NHS
Nottingham and Nottinghamshire

Integrated Care Board Meeting Agenda (Open Session)

Thursday 14 September 2023 09:00 – 12:00

New Arts Exchange, 39-41 Gregory Boulevard, Nottingham, NG7 6BE

"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: 13 July 2023	Kathy McLean	Decision	✓	-
5.	Action log and matters arising from the meeting held on: 13 July 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.	Mid-Nottinghamshire Place-Based Partnership • *This item will include a citizen story*	Dr Thilan Bartholomeuz /Adam Hill	Discussion	✓	09:30
9.	Population Health Management (PHM) Outcomes Framework	Jack Rodber	Discussion	✓	09:55
	Assurance and system oversight				

	Item	Presenter	Type *(For Assurance, Decision, Discussion or Information)*	Enc.	Time
10.	Highlight Report from the Strategic Planning and Integration Committee • Patient and Public Engagement Annual Report	Jon Towler	Assurance	✓	10:15
11.	Highlight Report from the East Midlands Joint Committees	Amanda Sullivan	Assurance	✓	10:25
12.	Highlight Report from the Quality and People Committee	Marios Adamou	Assurance	✓	10:30
13.	Performance Report: Quality and Workforce	Rosa Waddingham	Assurance	✓	10:35
14.	Nottingham and Nottinghamshire ICS People Plan: Strategic Delivery Update	Rosa Waddingham / Philippa Hunt	Assurance	✓	10:55
15.	Highlight Report from the Finance and Performance Committee	Stephen Jackson	Assurance	✓	11:15
16.	Performance Report: Finance and Service Delivery	Stuart Poynor	Assurance	✓	11:20
17.	Risk Management Policy	Lucy Branson	Decision	✓	11:40
18.	Remuneration Committee Highlight Report	Jon Towler	Assurance	✓	11:50
	Information items *The following items are for information and will not be individually presented. Questions will be taken by exception.*				
19.	Integrated Performance Report	-	Information	✓	-
	Closing items				
20.	Risks identified during the course of the meeting	Kathy McLean	Discussion	-	11:55
21.	Questions from the public relating to items on the agenda	Kathy McLean	-	-	-
22.	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: 09 November 2023 at 9:00 (Civic Centre)

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/09/2023
Paper Title:	**Declaration and management of interests**
Paper Reference:	ICB 23 032
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?
No.

Is this item confidential?
No.

Register of Declared Interests

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

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

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

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

Name	Current position(s) held in the ICB	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To:	Action taken to mitigate risk
ADAMOU, Marios	Non-Executive Director	South West Yorkshire Partnership NHS Foundation Trust	Employed as a Consultant Psychiatrist	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ADAMOU, Marios	Non-Executive Director	Marios Adamou LTD - 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 Association	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.
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.

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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 (the ICB holds no contracts with this organisation)	Joint Owner and Chief Executive Officer	✓				01/07/2022	Present	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.
LIM, Dr Kelvin	Primary Care Partner Member	Alike Ltd (GP private practice)	Business owner (business inactive for several years and is currently being liquidated)	✓				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.

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MAJID, Ifti	Mental Health Partner Member	Ellern Mede - provider of high intensity children and young people's eating disorder services	Spouse is Managing Director				✓	07/12/2022	Present	This interest will be kept under review and specific actions determined as required.
MALEY, Caroline	Non-Executive Director	Village Health Group	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	University Hospitals of Derby and Burton NHS Foundation Trust	Trust Chair	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Kathy McLean Limited - Private limited company to offer health related advice	Director	✓				01/07/2022	Present	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	Barking, Havering and Redbridge University Hospitals NHS Trust	Non-Executive Director	✓				01/09/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS Employers	Member of the Workforce Policy Board		✓			*Tbc*	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS Employers	Chair of the national negotiation committee for Staff and Associate Specialists on behalf of NHS Employers		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Care Quality Commission (CQC)	Occasional Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	The Public Service Consultants Ltd (Public Sector Consultancy)	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.
MCLEAN, Kathy	ICB Chair	NEMS Healthcare Ltd	Partner is a shareholder				✓	01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangement) relating to services that are currently, or could be, provided by NEMS.
MCLEAN, Kathy	ICB Chair	Oxehealth Ltd (vision-based patient monitoring and management)	Member of the advisory board	✓				*Tbc*	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangement) relating to services that are currently, or could be, provided by Oxehealth Ltd.
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.

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SULLIVAN, Amanda	Chief Executive	Hillview Surgery	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
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.
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	Care Quality Commission (CQC)	Specialist Advisor (temporary appointment supporting the ICS inspections pilot)	✓				09/10/2023	13/10/2023	This interest will be kept under review and specific actions determined as required.
WADDINGHAM, Rosa	Director of Nursing	NHS Professionals (An NHS staff bank, owned by the Department of Health and Social Care)	Member of the advisory board	✓				01/09/2023	Present	This interest will be kept under review and specific actions determined as required.
WADDINGHAM, Rosa	Director of Nursing	Florence Nightingale Foundation (FNF) (A charity supporting Nurses and Midwifes to improve patient care)	Chair of the FNF Members' Advisory Group		✓			01/09/2023	Present	This interest will be kept under review and specific actions determined as required.
WILLIAMS, Melanie	Local Authority Partner Member	Nottinghamshire County Council	Corporate Director for Adult Social Care and Health	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
WILLIAMS, Melanie	Local Authority Partner Member	Orchard Surgery	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
The following individuals will be in attendance at the meeting but are not part of the Board's membership:										
BRANSON, Lucy	Associate Director of Governance	St George's Medical Practice	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
KING, Daniel	VCSE Alliance Chair	Nottingham Trent University	Employee	✓				06/09/2023	Present	This interest will be kept under review and specific actions determined as required.
HUBBER, Lucy	Director of Public Health, Nottingham City Council	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable

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
HUNT, Philippa	Chief People Officer	NHS Staff Council	ICB Representative	✓				01/09/2023	Present	This interest will be kept under review and specific actions determined as required.

Appendix B

NHS
Nottingham and Nottinghamshire

Managing Conflicts of Interest at Meetings

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

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

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

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

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

Integrated Care Board (Open Session)
Unratified minutes of the meeting held on
13/07/2023 09:00-11:10
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
Paul Robinson	NHS Trust/Foundation Trust Partner Member
Amanda Sullivan	Chief Executive
Catherine Underwood	Local Authority Partner Member
Rosa Waddingham	Director of Nursing
Melanie Williams	Local Authority Partner Member
In attendance:	
Lucy Branson	Associate Director of Governance
Claire Culverhouse	Managing Director of the Nottingham and Nottinghamshire Provider Collaborative (for item ICB 23 024)
Lucy Hubber	Director of Public Health, Nottingham City Council
Philippa Hunt	Chief People Officer
Marcus Pratt	Programme Director System Finance (on behalf of Stuart Poynor)
Sue Wass	Corporate Governance Officer (minutes)
Apologies:	
Ifti Majid	NHS Trust/Foundation Trust Partner Member
Stuart Poynor	Director of Finance
Jon Towler	Non-Executive Director

Cumulative Record of Members' Attendance (2023/24)

Name	Possible	Actual	Name	Possible	Actual
Kathy McLean	2	2	Stuart Poynor	2	1
Marios Adamou	2	2	Paul Robinson	2	2
Dave Briggs	2	2	Amanda Sullivan	2	2
Lucy Dadge	2	2	Jon Towler	2	1
Stephen Jackson	2	2	Catherine Underwood	2	2

Name	Possible	Actual	Name	Possible	Actual
Kelvin Lim	2	2	Rosa Waddingham	2	1
Ifti Majid	2	0	Melanie Williams	2	1
Caroline Maley	2	2			

Introductory items

ICB 23 016 **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 Marcus Pratt, who was attending on behalf of Stuart Poynor.

ICB 23 017 **Confirmation of quoracy**

The meeting was confirmed as quorate.

ICB 23 018 **Declaration and management of interests**

In relation to item ICB 23 024, it had been noted ahead of the meeting 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 was required, it had been agreed that they should fully participate in discussions. Paul drew members attention to this interest at the start of the meeting.

No further interests were declared.

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

ICB 23 019 **Minutes from the meeting held on: 11 May 2023**

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

ICB 23 020 **Action log and matters arising from the meeting held on: 11 May 2023**

One action from the previous meeting remained open and on track for completion. All other actions were noted as completed.

No further matters were raised.

Leadership

ICB 23 021 **Chair's Report**

Kathy McLean presented the item and highlighted the following points:

a) Following a recent system-wide discussion on partnership working, Kathy drew members' attention to the principles and values listed at the top of the agenda and asked members to ensure that they continued to act and function in line with these values.

b) Highlighting that the NHS had recently celebrated its seventy-fifth anniversary, the milestone was noted as a great achievement, and it would be incumbent on everyone working in the NHS to ensure that its achievements were protected and improved upon going forward.

c) Kathy and Amanda had attended the vigil for the three individuals who had died in such shocking and sad circumstances in Nottingham city centre on 13 June 2023. The Board expressed its sincere condolences to the families and friends of the victims.

d) Kathy had attended a chancellor's dinner at both the University of Nottingham and Nottingham Trent University to hear the inspiring research taking place, noting good engagement from the universities with the ICS.

e) Executive colleagues from the ICB had met their counterparts from Derby and Derbyshire and had had a very useful discussion about potential areas for wider collaboration and joint working.

f) Members' attention was drawn to the Board's work programme for 2023/24, which had been developed to ensure the Board's time is focused on key responsibilities and delivering against statutory duties, regulations and agreed strategies. A refreshed meeting etiquette had also been developed following the recent review of committee effectiveness and members were asked to familiarise themselves with it.

g) Since the ICB's establishment, considerable Board time had been spent on the development of the Integrated Care Strategy and the Joint Forward Plan, the latter of which would be considered for approval later in the meeting. These strategies were necessary to to deliver sustainable service improvement for the long term; however, Board attention now needed to focus on the immediate challenges bought about by the current operating environment.

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

ICB 23 022 Chief Executive's Report

Amanda Sullivan presented the item and highlighted the following points:

a) The continuing hard work of colleagues during a time of significant disruption was acknowledged.

b) A working group of the ICB's Staff Engagement Group had been established to take forward several actions in response to the ICB's Staff Survey results. Although the results compared favourably with other ICBs, the action plan would focus on a few specific concerns raised and progress would be overseen by the Remuneration Committee.

c) The ICB was one of two midlands systems to have been chosen to be early adopters of the 'Getting to Equity' programme, designed to embed systemic race equity into their leadership teams. This was noted as a welcome development.

d) The ICB's first Annual Report and Accounts, covering the period 1 July 2022 to 31 March 2023, had been published and would be formally presented to the public during September. On establishment, the ICB had also assumed responsibility for approving the Annual Reports and Accounts of the former Bassetlaw and Nottingham and Nottinghamshire CCGs for the period 1 April to 30 June 2022. These Annual Reports and Accounts had also been approved and published.

e) NHS England had published guidance regarding the process for its annual assessment of ICBs. No formal rating would be given for the first year, although feedback would be given on areas of good performance and areas of challenge. The assessment outcome for the ICB will be shared with the Board once received.

f) The visit to Nottingham of the Prime Minister and Secretary of State for Health and Social Care to announce the extension of the targeted lung cancer screening programme had been welcomed.

g) A Nottinghamshire Special Needs and Disabilities (SEND) Partnership Improvement Board had been established to oversee the improvement actions needed following significant concerns raised in the Ofsted and Care Quality Commission Report. This Board would be chaired independently by a recognised sector expert, Dame Christine Lenehan, and children and young people with SEND and their families would be involved in the development of the improvement plan to address concerns raised in the report.

h) The Nottingham and Nottinghamshire Community Care Transformation Programme was congratulated on winning a national Integrated Health Award.

i) The NHS Mandate for 2023 had recently been published, which was very much in line with the requirements of the 2023/24 Operational Plan.

j) The NHS Long Term Workforce Plan had also been published, which set out three priority areas to train, retain and reform the NHS workforce.

