership model to enable effective coproduction.						✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Focus on babies, children and young people at the earliest stage of prevention and intervention improves outcomes over people's lives.	Inequity of service offer perinatally and for babies, children and young people, is addressed through local, personalised and streamlined services.
Enhance productivity and value for money	**Support broader social and economic development**
Investment in prevention and early intervention at the earliest opportunity in people's lives delivers the highest returns on investment.	Children and young people who are happy, healthy and have the best start in life are more productive and economically secure as adults.

Reducing emergency pressures in mental and physical health settings

Current state: Our challenges

- People are assessed for their long-term needs in hospital.
- People spend too long in our hospitals.
- People arrive at the emergency department and are admitted to hospital when their needs could have been met in the community.
- People often have to navigate several services before they reach the one that is most suitable for their needs.
- Our teams and pathways are not always integrated.
- We do not have seven-day working across all services.
- We have inequity of service provision across the ICS.
- We have delays in transferring people from one service to another.

Future State: Our ambition

Flow into the hospital	Flow through the hospital
• People know how and when to access urgent and emergency care services when they need it. • We have services in place to support people who have urgent care needs to be cared for at home for both their physical and mental health needs. • People who need to use 999 or our hospitals in an emergency are transferred to the hospital and seen in a timely manner. • We have services and pathways in place that allow people to receive the care they require in the right place, first time.	• People are treated and supported in hospital to a point when they are medically stable. They will be transferred to a place suitable to their ongoing care / rehab needs and plan for longer term support if required. • Discharge planning starts on admission (or pre-admission where possible). • Discharge teams are integrated and work seven days-a-week. • People are assessed for their longer term needs once they are discharged and not before. • Only those that need acute care that cannot be provided at home are admitted into a hospital bed, with the remainder going home the same day on same day/community/ virtual ward pathways. • Physical and mental health services are integrated.
Flow out of the hospital	**Preventing readmissions**
• Multi-disciplinary transfer of care hubs are established at each hospital and operational seven days-a-week. • People go home, or to a place that is suitable for the support they require, on the day they are medically safe to do so. • A culture of trusted assessment is embedded across all organisations. • Virtual wards are established and embedded across the ICS. • For people in an acute mental health bed, community provision, appropriate housing and supported living will support prevention of admission and timely discharge. • Community rehabilitation supports people to maximise their recovery in their own homes	• Integrated Neighbourhood Teams support people to remain at home and manage their health and wellbeing. • Our population health management approach supports us to identify those most in need. • Comprehensive care planning for our most vulnerable patients to keep them well and/or at home in a crisis.

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

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Develop a co-located urgent treatment centre at the QMC.	Develop model and agree business case.	Implementation, monitoring and evaluation with a view to expanding to Sherwood Forest Hospitals.						✓
Virtual wards.	Further develop and embed virtual wards. Integrated care pathways established for specific cohorts.						✓	✓
Embed P1 and the Transfer of Care Hubs.	Data dashboard developed. Invest in Transfer of Care Hub capacity.	Implementation, monitoring and evaluation.					✓	✓
Transform our P2 and P3 offer.	Scoping and agreeing model.	Transform our P2 and P3 offer to improve patient flow for MSFT patients.					✓	✓
Develop an urgent care coordination hub.	Develop IT solutions.	Integrate urgent community response and the urgent care coordination hub. Develop IT solutions.	Implementation, monitoring and evaluation.				✓	✓
Expanding the same day emergency care offer.	Mobilising surgical same day care at Sherwood Forest Hospitals. Expanding frailty and respiratory same day care at NUH.	Direct access for professionals.	Implementation, monitoring and evaluation.				✓	✓
Development of Integrated Neighbourhood Team (INT) working.	Establish routine engagement opportunities for clinical interface between secondary/primary clinicians.	Embedded INT working across community teams for priority cohorts identified through population health data to avoid admission / prevent re-admission.				✓	✓	✓
Social prescribing and care navigation.	Develop care navigation model aligned with Making Every Contact Count (MECC).	Ongoing development of communications and information resources co-designed with users of services with a focus on achieving improved equity.				✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Supporting more people to remain in their own homes and reducing time spent in hospital.	Commissioning services across the ICS and reviewing and transforming historical pathways while providing more personalised care.
Enhance productivity and value for money	**Support broader social and economic development**
Providers working collaboratively and in integrated teams to make best use of system resources.	Supporting more people to remain at home for longer with improved functional outcomes.

Early cancer diagnosis and planned care

Current state: Our challenges

- Long backlogs of patients waiting for cancer and routine planned care with an over-reliance of non-NHS providers.
- Patients may deteriorate while waiting for routine care and may enter the system via the emergency department.
- Potential inequity of access to some cohorts of the population.
- Workforce challenges across our acute providers.
- Our elective care capacity in acute hospitals can be compromised when there are surges in urgent care demand.
- There are long waiting times for diagnostic tests which can cause unnecessary delays in diagnosis.

Future state: Our ambition

- Cancer and elective waiting times are within national performance requirements.
- Patients have equitable access based on need with appropriate choice of provider.
- Shared decision making, patients offered options to avoid unnecessary procedures and acute intervention with conservative treatment considered at an early stage closer to home.
- Prioritisation of waiting lists includes clinical risk, health equity, population need. Consideration of the specific needs of children and young people and ensuring parity of esteem for physical and mental health.
- Elective hubs are in place, underpinned by best practice in productivity.
- Shared workforce plans and staff retention; support in place.
- Community diagnostic hubs established and GP direct access enabled.
- Expansion of targeted lung health programme starting this year and completed in 2025-26.
- Breast cancer – implementing community-based breast screening in areas of low uptake.
- Prostate cancer – implementing community-based clinics with high incidence – Afro-Caribbean communities.

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

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Reduce elective backlogs.	To 65 weeks maximum.	To 52 weeks maximum.	Meet national operational performance targets.			✓	✓	
Reduce cancer backlogs	Meet all cancer standards as defined in operational performance requirements and enable earlier diagnosis (maintain faster diagnosis standards).					✓	✓	
	Expansion of: • Lung health programme • Breast cancer screening • Community prostate clinics.		Expansion of targeted lung health programme complete.	Monitoring and evaluation.		✓	✓	
Establish elective hubs Establish CDCs	Newark elective hub. Phase one of city elective hub. Roll out Mansfield clinical diagnostic centre. Plan City clinical diagnostic centre.	City elective hub phase two. Roll-out City clinical diagnostic centre. Complete Mansfield clinical diagnostic centre.	City elective hub phase three. Complete City clinical diagnostic centre.			✓	✓	
	• Roll-out personalised care and optimise integrated health. Referral optimisation. Maximise pathways and productivity. • Make best use of workforce shared workforce plans and staff digital passports. • Implement Make Every Contact Count across teams and integrated care supporting improved patient care/increase efficient care provision. • Systematise the incorporation of prevention, reducing health inequalities and improving equity across all pathways of care in the management of waits, patient pathway redesign.					✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Earlier diagnosis and care closer to home.	Taking a more personalised approach to care with shared decision making and optimising health prior to elective procedures.
Enhance productivity and value for money	**Support broader social and economic development**
Making best use of our estate and workforce.	Enabling timely access to elective care and maximising health.

Quality improvement

Current state: Our challenges

- No agreed working distinction for quality improvement (QI), transformation and how this relates to system efficiencies.
- Mixed QI approaches exist within the system and partners with no central understanding of impacts.
- No scoping within the system to enable an understanding of the levels of expertise and skills to undertake QI.
- Clear expectation within the system that QI will be lead by clinical leadership and teams without protected time.
- No clear evidence of co-production principles/opportunities with patients/clients/families and how this informs QI.
- Benchmarking and aim correlation for QI does not always align with data insights from our current data collection schedules.
- Existing quality challenges do not directly link to programmes of QI with measurable outputs.
- Limited learning within the system to enable the adoption and spread of QI inventions where appropriate.

Future state: Our ambition

- QI, transformation and efficiencies impacts are understood within the system.
- Systematised QI learning and programmes platform accessible to the system.
- QI approaches occur within the system and partners with scoping, supporting levels of expertise to undertake QI.
- Clinical leadership and teams have protected time and embed ethos that QI is a second job.
- Co-production is a tenet of all QI projects or programmes and this informs those QI priorities.
- System agility and agreed QI responses to emerging quality challenges with known measurable outputs.
- Share and spread learning of evidence-based, high impact improvements, for example, NICE quality standards, appreciative inquiry improvement, and Get It Right First Time.

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

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
System scoping to enable the development of a system definition of QI.	Build consensus by scoping and reporting for system.	Monitor and adjust to align with benchmarking programme.	Monitor and adjust to align with benchmarking programme.	Monitor and adjust to align with benchmarking programme.	Monitor and adjust to align with benchmarking programme.	✓		✓
System understanding of the levels of expertise and skills to undertake QI.	Outline agreement with system partners on approach to systematic QI and training needs.	25% of relevant staff trained in system QI approach by Q4 2025-26.	50% of relevant staff trained in system QI approach by Q4 2026-27.	75% of relevant staff trained in system QI approach by Q4 2027-28.	100% of relevant staff trained in system QI approach by Q4 2028-29.	✓	✓	✓
ICS benchmarking programme.	Joint alignment of ICS data insights. Develop processes to support QI learning platform.	Evidence base / data shape with local population informs priorities for year one.	Progress check year two and use evidence to redefine or reprioritise year three ambitions.	Progress check year three and use evidence to redefine or reprioritise year four ambitions.	Progress check year four and use evidence to redefine or reprioritise year five ambitions.	✓	✓	✓
ICS commitment of co-production informs the current QI work.	Scope and build population engagement networks with ICS QI enablers.	Create core co-design and co-production within all aspects of programmes of work.	Monitor and adjust to align with population engagement feedback and impacts.	Monitor and adjust to align with population engagement feedback and impacts.	Monitor and adjust to align with population engagement feedback and impacts.	✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Targeting systematic QI interventions based on system health outcomes, co-designed with local people representation and clinical leadership, underpinning the commitment to continuous improvement.	Data and people insights will shape and inform QI system priorities to enable interventions to address place population needs.
Enhance productivity and value for money	**Support broader social and economic development**
Improvements in quality reduce costs and improve outcomes.	Supporting greater integrated system learning from QI programmes that can be utilised for adopt/spread interventions.

Personalisation

Current state: Our challenges

- Personalisation is not yet embedded fully as business as usual.
- Our workforce does not always have the tools it needs to deliver personalised care.
- Personalised care approaches are not currently included in all commissioning and contracting activity.
- People have to repeat their story and are not always empowered to share decision making.
- Personalised care initiatives do not receive the investment needed as part of the prevention agenda.
- Making every contact count not seen as a priority across the entire workforce.

Future state: Our ambition

- Personalised care is embedded as business as usual to support delivery of equitable services, with personalised approaches and the eight commitments being adopted in all our work, and as an enabler across all transformation programmes.
- A workforce trained in personalised care: with shared decision making and personalised care and support planning in pre-registration and post-registration professional training.
- Personalised care approaches are considered in all commissioning and contracts to ensure funds are invested to support people in a way that works for them, rather than the traditionally commissioned 'one size fits all' approach. Aligned with Make Every Contact Count.
- People only have to tell their story once and the focus of the conversation is 'what matters to them and what's important to them, not what's wrong with them.'
- Personalised care is a core function that we fund as part of prevention and equity approaches.

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

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Implementation of the Universal Personalised Care Delivery Model and ICB Personalised Care Strategy to embed the six personalised care approaches across all system areas.	Phased approach to include: • Primary care with complex and/or multiple long-term conditions • Cancer pathway • Mental health • Delivery of Make Every Contact Count training to INT staff • Use data to plan and target personalised care to those that would benefit most and to address health inequalities.	Phased approach to include: • Planned care activity • Hospital discharge - personalised care and support plan and, where appropriate, a discharge Personal Health Budget. • Urgent and emergency care.	Progress check and use evidence to redefine or reprioritise year ambitions.			✓	✓	✓
Social prescribing and community based support.	• Green social prescribing to support mental health and wellbeing established • Children and young people and all-age social prescribing models. • Maternity link worker offer pilot undertaken • Infrastructure development.	• Implementation of digital infrastructure solution • Maternity evaluation • Benefits analysis of pathway and system impact.	Expanding social prescribers relevant to benefits and population need.		Fully integrated model across local authority, voluntary sector and NHS for social prescribing and community connectors.	✓	✓	
Embedding personalised care into all commissioning and contracting activity.	• Social prescribing longevity agreed and commissioned • Personalised care elements included in all new commissioning activity.	• Review of all existing contracts to include personalised care • Development of flexibility in commissioning budgets to deliver personalised care including consideration of Place-based social prescribing models.	Ongoing review and refinement ensuring principles embedded in all new commissioning activity.			✓	✓	
Develop and embed a system culture to deliver personalised care and a trained and skilled workforce.	• Development of an ICS training offer and cultural change programme • Strengthen and develop system leadership • Continue to strengthen co-production.	• Roll out of training and culture change programme in phased approach to staff across the system.				✓	✓	

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Increase engagement by service users.	Personalised care ensures care and support is shaped to individual need and supports equity.
Enhance productivity and value for money	**Support broader social and economic development**
Reduce duplication of discussion, increase signposting to non-primary care support networks and reduced appointments. Patients better engaging with treatment plans, thus reducing waste, acute exacerbations, medicines safety errors and improving prognosis (reducing demand on services at later stage).	Supporting people in a holistic way has an impact on their individual social and economic circumstances and impacts wider society.

Working with people and their local communities

Current state: Our challenges

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

Future state: Our ambition

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

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

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Insights hub.	Review existing hubs.	Co-design new hub model with partners.	Implementation.				✓	✓
Citizens panel.	Recruit 800 panel members.	Evaluation of panel and development of mechanisms at Place.	Recruit additional 800 panel members.	Evaluation and expansion at Place.			✓	
Co-production.	Development of Strategic Co-production Representative Group. Recruitment focused on diversity.	Ongoing oversight of all co-production activity as part of Integrated Care Strategy commitments.					✓	
	Development of co-production toolkit to support staff upskilling. Development of co-production system network.	Review and roll-out of training offer. Maturing of network.					✓	✓
VCSE Alliance.	Expand to faith groups.	Develop commissioning framework.				✓	✓	✓
ICP and ICB reports.	Develop insight reports for the ICP and ICB.					✓	✓	✓
Service change.	Deliver public consultations for Tomorrow's NUH, Newark Hospital and Nottingham and Nottinghamshire and Bassetlaw CCG policy alignment.						✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Services will be better tailored for our population and access will be streamlined, leading to better outcomes.	We will use insights from our population to prioritise areas where we need to focus our attention.
Enhance productivity and value for money	**Support broader social and economic development**
By working together across all partners, we can gather intelligence once for the benefit of everyone. Co-production with people who use services will lead to improvement based on need and experience to support value for money.	Leveraging existing assets such as Nottingham's universities will have wider benefits on the economic and social development of our area.

Safeguarding

Current state: Our challenges

- Partnership working on safeguarding and promotion of the health and welfare of children and young people. We need to effectively work together to meet the future challenges of improving resilience across the system.
- Learn from local and national safeguarding reviews including Domestic Homicide Reviews to improve outcomes.
- This is an emerging speciality that requires development across the children's partnerships and safeguarding adult boards.
- We need to support parents and carers to provide the best possible care for their children - preparing young people for adulthood.
- Lack of specialist provision for domestic abuse survivors within primary care.
- Increasing numbers of referrals into the domestic abuse Multi-Agency Risk Assessment Conference.
- Appropriate access and identification of asylum seekers and survivors of trafficking and modern slavery.
- Child sexual exploitation and abuse across the system and increase in contextualised safeguarding.
- The ICB meeting their statutory duties for looked-after-children health assessments.
- Listening and responding to children and young people and adult victims and survivors of child abuse to guide how services are delivered.
- Assessing and authorising within the community – in patients' best interest and least restrictive options. Deprivation of Liberty Safeguards not fully embedded across community teams.
- Children being cared for in inappropriate settings.
- Implementing the new duties around serious violence and the Domestic Abuse Act 2021 within the ICB and prepare for future duties in the Victims and Prisoners Bill.
- Developing data to evidence safeguarding assurance across the system.
- Identifying the emerging themes and gaps within the system and partnerships.

Future state: Our ambition

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

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

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Children and young people will receive the right care, in the right setting, at the right time.	Influence the development of D2N2 appropriate care settings for children and young people.					✓	✓	✓
Develop and enhance transitional safeguarding.	Development of transitional safeguarding.					✓	✓	✓
Embedding a trauma-informed approach across the system.	Establishing a data informed approach. Revisiting and defining locally the NHS role in the Serious Violence Duty and Domestic Abuse Act 2021.	Fully integrated approach with primary care for domestic abuse that includes children as victims. Refine process for survivors of child sexual exploitation and abuse.	Data dashboard implemented	Ongoing developments towards model of integrated, data informed approach.	Fully integrated, data informed approach.	✓		✓
Working with our partners to improve outcomes for children in local authority care.	Children leaving care will have a comprehensive leaving care plan.	Processes embedded for children in care/looked after children to have their health assessments completed in a timely way.				✓	✓	✓
Support provided to adults in the community.	Identify Mental Capacity Act cohort, risk profile and proceed in the patients' best interests and least restrictive option.	Develop process of early identification of potentially restrictive care plans in the community and progress via appropriate Court of Protection route. Identify children with special educational needs and disabilities transitions cases requiring deprivation of liberty safeguards. Develop mechanism for early identification of fully-funded adult and pre-18 cases for quick response to application of the Mental Capacity Act/Court of Protection.				✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Support at system and place to embed a proactive safeguarding approach and aid early detection and intervention. This will aim to reduce the impact on people's physical and mental health. It will aim to help reduce adverse childhood experiences that go on to impact on health and socio-economic outcomes throughout people's lives.	Specialist local support that uses data intelligence and local knowledge of the population will improve the outcome of people, for example, those experiencing abuse and trauma and also restrictions upon their liberty.
Enhance productivity and value for money	**Support broader social and economic development**
Early recognition and responding appropriately to safeguard and promote the welfare of people across the system. This will assist in individuals going into crisis and/or requiring hospitalisation or a 'significant response'.	Improving resilience with the system, developing the workforce and promoting trauma-informed culture will aim to reduce all types of abuse, serious violence and responding to individual human rights.

Workforce

Current state: Our challenges

- Workforce is potentially the largest limiting factor in our ability to deliver the ICS strategy and improve health outcomes for our population.
- Workforce productivity is varied and difficult to measure, however using traditional measures of workforce productivity and despite significant increases in workforce numbers, productivity is lower than before the pandemic.
- Organisations' ability to both attract and retain staff has not improved despite great efforts to deliver the People Plan and the People Promise.
- High vacancy levels, sickness absence and transactional human resources' processing volumes have a negative impact on finances due to locum and agency cover and on quality and continuity of care.
- Organisations' interventions to attract high demand staff groups have a negative impact on system staff and adds to cost pressures.
- Workforce planning tends to be short-term and driven by operational targets and does not address the medium to longer term need for strategic workforce and education planning at a system level, informed by population health projections.

Future state: Our ambition

- The system 'one workforce' will consist of the right number of people, to meet demand and improve health outcomes, working at the right location to deliver the treatment and care our population deserves, with the skills and training to support prevention, as well as treatment to enable the population to stay healthy and at a cost that is affordable.
- Organisations will collaborate on a 'one workforce approach' recognising that the future workforce will want to have flexible, rewarding careers within a system that recognises and develops talent and is representative of the population of Nottingham and Nottinghamshire.
- Digital technology will be an enabler to flexibility and resourcing on a system footprint, not an organisational one.
- There will be multiple entry points to employment, supporting all levels of academic and physical ability, to create meaningful and fulfilling opportunities for those that desire a career in health and care.
- The financial pressures caused by workforce availability will be reduced by the development of a flexible contingent system workforce, alongside workforce policies, practices and procedures that are standardised across the system and use technology to automate transactional activity (wherever possible).
- NHS partners will confirm commitment to 'real living wage'.

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

What	Year 1 Scope and plan	Year 2 Start to deliver and see a difference	Year 3 Deliver and review	Year 4 Deliver and refresh plans	Year 5 Deliver	Prevention	Equity	Integration
Establish ICS people and culture plan and delivery process.	Governance and delivery plans.	Establishing a sustainable delivery team.	One workforce becomes a reality.	Population health needs drive plans.	Aligned public health, education & training and workforce plan.	✓	✓	✓
Resourcing including retention.	Scope and develop plans for shortage skill areas.	System attraction and retention approach, including local pipeline.	Expand digital solutions.	Operational system recruitment hub.	Review evaluate and further consolidate.	✓	✓	✓
Strategic workforce planning.	Agree scope with System Analytics and Intelligence Unit.	Work with partners on a common Strategic Workforce Plan approach.	Establish a common approach to productivity measurement.	Further support service transformation. .	Review evaluate and seek further opportunities.	✓	✓	✓
Delivering the future of human resources.	Agree scope and scale with partners.	Fully utilise digital passport.	Develop rotational placements across providers.	Establish core HR working including primary care.	Review evaluate and seek further opportunities.	✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
A skilled and present workforce is better able to deliver improved health and healthcare outcomes including prevention and equity via Make Every Contact Count.	A workforce representative of our diverse communities is better able to understand and address their needs. Our workplaces supported to be smoke free.
Enhance productivity and value for money	**Support broader social and economic development**
Better planning, resourcing and retention will reduce temporary worker costs and improve quality and care.	Supporting multiple entry points to employment for all levels of academic and physical ability supports social and economic development, and renumerate equitably.

Strategic estates and shared infrastructure

Current state: Our challenges

- Across our ICS partner organisations, we have in excess of 800 buildings, in varied condition.
- There is limited co-ordination of maintenance and utilisation of our estate capacity, and the ICS estates strategy is coming to an end.
- Some of our newer/better quality estate is not being fully used, and utilisation across all our estate is not well understood.
- Locations of services is mainly historic, rather than being situated where it is most needed.
- Since the Covid-19 pandemic, the move to hybrid or virtual working means we need less corporate capacity across our ICS.
- Annual capital funds are insufficient.
- There are significant challenges with some estate, for example, Nottinghamshire Healthcare dormitories, Rampton, magnetic resonance imaging (MRI) provision and location.
- Backlog of maintenance issues increasing across all providers.

Future state: Our ambition

- Services are located based on need rather than historic arrangements.
- Co-location of complementary services wherever possible.
- Our newer/better quality estate is fully utilised.
- Create a combined estate which is fit for purpose, big enough to cope with fluctuating demand, but no bigger than necessary.
- We have a clear pipeline of buildings/land for disposal.
- The cost of premises management is kept to a minimum.
- All our buildings are as carbon-efficient as possible.
- National Rehabilitation Centre (NRC) opportunities are maximised.
- *Tomorrow's NUH* has been successfully navigated through consultation phase, business case approvals and reconfiguration work has begun.

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

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Develop an ICS infrastructure strategy.	Compile strategy with partners, publish and commence delivery streams.	Year two delivery.	Year three delivery.	Year four delivery.	Year five delivery.			✓
Rationalise our ICS estate.	Gather detailed baseline, agree assessment and prioritisation process.	Hand back or dispersal of properties.	Hand back or dispersal of properties.	Hand back or dispersal of properties.	Hand back or dispersal of properties.		✓	✓
Support 'One public sector estate' approaches.	Encourage the collective consideration of estates needs and solutions across Places – working across statutory and non-statutory partners to find efficiencies in the use and adaptation of estates to promote integrated neighbourhood team working and primary care resilience.							✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	**Tackle inequalities in outcomes, experiences and access**
Support high quality environments for staff and patient care, optimising the opportunity for delivery of services that improve outcomes.	Understanding our total ICS estate allows us to make better decisions about sighting services in the most appropriate places for local people.
Enhance productivity and value for money	**Support broader social and economic development**
Ensuring our quality estate is used most productively, allowing us to release estate that is costly to maintain, and prevent capital investment in additional capacity.	Support estates development which contributes to social value within communities and across the system.

Digital

Current state: Our challenges

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

Future state: Our ambition

- Develop our patient-facing digital services - we will empower and enable our population to have greater control over their health and care by providing them with access to their digital health and care record so that they can self-manage and access key information and services.
- Support intelligent decision-making - use data to better understand the health and care needs of our local population, helping to focus and tailor resources where they have the most impact. Design and target interventions to prevent ill-health, and to improve care and support for people with ongoing health conditions. Recognising key factors helps us to adapt future local services to improve the overall health of the population.
- Digitise our services to support the frontline - our workforce will have access to effective and efficient digital assets and infrastructure to enable them to provide the best health and care services. Utilising digital assets such as electronic patient records, electronic prescribing, medicine administration systems and automation technologies to reduce burdensome processes, for example, log-in standardisation.
- Enable interoperability across the system - our population will receive the right care at the right time, always. By providing health and care providers with access to key information about the person, reduces unnecessary diagnostics, treatment and enables efficient access to health and care services.
- Support our population and workforce through digital inclusivity - our population and workforce are given access to support, training and equipment to enable them to use digital assets to benefit their health and wellbeing or deliver effective care services.

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

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Patient facing digital services.	Digital correspondence, access.	Expand the use of remote monitoring; explore use of robotics process automation.	Digital care planning, expand record access; deploy robotics process automation technology.	Personalised approach to health and care services through digital technology. AI technology to increase productivity.	Smart homes.	✓	✓	✓
Support intelligent decision making.	Infrastructure to enable data to be used.	Appropriate resources including better analytics, tools and techniques.	Embed a systematic approach to developing and monitoring system.	Augment artificial intelligence and human skills in designing care services.	Augment artificial intelligence and human skills in designing care services.	✓	✓	✓
Digitise frontline services.	Electronic patient record specification development.	Electronic patient record procurement, user based design. Staff enabled to work across any location.	Electronic patient record deployment, exploit existing assets.	Electronic patient record deployment.		✓	✓	✓
Interoperability.	Notts Care Record first tranche of users.	Notts Care Record to bring additional functionality and next cohort of organisations.	Greater functionality added with remaining organisations in Notts onboarded.	Further developments in the application including regional sharing.	Further developments in the application.	✓	✓	✓
Digital inclusivity.	Expand digital inclusion co-Ordinator roles.	Support skills development in community voluntary sector.	Develop non-medical information resources platform.	Whole system workforce training needs analysis.	System workforce development programme.	✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Improved access to services, ability to target services more effectively and reduce inequality.	Provide people with the tools and skills they need to access health and care service, increase patient satisfaction through improved access and services, keep people independent at home for longer.
Enhance productivity and value for money	**Support broader social and economic development**
Utilise technologies to remove time consuming activities such as administrative and chasing around for information to enable care to be provided, reduce did-not-attends, and improve patient flow.	Reduce net carbon footprint through reduced travel and reduction in unnecessary face-to-face appointments, less paper, increase employability through digital skills training.

Greener NHS / sustainability

Current state: Our challenges

- We have a comprehensive ICS Green Plan, approved by the ICS board and ICB Board in 2022. This plan builds on the individual plans/ strategies of our health and care partners.
- Organisations have strong plans and stakeholder buy-in and are delivering well within the confines of their organisation, and we are now starting to amplify learning gained at a system-level.
- The trajectory to carbon net zero cannot be achieved without the buy-in of clinicians and service users.
- Subject matter expertise and clinical capacity for designing sustainable care models, and supporting population health and involvement, has been limited.
- While we have many delivery initiatives, we are not currently able to make accurate measurements of the impact they are having on carbon emissions.

Future state: Our ambition

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

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

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Deliver our ICS Green Plan.	Deliver three-plus objectives per programme.	Deliver three-plus objectives per programme.	Refresh/refine Green plan and deliver three-plus objectives per programme.	Deliver three-plus objectives per programme.	Deliver three-plus objectives per programme.	✓	✓	
Securing and embedding clinical/ professional leadership and design for sustainable services.	Set up design authority onboard four clinical fellows. Develop clinical programme framework.		Staff across all organisations are empowered to make changes, reducing waste in their work.			✓	✓	✓
Achieve national NHS Net Zero targets.	Continue with delivery - strengthen with primary care focus.	Refine delivery to ensure annual objectives are covered.	Refine delivery to ensure annual objectives are covered.	Achieve 80 net zero for NHS footprint emissions. Refine delivery to ensure annual objectives are covered.	Refine delivery to ensure annual objectives are covered.	✓	✓	

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Supporting healthier environments that reduce the likelihood of disease onset or exacerbation, for example, respiratory-related conditions such as asthma caused by poor environmental conditions.	Those with higher levels of deprivation are more greatly affected by global warming, air pollution. Tackling the sources of these provides a better quality of life for local people.
Enhance productivity and value for money	**Support broader social and economic development**
Almost all forms of waste reduction support both carbon reduction and saving money, providing better value for the public pound.	Many carbon net zero initiatives have the added benefits of health promotion and/or mental wellbeing.

Medicines optimisation

Medicines are the most common therapeutic intervention, the second highest area of NHS spending after staffing costs, and are associated with a high degree of clinical and financial risk.

Current state: Our challenges

- Between 5 to 10% of all hospital admissions are medicines-related and around two-thirds of these admissions are preventable.
- 30 to 50% of the medicines prescribed for long-term conditions are not taken as intended.
- Investment in medicines to optimise health outcomes and reduce hospital admissions is not maximised.
- Processes to reduce medicines harm need to be embedded through system working.
- Current working practices and systems do not facilitate reduction in medicines waste.
- Lack of interoperability between clinical systems in organisations increases the risk of harm from medicines.
- Pharmacy workforce pressures in all sectors constantly challenge the delivery of system ambitions to transform and optimise medicines use.

Future state: Our ambition

- A quality and safety culture around the use of medicines will be embedded in our system with ownership from all system partners.
- Improvement in patient outcomes associated with the use of medicines through reducing harm, improving patient access, shared decision making and personalised care.
- Reduction in unwarranted clinical variation, health inequalities and equitable access relating to medicines use will improve outcomes, using population health management and prescribing data to identify need.
- System working and collaboration to transform medicines use to improve the health and wellbeing of our population. Ensure the efficient use of resources and support the greener NHS agenda.
- Pharmacy workforce development (pharmacists, pharmacy technicians working in hospitals, community pharmacies, health and justice, ICB, mental health trust) to attract and retain staff. Education and training to develop career pathways and specialist roles.
- Investment in medicines, digital technology and workforce to improve quality of life and outcomes, and reduce hospital admissions through use of medicines. Active partnership in new models of care such as virtual wards.

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

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Medicines across the system.	Develop system leadership. Co-produce ICS medicines optimisation strategy.	Strengthen system working and develop joint projects including discharge medicine service and community pharmacist consultation service.	System integration of all pharmacy services, improving equity through development of system-wide solutions.			✓	✓	✓
Medicines commissioning.	Strengthen Area Prescribing Committee capacity. Streamline system working.	Integration of specialised medicines commissioning.	Invest in expertise to support the evolving genomic medicines agenda.	Pharmacy representation in system and regional clinical advisory groups.		✓	✓	✓
Medicines safety and quality.	Antimicrobial stewardship, safety initiatives, reducing harm.	Access routes to provision of medication – patient group directions.	Oversight for increasing numbers of non-medical prescribers.	ICS and regional medicines waste reduction initiatives.		✓	✓	✓
Medicines finance.	Manage prescribing expenditure.	Develop ICS system medicines and prescribing efficiency plans.	Ensure medicines expenditure is fully accounted for in new service developments.			✓	✓	✓
Pharmacy workforce development.	Establish pharmacy faculty. Scope workforce, risks and gaps.	Develop system working for pharmacy placements for students.	Develop career pathways and specialist roles.	System pharmacy education programme.		✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health & healthcare	Tackle inequalities in outcomes, experiences & access
System working and collaboration with system partners to transform medicines use to improve the health and wellbeing of our population.	Identification and reduction in unwarranted clinical variation in medicines use to improve outcomes and ensure equitable access to the right care, at the right time, in the right place.
Enhance productivity and value for money	**Support broader social and economic development**
Through strategic medicines oversight and planning, ensure maximum benefit is gained from investment in medicines use.	Optimising health through appropriate medicines use enables communities and people to remain economically active. Reduction in medicines waste and promotion of greener medicines choices positively contributes to reduction in the net carbon footprint.

Research

Current state: Our challenges

- Better aligning the research that is undertaken and the research strengths, expertise and infrastructure of the ICS to the principles and priorities of the Integrated Care Strategy.
- Equity of access to place-based research opportunities with research being delivered where population need is greatest, with people from more diverse and under-served communities shaping, involved in and participating in research.
- Embedding research into everyday practice through opportunities for the workforce to be involved in research as part of their usual roles or to develop a research career.
- Systematically using the evidence from research to inform decision making.

Future state: Our ambition

- A collaborative, integrated and equitable approach to health and care research that aligns with the needs and priorities of the Integrated Care Strategy.
- The benefits and impact of research are maximised to continually improve population health and wellbeing outcomes, high quality joined up care and reduce inequalities.
- To attract, develop and retain a sustainable research workforce providing opportunities to lead and be involved in research that is embedded into everyday practice. Optimising integration as a means of undertaking research across the system and with all partners.
- Research is wrapped around what we do with an embedded evidence-informed approach. There is a strengthened alignment of research findings to shape interventions for mutual benefit and opportunities.
- A culture of evidence-based practice including the ability to test, learn and evaluate across the ICS.

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

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Develop an ICS research strategy.	Develop the strategy with partners.	Implement the strategy in years two-to-five.				✓	✓	✓
Better align research to the ICS strategy	Build a pipeline of research projects.	Develop ongoing mechanisms to support research active practices and awareness of and engagement with research activity across the system.				✓	✓	✓
Increasing the diversity of those involved in research.	Apply for NHSE Research Engagement Network Development funding to develop learning.						✓	

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Research, and the use of evidence from research, improves outcomes.	Research informs greater understanding of inequalities and how to tackle them.
Enhance productivity and value for money	**Support broader social and economic development**
Utilising the evidence from research enhances productivity and value for money.	Research brings investment into anchor institutions supporting economic prosperity.

ICB operating model

Current state: Our challenges

- Within the ICS family, the ICB has undertaken a considerable development journey from seven individual CCGs and an ICS team to a single organisation.
- The ICB inherited CCG accountabilities to assess health needs, plan, secure and monitor services.
- We also have a new duty to integrate services and a pressing requirement to reduce inequalities. ICBs are required to act as system conveners, coordinators, oversight bodies and as delivery partners.
- We have adapted our operating model accordingly and now operate in a very different manner. Changes to date are in line with our strategic direction, moving from transactional and tactical commissioning approaches to a system orientation.
- The Hewitt Review sets out once-in-a-generation opportunities to transform our health and care system.
- If we are to derive maximum benefit from our new structures, this will require a different culture and everyone will need to play their part.

Future state: Our ambition

Our aim is to move towards a more strategic enabling approach to improve health outcomes and to tackle long-standing operational and financial problems. This means that we will undertake fewer tactical / operational functions and will focus more on longer-term health improvement and broader public sector partnerships. We will:

- Serve as a pivot point within our health and care system to enable delivery of the four ICS aims.
- Be a well-run, transparent organisation that is effective and impacts on short and longer-term population health outcomes.
- Have the culture and capability to work with and through our partnerships and communities - to assess health needs and target NHS resources to achieve integration, prevention and equity.
- Be relentlessly ambitious for our population, working across the NHS to secure performance improvement, clinical and financial sustainability for local services.
- Approach challenges and constraints in an evidence-based and fair manner, maintaining constructive relationships but not accepting reluctance to progress or poor standards.
- Work systematically to achieve a combination of national NHS requirements and local priorities that are important to our people and communities.

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

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
ICB operating model.	Design and implement.	Implement.	Consolidate.	Review.	Refresh.	✓	✓	✓
Operating within the defined running cost.	Financial viability.	Tracking the running cost reductions.	Review.	Review.	Review.	✓	✓	✓
Engaging, consulting with and change management for our people.	Communications and change management.	Communications and change management.	Review and update communications.	Review.	Review.	✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Focus as a strategic commissioning organisation will improve the population's health and healthcare.	Focus as a strategic commissioning organisation will reduce inequalities in outcomes, experiences and access.
Enhance productivity and value for money	**Support broader social and economic development**
The financial viability review of the operating model options appraisal will enable enhanced productivity and value-for-money.	Focus as a strategic commissioning organisation will support greater social and economic development as a network of anchor organisations.

Supporting social and economic development

Current state: Our challenges

- Supporting social and economic development is the fourth aim of the ICS.
- NHS Trusts, as anchor organisations, have already established programmes in support of this agenda.
- The ICB established an Anchor Champions Network (ACN) in 2022 comprising of ICB, Trusts, Provider Collaborative, local authorities (public health and economic development) and Place Based Partnerships.
- The ACN agreed an approach to supporting social and economic value in October 2022.
- The ACN helped contribute to the ICP Strategy under the fourth aim. Priorities for 2023-24 are being taken forward through the net zero, estates, procurement and workforce ICS delivery groups.
- The ACN continues to provide a forum to showcase ideas, share best practice and support ICS delivery groups progress strategic priorities.
- The ACN is maintaining links with Nottingham's universities to ensure strategic alignment.
- Place Based Partnerships continue to support the cost of living crisis response.

Future state: Our ambition

- ICP strategic priorities continue to be delivered through ICS delivery groups in the short to medium term.
- Building on the foundations described above, the NHS now needs to stretch its ambitions and efforts to support social and economic development.
- To help with this, the NHS Confederation has agreed to facilitate an ICP event to challenge our thinking and forward plans:
    1. Stretching shared ICP priorities which leverage our potential as a system and individual anchor institutions
    2. Confirming forward plans for these priorities, including an anchor institution action plan
    3. Defining the role and resource to deliver these plans across Place Based Partnerships, Provider Collaboratives, Trusts and the ICB.
- Continue to identify opportunities to contribute to social and economic development, for example, understand how the NHS can best support D2N2 devolution priorities and enhance its role in civic leadership.

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

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Support ICS delivery groups to deliver.	See specific 2023-24 plans for green, estates, workforce and procurement.	Deliver two-to-three major innovations each year.	Deliver two-to-three major innovations each year.	Deliver two-to-three major innovations each year.	Deliver two-to-three major innovations each year.	✓	✓	✓
Strengthening contribution to key strategic partnerships. Enhance our support for social and economic development.	Build key strategic partnerships. Refresh ICP priorities. Confirm forward action plans. Agree roles and resource to deliver the plans at pace.	Increasing support at ICB, Place, Provider Collaborative and organisational level for social and economic development.	Continue to increase health contribution for social and economic development	Continue to increase health contribution for social and economic development	Continue to increase health contribution for social and economic development	✓	✓	✓
Putting actions in place to support local people with the rising cost of living.	Support health and wellbeing and financial wellbeing programmes through Place and anchor organisations.	Continue to support health and wellbeing and financial wellbeing programmes.				✓	✓	

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Promotes focus on the wider determinants of health including employment, training and economic development.	Encourages economic regeneration and growth which will impact directly or indirectly on inequalities.
Enhance productivity and value for money	**Support broader social and economic development**
Collaboration across partners will contribute to generation of efficient and effective use of anchor organisational and collective resources.	Actions are aligned to the fourth aim of the Integrated Care Strategy.

Appendices

Contents:

A. Matrix to show compliance to the legislative requirements outlined in the Health and Social Care Act
B. Matrix of compliance to the ICP Integrated Care Strategy priorities and agreed actions
C. How we developed the strategy / engagement
D. Statements of support from the Health and Wellbeing Boards
E. Case studies
F. Delivering the NHS Operational Plan 2023
G. Glossary of terms

Appendix A. Legislative requirements

Legislative requirement	Description	Where to find this
Describing the health services for which the ICB proposes to make arrangements.	The plan must describe the health services for which the ICB proposes to make arrangements in the exercise of its functions.	Section 5
Duty to promote integration.	Each ICB must exercise its functions with a view to ensuring that health services are delivered in an integrated way and that their provision is integrated with that of health related or social care services, where this would: • Improve quality of those services • Reduce inequalities in access and outcomes.	Section 5
Duty to have regard to wider effect of decisions.	In making decisions about the provision of healthcare, an ICB must consider the wider effects of its decisions, also known as the 'triple aim' of (a) health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing), (b) quality of healthcare services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) and (c) sustainable and efficient use of resources by NHS bodies.	Section 5
Financial duties.	The plan must explain how the ICB intends to discharge its financial duties.	Page 36
Implementing any Joint Local Health and Wellbeing Strategies (JLHWS).	The plan must set out the steps that the ICB proposes to take to implement any JLHWSs to which it is required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.	Section 1 and Appendix D
Duty to improve quality of services.	Each ICB must exercise its functions with a view to securing continuous improvement in: • the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness • outcomes including safety and patient experience.	Page 44
Duty to reduce inequalities.	Each ICB must have regard to the need to (a) reduce inequalities between persons with respect to their ability to access health services and (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services. There is also a duty to have regard to the wider effects of decisions on inequalities.	Section 5
Duty to promote involvement of each patient.	Each ICB must promote the involvement of patients, and their carers and representatives (if any), in decisions that relate to (a) the prevention or diagnosis of illness in the patients or (b) their care or treatment.	Page 46
Duty to involve the public.	ICBs and partner trusts have a duty to involve people and communities in decisions about the planning, development and operation of services commissioned and provided.	Page 46
Duty to patient choice.	Each ICB must act with a view to enabling patients to make choices with respect to aspects of health services provided to them.	Page 46
Duty to obtain appropriate advice.	Each ICB must obtain appropriate advice to enable it to effectively discharge its functions from persons who (taken together) have a broad range of professional expertise in (a) the prevention, diagnosis or treatment of illness and (b) the protection or improvement of public health.	Section 5
Duty to promote innovation.	Each ICB must promote innovation in the provision of health services (including in the arrangements made for their provision).	Pages 44 and 53
Duty in respect of research.	Each ICB must facilitate or otherwise promote (a) research on matters relevant to the health service and (b) the use in the health service of evidence obtained from research.	Page 53
Duty to promote education and training.	Each ICB must have regard to the need to promote education and training so as to assist the Secretary of State and Health Education England (HEE) in the discharge of the duty under that section.	Page 48
Duty as to climate change.	Each ICB must have regard to the need to (a) contribute towards compliance with (i) section 1 of the Climate Change Act 2008 (UK net zero emissions target) and (ii) section 5 of the Environment Act 2021 (environmental targets), and (b) adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008.	Page 51
Addressing the particular needs of children and young persons.	The plan must set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25.	Page 41
Addressing the particular needs of victims of abuse.	The plan must set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic and sexual abuse, whether children or adults). It must have due regard to the provisions of the Domestic Abuse Act 2021 and accompanying statutory guidance, and relevant safeguarding provisions.	Page 47

Appendix A. NHSE: other recommended content

Content	Description	Where to find this
Workforce	Evidence-based, integrated, inclusive workforce plans that ensure the right workforce with the right skills is in the right place to deliver operational priorities aligned to finance and activity plans.	Page 48
Performance	Specific performance ambitions with trajectories and milestones that align with NHS operational plan submissions and pay due regard to the ambitions of the NHS Long Term Plan, as appropriate.	Appendix F
Digital / data	Steps to increase digital maturity and ensure a core level of infrastructure, digitisation and skills. These actions should contribute to meeting the ambition of a digitised, interoperable and connected health and care system as a key enabler to deliver more effective, integrated care. This could include reducing digital inequity and inequalities and supporting net zero objectives.	Page 50
Estates	Steps to create stronger, greener, smarter, better, fairer health and care infrastructure together with efficient use of resources and capital to deliver them. This should align with and be incorporated within forthcoming ICS infrastructure strategies.	Page 49
Procurement / supply chain	Plans to deliver procurement to maximise efficiency and ensure aggregation of spend, demonstrating delivery of best value. This could include governance and development of supporting technology and data infrastructure to align or ensure interoperability with procurement systems throughout the ICS.	Page 55
Population Health Management	The approach to supporting implementation of more preventative and personalised care models driven through data and analytical techniques such as population segmentation and financial demand modelling. This could include: developing approaches to better understand and anticipate population needs and outcomes (including health inequalities); using population health management approaches to understand future demand and financial risk; support redesign of integrated service models based on the needs of different groups; and putting in place the underpinning infrastructure and capability to support these approaches.	Section 4
System Development	How the system organises itself and develops to support delivery. This could include: governance; role of place; role of provider collaboratives; clinical and care professional leadership; and leadership and system organisational development.	Section 5 and 6
Supporting wider social and economic development	How the ICB and NHS providers will support the development and delivery of local strategies to influence the social, environmental and economic factors that impact on health and wellbeing. This could include their role as strategic partners to local authorities and others within their system, as well as their direct contribution as planners, commissioners and providers of health services and as 'anchor institutions' within their communities.	Page 55

Appendix B. Agreed ICP priorities and actions

	Where to find this
We will support children and young people to have the best start in life with their health, development, education and preparation for adulthood	Page 41
We will support frail older people with underlying conditions to maintain their independence and health	Page 32
We will make Every Contact Count (MECC) for traditional areas of health e.g. mental health and healthy lifestyles, and incorporate signposting to other services like financial advice	Page 9
We will support children, young people and adults with the greatest needs (the 20% most deprived areas nationally, those vulnerable or inclusion groups and those experiencing severe multiple disadvantage	Page 41
We will focus and invest in prevention policies like tobacco, alcohol, healthy weight, oral health and mental health to support independence, prevent illness, poor birth outcomes and premature death from heart attack/stroke/cancer/COPD/asthma/suicide	Page 9
We will establish a single health and care recruitment hub	Page 48
We will adopt a single system wide approach to quality and continuous service improvement	Page 44
We will review our Better Care Fund Programme	Page 28
We will bring our collective data, intelligence and insight together	Page 9
We will make it easier for our staff to work across the system	Page 48
We will add social value as major institutions in our area	Page 55

Appendix C. How we developed the ICP Integrated Care Strategy and JFP

Integrated Care Strategy

The Integrated Care Strategy has its origins in the Joint Health and Wellbeing Strategies for Nottingham and Nottinghamshire and, as such, should be seen as both complementary to, and building upon, the aims set out in those documents.

As part of developing the strategy, we listened extensively to the public, patients and stakeholders to check that it reflected the hopes, needs and aspirations of local people and their communities.

The engagement programme included desk research of previous engagement and strategies within the system, stakeholder meetings, presentations at existing forums, public events and a survey. In total, just under 750 individuals were involved in a range of activities, between October and November 2022. Activities included:

- Targeted meetings with key stakeholders, including voluntary, community and social enterprise sector leaders, Healthwatch Nottingham and Nottinghamshire and local elected representatives.
- The October 2022 ICS Partners Assembly, which bought together 161 system stakeholders, carers, service users, patients and citizens.
- The annual Nottinghamshire County Council Shadow event, which was attended by more than 250 children and young people, including young adults with learning disabilities.
- Two virtual public events, which were attended by 48 individuals.
- A survey for people to provide their views on the emerging strategy, which received 206 responses.
- Discussions among ICS partner organisations and Place Based Partnerships during November and early December.
- An ICP workshop on 9 November.

A full engagement report has been produced.

NHS Joint Forward Plan

As described earlier, the JFP acts as the NHS delivery commitment for all NHS organisations within the Nottingham and Nottinghamshire ICS.

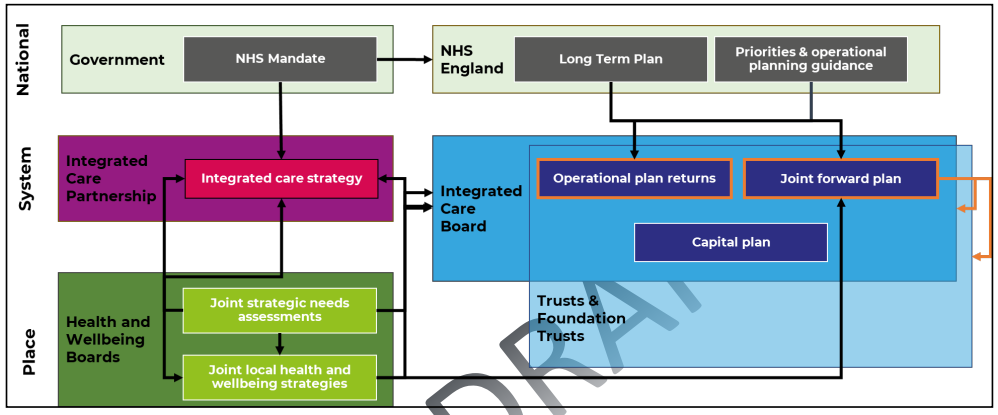
In developing the plan, we further engaged with public, patients and stakeholders. The engagement programme built on engagement for the Integrated Care Strategy and included stakeholder meetings, presentations at existing forums, public events and a survey. In total, just under 800 individuals were involved in a range of activities, between May and June 2023. Activities included:

- Targeted meetings with key stakeholders, including voluntary, community and social enterprise sector leaders, Healthwatch Nottingham and Nottinghamshire and local elected representatives.
- Specific workshop and/or meeting discussions with the two Health and Wellbeing Boards to ensure that the plan was aligned to the strategy.
- Hosting the second Nottingham and Nottinghamshire ICS Partners Assembly in May 2023, which was attended by more than 120 system representatives.
- Listening to and gathering insights from across our Place Based Partnerships.
- A survey for patients, local people and staff, which received 168 responses.
- Discussions with NHS organisations' board members and further established partner forums during May and June 2023.

An engagement report on how we have engaged with people and communities has been produced.

Appendix D. Joint Health and Wellbeing Strategies and relationship with the ICP Integrated Care Strategy and Joint Forward Plan

The Health and Wellbeing Strategies for Nottingham and Nottinghamshire summarise health needs and describe the agreed priorities for partnership working. We see these strategies as related and complementary, seeking alignment where possible. The diagram below shows how we see the relationship between these important system plans.



This plan articulates how, as NHS partners within the system, we will deliver the NHS Mandate, while also tackling the most challenging issues for the system, as well as demonstrating how we will meet the aims of the Integrated Care Strategy.

Appendix D. The relationship between the Joint Forward Plan and the Integrated Care Strategy

Our Integrated Care Strategy

Our Integrated Care Strategy was agreed in March 2023 and sets the vision for the system. The three guiding principles are:

Principle 1: Prevention is better than cure
By focusing on prevention, we can make sure we use our limited resources most efficiently and improve people's health and wellbeing. This can mean that people need less treatment, we can stop more serious illness and can stop diseases getting worse.

Principle 2: Equity in everything
The principle of equity recognises that not all people have equal health and care access, experience or indeed outcomes. The strategy sets out that for some people and communities more support and resource might be required to achieve similar outcomes to others.

Principle 3: Integration by default
Local people have told us that they want joined up and seamless services. By making collaboration between all the workforce and teams the normal way of working, and by harnessing our resource and ingenuity, we can re-shape services to become more integrated, treating the 'whole person'.

Underpinned by four strategic aims:
Aim one: Improve outcomes in population health and healthcare
We will support children and young people to have the best start in life and also work to ensure frail older people with underlying conditions maintain their independence and health. We will also maximise the benefits of working together across the health and care system to ensure that health advice is included in every conversation.

Aim two: Tackle inequalities in outcomes, experiences and access
We will focus our efforts on the 20% of our population that need our support the most due to their income or other circumstances that mean they are disadvantaged in society. We will also invest in prevention activities around issues such as: smoking, alcohol abuse and being overweight.

Aim three: Enhance productivity and value for money
We will combine our efforts on issues like recruitment and the movement of staff around the system as well as pooling our expertise around data, analytics and insights. We will also check that existing joint working programmes are still delivering what we need and work together to continually improve the productivity of our services.

Aim four: Support broader social and economic development
We will work together as large public sector organisations and with other partners like our universities and the private sector to maximise investment and support job creation for our population. We will also ensure that our activities are continually monitored and improved in terms of their impact on the environment.

Appendix D. Placeholder – Statements of support from Nottingham City Health and Wellbeing Board and Nottinghamshire County Health and Wellbeing Board

Nottinghamshire County Health and Wellbeing Board

The Nottinghamshire Health and Wellbeing Board is satisfied that the NHS Joint Forward Plan for Nottingham and Nottinghamshire has taken account of its feedback, and the plan clearly articulates the ICBs commitment and contribution to the delivery of the Nottinghamshire Joint Health and Wellbeing Strategy.

Nottingham City Health and Wellbeing Board

Nottingham City Joint Health and Wellbeing Board have been sighted on drafts of the NHS Joint Forward Plan and had the opportunity to review it. Formal agreement on this version is under consideration.

Appendix E. Building our integrated approach to delivering integration, equity and prevention

Case study: Promoting equity

Samantha had been in and out of prison throughout her adult life. She was homeless and suffering from poor mental health, but not receiving any mental health medication due to her high levels of substance misuse. The Homeless Health Team and Juno Women's Aid supported Samantha through links made by the multi-disciplinary team. She is now registered with a GP, accessing mental health services and has been referred to the YMCA. Samantha has engaged well and has not been seen by the Street Outreach Team since her move to YMCA accommodation. These outcomes would not have been possible without the new services being flexible and person-centred.

Case study: Promoting prevention

Slow cooker courses have been held to support people in Bassetlaw with food insecurity. They have been delivered by ABL Health, in conjunction with Bassetlaw Community and Voluntary Service and Bassetlaw Food Insecurity Network. The aim is to upskill people, improve confidence, connect people and boost health and wellbeing. Participants complete information on nutrition, physical health, mental health, smoking and alcohol and are signposted to different support services. New courses are being held with the Polish community and with adults with mental health and learning disabilities in Newark. Participants: *"The course made me have more confidence in cooking and to socialise more." "It has helped me consider planning menus that are healthier."*

Case study: Integration

Joint working has led to a reduction in people in mid-Notts attending emergency departments with end-of-life care needs from 5,304 (2019-20) to 3,433 (2021-22). The End of Life Together partnership identifies people with care needs and offers advanced care planning. It has access to a multi-disciplinary single point of access and links to the most appropriate service, such as day therapy, carer support or hospice at home support. This has resulted in 81% of people who expressed their preferred place of care being supported to achieve this. Dr Julie Barker, GP and end of life care lead, said: *"One of my patients was diagnosed with advanced cancer. He lived alone and although he had a caring family, they couldn't meet his complex care needs as he reached the end of his life. On discharge from hospital, the wonderful team at Beaumond House offered him the choice of support at home with their Hospice at Home team or bed based care. He opted for the latter and spent his last days comfortable, cared for, enjoying homemade soups he described as delicious and his family and friends spending as much time with him as they wished."*

Case study: Integrated strategic planning and collaborative commissioning

During 2022 Nottingham City Council, Nottinghamshire County Council and Nottingham and Nottinghamshire ICB developed an ICS Carers Strategy through co-production with unpaid carers. Carers highlighted inconsistency in the offers of support available, confusion about where to seek help and limited opportunity to influence the delivery and improvement of services.

The strategy confirmed a shared aim to improve the quality of life for unpaid carers and to support them to continue in their caring role, while maintaining their own health and wellbeing. Carers identified key priorities for support including:

- Identifying and supporting carers as early as possible.
- Tailoring support to each carer to meet their needs, support their health and wellbeing and maintain their independence.
- Planning for times of crisis.
- Access to respite or breaks to support resilience and ability of carers to continue in their caring role.

The strategy shaped a single ICS model of carers support services which will have the flexibility to deliver person-centred integrated care and continue to develop delivery approaches suitable for different communities through joint working with Place Based Partnerships.

Organisations involved are now undertaking a collaborative commissioning approach with a single joint procurement of new services for unpaid carers, with commencement of a new contract by October 2023.

Appendix F. Delivering the NHS Operational Plan 2023 compliance

The ICB Board has overseen development of the 2023-24 NHS operational plan which is ambitious for our population and aims for compliance with all national requirements.

Final operational plans were submitted to NHS England on 4 May following approval by NHS Trust Boards and the ICB Board. The final submitted operational plan is financially balanced and the majority of operational areas are compliant with national requirements (except learning disability and autism adult inpatients and follow-ups).

The 2023-24 operational plan complies with the majority of national requirements, as summarised on this slide.

- **Urgent and emergency care**: The plan is compliant with the requirement that no less than 76% of patients are seen within four hours by March 2024. The ICB plans to consistently meet the 70% two-hour urgent care response standard. The ICS is committed to accelerate the virtual wards programme to achieve the target of 400. Plans are in place to achieve acute bed occupancy below the 92% requirement through 2023-24.
- **Planned care**: The ICB continues to focus on eliminating 78-week waiters and has a plan to eliminate 65-week waiters by March 2024 (NUH has set an ambition to eliminate earlier). The ICB is compliant with the 105% VBA requirement at ICB level with oversight in place.
- **Cancer**: Plans are in place at both Nottingham University Hospitals and Sherwood Forest Hospitals to achieve the cancer 62-day backlogs defined by NHSE and meet the faster diagnosis standard by March 2024.
- **Diagnostics**: A trajectory has been submitted to NHSE which achieves 85% of patients receiving a diagnostic test within six weeks by March 2024 at aggregate and individual modality level.
- **Mental health**: The ICS is compliant against the mental health investment standard requirement and improving access to mental health support for children and young people, increasing IAPT (improving access to psychological therapies) access, increasing adults supported by community mental health services, eliminating inappropriate out-of-area adult placements, recovering dementia diagnosis and improving access to perinatal mental health services.
- **Learning disability and autism**: Plans are in place to achieve 75% of people over-14 on a GP learning disabilities register receiving an annual health check and health action plan by March 2024. The forecast for children and young people inpatient performance is compliant with long term plan projections.
- **Health inequalities**: The ICS continues to address health inequalities supported by a population health management approach, targeting resources and continued delivery of the five priority actions, Core 20+5 adults and Core 20+5 children plans.
- **People**: Plans are in place to improve retention and attendance through a focus on all elements of the NHS People Promise.

			Key priorities (as described in planning process)	Operational Plan Compliance
1. Recovering our core services and improving productivity	1A. Urgent and emergency care*	Objectives	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25	Compliant
			Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25	Compliant across the East Midlands.
			Reduce adult general and acute (G&A) bed occupancy to 92% or below	Compliant
	1B. Community health services	Objectives	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard	Compliant
			Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	To be confirmed
	1C. Primary care*	Objectives	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need	To be confirmed
			Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024	Compliant
			Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024	Plans in Place
			Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels	Compliant
	1D. Elective care	Objectives	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)	Compliant
			Deliver the system- specific activity target (agreed through the operational planning process)	Compliant
	1E. Cancer	Objectives	Continue to reduce the number of patients waiting over 62 days	Compliant
			Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days	Compliant
			Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Plans in place
	1F. Diagnostics	Objectives	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of	Compliant
			Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	Compliant
	1G. Maternity*	Objectives	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury	Maternity plans are in place and continue to be developed
			Increase fill rates against funded establishment for maternity staff	Maternity plans are in place and
	1H. Use of	Objectives	Deliver a balanced net system financial position for 2023/24	Compliant
2.Delivering the key NHS Long Term Plan ambitions and transforming the NHS	2A. Mental health	Objectives	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)	Compliant
			Increase the number of adults and older adults accessing IAPT treatment	Compliant
			Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services	Compliant
			Work towards eliminating inappropriate adult acute out of area placements	Compliant
			Recover the dementia diagnosis rate to 66.7%	Compliant
			Improve access to perinatal mental health services	Compliant
	2B. People with a learning disability and autistic people	Objectives	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024	Compliant
			Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12-15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit	Non compliant.
	2C. Prevention and health inequalities	Objectives	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024	Plans in place
			Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%	Plans in place
			Continue to address health inequalities and deliver on the Core20PLUS5 approach	Compliant
	2D. Investing in our workforce	Objectives	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise	Compliant

Final plan: Remaining compliance challenges

Area		Status in the final plan
Follow-ups – achieve a 25% reduction on 2019-20 activity levels through 2022-23.	The main reasons for non-compliance include: • Reducing follow-up appointments in some specialties will result in patients waiting longer, putting them at increased clinical risk and backlogs would rise. • In order to clear overdue numbers, the Trusts would need to recruit additional consultants which is problematic within ophthalmology as patients are on repeat reviews for many years. • 25% reduction in follow-ups equates to 239,664 appointments at NUH alone. • There are currently about 26,000 (reduced from 32,000 this time last year) patients at NUH alone waiting for an overdue follow-up appointment, half are within ophthalmology with audiological medicine and ear, nose and throat (ENT) also having large overdue backlogs. • Nationally target is challenging for most Trusts and compliance is only possible once backlogs are reduced across certain specialties. The Trust will be reducing follow-ups but not to 25%. • 2022-23 referrals are 4.3% higher than the same period for 2021-22, driven by a higher number of internal referrals. This results in more capacity required to address new referrals and less available for overdue reviews.	Not compliant.
Plans to deliver.	The 2023-24 plan to achieve compliancy is as follows: • The system plan will be to reduce the current out-patient backlogs (follow-up overdue reviews) during 2023-24 at both NUH and SFH. • Agree a specialty-by-specialty plan for backlog reductions with clinical oversight to minimise clinical risk. • After backlogs are eliminated, agree specialty-by-specialty plans to reduce by 25%. • The system will look to bench-mark by specialty and agree appropriate new to follow-up ratio. Map new to follow-ups at speciality levels. • Plans for patient-initiated follow-ups/A+G target remain robust and to hit target, but the system will look to extend to give headroom for the 25% reduction described above. • Virtual consultations to maintain 25% through 2023-24. • Capacity released should support the backlog of overdue follow-ups. The activity plan should aim to clear the backlogs and get back to steady state through additional capacity (weekends, insourcing, recruitment). • Overdue lists currently have clinical oversight and are risk assessed to minimise risk of deterioration and this will remain in place. • Focus on the specialties which will not impact on clinical risk or increase backlog during 2023-24. • Improve on schemes to reduce did-not-attends and late cancellations to maximise clinic slot utilisation.	
Learning disability – no more than 27 people in adult inpatient setting by March 2024.	• The ICB remains non-compliant for the number of adults with a learning disability or in an inpatient setting commissioned by the ICB or NHSE. • The current plan is for 37 inpatients by March 2024 (10 for the ICB and 27 for NHSE). • The partnership between the NHS, local authorities and IMPACT has agreed these trajectories as realistic and stretching. These were signed off at the Learning Disabilities and Autism Board on 28 March. • Although this trajectory is not compliant with the Long Term Plan requirement, it has been accepted by NHSE Midlands. • An email from NHSE Midlands on 2 March 2023 confirms that although the ICB is not meeting the LTP targets, the overall plan does not seem unreasonable or unachievable. It goes on to request that the ICB explores whether the LTP target can be met in 2024-25. In response, the system has committed to achieving the LTP commitment of 27 inpatients by March 2025. • The chief executive/executive leads for learning disability are confident that this is be best position that can be achieved in the 2023-24 plan and is viewed as acceptable by NHSE. • The system has ADASS (Association of Directors of Adult Social Services) visiting from 28-30 June 2023 to undertake a peer review to offer assistance on how the system achieves compliance . • Monthly meetings taking place with NHSE to focus compliance.	Not compliant.

Appendix G. Glossary of terms

Health	The state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity.	Integrated Care Partnership (ICP)	ICPs are a critical part of ICSs and the journey towards better health and care outcomes for the people they serve. ICPs provide a forum for NHS leaders and local authorities to come together with important stakeholders from across the system and community. Together, the ICP generates an integrated care strategy to improve health and care outcomes and experiences for their populations, for which all partners will be accountable.
Health inequalities/ Health inequities	Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.	Integrated Care System (ICS)	In an ICS, NHS organisations in partnership with local councils and others take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve. Statutory ICS arrangements include: • an Integrated Care Partnership, the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS • an Integrated Care Board, bringing the NHS together locally to improve population health and care. Within ICSs, it is expected that several place-based partnerships will be agreed. Four place-based partnerships have been agreed in our system.
Healthy life expectancy	The length of time a person spends in good health – in other words not hampered by long term conditions, illnesses or injuries.	Life expectancy	The average number of years that someone can expect to live.
Neighbourhood	The smallest and most local area that services are organised at.		

Appendix G. Glossary of Terms

Primary care network (PCN)	Local collaboration of GP practices, usually covering 30,000 to 50,000 people, working towards integrated primary and community health services.	Place Based Partnerships (PBP)	Place-Based Partnerships are collaborative arrangements that have been formed across the country by the organisations responsible for arranging and delivering health and care services in a locality or community. They involve the NHS, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities (people who use services, their representatives, carers and local residents).
System Analytics and Intelligence Unit (SAIU)	The SAIU brings together and develops existing ICB and ICS workforce with the purpose of delivering: • Population intelligence to support planning and strategy. • Analytical intelligence that spans the entire commissioning cycle. This includes capacity and demand modelling, population health management, and quantifying and evaluating the value of transformational initiatives. • Oversight of regional, national benchmarking data, as well as insight, contextual analysis and comparative information to support the interpretation of local data to improve quality of care and outcomes for our population. • Embedding an analytical approach to health inequalities which underpins all outputs. • Utilising best practice evidence-based interventions and new models to develop improved quality outcomes for our population. The SAIU is an independent team within the ICS that operates across the system.	Provider Collaborative at Scale	Partnership arrangements involving two or more trusts (NHS Trusts or Foundation Trusts) working at scale across multiple places, with shared purpose and effective decision-making arrangements, to: • Reduce unwarranted differences and inequality in health outcomes, access to services and experience • Improve resilience (for example, by providing mutual aid) • Ensure that specialisation and consolidation occur where this will provide better outcomes and value. The Nottingham and Nottinghamshire Provider Collaborative at Scale is between Nottinghamshire Healthcare NHS Foundation Trust, Sherwood Forest Hospitals NHS Foundation Trust, Nottingham University Hospitals NHS Trust, Doncaster and Bassetlaw NHS Teaching Hospitals Foundation Trust and East Midlands Ambulance Service NHS Trust, with an initial focus on programmes within the themes of discharge and workforce.
Outcomes	Change in health and wellbeing as a result of an intervention or action, either by an individual (exercising more), community (starting a running group) or organisation (creating more green spaces for people to exercise in).	Universities for Nottingham Civic Agreement	Partners have agreed as anchor institutions for Nottingham and Nottinghamshire a commitment to work together ensuring a joined up approach across several themes, including: • Economic prosperity • Educational opportunity • Environmental sustainability • Health and wellbeing which includes attracting the world's most talented clinicians and healthcare workers to the area, training and retaining local talent to develop their careers in Nottingham and Nottinghamshire; and maximising the economic opportunities provided by the strong local health and life sciences sectors.

Appendix 2

DRAFT document

Version Final DRAFT
30 June 2023

To be approved at the ICB Board meeting on 13 July 2023

Nottingham and Nottinghamshire NHS Joint Forward Plan

EXECUTIVE SUMMARY

2023-27

NHS Nottingham and Nottinghamshire

NHS Sherwood Forest Hospitals NHS Foundation Trust

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

NHS Nottingham University Hospitals NHS Trust

NHS Nottinghamshire Healthcare NHS Foundation Trust

NHS East Midlands Ambulance Service NHS Trust

EXECUTIVE SUMMARY

Our Joint Forward Plan

Our Integrated Care Partnership has published an an integrated care strategy which describes our ambitions for local people and how we are going to work together differently to ensure:

Every person will enjoy their best possible health and wellbeing.

We are now producing a **Joint Forward Plan** which outlines in more detail the work that NHS partners will undertake, working collaboratively across our system, to deliver these ambitions.

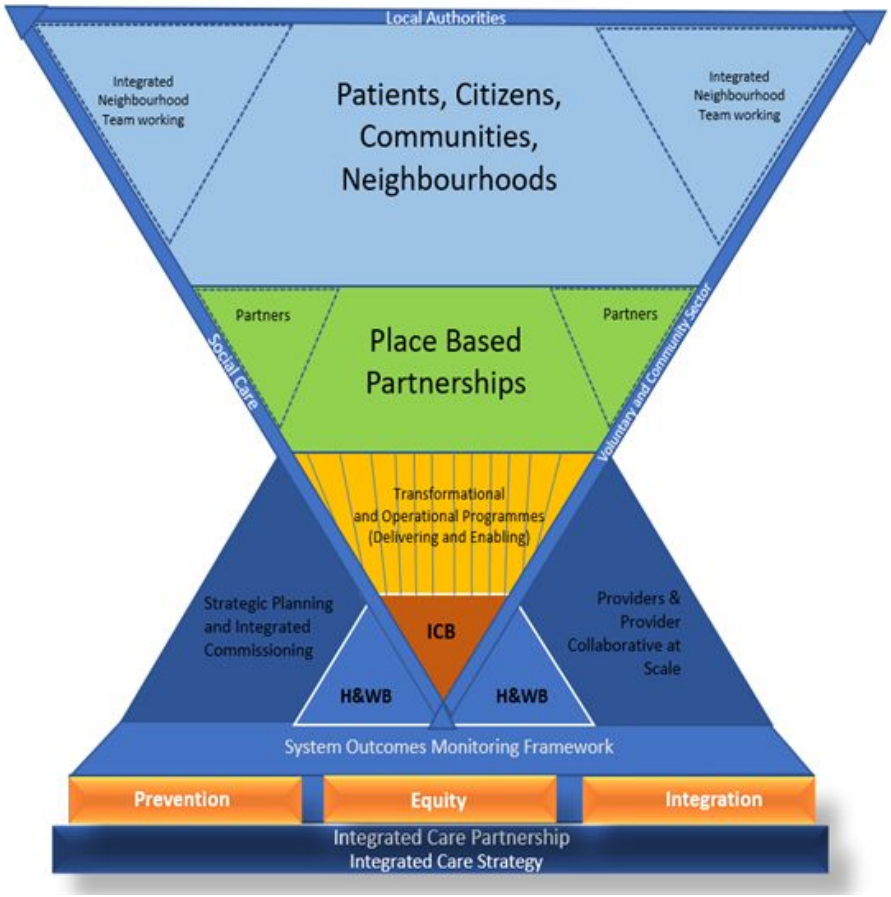
We recognise that there are still unacceptable differences in health and wellbeing outcomes, access to services and experience of services across our city and county. While some people live healthier lives for longer, this is often not the case for others, especially those living within more deprived communities. Taking action on these differences is a priority for our NHS. This applies to both physical and mental health needs. Our Joint Forward Plan outlines the actions we will take to radically alter the way in which we work together, focusing far more on preventing ill health, reducing health inequalities and inequity, using our combined commitment and resources. Our actions will be brave, ambitious and transformational.

As part of this transformation, we will work in a more integrated way at system and local level. Greater integration at a local level will be through Place Based Partnerships (PBPs) and local neighbourhood team working. Health and care provider organisations will work more closely at a system level in the form of a Provider Collaborative(s). Our Integrated Care Board (ICB) will also explore further opportunities to collaborate with NHS partners across the region and nationally. We will ensure an equal focus on mental and physical health, adopting a life course approach that addresses the specific needs of children and young people as well as those in later life.

NHS partners will accelerate partnership working with local authorities, public and voluntary sector organisations, our population and local communities. The principle of co-production will drive our agenda, ensuring that those with lived experience remain active participants in the design and delivery of local and system solutions. We will use population health data and intelligence, alongside local knowledge and experience, to identify priorities and opportunities for achieving better outcomes for people. Our local neighbourhood teams will build trusted relationships that ensure change will be embedded and sustainable.

Over the next five years, the combined impact of these changes will result in a significant cultural shift in the way we work together and will radically transform the system in which we work.

Evolving our integrated working model



What will our Joint Forward Plan mean for our Integrated Care System?

Success in delivering our five-year plan will mean our ICS will:

- ❑ Enable every person, young and old, to achieve their best possible health and wellbeing. This includes their physical and mental health.
- ❑ Be able to evidence positive impact for our communities in each of our Places and across the system, in terms of both physical and mental health outcomes.
- ❑ Demonstrate positive impacts on reducing health inequalities and inequity. Impact will be linked to targeted interventions, tracked through local and national outcomes metrics.
- ❑ Urgently make a real shift of NHS resources to prevention related initiatives over the next five years, reflected in how resources are allocated to key priorities and by developing new roles and ways of working.
- ❑ Have an inclusive, diverse and innovative culture across the NHS, with a sustainable workforce, local skills pipeline, developing and retaining local talent.
- ❑ Recover services fairly from the pandemic – achieve target waiting times with a focus on equity and close the mental and physical health gap for children and young people affected by the pandemic. We will meet quality and national performance metrics while continuing to adopt a more personalised and proactive approach to care. Care in hospital will be complemented by personalised care planning to maximise patient outcomes and help people to stay well at home for longer.
- ❑ Consistently make the best possible collective use of our resources and be ambitious to gain the best outcomes for local people – working collaboratively to maximise our impact on both physical and mental health and wellbeing during people's lives.
- ❑ Achieve financial balance within a safe health and care system, with high quality, high performing services.

- ❑ Be highly visible and relevant in communities, creating effective partnerships with local organisations that drive change and contribute to social justice, community resilience and economic development in our area.
- ❑ Use community assets, strengths-based approaches and digital tools to support people to take control of their health and wellbeing, with place-based inclusion strategies to promote health equity.
- ❑ Accelerate our research programmes, including service evaluation and audit. We will use population health data, best practice guidance and research evidence to inform the choices and decisions we make. We will work together with our population, Nottingham's universities and our local National Institute for Health and Care Research infrastructure to inform this approach.
- ❑ Use data and intelligence to help us understand issues better, like smoking and obesity, and to allocate resources on this basis. We will tailor and personalise support for people, so that they feel empowered to make healthy changes in areas that are important to them and their carers and families.

In combination, our success in these areas will lead to the delivery of our strategic ambitions:

What will our Joint Forward Plan mean for the way we work together?

The NHS Joint Forward Plan is based on three strategic principles:

Prevention is better than cure

Equity in everything

Integration by default

Guided by these principles, our delivery initiatives focus on four key areas that provide the greatest opportunity to improve population health by making better use of our scarce resources. By focusing on these four areas, we will release more capacity and resources to invest in prevention initiatives in the latter years of our transformational journey. This focus also enables us to meet the obligations required of us by national policy and the NHS Operational Plan. Our Plan will be refreshed annually to ensure we continue to focus on the right priorities for our people.

Our four areas of focus 2023-24 to 2027-28

1. **Prevention: Reduce physical and mental illness and disease prevalence**
2. **Proactive management of long-term conditions and frailty**
3. **Improve navigation and flow to reduce emergency pressures in both mental and physical health settings**
4. **Timely access and early diagnosis for cancer and planned care**

Initiatives that are most critical to meeting the expectations of our ICP Integrated Care Strategy, Joint Forward Plan and national policy expectations

Achieving	How?	What does this mean? Examples	Success factors
PREVENTION EQUITY INTEGRATION	Shifting resources into prevention, promoting equity and reducing health inequalities.	Minimum investment of a dedicated Health Inequalities Investment Fund of 0.2% of ICB budget in 2023-24 (£4.5m) with commitment to increase over the five-year period. Review of our Better Care Fund to support delivery of the JFP and Joint Health and Wellbeing Strategies. Implementation of a single system approach to exploring and delivering efficiency opportunities using benchmarking analysis/national tools to implement best practice. Systematic approach by all providers to 'bake in' principles of prevention, equity and integration into business as usual. Implementation of 'proportionate universalism' across strategic decision-making processes.	Minimum 1.4% investment dedicated to health inequalities by year five. Investment in initiatives that provide legacy of improved outcomes by reducing health inequalities/inequity. Efficiency and productivity expectations delivered and re-invested into patient care.
	Integrated neighbourhood team working and Place Based Partnerships (PBPs).	Increased collaboration and integration between health and care professionals at a local level aligned to delivery of specific interventions identified within Place Plans and/or system agreed programmes. Focus on high impact pathways of care, for example, frailty, severe mental illness, and best start. PBP Plans aligned to evidence-based priorities (Place and system level). Plans inclusive of mental and physical health needs, adults, children and young people, for example, smoking and obesity. Support primary care resilience and primary care network (PCN) development.	Embedded and evidenced integrated neighbourhood team approach across PBPs. Make Every Contact Count, co-production and asset-based approaches in place. Cultural shift to population focus.
	Provider Collaborative supporting 'at scale' transformation.	Joint working arrangements established across multiple provider organisations for targeted provision of services, for example, urgent care pathways, diagnostics, virtual wards, and social and economic development through anchor organisations.	Achievement of target outcomes and transformation of pathways as delegated including supporting system financial balance.
	System-level programmes providing leadership and expertise, for example, mental health, children and young people, maternity, ageing well, primary care, quality improvement.	Focus on population needs that address issues of health inequality and inequity across our system. Holistic support for individuals including parity and recognition for co-existence of physical and mental health needs. Outcomes will be improved over people's lives including equitable outcomes for vulnerable children and young people.	Programme activity focused on system priorities with multi-partner engagement and oversight delivering JFP commitments: • System mental health inpatient strategy implemented. • Mental health transformation plan implemented. • Delivery of children and young people's NHSE Core20+5.
	Developing our workforce. Promoting resilience and new ways of working.	Increased staff flexibility and flow across teams and geography to support outcomes. Promotion of, and embedding, our three strategic principles of prevention, equity and integration into the way that teams work.	Establishment of a recruitment hub, staff passports, shared/common training programmes. Common system level policies and processes including quality framework, service improvement and co-production approaches.

What will delivery of our Joint Forward Plan mean for our community?

	For People	For Staff	For NHS Organisations	For Partners
Promoting Prevention	• Earlier detection of disease • Reduced likelihood of future ill health or current ill health worsening • Empowered to work with staff to develop services and solutions based on need and real-life experiences	• Helping people to stay healthier for longer • Promoting a more holistic approach to patient care • Ensuring physical and mental health needs are addressed	• Avoiding future use of services, ensuring services are available for those that need them when they need them most	• Developing closer working relationships and reducing duplication across organisations • Supporting effective use of resources
Promoting Equity	• Supporting those with severe multiple disadvantage to have improved life chances • Ensuring all voices are heard • Promoting inclusion, valuing diversity	• Making sure all patients have equal opportunity to benefit from the services they provide • Valuing all our staff and supporting them	• Reducing or preventing people dying early from treatable conditions • Making better use of resources to benefit more people	• Enabling better access to non-NHS services that support personalised care • Enabling all our community to fulfil their potential
Promoting Integration	• Reducing the need to engage with multiple NHS staff about the same issue • Being supported on non-medical matters that are important to the individual • Promoting more seamless care across clinical and non-clinical support services	• Promoting multi-disciplinary team working and continuity of care • Making Every Contact Count • Staff feel empowered to work differently	• Creating streamlined care pathways • Increased staff resilience • Creating efficient use of estates • Implementing personalised care	• Making it easier to do business with the NHS • Greater recognition of the value of non-NHS services in supporting health and wellbeing • Building community resilience

What will delivery of our Joint Forward Plan mean for patient care?

1 Prevention: reduce physical and mental illness and disease prevalence

- Prioritise prevention and early intervention to effectively reduce the incidence and impact of diseases and costly treatments (including planned care) on our health and care system, leading to long-term cost savings and enhanced health outcomes for our population.
- People supported to lead healthy behaviours and maintain good health from birth and for as long as possible, including education to support self-care.
- Services are commissioned in an integrated way across health, education, social care, public health and housing, improving the experience of care for the population and optimising outcomes.
- Achieve an efficient and effective healthcare system, that optimises the workforce available to us, directing resources to where they are most needed.
- Embracing technology and innovation to enhance the tools available increasing productivity for our workforce.
- Adopting digital solutions in an inclusive way (primary care and community) to improve efficiency, accessibility and patient outcomes.

2 Proactive management of long-term conditions and frailty

- Case finding and screening programmes will target population groups where there are inequalities in uptake to support early detection of long-term conditions in line with our Core20PLUS5 approach.
- Priority for those cohorts where population health management data indicates there is greatest opportunity for impact at both Place and system level, for example, frailty, respiratory, hypertension, CVD.
- People with multiple long-term conditions will be supported in a co-ordinated way with personalisation of care and individualisation of targets.
- Staff will be trained to support the complexity of needs of people with long-term conditions and to manage different diseases providing an opportunity to up-skill staff across specialisms.
- We will make every contact count ensuring people are supported for both their physical and mental health needs.
- Integrated neighbourhood team working will promote proactive care co-ordination for the management of long-term conditions – creating a 'team of teams' that wraps care around people.
- We have services and pathways in place that allow people to receive the care they require in the right place, first time.
- System working and collaboration with system partners to transform medicines use to improve the health and wellbeing of our population.

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

Flow into the hospital

- People know how and when to access urgent and emergency care services when they need it.
- We have services in place to support people who have urgent care needs to be cared for at home for both their physical and mental health needs.
- People who need to use 999 or our hospitals in an emergency are transferred to the hospital and seen in a timely manner.
- We have services and pathways in place that allow people to receive the care they require in the right place, first time.

Flow through the hospital

- People are treated and supported in hospital to a point when they are medically stable. They will be transferred to a place suitable to their ongoing care/rehab needs and plan for longer term support if required.
- Discharge planning starts on admission (or pre-admission where possible).
- Discharge teams are integrated and work seven days-a-week.
- People are assessed for their longer term needs once they are discharged and not before.
- Only those that need hospital care that cannot be provided at home are admitted into a hospital bed, with the remainder going home the same day on same day/community/virtual ward pathways.
- Physical and mental health services are integrated.

Flow out of the hospital

- Multi-disciplinary transfer of care hubs are established at each hospital and operational seven days-a-week.
- People go home, or to a place that is suitable for the support they require, on the day they are medically safe to do so.
- A culture of trusted assessment is embedded across all organisations.
- Virtual wards are established and embedded across the ICS.
- For people in an acute mental health bed, community provision, appropriate housing and supported living will support prevention of admission and timely discharge.
- Community rehabilitation supports people to maximise their recovery in their own homes.

Preventing readmissions

- Integrated Neighbourhood Teams support people to remain at home and manage their health and wellbeing.
- Our population health management approach supports us to identify those most in need.
- Comprehensive care planning for our most vulnerable patients to keep them well and/or at home in a crisis.

4 Timely access and early diagnosis for cancer / planned care

- Cancer and planned care waiting times are within national performance requirements.
- Patients have equitable access based on need with appropriate choice of provider.
- Shared decision making, patients offered options to avoid unnecessary procedures and acute intervention with conservative treatment considered at an early stage closer to home.
- Prioritisation of waiting lists includes clinical risk, health equity, population need. Consideration of the specific needs of children and young people and ensuring parity of esteem for physical and mental health.
- Elective hubs are in place, underpinned by best practice in productivity.
- Shared workforce plans and staff retention, support in place.
- Community diagnostic hubs established and GP direct access enabled.
- Expansion of targeted lung health programme starting this year and completed in 2025-26.
- Breast cancer – implementing community-based breast screening in areas of low uptake.
- Prostate cancer – implementing community-based clinics with high incidence – Afro-Caribbean communities.

Appendix 3

DRAFT document

Version Final DRAFT
30 June 2023

To be approved at the ICB Board meeting on 13 July 2023

Nottingham and Nottinghamshire NHS Joint Forward Plan

2023-27

Easy-to-read version

NHS
Nottingham and Nottinghamshire

Nottingham and Nottinghamshire NHS Joint Forward Plan

This is a public summary of the Nottingham and Nottinghamshire Joint Forward Plan. The full plan can be found on the local ICS website: https://healthandcarenotts.co.uk/integrated-care-strategy/joint-forward-plan/

What is a Joint Forward Plan?

NHS organisations in Nottingham and Nottinghamshire have come together with partner organisations, including local authorities and the voluntary and community sector, to produce a strategy that explains how we are going to improve health and care for local people. This is known as our Integrated Care Strategy. You can watch a video explaining the strategy on our website. The strategy sets out how we are going to work together differently to ensure that:

Every person will enjoy their best possible health and wellbeing.

This strategy will guide our approach up to the year 2027. In order to achieve the aims of this strategy, we have now published a Joint Forward Plan, which provides the detail of what we are going to do. NHS organisations around the country, together with their partner organisations, are required to write these strategies and plans. Many local individuals, groups and organisations have been involved during spring 2023 in writing the plan.

Why do we need this plan?

There are growing differences in people's health and wellbeing in our communities. While some people are living healthier lives for longer, some people are living in poorer health and have worsening opportunities to reach their full potential. This applies to both people's physical and mental health. Our Joint Forward Plan outlines the actions we will take to radically alter the way we work together, and use our combined resources to meet these challenges. We believe our actions are brave and ambitious and will help transform services for the better.

What are the principles and priorities of the plan?

Our strategy and plan are based on three strategic principles. We believe that:

- Prevention is better than cure – making sure we use our limited resources more efficiently
- Equity in everything – recognising that some people and communities need more support
- Integration by default – providing joined up and seamless services.

Guided by these principles, we are focusing on **four** key areas:

1. Prevention: reducing illness and disease where we can
2. Proactive management of long-term conditions and frailty
3. Improving navigation and flow of people through services to reduce emergency pressures
4. Timely access and early diagnosis for planned care and cancer care.

Nottingham and Nottinghamshire NHS Joint Forward Plan

What does the plan seek to achieve in the next five years?

Success in delivering our plan will mean that we can:

- Enable every person to achieve their best possible health and wellbeing.
- Evidence positive impact for our communities across the city and county in terms of both people's physical and mental health.
- Demonstrate impacts on reducing health inequalities and inequity.
- Make a real shift of NHS resources to prevention – preventing people becoming ill wherever possible, or their illness worsening, rather than treating the results of illness.
- Have an inclusive, diverse and innovative culture across the NHS.
- Recover more services fairly from the pandemic and achieve target waiting times.
- Make our NHS organisations more efficient and effective by working together better.
- Achieve financial balance within a safe health and care system with high quality, high performing services.
- Create more effective partnerships with local organisations and better support local communities.
- Provide more personalised care to individuals based on all of their needs.
- Make better use of population health data and research in informing the choices and decisions we make.

What are some of the changes that will take place?

The plan details a large number of developments and changes that we wish to make over the next five years. Doing the same as we have always done is not an option. There is a rising demand on health and care services and ever-increasing pressure on budgets. We have to work differently and provide services increasingly based on the specific needs of individuals and local communities.