The following points were made in discussion:

k) Regarding the SEND Partnership Improvement Board, it was noted that its remit would be across both the Nottinghamshire County and Nottingham City local authority footprints to ensure that good practice and learning was disseminated across the entire ICS footprint.

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

Health inequalities and outcomes

ICB 23 023 **Joint Forward Plan**

Lucy Dadge presented the item and highlighted the following points:

a) The Joint Forward Plan presented the NHS's contribution to delivery of the Nottingham and Nottinghamshire Integrated Care Strategy. It detailed how NHS core services would be recovered and made sustainable over the five-year period 2023 to 2027.

b) The plan had been co-produced with system partners and citizens during May and June to ensure there was system support for the Joint Forward Plan as a collective plan.

c) The final draft plan had been published online on 30 June to meet NHS England requirements and was presented to the Board for approval.

d) The plan identified the key priority areas of transformational change and set out detailed expectations in relation to the delivery of NHS programmes and initiatives over the next five years that would transform the way partners worked together and how they focused their collective efforts and resources.

The following points were made in discussion:

e) Members welcomed the Joint Forward Plan, thanking its authors and contributors, and noting that it followed the core principles of the Integrated Care Strategy and gave a clear indication of collective commitments year on year.

f) Members noted the high level of engagement with system partners, including local authority partners, who had provided valuable feedback.

g) Discussing the audience for the public-facing version of the plan, members noted the most important audience as the staff that worked in the Nottingham and Nottinghamshire system. In light of this, several presentational recommendations were made.

h) The focus of the discussion moved to how the plan would be delivered and how progress would be monitored. Members queried whether a system-wide Programme Management Office approach should be developed. It was noted that delivery and oversight would need to be co-owned and the same performance monitoring metrics used across the Nottingham and Nottinghamshire system. It was noted that to avoid duplication, existing oversight and governance structures should be used and re-purposed. It was agreed that the key challenge would be the management of interdependencies.

i) It was agreed that a delivery plan that mapped ownership and oversight of each element of the Joint Forward Plan would be produced, which would also propose a cycle of reporting to the Board.

The Board **approved** the NHS Joint Forward Plan and supporting documents, indicating the preferred design for the formal launch of the plan by end of July 2023.

Action: Lucy Dadge to confirm delivery and oversight arrangements for the NHS Joint Forward Plan.

Claire Culverhouse joined the meeting at this point.

ICB 23 024 Nottingham and Nottinghamshire Provider Collaborative at Scale

The Chair welcomed Claire Culverhouse, who was in attendance to provide an update on the work of the Nottingham and Nottinghamshire Provider Collaborative at Scale.

Claire Culverhouse and Paul Robinson presented the item, and highlighted the following points:

a) The Provider Collaborative had been operating for one year. The report provided an overview of the progress that had been made in its development to date.

b) It was acknowledged that it was still early days for the Collaborative and that this was a different way of working for provider organisations. The Nottingham and Nottinghamshire Provider Collaborative at Scale had a membership wider than national guidance, encompassing all three acute trusts operating in Nottinghamshire, as well as Nottinghamshire Healthcare NHS Foundation Trust and East Midlands Ambulance Services NHS Trust. Having a single provider collaborative for the system differed to other areas where several collaboratives had been established to focus on different areas of service provision.

c) A Leadership Board had been established as a partnership of equals and a mission statement, objectives and principles had been agreed. A Managing Director for the Collaborative had also been appointed and a Distributed Executive Team would meet for the first time in July.

d) The priority programmes of work identified in the areas of urgent care and workforce were described.

e) The focus to date had been building the foundations to enable programmes to address the priority areas to move forward.

f) Risks to the delivery of the identified programmes were noted as capacity, the need for collaboration at all levels and the need to gain credibility and manage expectations.

The following points were made in discussion:

g) Members welcomed the report and the progress made; however, queried whether the Collaborative could be more ambitious. It was noted that there needed to be a period of identifying and testing the opportunities that could be owned in a collaborative space. Once credibility was gained, further opportunities where it would make sense for organisations to work together would be identified, which could include the development of whole system pathways.

h) It was noted that this was a sensible way forward and that, in time, it was expected that the Collaborative would move into other areas where there was a clear rationale that it would add value without duplicating existing activities.

i) Members queried how the Collaborative would manage the impact of its work on other organisations, such as primary care. It was noted that as the Collaborative developed, it would work with all other system partners, including primary care providers and Place Based Partnerships. There would also be a need, moving forward, to link in with system-level programmes, such as digital transformation, to influence areas not solely within the sphere and remit of the Provider Collaborative.

j) Members agreed that relationship management was the key to the success of the Collaborative and noted the positive relationships that had been built to date.

The Board **noted** the report, having discussed the work of the developing Provider Collaborative with that of the ICB and other parts of the system.

At this point, Claire Culverhouse left the meeting.

Assurance and system oversight

ICB 23 025 **Integrated Performance Report**

Marcus Pratt, Lucy Dadge, Dave Briggs, and Rosa Waddingham presented the item and highlighted the following points:

a) At the end of month two, the NHS system had reported a £29.5 million deficit position, which was £18.9 million adverse to plan. The main drivers of the variance related to a technical accounting issue regarding the misalignment of an income target to the urgent and emergency care improvement trajectory within Nottingham University Hospitals NHS Trust, the non-achievement of in-month efficiency targets, and agency staff costs above planned levels.

b) The ICB was reporting a break-even position, although there was considerable risk to this position due to budgetary pressures within prescribing and continuing healthcare.

c) The ICS Finance Directors' Group had 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. They were looking to strengthen financial controls in all organisations, using NHS England and Healthcare Financial Management Association best practice guidance. Internal Audit support to this area of work was also being explored.

d) Overall, mental health services were performing well, with improvements across several areas; however, access to talking therapy services was below planned levels of activity (previously Improving Access to Psychological Therapies). Additional capacity to address waiting lists had been put in place.

e) Continued pressures had led to additional out of area mental health inpatient placements being required and the ICB was working closely with Nottinghamshire Healthcare NHS Foundation Trust to address this.

f) There had been an increase in patient length of stay across all three acute trusts and the ICB continued to work with trust partners to improve discharge rates.

g) The industrial action had led to the cancellation of many elective and diagnostic procedures. Waiting lists continued to be monitored on a patient-by-patient basis.

h) Cancer services continued to perform relatively well against national comparators.

i) The Children and Young Peoples' Eating Disorders service had significantly improved its performance over the past few years with delivery for urgent referrals now at 100%.

j) Recommendations for investment through the Health Inequalities Innovation and Investment Fund would be discussed at an extraordinary meeting of the Strategic Planning and Integration Committee in August.

k) Each of the five clinical areas of the Core20Plus5 national approach to health inequalities had accompanying workstreams and plans. Plans were at a system level and were supported by action being taken at a neighbourhood and place level. However, it was noted that assurance could not be taken in some areas of perceived improvement, as factors influencing them were complex and open to a level of interpretation.

l) The Learning Disability and Autism (LDA) Partnership programme remained under limited assurance; however, during June there had been a further nine discharges from inpatient settings, which had moved the programme to being on plan for quarter one.

m) It was proving difficult to meet the new challenging targets regarding hospital acquired infections. However, recent industrial action had allowed deep cleaning routines to be reinstated during times of reduced bed occupancy.

n) There were a several areas of limited assurance regarding children and young people's services, including looked after children and children and young people with special educational needs and

disabilities (SEND). A system quality summit has been planned for September 2023 to consider how the system as a whole could address key areas of ongoing concern.

o) An update on the ICS People Plan was scheduled to be discussed at the September Board meeting. This would also include an assessment against the recently released national workforce plan.

p) Currently the workforce position in the system was being maintained, with some improvement on sickness absence levels, with focus being maintained on agency staff usage.

At this point, Kathy McLean welcomed feedback from the Chairs of the Board's assurance committee, as relevant to the Integrated Performance Report. As such, the Highlight Reports from the Finance and Performance Committee and Quality and People Committee were brought forward on the agenda and considered together with the Integrated Performance Report. The following points were made in discussion:

q) As Chair of the Finance and Performance Committee, Stephen Jackson fed back that the Committee had noted the enormous amount of work being undertaken to identify routes back to the achievement of in month financial plans, noting the financial impact of industrial action. However, only limited assurance could be taken at this time, as the impact of these measures was yet to be seen. The Committee considered that this situation was unlikely to change in the medium term.

r) Regarding performance, the Finance and Performance Committee continued to receive targeted assurance reports. However, as noted above, only limited assurance could be taken. Although there were areas of good performance compared to national averages, there were pockets of poor performance within individual providers, evidencing that partnership working was not yet operating effectively across the system.

s) When discussing health inequalities data, the importance of triangulating data with public health colleagues to promote a broader interpretation and understanding was noted.

t) As Chair of the Quality and Performance Committee, Marios Adamou noted that the Committee's focus for the forthcoming meeting would be on seeking assurance that the large number of operational risks were being appropriately managed.

u) Quality and People Committee members had noted limited assurance following a deep dive report on progress towards compliance with key quality domains in respect of Looked After

Children. Limited assurance continued to be taken over several areas of workforce reporting due to limitations in data.

v) Noting the large number of areas of limited assurance in the report from the Quality and People Committee, members queried whether there would be any benefit in a review of system processes. It was noted that there were some cross-system audits planned for this year and there was currently a discussion regarding whether an internal audit on finance systems would be of any benefit. However, audits on clinical systems may sit outside of the expertise of the internal audit function. It was agreed to circulate the ICB's Internal Audit Plan for information.

w) Welcoming the focused discussion on workforce at the Board's September meeting, it was noted that this should also be an opportunity to discuss what the workforce of the future needed to look like.

x) Although the Integrated Performance Report was acknowledged as a comprehensive document, members agreed that it could be reviewed to ensure that key areas are clearly highlighted for Board attention, following Committee scrutiny.

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

Actions:

- **Stuart Poynor to review the content and presentation of the Integrated Performance Report to the Board.**
- **Dave Briggs to review the approach to health inequalities thematic reviews, as set out within the Finance and Performance Committee's annual work programme.**
- **Lucy Branson to circulate the ICB's Internal Audit Plan for information.**

ICB 23 026 Committee Highlight Reports

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

Members' attention was drawn to the highlight reports that had not already been considered during the Integrated Performance Report item. As such, Caroline Maley and Amanda Sullivan highlighted the following points:

a) Audit and Risk Committee members had approved the ICB's Annual Report and Accounts for the period 1 July 2022 to 31 March 2023 and 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).

b) The first highlight report from the East Midlands Joint Committees had been received, which provided a summary of items considered.

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

Closing items

ICB 23 027 **Risks identified during the course of the meeting**

No new risks were highlighted.

ICB 23 028 **Questions from the public relating to items on the agenda**

No questions had been received.

ICB 23 029 **Any other business**

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

Date and time of next Board meeting held in public: 14 September 2023 at 9:00 (Venue to be confirmed)

NHS Nottingham and Nottinghamshire

ACTION LOG from the Integrated Care Board meeting held on 13/07/2023

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
Closed – Action completed	09/03/2023	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	14/09/2023	The Strategic Planning and Integration Committee considered this at an extraordinary meeting in August. A further report is scheduled for October/November. The Board will receive the outcome of this work via the Committee's Highlight Reports – see agenda item 10 for an initial update.
Open – On track	13/07/2023	ICB 23 024: Joint Forward Plan	To confirm delivery and oversight arrangements for the NHS Joint Forward Plan.	Lucy Dadge	12/10/2023	Not yet due. This is scheduled for agreement at the Board Development Session in October.
Closed – Action completed	13/07/2023	ICB 23 026: Integrated Performance Report	To review the content and presentation of the Integrated Performance Report to the Board.	Stuart Poynor	14/09/2023	A new approach to presenting the Integrated Performance Report content is being trialled on this agenda. The approach aims to satisfy public reporting and transparency requirements, while recognising the detailed work of the Board's committees. and Feedback from Board Members is welcomed on

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
						whether this approach supports more effective use of the Board's time.
Closed – Action completed	13/07/2023	ICB 23 026: Integrated Performance Report	To review the approach to health inequalities thematic reviews, as set out within the Finance and Performance Committee's annual work programme.	Dave Briggs	14/09/2023	A programme of thematic health inequalities reports is included within the Finance and Performance Committee's annual work programme. This will cover all Core20+5 clinical areas requiring accelerated improvement during the business cycle. This approach will be reviewed as part of the committee effectiveness work for 2023/24.
Closed – Action completed	13/07/2023	ICB 23 026: Integrated Performance Report	The ICB's Internal Audit Plan to be circulated for information.	Lucy Branson	14/09/2023	The ICB's 2023/24 Internal Audit Plan was circulated to Board Members on 08/09/2023.

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:	14/09/2023
Paper Title:	**Chair's Report**
Paper Reference:	ICB 23 035
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: Draft ICS Partnership Agreement

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. Later today, the ICB will hold its Annual Public Meeting – the first since our establishment on 1 July last year. I am looking forward to seeing our system partners, Voluntary, Community and Social Enterprise (VCSE) colleagues and members of the public at that meeting for a discussion about the ICB’s delivery over the first period of its existence. It will also be great for the ICB’s leadership to be able to answer questions on last year’s delivery and priorities for the year ahead.

2. I am really pleased to welcome Professor Daniel King as an attendee to this and future Board meetings. Daniel is Chair of the Integrated Care System’s VCSE Alliance and so will be aiming to bring the perspective of this vibrant and diverse sector to our discussions. One person cannot possibly hope to represent an entire sector, but I hope that Daniel’s expertise and the intelligence from the wider Alliance will help inform and enrich our discussions. In his day job, Daniel is co-director for the People, Work and Organisational Practice research centre at the Business School at Nottingham Trent University and has a particular interest in the VCSE sector, having worked and volunteered in the sector for a number of years, setting up and running small-scale charities and working in homelessness and mental health hostels.

3. Finally, in terms of introductory matters, partners have over the summer been discussing a refresh of the Nottingham and Nottinghamshire Integrated Care System (ICS) Partnership Agreement, which sets out our values and behaviours as partners. This work was initiated at a meeting of the ICS Reference Group in July and it was clear from discussions at that meeting that current Partnership Agreement is broadly fit for purpose but does need some updating to reflect the new Integrated Care Strategy and to include reference to how we will work with people and communities in developing our plans and how we will behave when we fall short of the standards we set ourselves. Board members can see the latest updated version of the Partnership Agreement that is being discussed by partners at Appendix A of this report and I would welcome any comments further to those already provided. Feedback from all partners will be presented to the Integrated Care Partnership in October, where a final version agreement will be approved.

Developing our services and system

4. As I have said consistently since the start of this year, we have a strong Integrated Care Strategy and a clear NHS Joint Forward Plan, which sets out how the Integrated Care Strategy will be delivered, alongside the Joint Local

Health and Wellbeing Strategies for Nottingham City and Nottinghamshire County. The task now is to have a clear focus on delivery, as we cannot afford for our population's sake to not follow through on our commitments to equity, prevention and integration.

5. We are starting to deliver the changes that we need to see in many areas and getting recognised for that too – in recent weeks, our collective work based on data and intelligence identifying citizens at risk of fuel poverty and food insecurity has been noted in reports by The Health Foundation and NHS England.

6. Also, a key area of focus for us is the ongoing development of our Place Based Partnerships and I was pleased to see all the great progress that our Places are making shared and discussed at our collaborative event last week at Mansfield Civic Centre. It was excellent to see so many people from across our system coming together to share best practice, ideas and initiatives that will make a difference for the health and wellbeing of our citizens.

7. Despite this positive progress and commitment from colleagues throughout the ICB and across the system, there are still considerable challenges facing our work as we enter the second half of the financial year. The pressure of the ongoing industrial action continues to impact on our waiting lists and on the resilience of our staff. I am proud of how teams have navigated the disruption caused by these various waves of industrial action and that we have all made efforts to maintain access to general practice and continue to make progress on delivery of planned operations and diagnostic tests. However, it is clear that we have considerable ground to recover in several areas, not least our financial performance (including the impact of the use of agency staff) and getting back on track with waiting times and access to emergency care, which is a top priority for the NHS. We have a track record in Nottingham and Nottinghamshire of successful collaboration during times of pressure on our health and care system and all partners will continue to work together to support citizens and staff through the winter period.

8. As part of the ongoing promotion and dissemination of our Integrated Care Strategy, I was pleased to be part of a discussion in our first ICS Podcast exploring the development of the strategy. I was joined by Lucy Hubber, Director of Public Health at Nottingham City Council, Joanna Cooper, Assistant Director of Strategy for the ICB and also Professor Daniel King, VCSE Alliance Chair in a lively and illuminating discussion. Colleagues can access the podcast here: https://healthandcarenotts.co.uk/integrated-care-strategy-podcast/.

Looking forward

9. A good example of the prevention strand of our strategic approach is the work that Nottinghamshire County Council are leading on Fluoridation. At July's Full

Council meeting, backing was given to champion this simple intervention that hugely boosts oral health. The potential rewards are impressive: a 35% reduction in decayed, missing and filled teeth in five-year-old children, a 56% decrease in hospital admissions for tooth extractions in children from the most deprived areas, and a remarkable return of £12.71 after five years and £21.98 after ten years for every £1 invested in fluoridation. Councillor Dr John Doddy, Chairman of the Nottinghamshire County Health and Wellbeing Board and Vice-Chair of our Integrated Care Partnership, who proposed the approved motion to champion the oral health agenda, has particularly impressed upon me the fact that this is a completely avoidable health inequality. I understand from John that if we fluoridated the water across Nottinghamshire, we would see a 15% increase in five year old children who are completely free of dental decay and there would be a significant reduction of people going into hospital for tooth extractions. I look forward to working with the Nottinghamshire County Council and other partners to push this forward. It will be an item on the agenda of October's meeting of the Integrated Care Partnership.

10. We are starting to know more about the future landscape of the devolution of powers and money to Nottingham and Nottinghamshire and Derby and Derbyshire and the creation of a new Combined Authority under an elected Mayor. The political parties are starting to select their candidates with two already confirmed and the deal will see an extra £38 million a year coming to the East Midlands from 2024. Mark Rogers has recently been appointed as the Interim Chief Officer of the East Midlands devolution programme. Having played a pivotal role in the formation of the West Midlands Combined Authority, Mark will take the lead in ensuring that the region is well-placed to establish the East Midlands Combined Authority, which is due to come into existence next year subject to Royal Assent for a new Act of Parliament. We already work closely with Derby and Derbyshire ICB colleagues and the onward progress of work to establish the new Combined Authority and the election of the Mayor will only accelerate that.

11. Later this month we are welcoming Steve Russell, NHS England's Chief Delivery Officer and Adam Doyle, Chief Executive of NHS Sussex ICB, who is advising NHS England on ICS policy. Steve and Adam will see a number of projects demonstrating our commitment to integration, prevention and equity and also participate in a leadership roundtable. I am looking forward to highlighting the great work of our teams here in Nottingham and Nottinghamshire to these national leaders.

12. Nominations for our first system-wide Health and Care Awards closed last week. We have received a strong set of entries which the judging panels are currently working through. The award categories are aligned to the four aims and the three principles of our Integrated Care Strategy and so these awards will be a key way that we can celebrate work that stretches across the

boundaries of individual organisations. I am also delighted that the awards will be supported by the Lord Lieutenant for Nottinghamshire, Sir John Peace. The winners will be announced at a ceremony held at Nottingham University on 24 October.

New standards for NHS Board members to strengthen leadership and governance

13. NHS England has recently released a revised Fit and Proper Person Test Framework in response to recommendations made by Tom Kark KC. Its intention is to ensure high standards of leadership in the NHS. It applies to all Board members of ICBs, NHS trust and foundation trusts, NHS England and the Care Quality Commission and is designed to assess the appropriateness of an individual to effectively discharge their duties in the capacity of a Board member. The framework introduces new and more comprehensive requirements around Board appointments and annual reviews and ties the Fit and Proper Person Test (FPPT) into the annual appraisal process.
14. As Chair, I have overall accountability for the FPPT within the ICB and work is currently ongoing to complete these tests for ICB Board members for this year.
15. NHS England is currently finalising a new NHS Leadership and Competency Framework for Board level roles and a new Board appraisal framework will also be introduced. Alongside this work, NHS England has published the first suite of Board level learning and development offers, which can be found here: https://www.england.nhs.uk/long-read/directory-of-board-level-learning-and-development-opportunities/.

Integrated Care System
Nottingham & Nottinghamshire

Nottinghamshire County Council

Appendix A

Agreement as Signed Summer 2021

Integrated Care System
Nottingham & Nottinghamshire

Nottinghamshire County Council · Nottingham City Council · NHS

Nottingham & Nottinghamshire Integrated Care System (ICS)
Partnership Agreement

We, the members of the Nottingham and Nottinghamshire ICS Board, have agreed to establish a 'Partnership Agreement' to demonstrate our commitment to work effectively together for the benefit of all our communities and citizens.

In supporting, being compassionate and caring for local people, the role of our ICS is to enable health and care professionals to work together across organisational boundaries to maximise the use of our energies and resources.

We do not underestimate the challenges ahead as our NHS and social care system looks to recover and reset from the global pandemic but through our Partnership Agreement we commit to work together with the shared purpose of:

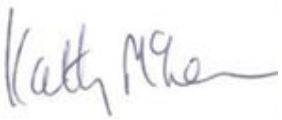
"Every citizen enjoying their best possible health and wellbeing"

We have agreed three main principles, focused on what really matters, that will guide our ways of working together:

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

These principles will be underpinned by the following core values:

- We will be **open** and **honest** with each other;
- We will be **respectful** in working together;
- We will be **accountable**, doing what we say we will do and following through on agreed actions.



Signed by Kathy McLean OBE
ICS Chair on behalf of the ICS Board






#TogetherWeAreNotts

Integrated Care System
Nottingham & Nottinghamshire

Nottinghamshire County Council

Proposed Updated Agreement

Integrated Care System
Nottingham & Nottinghamshire

Nottinghamshire County Council · Nottingham City Council · NHS

Nottingham and Nottinghamshire Integrated Care System (ICS)
Partnership Agreement

We, the collective leaders of Nottingham and Nottinghamshire ICS, have agreed to establish a 'Partnership Agreement' to demonstrate our commitment to work effectively together for the benefit of all our communities and citizens.

In supporting, being compassionate and caring for local people, the role of our ICS is to enable health and care professionals to work together across organisational boundaries to maximise the use of our energies and resources.

We do not underestimate the challenges ahead as our NHS and social care system looks to implement our shared Integrated Care Strategy but through our Partnership Agreement we commit to work together with the shared purpose of:

"Every person enjoying their best possible health and wellbeing"

We have agreed three main principles and confirmed four aims within our Integrated Care Strategy that will guide our ways of working together:

- **Prevention** is better than cure;
- **Equity** in everything;
- **Integration** by default.

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

These principles will be underpinned by the following core values:

- We will be **open** and **honest** with each other;
- We will be **respectful** in working together;
- We will be **accountable**, doing what we say we will do and following through on agreed actions.
- We will **challenge others** when they fall short of the standards in this Agreement and accept the same challenge back

Finally, all system partners are committed to consistently listening to, and collectively acting on, the experience and aspirations of local people and communities.

Signed by Kathy McLean OBE
Integrated Care Partnership Chair






#TogetherWeAreNotts

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/09/2023
Paper Title:	**Chief Executive's Report**
Paper Reference:	ICB 23 036
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

Outcome of NHS England's annual assessment of ICB performance

1. NHS England has completed its assessment of the ICB's performance for 2022/23. The approach to the assessment was developed in collaboration with ICB leaders and subject matter experts and considered how effectively the ICB has led its system, as well as its contribution to the four fundamental purposes of an Integrated Care System.
2. The assessment recognises the relative infancy of ICBs, but nevertheless the assessment has concluded that the ICB has demonstrated effective leadership, with a strong collaborative approach and good engagement with partners and stakeholders. The assessment notes good progress in the recovery of services following the pandemic and good progress on specific challenges, such as the plans to tackle health inequalities.
3. The assessment also notes areas of challenge for this ICB regarding its financial position, the need to roll out technology enabled care more widely, and the need for continued focus on the metrics associated with urgent and emergency care and learning disabilities and autism.
4. The full assessment can be found here: https://notts.icb.nhs.uk/wp-content/uploads/sites/2/2022/04/NN-Annual-Assessment-Letter-2023.pdf.