Prevention of ill health

We aim to:

- Intervene earlier in people's care, to prevent or stop any health problems occurring.
- Better support people to lead healthy behaviours, so they can maintain good health for as long as possible.
- Better join up services around an individual, including health, social care, education and housing.

People with long-term conditions and/or frailty

We aim to:

- Target people in communities who might experience generally worse health – conditions like breathing problems, high blood pressure and heart disease – and provide more dedicated support.
- Provide more training to staff who manage patients with more complex health needs.
- Make every contact that a health and care professional has count with a member of the public – making a difference wherever we can.

Nottingham and Nottinghamshire NHS Joint Forward Plan

Reducing pressures on physical and mental health services

We aim to:

- Establish 'care hubs' at hospitals to ease patients' entrance into, their stay during, and discharge from hospital, ensuring that everything runs as smoothly as possible.
- Develop more 'virtual wards' where people can remain at home, under the supervision of health and care professionals, using technology where appropriate.
- Establish 'integrated neighbourhood teams' where health and care professionals, working with support from the voluntary sector, can plan and manage care for local people.

Timely access to cancer services and planned care services

We aim to:

- Make sure waiting times for cancer services and planned care services are within national performance requirements.
- Establish community diagnostic hubs, to improve how we can diagnose certain conditions.
- Expand key health programmes, such as breast cancer screening, prostate cancer community-based clinics, and the lung health programme.

These are just a few examples of our ambitions for change over a five-year period. The plan shows what we need to do in 2023 and in each year ahead.

What will this mean for local people?

Promoting prevention	• Earlier detection of disease • Reduced likelihood of future ill health or current ill health worsening • People being empowered to work with staff to develop services and solutions based on need and real-life experiences
Promoting equity	• Support for those with greater needs to have improved health • Ensure all voices are heard • Promote inclusion and value diversity
Promoting integration	• Reduce the need for an individual to engage with multiple staff about the same thing • Support on non-medical matters that are important to the individual • Promote more seamless care across clinical and non-clinical support services.

How can I find out more?

Visit the website to find out more about our Integrated Care Strategy and the Joint Forward Plan: https://healthandcarenotts.co.uk/integrated-care-strategy/ and https://healthandcarenotts.co.uk/integrated-care-strategy/joint-forward-plan/

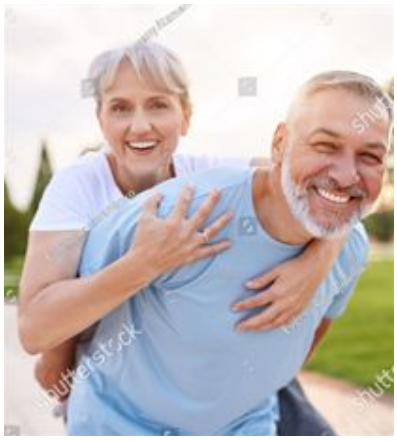
Visit the website to get involved in local NHS organisations: https://healthandcarenotts.co.uk/get-involved/

Contact us at: nnicb-nn.icstrategy@nhs.net

Appendix 4. Proposed design options for the final NHS Joint Forward Plan
Option A

NHS
Nottingham and Nottinghamshire






NOTTINGHAM AND NOTTINGHAMSHIRE NHS JOINT FORWARD PLAN

2023 - 2027

Section 1.

OUR APPROACH

INTRODUCTION

Our Nottingham and Nottinghamshire Integrated Care Partnership has developed an integrated care strategy for our system, with the expectation that collaboration across all partners will deliver four core aims, and that delivery of these will be guided by three underlying principles:

1. Improve outcomes in population health and healthcare	2. Tackle inequalities in outcomes, experiencess and access	3. Enhance productivity and value for money	4. Support broader social and economic development

We now have to translate this intent into action – encouraging local people, neighbourhoods, communities, staff, Place Based Partnerships and system partners to all play their part. This Joint Forward Plan acts as the NHS delivery commitment for all NHS organisations within the Nottingham and Nottinghamshire Integrated Care System (ICS), with intentions in line with our two Joint Health and Wellbeing Board Strategies for the city and county.

This Plan sets out the role that NHS partners will play in collaboration with our wider system partners in delivering our Strategy as well as the national expectations set out by NHS England. We want to be ambitious – we trust the passion, experience and commitment of our staff to enable us to be brave in the changes we intend to introduce or accelerate. We recognise that our communities face huge challenges and that we need to ensure every public pound, and all our combined effort, is focused on helping every person within Nottingham and Nottinghamshire to enjoy their best possible health and wellbeing.

We want to emphasise in this Plan how, by acting as an NHS team within our ICS, we will address the challenges of today as well as tomorrow. We outline the changes that our system will take over the next five years to ensure we have sustainable services by working differently, co-producing these changes with children, young people and adults, and being courageous in our approach. Our delivery plan responds directly to the priorities identified within our Strategy.

Our agreed 11 Integrated Care Strategy priorities

- We will support children and young people to have the best start in life with their health, development, education and preparation for adulthood.
- We will support frail older people with underlying conditions to maintain their independence and health.
- We will 'Make Every Contact Count' for traditional areas of health, for example, mental health and healthy lifestyles, and incorporate signposting to other services.
- We will support children and young people and adults with the greatest needs (the 20% most deprived areas nationally, those in vulnerable or inclusion groups and those experiencing severe multiple disadvantage).
- We will focus and invest in prevention priorities, like tobacco, alcohol, healthy weight, oral health and mental health, to support independence, prevent illness, poor birth outcomes and premature death from heart attack, stroke, cancer, chronic obstructive pulmonary disease (COPD), asthma and suicide.
- We will establish a single health and care recruitment hub.
- We will adopt a single system-wide approach to quality and continuous service improvement.
- We will review our Better Care Fund programme.
- We will bring our collective data, intelligence and insight together.
- We will make it easier for our staff to work across the system.
- We will add social value as major institutions in our area.

Underlying principles guiding our delivery

Prevention is better than cure
Equity in everything
Integration by default

BUILDING OUR INTEGRATED APPROACH

Working and behaving differently to deliver maximum impact

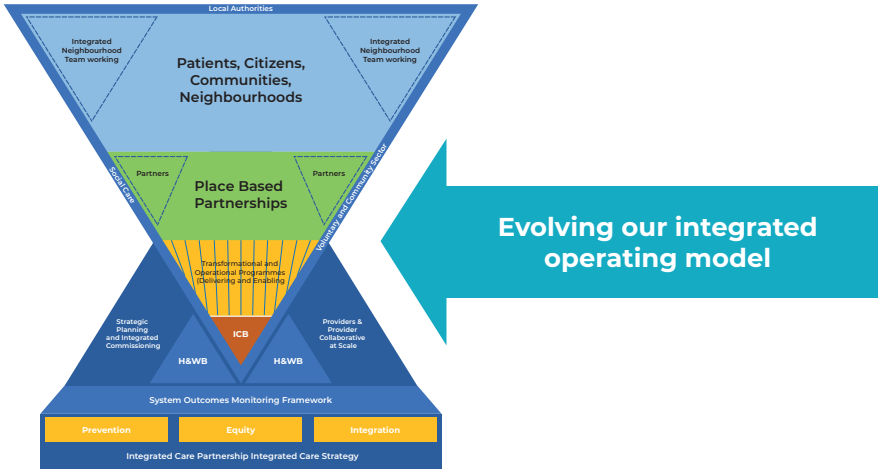
We want to transform the way our system works, to improve the lives of the people it serves. In line with the national **Hewitt Review** and the **Fuller Review**, our integration approach is widespread, taking in all levels, including colleagues within existing NHS organisations and the development of our four Place Based Partnerships (PBPs), working alongside system-level transformational programmes. Our PBPs will be characterised by empowered local teams working together across upper and lower tier councils. PBPs will be supported to work with our Primary Care Networks (PCNs) and develop integrated neighbourhood working (sometimes in the form of multi-disciplinary teams). Focus for these teams will be where population health intelligence suggests it would be most impactful, either in terms of improving health and wellbeing outcomes and/or improving cost-effective use of our collective resources. Ongoing evaluation and system level assurance mechanisms will enable us to refine and adapt these approaches as well as rapidly spread good practice and learning.

Our system model (see Figure 1) shows how our various partners 'lock' into our shared integrated system approach. The triangle of inter-dependency is strong, with all partners and elements of our system playing their role in delivering change based on the platform of the Integrated Care Partnership and the Integrated Care Strategy. The three strategic principles of Prevention, Equity and Integration remain the basis for this platform.

The benefits of this approach will be:

- Transformational change driven and owned by people closer to where people live
- Interventions co-designed with a better understanding of the context within which people live – interventions more sensitive to local need and therefore more impactful and cost efficient
- Relationships across partners and with communities are stronger and better able to use local resources – for example, creating innovation through integration/combined posts/shared knowledge and skills transfer
- More direct communication channels – professionals get to the right person/organisation more quickly to resolve the problem. Informal and formal mechanisms of engagement expand opportunities to make appropriate professional connections
- PBPs offering a way to drive local transformational change initiatives working in collaboration with system level experts, in areas such as public health, clinical and social care.

We will review our ICB operating model to further support this integrated system approach (see page 54).



Evolving our integrated operating model

Option B

NHS
Nottingham and Nottinghamshire







Nottingham and Nottinghamshire NHS Joint Forward Plan

2023 - 2027

Photo Credit: 1. Tram Peter Garwood / 2. Nottingham Castle Callis Hagg / 3. Rufford Abbey Paul Boast / 4. Wollaton Hall Derek Chapman / 5. Major Oak Neil Kemp / 6. Trent Bridge Jonathan Burley / 7. Robin Hood Statue

Introduction

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- **1. Improve outcomes** in population health and healthcare
- **2. Tackle inequalities** in outcomes, experiencess and access
- **3.** Enhance **productivity and value for money**
- **4.** Support broader **social and economic development**

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Our agreed 11 Integrated Care Strategy Priorities

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We will 'Make Every Contact Count' for traditional areas of health, for example, mental health and healthy lifestyles, and incorporate signposting to other services.

We will support children and young people and adults with the greatest needs (the 20% most deprived areas nationally, those in vulnerable or inclusion groups and those experiencing severe multiple disadvantage).

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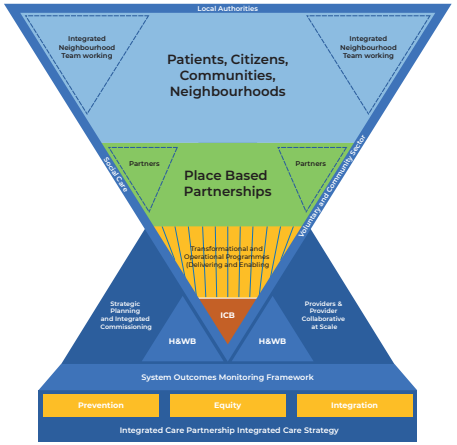


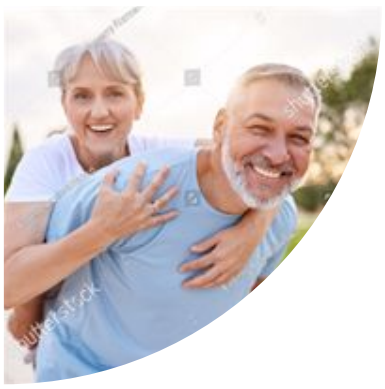
Option C

NHS
Nottingham and Nottinghamshire









Nottingham and Nottinghamshire NHS Joint Forward Plan

2023 - 2027

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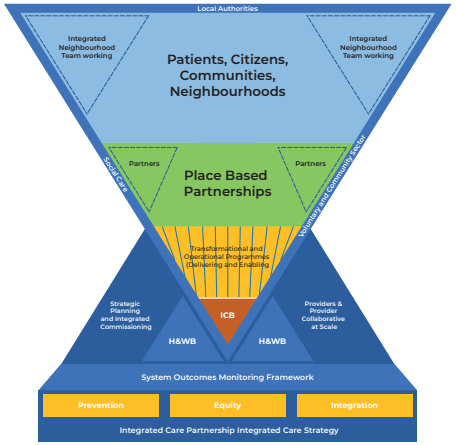

Appendix 5: Summary Engagement Plan for Joint Forward Plan Development

Date	Meeting
15 May	ICS Partners Assembly
18 May	ICS Reference Group
18 May	Planning Group
18 May	Strategy Steering Group
24 May	Nottinghamshire Health and Wellbeing Board (workshop)
25 May	System Planning Group
26 May	ICS Clinical and Care Professional Leadership Group
26 May	ICS Executive Leadership Group
26 May	NHS England review meeting
30 May	ICB Citizen Intelligence Advisory Group
31 May	Nottingham City Health and Wellbeing Board
1 June	ICS Planning Group
1 June	ICB Strategic Planning and Integration Committee
1 June	Sherwood Forest Hospitals NHS Foundation Trust Board
1 June	South Notts Place-Based Partnership
6 June	Feedback session with authors
6 June	ICS People and Culture Steering Group
6 June	Voluntary, Community and Social Enterprise Alliance
6 June	ICB Savings and Efficiency Working Group
7 June	Feedback session with authors
8 June	Bassetlaw Place-Based Partnership
8 June	Planning Group
14 June	Nottingham City Place-Based Partnership
15 June	Planning Group
15 June	Strategy Steering Group
15 June	Nottingham University Hospitals NHS Trust Board
19 June	Personalisation Oversight Group
21 June	Nottinghamshire Health and Wellbeing Board pre-agenda
21 June	ICB Quality and Performance Committee
22 June	Planning Group
23 June	ICS Executive Leadership Group
26 June	Health Inequalities Group
27 June	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust Board
29 June	Planning Group
5 July	Nottinghamshire Health and Wellbeing Board
6 July	ICB Strategic Planning and Integration Committee
6 July	Planning Group
13 July	**ICB Board**
26 July	Nottingham City Health and Wellbeing Board

*Sharing virtually with East Midlands Ambulance Services NHS Trust Board and Nottinghamshire Healthcare NHS Foundation Trust Board, due to timing of meetings.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/07/2023
Paper Title:	**Nottingham and Nottinghamshire Provider Collaborative at Scale**
Paper Reference:	ICB 23 024
Report Author:	Claire Culverhouse, Managing Director – Provider Collaborative
Report Sponsors:	Ifti Majid, Chief Executive of Nottinghamshire Healthcare NHS Foundation Trust (and NHS Trust/Foundation Trust Partner Member of the ICB Board) Paul Robinson, Chief Executive of Sherwood Forest Hospitals NHS Foundation Trust (and NHS Trust/Foundation Trust Partner Member of the ICB Board) Anthony May, Chief Executive of Nottingham University Hospitals NHS Trust
Presenter:	Claire Culverhouse, Managing Director of the Nottingham and Nottinghamshire Provider Collaborative

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

Summary:
The Nottingham and Nottinghamshire Provider Collaborative at Scale has now been operating for one year. This paper sets out the progress that has been made in developing the collaborative, the approach taken and the initial areas of focus. It also asks the ICB to help us consider how we can best work in a mutually supportive way to deliver our collective ambitions.

Recommendation(s):
The Board is asked to acknowledge this update and consider how we can best align the work of the developing Provider Collaborative with the work of the ICB and other parts of our system.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	The Provider Collaborative will form a core component of a functioning health and care system, so over time will be able to play a role in delivering all of the core aims of the ICB.
Tackle inequalities in outcomes, experience and access	
Enhance productivity and value for money	
Help the NHS support broader social and economic development	

Appendices:
Appendix A: What is the Provider Collaborative at Scale and why does it exist? Appendix B: Our Mission Statement, Objectives and Principles.

Board Assurance Framework:
The development of the Provider Collaborative could contribute 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 3: Transformation (for Making Tomorrow Better) – Effective system working may not transform (reform) and improve services to ensure best possible future health outcomes within available resources. • Risk 6: Quality Improvement – Failure to maintain and improve the quality of services. • 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.

Report Previously Received By:
Not applicable.

Are there any conflicts of interest requiring management?
Yes - it should be noted that Paul Robinson and Ifti Majid are both Chief Executives in organisations that are members of the Nottingham and Nottinghamshire Provider Collaborative at Scale, alongside being Partner Members of the ICB Board; however, as no decision is required by this item, they can both fully participate in discussion.

Is this item confidential?
No.

Nottingham and Nottinghamshire Provider Collaborative at Scale

Introduction

1. The Nottingham and Nottinghamshire Provider Collaborative at Scale has now been operating for one year. This paper sets out the progress that has been made in developing the collaborative, the approach taken and the initial areas of focus. It also asks the ICB to help us consider how we can best work in a mutually supportive way to deliver our collective ambitions.

Our journey

2. While collaboration across NHS providers has existed for many years; in summer 2021, NHS England formalised the move to collaborative working and set out guidance for how providers should work together at scale in collaboratives.
3. In 2021 we established a Chairs and Chief Executive Officers (CEOs) group between Nottinghamshire Healthcare NHS Foundation Trust (NHT), Sherwood Forest Hospitals NHS Foundation Trust (SFH) and Nottingham University Hospitals NHS Trust (NUH) in order to connect our organisations and build trust and confidence between us.
4. In Spring 2022 we invited East Midlands Ambulance Services NHS Trust (EMAS) and Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBH) to that group, as our ICS boundary changed.
5. Between April and June 2022, we sourced external support to help us set up the collaborative and identify our initial priority areas. We considered our population health data, our performance data and spoke to Executive Directors to better understand our collaborative opportunities. Where opportunities spanned all three of these areas, we long listed them. From the long list we applied a prioritisation framework which enabled us to consider what we should do, not just what we could do. The priority areas identified were workforce and discharge/urgent care.
6. In July 2022 a Provider Leadership Board was established between our organisations as a partnership of equals. We have not delegated any decisions into our Leadership Board as we have agreed that form should follow function. We also agreed that NUH would host the Provider Collaborative team, with the NUH CEO acting as the lead CEO for the collaborative. This aligned with an agreement for us to collectively nominate the NHT CEO and the SFH CEO to be the NHS Trust/Foundation Trust Partner Members of the ICB Board.
7. In November 2022, a Managing Director for the collaborative was appointed and in January 2023 we held a visioning session for the collaborative. This session allowed us to reaffirm our collective appetite for collaboration and reconfirm our

initial areas of focus. The focus areas remained as workforce and urgent care (to include discharge), alongside an agreement to develop a Provider Collaborative Prospectus, which will be used to set out what we are and our operating model.

8. Between February and May 2023 we identified work-stream leads and further scoped our work-streams, alongside developing the content needed to populate our prospectus e.g. articulating the purpose of our collaborative, a mission statement, objectives and principles (see Appendices A and B).

9. At the end of June 2023, we brought Board members from across our organisations together for a Joint Board Development session, to discuss the evolution of the collaborative and involve our Non-Executive Directors in our development journey. This has been accompanied by ongoing work with member organisation's Boards and Executive teams.

Next steps

10. The focus of the Nottingham and Nottinghamshire Provider Collaborative at Scale so far has been on building relationships and setting out the foundations for us to move forward.

11. We plan to have the first meeting of our Provider Collaborative Distributed Executive Team in July, where we are bringing together Executives from across our member organisations in order to build a shared team to govern and drive forward the work of the collaborative.

12. We are also now ready to move forward with our programmes of work. Our priorities for this year are:

13. **Urgent care** – We will deliver care improvements for our patients by streamlining Pathway 0 (simple discharge) pathways, providing consistency across the frailty pathway; and actively align and contribute to the system wide work on demand, capacity and flow, taking ownership and leadership for relevant elements. We will align our work and timeline for delivery with system work and will distinguish between partnership and delivery requirements, taking account of regulatory assurance needs.

14. **Workforce** – We have four work-streams which are as follows and will be delivered by March 2024;

    a) Delivery of a Talent Management Framework underpinned by a Leadership Programme; Nottingham(shire) Graduate Scheme; and a local 360° Feedback system across the provider collaborative.

    b) Embed a portability approach that ensures our staff/people can move across the provider collaborative with mandatory training, DBS checks, references and pre-employment checks.

c) Have a flexible workforce programme that puts the systems and processes in place to enable portability to happen.

d) Deliver the NHS Workforce Plan by aligning, distinguishing and delivering provider responsibilities from national and ICS responsibilities.

15. **Prospectus development** – We will produce a Provider Collaborative prospectus by the end of September that will have been through individual Trust Boards for approval. We are actively considering the relationship between form and function, having taken external advice and discussing it with Board members at the end of June. Our form/governance arrangements will be detailed in the prospectus to provide control and legitimacy across our programmes of work. It will also support us to further engage with our colleagues and wider partners about what we are doing and what we might want to do in future years.

16. A CEO has taken on the role of SRO for each of the work areas and will be supported by an Executive Director in order to help drive the detailed content of the programme. Ifti Majid (NHT) will be the SRO for the Workforce Programme, Paul Robinson (SFH) will be the SRO for the Urgent and Emergency Care Programme and Anthony May (NUH) will lead on the overall development of the collaborative, which in the first instance includes the development of the prospectus.

Benchmarking our provider collaborative

17. In Spring 2023, NHS England released a maturity matrix for provider collaboratives. This is based around three domains: Outcomes and Benefits, Governance and Leadership, and System Leadership.

18. We have undertaken a self-assessment against this matrix and will be continuing to use this with our work-stream leads in order to identify the specific areas that we need to concentrate our progress around in the next year.

19. There are areas within the maturity matrix that within Nottingham and Nottinghamshire, are more aligned to our current system infrastructure than the Provider Collaborative e.g. Digital. We don't want to suggest that we 'lift and shift' functions into the Provider Collaborative without us being able to articulate the added value in doing so. On that basis, we have looked at the matrix as a guide to consider the components that are needed in order for us to collaborate, as opposed to these having to be owned by the collaborative.

20. In order to fully progress with our work-stream areas however, there may be some functions sitting at system level e.g. Digital, that the collaborative may need to take a more proactive role in influencing the direction of. As our work progresses and further detail emerges for our work-streams, we will want to discuss how we can work in partnership with colleagues from across the ICB and what we will need from system programmes of work.

21. Alongside the conversations around the maturity matrix, we have also linked with a growing number of other Provider Collaboratives across the country, in order to share our collective learning and not ‘reinvent the wheel’.

Risks to delivery

22. As with any work programme, there are risks to the delivery of the work of the Provider Collaborative. Some of the key risks for us are detailed below:

23. **Capacity** – Our member organisations are all under significant pressure both operationally and financially and therefore the capacity of people to engage in additional programmes of work is limited. We have discussed what we may need to stop doing to create this capacity, as well as how we get absolute clarity of roles and functions of different people/groups across the system, to remove any unnecessary duplication. Whilst we realise that some of those decisions are within the gift of our member organisations, some will need to be discussed more broadly across the system.

24. **Collaboration at all levels** – We have done lots of work with Boards and senior leaders of our member organisations but this work has not yet diffused throughout our organisations. We have more work to do to bring our colleagues and teams with us on this collaborative journey.

25. **Gaining credibility and managing expectations** – We are ambitious and believe in the opportunity to deliver collectively but we are balancing gaining credibility by showing that we can deliver something, alongside high expectations of the role that we could be playing in the system. We want to start with a small number of priorities and deliver them well but want to ensure we are also capitalising on our opportunity to be a vehicle for strategic transformation. How we manage the pace and scale of our growth journey will be vital to our longer-term success.

Working together

26. As we move forward with the development of the Provider Collaborative, we know that we can only truly do that alongside our system partners. We want to be a good partner and we want to help our partners to deliver their ambitions, in the areas we can add value.

27. We have initiated discussions with leads of Place Based Partnerships to collectively consider our work programmes and think about where we can support each other. We have also spent time discussing whether there are areas of the Primary Care Strategy that we might be able to support our primary care colleagues with.

28. Conversations have taken place with Nottingham CityCare and both Local Authorities, to explain our development journey and initial areas of focus and we will continue to maintain those relationships and lines of communication as we progress.

29. We have developed the scope of our work-streams whilst engaging with leads and teams from the ICB and system. We would welcome further conversations on how we can strengthen our work together, aligning our collective resource around the areas of work that add most value to our system, eliminating duplication and collectively delivering our shared goals and ambitions.

Conclusion

30. Our Provider Collaborative is developing. The focus this year will be:

    a) Delivering a Provider Collaborative prospectus by September 2023.

    b) Delivery and leadership of urgent care programmes in line with system timelines.

    c) Delivering on the workforce programme by March 2024.

31. The Board is asked to acknowledge this update and consider how we can best align the work of the developing Provider Collaborative with the work of the ICB and other parts of our system.

Appendix A: What is the Provider Collaborative at Scale and why do we exist?

1. We are a Provider Collaboration of the five NHS Trusts and Foundation Trusts in Nottingham and Nottinghamshire. Our work focuses on where we can add value by working together in both clinical and non-clinical areas.
2. We currently work on a small number of priorities, focusing on delivery and letting our form evolve to support what we do.
3. Our mission statement is simple 'We will work together, as relevant, for the benefit of our patients, our colleagues and teams and our communities'.
4. We are not an organisation or an exclusive 'club'. We will continue to collaborate with other providers in our system.
5. We are not able to fix our final form for the long term (five to ten years). We want to co-produce system changes with our partners and then work out what the best form is to deliver these changes. National guidance is helpfully permissive, and we recognise that our role in the system will evolve.
6. We are not planning on merging our organisations into one Trust. We agree that all organisations have strong and positive pre-existing relationships with a range of other organisations across Nottingham and Nottinghamshire, which will continue. We are clear on our reason for the Collaborative.
7. We do not want to have a Collaborative bias so will be alert to this risk. We invite our partners to raise this issue with us as it may be valid.
8. We do not want to make all decisions at system level. We support subsidiarity, i.e. delegate decision making to the most local level possible and will restrict system level decisions to those that need to be made at scale.
9. We want to share best practice and learn from each other to tackle unwarranted variation and inequalities in access, outcomes and experience for our patients and service users and improve staff experience.
10. We want to build on existing local, less formal, collaboration and build trust throughout our member organisations.
11. We want to provide a forum for NHS Trusts to support a single voice into the ICS and ICP on relevant topics.
12. We established the collaborative in line with the national policy direction.

How we operate

13. We are delivering change programmes, focussing on pathways of care and service integration between members.
14. We facilitate clinical, operational collaboration and mutual aid.

15. We will not duplicate the work taking place across our broader health and care system.
16. We do not ‘do things to’ our members, we work on issues that we all recognise as areas of opportunity.
17. We set the tone for collaboration between members as not all collaborative work will be governed by the collaborative.
18. We are self-funded by member organisations.

Appendix B: Mission Statement, Objectives and Principles

Mission Statement:

We will work together, as relevant, for the benefit of our patients, our colleagues and teams and our communities.

Objectives:

a) Reducing variation

b) Visibility and sharing of existing work to support alignment and collective delivery

c) Connectivity of programmes and people

d) Providing a single voice

e) Not recreating other system structures or functions

f) Identify opportunities in areas where we have collective risk

g) Focus on service interfaces and pathways

h) Deliver the components of the ICP strategy that are most relevant to us

Principles:

a) Work on a small number of things initially with a clear scope

b) Collaboration by default

c) Co-production – not doing things to members, partners or stakeholders

d) Choosing areas of work where all members have an interest

e) Being a good partner

f) Staying true to our unique value – what should we do, not what could we do

NHS
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Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/07/2023
Paper Title:	**Integrated Performance Report**
Paper Reference:	ICB 23 025
Report Author:	Sarah Bray, Associate Director of Performance and Assurance
Report Sponsor:	Stuart Poynor, Director of Finance
Presenter:	Stuart Poynor, Director of Finance

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

Summary:

The purpose of this report is to present progress against compliance and commitment targets as required for 2023/24. The report includes progress and exception reports for areas of concern including quality, service delivery, finance, workforce, and health inequalities. 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 to delivery across all areas.

A review against the NHS Oversight Framework metrics as an ICB is also included for the first time; this will be included quarterly throughout the year. A summary of the highest and lowest performing areas is included in Appendix 1, page 74.

A table has been provided at the end of this cover paper (page 13) outlining the actions and recovery timeframes being worked towards for the areas of most significant concern.

Recommendation(s):

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

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

Appendices:

Appendix 1 – Integrated Performance Report

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.

Report Previously Received By:
Sections of the Integrated Performance Report 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 to delivery across all areas of the ICS aims.
2. Industrial action by junior doctors took place in June for a three-day period, which reduced the volume of activity that providers were able to deliver and raised pressure on non-elective services. There was a direct impact on patients waiting over 78 weeks, which affected 23 patients, which has been included in the June reported position.
3. The challenges around discharge processes within the system continue, with high levels of patients that are medically safe for transfer, which contributes to the high volume of patients with a length of stay of 21 days or more.

Finance

4. At the end of month two, the NHS system reported a £29.5 million deficit position, which is £18.9 million adverse to plan. The adverse variance is experienced in the all the system providers - £13.3 million deficit at Nottingham University Hospitals NHS Trust (NUH), £1.0 million deficit at Sherwood Forest Hospitals NHS Foundation Trust (SFH) and £4.5 million deficit at Nottinghamshire Healthcare NHS Foundation Trust (NHT). The ICB is reporting a break-even position as at the end of month two.
5. On review of plans, there is a phasing issue at NUH, where income target is misaligned to the urgent and emergency care improvement trajectory. If this was adjusted, it would lead to a £5 million improvement at month two.
6. The main drivers of the May 2023 adverse variance are:
    a) Urgent and emergency care stretch not achieved - £7.3 million (noting point above)
    b) Internal efficiency programmes - £2.9 million
    c) Pay/agency costs above planned levels - £5.6 million
7. At month two, the reported total system forecast was a break-even position against the break-even plan submitted.
8. **Capital** – The system capital envelope is underspent by £1.7 million to the end of month two. Forecast is £105.6 million, which is break-even against plan, but

£5 million over the total system envelope of £100.6 million, which will need to be managed back within the envelope as the year progresses.

9. **Agency** – NHS England has set an 2023/24 agency cap of £68.7 million for NHS Nottingham and Nottinghamshire ICS. Agency plans are to spend £62.9 million. At month two, the forecast is to spend £63.2 million, which will be £5.5 million under the agency cap. Year-to-date £16.1 million has been spent, which is £4.1 million adverse to plan.

Service Delivery

Urgent Care (Appendix 1, pages 30-33)

10. The challenges in discharging patients from acute episodes of care continues, which impacts acute and mental health services. These issues are exposed within the medically safe for transfer (MSFT) and Length of Stay measures.

11. Discharge pressures continue to impact the front door emergency department as reported through the high levels of people waiting over 12 hours in Accident and Emergency Departments and increased delays in handover from Ambulances into the Departments.

12. Across all three acute trusts one of the key reasons for highest length of stay is access to a Pathway 2 and Pathway 3 beds. Work is ongoing to attain a shared understanding of Pathway 2 and Pathway 3 gaps, patient need and commissioning intentions. However, around 90% of discharges relate to Pathway 0 patients, which do not require additional support and can return to their usual place of residence. Therefore, it is key that processes to discharge these patients are as efficient and timely as possible to facilitate flow through the system.

13. Long Lengths of Stay over 21 days have increased during the financial year. The system's 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, however internal acute delay reasons are also being reviewed.

14. A revised trajectory for Virtual Wards was submitted to NHS England on 19 June. The plan is to achieve a level of capacity equal to 243 beds by March 2024. The focus of performance management from NHS England will be to deliver an occupancy level of 80% by September 2023.

Planned Care (Appendix 1, pages 34-39)

15. As a system the ICS performs relatively well regionally for elective care delivery.
16. The expected end of June position for 78-week waits is 74 patients, of which 62 are due to capacity, 11 are due to complexity and one patient has exercised their choice to be treated at a later date. The current forecast for July is zero however this is dependent upon the industrial action and additional capacity being made available.
17. The industrial action has impacted the volume of activity delivered in June. Monitoring of cancellations under reports the magnitude of the impacts, given that the providers were aware in advance of the strike action and under booked slots. NUH advised that Outpatient and Day Case levels were operating at 90% of what they were planned to do, however Inpatients performed at 40-45% of typical levels. Diagnostics services was relatively unaffected.
18. The industrial action increased the month end forecast of 78-week waiters by 23 patients. These will be re-scheduled in July for treatment.
19. There are expected to be two patients forecast to be waiting 104 weeks or more for treatment at the end of June, and zero in July.
20. The latest weekly ICB data for the cancer backlog volume is week ending 11 June, with 397 patients against a plan of 390 patients. NUH has 345 patients against a plan of 333 and SFH has 52 patients against a plan of 57. Both providers continue to work towards reducing the backlog levels further despite high demand for cancer services, as well as an increased number of late tertiary referrals, which are received after day 62 of the pathway. These patients directly increase the backlog volume.
21. There are challenges with MRI, Echocardiography, and non-obstetric ultrasound diagnostic modalities due to the high volume of patients waiting over six weeks at system level. Revised trajectories for the waiting list and volume of six and 13-week waiters were submitted to NHS England on 14 June, which illustrate that all modalities, except for Echocardiography and CT at SFH, are scheduled to achieve the national expectation of no more than 15% of the waiting list waiting more than 6 weeks for a diagnostic test by March 2024. Discussions are taking place within the system to explore a range of options to reduce the variation in waiting times at modality level and provide a more equitable offer to patients.

Mental Health (Appendix 1, pages 40-44)

22. As a programme, mental health performs well, with improvements being made across many service areas. However, there are a few areas which have been experiencing declining performance, including Talking Therapy (previously

IAPT) waits between first and second treatment, Talking Therapy Recovery Rates, and Dementia Diagnosis rates.

23. Areas which consistently fail the target, and which are unlikely to achieve the targeted levels, have improvement plans in place to progress towards delivery in 2022/23 and into 2023/24, these include Talking Therapies Access, Out of Area Placements, SMI health checks, perinatal access and children and young peoples' eating disorders.

24. Talking Therapies access remains significantly below plan. A new provider commenced on 1 April, which included additional activity expectations to address the increased access requirements. Additional activity to address the waiting lists commenced in March. Routine meetings are undertaken by the mental health commissioning team and the provider to ensure close oversight of management and monitoring of the contract performance.

25. Children and Young Peoples' Eating Disorders has significantly improved its performance over the past few years with delivery for urgent referrals now at 100%. The routine referrals are not achieving the 95% compliance, however patient volumes are small and so small numbers of non-compliance have a significant impact on the overall compliance rates. Any patients who are not seen within the four weeks as expected, are all individually reviewed to determine the reason for the delay. In all cases, the delay was a result of patients choosing to wait longer than the four weeks and do not relate to capacity issues.

26. Staffing levels remain an issue due to staff absences and sickness levels. NHT has been undertaking various recruitment campaigns and there has been some local success in recruitment to Healthcare Assistant posts.

27. Recent continued pressures have led to some additional Out of Area placements being required, with increasing volumes in Q4 2022-23. Multi-Agency Discharge Events focusing on mental health discharges are regularly undertaken to facilitate flow through the inpatient settings. There are further plans for 2023/24 to reduce the reliance on sub-contracted beds and support the reduction of Out of Area Placements and the eradication of dormitory accommodation.

Primary Care and Community (Appendix 1, page 46)

28. Total GP appointments in April were 0.8% below the planned level. The percentage of appointments held face to face remains consistent with previous months at 70.9%. GP Appointments within two weeks data shows that 76.2% of appointments were offered within two weeks in April 2023.

29. The community waiting list for adults has increased gradually from the January position of 9,168 through to the April position of 10,560. Analysis is taking place

to break the position down by constituent service, which will be escalated for discussion with the providers. There are also long waits for some services, which will also be part of the dialogue. The waiting list includes NHT and Nottingham CityCare community services for Nottingham and Nottinghamshire patients. In April, there were 5,791 adult patients waiting for services at NHT and 4,769 patients waiting at CityCare. The largest waiting list is for the musculoskeletal service, which has 3,232 patients waiting. There are 117 adult patients waiting more than 52 weeks, which span a number of services. The largest cohort of 35 patients waiting beyond a year is for Podiatry and Podiatric Services.

Health Inequalities (Appendix 1, pages 59-67)

30. We are into the final stages of the Health Inequalities Innovation and Investment Fund with recommendations being discussed in the Strategic Planning and Integration Committee at the beginning of August.

31. Through the work of the Place-Based Partnerships, the ICS has submitted an expression of interest for the Core20+5 Community Connectors Programme for oral health in children and young people. This will provide valuable resource to work with our voluntary sector and local children and young people in Nottinghamshire to improve oral health.

Quality (Appendix 1, pages 12-27)

32. Appendix 1 provides detail in relation to delivery against quality plan requirements and trajectories across: learning disability and autism (LDA), personalisation, co-production, maternity, infection prevention and control (IPC), vaccinations, patient safety, adult and children safeguarding, looked after children (LAC), special educational needs and disabilities (SEND).

Exception reporting and areas of concerns

33. Based on 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. In May 2023, overall IOAG praised progress made in areas such as “Time-to-Hire” and other recruitment priorities. The IOAG noted that work still needed to be done to embed the changes needed in the most recent CQC maternity inspection. IOAG also highlighted the need to ensure that the support to Donna Ockenden’s Review enables the Trust and the Review Team to hear directly from women and families from diverse cultural groups.

34. One NHS provider is subject to **enhanced surveillance**: NHT. The Quality Improvement Group met again at the end of June with core assurance items focused on progress and improvement initiatives, and a CQC action plan update including directly commissioned, non-commissioned (specialised commissioning) and sub-contracted services, which remain areas for improvement.

35. **Care Sector and Home Care** training for Social Care continues to be an issue as there is variation across the sector. Preliminary work has begun to scope potential access to NHS trust training for Social Care staff where capacity allows. 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. Initial conversations have taken place with SFHFT to scope any capacity within the Objective Structured Clinical Examination training they deliver for international nurses. If capacity allows, further work will be undertaken to understand how we can offer this capacity out to the care sector and increase the international nursing workforce within social care.

36. System partners continue to work closely with NUH and regulators in relation to **Maternity Services**, in order to oversee and support improvements. An NHS England Insight Visit is being rescheduled. The new dates for the insight visit are awaiting confirmation.

37. The **Local Maternity and Neonatal System (LMNS) programme remains under limited assurance** due to quality concerns identified and support in place for NUH maternity improvement. A schedule is in place for LMNS assurance based on NHS England guidance and local intelligence. Publication of the new technical guidance for the 3-year delivery plan and Saving babies Lives Care Bundle v3, has led to the scheduling of the first LMNS Quarterly Oversight and Assurance Panel in early July to allow for sufficient scrutiny of the KLOEs to be developed and shared in advance with both trusts. The LMNS Executive Partnership Board has agreed a local approach and priorities for the implementation of the 3-year delivery plan. Key priorities are equity and working with women and families (Appendix 1 IPR page 18-19).

38. **The Learning Disability/Autism (LDA) Partnership programme remains under limited assurance** with a NHS England system performance meeting and LDA Peer Review planned. Further information on performance recovery trajectory in Table 1: Non-Compliant Performance Areas – Recovery Overview Appendix 1 IPR page 13-14.

39. **Infection Prevention and Control and Hospital Acquired Infections (HCAIs) remains under partial assurance** due to recovery work to reinstate deep cleaning programmes in secondary care being reliant on reduced bed occupancy, and recent OPEL 4 status has led to cancellations in deep cleaning routines. New annual HCAI targets are challenging and reducing HCAI will be hard to achieve

without restoration of the required cleaning programmes and the wider community prevention measures needed (Appendix 1 IPR page 20-21).

40. **Vaccinations shows partial assurance** due to uptake for the spring booster campaign (ending 30 June 2023) currently being at 61%, which is less than the national assumption of 68% (Appendix 1 IPR page 22-23).

41. **Patient Safety shows partial assurance** due to the ICS Patient Safety Incident Response Framework (PSIRF) implementation group continuing to acknowledge variable progress towards PSIRF implementation for NUH, SFH, NHT and CityCare. There are challenges in recruiting Patient Safety Partners and emerging issues with executive support and engagement for some partners (Appendix 1 IPR page 24).

42. **Looked After Children (LAC) shows limited assurance** due to the statutory health assessment for looked after children being significantly delayed, which could have an impact on children (Appendix 1 IPR page 26).

43. **Special Educational Needs and Disabilities (SEND) shows limited assurance** due to a SEND local area inspection by Ofsted and the Care Quality Commission being published 16 May 2023. The report has highlighted significant concerns about the experiences and outcomes of children and young people with SEND, which need to be addressed urgently – SEND Partnership leaders have developed an action plan in response to this (Appendix 1 IPR page 27).

Workforce

44. The workforce report predominantly focuses on the three acute trusts and the community and mental health trust within the system, reporting on the May 2023 position against the Operational Plan for 2023-24. The collective position shows that the trusts are above plan on substantive staff (242.6 wte). This is alongside an improvement in the increased use of Bank and reduced use of Agency Staff. Bank usage was 17 wte above plan and Agency usage was 101.3 below plan (Appendix 1, page 52).

45. Reporting at system level has been impacted by changes to the data reporting source of the Provider Workforce Return, with removal of KPI reporting including the two metrics included in the Operational Plan. This has been escalated to NHS England.

46. Sickness absence in the acute, community and mental health trusts has remained relatively stable across April and May, where alternative reports have been provided, suggesting that the collective position will be on plan against the target included in the operational plan of 5.6%. Trusts continue to review and enhance their wellbeing plans with investment in additional capacity including professional advocate roles. The recruitment of a system Health and Wellbeing lead is in progress with this role focusing on assessing the organisational offers

and looking at where system interventions can add value, looking at consistency of offers as well as equity of offers across the system partners, as well as scoping the delivery of the Occupational Health provision across the system.

47. Retention of our existing workforce is a key focus, with Nursing and Midwifery retention plans developed in each trust and additional capacity of a system retention lead starting in post next month.

48. Recruitment strategies for both domestic and international recruitment across registered nursing continue to be successful with increases seen in substantive positions. International recruitment for wider professional groups such as Allied Health Professionals is also being explored

49. Joint work with finance teams continues in the Agency High Impact Action Group analysing agency usage, aligned to an analysis developed on understanding the substantive workforce and its deployment in delivery of the 23/24 Operational Plan, with a collaborative action plan being developed. Greater pace and impact will be needed to reduce the cost to 3.7% of the pay bill (currently at 5%). The ICB Chief People Officer will act as joint SRO on this High Impact Action along with the CFO from SFH.

50. Primary Care General Practice data, which includes the additional roles position, a national priority for growing our general practice workforce, is presented at a high level, showing indicative workforce numbers against the 2023/24 Operational Plan. 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.

51. 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 plans for 23/24 have been developed and submitted for regional/national scrutiny, which includes a consolidation of the programmes for GPs and GPNs and widening the work to include the development of a career framework for non-clinical staff. The inclusion of health and wellbeing approaches is also described, which will be further informed by the findings of the recent Primary Care Staff survey, the system being one of several pilots nationally with a successful level of response of 35%.

52. 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.

53. 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.

54. The Primary Care Workforce Group is aligning workforce development plans to match the Primary Care Strategic objectives, reporting into the recently re-established Primary Care Transformation Board as well as into the People and Culture governance.