Executive lead roles within Integrated Care Boards

5. A commitment was given to Parliament during consideration of the Health and Care Act 2022, that every ICB would identify lead members of their Boards with explicit responsibility for the following population groups:
    a) Children and young people (aged 0 to 25)
    b) Children and young people with special educational needs and disability (aged 0 to 25)
    c) Safeguarding (all-age)
    d) Learning disability and autism (all-age)
    e) Down syndrome (all-age)
6. In each ICB, these executive leads support the Chief Executive and the Board to ensure that the ICB functions effectively in relation to the groups above. These executive leadership roles have been added to the statutory requirement for each ICB with the intention to secure visible and effective Board-level leadership for addressing issues faced by the groups, and to ensure that statutory duties related to safeguarding and special educational needs and disabilities receive sufficient focus. These individuals will be a key contact point

for NHS England regional and national teams and local partners across health, social care, housing, youth justice, criminal justice, education, and regulators, including the Care Quality Commission and Ofsted.

7. For NHS Nottingham and Nottinghamshire ICB, Lucy Dadge, the ICB's Director of Integration, is the Executive lead for children and young people and Rosa Waddingham, the ICB's Director of Nursing and Quality, is the Executive lead for children and young people with special educational needs and disability, safeguarding, learning disability and autism and down syndrome.

8. The full guidance setting out the responsibilities of these Executive lead roles can be found here: https://www.england.nhs.uk/long-read/executive-lead-roles-within-integrated-care-boards/.

9. In addition, the role requirements for the ICB's Accountable Emergency Officer have recently been strengthened in line with the latest guidance from NHS England to provide executive level responsibility for emergency preparedness, resilience, and response (EPRR). Following a national review of non-executive director champions, the requirement for a non-executive Board member to support the Accountable Emergency Officer has been removed, recognising that the responsibility for EPRR sits with the whole Board and that the Board should assure itself that requirements are being met. The Accountable Emergency Officer, who should be a Board-level director, must provide reports to the public Board on EPRR activity no less frequently than annually and must publicly state its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements.

10. The ICB's Accountable Emergency Officer is Lucy Dadge and the Audit and Risk Committee will continue its role of scrutinising the ICB's EPRR arrangements on behalf of the Board (albeit that Caroline Maley is no longer required to act as Non-Executive Lead for EPRR), with an annual EPRR Report scheduled as part of the Board's work programme.

Independent Review into Maternity Services at Nottingham University Hospitals Trust

11. On 7 September 2023, the Chief Constable of Nottinghamshire Police gave formal notification that she is preparing to open a Police investigation to work alongside the ongoing Independent Review into maternity services at Nottingham University Hospitals Trust. The ICB will cooperate fully with the police investigation, as well as continuing to provide targeted support and oversight at Nottingham University Hospitals NHS Trust.

12. The ICB, though the Local Maternity and Neonatal System (LMNS), continues to coordinate local activity and actions in response to the Independent Review and to ensure high standards of care for all those accessing maternity services across Nottingham and Nottinghamshire, working closely with maternity

providers and the Maternity Voices Partnership. Our thoughts at this time are with the women, their babies and families who have been impacted by these events.

13. At the time of writing this report, we were expecting the imminent publication of the Care Quality Commission's updated report and rating into maternity services and the leadership of Nottingham University Hospitals NHS Trust. It may be possible to provide a verbal update at the meeting once this report has been published.

Verdict in the trial of Lucy Letby

14. Amanda Pritchard, Chief Executive of NHS England, has written to all ICBs and NHS trusts following the outcome of the trial of Lucy Letby. The letter recognises that colleagues across the health service have been shocked and sickened by these appalling crimes and that our collective thoughts are with all the families affected.

15. NHS England is committed to doing everything possible to prevent anything like this happening again and has welcomed the independent inquiry into the events at the Countess of Chester and will cooperate fully and transparently to ensure every possible lesson is learnt from this awful case. In the Autumn, a new Patient Safety Incident Response Framework will be implemented across the NHS, representing a significant shift in the way the NHS responds to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

16. NHS leaders have also been reminded of the importance of listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance arrangements, including adoption, implementation and oversight at Board-level of the national Freedom to Speak Up (FTSU) Policy by January 2024 at the latest. Obligations under the Fit and Proper Person Test (FPPT) requirements have also been stressed, in line with NHS England's strengthened FPPT Framework.

17. The CQC is primarily responsible for assuring speaking up arrangements; however, ICBs have been asked to consider how all NHS organisations have accessible and effective speaking up arrangements. The ICB is in the process of undertaking a stocktake in response to this request.

18. Amanda Pritchard's letter can be found here: https://www.england.nhs.uk/long-read/verdict-in-the-trial-of-lucy-letby/.

Industrial action

19. Industrial action continues, with two further periods of industrial action being undertaken by junior doctors on 13 to 18 July and 11 to 15 August. The cumulative total of acute inpatient and outpatient appointments cancelled in eight months of industrial action now stands at 698,813 across England. For the first time, consultant doctors and hospital-based dentists took industrial action from 24 to 26 August. In contrast to strike action among other staff groups, no other clinicians can provide cover for consultants, so planned care activity had to be rescheduled.

20. Further industrial action has recently been announced and consultants are expected to go on strike later this month on 19 to 20 September. Junior doctors will also take further action on 20 to 22 September. In October, a joint strike from 2 to 5 October has been announced.

21. The industrial action continues to impact our hospitals, mental health services, GP practices and other NHS services and the local NHS is working hard to keep critical services like emergency treatment, neonatal care, maternity, and trauma open and running smoothly. However, elective, or planned services will continue to be affected. The safety of patients and staff remains the top priority and measures continue to be in place to ensure the safety and welfare of patients and staff.

Flu and Covid vaccination programmes

22. Following the announcement by the Department of Health and Social Care and the UK Health Security Agency, NHS England has set out the risks presented by the new BA.2.86 variant of Covid 19, and the measures the NHS has been asked to take. The guidance notes that whilst it is difficult to predict the combined effect of the large number of mutations on severity and transmissibility, expert advice is clear that this represents the most concerning new variant since Omicron first emerged. The Secretary of State for Health and Social Care has therefore asked NHS England to start the vaccination programme earlier and to accelerate the delivery of the programme to vaccinate eligible people more quickly.

23. Flu and Covid 19 vaccination for adults will now be brought forward for this year to start in September to maximise uptake of both vaccines. The eligible cohorts for both flu and Covid 19 vaccination remain unchanged. They include residents in a care home for older adults, all adults aged 65 years and over, persons aged six months to 64 years in a clinical risk group, frontline health and social care workers, persons aged 12 to 64 years who are household contacts of people with immunosuppression, persons aged 16 to 64 years who are carers, and staff working in care homes for older adults. Interim arrangements

to support programme acceleration will be put in place to recognise additional administrative, organisational and delivery costs.

2023/24 winter planning

24. NHS England has recently issued guidance on the national approach to 2023/24 winter planning. The guidance builds on the existing national recovery plans and takes learning from last year's challenging winter season, which saw high rates of infectious disease, industrial action, and capacity constraints, due in the main to challenges discharging patients into social and community care.

25. Four areas of focus have been set out:

    a) Continuation of the Urgent and Emergency Care Recovery Plan by ensuring ten evidence-based high-impact interventions are in place, which focus on reducing waiting times, improving flow, and reducing length of stay.

    b) Completing operational and surge planning to prepare for multiple different scenarios. National templates will be issued for this, which will be flexed to reflect local challenges.

    c) Ensuring effective system working across all parts of the system, including social care and the voluntary and community sector. ICBs will play an important role in leadership and co-ordination. NHS England will issue role and responsibility descriptions and revised specifications for system co-ordination centres. The Department of Health and Social Care will also write to local authorities and the adult social care sector to set out priority actions for improving winter resilience and encouraging cross-system working with the NHS on winter planning.

    d) Supporting the workforce by ensuring that providers have an established pathway for identifying patients at-risk of Covid 19 and flu in their care, including those who are immunosuppressed.

26. The full guidance can be found here: ttps://www.england.nhs.uk/long-read/delivering-operational-resilience-across-the-nhs-this-winter/.

Nottingham University Hospitals Trust assessment ward for the elderly

27. Linked to the work to prepare for winter, it has been confirmed that Nottingham University Hospitals NHS Trust will receive £9.8 million to provide a specialised 24-bed assessment ward for the elderly as part of the Government's national Urgent and Emergency Care Recovery Plan. The ward will improve patient flow through the hospital and improve the quality of care and experience for this vulnerable group of patients in a purpose-built, dementia-friendly space. It will also support greater collaboration between Accident and Emergency, Acute

Medicine, and Healthcare for Older People services, to ensure patient assessments are undertaken more quickly and efficiently.

Community Diagnostic Centre announced for Nottingham City

28. The Department for Health and Social Care has recently announced that six further Community Diagnostic Centres (CDCs) will be created nationally, including a site in Nottingham, which will complement the CDC in Mansfield, agreed earlier this year. The centre, set to open by 2025, will offer a range of scans and tests to help with the diagnosis and treatment of people with different conditions, from cancer to joint problems. It will provide x-ray, CT (computerised tomography) and ultrasound scans, blood tests and other tests to assess heart and lung problems. Work is currently underway to finalise the exact location of the CDC and the ICB will continue to work with Nottingham University Hospitals NHS Trust and Nottingham City Council on the plans.

Newark Urgent Treatment Centre opening hours

29. People in the Newark area are being asked about the opening hours of the Urgent Treatment Centre (UTC) at Newark Hospital and to share their experience of accessing NHS urgent care services overnight. The UTC has been open from 9am to 10pm, seven days per week since March 2020, when the impact of the Covid 19 pandemic on staffing meant that it was not possible to continue to provide a reliable, safe urgent care service at the hospital 24 hours a day. Prior to the pandemic, before the temporary hours were put in place, the UTC was also often closed overnight at short notice due to lack of staff availability. Typically, when the UTC was open overnight, it would treat, on average, one patient per hour, in contrast to between four and six patients per hour during the daytime.

30. An online survey has been developed for feedback and five public events are being held in Newark and the surrounding areas and online during September and October, the details of which can be accessed here https://notts.icb.nhs.uk/get-involved/current-and-previous-engagement-consultations/.

Extension of services at local pharmacies

31. People needing medical care across in Nottingham and Nottinghamshire are now able to get professional clinical advice and treatment at a place more convenient for them as part of an extended service agreement between community pharmacists and NHS England in the Midlands. The agreement covers a variety of minor illnesses including urinary tract infections and some skin infections. More than 400 community pharmacists in the East Midlands

have signed the agreement and have completed the necessary training requirements.

32. Patients needing clinical advice can check if their local pharmacist is taking part at https://www.england.nhs.uk/midlands/nhs-england-and-nhs-improvement-midlands-work/community-pharmacy-extended-care-services/pharmacies-providing-service-2022-2023/.

Nottinghamshire Local Pharmaceutical Committee recognition

33. In line with the NHS England Delegation Agreement to the ICB in respect of Pharmaceutical Services and Local Pharmaceutical Services, the ICB is required to recognise one or more Local Pharmaceutical Committees which it considers are representative of Pharmaceutical Services Providers in the ICB's Area, and to liaise with and consult with the Local Pharmaceutical Committees as required by the Pharmaceutical Regulations.

34. The Nottinghamshire Local Pharmaceutical Committee operating as Community Pharmacy Nottinghamshire is recognised by NHS Nottingham and Nottinghamshire ICB as the representative body for pharmacy contractors in Nottinghamshire. More information about the work of Community Pharmacy Nottinghamshire can be found here: https://nottinghamshire.communitypharmacy.org.uk/.

Health and Wellbeing Board updates

35. The Nottinghamshire County Health and Wellbeing Board met on 5 July 2023. The meeting received a Covid Impact Assessment on pregnancy, childbirth and early years, a progress report on the Best Start Strategy, a delivery update on the Joint Local Health and Wellbeing Strategy and a report on the Nottingham and Nottinghamshire NHS Joint Forward Plan.

36. 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.

37. The Nottingham City Health and Wellbeing Board met on 26 July 2023. The meeting received a delivery update on the Joint Local Health and Wellbeing Strategy, a report on the Nottingham and Nottinghamshire NHS Joint Forward Plan, a Gambling-related Harm Strategy for 2023-28 and a report into the Government's response to the Hewitt Review.

38. 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

Revised Operational Pressures Escalation Levels (OPEL)

39. To complement preparations for winter, and to reflect changes in the NHS landscape with the introduction of Integrated Care Systems, a revised OPEL framework has been released to support a more integrated and coordinated response to acute trust operational pressures. It provides a more unified and consistent approach to the measurement of, and response to, operational pressures. The aim is to improve communication, efficiency, aid better decision making, and improve patient safety.

40. The full report can be found here: https://www.england.nhs.uk/wp-content/uploads/2023/08/PRN00551-opel-framework-2023-24-v1.pdf.

NHS enforcement guidance

41. NHS England has recently released updated guidance about how it intends to exercise its enforcement powers for ICBs and providers, by setting out how it would use these powers to direct an ICB, and the licence enforcement mechanisms that will apply to foundation trusts, NHS trusts, licensed independent providers of NHS services and licensed NHS controlled providers. It explains the regulatory and statutory processes in the event of enforcement action and the subsequent rights of appeal. Regarding ICBs, NHS England will use its powers if an ICB is failing, or if there is a significant risk of it failing, to discharge any of its statutory functions properly, with what NHS England considers to be in the interests of the health service.

42. The guidance can be found here: https://www.england.nhs.uk/long-read/nhs-enforcement-guidance/.

Major Conditions Strategy

43. The Department of Health and Social Care has developed a major conditions strategy, which sets out the Government's approach to how health and care delivery will evolve to meet population needs and tackle health disparities. The strategy makes the case for adapting the model of care to tackle the multimorbidity challenge and identifies how Integrated Care Systems can provide the infrastructure to join up health and care locally. It provides a blueprint for improving outcomes over the next five years covering cancer, heart disease, musculoskeletal disorders, mental ill-health, dementia and respiratory diseases, the six major health conditions that drive over 60% of mortality and morbidity in England. A plan to deliver the commitments in the strategy will be developed across Government and with NHS England and its delivery partners.

44. The full report can be found here: www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework/major-conditions-strategy-case-for-change-and-our-strategic-framework--2.

NHS England appointment

45. Professor Claire Fuller has recently been appointed as NHS England's Medical Director of Primary Care. Professor Fuller has led Surrey Heartlands Integrated Care System since 2017, and she authored the 'Fuller Stocktake Report' in 2022, which advocated the next steps for integrating primary care.

National Improvement Board

46. NHS England has announced the appointment of David Fillingham CBE as Chair, and Professor Andy Hardy as Deputy Chair, of the newly established National Improvement Board to underpin the ongoing work of NHS IMPACT (Improving Patient Care Together). NHS IMPACT is the new, single, shared NHS improvement approach to support organisations, systems, and providers to shape their strategy underpinning this with continuous improvement, and to share best practice and learn from one another. Collectively the Board will set the direction of system wide improvement by bringing in the right stakeholders to achieve shared aims through collaboration and co-design.

NHS Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/09/2022
Paper Title:	**Mid Nottinghamshire Place-Based Partnership Report**
Paper Reference:	ICB 23 037
Report Author:	Leanne Monger, Interim Programme Director for Mid Nottinghamshire Place-Based Partnership and Deputy Locality Director Victoria McGregor Riley – Mid Nottinghamshire Locality Director
Report Sponsor:	Lucy Dadge, Director of Integration
Presenter:	Adam Hill, Convenor/Chair of Mid Nottinghamshire Place-Based Partnership and Chief Executive of Mansfield District Council Thilan Bartholomeuz, Clinical Lead of Mid Nottinghamshire Place-Based Partnership Louise Casey-Simpson – Deputy Chief Executive Officer, Newark and Sherwood CVS.

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

Summary:

The Health and Care Act 2022 has facilitated significant opportunities for collaboration and partnership working at all levels within the health and care system. Place-Based Partnerships (PBPs) are recognised as significant contributors to partnership working by bringing together key stakeholders in formal collaborative mechanisms. As such, PBPs are well placed to support Integrated Care Boards (ICBs) to deliver their core aims, priorities and objectives.

This report provides an update on the work of the Mid Nottinghamshire Placed-Based Partnership (MN PBP), which has a long history of collaborative working to address the population needs of it 343,059 (2023) citizens, building upon the successful Mid Nottinghamshire Better Together Alliance from 2016 (see Appendix A – MN PBP Maturity journey).

During the past 12 months, the MN PBP has sought to actively engage and align with the strategic priorities of the Nottinghamshire Health and Wellbeing Strategy (the Joint Local Health and Wellbeing Strategy for 2022 – 2026), the Nottingham and Nottinghamshire Integrated Care Strategy 2023 – 2027, the Nottingham and Nottinghamshire NHS Joint Forward Plan 2023 – 27 and the system blueprint for PBPs.

In April 2023, the MN PBP published its Place Plan 2023/24 setting out a refreshed vision *"Working together to enable everyone across Ashfield, Mansfield, Newark and Sherwood to live healthier and happier lives, to prosper in their communities and remain independent throughout life"*, four ambitions and five themed priority PBP programmes. Introducing our Mid-Nottinghamshire Place-Based Partnership Plan - NHS Nottingham and

Summary:
Nottinghamshire ICS - NHS Nottingham and Nottinghamshire ICS (healthandcarenotts.co.uk) The MN PBP comprises partners from local statutory, voluntary, community and social enterprise organisations. Executive colleagues also provide the Executive Sponsorship for the priority PBP work programmes to focus our collective efforts for maximum impact and "added value." The MN PBP is a committed proactive partnership which seeks to improve and integrate services working alongside our communities to address health inequalities and local challenges. The MN PBP is a mature partnership and is at time of real opportunity to work together like never before to bring about lasting benefits to the lives of people who live in Mid Nottinghamshire with the support of the Integrated Care Board. The presentation of this paper will include a citizen story, giving insight into the Mid Nottinghamshire Butterfly Service, which provides a compassionate and holistic approach to End-of-Life care complementing and enhancing existing local services.

Recommendation(s):
The Integrated Care Board is asked to **receive** and **discuss** the Mid Nottinghamshire Place-Based Partnership Report.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	MN PBP aims to improve outcomes in population health through increased collaboration and integrated place-based models of delivery, using established Population Health Management (PHM) approaches. MN PBP intends to upscale and accelerate this work through the development of integrated neighbourhood team working.
Tackle inequalities in outcomes, experience and access	MN PBP priorities align to wider Notts & Nottinghamshire Health and Wellbeing Strategies which aim to reduce health inequalities across Nottinghamshire. There is also a well-established Mid Nottinghamshire PBP Health Inequalities Oversight Group which seeks to address the three core strategic priorities of the N&N system of promoting Prevention, Integration and Equity and this group will also have oversight of the work undertaken and funded through the Health Inequalities Investment and Innovation Fund (HIIIF).
Enhance productivity and value for money	By working together, partners aim to reduce the burden on health care services, preventing or reducing presentation in primary, community and secondary care. Collective data, intelligence and insight from place partners has been used to inform PBP priorities and opportunities for integrated sustainable funding arrangements and use of One Public Estates are being explored.
Help the NHS support broader social and economic development	MN PBP brings together local government and voluntary sector partners to support the broader social and economic development agenda, which includes looking at ways to maximise funding opportunities, such as UK Shared Prosperity Fund allocations, to ensure alignment with the wider determinants of health. Work continues with SAIU colleagues to develop an PBP Outcomes Framework, aligned to the ICS

How does this paper support the ICB's core aims to:	
	Outcomes Framework to ensure impact, including social and economic value can be measured.

Appendices:

Appendix A – MN PBP maturity journey
Appendix B – Mid Nottinghamshire Key Health Challenges
Appendix C – MN PBP Objectives and Partnership delivery 2022/23
Appendix D – MN PBP Programmes and Achievements 2022/23
Appendix E – MN PBP Operating Model and Governance Structure
Appendix F – MN PBP sample PCN PHM outcomes

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.
- Risk 4: Citizen Voice – Failure to effectively work in partnership with citizens and communities.
- Risk 6: Quality Improvement – Failure to maintain and improve the quality of services.
- Risk 7: People and Culture – Failure to ensure sufficient capacity and capability within the local workforce.

Report Previously Received By:

Not applicable.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Mid Nottinghamshire Place-Based Partnership – Progress Report and 2023/24 Place Plan

Background of the Partnership

1. MN PBP is a collaboration of health and care providers and commissioners, local authorities and community and voluntary organisations working together towards a shared ambition.
2. Membership of the MN PBP partnership brings together over 40 organisations and citizen representatives working together within an agreed set of principles. Executive representation includes:
    a) Ashfield District Council
    b) Ashfield Voluntary Action (AVA)
    c) Mansfield Community and Voluntary Service (CVS)
    d) Mansfield District Council
    e) Mid Nottinghamshire Primary Care Network (PCN) (Ashfield North, Ashfield South, Mansfield North, Rosewood, Newark and Sherwood – incorporating 38 general practices)
    f) Newark and Sherwood District Council
    g) Newark and Sherwood Community and Voluntary Service (CVS)
    h) NHS Nottingham and Nottinghamshire Integrated Care Board (ICB)
    i) Nottinghamshire County Council
    j) Nottinghamshire Healthcare NHS Foundation Trust (NHCT)
    k) Sherwood Forest Hospitals Foundation Trust (SFHT)
3. The Local Authority and PCN boundaries in Ashfield are not coterminous with the MN PBP, with Hucknall falling into the South Notts PBP. This means some partners are members of both MN and SN PBPs.

Our population

4. Mid Nottinghamshire has a registered population of 343,059 (2023). Appendix B is taken from the MN PBP Place Plan 2023/24 and highlights the key health challenges, demographics and life expectancy for Mid Nottinghamshire.
5. 27.1% of the population are living in the most deprived quintile (Ashfield 26.9%, Mansfield 41%, Newark and Sherwood 14.6%). The Mid Nottinghamshire indices of multiple deprivation score is 24.6% which is 2.9% higher than England’s average.

6. Ashfield and Mansfield have identified priority neighbourhoods (Ashfield: Broomhill, Coxmoor, Leamington Estate, New Cross, Stanton Hill, Mansfield: Bellamy Estate, Bull Farm, Oak Tree, Portland town centre) whilst Newark and Sherwood have adopted a flexible, data-led approach rather than identify geographical areas as a priority.

Delivery of 2022/23 Priorities

7. During 2022/23 the MN PBP committed to five strategic objectives and each objective had an identified lead from across the partnership.

8. MN PBP partners supported the delivery of these strategic objectives through their own programmes of work and updates on progress were received by the Executive Team and Partnership Forum. Appendix C provides an overview of delivery for each objective.

9. The MN PBP also identified four significant programme areas to improve the health and wellbeing of the population of Mid Nottinghamshire:

   a) End of Life Together Services

   b) MSK (Musculoskeletal) Together Service

   c) Integrated Model for Care Homes

   d) Focus on our Communities.

10. Key outcomes and achievements of these programmes in 2022-23 can be found in Appendix D. There continues to be successful development of these programmes, especially with the End of Life Together Service (which is to be commissioned for a further five years from October 23 and working towards a formal Provider Collaborative from April 24) and MSK Together Service (which is also moving towards the formation of an Alliance/Provider Collaborative model). These are now independent programmes, demonstrating the success of the PBP to nurture new and innovative ways of service transformation.