NHS Oversight Framework

55. All parts of the NHS are reviewed as part of the NHS Oversight Framework (NHSOF). This determines the segmentation ratings applied to all NHS organisations, both providers and ICBs. To support the review and segmentation process undertaken by NHS England, an Oversight Metrics Framework was established during 2022/23, which enables performance benchmarking to be undertaken by sector and system.

56. An overview of the performance of the ICB, and sub-ICB against the metrics, highlighting the highest and lowest performing areas, as at Quarter 1 2023/24 has been included. Please note, that some of the national data reported is quite dated, as the national benchmarking includes latest published information, so areas such as neonatal are a few years behind. Where this is the case the system reviews local intelligence to ensure progress is being made.

57. The majority of the ICB performance is within the inter-quartile range. Areas of concern relate to cancer treatments, diagnostic activity, extended waits, virtual wards, neonatal deaths, Learning Disability and Autism inpatient placements, weight management services and sickness absences. All these areas are areas of focus for the system and are included in the various system meetings to support improvement.

58. Areas where the system performs well relative to others, relate to urgent community response, children and young people numbers accessing mental health services, inappropriate out of area mental health placements, personalisation, inpatient smoking cessation, leaver rates and number of GP Doctors per 10,000 weighted population.

59. The ICB has a role to undertake in providing recommendations on a quarterly basis to NHS England, on the performance of their local NHS providers, against the NHS Oversight Framework. The 2022-23 Q4 and Year End positions have now been confirmed with the local trusts these are as follows:

a) Nottingham University Hospitals NHS Trust – remains at NHSOF Level 4 (Recovery Support Programme), due to CQC Well Led and Maternity reports

b) Nottinghamshire Healthcare NHS FT – remains at NHSOF 3 (Mandated Support), due to Rampton and Well Led CQC reports.

c) Sherwood Forest Hospitals NHS FT – remains at NHSOF 2

Table 1: Non-Compliant Performance Areas – Recovery Overview

Programme Area	Performance Metric	Latest Performance	Recovery Trajectory
Quality	LD&A Inpatients	As of 31 May 2023 Adult Commissioned by ICB is 13 against a plan of 15 inpatients. Adult commissioned by NHSE is 35 against a plan of 31 inpatients. CYP commissioned by NHSE is three against a plan of three inpatients. Further detail is shown in Appendix 1: IPR Page 13-14	As of 31 May 2023, there are currently 48 adult inpatients against a target of 46. There have been zero admissions and one discharge during May. ICB performance is ahead of target (13 inpatients against a target of 15) and IMPACT performance is behind target (35 inpatients against a target of 31). Despite good levels of adult inpatient discharge activity (26 discharges this year), admission rates remain consistent (21 this year) which has affected total performance (a reduction in total number of three people in inpatient settings across the year). Revised forecasts have been agreed with ICS LDA Board. Discussions have taken place with NHSE and informal feedback on the submission indicated support for the revised forecast. Revised forecast aims to achieve 37 adult inpatients by March 2024 with a plan to achieve 27 inpatients by March 2025. Work will be undertaken with LDA Board to agree an additional internal stretch target to increase the likelihood of full compliance by March 2025. The first LDA Monthly System Performance Meeting is scheduled for 27th June with NHSE region. These meetings have been established to provide targeted review and designed to help identify what additional support the ICB may require to ensure delivery. The key KLOEs for this meeting will focus on inpatient performance. The LDA Peer Review (scheduled for 28-30 June 2023) has been developed with partners to support thorough review and opportunity to identify any improvements to inpatient performance and autism pathways, with a focus on admission avoidance and increased discharge. The system recognises that admission volume is a key challenge in this area and there will be focused activity undertaken to address this.

Programme Area	Performance Metric	Latest Performance	Recovery Trajectory
			The ICS Learning Disability & Autism Board will maintain oversight of performance and progress, with governance reporting through to ICB Board to ensure a robust grip on assurance.
	Personal Health Budgets	6921 Personal Health Budgets against a 2022/23 target of 7250. Appendix 1: IPR Pages 15-17	Quarter 4 2022/2023 data has been released, which shows Personal Health Budget (PHB) off plan by 329. The Personalisation Team are working on mitigating actions to be presented to the Personalisation Board.
Urgent Care	12 Hour Breaches	899 in May 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.
	Length of Stay > 21 days	434 in May 23 against a plan of 384.	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 seasonal historical levels.
Planned Care	Long Waits +104 & +78 weeks	104ww – confirmed position was two patients at end of June 2023 78ww – 74 patients at the end of June 2023	The current forecast for the end of July is zero 78-week breaches for the system, however there are risks primarily due to the scheduled industrial action by junior doctors and consultants as well as the complexity of some patients.
	Diagnostic Waits	Across all 15 modalities, 41% of patients waited 6 weeks or more for a	Trajectories were submitted to NHSE in June. The NUH trajectory was compliant against the national ambition to achieve a maximum of 15% of patients waiting six weeks or more in March 2024. For SFH, CT and Echo are forecasting to be above the 15% ambition in March 2024. CT is forecast to be at 19% and Echo at 74%. Around CT, performance remains challenged due

Programme Area	Performance Metric	Latest Performance	Recovery Trajectory
		diagnostic test in April 2023.	to CT cardiac demand, despite increasing capacity from July. For echo, the focus is on holding the backlog position until an outcome of the SFHT internal funding request has been received. Additional funding would enable the trajectory to be improved. The ICB Is convening a meeting in July with providers to discuss mechanisms to address variation in performance and explore how the pressures could be re-balanced within the system.
Mental Health	NHS Talking Therapies	7375 patients against a plan of 9648 at Mar 23 (3 month rolling position).	Referrals increased by 18% in quarter four compared to quarter three, but numbers into treatment increased only by 5%. The service continues to achieve and exceed the 6 week (93.2%) and 18 week (100%) waiting time standards. The new service went live 1 April 2023, actions are now focussed on the new provider working through their inherited caseload and managing new referrals into the service.
	Out of Area Placements	275 at Mar 23 against a zero national target	The number of OBDs reported in April 2023 has increased to 328 from 275 in March 2023. Performance impacted by demand for inpatient admissions, patient acuity, and complex delayed patients which means that there are still patients being placed out of area when local provision is full.
	SMI Physical Health Checks	4591 at May 23 against a plan of 7029	There is variation in performance across the ICS, in Bassetlaw performance is greatest (62.7%), with Nottingham City the lowest performing place (49.3%). Actions are underway to improve performance. Nottingham City have the greatest SMI prevalence and a population that is harder to engage, targeted actions are being undertaken.
Community Services	Community Waiting List Volume	Position for patients aged 0-17 is 2049 patients against a plan of 1938. For patients aged 18+ the position is 10,560 against a plan of 8351.	The waiting list for adults has increased gradually from the January position of 9,168 through to the April position of 10,560. Analysis is taking place to break the position down by constituent service, which will be escalated for discussion with the providers. There are also long waits for some services, which will also be part of the dialogue.

NHS
Nottingham and Nottinghamshire

Nottingham & Nottinghamshire Integrated Care Board

Integrated Performance Report

Reporting Month: June 2023

Board Month: July 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 system reported a £29.5 million deficit which is £18.9 million adverse to plan at month 2. On review of financial plans there is a phasing issue at NUH where income target is misaligned to Urgent & Emergency Care improvement trajectory. If this were adjusted, it would lead to a £5m improvement at month 2.

During April and May there were two periods of industrial action from Junior Doctors which significantly constrained the elective services that could be delivered within the system. Further narrative is included throughout the report where the impact has been most significant.

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 – 73.

1. ICB Scorecard by ICS 4 Aims – Reporting Period April 2023/24

NHS Nottingham and Nottinghamshire

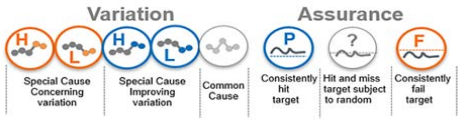
AIM-01	Improve Outcomes in Population Health and Healthcare						
ID	Key Performance Indicators	Date	Plan	Actual	In Month	Variation	Assuran
	Quality						
	LD&A Annual Health Checks	May-23	482	484		-	-
	LD&A Inpatients - ICS	May-23	15	13		-	-
	LD&A Inpatients - NHS England	May-23	31	35		-	-
	LD&A Inpatients - CYP (NHSE)	May-23	3	3		-	-
	No. Personal Health Budgets	Q4 22/23	7250	6921		-	-
	No. stillbirths per 1000 total births	Feb-23	8.3	7.1		-	-
	No. neonatal deaths per 1000 live births	Feb-23	5.5	3.6		-	-
	MRSA	Apr-23	0	0		-	-
	CDI	Apr-23	22	26		-	-
	Ecoli BSI	Apr-23	72	92		-	-
	Klebseilla BSI	Apr-23	21	23		-	-
	Pseudomonas BSI	Apr-23	6	3		-	-
	% Over 65s Flu Vaccinations	Feb-23	-	82.1%	-	-	-
	Planned Care						
	Extended Waits > 78 weeks	Apr-23	0	124			
	Urgent Care						
	12 hour delays from arrival in ED	May-23	0	899			
	Handover delays > 60 minutes	May-23	0	338			
	Length of Stay > 21 days	May-23	384	434			

AIM-03	Improving the Effective Utilisation of Our Resources						
			Plan	Actual		Variance	FOT Var
ID	Key Performance Indicators	Date	£m	£m		£m	£m
	Delivery against system plan	May-23	-10.6	-29.5		-18.9	0.0
	Efficiency Target	May-23	15.4	7.8		-7.6	0.0
	ERF Income	May-23	18.9	12.7		-6.2	0.0
	Agency Spend	May-23	-	16.1		-	5.5
	MHIS	May-23	-	32.8		-	0.0
	Capital Spend (Plan)	May-23	14.3	12.6		-1.7	5.0

AIM-04	Support Broader Social and Economic Development						
ID	Key Performance Indicators	Date	Plan	Actual	In Month	Variatic	Assurai
	Provider Substantive Staffing	May-23	30,229	30,472			
	Provider Bank Staff	May-23	1,923	1,940			
	Provider Agency Staff	May-23	1,096	994			
	Provider Staff Vacancy Rate*	May-23	-	-	-	-	-
	Provider Staff Absence Rate*	May-23	-	-	-	-	-
	Primary Care Workforce	Apr-23	3539	3495			

* unable to report at month 2 due to changes in national NHSE Provider Workforce Returns content

AIM-02	Tackle Inequalities in Outcomes, Experience and Access											
		Population						Provider View				
ID	Key Performance Indicators	Date	Plan	Actual	In Month	Variation	Assurani	Plan	Actual	In Month	Variation	Assurani
	Planned Care											
	Total Waiting lists	Apr-23	125979	115599				119370	124780			
	Patients Waiting >65 weeks	Apr-23	2374	990				1466	967			
	Referral to Treatment Pathway +18 weeks	Apr-23	-	42714	-	-	-	-	47049	-	-	-
	Elective Value Weighted Activity	To be included in future reports										
	Outpatient Follow-up Reductions	Apr-23	48032	54641				57722	52421			
	Diagnostics +6 weeks Wait	Apr-23	11957	10079				11501	11200			
	Cancer 2 week waits	Apr-23	93%	90%				93%	87%			
	Cancer 31 Day First Treatment	Apr-23	96%	87%				96%	86%			
	Cancer 62 Day Performance (85%)	Apr-23	85%	67%				85%	67%			
	Cancer 62 Day Backlog	Apr-23	-	-	-	-	-	395	421			
	Cancer Faster Diagnosis	Apr-23	75%	75%				75%	74%			
	Urgent Care											
	Ambulance Cat 1 Response (mean)	Apr-23	00:07:00	00:07:32				-	-	-	-	-
	Ambulance Cat 2 Response (mean)	Apr-23	00:18:00	00:27:22				-	-	-	-	-
	ED 4 hour waits	-	-	-	-	-	-	lease note: NUH data not yet availab				
	% Beds Occupied with no criteria to reside	-	-	-	-	-	-	-	-	-	-	-
	% Bed Occupancy	May-23	-	-	-	-	-	-	93.16%	-	-	-
	Community											
	Community Waits - Adult	Apr-23	8351	10560				-	-	-	-	-
	Community Waits - CYP	Apr-23	1938	2049				-	-	-	-	-
	Primary Care											
	GP Appointments	Apr-23	517378	513098				-	-	-	-	-
	GP Appointments < 14 days (85%)	Apr-23	-	76%	-			-	-	-	-	-
	% Units of Dental Activity	To be included in future reports						-	-	-	-	-
	NHS App	May-23	60%	52%				-	-	-	-	-
	Mental Health											
	Talking Therapies Access	Mar-23	9648	7375				-	-	-	-	-
	Talking Therapies Recovery Rate	Mar-23	50%	53%				-	-	-	-	-
	Dementia Diagnosis Rates	Apr-23	67%	70%				-	-	-	-	-
	Perinatal Access	Mar-23	1320	1135				-	-	-	-	-
	Individual Placement Support Access	Mar-23	899	919				-	-	-	-	-
	EIP < 2 weeks referral	Mar-23	60%	85%				-	-	-	-	-
	CYP Access	Mar-23	13559	17845				-	-	-	-	-
	Out of Area Placements	Mar-23	0	275				-	-	-	-	-
	SMI Physical Health Checks	May-23	-	4591	-			-	-	-	-	-
	SMI Access to Community Services	Mar-23	14101	13125				-	-	-	-	-
	Health Inequalities - Prevention											
	NHS Digital Weight Management Referrals per 100k pop	Q4 22-23	-	16.3	-	-	-	-	-	-	-	-
	Inpatients % Smokers Offered Tobacco Treatment	Mar-23	-	66.7%	-	-	-	-	-	-	-	-

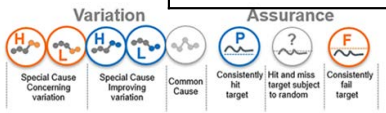


2. Quality Scorecard

NHS Nottingham and Nottinghamshire

Quality Scorecard

Quality Scorecard – June 2023	Latest Period	Plan	Actual	Variance	Exception Report
Learning Disability & Autism					
LD&A Inpatients Rate Adults - ICB	May-23	15	13	-2	Slides 13 -14
LD&A Inpatients Rate Adults - NHSE	May-23	31	35	4	
LD&A Inpatients Rate CYP - NHSE	May-23	3	3	0	
LD&A Annual Health Checks	May-23	482	484	2	
Personalisation					
No. of Personal Health Budgets	Q4 22/23	7250	6921	-329	Slides 15 -17
No. Social prescribing referrals into link workers	Q4 22/23	13610	15455	1845	
No. active PCSPs in place	Q4 22/23	27000	32086	5086	
Maternity					
No. stillbirths per 1000 total births	Feb-23	8.3	7.1	-1.2	Slides 18-19
No. neonatal deaths per 1000 live births	Feb-23	5.5	3.6	-1.9	
Hospital Acquired Infections					
MRSA	Apr-23	0	0	0	Slides 20 -21
C-Diff	Apr-23	22	26	4	
Ecoli BSI	Apr-23	72	92	20	
Klebseilla BSI	Apr-23	21	23	2	
Pseudomonas BSI	Apr-23	6	3	-3	



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

NHS Nottingham and Nottinghamshire

Urgent Care Access - Front Door

Population

Name	Latest Period	Plan	Actual	Variance	V	A
Ambulance Conveyances to ED (%)	Apr-23	52%	57%	✗ 5%		
Ambulance Conveyances to ED (Vol)	Apr-23	7990	7478	✓ -512		
Total A&E Attendances - ICB Population	Apr-23	-	36298	-		
SDEC % of Total Admissions	-	-	-	-		
Total NEL admissions - ICB Population	Apr-23	-	12656	-		

Provider

Name	Latest Period	Plan	Actual	Variance	V	A
Ambulance Conveyances to ED (%)	-	-	-	-		
Ambulance Conveyances to ED (Vol)	-	-	-	-		
Total A&E Attendances - ICB Provider	Apr-23	31868	31664	✓ -204		
SDEC % of Total Admissions	Apr-23	33%	33%	✓ 0%		
Total NEL admissions - ICB Provider	Apr-23	12360	13200	✗ 840		

Urgent Care - In-Hospital Flow

Name	Latest Period	Plan	Actual	Variance	V	A
Pts medically safe to transfer from acute >24hrs	-	-	-	-		
Length of Stay > 21 days	-	-	-	-		
No. Patients utilising Virtual Ward	May-23	100	49	✗ -51		
2 Hour Urgent Care Response Contacts	Apr-23	286	1005	✓ 719		
2 Hour Urgent Care Response %	Apr-23	70%	97%	✓ 27%		
Pthy 1 - Disch home w/ hlth and/or social care	May-23	1212	837	✗ -375		

Name	Latest Period	Plan	Actual	Variance	V	A
Pts medically safe to transfer from acute >24hrs	May-23	231*	284	✗ 53		
Length of Stay > 21 days	May-23	384	434	✗ 50		
No. Patients utilising Virtual Ward	May-23	100	49	✗ -51		
2 Hour Urgent Care Response Contacts	-	-	-	-		
2 Hour Urgent Care Response %	-	-	-	-		
Pthy 1 - Disch home w/ hlth and/or social care	May-23	1212	837	-375		

* NUH portion of MSFT plan TBC

Urgent Care - Pre-Hospital Compliance

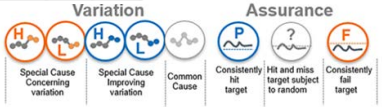
Name	Latest Period	Plan	Actual	Variance	V	A
Ambulance (mean) resp time Cat 1 (Notts)	Apr-23	00:07:00	00:07:32	✗ 00:00:32		
Ambulance (mean) resp time Cat 2 (Notts)	Apr-23	00:18:00	00:27:22	✗ 00:09:22		
Ambulance (mean) resp time Cat 3 (Notts)	Apr-23	02:00:00	04:55:57	✗ 02:55:57		
% Cat 2 waits below 40 minutes (Notts)	Apr-23	90%	68%	✗ -22%		

Name	Latest Period	Plan	Actual	Variance	V	A
Ambulance (mean) resp time Cat 1 (Notts)	-	-	-	-		
Ambulance (mean) resp time Cat 2 (Notts)	-	-	-	-		
Ambulance (mean) resp time Cat 3 (Notts)	-	-	-	-		
% Cat 2 waits below 40 minutes (Notts)	-	-	-	-		

Urgent Care - In-Hospital Compliance

Name	Latest Period	Plan	Actual	Variance	V	A
Hospital Handover Delays >60 minutes	-	-	-	-		
12 Hour Breaches ED	-	-	-	-		
12 Hour Breaches as % ED Atds	-	-	-	-		
A&E 4hr % Perf (All) - ICB Population	-	-	-	-		

Name	Latest Period	Plan	Actual	Variance	V	A
Hospital Handover Delays >60 minutes	May-23	0	770	✗ 770		
12 Hour Breaches ED	May-23	0	899	✗ 899		
12 Hour Breaches as % ED Atds	Apr-23	2%	3%	✗ 1%		
A&E 4hr % Perf (All) - ICB Provider	-	-	-	-		



NHS Nottingham and Nottinghamshire

3b. Service Delivery Scorecard - Planned Care Recovery

Elective Recovery - Total Waiting List & Long Waits

Population

Name	Latest Period	Plan	Actual	Variance	V	A
Total Waiting List Size	Apr-23	125979	115599	✓ -10380		
Incomplete RTT pathways >52 Wks	Apr-23	5754	3879	✓ -1875		
Incomplete RTT pathways >65 Wks	Apr-23	2374	990	✓ -1384		
Incomplete RTT pathways >78 Wks	Apr-23	0	124	✗ 124		

Provider

Name	Latest Period	Plan	Actual	Variance	V	A
Total Waiting List Size	Apr-23	119370	124780	✗ 5410		
Incomplete RTT pathways >52 Wks	Apr-23	4372	4028	✓ -344		
Incomplete RTT pathways >65 Wks	Apr-23	1466	967	✓ -499		
Incomplete RTT pathways >78 Wks	Apr-23	0	135	✗ 135		

Elective Recovery - Activity

Name	Latest Period	Plan	Actual	Variance	V	A
Total Referrals	Apr-23	-	22157	-		
Total Ordinary Electives	Apr-23	2045	1836	✗ -209		
Total Daycases	Apr-23	11593	12377	✓ 784		
Total Outpatients 1st (Spec Acute)	Apr-23	22554	21738	✗ -816		
Total Outpatients FUp (Spec Acute)	Apr-23	48032	54641	✓ 6609		
Total Diagnostic Activity	Apr-23	36097	30273	✗ -5824		

Name	Latest Period	Plan	Actual	Variance	V	A
Total Referrals	Apr-23	-	19853	-		
Total Ordinary Electives	Apr-23	2818	1772	✗ -1046		
Total Daycases	Apr-23	12162	11508	✗ -654		
Total Outpatients 1st (Spec Acute)	Apr-23	23133	19424	✗ -3709		
Total Outpatients FUp (Spec Acute)	Apr-23	57722	52421	✗ -5301		
Total Diagnostic Activity	Apr-23	30142	30715	✓ 573		

Elective Recovery - Productivity & Transformation

Name	Latest Period	Plan	Actual	Variance	V	A
Total Outpatients - Virtual(%)	Apr-23	25%	19%	✗ -6%		
Patient Initiated Fups (%)	-	-	-	-		
Advice and Guidance (% of 1st OP)	Apr-23	-	30	-		
Completed Adm RTT Pathways	Apr-23	5037	3572	✗ -1465		
Completed Non-Adm RTT Pathways	Apr-23	22863	18123	✗ -4740		

Name	Latest Period	Plan	Actual	Variance	V	A
Total Outpatients - Virtual(%)	Apr-23	25%	20%	✗ -5%		
Patient Initiated Fups (%)	Apr-23	5%	4%	✗ -1%		
Advice and Guidance (% of 1st OP)	Apr-23	-	30	-		
Completed Adm RTT Pathways	Apr-23	5906	3466	✗ -2440		
Completed Non-Adm RTT Pathways	Apr-23	21450	18547	✗ -2903		

Diagnostic Recovery

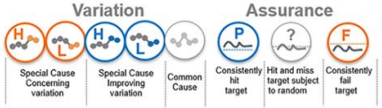
Name	Latest Period	Plan	Actual	Variance	V	A
Total Diagnostic Activity	Apr-23	36097	30273	✗ -5824		
Diagnostic Waiting List	Apr-23	29584	24989	✓ -4595		
Diagnostic Backlog	Apr-23	11957	10079	✓ -1878		
Diagnostics +6 Wks	Apr-23	40%	40%	✓ 0%		

Name	Latest Period	Plan	Actual	Variance	V	A
Total Diagnostic Activity	Apr-23	30142	30715	✓ 573		
Diagnostic Waiting List	Apr-23	27815	26554	✓ -1261		
Diagnostic Backlog	Apr-23	11501	11200	✓ -301		
Diagnostics +6 Wks	Apr-23	41%	42%	✗ 1%		

Cancer Recovery

Name	Latest Period	Plan	Actual	Variance	V	A
Cancer 2ww %	-	-	-	-		
Cancer - Faster Diag Std 28 Days	Apr-23	75%	75%	✗ 0%		
Cancer - No. 1st Definitive Treatments	Apr-23	-	434	-		
Cancer - No.receiving 1st Trt <31 days %	Apr-23	96%	87%	✗ -9%		
Cancer - No. patients waiting <62 days %	-	-	-	-		
Cancer - 62 day backlog	-	-	-	-		

Name	Latest Period	Plan	Actual	Variance	V	A
Cancer 2ww %	Apr-23	93%	87%	✗ -6%		
Cancer - Faster Diag Std 28 Days	Apr-23	75%	74%	✗ -1%		
Cancer - No. 1st Definitive Treatments	Apr-23	-	511	-		
Cancer - No.receiving 1st Trt <31 days %	Apr-23	96%	86%	✗ -10%		
Cancer - No. patients waiting <62 days %	Apr-23	85%	67%	✗ -18%		
Cancer - 62 day backlog	Apr-23	395	421	✗ 26		



NHS Nottingham and Nottinghamshire

3c. Service Delivery - Mental Health Scorecard

Mental Health - Talking Therapies (Previously IAPT)

Population

Name	Latest Period	Plan	Actual	Variance	V	A
Talking Therapies - Referrals	Mar-23	-	4055	-		
Talking Therapies- 1st Treatment <6 Weeks	Mar-23	75%	93%	✓ 18%		
Talking Therapies- 1st Treatment <18 Weeks	Mar-23	95%	100%	✓ 5%		
Talking Therapies - Entering Treatment (3mth)	Mar-23	9648	7375	✗ -2273		
Talking Therapies- >90 Days 1st & 2nd Treatment	Mar-23	10%	14%	✗ 4%		
Talking Therapies- Recovery Rate (3mth Rolling)	Mar-23	50%	53%	✓ 3%		

Mental Health - Adult Mental Health

Name	Latest Period	Plan	Actual	Variance	V	A
Adult MH IP Discharges - % Fup 72 hours	Mar-23	80%	80%	0%		
Inappropriate OAP Bed days	Mar-23	0	275	✗ 275		
Rate per 100,000 Older Adult MH LOS > 90 Days	Dec-22	11	12	✗ 1		
SMI Health Checks	May-23	-	4591	-		
Access SMI +2 Contacts Community MH Services	Mar-23	14101	13125	✗ -976		
Dementia Diagnosis	Apr-23	67%	70%	✓ 3%		

Mental Health - Access

Name	Latest Period	Plan	Actual	Variance	V	A
Perinatal Access % (12 month rolling)	Mar-23	10%	9%	✗ -1%		
Perinatal Access - Volume	Mar-23	1320	1135	✗ -185		
Individual Placement Support	Mar-23	899	919	✓ 20		
Early Intervention in Psychosis (EIP)	Mar-23	60%	85%	✓ 25%		

Mental Health - Children & Young People

Name	Latest Period	Plan	Actual	Variance	V	A
CYP - New Referrals	Mar-23	-	2385	-		
CYP Eating Disorders - Routine Ref Perf (Qtr)	Mar-23	95%	83%	✗ -12%		
CYP Eating Disorders - Urgent Ref Perf (Qtr)	Mar-23	95%	100%	✓ 5%		
CYP Access (1+ Contact) (12 Mth Rolling)	Mar-23	13559	17845	✓ 4286		

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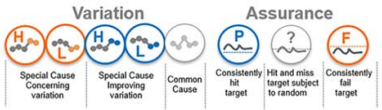
Nottingham and Nottinghamshire

3d. Service Delivery – Primary & Community Scorecard

Primary Care and Community Recovery						
Population						
Name	Latest Period	Plan	Actual	Variance	V	A
Total Appointments	Apr-23	517378	513098	-4280		
% Face to Face Appointments	Apr-23	-	71%	-		
% Same Day Appointments	Apr-23	-	42%	-		
% Pts able to book within 2 Weeks	Apr-23	-	76%	-		
Number of NHS App Registrations	May-23	60%	52%	-8%		
Community Waiting List (0-17 years)	Apr-23	1938	2049	111		
Community Waiting List (18+ years)	Apr-23	8351	10560	2209		



4. Finance - Scorecard

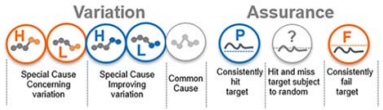
	YTD Variance £m's			YE FOT Variance £m's			RAG	
Indicator Measure	Plan	Acts	Variance	Plan/ Ceiling/ Envelope	FOT	Variance	YTD	FOT
Financial Sustanability (Variance from b/e)	-10.6	-29.5	**-18.9**	0.0	0.0	**0.0**	🔴	🟢
Financial Efficiency Vs Plan	15.4	7.8	**-7.6**	192.7	192.7	**0.0**	🔴	🟢
Achievement of MHIS		32.8		204.6	204.6	**0.0**		🟢
Agency Spend - price cap compliance	100%	59%	**-41%**				🔴	
Agency Spend Vs Ceiling		16.1		68.7	63.2	**5.5**		🟢
Capital Spend Vs System Envelope	14.3	12.6	**-1.7**	100.6	105.6	**5.0**	🟢	🔴
Elective perf not achieved above 105% target	18.9	12.7	**-6.2**	102.6	102.6	**0.0**	🔴	🟢

- £29.5m deficit experienced to end of month 2, which is £18.9m adverse to plan.
- The adverse variance is experienced in the all the system providers - £13.3m deficit in NUH, £1.0m in SFH and £4.5m at NHT.
- The ICB is reporting a break-even position as at month 2.
- At M2, the reported total system forecast was a break-even position against the break-even plan submitted
- Agency spend YTD position is over plan with an adverse YTD variance of £4.1m. The system agency plan of £62.9m is £5.8m below the system agency cap of £68.7m. The forecast at M2 is £5.5m under the agency cap & £0.3m over plan.
- The system is reporting a 58.7% (YTD) of shifts being filled by agency as being compliant with the price cap rules with 41.3% being non-compliant. Each provider has set quarterly financial improvement trajectories for 2023/24. The NHSE target is 100% compliance for the system.
- The ICB is forecasting spend to £204.6m MHIS target, which delivers achievement of the MHIS, with £32.8m spend to the end of Month 2.
- The system has spent £12.6m of its capital envelope which is £1.7m under plan.
- Forecast is £105.6m which is break-even against plan but £5m over the total system envelope of £100.6m which will need to be managed back within the envelope as the year progresses.

NHS
Nottingham and Nottinghamshire

5. Workforce - Scorecard

Workforce Scorecard	Latest Period	Total Provider			Variation	Assurance	Exception Report
		Plan	Actual	Variance			
Total Provider Workforce							
Total Provider Workforce	May-23	33,247	33,405	158			
Total Provider Substantive	May-23	30,229	30,472	243			Page 52
Total Provider Bank	May-23	1,923	1,940	17			
Total Provider Agency	May-23	1,096	994	-101			
Total Primary Care Workforce	Apr-23	-	2,987	-			Page 53
Key Workforce Performance							
Total Provider Turnover Rate % (12 month rolling)	Mar-23	11.0%	12.8%	1.8%			
Total Provider Sickness Absence Rate %	Mar-23	4.6%	5.6%	1.0%			Page 54
Total Provider In-Month Vacancy Rate %	Mar-23	8.7%	11.9%	3.2%			



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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
- 6.6 – Exception Report Safeguarding, LAC & SEND

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

NHS Nottingham and Nottinghamshire

Learning Disability and Autism (LD&A)

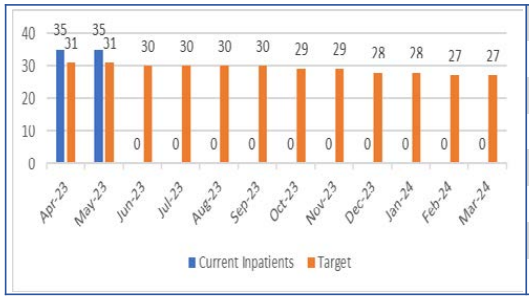
ICB Adult LD&A Inpatients

May-23
13
Target
15
Assurance
-
SPC Variation
-

Data Cut-Off Date: 31/05/23

Explanatory Note/Insight Analysis and Assurance: -
ICB performance is ahead of target (13 inpatients against a target of 15)

NHS England Adult LD&A Inpatient



May-23
35
Target
31
Assurance
-
SPC Variation
-

Data Cut-Off Date: 31/05/23

Explanatory Note/Insight Analysis and Assurance:
IMPACT performance is behind target (35 inpatients against a target of 31).

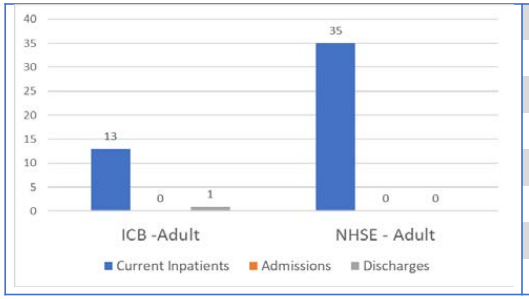
NHS England CYP LD&A Inpatient

May-23
3
Target
3
Assurance
-
SPC Variation
-

Data Cut-Off Date: 31/05/23

Explanatory Note/Insight Analysis and Assurance:
CYP performance is on target.

LD&A Adult Inpatient Movements

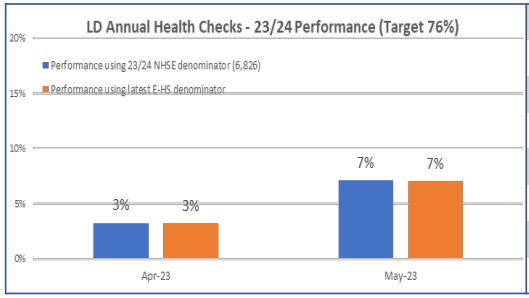


May-23
48
Admissions
0
Discharges
-1
SPC Variation
-

Data Cut-Off Date: 31/05/23

Explanatory Note/Insight Analysis and Assurance:
During May there were no admissions and 1 discharge.

LD Annual Health Checks



May-23
484 / 7%
Target
482 / 7%
Assurance
-
SPC Variation
-

Data Cut-Off Date: 31/05/23

Explanatory Note/Insight Analysis and Assurance: Completion rate of 7% which is positive for this stage in the year. Currently engaging with those low performing practices who completed less than 50% of health checks for their eligible patient population in 2022/23

LeDeR

2022-23
34
Target
58
Assurance
-
SPC Variation
-

Data Cut-Off Date: 31/03/23

Explanatory Note/Insight Analysis and Assurance: -
National target to complete 100% of reviews within 6 months. Locally, this has not been achieved due to lack of capacity and challenges with receiving medical notes from primary and secondary care. Mitigations have been established, including completion of reviewer recruitment, info sharing agreements and smart card access.

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

NHS Nottingham and Nottinghamshire

Learning Disability and Autism (LD&A)

System Quality Group Assurance – Limited Assurance

Rationale for assurance level: Focus on performance in place for this month with NHSE system performance meeting and LDA Peer Review planned.

Current Position

Exceptions for this month:

The first LDA Monthly System Performance Meeting is scheduled for 27th June with NHSE region. These meetings have been established to provide targeted review and designed to help identify what additional support the ICB may require to ensure delivery. The key KLOEs for this meeting will focus on inpatient performance.

The schedule for the LDA Peer Review has been developed with partners to support thorough review and opportunity to identify any improvements to inpatient performance and autism pathways, with a focus on admission avoidance and increased discharge.

Inpatient performance
As at 31st May, there are currently 48 adult inpatients against a target of 46. There have been 0 admissions and 1 discharge during May. ICB performance is ahead of target (13 inpatients against a target of 15) and IMPACT performance is behind target (35 inpatients against a target of 31).
Adult Dynamic Support Register: We have 71 people on our register who we are actively being supported by our community MDT. Since the inception of the adult DSR (Nov 2022) there have been 12 people that have been discharged from the register. This is strong performance by the ICS operational teams on the ground.
CYP Dynamic Support Register: We currently have 99 CYP on the DSR register who we are actively supporting. All these have been identified at risk of being admitted into an inpatient setting. This is demonstrating strong performance of the ICS operational teams on the ground in preventing admissions.
Autism Waiting Times: Waiting times for neurodevelopmental assessments have significantly increased over the past 2 years both nationally and locally as prevalence rates have increased and services are struggling to meet increased demand. There has been increased public, media and ministerial interest in this area with the ICB having received two ministerial requests and an increasing number of FOIs, requesting information.

Actions Being Taken & Next Steps

Monthly System Performance Meeting is scheduled for 27th June with NHSE region

LDA Peer Review is scheduled for 28th-30th June, with a focus on inpatient performance and autism pathways.

Focused work on length of stay in inpatient settings

Work to improve neurodevelopmental pathways and waiting times: Actions being taken include increasing capacity within commissioned services; review of the CYP neurodevelopmental pathway; capacity and demand modelling; and improving referral processes.

Risks & Escalations

Of the 81 LeDeR mortality reviews received in 22/23, 18 have missed the completion deadline of 6 months. This is due to delays in statutory processes and delays in accessing information such as GP records, Hospital notes and Structured Judgement Reviews (SJRs). Focused work is underway to improve this performance. Recent recruitment into the team will have a positive impact.

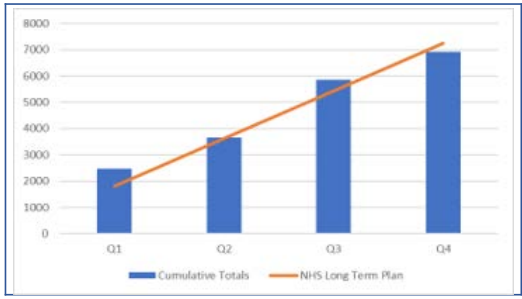
The long waiting times for neurodevelopmental assessments means that CYP and adults are not always receiving the support they require.

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

NHS Nottingham and Nottinghamshire

Personalisation

Personalised Health Budgets

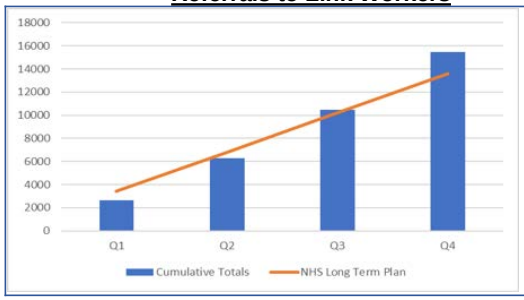


Q4 22-23
6921
2022/23 Plan
7250
Assurance
-
SPC Variation
-

Data Cut-Off Date: 31/03/2023

Explanatory Note/Insight Analysis and Assurance: Q1 data is not available until July 2023

Referrals to Link Workers

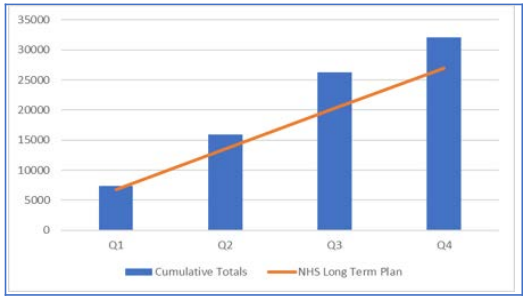


Q4 22-23
15455
2022/23 Plan
13610
Assurance
-
SPC Variation
-

Data Cut-Off Date: 31/03/2023

Explanatory Note/Insight Analysis and Assurance: Q1 data is not available until July 2023

Personalised Care & Support Plans



Q4 22-23
32086
2022/23 Plan
27000
Assurance
-
SPC Variation
-

Data Cut-Off Date: 31/03/2023

Explanatory Note/Insight Analysis and Assurance: Q1 data is not available until July 2023

Number of Social Prescribing Link Workers & Funding Source

Q4 22-23
107
2022/23 Plan
N/A
Assurance
-
SPC Variation
-

Data Cut-Off Date: 31/03/2023

Explanatory Note/Insight Analysis and Assurance: Q1 data is not available until July 2023

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

NHS Nottingham and Nottinghamshire

Personalisation

System Quality Group Assurance – Significant Assurance

Rationale for assurance level: Data is collated on a quarterly basis the slides represent year end data (quarter 4 2022/2023). Progress within targets continue. The progress position against quarter 1 2023/2024 will be available in July 2023.

Current Position

Exceptions for this month:

Quarterly SRO meeting with NHSE
Feedback from NHSE indicates performance within the ICS is on plan in region . NHSE are assured with progress to date.

Joint Forward Plan
Personalised Care reflects importance across all aspects of the Joint Forward Plan in line with the Personalised Care Strategy. The ICS Personalised Care Strategic Oversight Group have agreed Personalised Care section and reflected priorities for the next 5 years featured in the JFP. Assurance: all stakeholders agreed with next steps to focus on delivery.

Personal health budget targets
Achievement of 95% for 22/23 was recognized by the NHS Regional team as better than expected against stretch targets. Learnings from this will be considered in developing PHB planning and delivery for 23/24. There is recognition regionally that identifying and taking advantage of every opportunity to offer a PHB may be a more useful metric than volume, and this will be explored further locally.

Work with Children and Young Peoples commissioners in exploring PHB offers will require using resource differently to achieve good health outcomes by improving the environment they are living e.g., their housing. However, concern about 'precedent' that will be set by offering support with a non-medical approach is being discussed with finance.

Integrated Personalised Commissioning and Practice
Nottinghamshire and Nottingham ICB and Nottinghamshire County Council (in partnership with Nottingham City Council) jointly funded and commissioned an Independent Consultant to complete a review of Integrated Personalised Commissioning and Practice in our joint funded cases. The recommendations draw on insights from both people with lived experience and staff. Improvement work will now focus on:

- consistent application of the well-managed needs principle
- increasing understanding of thresholds within care domains
- promoting personalisation, strength-based approaches, person centred behaviours
- embedding co-production in Continuing Health Care Systems & Processes
- streamlining processes for jointly funded packages
- opportunities for joining up arrangements

Annual Health Check Project
The work to introduce personalised care and support planning within the annual health check process for people with Learning Disabilities, Dementia and Severe Mental Illness has made progress. Assurance levels the overcoming time commitment challenges (both to support the development of the work as well as incorporating into practise) does not present a matter for escalation.

Actions Being Taken & Next Steps

Personal health budget targets
Continued planning and working with commissioner and finance leads.

Integrated Personalised Commissioning and Practice
To support this work, senior leaders from the Integrated Care Board, City Council and County Council will be developing a Road Map for Integrated Personalised Commissioning.

Annual health check project
Working with commissioners to overcome time commitment challenges within the area

Risks & Escalations

Commissioning for Personalised Care
The proposal set out for CYP with asthma is a different way to commission and support people. The approach aligns with the ICS Strategy and our Personal health budget policy. To achieve our ambitions, it is essential that finance support the change in the way we use public funds in order to commission personalised care effectively.

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

NHS Nottingham and Nottinghamshire

Co-Production

System Quality Group Assurance – Significant Assurance

Rationale for assurance level: The Strategic Coproduction Group continues to meet monthly; the group are co-creating their workplan for the year which includes ICB and System coproduction information. The Group are starting to receive coproduction updates under the check and challenge remit of the TOR. Coproduction Network is being developed, currently in the scoping phase assessing what is already running across the system. Coproduction Toolkit content is being created for launch in July 2023.
Coproduction Strategy status remains unchanged, it has been authorised by the ICB Board and will be made into a visually appealing document through the Strategic Coproduction Group.

Current Position

Exceptions for this month:

Joint Forward Plan – Coproduction is a golden thread throughout the Joint Forward Plan which will support large scale embedding of coproduction in line with the Coproduction Strategy. Oversight and assurance of coproduction activity will be undertaken by the Strategic Coproduction Group.

Strategic Coproduction Group - focus remains on the maturing Strategic Coproduction group to provide support and challenge to how the system embeds coproduction more thoroughly. Whilst the numbers of lived experienced members has increased, further work is needed to broaden the numbers and diversity of our group.

Toolkit - Work on developing and releasing support from the toolkit is underway, with plans for a soft launch in Coproduction Week (w/c 3rd July). Providing a consistent and easy to use approach is foundational to increasing coproduction in all activity. Resources will be available on approaches to coproduction and the ladder of involvement and how to run a coproduced meeting. This includes developing tools for supporting lived experiences members to feel empowered and supported to engage with coproduction.

The development of a whole system assessment is provisionally planned to start in august.

Actions Being Taken & Next Steps

- Development and creation of the Coproduction Toolkit ready for soft launch July 2023.
- Coproduction week planning and delivery (w/c 3 July)
- Scoping of the Coproduction Network.
- Ongoing recruitment to the Coproduction Apprentice role inc developing easy read job advert.
- Ongoing coproduction of the new Maternity Voices Partnership (MVP) model

Risks & Escalations

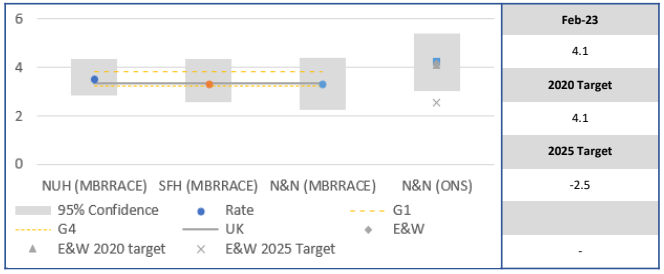
The Coproduction Apprentice role remains under the recruitment stage due to quality of applications. The delay in recruitment is impacting capacity of the team who have prioritised workload.

6.3 - Improving Quality of Services – Exception Report Maternity

NHS Nottingham and Nottinghamshire

Local Maternity & Neonatal System (LMNS)

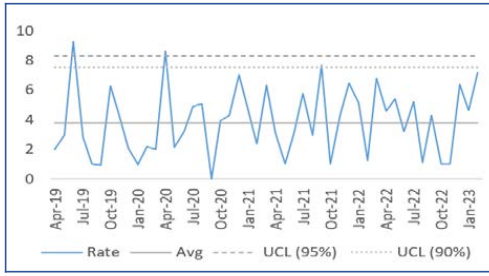
N&N Trusts and County vs Peers – last MBRRACE publication (2020) & last ONS publication (2020)



Feb-23
4.1
2020 Target
4.1
2025 Target
-2.5
-

Data Cut-Off Date: 22/05/2023
Explanatory Note/Insight Analysis and Assurance: -
New data published in May will be reflected next month. It shows that NNICS remains within 5% of the UK average for perinatal mortality, however this is increasing nationally - MBRRACE mortality rates 2021

N&N Monthly Stillbirth Rate (per 1,000 live births) – SPC Chart (local data)



Feb-23
7.1
Mean
3.8
Upper Control Limit
-8.3
SPC Variation
-

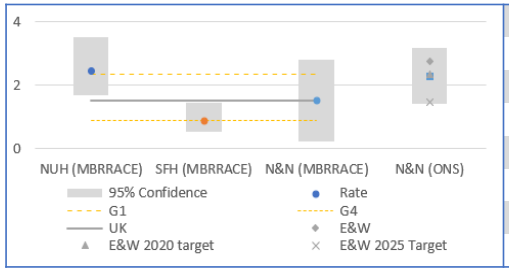
Data Cut-Off Date: 22/05/2023
Explanatory Note/Insight Analysis and Assurance: -
Individual exception reporting indicates no special cause for concern for the latest reporting month. Data quality is good. Birthrate has dropped which increases the 'rate per 1000 births.

Ockenden Assurance

	NUH					SFH				
	Jan-22	Apr-22	Sep-22	Dec-22	Apr-23	Jan-22	Apr-22	Sep-22	Dec-22	Apr-23
IEA1 Enhanced Safety	56%	100%	100%	100%	100%	100%	100%	100%	100%	100%
IEA 2 Listening to women and families	88%	99%	100%	100%	100%	88%	100%	100%	100%	100%
IEA3 Staff training and working together	56%	63%	96%	97%	100%	100%	100%	100%	100%	100%
IEA4 Managing complex pregnancy	79%	89%	100%	96%	100%	100%	100%	100%	100%	100%
IEA5 Risk assessment throughout pregnancy	67%	70%	98%	100%	100%	100%	100%	100%	100%	100%
IEA6 Monitoring fetal wellbeing	67%	94%	100%	97%	100%	100%	100%	100%	100%	100%
IEA7 Informed consent	50%	57%	93%	93%	100%	71%	71%	93%	93%	100%
Workforce	70%	80%	95%	95%	100%	100%	100%	100%	100%	100%

Up-to-date as of: 22/05/2023
Explanatory Note/Insight Analysis and Assurance: -
The 100% compliance for NUH has been reviewed following request for clarity from the NHSE regional team. Further information provided which supports the compliance rating. Insight visit scheduled for Q2 as planned.

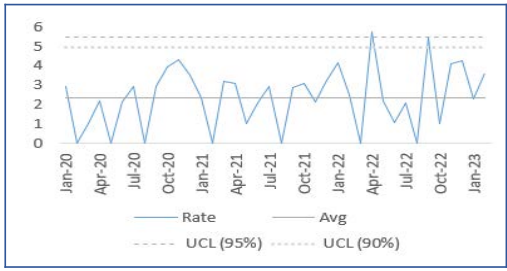
N&N Monthly Neonatal Deaths (per 1,000 live births) – SPC Chart (local data)



Feb-23
1.52
2020 Target
2.3
2025 Target
1.53
SPC Variation
-

Data Cut-Off Date: 22/05/2023
Explanatory Note/Insight Analysis and Assurance: -
Neonatal deaths continue to be rigorously scrutinised through perinatal mortality reporting and review. N&N is line with the national picture, the implementation of safety measures through SBLCBv2 has not yet had demonstrable impact on the level of neonatal deaths.

N&N Trusts and County vs Peers – last MBBRACE publication (2020) & last ONS publication (2020)



Feb-23
3.6
Mean
2.3
Upper Control Limit
-5.5
SPC Variation
-

Data Cut-Off Date: 13/04/2023
Explanatory Note/Insight Analysis and Assurance: -
(see left)

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

NHS Nottingham and Nottinghamshire

Local Maternity & Neonatal System (LMNS)

System Quality Group Assurance – Limited Assurance

Rationale for assurance level: Quality concerns identified and support in place for NUH maternity improvement. Schedule in place for LMNS assurance based on NHSE guidance and local intelligence.

Current Position

Exceptions for this month:

NHSE raised some concerns in relation to NUH compliance with Ockenden IEA 7 and Saving Babies Lives Care Bundle V2. Ockenden. The compliance panel process has been reviewed and it was agreed that as assessment for compliance was undertaken against the NHSE evidence list, it was felt that the compliance percentage confirmed at the last Ockenden panel meeting was reflective of NUH's position. Additional scrutiny on these elements will be undertaken during the upcoming Insight Visit to provide additional assurance.

Due to the Junior Doctors strike, it was agreed that the original planned dates of 14th & 15th June for NUH's Ockenden Insight Visit would be rearranged and confirmation of a new date is awaited.

Publication of the new technical guidance for the 3 year delivery plan and SBLCBv3, has led to the scheduling of the first LMNS Quarterly Oversight and Assurance Panel in early July to allow for sufficient scrutiny of the KLOE's to be developed and shared in advance with both Trusts. This taking place in early July will also support the identification of areas for closer scrutiny for the NUH Ockenden Insight Visit.

LMNS Executive Partnership Board have agreed local approach and priorities for the implementation of the 3 year delivery plan. Key priorities are equity and working with women and families.

Equity:
- System focus is underway to increase uptake of antenatal education within diverse communities, with focus on supporting people with different language needs.
- WhoseShoes? coproduction event to hear the voices of marginalised communities in NUH maternity is planned for July 2023.

Working with women & families:
- The Independent Senior Advocate (ISA) for NUH is currently out to recruitment. The ISA for SFH is now in post.
- Following feedback from women and families, work on a seven day per week bereavement support service will focus on the potential for community-based initiatives, rather than this being a solely hospital based service.

Safety
- The LMNS SI panel has increased to a 4 weekly meeting with time allocated for learning and improvement tracking in addition to report sign off.
- Working group underway exploring automatic coding protocols for GP computer systems to trigger vulnerabilities searches upon notification of pregnancy from booked Trust to support appropriate safeguarding information sharing. This will include: substance misuse, complex social factors, breastfeeding at d10 and 6-8w and BMI>30, BMI>40.
- MVP volunteers have undertaken safeguarding training and a process for them to refer cases or seek support has been established.
- NUH continue to make workforce progress with non-compulsory rotation opportunities for junior midwives. Rotation is now contained within new starter contracts.

Actions Being Taken & Next Steps

NUH Insight Visit scheduled 24th & 25th July. LMNS Quarterly Oversight and Assurance Panel scheduled for July for assurance against 3 year delivery plan & Ockenden deliverables

Application of PSIRF principles to serious incident management and review, pending maternity PSIRF webinar at the end of June.

System equity working group formed, with links into the NUH working group being established.

Work progressing with University of Nottingham evaluation of bereavement services will inform further development of services.

Risks & Escalations

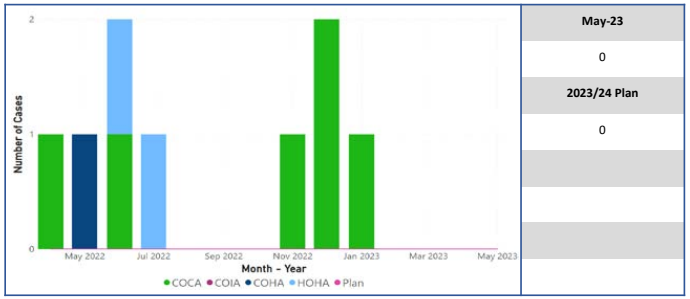
SFH will no longer be progressing to full Badgernet Electronic Patient Record for Neonatal, despite the system commitment to this, due to an unforeseen SFH digital funding deficit. Internal escalations at SFH are underway and LMNS Executive Partnership will maintain oversight.

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

NHS Nottingham and Nottinghamshire

Infection Prevention and Control

HCAI Data 22-23 – MRSA Bloodstream Infections

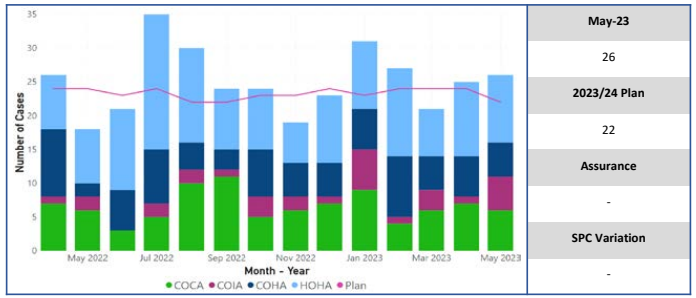


May-23
0
2023/24 Plan
0
Assurance
SPC Variation

Data Cut-Off Date: 19/06/2023

Explanatory Note/Insight Analysis and Assurance:

HCAI Data 22-23 – C-Diff

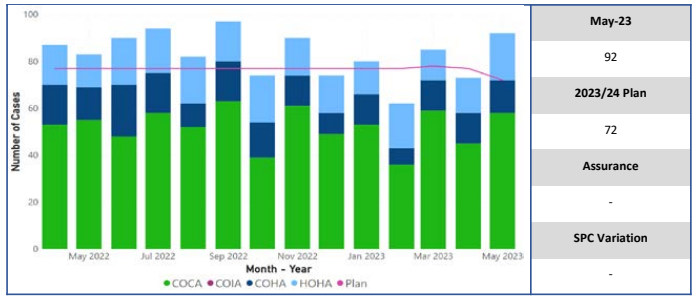


May-23
26
2023/24 Plan
22
Assurance
-
SPC Variation
-

Data Cut-Off Date: 19/06/2023

Explanatory Note/Insight Analysis and Assurance:

HCAI Data 22-23 – E-coli Bloodstream Infections

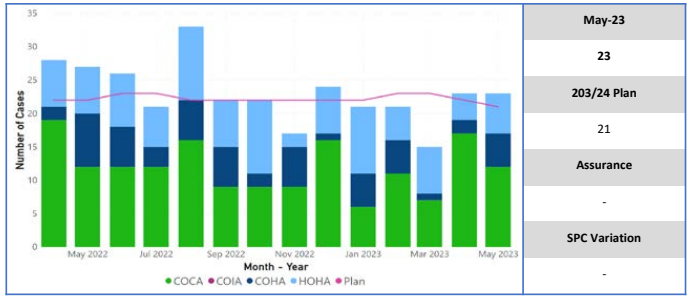


May-23
92
2023/24 Plan
72
Assurance
-
SPC Variation
-

Data Cut-Off Date: 19/06/2023

Explanatory Note/Insight Analysis and Assurance: -

HCAI Data 22-23 – Klebsiella Bloodstream Infections



May-23
23
203/24 Plan
21
Assurance
-
SPC Variation
-

Data Cut-Off Date: 19/06/2023

Explanatory Note/Insight Analysis and Assurance: -

HCAI Data 22-23 – Pseudomonas Bloodstream Infections

May-23
3
2023/24 Plan
6
Assurance
-
SPC Variation
-

Data Cut-Off Date: 19/06/2023

Explanatory Note/Insight Analysis and Assurance: -

Note: HCAI graphs have been refreshed to show a combined view of the ICB including Bassetlaw from April 22 onwards.
The Plan figures were updated in April '23 to reflect new HCAI targets.

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

NHS Nottingham and Nottinghamshire

Infection Prevention and Control

System Quality Group Assurance – Partial Assurance

Rationale for assurance level: Recovery work to reinstate deep cleaning programmes in secondary care is reliant on reduced bed occupancy recent OPEL 4 status has led to cancellations. Use of hydrogen peroxide cleaning post discharge is impacted by the urgent need for beds making this IPC action hard to achieve. New annual HCAI targets are challenging. Reducing HCAI will be hard to achieve without restoration of the required cleaning programmes and wider community prevention measures needed.

Current Position

Exceptions for this month:
New national HCAI reduction targets have been issued 2023-24. In the current form there is ICB data and sub location data (Bassetlaw) it is anticipated that these will merge from July, based on this the data and targets have been added together for both locations from April 23 to reflect one ICB total data set.
*Caution must be applied when viewing the performance graphs as this reflects changes to the annual targets and plan from April 23. These graphs reflect the total data (ICB and Bassetlaw cases as sub location added together along with the merged targets to form one dataset)
•HCAI targets are formed from earlier known baseline data and are counts/case numbers. The targets do not consider rates which would reflect the sustained increase in patients being admitted and the high levels of activity in secondary care**.**
•The HCAI targets are highly challenging. IPC leads across the system are indicating a low confidence in the ability to deliver against the new targets, particularly if the sustained operational pressure on inpatient beds continues along with increase patient acuity. Sustained demand for beds is impacting IPC control measures. This view is reflected across the region.
•The revised national ambition to reduce gram-negative BSI by 50% 2024/2025 is not considered achievable locally and regionally.
•The system IPC leads will focus on known trend rates and preventing avoidable infections and taking actions that address learning from patient reviews where a lapse in care is identified. Lapses in care include: inappropriate antibiotic prescribing, lack of timely testing for infection identification, patient management and environmental cleaning issues. Not all HCAI cases are avoidable despite optimal treatment this particularly applies to some highly complex patients.

System position for May 2023
***C.difficile* infections**
•ICB (total) breached plan 26/22 cases. This is negatively impacted by Bassetlaw sub location with breach 4/1 cases
•NUHT breached month plan 10/8 cases, (6) HOHA cases, this is a slight improvement on last month's position

Gram Negative BSI
***E.coli* bloodstream infections**
•ICB (total) breached plan 92/72 cases (63% (58) COCA)
•NUHT breached month plan 34/21 cases
***Klebsiella* bloodstream infections**
•ICB (total) breached month plan 23/21 cases, (52% (12) COCA)
***Pseudomonas* bloodstream infections**
•NUHT breached month plan 6/4 cases

Actions Being Taken & Next Steps

- The system IPC leads will focus on known HCAI rates and trends, preventing avoidable infections and taking actions that address learning from patient reviews where a lapse in care is identified. Lapses in care include: inappropriate antibiotic prescribing, lack of timely testing for infection identification, patient management and environmental cleaning issues.
- Secondary care will focus on reinstating the deep cleaning programmes and highlighting the risks from measures that place additional patients on wards before a discharge has occurred and environmental and equipment cleaning has been completed.
- Public health have been approached for wider consideration of the measures needed to prevent gram negative infections in those not associated with healthcare.
- Steps to establish timely community HCAI rates data is being explored.

Risks & Escalations

- Inability to fully progress 'deep cleaning programmes' in secondary care due to high pressure on beds.
- The ability to meet new HCAI targets that remain case based not rates.
- SFHT have a reduced annual *C.diff* target by 35 cases 2023-24
- The new merged HCAI data set for the ICB will include Bassetlaw data. All HCAI targets in Bassetlaw were breached 22-23 so the merged data is likely to be impacted negatively.
- The ICB has a system risk around the provision of community IPC consultant microbiologist services.

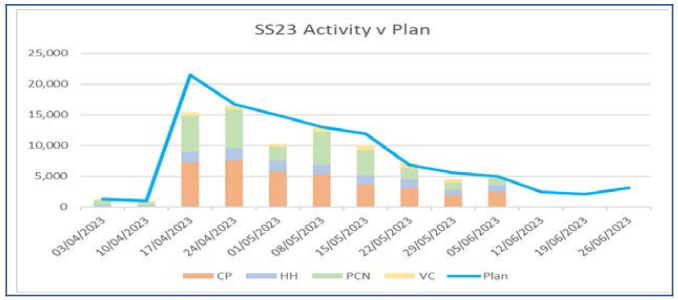
6.5 - Improving Quality of Services – Exception Report Vaccinations & Patient Safety

NHS Nottingham and Nottinghamshire

Vaccinations

COVID Spring Booster Campaign Performance to 11/06/23

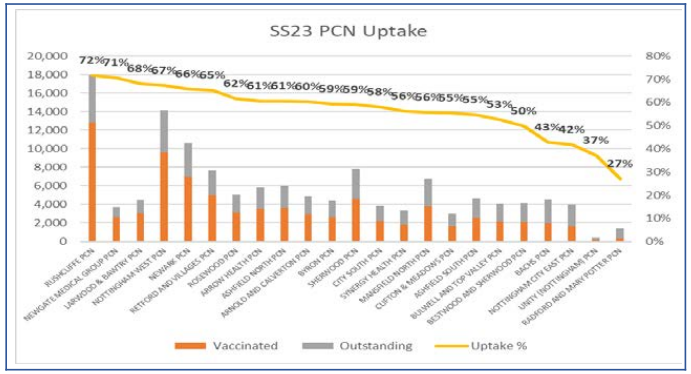
SS23 Activity v Plan



Data Cut-Off Date: 11/06/23

Explanatory Note/Insight Analysis and Assurance: Vaccination events recorded by provider type against plan

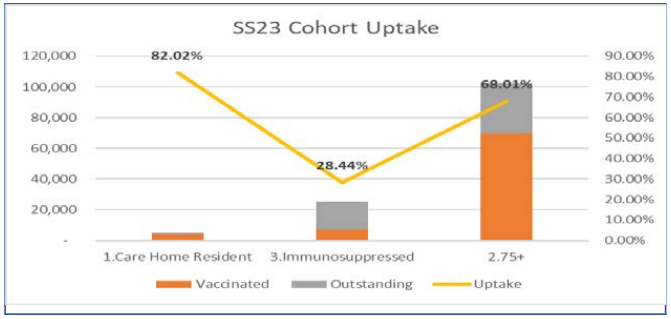
SS23 PCN Uptake



Data Cut-Off Date: 11/06/23

Explanatory Note/Insight Analysis and Assurance: PCN covid-19 vaccination activity and uptake (%)

SS23 Cohort Uptake



Data Cut-Off Date: 11/06/23

Explanatory Note/Insight Analysis and Assurance: Vaccination uptake by eligible cohort (Spring 2023 booster)

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

NHS Nottingham and Nottinghamshire

Vaccinations

System Quality Group Assurance – Partial Assurance

Rationale for assurance level: Uptake for the spring booster is currently at 61%, this is less than the national assumption of 68%

Current Position

Spring booster campaign being delivered by:

- 1 hospital hub at Kings Mill Hospital offering
  - Clinics on site
  - Satellite clinics at Balderton, Warsop and Ollerton
  - Medivan and pop ups for hyper-localised offer
- 1 vaccination hub at Glasshouse Street offering:
  - Satellite clinics at Old Basford, Clifton Cornerstome and Park House
  - Medivan and pop ups for hyper-localised offer
- 10 PCNs
- 42 Community Pharmacy sites

6m to 4yo at risk due to start w/c 12th June, offer will be from Kings Mill Hub and Clifton Cornerstone

Actions Being Taken & Next Steps

- Spring booster campaign ends on 30th June 2023
- Additional satellite clinics planned in the remaining 2 weeks
- National mandate for continued primary vaccination offer from 1st July to start of autumn campaign for newly severe immunosuppressed. Process, pathway and service offer in place to account for this requirement
- Working with our workforce to explore options for the two months between the end of June and the start of the Autumn programme, options include:
  - Redeployment to other vacant posts within the acute and community settings
  - Staff taking unpaid leave
- Covid and Flu vaccine equity steering group planning for autumn outreach and inequalities started
- Wider imms and Vaccination strategy meeting in place with parents from NHSE, PH and IC

Risks & Escalations

No escalations this month

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

NHS Nottingham and Nottinghamshire

Patient Safety

System Quality Group Assurance – Partial Assurance

Rationale for assurance level: The ICS PSIRF implementation group continues to acknowledge variable progress towards PSIRF implementation for NUH, SFH, NHT and CityCare. There are challenges in recruiting Patient Safety Partners and emerging issues with executive support and engagement for some partners.

Current Position

Exceptions for this month:

PSIRF position paper shared with Quality & People Committee which details five recommendations:

- Two additional patient safety specialists (PSS) for the ICB
- Recruitment of two patient safety partners (PSP) from the local population by end Q2
- System support for partners without PSP to support transition to PSIRF
- Board and oversight training for executive colleagues
- Adoption of PSIRF principles in the ICS Quality Framework

Partner Quality Assurance & Improvement Group (PQAIG)
Quality, governance and safety leads keen to implement thematic reviews of high volume patient harm incidents, especially pressure ulcers. This approach is endorsed by members and supported by the newly established system wide tissue viability group.

The Quality Risk Profiles for Q4 were ratified at the meeting in June.

Never Events; Section 28 (PFD); CQC inspections & reports
Two Never Events at NUH – retained guide wire and wrong site surgery.
No new PFDs
CQC reports- well led report published regarding BPAS no rating currently published; Priory Arnold

Actions Being Taken & Next Steps

- ICB led PSIRF webinar for small & independent providers
- Representation at regional PSIRF implementation group meeting
- Application for National Wound Care Programme involvement from the tissue viability group – interview 15 June 2023
- NNICB joining a national quality improvement group following publication of BPAS CQC report
- SFH PSIRP going to board 29th June

Risks & Escalations

No new risks since last update.

6.6 - Improving Quality of Services – Exception Report Safeguarding, LAC & SEND

NHS Nottingham and Nottinghamshire

Adult & Children Safeguarding

System Quality Group Assurance – Significant Assurance

Rationale for assurance level: All major statutory duties for the ICB and system partner are being met. Where concerns have been raised around specific issues the ICS Safeguarding Public Protection and Assurance Group are monitoring and actioning these issues. No specific risks that require escalation but there are some key messages to share.

Current Position

Exceptions for this month:

- The Liberty Protection Safeguard implementation has been ceased for the lifetime of this parliament.
- The joint work with Nottinghamshire Safeguarding Adult Board assessing what assurance we have about Mental Private Providers is underway and will be completed within this quarter. Any identifiable risks will be escalated to the appropriate committees.
- MASH County Health Team continues to be supported by NHCT in relation to strategy discussions and has reviewed the wider safeguarding team input with a tiered approach to support. Interviews for MASH practitioner secondments were successful and will commence in June and Early August. Admin interviews have progressed and anticipate successful recruitment subject to clearance, Further requests have been made to partners for cover due to a pending maternity leave.
- A further interview for the Named Safeguarding GP vacancy was not successful and alternative plans are in discussion with the team.
- A successful appointment subject to clearance to the Associate Designated Nurse for SGC (GP & LAC lead) position was made and commencement dates being negotiated.
- The ICB is fully engaged in the NCSCP Improvement Board work and business plan developments for the partnership.
- The ICB is fully engaged in the NSCP business development plan.
- The safeguarding team are responded to requests for quarter 1 NHSE Heat Maps focussing on safeguarding developments in the ICB and self-assessed overall as amber due to some key areas in the NHSE safeguarding joint forward planner being under development. This planner has been matched across into the ICB priority areas and some noted in the N&N ICS JFP.
- Following the news that the LPS will not be implemented within this parliament the unauthorised CHC Community DoLS within the Bassetlaw & Mid Notts have ben re-entered onto the ICB Risk Register. This is due to disparities within Deprivation of Liberty Safeguards (DoLS) practices across Nottingham and Nottinghamshire and there is a risk the ICB may not be fulfilling this statutory requirement and individuals experiencing deprivation of liberty will not have the relevant legal framework in place.
- C&YP in crisis/inappropriate settings continues to be challenging impacting on safeguarding concerns for individual C&YP & providers.

Actions Being Taken & Next Steps

MASH County Health Team continue to be supported by NHCT in relation to strategy discussions and the wider safeguarding team as noted in current position.. Recruitment continues to progress for administrators.

MASH Health Safeguarding Practitioners have been appointed and 1.0 WTE has commenced working on a 6 months secondment and another part-time secondment subject to clearance.

Progress has commenced on the recommendations from the MASH Review commissioned by the NSCP Strategic Leadership Group across the partnership.

Risks & Escalations

MASH demand and capacity in the County Health Team is identified as a risk.

6.6 (continued) - Improving Quality of Services – Exception Report Safeguarding, LAC & SEND

NHS Nottingham and Nottinghamshire

Looked After Children

System Quality Group Assurance – Limited Assurance

Rationale for assurance level: The statutory health assessment for looked after children are significantly delayed which is could have an impact on these children.

Current Position

Exceptions for this month:

The ICB Quality & People Committee received an exception report (deep dive) in February 2023 and a further update report with a high-level briefing on 21st June following noting the outcomes of the 2 workshops that took place on 5th June (IHA and RHA) and the next steps with a focus on:

- Options for resolving issues address relating to backlog (short-term)
- Options for bridging the gap (medium-term)

Due to the short turnaround of this, it has been acknowledged that engagement could be limited from our partners at the workshops; therefore, stakeholders are being offered the opportunity to share their views outside the sessions to inform the final options for the June 2023 Quality & People Committee. The 0-19 years Public Health Commissioners for both City and County where unable to participate in the workshops or meet prior to the June Q&PC and it is essential the options are discussed with them as some have some impact on these services.

In addition to the immediate plans outlined above, there will be an organised and planned workshop scheduled later in Q2 2023/2024 to consider the future commissioning and provision of LAC statutory duties.

Actions Being Taken & Next Steps

- The ICB has agreed to consider the requirements for both IHAs and RHAs to enable the providers to catch up on their backlogs and meet current requirements.
- Feedback from Q&PC June meeting will support the direction of travel.
- NHCT mitigation action plan has already seen some benefits with better performance noted particularly in the under 5 year RHAs and those who are leaving care.
- Capacity within the ICB LAC team will increase during Q2; the full time Designated Nurse Safeguarding Children / Looked After Children commences employment on 20th July; Associate Designated Safeguarding Children Nurse with LAC responsibilities has is expected to commence employment mid August.

Risks & Escalations

There are no new risks

The risk for Initial Health Assessments (IHAs) and Repeat Health Assessments (RHAs) have been separated so there are now 2 LAC risks on the risk register to reflect this.

6.6 (continued) - Improving Quality of Services – Exception Report Safeguarding, LAC & SEND

NHS Nottingham and Nottinghamshire

Special Educational Needs & Disabilities (SEND)

System Quality Group Assurance – Limited Assurance

Rationale for assurance level: A Special Educational Needs and Disabilities (SEND) local area inspection by Ofsted and the Care Quality Commission was published 16th May. The report has highlighted significant concerns about the experiences and outcomes of children and young people with SEND which need to be addressed urgently – SEND Partnership leaders have developed an action plan in response to this.

Current Position

Exceptions for this month:

SEND partnership leaders have developed an Improvement Action Plan to respond to the outcome of the SEND joint local area (Ofsted & CQC) inspection.

Briefings of the SEND inspection outcomes and next steps have been delivered jointly to Education services and Parent carer forums. A briefing session was held with young people is planned for the 8thJune 23.

Voice of Children and Young People with SEND in Nottinghamshire project event took place on the 24th May, to enable partners to work together, identify emerging themes from the project to take forward.

Operational Model and options appraisal for future arrangements for the DCO/DMO team has been submitted.

ICB are working to respond to NHSE SEND regional leads KLOE's (with a return deadline of 27th June) to support work being undertaken to address the national issue relating to clinical interventions for CYP with complex health needs in education settings.

Actions Being Taken & Next Steps

Briefing provided to DfE to demonstrate progress in response to the outcome of the Nottinghamshire SEND inspection.
A 'Deep Dive' report was presented at the June 2023 Q&P committee, outlining process on the next steps.
A project officer has been recruited to work on behalf of ICB and local authority to co-ordinate progress the SEND improvement action plan.
Governance structures, to strengthen oversight and accountability at executive level have been implemented.
An independent chair has been appointed to ensure scrutiny and progress of SEND priorities.
ICS SEND Health Assurance Group structure and TOR to be reviewed, with the SRO for SEND in quality and nursing team and CYP commissioning team to become the chairs of the forum to ensure executive leadership and progress direction of work

Risks & Escalations

SEND Q&P risk have been collated and placed on risk register. Briefings have been provided to ICB and stakeholder partners.

Implications of risks identified pose financial and reputational damage.

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

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 June 2023/24

NHS Nottingham and Nottinghamshire

June 2023		Assurance: Pass	Assurance: Hit & Miss	Assurance: Falling Below
Variation	Special Cause - Improvement	2Hr Urgent Care Response Contacts 52 Week Waits (Pop) 65 Week Waits (Pop) Talking Therapies <6 weeks Early Intervention Psychosis CYP Eating Disorders - Urgent	52 Week Waits (Prov)	65 Week Waits (Prov) 78 Week Waits (Pop & Prov) Cancer 2ww % (Prov) Perinatal Access % Perinatal Access Volume Individual Placement Support CYP Eating Disorders - Routine NHS App Registrations
	Common Cause - Random	SDEC % of Total Admissions 2Hr Urgent Care Response % Diagnostic Backlog (Pop) Talking Therapies < 18 weeks Dementia Diagnosis CYP Access (1+ Contact)	Amb Conveyance to A&E Vol & % A&E Attendances - Prov Patients Using Virtual Wards (Pop & Prov) NEL Admissions (Prov) Length of Stay >21 days Pathway 1 - Discharge Home (Pop & Prov) Ambulance Response Cat 1 Ambulance Response Cat 2 Ambulance Response Cat 3 12 Hour Breaches % Ed Atts Ordinary Electives (Pop) Daycases (Pop & Prov) Outpatient 1st (Pop & Prov) Outpatient Fups (Pop & Prov) PIFU RTT Admitted (Pop & Prov) RTT Non-Admitted (Pop & Prov) Total Diagnostic Activity (Prov) Diagnostic Waiting List (Pop & Prov) Diagnostic Backlog (Prov) Diagnostic 6 Weeks % (Pop & Prov) Cancer FDS (Pop & Prov) Cancer 62 Backlog (Prov) Talking Therapies <90 days 1st to 2nd Talking Therapies Recovery Rate Adult MH - 72 Hour Follow Ups Older Adult MH >90 day LOS Total Appointments	% Cat 2 waits below 40 minutes 12 Hour Breaches Actual Ordinary Electives (Prov) Total Diagnostic Activity (Pop) Cancer 1st <31 days % (Pop & Prov) Cancer 62 Day % (Prov) Talking Therapies Entering Treatment Inappropriate OAP Bed Days Adult SMI +2 Contacts Community
	Special Cause - Concern	Total Waiting List (Pop)	Hospital Handover Delays > 60 mins Total Waiting List (Prov) Community Waiting Lists Aged 0-17 Community Waiting Lists Aged 18+	Total Outpatients - Virtual (Pop & Prov)

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

Community:
- Community Waiting Lists Aged 0-17 - Page 46
- Community Waiting Lists Aged 18+ - Page 46

Planned Care:
- Total Waiting List – Page 35
- Total Outpatients Virtual – Page 37

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.

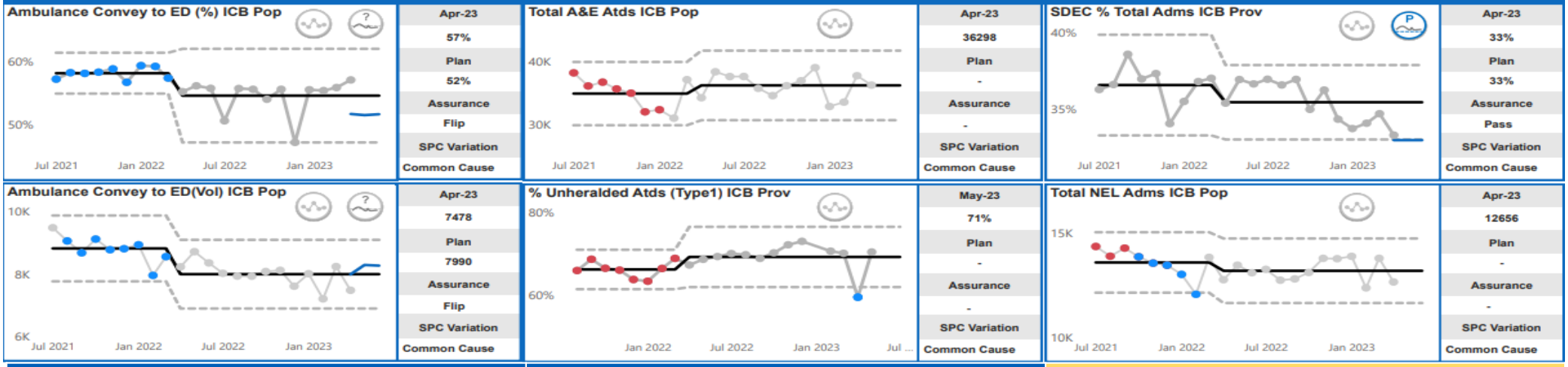
7.2 Service Delivery
Urgent Care Performance

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

Streamline Urgent Care - Exception Report : Access



Summary

A&E and NEL activity plans – The volume of attendances to ED is 204 or -0.6% below the plan of 31,868 attendances for the combined NUH and SFH position in April 2023. However, for the same period NEL Admissions are 6.8% or 840 attendances above the planned level.

Unheralded Attendances are 71% in May 2023, which is in line with the mean level. These are patients that have attended A&E without accessing 111 or their GP practice in advance.

Actions

A&E – Flow has been a challenge against medical, surgical and cancer areas which has added pressure to ED as well as impacting off loading of patients from ambulances. Halo has been on site regularly. There was a sustained period of challenge over the Bank Holiday periods. Good support has been received form system partners with P1 as well as P2 and P3. P0 discharges remain challenging. Work is ongoing to improve acute flow to facilitate a smoother journey through emergency departments and reduce the number of bed waiters in department. A push on virtual ward, SDEC and Urgent Community Response service utilisation is taking place in Q1 2023/24 to further improve patient flow.

A&E Flow - SDEC Services - 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 April shows that 33% of total admissions are SDEC, which meets the 33% target.

Oversight Level – Further Information Required

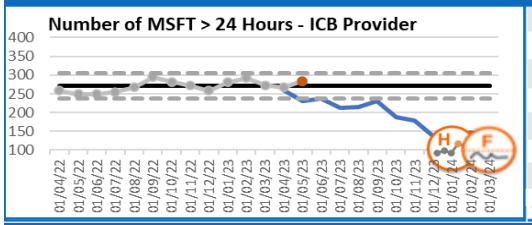
Challenges remain around the discharge process, in particular around the Pathway 0 patients. These are patients that do not require additional support and the patient is able to return to their usual place of residence, which may be their own home or a care home.

During the week ending the 18th June, there were 2644 discharges within the system, of which 90% (2385) were P0. It is therefore key that these processes are efficient and that mechanisms to treat patients without the need for an admission are effective.

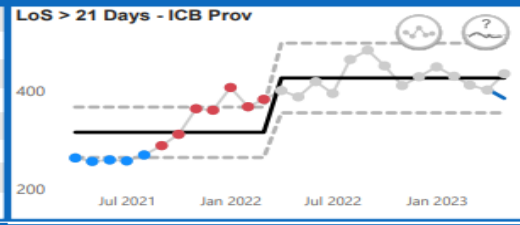
7.2b - Streamline Urgent Care – Exception Report: Discharges and Out of Hospital Provision

NHS Nottingham and

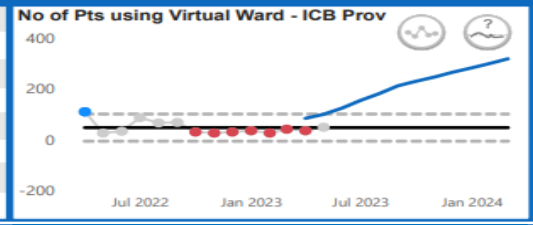
Streamline Urgent Care - Exception Report : Discharges and Out of Hospital Provision



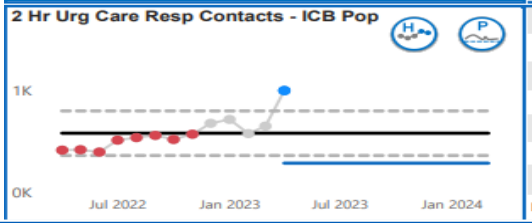
May-23
284
Plan
231*
Assurance
Fail
SPC Variation
Concerning - High



May-23
434
Plan
384
Assurance
Flip
SPC Variation
Common Cause

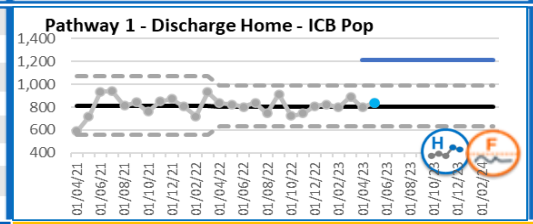


May-23
49
Plan
100
Assurance
Flip
SPC Variation
Common Cause



Apr-23
1005
Plan
286
Assurance
Pass
SPC Variation
Improving - High

Apr-23
19%
Plan
-
Assurance
-
SPC Variation
Common Cause



May-23
837
Plan
1212
Assurance
Fail
SPC Variation
Improving - High

Summary

Patients Medically Safe to transfer - The volumes of MSFT 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 level (104).

LOS >21 days remains higher than the planned level for May. There were 434 patients in acute beds in May with a length of stay or 21 days or more against a plan of 384. Within the system, 17.5% of all available acute beds are currently occupied by +21 day patients as of 13th June 2023. 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, however internal acute delay reasons are also being reviewed.

Pathway 1 - Discharges - Volumes have remained around the mean since June 2021, reporting minimal improvement since the introduction of the P1 business case. However, performance for May 2023 is above planed levels.

Actions

Virtual Wards - NHSE have recently broadened the definition of what constitutes virtual ward capacity, An initial count takes the potential system capacity to over 320 virtual ward beds, although not all are in operation. Work continues to explore more possibilities.

2 Hour UCR - City Care Community Nursing went live with UCR April 23. Increase in referrals to City Care UCR has been exceptional as a result, which is in part related to better data capture in the community nursing service. Crisis Response Intermediate Care within 2 Hours – average per month during 22/23 was 47 referrals. April 23 saw 385 referrals. Achievement of the 2-hour standard based on local data was almost 100% - 384 out of 385 achieved.

P1 Discharges - ICB Operational Director of Finance is to write to City LA to request improved engagement in system forums. Discharges into P1 from community beds to be considered for capture in the 23/24 P1 Trajectory. Awaiting update on work being undertaken to address Abandoned Discharges and issues on Prescribing & Administering MARS Chart. Partner 23/24 D2A plans will be submitted to the next ICS Discharge Operational Steering Group.

Oversight Level – Enhanced

A revised trajectory for Virtual Wards has been submitted to NHSE on the 19th June to the national virtual wards team. The plan is to achieve a level of capacity equal to 243 beds by March 2024. The focus of performance management from NHSE will be to deliver an occupancy level of 80% by September 2023.

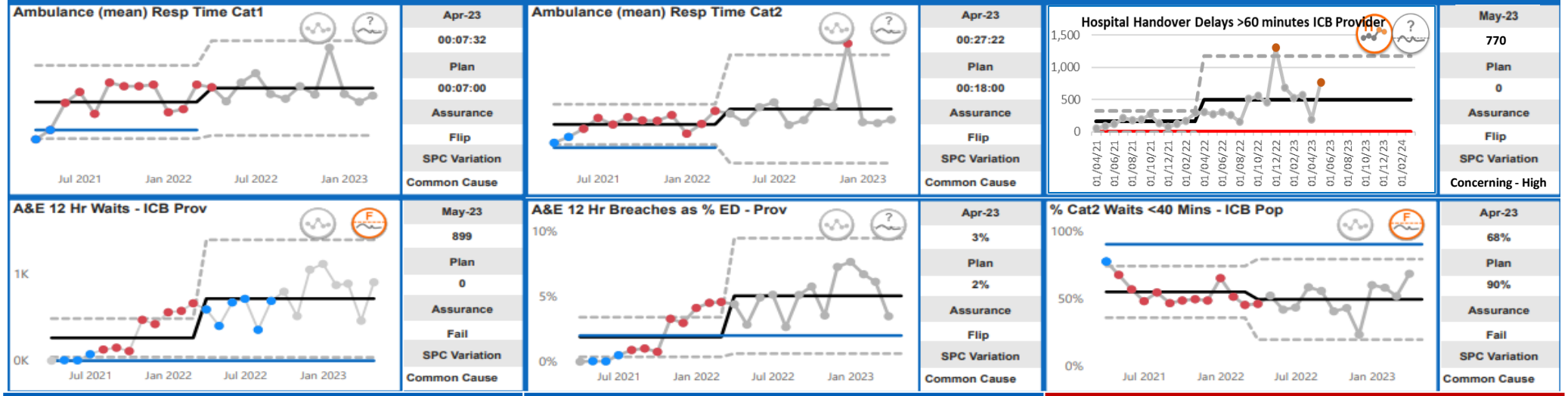
This will be monitored through fortnightly granular submissions via the foundry system and will be routinely reported within the ICB IPR. A face-to-face meeting is scheduled in early July between the ICB and providers to identify existing activity that could be captured within the virtual ward submission.

* NUH portion of MSFT plan TBC

7.2c - Streamline Urgent Care – Exception Report : Compliance

NHS Nottingham and

Streamline Urgent Care - Exception Report : Compliance



Summary

Ambulance Handover Delays >60 minutes: There is a common cause alert for this metric due to high values remaining in line with the mean. The 15 minute handover metric achieved the local stretch target. Average pre handover performance for the ICS was 19:57 in April, which achieved the 20:00 local stretch trajectory. May data will show a reduction against all trajectories as multiple bank holiday weekends and industrial action put severe strain on the local health and social care system, ultimately impacting flow and performance. The data from EMAS for May will include a breakdown of performance by site, allowing for more targeted improvement work to take place where trajectories are being missed.