11. Back in August 2022, ICB Board Members were able to see first-hand the impact of the MN PBP work in communities with the NHS England Prevention Programme in Bellamy, Mansfield which was also showcased at the recent Place-Based Partnership showcase event on 5 September 2023. The MN PBP also participated in the National Place Development Programme in 2022 to develop its Population Health Management capacity and capability.

Developing our Partnership

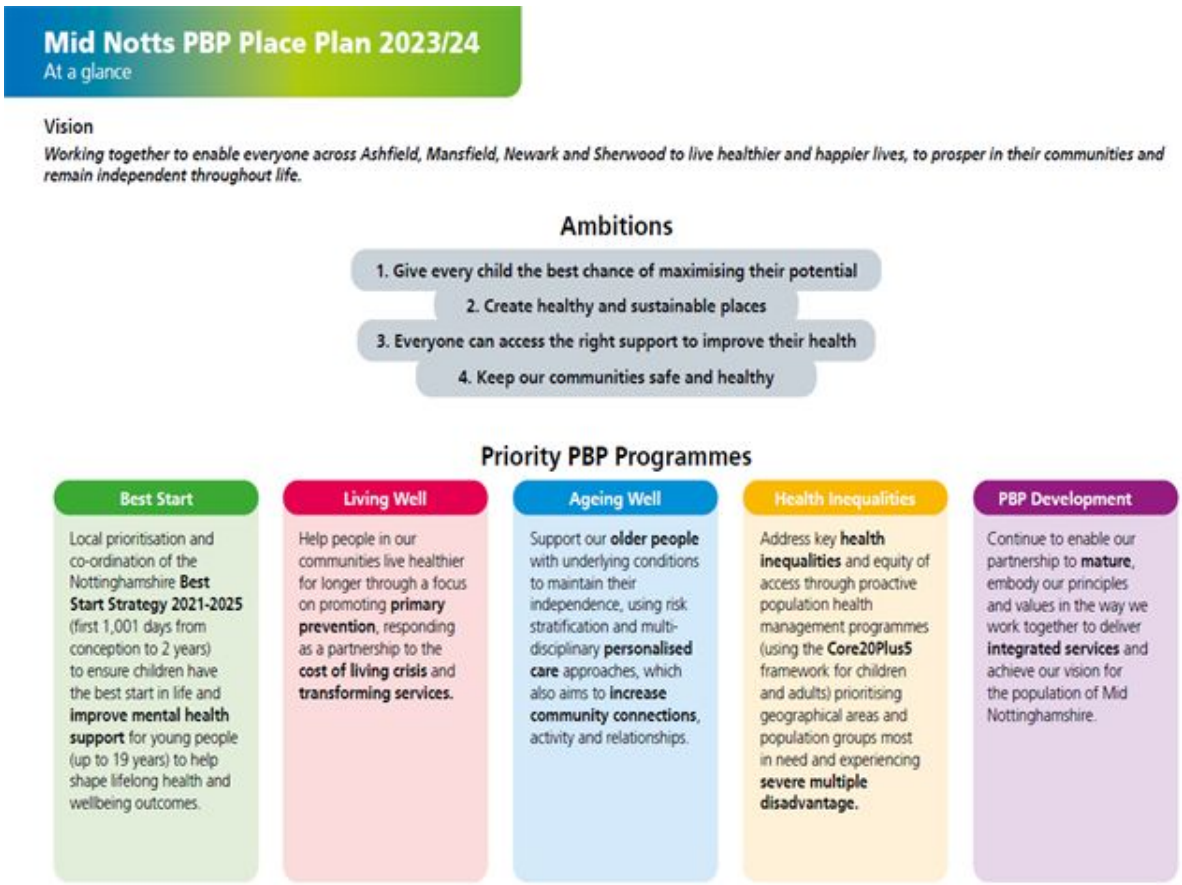
12. In April 2023, the MN PBP published its Place Plan 2023/24 Introducing our Mid-Nottinghamshire Place-Based Partnership Plan - NHS Nottingham and Nottinghamshire ICS - NHS Nottingham and Nottinghamshire ICS

(healthandcarenotts.co.uk) which sets out a refreshed vision: *"Working together to enable everyone across Ashfield, Mansfield, Newark and Sherwood to live healthier and happier lives, to prosper in their communities and remain independent throughout life".*

13. This was informed and co-produced through a Mid Nottinghamshire PBP Workshop held on 25 January 2023 in Mansfield, various meetings, surveys and community conversations.

14. The 'at a glance' infographic below summarises the four ambitions and five themed priority PBP programmes in the MN PBP Place Plan 2023/24:

Figure 1



15. There will be a primary focus on addressing the significant health inequalities in Mid Notts through integrated neighbourhood working. On the 29 June 2023, the MN PBP held an energetic and successful Accelerated Design Event in Newark, working with NHS Horizons and a definition for integrated working in Mid Notts was agreed and pledged: *"Working as one team to respond to what matters to the individuals and communities of Mid Notts, in a way that empowers them and improves quality of life for all".*

16. The MN PBP will be working closely with Bassetlaw PBP and South Notts PBP following the successful outcome of each of our bids into the Health Inequalities

Innovation and Investment Funds (HIIIF) announced on 3rd August 2023 for the development of integrated neighbourhood team working approaches.

17. The proposal in Mid Notts is to mobilise four Integrated Neighbourhood Teams (INTs) to enable targeted interventions, co-designed with local people, to better support improved health and wellbeing outcomes for a specified population cohort – building upon the successful community services transformation accelerator sites in Mid Notts.

18. Population cohorts across the life course have been identified through Population Health Management (PHM) approaches as consuming (or have potential to consume) higher proportions of local healthcare resources; are amenable to receiving primary and secondary prevention interventions that mitigate against deteriorating health outcomes; contributing significantly to overall health inequalities. The four INTs will be matured within a generic model, but each will prioritise sub-cohorts most sensitive to population need at a PCN level working with established local transformation/design teams across Ashfield, Mansfield, Newark and Sherwood. This aligns with the three core strategic priorities of the Notts and Nottinghamshire system of promoting Prevention, Integration and Equity.

Delivering and resourcing the MN PBP Place Plan (2023/24)

19. MN PBP has a clear direction of travel with the development of its Place Plan 2023/24. The first 2023/24 quarterly highlight reports were presented to PBP Executives on 17 August 2023 for their oversight and to endorse the direction of travel for the five priority programme areas. In developing and delivering these programmes and projects, place partners are continuing to evidence how, through an integrated approach, how PBPs and PCNs can improve the coordination of care, support and planning, positively impacting on local health and wellbeing outcomes.

20. Whilst not an exhaustive list, key achievements include:

Best Start +	• Ongoing work to establish Family Hub Networks (Sutton in Ashfield – by 01.04.24, Hawtonville – by 01.04.24, Oak Tree – by 01.09.24) and increase rates of breast feeding and accredited venues across Mid Notts.
Living Well	• Our Cost-of-Living partnership response (covering financial wellbeing, fuel poverty, food insecurity, health promotion), which includes partnership winter/seasonal planning. • Delivering the Community Services Transformation Programme, which includes continuing our Local Design Team approach to reviewing challenges and promoting

	coordinated coproduced responses at a community level, making every contact count and co-production with communities to transform services.
Ageing Well	• Understanding and addressing social isolation and loneliness across Mid Notts to increase community connections and wellbeing and proactively tackling frailty.
Health Inequalities	• Development and delivery of the Mid Notts PBP Health Inequalities Oversight Group (MNHIOG) plan, framed around the CORE20+5 framework for Adults and Children and a successful PBP partnership bid into the HIIIF Programme to develop Integrated Neighbourhood Teams. • Co-ordination and facilitation of PCN led population health management projects and collaborating to support our most vulnerable (e.g., those experiencing fuel poverty). There are currently 10 projects 'live' across the Mid Nottinghamshire PCN's footprint (please see sample outcomes in see **Appendix F**). • Promoting primary prevention (e.g., through highly successful local vaccination campaigns led by our PCNs working with place partners to address inequalities)
PBP Development	• Development of co-ordinated place-based communications and engagement approaches across our partnership workforce and communities. Includes a bi-monthly newsletter, campaigns and promoting joint training opportunities, for example.

21. A PBP outcomes framework is being developed jointly with the System analytics and Intelligence Unit (SAIU), County Public Health, Bassetlaw PBP and South Notts PBP to demonstrate delivery and outcomes, including added/social value.

22. Delivery is through a wide range of partners who are committed and attend sub-group meetings as set out in the MN PBP governance structure, Appendix E. Our core structure includes:

    a) An Executive Group

    b) A Partnership Forum

    c) A Health Inequalities Oversight Group (which has several Task and Finish Groups delivering specific pieces of work).

    d) A Partnership Network

23. MN PBP has worked effectively to maximise the resources available to help shape and develop its role but has undergone significant changes in the past 12 months, which includes the gradual withdrawal of resource from place partners (five whole time equivalent roles).

24. The MN PBP currently has an Interim Programme Director (Leanne Monger, Deputy Locality Director, NHS Nottingham and Nottinghamshire ICB), a Clinical Lead (Dr Thilan Bartholomeuz), a Health Inequalities Clinical Lead (Dr Stephen Wormall), a Convenor/Chair (Adam Hill, CEO, Mansfield District Council), Vice Chair (Theresa Hodgkinson, CEO, Ashfield District Council) and interim admin support (Zoe Stockham).

25. NHS Nottingham and Nottinghamshire ICB contribute resources from the ICB Place/Locality team (for primary care support for PCN development, integrated care pathways, service transformation and population health improvement), clinical leadership and aligned support from ICB teams such as the SAIU, for example. Sherwood Forest Hospitals Foundation Trust currently fund the PBP administration support role until March 2023 and provide a modest core MN PBP communications function, working with our wider place communications community. Several partners with Executive level representation in the MN PBP provide in kind resource contributions to support leadership and delivery of projects.