Ambulance Response Times: Category 1 and 2 response times have returned to the mean position, which is higher than target . (Category 1 : immediate response is required due to a life-threatening condition, such as cardiac or respiratory arrest. Category 2 : serious conditions, such as a stroke or chest pain which may require rapid assessment and/or urgent transport).

A&E 4hr Wait: Data for NUH not yet available. SFH Apr23 = 75.6% against the 95% standard

Actions

Ambulance Handover Delays -the system advocates a total system partner response to delays with ambulances and aims to release ambulances at the earliest opportunity. Significant work has been undertaken across the front of the pathway to avoid admission and transfers into the hospitals, which can be evidenced by the reduced % of ambulance conveyances, however as the quantum of demand for ambulances has significantly increased this has still meant additional activity being directed to the hospitals overall. Reducing conveyances continues to be a focus across the system. Monthly meeting between senior operational leads from EMAS, BDGH, NUH, SFH and Urgent Care Resilience team taking place with aim of improving ambulance turnaround performance. All providers have now fully signed up to the local stretch trajectories.Monthly meeting between senior operational leads from EMAS, BDGH, NUH, SFH and Urgent Care Resilience team taking place with main-focus of improving ambulance turnaround performance.

Oversight Level – Escalated Risk

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

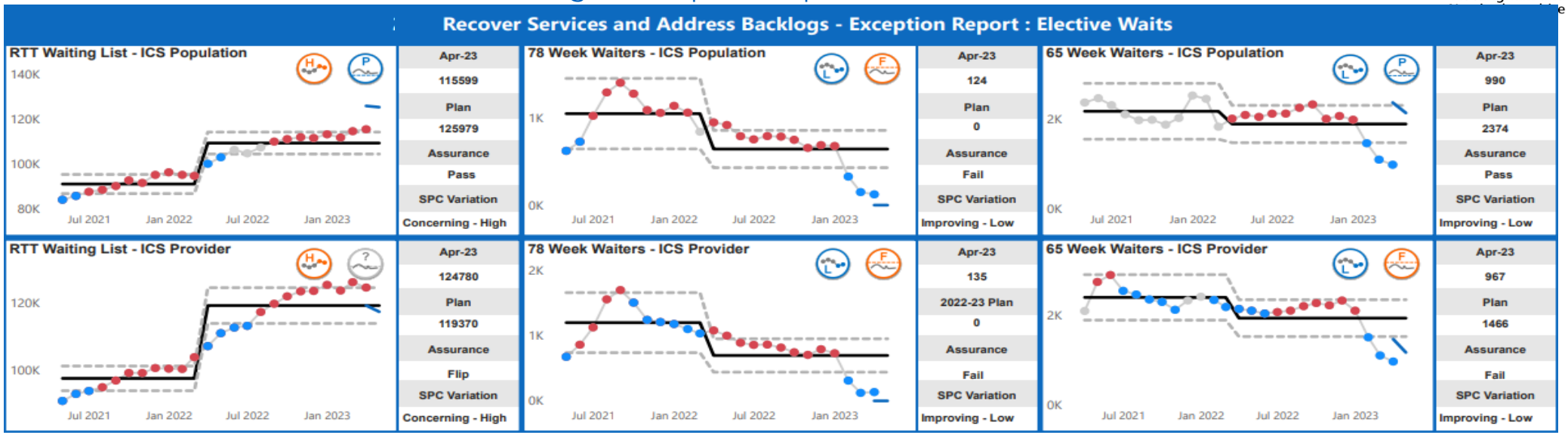
ED Quality Metrics – an NUH quality group has been established to implement a set of quality metrics for use in ED for long waiting patients. These metrics are regularly reviewed and discussed through the A&E Board.

Ambulance Delays – Despite the continued improved position since the peak in December, this 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. The routine monthly meeting with senior operational leads will be a key forum to identify opportunities to improve 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



Summary

Waiting List - showing concerning-high variation due to continual deterioration of the position and failure to deliver against the plan. The waiting list position continues to increase and a reduction of 5,410 patients is required to return to the April plan.

78 Week Waits - showing special cause low-improving variation as the position has improved to below the mean. This is positive as a reduction has been seen, However, the volume of 78 week waiting patients in April was 135 against a plan of zero.

65 Week Waits - showing special cause low-improving variation as the position remains below the mean. In April, there were 967 patients waiting 65 weeks or more for the system against a plan of 1,466.

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.

Patients waiting 78 weeks or more – Action is being taken to improve the position each week, supported by additional NHS funding. Actions include: mutual locally and nationally, insourcing, IS activity, increased theatre utilisation, and extra lists.

The forecast for the end of June 2023 is that there will be 83 patients waiting over 78 weeks. The forecast for the end of July is that zero patients will be waiting 78 weeks or more for treatment.

Oversight Level – Enhanced

Internal Oversight of the 104-week and 78-week position continues to take place daily by providers. Weekly meetings with NHSE/I enable a granular discussion around specialty level risks and mitigations.

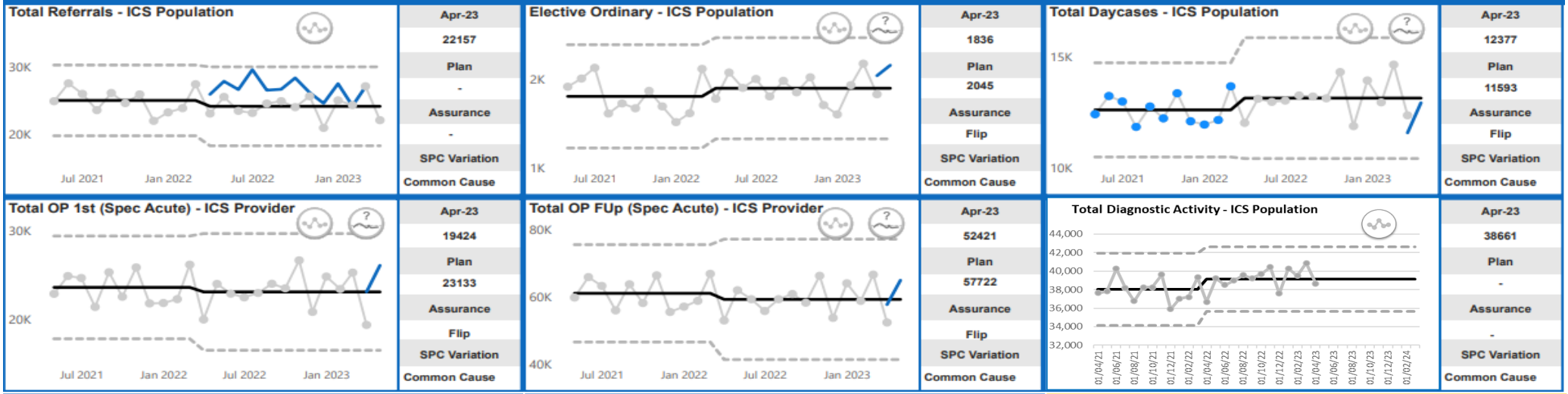
Provisional data shows that the system position for 78-week waiters is 115 patients at 25/06/23 (103 at NUH, 12 at SFH).

There is a high risk for elective orthopaedics and ENT patients at NUH and a moderate level of risks across other specialties. The current forecast for the end of June is 79 at NUH. SFH will have 4 patients waiting over 78 weeks, which are related to a patient being unfit for treatment and patient choice.

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

NHS Nottingham and Nottinghamshire

Recover Services and Address Backlogs - Exception Report : Activity

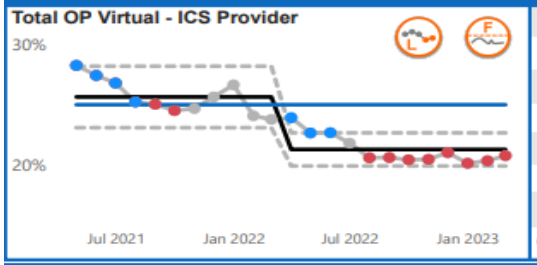


Summary	Actions	Oversight Level – Enhanced
These charts compare the April activity level to the operational plan. The charts include activity for the whole ICB population and at all providers (NHS and IS). All charts are showing common cause variation, which indicates a period of sustained activity around the mean (the black line). Elective Ordinary admissions, Day Cases, Outpatient First and Outpatient follow up activity levels were below plan in April for NUH and SFH combined. However, the volume of diagnostic activity was 573 tests or 1.9% above the planned level of 30,142 tests in month.	**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. Industrial action has constrained the volume of elective activity that has been delivered in April. **Sourcing Additional Capacity** -Fully utilising Independent Sector capacity and identifying mutual aid potential across NHS Providers where clinically appropriate. Around 700 patients have transferred between NUH and SFHT to support treatment and future agreements are in place to ensure a planned approach to transfers and mutual aid in the future.	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. There is also a risk around further industrial action. The system needs to determine the most appropriate way to protect elective activity wherever possible. The system also 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).

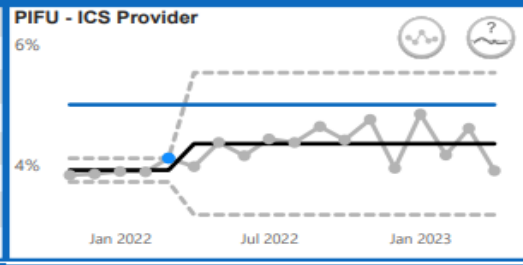
7.3c - Recover Services and Address Backlogs – Productivity & Transformation

NHS Nottingham and

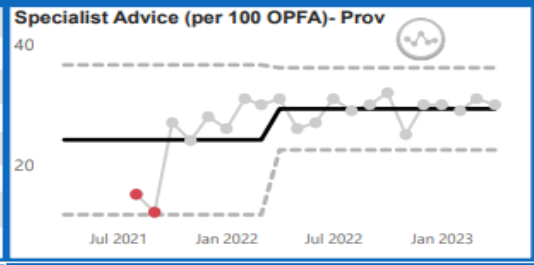
Recover Services and Address Backlogs - Exception Report : Productivity & Transformation



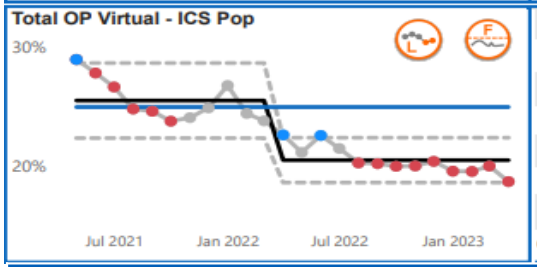
Apr-23
20%
Plan
25%
Assurance
Fail
SPC Variation
Concerning - Low



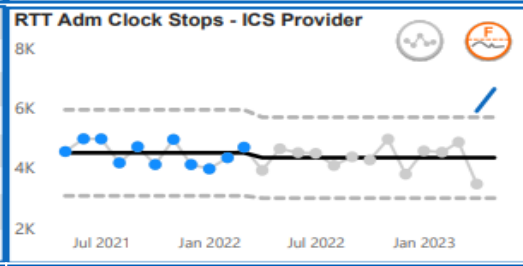
Apr-23
4%
Plan
5%
Assurance
Flip
SPC Variation
Common Cause



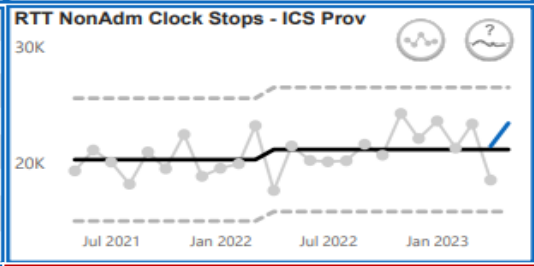
Apr-23
30
Plan
-
Assurance
-
SPC Variation
Common Cause



Apr-23
19%
Plan
25%
Assurance
Fail
SPC Variation
Concerning - Low



Apr-23
3466
Plan
5906
Assurance
Fail
SPC Variation
Common Cause



Apr-23
18547
Plan
21450
Assurance
Flip
SPC Variation
Common Cause

Summary

Outpatient Virtual: Concerning - Low variation, 'flip' target delivery as the target is near the mean. The latest position for the system is 19%, which is below the national standard of 25%. Since April 2022, the position for the system has reduced from 24% to the current position. **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. This remains a significant challenge for 23/24.

PIFU – did not achieved the target during 2022/23 and remains around the mean.

Advice & Guidance Target. The ICS has exceeded this standard throughout 2022/23, hence the 'pass' assurance that this is expected to deliver into future months. The utilisation rate in April 2023 was 30.

Admitted and Non-Admitted Clock Stops: These charts show common cause variation, but with a failure alert for admitted clock stops. Both admitted and non-admitted clock stops are below their respective plans in April. These need to significantly increase in order to impact on waiting lists and subsequently deliver the planned level of ERF funding.

Actions

Outpatient Virtual: The root cause of the underperformance at SFH has been a preference for clinicians to see patients face to face. A number of actions are to be implemented by the end of Q1 2023/24 to improve performance, these include - Presenting benchmarking data to divisions/specialties; approaching neighbouring trusts to identify specialties that are performing significantly better than SFH and find out the actions that they are taking; based on national guidance, developing a toolkit to assess suitability and appetite for each speciality to understand current virtual attendance position, potential trajectories, challenges and risks; trial capturing patient amenability to a virtual follow up appointment via reconciliation slips; develop communications to share with clinicians to highlight the benefits of virtual appointments.

Patient Initiated Follow Up (PIFU): As part of the 2023/24 planning round both providers submitted plans to increase the number of episodes moved or discharged to patient initiated outpatient follow-up pathway as an outcome of their attendance.

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.

Oversight Level – Escalated Risk

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.

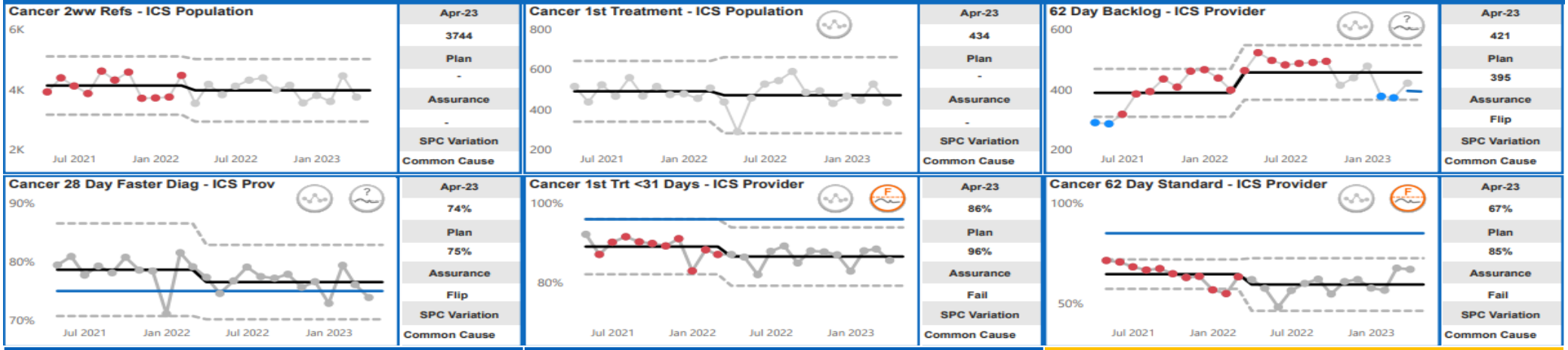
Utilisation of **Advice and Guidance** continues to consistently achieve the national standard. Work is taking place within the Elective and Outpatient board to understand variation in utilisation across the system in order to drive further work at place level.

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

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

NHS Nottingham and

Recover Services and Address Backlogs - Exception Report : Cancer



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 April 2021. This is across all tumour sites and continues to lead to pressures on services and impacts all other measures. SFH achieved the 2ww standard in April 2023 for the fourth consecutive month, NUH failed to meet the 93% standard, performance deteriorated to 84.22%.

28 Day Faster Diagnosis: common cause and 'flip' assurance indicate activity remains around the mean and will therefore hit or miss the target. FDS was not achieved by providers in April 2023.

31 Day & 62 Day Performance: Common cause assurance indicates activity remains around the mean and will therefore hit or miss the target.

62 Day Backlog: Common cause assurance, volumes have reduced and remains around the mean. Most 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.

To address the 62-day backlog, NUH continue to hold Internal meetings with all tumour site leads and clinical leads which enable discussion around reviewing approaches to follow ups, and forward scheduling theatres and treatments. 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.

The main issues preventing increase in performance at NUH are operational pressures and workforce challenges, especially within oncology treatment services. To recover performance the following actions are being taken –

- Weekly PTL meetings take place where potential delays are escalated and actions agreed, each tumour site has updated action plans in place which are reviewed regularly.
- Changes to cancer centre tracking have taken place, with greater daily senior management overview and improved escalation processes
- Cancer performance is overseen by Elective Pathway Board which receives regular reports from the Cancer Taskforce and continues to be monitored weekly by NHSE under Tier 3 performance monitoring

Oversight Level – Enhanced

62 Day Backlog- The latest weekly ICB data for week ending 25/06/23 is 366 patients against a plan of 390 patients. NUH have 316 patients against a plan of 333 and SFH have 50 patients against a plan of 57.

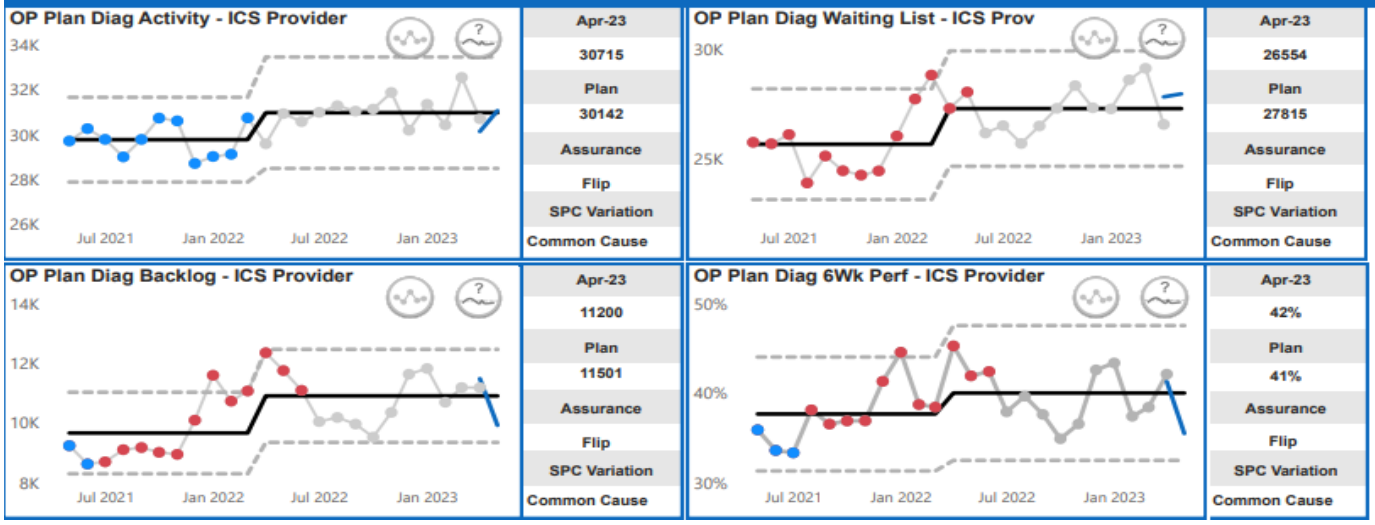
As at 25/06/2023 the proportion of patients waiting over 62 days at NUH is 10.88%, this is above the national position of 8.21%. The 104-week waiter meetings that take place with NHSE continue to cover cancer performance on a fortnightly basis. This enables a granular discussion to take place around plans to reduce the 62-day cancer backlog.

Industrial action has limited the volume of activity delivered, which has driven growth in the backlog volume during April and into May. Initial stages of a reduction in the backlog is beginning to be seen at NUH, with recent reductions seen via tracking the weekly unvalidated data.

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

NHS Nottingham and Nottinghamshire

Recover Services and Address Backlogs - Exception Report : Diagnostics



ICS Provider	Waiting List	Backlog	%
MRI	6,763	3,342	49.4%
Computed Tomography	4,037	1,339	33.2%
Non-obstetric ultrasound	6,978	1,794	25.7%
Echocardiography	6,259	3,672	58.7%
Colonoscopy	831	289	34.8%
Flexi sigmoidoscopy	501	297	59.3%
Gastroscopy	1,185	467	39.4%
Total - Plan Modalities	**26,554**	**11,200**	**42.2%**
DEXA Scan	1,010	191	18.9%
Audiology	1,723	635	36.9%
Neurophysiology	310	23	7.4%
Sleep studies	1,347	775	57.5%
Urodynamics	184	78	42.4%
Cystoscopy	406	133	32.8%
Total - All Modalities	**31,534**	**13,035**	**41.3%**

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 significantly 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: April at 40.33% with the 6-week backlog decreasing to 10,079 patients in the month.

MRI: challenging at NUH, however improvements have been seen over recent months. Mutual aid has been provided by SFHT during this time. However, the backlog remains high for the system at 3,342 patients at the end of April 2023.

Echocardiography: The data for April shows that Echo is performing at 58.89% for SFH and NUH. After a period of rapid increase, the backlog and waiting list are now showing signs of reduction at NUH. However, significant 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. A third MRI has been in place at QMC since the end of January, which has provided further capacity. However, this does place further pressure on the capacity to report the images.

Echocardiography (ECHO) at SFH continues to be very challenging. One team member has been on long term sick leave for a month and a routine locum staff member departed from the trust for a three-month period. These issues led to the backlog increasing by around 640 scans. The service has requested additional funding to be able to offer waiting list initiatives at weekends. The service are working to expand in-sourcing use. Longer term solutions around recruitment and the development of the CDC are required to support the service in future.

Oversight Level – Enhanced

In April, the activity level has exceeded plan, which is positive. The waiting list volume is below the planned level, but the backlog volume exceeds the planned level.

Variation in the waiting list and backlog volume of modalities within the system is significant between providers. This has been discussed at the Planned Care Board as well as the Diagnostic Board. The ICB Is convening a meeting with providers to discuss mechanisms to address this and explore how the pressures could be re-balanced within the system.

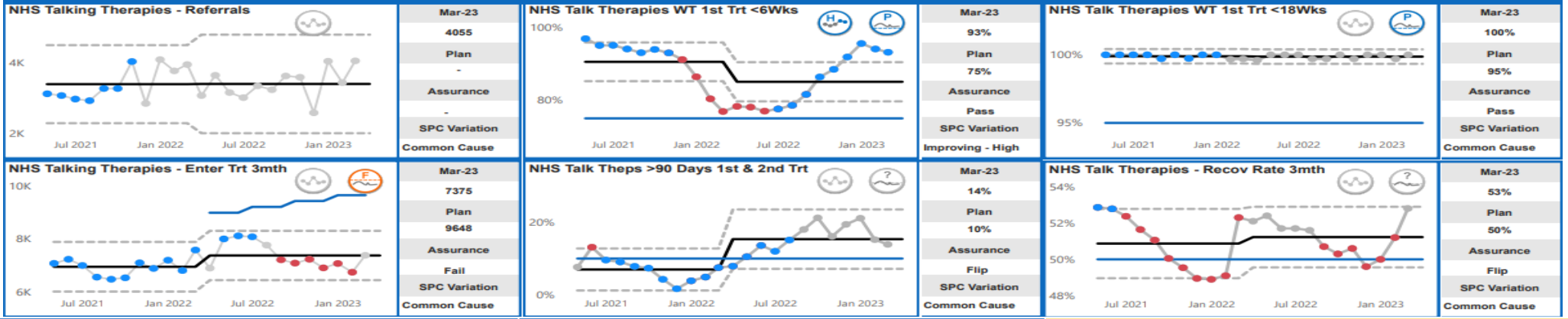
(To note: the 2023/24 end of year target is to achieve 15% within 6 weeks, green highlights are below 15%, amber highlights are below 25%)

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

Recover Services and Address Backlogs - Exception Report : Mental Health - NHS Talking Therapies



Summary

NHS Talking Therapies (formerly IAPT) referrals are above the mean showing common cause variation.

Treatment numbers (3-month) rolling access performance remains under target, with 7375 patients entering treatment against a target of 9648. Referrals increased by 18% in quarter 4 compared to quarter 3, but numbers into treatment increased by 5%.
The service continues to achieve and exceed the 6 week (93.2%) and 18 week (100%) waiting time standards. The average wait for treatment for March 2023 was 21 days in line with previous months. Fewer people waited over 90 days for their 2nd appointment (13.9%, down from 15.2% in February).

Patients **waiting over 90 days** between 1st and 2nd treatments have reduced, causing a common cause alert in month.

Recovery Rate achieved the 50% target and has flip assurance and common cause variation.

Actions

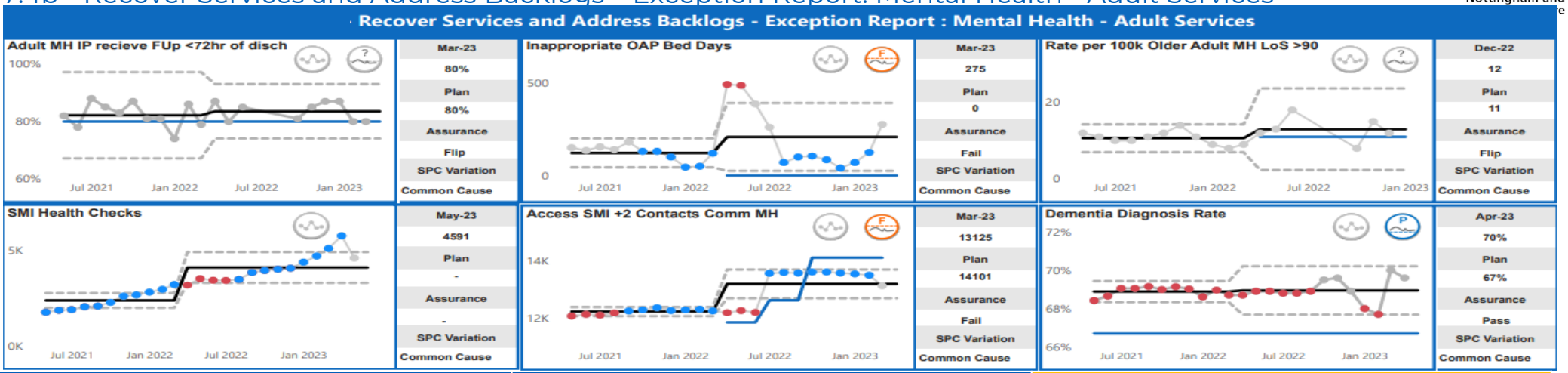
The new service went live 1 April 2023, actions are now focussed on the new provider working through their inherited caseload and managing new referrals into the service. Actions being taken include:
- Monthly monitoring of data to review variation in activity numbers and assess impact of mitigations plans
- Capacity – additional capacity implemented March 2023 for a waiting list initiative. The impact of this will be when March referrals complete treatment. The provider is utilising agency staff to mitigate gaps in the workforce plus ongoing recruitment. 26 Psychological Wellbeing Practitioners (PWP) and High Intensity Therapists (HIT) trainees started in March, a further 51 will commence later in the year which will further increase capacity.
- Access – ICB led mental health communications includes talking therapies promotion as part of a mental health toolkit which has been distributed to stakeholders to promote services. New ICB mental health communications lead working with provider communications lead to join up with system communications activities. The provider is developing a marketing plan which will include targeting key populations and organisations in each place through marketing and engagement.
- Waiting times – waiting list initiative commenced March 2023 to relieve waiting pressures during transition to the new provider; increased capacity as above to mitigate establishment gaps; plan to hold assessment focused weeks in May and June for step 2 staff supporting the longer waiting for assessment list.

Oversight Level – Further Information Required

Mobilisation of the new provider is complete with monthly formal contract meetings in place to review delivery and performance.

Recovery of the plan for those entering treatment will be monitored through this process.

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



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
OAPs - In Q4 2022/23 there were 456 OBDs, against a trajectory of 0. This is a decline on the quarter 3 position where 154 OBDs were reported. The number of OBDs reported in April 2023 has increased to 328 from 275 in March 2023. Performance impacted by demand for inpatient admissions, patient acuity, and complex delayed patients which means that there are still patients being placed out of area when local provision is full.
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 -In 2023/24 the ICS target is 7029, the May 2023 performance is below target, however, is showing an improved position compared to the same time last year. There is variation in performance across the ICS, in Bassetlaw performance is greatest (62.7%), with Nottingham City the lowest performing place (49.3%). Actions are underway to improve performance. City have the greatest SMI prevalence and a population that is harder to engage.
Adult SMI +2 contacts - are under plan and are not likely to achieve plan as the stepped increase has not been delivered (Fail assurance)
Dementia –The ICB continues to exceed the national dementia diagnosis rate standard (69.6%) in April 2023. Performance remains above the regional average (61%).

Actions

OAPS - Crisis Resolution and Home Treatment Teams (CRHT) delivering Intensive Home Support and in-reach to wards. CRHT are providing 24/7 home treatment. The 24/7 mental health crisis helpline is provided in partnership by NHT and Turning Point (VCS). A partnership with national charity TextShout went live in March 2023.
SMI Health Checks - An ICS recovery action plan is in place to support improvements in performance. Actions include:

- Engagement with PCNs is underway during Q1 to understand the variation across the ICS, exploring practice processes in inviting patients in for checks, use of tools such as GP workflows, recording and reporting. This will complement the Health Improvement Worker review and will identify opportunities for sharing best practice and identifying support needs.
- The data recording system being used by Health Improvement Workers (HIWs) is transferring to SystemOne which will improve data analysis and identify the split of activity in primary and secondary care. Training for HIW on the new system has commenced and is expected to be rolled out by the end of June 2023.

Dementia - MAS teams continue to flex staffing, to ensure equitable waits across the system. Non-recurrent funding of 2.2 WTE Non-Medical Prescribers has been agreed to increase capacity and manage waiting times from 2022/23, this has been made recurrent from April 2023.

Oversight Level – Enhanced

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.

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.

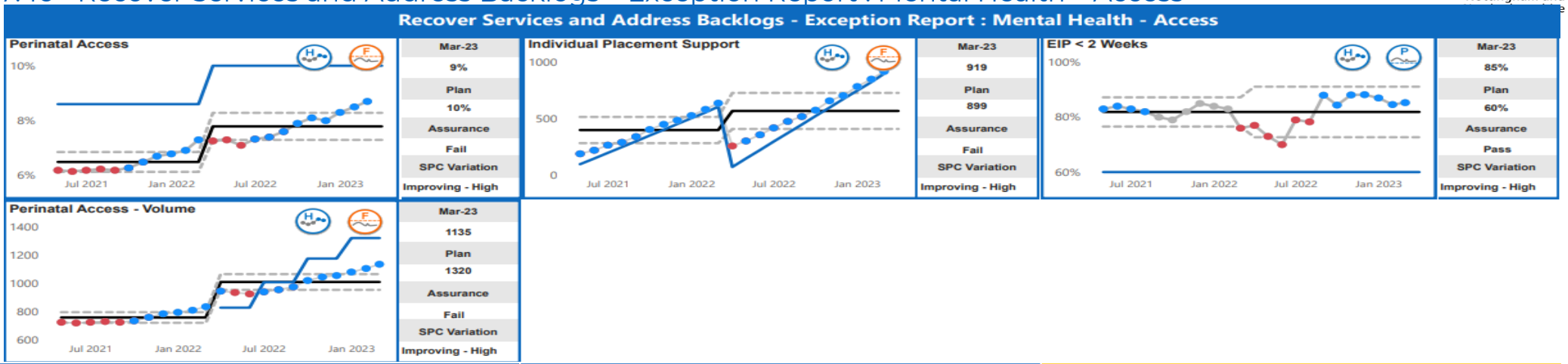
Dementia - The Memory Assessment Service (MAS) has reduced average waited waiting times significantly since its reinstatement in September 2020 from 36 weeks to 12.7 weeks in April 2023.

An NHSE led audit of MAS took place in February 2023 and the MAS service signed up to the Memory Services National Accreditation Programme (MSNAP) process in November 2022 with results from the self-review published in April 2023. The results from these findings have been embedded into a new waiting time recovery plan.

The Older Person Mental Health Delivery group continues to meet monthly to monitor MAS performance, reporting up to the ICS Dementia Steering Group where required.

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

NHS Nottingham and



Summary

Perinatal - Performance continues to remain below the 2023/24 10% access target. Performance in Nottingham and Nottinghamshire is below the access rate and the original forecast trajectory, with the two biggest contributors being low referral numbers into the service and disengagement within the service.

IPS - The ICS performance is exceeding trajectory with 315 people accessing IPS as of April 2023.

EIP - The access standard has been consistently exceeded at an ICS level.

All access standards are at Level 3, Performing Well or above with Access and Supported Employment and Education at Level 4, Top Performer.

Data for March 2023 shows a slight decrease in performance with 85% of patients accessing EIP within 2 weeks, compared to 84.2% in February 2023.

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.
- The continuation of the facilitation of workshops for parents/carers at Children's Centres to raise awareness of perinatal mental health and the support available – March 2023 onwards. The team review in June 2023 to establish how effective the workshops were i.e.., attendance and any feedback
- Continuous targeted work within areas where there is underrepresentation (BME groups) to understand reasons and increase engagement.
- Exploring alternative venues across the City and County where it is recognised that there are higher levels of disengagement within the service or that that access to clinics can be a barrier – complete.

EIP - The focus remains on maintaining a level 3 NICE compliant service and ensuring the access standard is met. The service received positive NCAP results in May 2023 with the service identified as 'Top Performing'.

An ARMS pilot model has been fully recruited to in Q3 2022/23 and commenced in Q4 2022/23. The model will be tested with the North EIP Team and across the Children and Young People Head 2 Head service, before interim evaluation across the ICB in Q2 2023/24.

Oversight Level – Enhanced

Perinatal - The team is commissioned to meet the LTP ambition. An ICS Perinatal Recovery Action Plan has been developed, with an update for 23/24 due to be presented to NHSE shortly. The recovery improvement trajectory is March 2024 (12 months rolling performance). The provider submits data for the Trauma and Bereavement service under a team code for the Maternal Mental Health Service (F02) rather than the perinatal code (C02). It is important to note that national reporting on a rolling 12-month metric includes C02 and F02, whereas the year-to-date metric just includes C02, and should be reviewed with caution as it will not include all activity which contributes to the target.

IPS - All four place-based IPS teams have completed fidelity reviews achieving centre of excellence status. Reviews are accompanied by an action plan for further improvement. These are reviewed on at the IPS steering group.

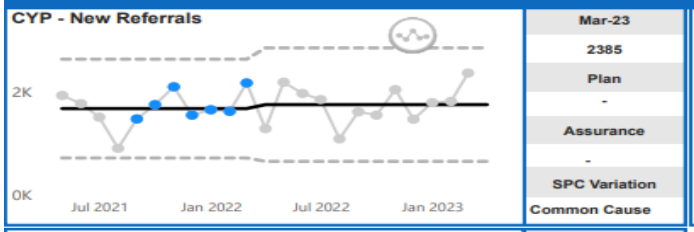
The IPS steering group continues to meet bimonthly to monitor and address performance, issues, and risks. Work has been undertaken to improve reporting and data capture which is anticipated to have a positive impact on the referral numbers. All vacant posts have now been recruited to and are operational. Staffing numbers have increased to ensure equity of access in Bassetlaw. New staff are in post and are operational.

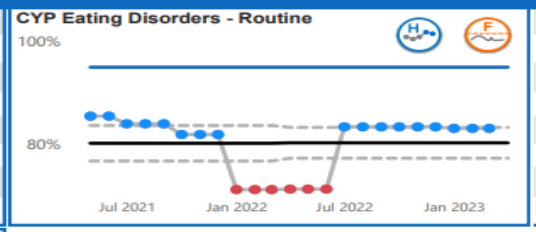
EIP - The EIP Steering Group continues to meet bi-monthly to review progress against agreed actions

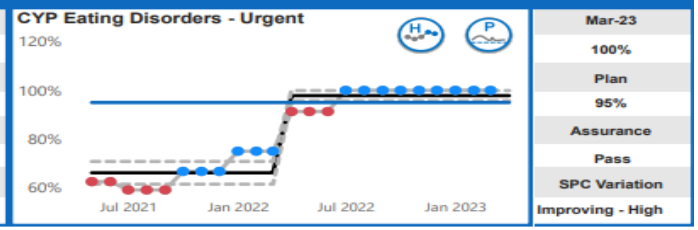
7.4d - Recover Services and Address Backlogs – Exception Report : Mental Health – Children & Young People

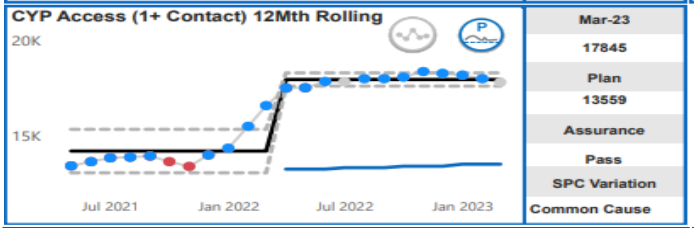
NHS Nottingham and Nottinghamshire

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







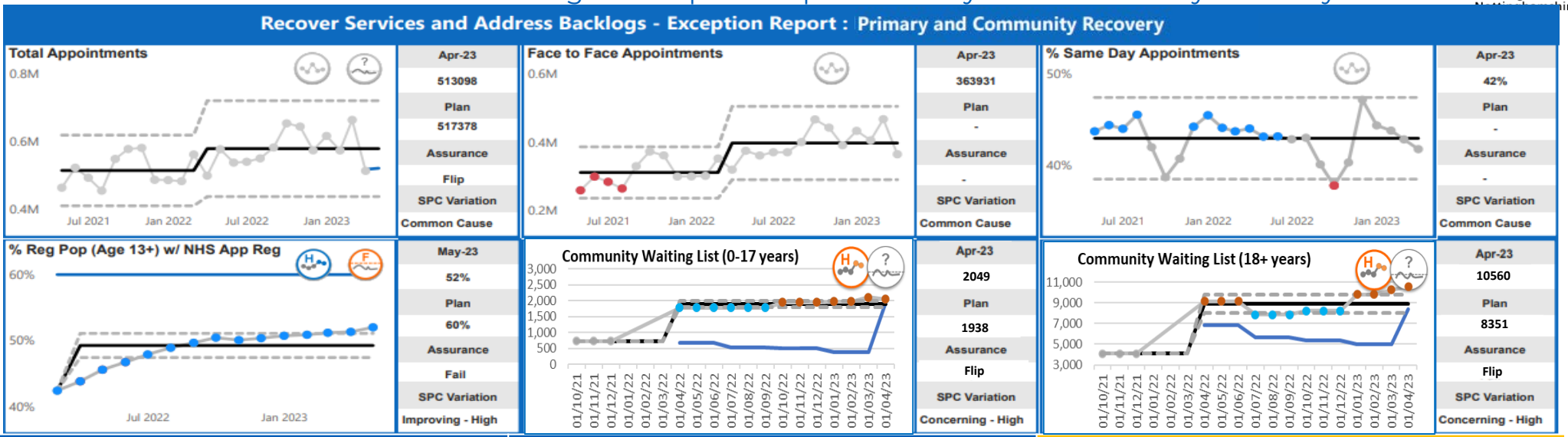


Summary	Actions	Oversight Level – Further Information Required
CYP Referrals – have remained around the mean and are showing common cause variation. **CYP Access (1+ Contact)** - The ICS is exceeding the access target of number of children and young people (CYP) receiving support (1-contact); 18,030 CYP were recorded as having at least 1 contact in the rolling 12 months ending March 2023 exceeding the annual plan of 13,559. **CYP ED Routine (< 4 weeks)** - Improving - High variation due to the improvement 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.	**CYP Access** – None Required **CYP Eating Disorder Service** - 2023/24 investment plans have been agreed to increase capacity to achieve the waiting time standards. This will include a service offer to support children and young people presenting with Avoidant Restrictive Food Intake Disorder (ARFID). This remains on track and scheduled to be operational by September 2023. The service is working on several initiatives to eliminate the risk of service-related breaches including: •Working closely with Community Teams to ringfence availability for joint assessments •Reviewing space utilisation to expand access to clinical room availability. The service is looking to become co-located within an all-ages eating disorders hub which will create more clinic space. The team are working towards this, and whilst no exact timescales are available currently, an engagement session is planned for the 27th July. This is to explore with the CYP and adult eating disorder teams any barriers that may exist in moving to this model, and from there they can build on developing an all-age service. A recovery trajectory for 23/24 will be developed during Q1 23/24. Work will continue with NHS England to ascertain if reduction in access is a national picture.	**CYP Access** -Investment has been agreed to deliver the Long Term Plan objectives for 2023/24 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. 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 monthly. Exception reporting is received as part of monthly contract reports which is received by the ICB at the end of each month. This is reviewed and used to inform performance reports and CYP ED action plan. Themes are reviewed and these currently link to patient choice.

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



Summary

Total GP Appointments in April were 0.8% below the planned level. The percentage of appointments held face to face remains consistent with previous months at 70.9%. GP Appointments within two weeks data shows that 76.2% of appointments were offered within two weeks in April 2023.

NHS App - registrations onto the NHS App have continued to increase over the past few years. The ICB remains under the target of 60%%, with the current position at 52% in May.

Community Waiting Lists - The April position has been received and aligned to re-based plans for 2023/24. It shows that there are significant pressures on the adult waiting list. There are high levels of demand with extended waits for patients for some services.

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 the PFDS programme as the strategic direction is NHS App as the single front door.

The DDAT team (Digital and Data team) have been supporting GP practices to promote the NHS App via specific targeted communication activities such as social media, radio ads and bus and tram advertisement.

Oversight Level – Enhanced

The waiting list for adults has increased gradually from the January position of 9,168 through to the April position of 10,560. Analysis is taking place to break the position down by constituent service, which will be escalated for discussion with the providers. There are also long waits for some services, which will also be part of the dialogue.

NHS
Nottingham and Nottinghamshire

8.0 Finance

ICS Aim 3: Improving the Effective Utilisation of Our Resources (Enhance productivity & VFM)

8.1 Month 2 Financial Position

8.2 Organisational Analysis

8.3 Efficiency & Productivity Plans

8.1 - Finance Position Month 2 2023/24 – Key Metrics

- £29.5m deficit at month 2. £18.9m adverse to plan.
- £10.6m planned deficit due to efficiency schemes planned for later in the year and profiling of UEC stretch plans.
- On review of plans there is a phasing issue at NUH where income target is misaligned to UEC improvement trajectory. If this were adjusted it would lead to a £5m improvement at month 2.
- The position assumes coverage of ERF shortfall up to 105% due to strike action.
- Drivers of the variance can be seen in the table to the right. Top 3 areas, driving £15.8m of the variance:
  - UEC stretch not achieved - £7.3m (noting point above)
  - Internal efficiency programmes - £2.9m
  - Pay/agency costs above planned levels - £5.6m of which:
    - £3.6m at NUH due to substantive recruitment enacted as per the plan but agency costs remain in place
    - £2.0m increased agency costs at NHT due to increased acuity, high staff absence and off-framework agency rates.
- All partners continue to forecast to achieve break-even. There are significant risk to the achievement of this position.
- Financial risks remain as described in the plan. Key risks includes inflation, efficiency, urgent care pressures and elective recovery.