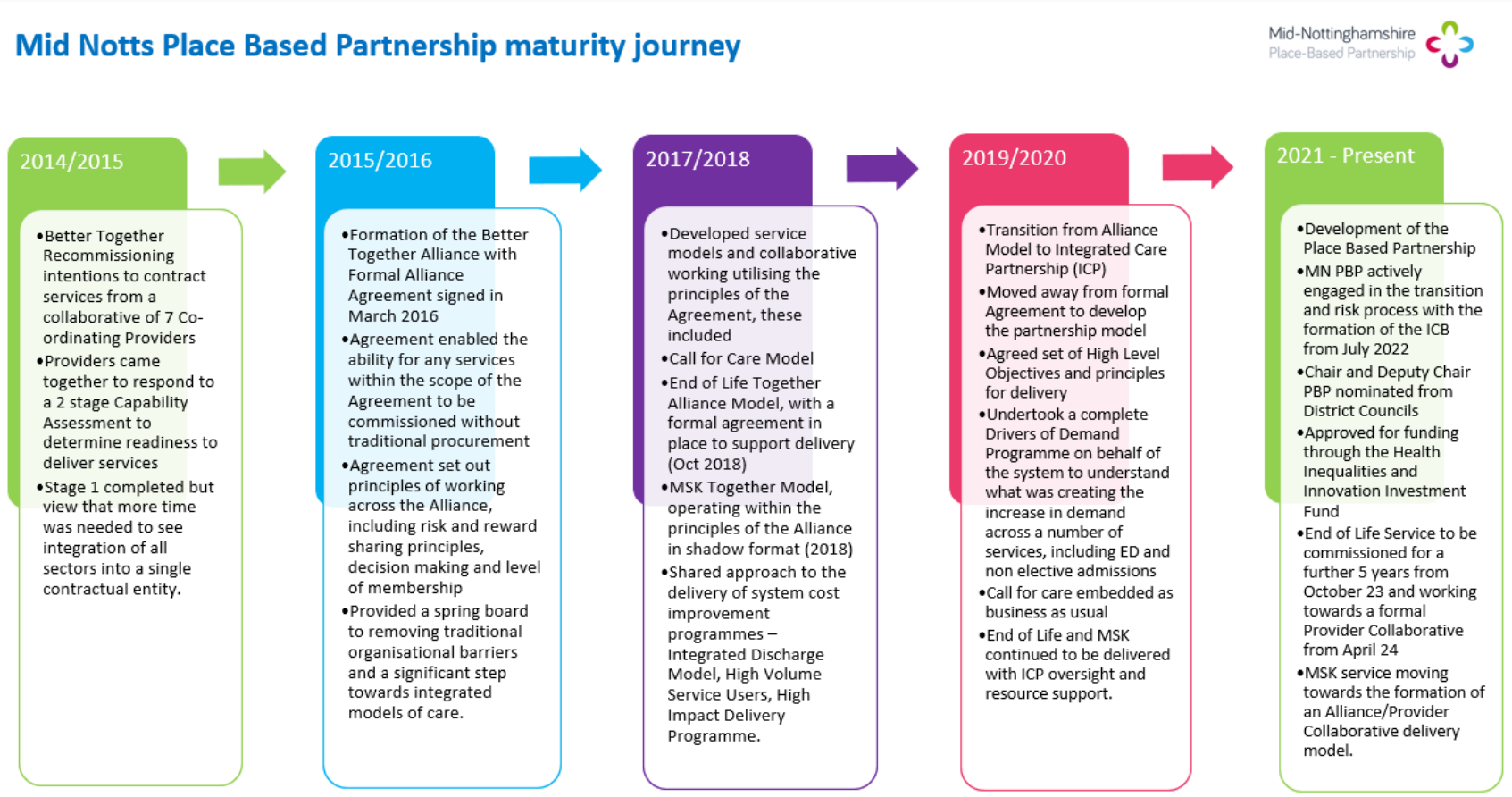
26. Opportunities for additional flexible resources from partner organisations to meet the delivery requirements of the MN PBP are currently being explored to ensure achievement of collective ambitions. There are also system wide discussions taking place to help provide a programmatic approach to the implementation of the ICB Five Year Forward Plan, and sustainable PBP funding is one of the objectives in that plan. Any resources aligned/delegated to place should support a ‘place-first’ culture and focus on Prevention, Integration and Equity.

Conclusion

27. MN PBP is a mature group of organisations committed to the principle of working in partnership and is an equal coalition of partners with a track record delivering improved outcomes through an agreed set of programmes, as evidenced in this report.

28. The MN PBP Place Plan clearly sets out a shared vision and local ambitions and through integration at neighbourhood, place and system level the MN PBP is well placed to support the delivery of the system ambition to enable each citizen to enjoy their best possible health and wellbeing.

Appendix A – MN PBP maturity journey



Appendix B – Mid Nottinghamshire Key Health Challenges

Mid Nottinghamshire

Key health challenges for Mid Nottinghamshire

People living in the more deprived areas have higher levels of unemployment, lower levels of qualifications, less healthy lifestyle choices and poorer health and wellbeing outcomes compared to those in less deprived areas.

POPULATION

The registered population in Mid Nottinghamshire was 343,059 in 2023.

- The population is made up of 50.3% female and 49.7% male
- The area's 10-year population increase since 2013 is 9.6%

AGE

Mid Notts population is older than England average and getting older.

- 20.1% are aged 65+ [Higher than the national average (20.1% compared to 18.6%)].

Since 2011:

- 65+ population has increased by 15.6%
- 0-19yrs has reduced by 5.4%.

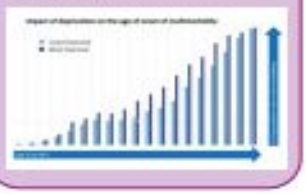
HEALTH INEQUALITIES

There is a higher percentage of multi-morbidities for those populations who are most deprived. This is a particularly marked between 45 and 70 years.

78% of Mid Notts population report they are in good or very good health. England and Wales average is 80%.

21.3% of Mid Notts population are 'disabled under the Equality Act'.

6.7% of Mid Notts population are 'not disabled but have a long-term physical or mental condition'.



ETHNICITY

Mid Notts population is less diverse than the national average.

91.1% of the population identifying as White British compared to 74.4% nationally.

Asian/Asian British is the second largest ethnic group in Mid Notts (1.8%) [2021 Census].

LIFE EXPECTANCY

Mid Notts females and males are below the England average for life expectancy.

MID NOTTS	82.1	78.1
ENGLAND	83.1	79.4

BEST START

22,000 of 0-19 years in Mid Notts had a recording of a mental health condition, majority are low complexity and in medium or high deprivation, evenly spread through each year of age. (75,000 0-19 years).

849 mothers reported to have a smoking history (in last two years). 62% were in the highest deprivation.

LIVING WELL

There were almost 3,000 potential years lost across Mid Notts in male citizens during 2020 (1177 in female citizens) due to alcohol.

Ashfield, Mansfield and Newark & Sherwood have three of the four highest smoking prevalence (ranging from 16.5% to 23.1%) in Nottinghamshire where the average is 15.4%.

Residents of Mansfield and Ashfield are 10% below the national average in achieving recommended physical activity levels.

AGEING WELL

Older people who are severely frail are 13.8 times more likely to have a hospital admission. Those who live alone are 8.8 times than those not living alone.

Mid Notts has the largest number of people identified as severely frail compared to other Nottinghamshire Places.

The Mid Notts PCNs have the highest percentages of older people living alone (15% to 20%).

Appendix C – MN PBP Objectives and Partnership delivery 2022/23

To give every child the best start in life

- For the first time ever, more children in Nottinghamshire (66.9%) have a greater level of development than England (65.2%)
- Through the Children's Centre services more universal antenatal and post natal support has been established including new parents groups "Little Talkers" and "Now I am One"
- Performance data from the 0-19 Healthy Programme remains good at County Level

To promote and encourage healthy choices, improved resilience and social connection

- A Bfit back pain exercise and education group has gone live supporting 2 PCNS
- Within the MSK service a pilot is being established where people who are considering surgery are referred to a Healthy Lifestyle course, either group based or 1:1to ensure people considering surgery optimise any pre-surgery risk
- Referrals into the smoking cessation service have increased by 9% with the 4-week quit rate at 68% which is good and higher than the national average

To support our population to age well and reduce the gap in healthy life expectancy

- Ashfield North PCN are taking part in a pilot around anticipatory care, the pilot will focus on secondary care admissions and readmissions where the primary diagnosis is a respiratory condition
- The NHSEI Prevention Project is being delivered within two priority areas to understand and hear the voice of the residents in understanding their needs focusing on health, well being and education
- Ashfield Voluntary Action (AVA) secured additional funding to extend work supporting people who are frail, elderly and/or living with dementia

To maximise opportunities to develop our built environment into healthy places

- Delivery of the Bellamy Masterplan and the redevelopment of the centre of the estate has now secured planning permission and a contractor has been appointed. As well as improvements to housing and infrastructure, redevelopment also includes the provision of a new children's play area which is now complete and was opened for use on 23 July 2022
- Warsop Health Hub – funding secured; acceptance of the expression of interest submitted to Sport England; development of the scheme through to the end of RIBA Stage 2 and the start of RIBA Stage 4

To tackle physical inactivity, by developing our understanding of barriers and motivations

- In Ollerton the Thursday night project set up as a partnership between the secondary school, youth service, police, community partners, Newark and Sherwood DC and Walesby Adventure centre to offer young people a local positive activity to take part in is going from strength to strength
- Across each district community based conversations are continuing to build our collective understanding of what it takes to support and enable people to move more. In all 3 districts partners are now coming together to better understand what PA looks like in their areas and what needs to be done to enable communities to move more

Appendix D – MN PBP key programmes of work and achievements 2022/23

End of Life Together Service

- Review of the current service model including a capacity and demand review
- Programme Budget Approach
- Inclusion of Fast Track into a single service model that supports our population at all stages of end of life
- Development of an integrated hub

Outcome

- Capacity and Demand Review completed
- Fast track model developed through engagement events
- New service model to be developed to coincide with new contract period Oct 23 and as provider collaborative – meaning this will no longer be a PBP led service

MSK Together Service

- MSK Together – a collaboration of providers with a programme budget approach and strong governance structure
- MSK Low Level – Build on the links between the MSK hub and primary care
- MSK Prevent – PBP support in delivery in opportunities closer to our population cohorts

Outcome

- Achieved pooled budget within MSK Therapy services and the hub to enable resources to be flexed
- Work on the next population segment for back pain is progressing well to determine notional budget approach for investment and disinvestment
- Exercise and education groups gone live
- Transition to Provider collaborative from PBP service underway, key decisions identified to progress

Integrated Model for Care Homes

- Bringing together existing services into a single model of support for the care homes
- Build on learning from the Enhanced Care Response Team
- Recognising that we may be able to do it differently with the same resources to deliver sustainability and consistency across the care homes

Outcome

- Proof of concept undertaken in 3 care homes, demonstrated 87% return on investment with GP call outs, ED attendances and Non elective admissions all reduced
- Option for a larger pilot being explored to validate the proof of concept delivered by a provider collaborative
- MN PBP offered the contract to deliver the Deterioration training due to learning from ECRT team and experience in the sector. SFH hosting

Focus on our Communities

- NHS England Prevention Programme
- Transformation of Community Services – 3 early adopter sites
- Local Health Inequalities Oversight Group – multiagency and focusing in on the local intelligence and population need

Outcome

- NHSE programme delivery continues (funded until Sept 2023)
- Transformation of Community services remains an ICS priority with the MN PBP involved and engaged in the programme with 3 early adopter sites.
- MN PBP bid submitted for Health Inequalities funding to develop integrated neighbourhood teams
- PCN PHM project delivery is ongoing and remains a priority for the PBP

OUR PLACE BASED PARTNERSHIP

Mid-Nottinghamshire
Place-Based Partnership

2022-23 Mid Nottinghamshire PBP Achievements

In conjunction with the City and the South PBP undertook a Maturity Assessment to determine readiness for the role of Place and in response to the White Paper. Underpinned the MN PBP review of governance

As part of the Place workstream within the ICS Transition and Risk programme supported the development of the Description of Arrangements Paper that set out the interface between the ICS and PBPs

In March 22 submitted a collective PBP response to the national consultation on the Integration White Paper

In March 22, PBP undertook a self-assessment against the Policy Proposals set out within the Integration White Paper and agreed a series of next steps to enable our readiness

Successful award of NHSEI Prevention Programme funding supporting projects across 6 priority areas across the ICS, 2 in MN (Bellamy and Coxmoor)

Continued delivery of the MN PBP Objectives and Priorities through partners

Bellamy Health Prevention Project – show cased at the Best Practice Conference in October 22 and included in the Complete Care in the Communities event held at the Houses of Parliament

Hosted a visit from ICS Chair and CO to Bellamy Estate, to hear the lived experience from the residents. Project was well received and seen as a great example of collaboration

EOL Together Service showcased at the national Hospice Conference in November 22

Head of MSK Services invited to speak at a conference in Switzerland to showcase our approach to MSK services

Nominated to take part in the national Population Health Development Programme - excellent data sets developed

Successful award of NHS Charities funds to develop the Butterfly service as part of the EOL service, supporting patients, families and carers in their own homes with a personalised plan of support

MN PBP held the Nottingham and Nottinghamshire wide contract for swabbing, linked to the pandemic – swabbed 3756 care home residents and staff since April 22