Month 2 Financial Position Year to date variance £'m	YTD Plan	YTD Actuals	YTD Variance	Forecast
NUH	-£5.3	-£18.6	-£13.3	£0.0
SFH	-£2.9	-£3.9	-£1.0	£0.0
NHT	-£2.4	-£7.0	-£4.5	£0.0
N&N ICB	£0.0	£0.0	£0.0	£0.0
TOTAL	**-£10.6**	**-£29.5**	**-£18.9**	**£0.0**

Drivers of Variance £'m	NUH	SFH	NHT	ICB	Total
UEC stretch target not achieved	-6.2	-1.1	0.0	0.0	-7.3
Organisational efficiency programmes	-1.7	0.4	-0.6	-1.0	-2.9
Unmitigated stretch target	0.0	0.0	-1.6	0.0	-1.6
NR impact of industrial action (April)	-1.7	-0.3	0.0	0.0	-2.0
Inflation & pay award pressures	0.0	0.0	-1.0	0.0	-1.0
Pay/agency run rate pressures	-3.6	0.0	-2.0	0.0	-5.6
Offsetting mitigations/balance	-0.1	0.0	0.6	1.0	1.5
TOTAL	**-13.3**	**-1.0**	**-4.5**	**0.0**	**-18.9**

8.2 - Finance Position – Organisational Analysis

Orgn - as at M2 £'m	YTD Plan	YTD Actuals	YTD Variance	In-month Plan	In- month Actuals	In Month Variance	Total FY Plan	FOT	Variance
NUH	-5.3	-18.6	-13.3	-1.3	-6.9	-5.6	0.0	0.0	0.0
SFH	-2.9	-3.9	-1.0	-1.4	-2.4	-1.0	0.0	0.0	0.0
NHT	-2.4	-7.0	-4.5	-1.3	-4.6	-3.2	0.0	0.0	0.0
N&N ICB	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	**-10.6**	**-29.5**	**-18.9**	**-4.1**	**-13.9**	**-9.8**	**0.0**	**0.0**	**0.0**

NUH

- Year to date position of £18.6m deficit, which is £13.3m adverse to plan.
- This is mainly driven by UEC stretch target not achieved £6.2m above plan, £1.7m shortfall on internal efficiency programme, impact of industrial action £1.7m and £3.6m pay/agency run rate pressures above plan.
- The pay run rate pressure is due to substantive recruitment enacted as per the plan but agency costs remain in place

SFH

- Year to date position of £3.9m deficit, which is £1m adverse to plan.
- This is mainly driven by UEC stretch target not achieved £1.1m above plan, £0.4m over-achievement on internal efficiency programme and impact of industrial action £0.3m.

NHT

- Year to date position of £7.0m deficit, which is £4.5m adverse to plan.
- This is mainly driven by £0.6m shortfall on internal efficiency programme, £1.6m shortfall on unmitigated stretch target, £1m inflation & pay award pressures and £2.0m pay/agency run rate pressures above plan.
- The agency pressure due to increased acuity, high staff absence and off-framework agency rates.

ICB

- Year to date and forecast break-even position against plan at M2.
- Forecast pressures include continuing healthcare (CHC) £1.0m adverse forecast, community contracts £0.8m adverse forecast, mental health £1.6m adverse forecast and prescribing £1.6m adverse forecast.
- Offsetting these overspending areas is a forecast underspend on main reserves which effectively is an assumption that there will be slippage on allocations and other budgets held in reserve.

8.3 - Finance Position – Efficiency and Productivity Plans

Organisational Efficiencies

- The majority of the system efficiency programme will be delivered within partner organisations.
- The financial plan describes flat growth in workforce and pay bill. The focus of our efficiency schemes are therefore to deliver improved performance and increased activity within existing resources
- Key delivery schemes include – covid expenditure, agency reduction, procurement, medicines management, GIRFT, theatre utilisation, outpatient innovation and reduction in MH private bed usage
- The ICS Finance Director's Group has renewed its focus to oversee delivery of the financial challenge at a system level including scrutiny of the efficiency programme, identifying gaps and driving action where appropriate.

Efficiency Development Status	2023/24 Plan £'m	M2 reporting £'m	M2 FOT Movement: Increase / (Decrease) £'m
Fully Developed	34.8	76	41.2
Plans in Progress	70.5	14.9	-55.6
Opportunity	81.9	95.4	13.5
Unidentified	5.5	6.4	0.9
Total Efficiencies	**192.7**	**192.7**	**0.0**

Urgent Care Reform and Elective Recovery

- The 2023/24 operational plan is reliant on reform of the urgent care system to reduce the burden on bedded capacity across the pathway.
- This will release cost and allow our acute hospital services to focus on elective recovery – leading to reduced waiting lists and increased elective income.
- A system wide urgent care reset has been established alongside an external delivery partner. A focussed piece of work has been taken forwards in advance of business case approval. This includes initial review of all of the schemes that will contribute to delivery of the plan and understand the collective impact.
- The system will work with the UEC partner to instigate a regime to monitor the key metrics on a regular basis and seek mitigation where the plan is off-track.

Productivity

- Key system wide workstream in place that continues to establish a granular understanding of cost increases through the pandemic period.
- Work to date has established that 10% of our 24% increase in cost base relates to activity without any commensurate increase in activity. 23/24 plans look to address this with significant increases in elective activity within existing resources.
- Further work through the productivity workstream will look to identify areas of lost productivity at a service level, which will support development of targeted efficiency schemes.

NHS
Nottingham and Nottinghamshire

9.0 People and Culture

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

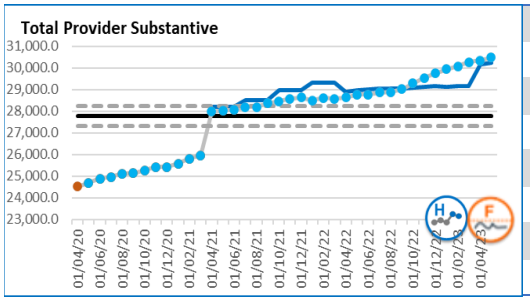
- 9.1 – Workforce – Exception Report Provider Workforce – Operational Plan v Actual
- 9.2 – Exception Report Agency Cost
- 9.3 – Exception Report Agency Usage
- 9.4 – Social Care Employment Overview
- 9.5 – Social Care Projections
- 9.6 – Care Homes Workforce

9.1 - Workforce – Exception Report Provider Workforce – Operational Plan v Actual

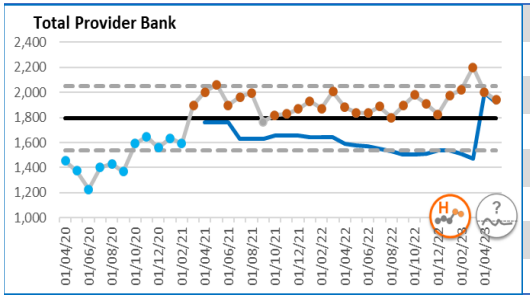
NHS Nottingham and Nottinghamshire

Workforce

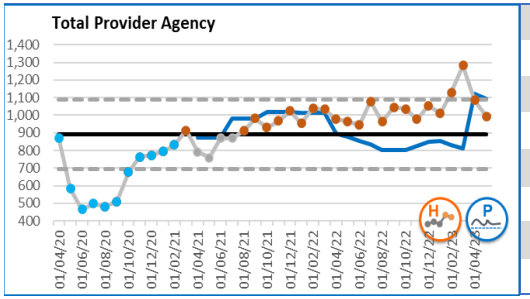
Total ICB Provider Workforce - Operational Plan v Actual 2023/24



May-23
30471.7
2023-24 Plan
30229.1
Assurance
Fail
SPC Variation
Improving - High



May-23
1939.5
2023-24 Plan
1922.5
Assurance
Fail
SPC Variation
Concerning - High



May-23
994.2
2023-24 Plan
1095.5
Assurance
Fail
SPC Variation
Concerning - High

Trust Positions

	NUH			SFH			NHCT		
	May Planned	May Actual	Variance to Plan	May Planned	May Actual	Variance to Plan	May Planned	May Actual	Variance to Plan
No. Substantive staff	17,139.2	17,251.2	112.0	4,781.0	4,935	154.4	8308.83	8,285	- 23.8
No. Bank Staff	948.5	872.7	- 75.8	568.7	471	- 97.6	405.21	596	190.5
No. Agency Staff	704.3	566.3	- 138.0	125.1	113	- 12.4	266.17	315	49.1
Total Workforce	**18,792.1**	**18,690.2**	**- 101.9**	**5,474.8**	**5,519**	**44.4**	**8980.21**	**9,196**	**215.8**

Actions

Trusts continue with action on recruitment and retention strategies to achieve the substantive staff in post position which includes both international and domestic recruitment.
Improved utilisation of bank staff is a positive position as is the reduction in agency usage. However, this needs to be assessed against the spend and in particular the off framework and above price cap as the rates of pay may well be at a premium it is not positively affecting the expected reduction in cost. The Agency Reduction working group will be reviewing the month 2 usage and spend in detail and assessing the impact of trust action plans.
The appointment of a System Retention lead (delayed twice due to changes in the hosting arrangements of this secondment role) will enable interrogation of the WTE position and trends around leaves to ensure we have the right actions to continue to support substantive staffing positions required to meet the challenging agency reductions built into provider plans.

Total Provider Current position:

A stepped change in the plan for 2023-24 compared to the plan for 2022-23 is seen which is as a result of improved processes in determining the plans and stronger alignment with the financial plan. The total provider WTE position for substantive, bank and agency are above the plan for this month. However, when looking at the separate Trust positions NHT presents a different picture to the other two trusts with lower than plan substantive, above plan bank usage and above plan agency usage is seen.

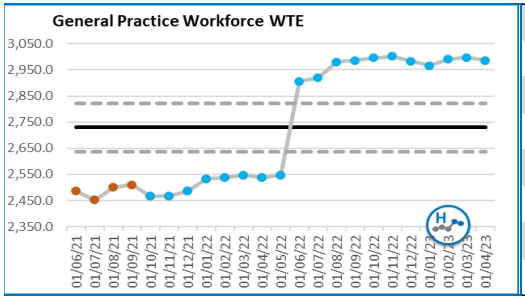
P&C Group Limited Assurance - Further Information Required

Total Providers:
Plans are in place as per submitted operational plan improved monitoring of in- year performance in progress impacted by national return changes to the PWR .

9.1 - Workforce – Exception Report Provider Workforce – Operational Plan v Actual (continued)

NHS Nottingham and Nottinghamshire

Total ICB Primary Care Workforce - Operational Plan v Actual 2023/24



Apr-23
2987
Target
Assurance
SPC Variation
Improving - High

Primary Care	Baseline Staff in post outturn	Actual	Plan Q1	Plan Q2	Plan Q3	Plan Q4
Nottingham And Nottinghamshire Health And Care STP	Year end Mar-23	As of the end of Apr-23	As at the end of Jun-23	As at the end of Sep-23	As at the end of Dec-23	As at the end of Mar-24
Workforce (WTE)	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE
Total Workforce	3505	3495	3539	3624	3687	3731
GPs excluding GPs in Training Grade	580	568	574	571	576	570
GPs in Training Grade	235	233	226	254	263	256
Nurses	355	358	356	356	359	359
Direct Patient Care roles (ARRS funded)	507	554*	546	596	634	679
Direct Patient Care roles (not ARRS funded)	272	274	270	272	273	277
Other – admin and non-clinical	1556	1508	1568	1574	1582	1589

Total Primary Care Current position:

Data collection at practice level shows variation due to unclear definitions on the workforce detail to be recorded. The workforce data is therefore indicative data.

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.

A workforce programme for 23-24 has been submitted to region awaiting national team feedback. A potential risk exists of reduced funding for workforce schemes

P&C Group Limited Assurance - Further Information Required

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.

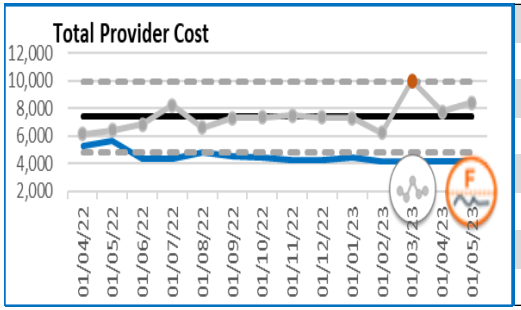
Leads from the Primary Care Workforce group are engaging with PCN leads to determine next steps in supporting retention and recruitment challenges being experienced.

The re-establishment of the Primary Care Transformation Board will provide direction in relation to requirements in delivering the primary care strategy noting changed models of care, at scale and move to integration.

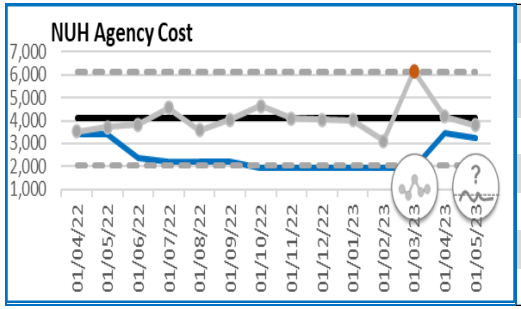
9.2 – Workforce – Exception Report Agency Cost

NHS Nottingham and Nottinghamshire

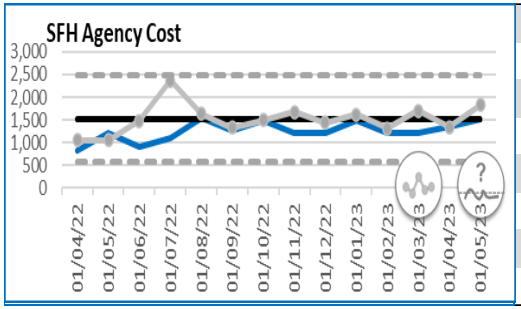
Total Provider Agency Cost



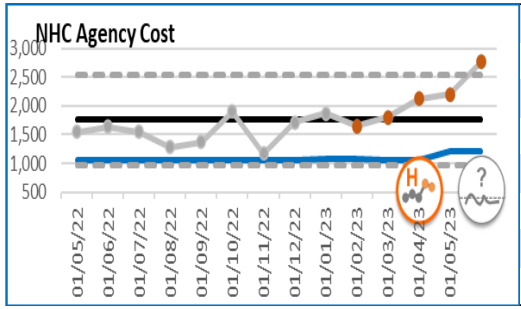
May-23
£8,381
Assurance
Fail
SPC Variation
Common Cause



May-23
£3,789
Assurance
Fail
SPC Variation
Common Cause



May-23
£1,825
Assurance
Flip
SPC Variation
Common Cause



May-23
£2,767
Assurance
Fail
SPC Variation
Concerning - High

Summary

The underlying cause of agency use/cost is the impact of increased demand and industrial action. WTE reports through Provider Workforce Returns for month 2 informs that the providers are above plan on substantive, have increased use of bank staff but still below plan and that agency usage has reduced. This summary position masks the individual trust positions with NHT being an outlier in terms of below plan

Actions

Trusts have individual action plans to deliver the expected reduction in agency usage and spend which crosses over recruitmen, retention and wellbeing strategies. The Agency Reduction Workign Group will review the month e 2 position and actions plans to strengthen teh actions or define new actions required. The group meets on 22.06.23 and will generate a highlight report to detail the current actions taken or in place.

People & Culture Group Assurance - Further Information Required

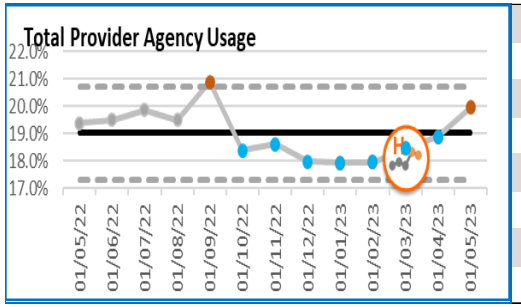
Plans are in place but more detail is needed to determine if further targeted interventions are required.

Please note plan trajectories will be included in future reports on the two key metrics once available from Finance

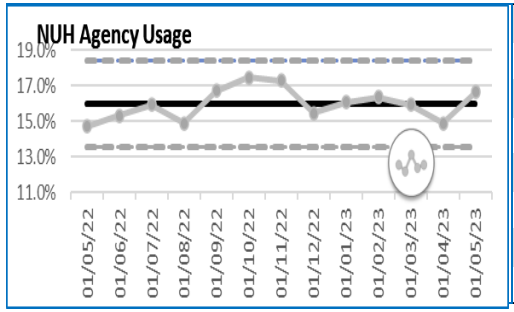
9.3 – Workforce – Exception Report Agency Usage

NHS Nottingham and Nottinghamshire

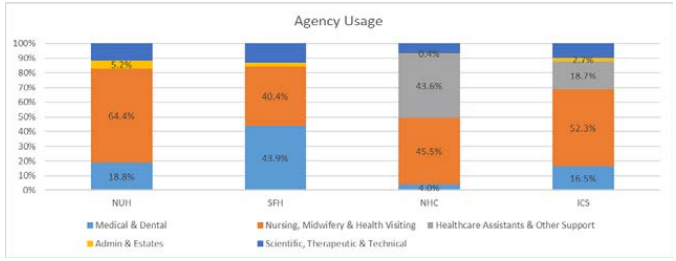
Total Provider Agency Usage

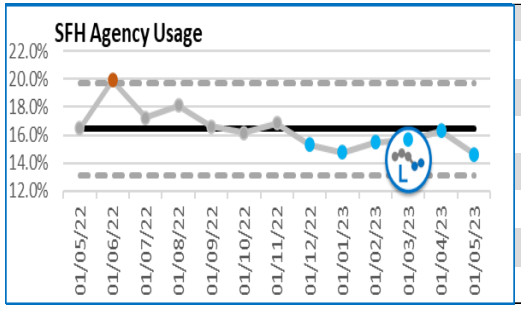


May-23
19.95%
2023-24 Plan
-
Assurance
-
SPC Variation
Common Cause

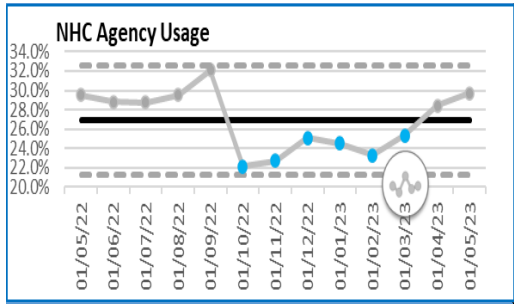


May-23
16.62%
2023-24 Plan
-
Assurance
-
SPC Variation
Common Cause





May-23
14.61%
2023-24 Plan
-
Assurance
-
SPC Variation
Common Cause



May-23
29.69%
2023-24 Plan
-
Assurance
-
SPC Variation
Common Cause

9.4 – Workforce – Social Care Employment Overview

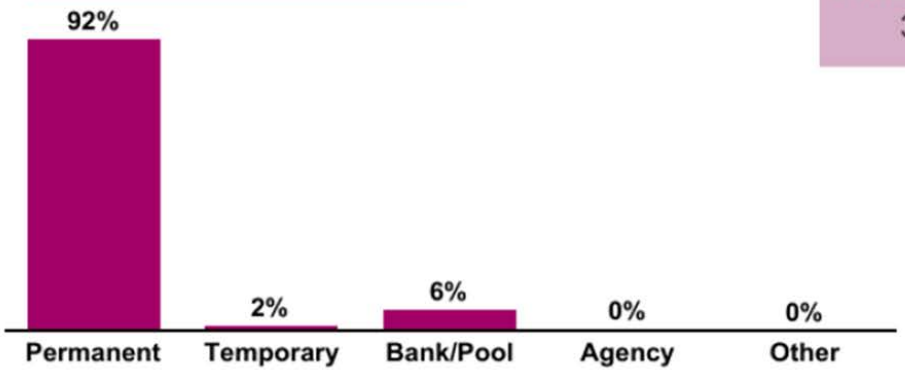
NHS Nottingham and Nottinghamshire

Integrated Care System

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**)

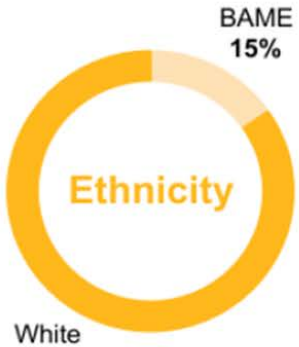
Demographics

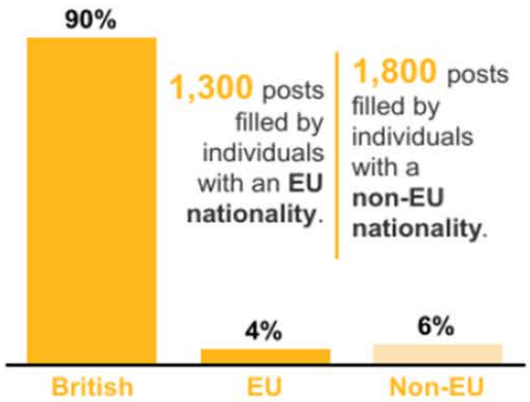
Gender

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

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

Ethnicity and nationality



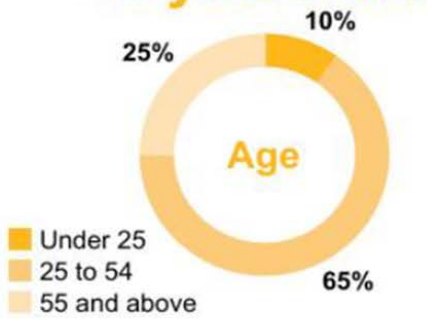


1,300 posts filled by individuals with an **EU nationality**.

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

Age

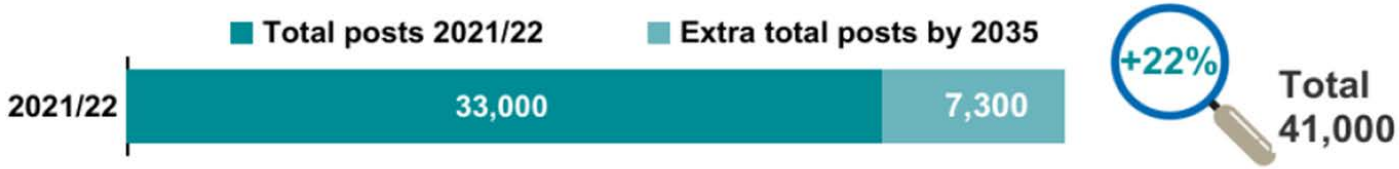
The average **age** was
43 years old



9.5 – 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.

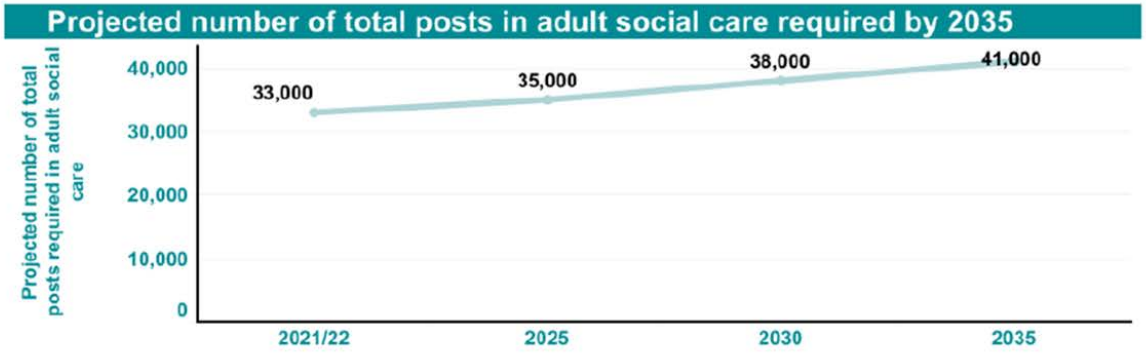


If the adult social care workforce grows proportionally to the projected number of people aged **65 and over** in the population then the number of adult social care filled posts will...

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



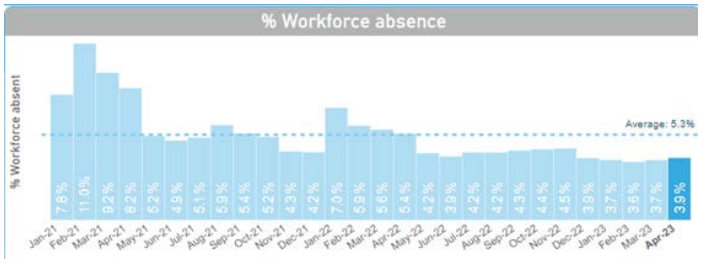
9.6 – Workforce – Care Homes

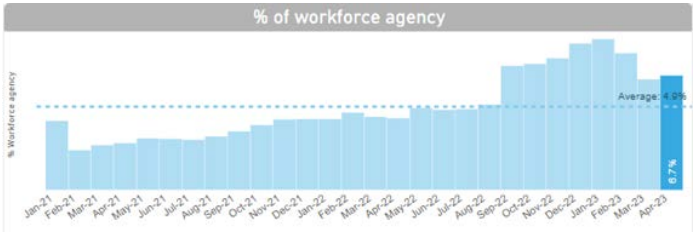
Care Homes Workforce

Workforce absence and agency staff

Monthly staff trend: All staff

Aligned PBP	Employed	Absence	%	Agency	%
Bassetlaw	1,560	40	2.6%	149	8.7%
Mid Notts	4,290	201	4.7%	281	6.1%
Nottm City	2,616	94	3.6%	166	6.0%
South Notts	4,478	165	3.7%	332	6.9%
Total	**12,944**	**500**	**3.9%**	**928**	**6.7%**





Data and visuals taken from the Care Home & Home Care SIR April 2023 on the SAIU Portal

Care Home workforce absence is a currently 3.9% across all staff groups. This is much lower than the 8.2% during Apr 21 and 5.4% during Apr 22. During Apr 2023, nursing staff have the lowest absence reporting with 2.3%, non care workers are reporting 3.8% absence. Care Workers are the largest staff group and are reporting the highest 4% absence

Agency staff percentage increased significantly up to Jan 23. This was possibly due to incorrect reporting by the Care Homes on the National Capacity Tracker. After raising this in the Care Home and Home Care Data Streams - Operational Meeting, this number has now started to decrease. 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 – Health Inequalities Headlines
- 10.2a – The 5 in the 'Core20plus5' Adults
- 10.2b- The 5 in the 'Core20plus5' Children
- 10.3 – A Neighbourhood Overview
- 10.4a – Access and Experience – Waiting Lists
- 10.4b – Access and Experience – Waiting Lists
- 10.5a - Health Inequalities Dashboard – Ethnicity
- 10.5b - Health Inequalities Dashboard - Deprivation

10.1. - Health Inequalities Headlines

NHS Nottingham and Nottinghamshire

Key Deliverable
Core20+5 Accelerator - The core group has been established to drive forward the programme, including working directly with and learning from the Institute of Healthcare Improvement (the core group includes providers, expert people, Core20+5 ambassador, ICB, Place Based Partnerships and Public Health). The area of focus is CVD and the aim of the Nottingham and Nottinghamshire programme is as follows: Aim - By 31st March 2028, people in the N&N ICS living in the 20% most deprived areas nationally who are dying early of CVD can expect to live as long as those in the least deprived. We are focusing on hypertension case finding and management with high blood pressure being the biggest modifiable risk factor for circulatory disease (this is in the context that circulatory diseases account for Nottm 18.1%/Notts 17.5% of the life expectancy gap in males and 24.1%/18.8% in males). Through the data and analysis the at risk population cohorts of interest are Black males in Nottingham City and White males in core20+5 in Mansfield and Nottingham West. In recognising that increasing case finding will only be successful if we have corresponding and proportionate capacity for diagnosis, the initial stages of the programme include an element of testing our approaches to diagnosis. Co-production is fundamental for this programme and we are linking in with local groups and taking forward with the expertise of the Place Based Partnerships.
Health Inequalities Innovation and Investment Fund – The ICB, with approval from the ICS, has launched a £4.5m health inequalities innovation and investment fund. The fund was opened to expressions of interest from partners across the ICS and these were reviewed against set criteria including: Equity as a core principle; Clear consideration of the 4 ICS aims; demonstrate improvement in clinical outcomes for health; demonstrate and measure how the investment will impact on avoidable mortality through innovative place based approach to health & care interventions; Joined up approach with communities (including the voluntary sector) and across relevant health and care services; Identification of a specific inequality and population need (including unmet) with a tangible targeted improvement and corresponding outcomes including avoidable mortality; Innovative practice and new ways of working; Demonstration of positive return on investment recognising that this may be over more than one year; Clear approach to evaluation and how the offer could be scaled-up throughout the ICS as relevant to population need; Demonstration of wider benefits including clinical outcomes, operational benefits, value for money, integration, impact on wider determinants of health. Approximately 100 expressions of interest and through the process of three main stages, 14 bids were reviewed for recommendation for approval. Final recommendations will be going to our Strategic Planning and Integration Committee in August.
Core20+5 Connector Programme – The ICB has submitted an EOI for the Core20+5 connector programme. Dental decay is a largely preventable condition; good oral hygiene, health education, a balanced diet lower in sugar and regular dental check-ups are just some of the ways dental decay can be prevented. Prevention is a key part of reducing the rate of tooth extractions, investing in preventative measures is a way in which we can reduce health inequalities and prevent more intensive interventions such as tooth extractions. We will utilise the Core20 Connectors Programme to help in the prevention of children's tooth decay within the most at risk populations as well as enabling people to seek the right help at the right time. In the district of Newark and Sherwood (Mid-Notts) around 23% of Children aged 5 have experienced some kind of tooth decay, which is 5-7% higher than the majority of the remaining County areas. In addition to this, the Decayed, Missing and Filled data from hospital extractions indicates that in the districts of Mansfield, Newark and Sherwood and Broxtowe, children are potentially not accessing or are not able to access dental care due to a higher number of obvious untreated dentally decayed teeth in 5 year olds. Gypsy & Irish Traveller communities have the highest % of tooth decay for 5 years olds within White populations and those from Asian Ethnic backgrounds have a higher rate of tooth decay in 5 year olds when compared to other ethnic groups. Other vulnerable groups when it comes to tooth decay are children in care, children and young people experiencing homelessness and those in secure settings who may struggle to access dental care provision. The provision for community connectors will aim to explore access to these populations as the programme develops and potentially expands.
ICS Priorities and a PHM Approach - Through the Clinical Design Authority (CDA) and the Clinical and Care Professional Leadership Group (CCPL), clinical priorities have been established for the next 24 months. The priorities have been identified through detailed analysis and an understanding of the activity and pressures that they are contribute to and the opportunity to drive forward primary and secondary care preventable actions. The clinical priorities include COPD; Stroke; Heart Failure; Cancer; Dementia; Delirium and Confusion; Pneumonia; Cellulitis; Sepsis; Falls and injuries; MSK; Maternity; CYP; Mental Health. Each will be supported by a PHM approach that includes detailed analysis and an in depth review with recommendations approved through different levels of clinical leadership.

NHS Nottingham and Nottinghamshire

10.2a 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 – 1. Maternity 2. Severe Mental Illness 3. Chronic Respiratory Disease 4. Early Cancer Diagnosis 5. Hypertension Case Finding. The below table provides an overview of performance to targets.

	KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
1	Continuity of care for 75% of women from BAME communities and from the most deprived groups.	Jan 23	0%	75%	F		0%	0%	0%
2	Annual health checks for 60% of those living with SMI	Jun 23	642	7029	F	L	3695	1510	5880
3	Uptake of Covid and Flu Vaccine in people with COPD	Jun 23	39%	100%	F	L	60%	51%	68%
3	Reduction of emergency admissions in people with COPD	Jun 23	4%	0%	F	L	4%	4%	4%
4	75% of cancer cases diagnosed at stage 1 or 2 by 2028	Jan 20	50%	75%	F		53%	50%	56%
5	Reach 80% of expected hypertension diagnoses by 2029	Jun 23	74%	80%	F	H	69%	65%	74%
5	Optimal treatment of high risk CVD (QRISK > 20% currently on statins)	Jun 23	78%	80%	F	H	76%	74%	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. Plans also extend broader than the targets and actions identified as part of the Core20+5.

NB
1. Continuity of care has been suspended nationally due to workforce challenges to implementation.
2. SMI checks have been reset for the new financial year. Quarter ending March 2023, Nottingham and Nottinghamshire were at 56.7% against a target of 60%
3. COVID and Flu vaccination values have been reset for the new financial year.
4. Cancer staging data is only available from 2013 – 2020.
5. Hypertension KPI (Optimal treatment of hypertension patients) has been changed to optimal treatment of high risk CVD (this with QRISK > 20% currently on statins), this is a IIF measure. Optimal treatment of hypertension varies from lifestyle changes to antihypertensive drugs, we don't currently have data to capture the variation in optimal treatment for hypertension

Calculations and metrics are from the 'Midlands Health Inequalities Dashboard' available in the 'National Commissioning Data Repository (NCDR)' developed by Arden and Gem. Data sets are obtained from SUS, IAPT, General Practice Workforce and Maternity Services Data Set.

10.2b Tackling Health Inequalities – The 5 in the 'Core20Plus5' – Children

Overview:

- It's important to note that the Core20+5 clinical areas are NHS focused and in order to fully understand and impact on health inequalities in children and young people, the ICS is taking a much broader approach that incorporates Health and Wellbeing Strategy priorities and Best Start in Life.
- Workstreams are in place covering the five clinical areas.
- Diabetes is a priority for the ICS due to an increasing risk and incidence of Type w Diabetes in CYP. Diabetes is a much more complex condition in CYP and they are at higher risk of more acute complications resulting in a focus on the older age group of Type 1 diabetics, including a pilot in SFH on transition. Diabetes includes the roll out of new technologies which is dependant on approval of the new NICE guidelines.
- Weight management is also an area of focus sitting alongside the Diabetes programme.
- A networks has been in place for asthma. A work programme for asthma has been done based on a paediatric evidence pack. The asthma plan includes preventative measures including quality of housing, parental smoking and air pollutants.
- A network has been set up for epilepsy which will drive forward the work programme.

As an ICS we have more than 15,000 children and young people aged 0-19 registered with asthma. A PHM review has been carried out in relation to Asthma and from this, interventions identified.

Key Stats:

- GP recorded prevalence of Asthma in the age group 0-19 is 5.5%. The number of new children and young people diagnosed with Asthma each year is 1,100. GP recorded prevalence is higher in older children compared to younger children.
- Local data does not show any association between GP recorded asthma and deprivation. Asthma is expected to be more prevalent in more deprived areas due to risk factors. Therefore, consideration has to be given to understanding and engaging with the undiagnosed.
- Second hand or passive smoking is one of the main risk factors for the development of Asthma
- A large body of evidence shows that breastfeeding is associated with a lower risk of asthma. In Nottingham and Nottinghamshire. Between 44% and 50% of babies are totally or partially breastfed at 6-8 weeks from birth. However, less than 1 infant in 3 is totally breastfed.
- 1 child aged 4-5 years in 4 is classified as overweight or obese
- 58% of children diagnosed with asthma are prescribed an asthma-related treatment in the last 12 months. Asthma treatment is a proxy for "active" asthma given the variability of the condition.
- 1.5% of the population in the 0-19 age group ever diagnosed with asthma have had an asthma emergency hospital admissions
- over a 12-month period.8% of all emergency admissions for respiratory diseases are for asthma
- 4% of children ever diagnosed with asthma have had an A&E attendance for asthma exacerbations over a 12-month period

Interventions:

1. **Passive smoking** is one of the main risk factors for developing childhood asthma. Smoking advice and referral to smoking cessation services are important interventions for family who smoke. Smoke-free homes.
2. Research shows that **breastfeeding** is associated to a lower childhood asthma risk. Interventions to encourage breastfeeding should be promoted. Less than 1 infant in 3 is totally breastfed at 6-8 weeks from birth.
3. Improve case-finding, detection and diagnosis of asthma, especially in areas of higher socio-economic deprivation.
4. **Brief interventions / advice on obesity**, given a possible link between asthma and obesity. 1 in 4 reception year children are overweight or obese.
5. Consider the use of **Vitamin D** supplements to reduce asthma exacerbations.
6. **Improve compliance with inhalers** through education and regular follow-ups. Research shows that incorrect inhaler technique is "unacceptably frequent" (overall prevalence of poor technique is estimated to be 31%, that is almost 1 in 3 patients).
7. Evidence show that compliance with inhaler techniques is better when children use their **inhalers with spacers**.
8. Evidence show that "**regularly supported self-management**" for asthma can reduce A&E attendances and emergency hospital admissions. Core components are: 1) education, 2) action plan and 3) regular professional review.
9. SIGN guidelines recommend that "**culturally appropriate**" supported self-management education should be provided for people from ethnic minority groups.
7. Appropriately tailored education and support needs to be provided for people with **Learning Disability or Autism**.
8. Break the cycle of over-reliance on short-acting beta agonist (SABA) inhalers, such as Salbutamol. Evidence from the Global Initiative for Asthma (GINA) shows **that higher use of a short-acting (SABA) reliever inhaler (such as Salbutamol) over a year is associated with a higher risk of severe exacerbations** and is a warning sign of poor asthma control.
9. Proactively identify patients who should be considered for specialist **biologic treatments** for severe asthma (monoclonal antibodies).
10. Proactively target a small cohort of young patients aged 0 to 14 (circa 30-70 patients) with multiple A&E attendances and/or Emergency admissions for asthma in a year, as their asthma may not be under control.

10.3 – Preventing Ill Health and Reducing Health Inequalities – Neighbourhood Overview

PCN Neighbourhood	BACHS	Clifton & Meadows	Bulwell & Top Valley	Radford & Mary Potter	Nottingham City East	Bestwood & Sherwood	Ashfield North	Mansfield North	Rosewood	Ashfield South	Byron	Newgate	Larwood & Bawtry	Sherwood	Retford And Villages	City South	Eastwood/ Kimberley	Synergy Health	Newark	Stapleford	Arnold & Calverton	Arrow Health	Beeston	Rushcliffe North	Rushcliffe Central	Rushcliffe South
Number of patients	61,680	34,203	45,878	47,166	65,793	54,040	51,540	59,164	50,717	40,460	38,408	30,076	40,191	62,794	53,960	38,198	37,549	30,275	78,719	22,086	33,759	44,875	49,501	41,925	52,570	42,646
IMD	2.4	2.5	2.6	2.7	3.0	3.5	3.9	4.1	4.1	4.3	4.5	4.6	5.1	5.3	5.3	5.6	5.9	5.9	6.0	6.1	6.5	6.6	7.4	8.5	8.8	9.0
Income	2.5	2.9	2.7	3.5	3.2	3.5	4.1	4.5	4.5	4.3	4.3	5.1	5.4	5.5	5.8	5.9	5.5	5.4	6.3	5.7	5.9	6.0	6.6	7.8	8.0	8.2
Employment	2.4	2.9	2.4	4.1	3.2	3.4	3.3	3.6	3.8	3.6	4.1	4.0	4.5	4.4	4.9	5.9	4.6	5.0	5.8	5.3	5.1	5.4	6.6	7.5	7.9	8.1
Education, Skills and Training	2.6	2.2	2.5	2.7	3.2	4.6	3.1	3.3	3.4	3.2	3.3	4.1	4.5	4.3	4.9	6.0	4.7	5.0	5.4	4.9	5.5	5.7	6.9	7.8	9.4	8.2
Health and Disability	2.5	2.2	2.4	2.2	2.7	3.0	3.0	2.9	2.9	3.6	4.1	3.2	3.5	4.4	4.6	4.4	5.5	5.8	6.4	6.1	6.1	6.3	6.8	8.7	8.5	9.0
Crime	3.0	3.9	3.6	2.3	4.0	3.7	4.3	5.0	4.4	5.0	4.9	4.9	5.1	6.7	6.4	6.1	6.0	6.6	6.6	5.0	6.8	6.7	7.5	9.1	8.3	8.9
Living Environment	4.2	4.5	5.3	2.4	3.4	3.6	7.2	7.2	6.8	8.0	7.5	7.2	8.0	8.0	6.1	4.5	7.2	6.2	5.8	5.4	7.5	6.6	5.6	8.4	6.6	7.6
Housing and Services	4.9	4.7	4.9	3.8	4.7	6.0	6.7	6.4	6.5	7.0	6.4	6.9	6.6	6.5	5.1	5.2	8.4	7.7	5.7	9.3	7.3	7.4	8.4	6.4	7.9	7.3
Obesity	21.5%	21.6%	22.8%	17.5%	17.7%	18.7%	24.6%	22.9%	20.6%	24.4%	21.4%	21.5%	22.3%	22.3%	21.7%	15.9%	21.4%	20.0%	18.2%	21.7%	19.0%	17.9%	16.7%	17.5%	12.9%	16.4%
Current smoker	16.9%	17.2%	18.6%	17.0%	16.9%	13.9%	15.0%	13.9%	16.7%	14.3%	13.1%	16.3%	13.1%	12.6%	11.7%	9.8%	10.9%	13.0%	12.5%	12.5%	11.0%	11.0%	9.9%	8.8%	6.0%	7.7%
Hypertension	16.8%	16.7%	16.4%	16.9%	14.7%	13.9%	14.8%	15.4%	13.6%	14.0%	13.9%	11.6%	14.3%	14.8%	13.1%	13.9%	13.3%	13.3%	13.1%	14.8%	12.9%	13.2%	13.2%	12.1%	12.0%	12.2%
Diabetes Type 2	7.9%	7.2%	7.1%	10.4%	7.3%	6.2%	6.4%	6.3%	6.2%	6.4%	6.0%	6.0%	6.6%	6.0%	5.4%	5.4%	5.6%	5.1%	4.8%	5.8%	4.9%	4.8%	5.0%	4.0%	4.2%	4.0%
COPD	3.1%	3.0%	3.0%	2.2%	2.7%	1.9%	2.4%	2.3%	2.4%	2.4%	2.2%	3.3%	3.2%	2.2%	1.9%	1.6%	1.9%	1.7%	1.4%	1.9%	1.6%	1.4%	1.5%	1.3%	1.0%	1.0%
Heart Failure	1.6%	1.4%	1.3%	0.9%	1.3%	1.2%	1.5%	0.9%	1.1%	1.0%	1.0%	1.1%	1.8%	1.0%	0.9%	0.8%	1.4%	0.9%	1.0%	1.2%	0.7%	0.9%	1.1%	0.8%	0.8%	0.9%
Stroke	1.6%	1.7%	1.6%	1.4%	1.5%	1.5%	1.4%	1.3%	1.3%	1.3%	1.4%	1.2%	1.4%	1.4%	1.1%	1.2%	1.3%	1.4%	1.1%	1.0%	1.4%	1.2%	1.2%	1.2%	1.1%	1.1%
CHD	3.6%	3.6%	3.5%	4.2%	3.3%	3.3%	3.5%	3.4%	3.5%	3.2%	3.1%	2.8%	3.6%	3.5%	2.7%	3.3%	3.1%	2.9%	2.8%	3.0%	2.8%	2.7%	2.7%	2.6%	2.6%	2.4%
Cancer	3.9%	3.7%	4.1%	3.2%	3.8%	3.8%	4.4%	4.0%	3.8%	4.0%	4.3%	4.0%	4.1%	4.2%	4.1%	4.0%	4.3%	4.4%	4.5%	4.2%	4.3%	4.2%	4.4%	4.3%	4.4%	4.2%
Serious Mental Illness	1.0%	0.9%	0.9%	1.5%	1.4%	1.0%	0.7%	0.6%	0.8%	0.7%	0.5%	0.7%	0.7%	0.6%	0.5%	0.7%	0.6%	0.7%	0.5%	0.6%	0.7%	0.6%	0.7%	0.3%	0.6%	0.4%
Moderate/ Severe Frailty	3.9%	2.1%	1.5%	4.0%	3.4%	2.0%	1.7%	2.2%	2.0%	1.9%	1.7%	1.6%	3.6%	2.5%	2.0%	2.6%	1.8%	5.5%	1.7%	1.9%	2.0%	1.3%	2.4%	1.7%	1.2%	1.0%
NELs 1+ LOS (age-adjusted) -TOTAL	8,004	8,400	8,227	8,869	7,730	7,076	7,586	7,295	7,291	7,312	7,496	5,917	6,427	6,726	5,246	6,975	6,991	6,653	5,698	6,637	6,453	6,400	6,141	5,811	5,126	5,169
NELs 1+ LOS (age-adjusted) - Cancer	282	267	309	300	265	226	210	200	206	220	263	188	187	169	218	232	240	202	187	267	266	278	176	215	224	207
NELs 1+ LOS (age-adjusted) - CVD	1,070	1,125	1,081	1,299	1,134	907	947	917	933	913	1,043	809	891	846	813	994	989	967	789	948	868	882	839	801	761	713
NELs 1+ LOS (age-adjusted) - COPD	576	542	550	465	360	379	447	382	366	401	448	316	382	336	233	279	302	305	209	288	327	281	192	130	83	119
Avoidable deaths (age-adjusted)	355	329	349	429	380	296	323	326	294	294	278	300	251	221	207	228	240	274	235	233	203	219	235	163	171	165
Av deaths (age-adjusted) - Cancer	92	97	109	97	90	89	99	106	87	85	89	91	85	61	78	54	72	84	80	74	74	83	69	64	56	65
Av deaths (age-adjusted) - CVD	103	110	93	124	107	92	77	93	68	84	78	88	63	66	57	61	76	70	64	60	54	65	64	39	56	43
Av deaths (age-adjusted) - COPD	23	19	21	32	26	17	26	19	27	17	17	12	17	11	14	18	8	16	9	-	9	-	10	-	-	-
Median age of death	78	83	80	74	76	81	80	79	81	79	81	80	81	81	82	82	81	81	81	80	83	83	84	83	84	84

This table provides a breakdown to neighbourhood level on deprivation, risk factors and contributors to health inequalities. This is a high level view that is supported by more detailed analysis to understand the complexities in relation to health inequalities. Understanding the complexities is important in order to identify disparities and define how best to target resources.

10.4a Access & Experience – Waiting Lists

NHS Nottingham and Nottinghamshire

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.

Deprivation

Current Waiting List Date Ending - 04/06/2023

IMD Quintile (1 - Very Deprived)	Patients	% Patients	Population Count	% Population
5	22757	17.40%	231,491	18.65%
4	21373	16.34%	198,141	15.96%
3	24825	18.98%	232,825	18.76%
2	25249	19.30%	235,774	19.00%
1	35246	26.95%	342,990	27.63%
Total	**130795**	**100.00%**	**1,241,221**	**100.00%**

Ethnicity

Current Waiting List Date Ending - 04/06/2023

Ethnic Group	Bassetlaw ICP	Mid Notts ICP	Nottingham City ICP	South Notts ICP	Total
Asian/Asian British	96	475	2677	963	**4211**
Black/African/Caribbean/Black British	49	253	1736	339	**2377**
Mixed/Multiple ethnic groups	81	310	960	452	**1803**
Not stated	2546	7156	9126	10855	**29683**
Other ethnic group	81	236	1042	643	**2002**
White	11173	40124	15456	23836	**90589**
Total	**14142**	**48567**	**30998**	**37088**	**130795**

10.4b 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

10.5a - 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.*

10.5b - Health Inequalities Dashboard – Nottingham and Nottinghamshire Health Inequalities Metrics by Deprivation

NHS Nottingham and Nottinghamshire

Health Inequalities Metrics				
		Deprivation		
Topic	Metric	RII	Trend (2017 - 2021)	Description
Cancer	Cancer morbidity in adults (percent)	0.97	Steady	Cancer morbidity in adults is similar between most and least deprived populations.
	Cancer mortality age <75 (per 100,000 pop')	2.53	Widening	Cancer mortality under 75 is 2.5 times higher in the most deprived population, and the inequality between groups has been widening over time.
Elderly persons	A&E Attendances age 75+ (per 100,000 pop')	1.86	Steady	A&E attendances over 75 are 1.86 times higher in the most deprived population.
	Hip fracture NE Admissions age 75+ (per 100,000 pop')	1.78	Widening	Hip fracture NE admissions are 1.78 times higher in the most deprived population. The difference between groups has been widening over time.
H&J Spec Com	Renal morbidity in adults (percent)	1.53	Steady	Renal morbidity in adults is higher in the most deprived areas.
Healthy people	A&E Attendances in adults (per 100,000 pop')	1.97	Widening	A&E attendances in adults is higher in more deprived areas and the inequality by deprivation has been widening over time.
	All-cause mortality age <75 (per 100,000 pop')	3.59	Widening	All-case mortality under 75 is 3.59 times greater in more deprived areas, and this inequality is widening over time.
	CVD morbidity in adults (percent)	1.64	Steady	CVD morbidity is 1.64 times greater in more higher areas.
	Diabetes morbidity in adults (percent)	2.37	Steady	Diabetes morbidity is 2.37 times higher in more deprived areas.
	Mortality within 60 days of a stroke (per 100,000 pop')	1.31	Narrowing	Mortality within 60 days of a stroke is 1.31 times higher in the most deprived areas, but the difference between areas has been narrowing over time.
	Respiratory morbidity in adults (percent)	1.76	Steady	Respiratory morbidity in adults is 1.76 times higher in the most deprived areas.
	T&O Outpatient App. in adults (per 100,000 pop')	1.04	Steady	T&O outpatient appointments are similar by deprivations
Maternity & Child	Maternal C-section (per 100,000 pop')	0.97	Steady	Maternal C-section rates are similar by deprivation.
	Maternal post-partum haemorrhage (per 100,000 pop')	0.80	Steady	Maternal post-partum haemorrhage is lower in more deprived population.
Mental health	Alcohol related Admissions in adults (per 100,000 pop')	6.26	Narrowing	Alcohol related admissions are 6.26 times higher in the most deprived populations, but this difference is narrowing over time.
	IAPT referrals in adults (per 100,000 pop')	0.88	Steady	IAPT referrals in adults are lower in more deprived areas.
	NE Admissions for self-harm age 12+ (per 100,000 pop')	3.15	Narrowing	Non-elective admissions for self harm aged 12+ are 3.15 times higher in more deprived areas. The difference between areas is narrowing over time.
Primary Care	Number of GPs in registered practice (per 1,000 pop')	0.86	Steady	Number of GPs in registered practices are higher in less deprived areas.
	Number of nurses in registered practice (per 1,000 pop')	0.94	Steady	Number of nurses in registered practice is similar by deprivation
	Received first dose of Covid-19 vaccine by 18/07/21 (%)	0.78	N/A	Covid vaccination rates are lower in more deprived areas.

Higher Health Inequality in Least Deprived population

Higher Health Inequality in Most Deprived Population

Calculations and metrics are from the 'Midlands Health Inequalities Dashboard' available in the 'National Commissioning Data Repository (NCDR)' developed by Arden and Gem. Data sets are obtained from SUS, IAPT, General Practice Workforce and Maternity Services Data Set.

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11.0 NHS Oversight Framework

ICS Aim 2: Tackle inequalities in outcomes, experience and access

11.1 – ICB Summary Highest and Lowest Quartile Performance Areas

11.1 – NHS Oversight Framework – ICB Summary Highest and Lowest Quartile Performance Areas

– National Benchmark data @25th May 2023

Nottingham and Nottinghamshire

Quality of care, access and outcomes

(52 out of 55 metrics populated @25.05.2023)

Lower Quartile Areas:

- Total patients treated for cancer compared with the same point in 2019/20 (ICB)
- Outpatient follow up activity levels compared with 2019/20 baseline (ICB)
- Neonatal deaths per 1,000 total live births (ICB)
- Available virtual ward capacity per 100k head of population (ICB)
- Number of Completed Referrals to CPCS from a general practice (ICB)
- IPs with a learning disability and/or autism per million head of population (ICB)
- Patients waiting more than 78wks to start consultant led treatment (NNICB)
- patients waiting more than 104wks to start consultant led treatment (NNICB)
- Diagnostic activity levels: Imaging (NNICB)
- Diagnostic activity levels: Physiological measurement (NNICB)
- Diagnostic activity levels: Endoscopy (BICB)
- Clostridium difficile infection rate (BICB)
- E. coli bloodstream infection rate (BICB)

Higher Quartile Areas:

- % of 2-hr Urgent Community Response referrals - care provided within 2 hrs (ICB)
- Children and young people accessing mental health services as a % of pop (ICB)
- Inappropriate adult acute MH placement out of area placement bed days (ICB)
- Rate of personalised care interventions (ICB)
- Personal health budgets (ICB)
- Antimicrobial resistance: total prescribing of antibiotics in primary care (NNICB)
- Clostridium difficile infection rate (NNICB)
- Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care (BICB)
- Proportion of patients meeting the faster cancer diagnosis standard (BICB)
- Patients waiting more than 104 wks to start consultant led treatment (BICB)
- Patients waiting more than 78 wks to start consultant led treatment (BICB)
- Patients waiting more than 52 wks to start consultant led treatment (BICB)

Preventing ill-health and reducing inequalities

(14 out of 15 metrics populated @25.05.2023)

Lower Quartile Areas:

- Referrals to NHS digital weight management services per100k head of pop (NNICB)

Higher Quartile Areas:

- Proportion of adult acute inpatient settings offering smoking cessation services (ICB)
- Proportion of maternity inpatient settings offering smoking cessation services (ICB)
- % of hypertension patients who are treated to target as per NICE guidance (BICB)

People

(12 out of 12 metrics populated @25.05.2023)

Lower Quartile Areas:

- Sickness absence rate (ICB)

Higher Quartile Areas:

- Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers (ICB)
- Leaver rate (ICB)
- FTE doctors in General Practice per 10,000 weighted patients (ICB)

Finance and Use of Resources

(0 out of 4 metrics populated @25.05.2023)

Finance Metrics Identified in NOF:

- MHIS
- Finance Efficiency
- Financial Sustainability
- Agency Cap

Leadership & Capability

(2 out of 2 metrics populated @25.05.2023)

- Aggregate score for NHS Staff Survey questions that measure perception of leadership culture (8/42)

Local Strategic Priorities

(No specific metrics)

- NUH - Maternity
- NHT – CQC, Well led, Staffing, Governance
- Financial Sustainability – Recurrent exit position
- Elective Recovery – activity v 19/20

80 of the metrics have been populated as at 25th May 2023. Majority as ICB are in the inter quartile area.

Content Author: Sarah Bray | Executive Lead: Amanda Sullivan | System Oversight: System Oversight Group | ICB Committee: Finance & Performance Committee

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Appendices

i – ICS Assurance Escalation Framework

ii - Key to Variation and Assurance Icons (SPC) iii - Glossary of Terms

NHS Nottingham and Nottinghamshire

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:

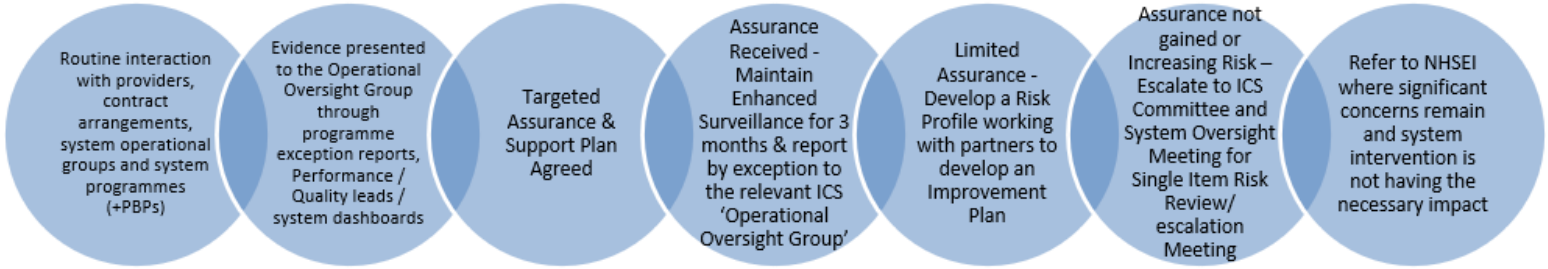
What does this mean? What is the assessment of risks to delivery / quality

No Specific areas of concern identified	Potential for concern. Key milestones not achieved. More information required to determine level of risk	Delivery or quality concerns identified	Serious, specific risk to delivery or quality identified, including where there is a need to act rapidly to protect patients or staff

What actions may be taken by the relevant 'Operational Oversight Group' in response to this assessment

Actions to be taken by Relevant Operational Oversight Group	Agree route to follow up to gain necessary information to assess risk and agree who will lead	Agree actions, and schedule for discussion at each 'Operational Oversight Group' until concerns are resolved	Trigger Escalation Review/ Deep Dive / Risk Summit

Evidence Based Assurance Process



ii – Key to Variation & Assurance Icons (SPC) and Assurance Escalation Framework

NHS Nottingham and Nottinghamshire

This performance report incorporates Statistical Process Control (SPC) charts, which plot data over time around a centre line (the average). They help us to understand variation which guides us to make appropriate decisions.
The Upper Control Limit (UCL) and Lower Control Limit (LCL) are derived by the variability of the data. It is expected that 99% of data points will fall within the process limits (probability) and SPC are therefore useful to identify / consider how likely it is that the target will be achieved.

The **Variation Icons** are derived from the movement of the actuals, either as an indication of run rate over 6 data points, or against the mean (higher or lower than the mean), showing whether the process is improving, deteriorating or having no significant change.

The **Assurance Icons** are derived from the position of the Lower Control Limit against the plan or standard – and the confidence level that provides as to whether the target or plan is expected to be achieved in the future. If the plan or target is higher than the lower control limit this will indicate 'inconsistent' passing or falling short. If plan or target is lower than the lower control limit this indicates that the target is being consistently passed. If the plan is higher than the higher control limit, this will indicate consistent falling short.

Essentially, the assurance icon is all about the future not the past. We don't need SPC to tell us whether we've hit our target in the past, we know if we have or not and we can report on that as is customary. However that approach doesn't give much assurance about what happens in future. Even if we've consistently missed our target for the past 10 months, what's the likelihood that we will do so again next month? Traditional reporting does not have an answer for that but SPC does. SPC charts allow us to see how the process we are monitoring is behaving. We can therefore use the mean and limits to 'predict' future performance which is what the assurance icon does.

Variation			**Assurance** (capability of meeting target)		
					
Common Cause - no significant change Up/Down arrow no special cause	**Special Cause** of *concerning* nature or *higher pressure* due to (H)igher or (L)ower values	**Special Cause** of *improving* nature or lower *pressure* due to (H)igher or (L)ower values	Variation indicates ***inconsistent*** passing or falling short of target - random	Variation indicates ***consistently (P)assing*** the target	Variation indicates ***consistently (F)alling short*** of the target

Blue lines on the charts represent the operational plan for 2022/23
Red Lines on the charts represent a required target position

Exception Reporting Rules

'Exception Reports' will be triggered if:

- An 'Orange' Variation icon or a 'Falling' short Assurance icon
- A Special Cause Variation (positive or negative)
- An area of escalation proposed via a sub-committee
- An area of escalation highlighted through the Executive Director from ICS Oversight Groups
- An area of escalation relating to sub-organisational level concerns

Further Reading / other resources
The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://improvement.nhs.uk/resources/making-data-count

iii – Glossary of Terms

NHS Nottingham and Nottinghamshire

Acronym	Meaning	Acronym	Meaning	Acronym	Meaning	Acronym	Meaning
A&E	Accident & Emergency	FD	Finance Director	NEMS	Nottinghamshire Emergency Medical Services	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		

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/07/2023
Paper Title:	**Committee Highlight Reports**
Paper Reference:	ICB 23 026
Report Author:	Committee Secretariat
Report Sponsor:	ICB Committee Chairs
Presenter:	ICB Committee Chairs

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

Summary:

This report presents an overview of the work of the Board's committees since its last meeting in May 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 report also includes the first update from the East Midlands Joint Committees, established between the five East Midlands ICBs following the delegation of commissioning functions relating to primary pharmacy and optometry services and primary and secondary dental services (POD) services from 1 April 2023; and between NHS England and the East Midlands ICBs for 2023/24 in relation to 59 specified specialised services, ahead of formal delegation on 1 April 2024.

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.

Recommendation(s):

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

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

Appendices:

A: Highlight Report from the Strategic Planning and Integration Committee
B: Highlight Report from the Quality and People Committee

Appendices:
C: Highlight Report from the Finance and Performance Committee D: Highlight Report from the Audit and Risk Committee E: Highlight Report from the East Midlands Joint Committee F: Current high-level operational risks being oversighted by the Board's committees

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

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

Levels of assurance:	
	Immediate and fundamental remedial and/or developmental action is required.

Report Previously Received By:
Not applicable.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Appendix A: Strategic Planning and Integration Committee Highlight Report

Meeting Dates:	**1 June and 6 July 2023**
Committee Chair:	**Jon Towler, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance
Working with People and Communities Annual Report	Members received a comprehensive report that described how the ICB had discharged its legal duties for public involvement and consultation over the past nine months from ICB establishment (1 July 2022 to 31 March 2023). This will soon be published on the ICB's website.	**Full Assurance**
Individual Funding Request Annual Report	The Annual Report for the Individual Funding Request (IFR) Panel, which covered the period 1 July 2022 to 31 March 2023, was received. Whilst members noted that clear criteria set out within the IFR Policy was being worked to, it was felt that the information provided around the robustness of decision-making was somewhat limited and it was requested that further detail on this be provided in future reports.	**Adequate Assurance**
Mental Health and Learning Disability Specialist Treatment/Funding Panel Annual Report	The Annual Report, covering the period 1 July 2022 – 31 March 2023, for the Mental Health and Learning Disability Specialist Treatment/ Funding Request Panel provided an overview of the activity of the Panel since its establishment.	**Full Assurance**

Other considerations:

Decisions made and endorsements for approval from the Board:
The Committee: • Approved a three-year contract award to the preferred bidder for the Primary Care Interpreter and Translation service.

- Approved a six-month direct award contract extension for the Acute Home Visiting Service in Mid Nottinghamshire for the remainder of 2023/24.
- Approved a direct award to the current providers within the End of Life Care Together Service for a two year contract, with the option to extend annually for a further three years following evidence of transformation and innovation from the service from October 2023 to September 2025.
- Approved an extension to the ICB's Procurement Policy review date to March 2024, which was requested to accommodate the delay in the introduction of the NHS Provider Selection Regime (PSR). Members were assured that the current policy remained in line with the current legal procurement framework.
- Ratified an urgent decision made by the Committee's Chair and the Chief Executive on 29 June 2023 utilising the Committee's emergency powers. This was to approve new investments for 2023/24 which had been prioritised as part of a system-wide investment process. The investments related to diabetes blood glucose monitoring, increasing the current financial envelope for the Urgent Treatment Centre to address staffing capacity and the additional cost to the ICB due to the introduction of a national tariff for abortion.

In line with the ICB's Scheme of Reservation and Delegation a number of matters were also endorsed by the Committee for onward consideration and approval by the Board. These included endorsing the finalised Joint Forward Plan (JFP) following updates received in June and July on development and progress. Following feedback at the May meeting, extensive work had taken place and a re-worked draft of the plan had been submitted to NHS England on 22 May for informal assurance that all legal and national requirements had been addressed. Overall, the feedback had been positive and useful, highlighting a few areas for improvement.

Matters of interest:

The Committee also:

- Received a paper that described the process that had been undertaken for the distribution of a £4.5 million Health Inequalities and Innovation Investment Fund, which had been identified from within the ICB's baseline allocation as part of the financial planning process with system partners. Members requested that learning should be taken from the process used in this first round to improve governance and decision-making arrangements going forward.
- Received a paper that provided an overview of the key areas of the recently published NHS England delivery plan for recovering access to primary care and the ICB's proposed approach to the delivery of the plan. The timeline indicated that a system-level access improvement plan would need to be presented at the ICB's Board meeting in November for approval, with an update presented to the Committee ahead of this. Whilst welcoming the national plan, members noted the significant potential risks to meeting the targets set out within the plan.

- Received a paper discussing a proposed strategic approach to ICB collaborative commissioning agreements, which would provide greater opportunities to work with local authority partners in social care and public health for closer alignment of commissioning and associated resources. This, in turn, would create more integrated models of delivery.
- Received an update on the progress of the Community Services Transformation programme.
- Received an update on the work being undertaken with Sherwood Forest Hospitals Trust (SFHT) to support the delivery of a sustainable Urgent Treatment Centre (UTC) based at Newark Hospital.
- Received an update and endorsed proposed next steps for the Tomorrow's NUH Programme following the announcement of changes to the National Hospitals Programme, given the need to focus on those hospitals constructed using reinforced autoclaved aerated concrete.
- Received an update on the alignment of contracting arrangements for locked rehabilitation provision, agreeing that a more detailed report would be shared at the September 2023 meeting.
- Received a highlight report from the Primary Medical Services Contracting Sub-Committee from its meeting on 10 May 2023.

Appendix B: Quality and People Committee Highlight Report

Meeting Dates:	**17 May and 21 June 2023**
Committee Chair:	**Marios Adamou, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance
1. ICB Quality Scorecard and Integrated Performance Report (IPR)	The report presented progress against areas of quality by exception and included Learning Disability and Autism (LDA), the Local Maternity and Neonatal System (LMNS), Personalisation, Infection Prevention and Control, Looked After Children (LAC) and Special Educational Needs and Disability (SEND). As discussed at previous meetings, the IPR report is under development, an example template was shared in order that members could provide their comments. Members suggested that the report be expanded to include measures for all areas of quality. It was reported that the LDA position remains a significant challenge. The year 2022/23 ended with 47 inpatients against a target of 39. Despite good levels of adult inpatient discharges, high admission rates affected overall performance. The current plan submitted to NHS England (NHSE), and supported by the ICS LDA Board, is for 37 adult inpatients by March 2024 and achievement of the 2023/24 long term plan commitment of 27 inpatients by March 2025. Looked After Children and Special Educational Needs and Disabilities (SEND) updates were provided in May and subject to deep dives at the meeting June 2023. Infection Prevention and Control (IPC) data for quarter four was presented in May and remains off track, particularly in relation to cases of E Coli. A deep dive on IPC would take place at a future meeting as a thematic deep dive. The IPC team are reviewing national data sets to benchmark the Nottingham and Nottinghamshire position in respect of community acquired infections. The position	**Limited Assurance** in respect of the areas reported in May. **Partial Assurance** in relation to the June report.

Item	Summary	Level of assurance
	remained static at the June report with IPC leads across the system are indicating a low confidence in the ability to deliver against the new targets, particularly if the sustained operational pressure on inpatient beds continues. There is a system approach to addressing the Consultant Microbiologist workforce pressures. Provider Quality Assurance will be developed to include the Primary Care workforce over time. The ICB are working with Nottingham University Hospitals NHS Trust (NUH) currently to join up Board to Ward Leadership. The ICB Quality Team have an increased visibility across all providers. Assurance was provided in June that the System had reached 100% compliance with the Ockenden Immediate and Essential Actions.	
2. Deep Dive - Nottinghamshire Joint local area SEND Inspection Outcome	In June, members received a deep dive report focused on the Nottinghamshire Joint Local Area SEND Inspection outcome, including the latest draft of the Nottinghamshire Partnership Improvement Plan. Members were assured by the level of oversight and external scrutiny in place.	**Adequate Assurance**
3. Statutory Health Assessments for Children and Young People who are Looked After	The June meeting received a report detailing the immediate, medium and long-term recovery plans under development to improve performance in respect of Initial Health Assessments (IHAs) and Review Health Assessments (RHAs). Members felt that there was an absence of a clear action plan that included defined actions, ownership and a timeline for completion.	**Limited Assurance**
4. System Workforce Integrated Performance Report and Exception Reports	Due to issues in aligning data and reporting schedules, the report to the Committee in June covered a limited number of areas. There are plans to ensure the report develops over the coming months to provide greater detail on trends and associated action. Members heard that Providers are seeing an improved picture in terms of attracting and recruiting to the workforce, including international recruitment. Focused work is underway to address workforce retention. A workforce retention conference would take place in early July 2023.	**Limited Assurance**

Item	Summary	Level of assurance
	Agency spending continues to be high and had been exacerbated by industrial action. A deep dive on agency spending would be presented to the Committee in July 2023. The report included the NHS Staff Survey results, key themes and recommendations. Members sought to understand the role of the oversight role of the Committee in respect of the action plan. Due to limitations with the breadth and depth of data reported, limited assurance was awarded.	
5. System workforce plans and workforce growth since 2019/20.	System workforce plans were submitted to NHSE on the 3 May 2023. The planning process heavily focused on the ability of the system to achieve financially balanced plans, which raises some risk from a workforce perspective. The newly formed ICS People and Culture Performance, Planning and Risk group met for the first time on 1 June 2023 and will meet monthly to review plans. Key features of plans include ambitious plans to reduce agency spending, planned increases in support to clinical staff across all Providers, low planned growth in Primary Care for GPs and Practice Nurses, whilst the Additional Roles Reimbursement Scheme (ARRS) roles planned growth is significant at 34%. Members noted that during the pandemic, workforce numbers grew significantly but productivity had not returned to pre-pandemic levels. It is suggested that acuity and length of stay impacts on productivity, but further exploration is required.	**Limited Assurance**
6. Deep dive – Delivery of ICB People Functions Priority One: Supporting the health and wellbeing of all staff.	The deep dive focused on the first People Functions Plan Priority; Supporting the Health and Wellbeing of all staff. The intention being to ensure staff feel safe and supported in their physical and mental health and wellbeing, enabling them to be able to provide high-quality, compassionate care to patients. The presentation detailed the ICB responsibilities and system responsibilities along with key lines of enquiry for Nottingham and Nottinghamshire ICB and ICS.	**Partial Assurance**
4. Deep dive – Delivery of ICB People Functions Priority Two:	The deep dive focused on the second People Functions Plan Priority; Growing the Workforce for the Future and Enabling Adequate Workforce Supply. This function is	**Limited Assurance**

Item	Summary	Level of assurance
Growing the workforce for the future and enabling adequate workforce supply.	designed to support the system approach to retaining, recruiting and, where required, growing its workforce to meet future need. The 'one workforce' across the ICS is representative of the local communities served. The presentation detailed the ICB responsibilities and system responsibilities along with key lines of enquiry for Nottingham and Nottinghamshire ICB and ICS. Discussion focused on the fact that there is a long way to go before assurance can be taken that the system has a sustainable workforce of the future.	

Other considerations:

Decisions made:
• No items required a decision at the meetings in May and June 2023.
Matters of interest:
• System quality oversight arrangements were discussed in May and June. The System Quality Framework would be developed by the system and focus not only on assurance but on creating an improvement-led, learning system. Seven focused priorities for quality had been identified. Quality improvement, quality control and quality assurance would be integrated at System, Place and Neighbourhood levels. A workshop had taken place in June Workshop where there was an appetite for the framework development to feel and be different. A delivery plan would be presented to the Committee in July 2023. • NHS Provider risk profiles were shared for information in May. NUH remains under the most scrutiny, with an 'Intensive' quality monitoring status, due to the continued challenges they face. Nottinghamshire Healthcare NHS Foundation Trust (NHT) is subject to 'Enhanced' quality monitoring due to challenges with sub-contracted services and issues at Lings Barr. Sherwood Forest Hospitals NHS Foundation Trust (SFH) and CityCare are subject to 'Routine' quality monitoring. The risk profiles had been co-produced with providers. • The Committee received a progress report on the implementation of the Patient Safety Incident Response Framework (PSIRF) in May. The framework represents a significant shift in the way the NHS responds to patient safety incidents (events) and is a major step towards setting up a safety management system across the NHS.

- The System Operational Risk Report is received at each meeting. The number of risks within the remit of the committee is high, currently 42. Members suggested there should be more time for discussion of risks and perhaps a different way of approaching risks at meetings to enable the right level of focus of scrutiny. It was agreed that the approach would be reviewed before the next meeting.

Appendix C: Finance and Performance Committee Highlight Report

Meeting Dates:	**31 May and 28 June 2023**
Committee Chair:	**Stephen Jackson, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance
1. System Finance Report	The reports included detailed analysis of the financial performance for the system for months one and two against a breakeven plan. A deficit position was reported at both meetings with the majority overspend attributed to Nottingham University Hospitals (NUH). It was noted that this was partially due to a phasing issue within NUH's plan. The financial impact of the Junior Doctors strikes was also noted. Members were advised that work was ongoing throughout the system to identify a route back to plan and there was particular focus on staffing costs.	**Limited Assurance**
2. ICB Financial Recovery Plan	This item was presented initially at the May meeting and members agreed to add it as a standard item on the agenda so long as the ICB position remained off-plan. The June report had been produced shortly after the May report and so the numbers remained mainly unchanged. It was explained that a full meeting cycle would have passed when future reports were produced, which would give a more up-to-date position at the time of presenting. The June report assumed delivery of all plans by year end. This included £31.36 million of risk which had been fully mitigated as part of the 'financial turnaround' process adopted within the ICB.	**Partial Assurance**
3. ICB Finance Report	The reports included detailed analysis of the financial performance for the system for months one and two against a breakeven plan. The risk associated with a £56 million efficiency target was highlighted. A discussion ensued at the May meeting around the financial impact of 'No Cheaper Stock Obtainable' (NCSO) medication and it was	**Partial Assurance**

Item	Summary	Level of assurance
	determined that there were no local solutions to avoid the price fluctuations which were a result of issues in the supply chain. At the June meeting Continuing Healthcare costs were flagged as being over planned levels by £950k. Work was underway to identify actions to mitigate this cost pressure.	
4. Service Delivery Performance Report	The report was presented at both meetings. Discussion at the May meeting centred around the scale of challenge to improve performance in both primary and acute settings. The tremendous effort of primary care colleagues to increase appointments was acknowledged. It was noted that overall performance had increased marginally since establishment of the ICB and that greater improvements had been expected given the strengthened system working arrangements. Feedback was given on the content of the report, and it was requested that future reports include additional detail on fluctuations within the community waiting list and the impact of any strike action.	**Partial Assurance**
5. Thematic Service Delivery Review: Discharges (Including Medically Safe for Discharge and Length of Stay)	The report was the second in a programme of deep-dive reviews into service delivery areas. The report included analysis of the ICB's progress in delivery of Discharge to Assess (D2A), and reduction of Long Length of Stays (LLOS), both of which were national priorities. Ongoing challenges and next steps were summarised, and discussion focused on separating the factors which were/were not within the control of the ICB. Culture and leadership were also flagged as levers for success.	**Partial Assurance**
6. Health Inequalities Dashboard and Exception Report	The report provided an overview of exceptions within the below dashboards, and summarised actions being taken to address these. • National Health and Inequalities Improvement dashboard • Regional Core20+5 dashboard • System Analytics and Intelligence Unit (SAIU) Health Inequalities Dashboard	**Partial Assurance**

Item	Summary	Level of assurance
	It was agreed that a schedule of focused areas would be agreed for reporting to future meetings, to enable the Committee to have a more detailed discussion regarding outcomes.	

Other considerations:

Decisions made:
No items required a decision at the meetings in May and June 2023.
Matters of interest:
The Committee: • Received an overview of work undertaken to align finance, activity and workforce within the 2023/24 plan at the May meeting. This triangulation was assisted by a national analytical tool for productivity and Key Lines of Enquiry (KLOEs) from NHS England (NHSE). Further work would continue within the ICS Directors of Finance group to understand changes in staffing costs and activity levels since the COVID-19 pandemic, with the aim of driving productivity benefits.

Appendix D: Audit and Risk Committee Highlight Report

Meeting Dates:	**13 June 2023**
Committee Chair:	**Caroline Maley, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance
1. Personal Health Budget Internal Audit Report	The ICB's Internal Audit function had examined the decision-making process for Personal Health budgets and had given a 'limited assurance' opinion. It had concluded that the risk management activities and controls were not suitably designed, or were not operating with sufficient effectiveness, to provide reasonable assurance that the control environment was effectively managed during the period of the review. Assurance was provided on the strengthening of processes, and it was noted that good progress was being made towards the completion of the actions recommended in the report.	Adequate Assurance
2. Information Governance DPST Report	Members were assured to the arrangements established within the ICB to ensure compliance with the requirements of the Data Security and Protection Toolkit (DSPT) and to report on the ICB's position ahead of the year-end (2022/23) submission by 30 June 2023. An Internal Audit check on the ICB's self-assessment had concluded, with an overall 'substantial' opinion.	Adequate Assurance
3. Tender Waiver Register	Members received an update on details of all instances where competitive tendering requirements had been waived during the period 1 July to 31 March 2023 as assurance of the ICB's compliance with the competition waiver process. Members	Adequate Assurance

Item	Summary	Level of assurance
	asked for additional information to be added to future registers to further understand the requirement for the waivers.	
4. Policy Management Framework update	This report provided with assurance that the process for reviewing the ICB's corporate policies were being managed effectively. Following scrutiny, members agreed that the reasons given for agreeing extensions to several policies were sensible and approved the extensions.	**Full Assurance**
5. Health and Safety Year End Report	An annual report on the embedment of arrangements across the ICB to meet health and safety requirements was received by the Committee. As the ICB is classified as a 'low risk' organisation, with staff being predominantly office or home based, focus in this area related to the health, safety, and welfare of its workforce. Members considered the governance in this area to be proportionate to the level of risk and gave a rating of full assurance.	**Full Assurance**
6. Statutory and Mandatory Training	The Committee reviewed ICB's current statutory and mandatory training compliance figures and the processes in place to monitor and improve compliance rates. Whilst overall compliance was high, there were pockets where compliance was relatively low and members urged the ICB to ensure full compliance with statutory and mandatory training requirements.	**Adequate Assurance**
7. Counter Fraud Annual Report	Members received an Annual Report from the ICB's counter fraud specialists, which noted that the ICB had met all requirements of the Counter Fraud Functional Standard and had achieved a 'Green' compliance rating.	**-**

Other considerations:

Decisions made:

• The Committee approved:
  ○ the Annual Report and Accounts for the former NHS Bassetlaw CCG for the period 1 April to 30 June 2022
  ○ the Annual Report and Accounts for the former NHS Nottingham and Nottinghamshire CCG for the period 1 April to 30 June 2022
  ○ the Annual Report and Accounts for the ICB for the period 1 July 2022 to 31 March 2023
for onward submission to NHS England ahead of the deadline of 30 June 2023. The Committee also endorsed the signing of the letters of representation for all three organisations, which stated compliance with accounting and auditing standards. These approvals followed scrutiny of the External Audit reports of the three sets of accounts; third party assurance reports; and the Head of Internal Audit Opinion reports for the two former CCGs and the ICB, which had provided an overall rating of 'significant assurance' for all three organisations. The External Audit opinion was 'unqualified' for all three organisations.
• Following scrutiny of the request, the Committee approved changes to the EPRR Policy and Business Continuity Plan.
• Following an update on the ICB's Policy Management Framework, the Committee approved extensions to several policy review deadlines.
• The Committee approved changes to the ICB's Health and Safety Policies.
• The Committee approved its work programme for 2023/24.

Matters of interest:
• Members received an update on progress of the Internal Audit Plan 2022/23. Four reports remained outstanding. The Committee was concerned by this and asked the ICB to ensure a timely response to auditors' requests. One report on the Data Security and Protection Toolkit, which provided 'substantial' assurance, had been issued as part of the 2023/24 Internal Audit Plan. • The Committee endorsed the actions taken following the receipt of the Committee Effectiveness Review at its May meeting, endorsing the refreshed Board and Committee Etiquette and the rolling programme of committee effectiveness reviews for 2023/24.

Appendix E: East Midlands Joint Committees' Highlight Report

Meeting Dates:	**18 April 2023**
Committee Chair:	**David Sissling, Chair of NHS Leicester, Leicestershire and Rutland ICB**
NN ICB Members:	**Amanda Sullivan, Chief Executive (voting) Kathy McLean, ICB Chair (discretionary)**

Item	Summary
1. Formalisation of the Joint Committees	Both committees adopted their respective Terms of Reference and confirmed the Committees' memberships and chairing arrangements.
2. Proposal for Development of Future Commissioning Arrangements	Members received an outline proposal for how NHS England and the ICBs will work to support future commissioning arrangements with alignment to the delegation of services from April 2024.
3. Midlands Acute Specialised Commissioning Groups Update	Members noted the update presented on the meeting held on 13 March 2023. The committee requested that future reports provide a focus on the highest priority issues for services and for this approach to be tested at the next meeting.
4. 2023/24 Operational Plan for NHSE Directly Commissioned Services Including Pharmacy, Ophthalmic and Dental (POD) Services	The report noted that NHS England has taken steps to work collaboratively with ICBs to develop a plan that focused deliver of the triple aim of better health, better care, and lower costs, and the identification of priority pathways which addressed national and regional transformation priorities. The committee noted the plan presented by NHS England and discussed the need to develop the process of enhancing collective insight to shape future plans.

Item	Summary
5. 2023/24 Financial Plan for NHSE Directly Commissioned Services	Members noted the plan presented by NHS England with regard to Directly Commissioned Services.
6. Primary Care Delegation POD Governance Arrangements	Members received a proposal for the governance framework with regard to POD services, which provided examples of the enaction of decision-making processes. It was agreed that a review would be undertaken to learn from reality after a few months of operating the committee/ groups. The associated Standard Operating framework and Hosting Agreements are in development and will be presented to the meeting in June. Members approved the relevant terms of reference and scheme of reservation and delegation presented within the framework.
7. 2023/23 Financial Plan for PODs	Members approved the proposal for the 2023/24 Financial Plan for POD services, noting that an established collaborative finance group would maintain overview of delivery against the wider plan, and would operate with the intent of exploring opportunities to ensure monies are allocated in the most appropriate manner in terms of efficiency and equity.
8. NHS Midlands 111 Procurement Update	Members received an update on the Midlands 111 procurement process and sought assurance on the process being undertaken. It was requested that a more detailed update be provided at the meeting in June.

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

Risk Ref.	Risk Description	Current Score	Responsible Committee
ORR042	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
ORR072	If we are unable to improve clinical support, engagement and confidence in the concept of Virtual Wards, there is a risk that the system may not realise the benefits in terms of reducing demand, improving flow and increasing capacity.	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee
ORR006	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 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
ORR023	If Nottingham University Hospitals NHS Trust (NUH) do not have the capability to make improvements in a timely manner following CQC recommendations, the quality of maternity services 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
ORR024	If Nottingham University Hospitals NHS Trust (NUH) do not have the capacity to make improvements in a timely manner (following CQC visits), the quality of services may deteriorate.	**High** 16 (I4 x L4)	Quality and People Committee

Risk Ref.	Risk Description	Current Score	Responsible Committee
	This may lead to poor patient experience, adverse clinical outcomes and/or patient safety issues for the population of Nottingham and Nottinghamshire.		
ORR049	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
ORR053	If the flow of patients who are medically safe for discharge 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
ORR069	If the system does not have sufficient workforce to supply high-quality maternity business as usual services and service transformation activity, across the three NHS providers (NUH, SFHT and DBHT), there is a risk that the quality of maternity services will deteriorate for the population of Nottingham and Nottinghamshire. This may, in turn, result in poor patient experience, adverse clinical outcomes and/or patient safety issues for women and their families.	**High** 20 (I5 x L4)	Quality and People Committee
ORR077	If sustained levels of significant pressure on health and social care services continues, due to high levels of demand (exacerbated by the pandemic), 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
ORR083	If discharges from learning disability and autism inpatient settings are delayed due to lack of available capacity in community based settings, patients may stay in inpatient settings longer than necessary. This may lead to poor patient experience, adverse clinical	**High** 16 (I4 x L4)	Quality and People Committee

Risk Ref.	Risk Description	Current Score	Responsible Committee
	outcomes and/or patient safety issues for the population of Nottingham and Nottinghamshire.		
ORR085	If there is insufficient workforce capacity within health providers across the system, due to issues with recruitment and retention, there is risk to patient flow across the non-elective pathway. This may adversely impact the delivery of urgent and emergency care to the population of Nottingham and Nottinghamshire.	**High** 20 (I5 x L4)	Quality and People Committee
ORR101	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.	**High** 16 (I4 x L4)	Quality and People Committee
ORR129	If Nottingham and Nottinghamshire ICS does not have the capacity to make improvements in a timely manner, the quality of Special Educational Needs and Disability (SEND) may deteriorate further. This may lead to poor patient experience, adverse clinical outcomes and/or safety issues for the children and young people with special educational needs and disabilities in Nottingham and Nottinghamshire.	**High** 16 (I4 x L4)	Quality and People Committee
ORR134	If providers are consistently unable to meet the statutory timeframe for a looked after child's (LAC) Initial Health Assessment (IHA) this may result in children and young people having unmet needs and lack of access to required health and social care or medical provision. This may impact on outcomes in childhood and as they journey into adulthood. This risk relates to children placed out of area and children placed in our area from other Local Authorities.	**High** 16 (I4 x L4)	Quality and People Committee

Risk Ref.	Risk Description	Current Score	Responsible Committee
ORR084	If organisations within the ICS are unable to access IT systems, they may not be able to conduct core business as usual functions. This may result in patients not receiving timely diagnosis or treatment due to necessary equipment not functioning or patient records being unavailable.	**High** 15 (I5 x L3)	Finance and Performance Committee
ORR090	If the system does not have sufficient system partner 'buy in' and capacity to engage with and deliver transformation schemes alongside business-as-usual delivery it may not be possible to progress the System, Primary Care and ICB Digital transformation agenda.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR145	Due to a continued period of sustained pressure, further organisational change and ICB cost reductions, there is a risk of increased sickness absence and reductions in staff productivity alongside staff feeling disconnected or disengaged with the ICB.	**High** 16 (I4 x L4)	Human Resources Executive Sub-Committee