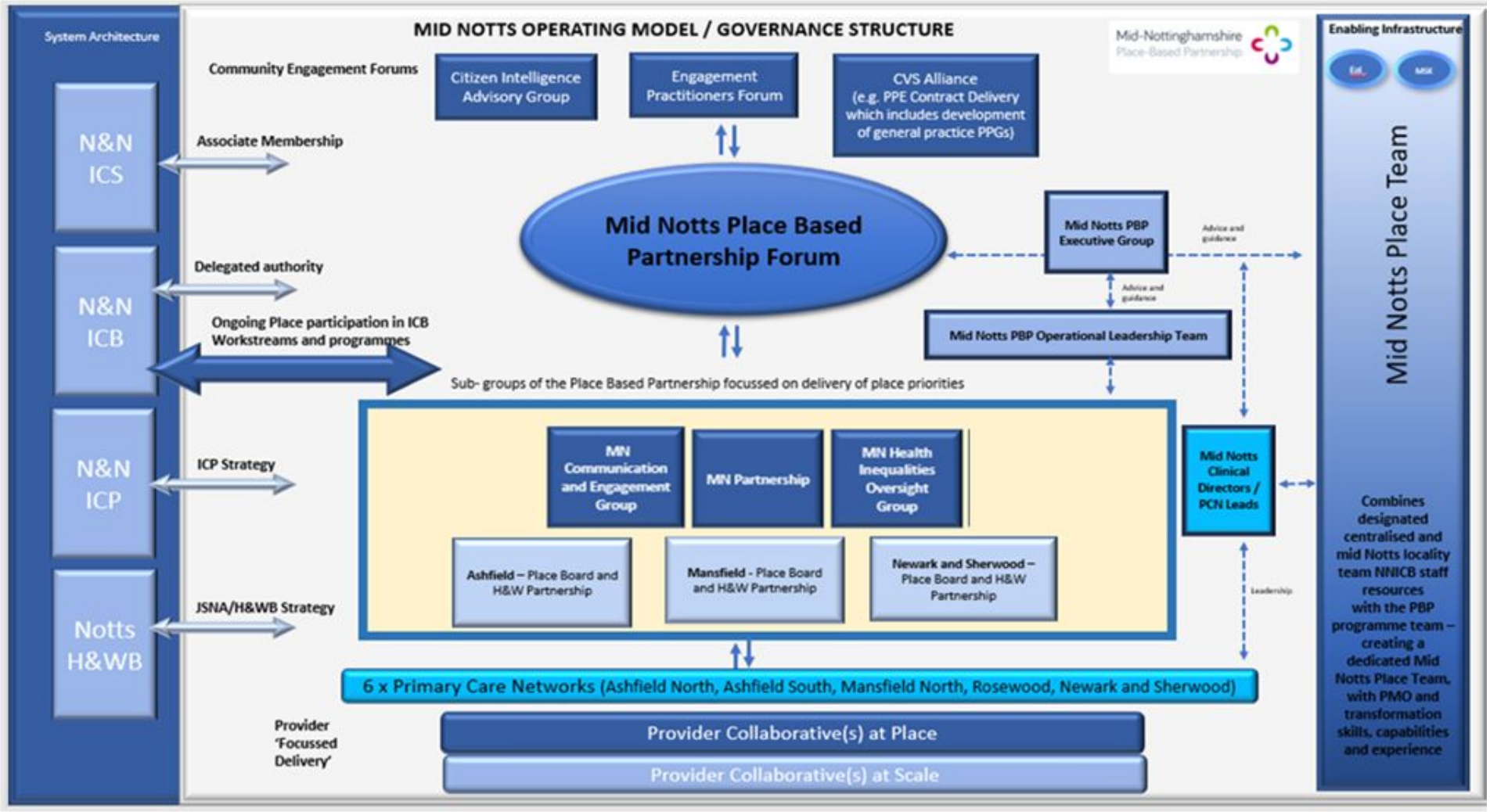
Since the start of the Deterioration Programme into care homes on 7th February 23 – 20 care homes received the training, 111 staff trained

Supported by NHT and NCC undertook a successful proof of concept care home model demonstrating 87% return on investment and reduction in GP calls, ED attendances and Non Elective admissions

MN PBP led the Roving Service within the vaccination programme from December 2020, providing vaccinations into care homes, housebound and the vaccination bus. Booster vaccinations completed in 22/23

Active Mid Notts Health Inequalities Group delivering focussed Population Health Management Projects as part of a delivery plan aligned to the CORE20+5 Framework for adults and children.

Appendix E – Mid Nottingamshire Operating Model and Governance Structrure



Appendix F – MN PBP sample of PCN PHM outcomes:

PICS and ICB Spirometry Restoration Project

Aims:

The project aimed to support the GP practices in the restoration of Spirometry in Primary Care, develop the utilisation of spirometry clinics and ensure quality assured Spirometry as a diagnostic tool for respiratory conditions. This report covers the period from September 19th, 2022, to September 4, 2023.

Project Scope:

The project encompassed 39 Practices located in Mansfield, Ashfield, Newark, and Sherwood. The initiative introduced 45-minute patient sessions dedicated to spirometry, and result interpretation, as well as reversibility testing when clinically appropriate. Although this was the primary scope of the pilot it is also worth recognising by utilising a Respiratory Nurse Specialist in the role the practices and patients received an enhanced service which included where appropriate a comprehensive record review, smoking history and cessation advice, and supportive advice were appropriate.

Outcome:

Over the course of the project the service offered 881 Spirometry appointments to Primary Care in Mid Notts. Of the 881 appointments offered the service successfully completed 622 quality assured spirometry tests. Of the 881 appointments offered 35 patients were contraindications and ineligibility for spirometry due to contraindications, including recent chest infections, surgery, or recent tobacco or cannabis use causing elevated heart rate.

The Fuel Poverty Project (FPP) is provided by Mid Motts ICP – PICS social prescribers and Climate change and Fuel Poverty charity Nottingham Energy Partnership (NEP).

Aim:

The project aims to contact patients at risk of cold related harm and who are likely to be eligible for free or subsidised domestic retrofit measures including home insulation, low carbon heating and renewable energy to cut energy demand and household energy bills.

Project Scope

A controlled intelligent screening programme matching eligible candidates at most risk, with phone consultations with Primary Care Network (PCN) link workers and Care Navigators ensures a secure workflow to NEP.

Outcomes:

From 6th December 2022 to 31st March 2023, 74 patients were referred receiving 205 support measures, totalling £141,052.98 annual savings.

From July 2023 the Government launched phase two of funding to support patients that are living in fuel poverty through the Home Upgrade (HUG2). This scheme will provide more grants for free energy saving measures for off gas properties. A report summary will be available in a few months.

Diabetes Equity Payment

Aim:

To address health inequalities and support the care of patients with Type II Diabetes who have not had all eight care processes completed and are living in the 20% most deprived areas.

Project Scope:

Millview Surgery was the first practice to participate in the scheme which commenced June 2023. 62 patients were identified of which were 52 contactable.

Outcomes:

Out of the 52 contacted, 30 patients got some or all outstanding care processes. The remaining patients either declined an appointment as housebound, could not afford to come to surgery or declined to make an appointment at this time. There is a plan to contact the patients who declined an appointment due to cost of travel.

Severe Multiple Disadvantaged (SMD)

Rosewood PCN are continuing with their SMD Service and are the only PCN in the Country to do so. The aim of the service is to provide.

- Accessible primary care to people who experience SMD.
- Improve the physical and mental health of people who experience SMD.
- Improve partnership between the practice and specialist SMD services.
- Reduce inappropriate ED attendances and secondary care admissions.

To date 265 patients have been identified on the Rosewood SMD Register. The Case Study attached demonstrates the impact the services have had for an individual.

Case Study

- Patient A referred to Care Coordinator via MDC Housing Management Officer – Specialist Support
- Patient under probation, using drugs occasionally, getting in with wrong crowd and living in accommodation that was previously resided by a drug pusher.
- Patient also a number of health and medical needs
- Liaised with Probation Service and attended some meetings with patient to build up a relationship as patient was very volatile and did not trust anyone. Has numerous social issues which have been out of her control, i.e., burglary, theft of phone and money. Encouraged patient to disengage with some of the friendships which has been successful.
- Escorted patient to GP appointments.
- Worked in partnership with Housing Management Officer and maintained constant communication on patient's success/hurdles.
- Patient desperate to move house and was keen to make progress.
- Rehousing has now been successful and patient very happy about it.
- Patient reported to me that she would like to work on social well-being, and I will be referring the patient to Health & Wellbeing Coach after discussion with him. Has been free of drug use and only occasional alcohol use.
- Patient, support worker and probation reported the patient being in the best place in health, attitude, and desire to get her life back, in a number of years, due to the wrap around care she has received.

Cost of Living

- Two cost of living workshops have taken with representation from PBP Partners which have generated an action plan with short-, medium- and long-term actions. Training resources have been sourced in respect of Suicide Prevention and Making Every Contact Count which will be made available to all front-line staff throughout the PBP. A further workshop is being planned for September 2023.

- Ashfield LDT ran a 50-day cycle focusing on support to citizens and access to support services over winter and outputs were the development of a COLC directory developed by AVA and ADC. This brochure was shared electronically with registered patients of the Ashfield practices and hard copies given to the SPLWs to use. Hard copies also given to GP practices. We also worked with ADC to promote 'Warm Hubs' available across the district.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/09/2023
Paper Title:	**Progressing Towards Stage One of An Integrated Approach to Population Health Management (PHM) Outcomes Monitoring**
Paper Reference:	ICB 23 038
Report Author:	Maria Principe, Population Health and Outcomes Lead
Report Sponsor:	Dr Dave Briggs, Medical Director
Presenter:	Jack Rodber, Associate Director of Financial Recovery

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

Summary:

This report details the progress of the integrated approach to Population Health Management (PHM) Outcomes Monitoring since the endorsement of the approach by the Board at its meeting in May 2023. In stage one, which focused on metrics definition and dashboard integration, we successfully defined key metrics for phase one in collaboration with public health experts, which include reduction in avoidable mortality, increase in life expectancy, emergency admissions, and prevalence of long-term conditions. A strategic outcomes dashboard has been integrated and made available on SharePoint.

Challenges include the need for defined outcome targets. Stakeholder engagement remains strong with an outcomes technical group established. Our achievements in stage one emphasises our dedication to an integrated PHM monitoring approach, aiming for services that are safe, effective, and equitable. To maintain this momentum, our proposals include continuous framework evaluation, further expert group consultations, and transparent collaboration. Upcoming steps encompass finalising metrics, data source integration, and launching the final dashboard by March 2024.

Recommendation(s):

In light of the progress and challenges, members of the Board are asked to:

- Note the achievements to date.
- Recognise the gap in governance and accountability structure for outcomes monitoring.
- Recognise the gap in outcome trajectory targets.
- Reconfirm support for the existing phased/timescale approach of delivery.
- Continue encouraging system partners to engage, inform, and share data.
- Support ongoing collaboration with public health colleagues and task groups to confirm and set PHM outcome targets and ambitions in line with our timelines.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	The integrated approach to Population Health Management (PHM) emphasizes key health metrics like reducing avoidable mortality and increasing life expectancy. With the strategic dashboard on SharePoint, stakeholders can make data-driven decisions swiftly. This initiative, supported by strong stakeholder engagement and continuous evaluation, aims to enhance both population health outcomes and the overall quality of healthcare services, ensuring a comprehensive and fair health system.
Tackle inequalities in outcomes, experience and access	The paper highlights the need to address health inequalities in outcomes, experiences, and access. Using an integrated Population Health Management approach, it advocates for tracking critical metrics via a SharePoint dashboard. With robust stakeholder engagement and data-driven strategies, the goal is to ensure consistent, high-quality care and equitable health outcomes for all.
Enhance productivity and value for money	The paper presents an integrated Population Health Management approach as a means to optimize healthcare outcomes. By utilising a data-driven SharePoint dashboard and fostering stakeholder engagement, it suggests that healthcare systems can achieve greater productivity and ensure better value for investment, ultimately delivering more effective and cost-efficient care.
Help the NHS support broader social and economic development	As above.

Appendices:

-

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 8: Equality, Diversity and Inclusion – Failure to comply with the general and specific Public Sector Equality Duties.

Report Previously Received By:

No.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Progressing Towards Stage One of An Integrated Approach to PHM Outcomes Monitoring

Introduction

1. This paper serves as a marker to report the progress of the integrated approach to Population Health Management (PHM) Outcomes Monitoring. The actions undertaken and our alignment towards achieving the set targets are described here since the endorsement of the approach by the Board at its meeting in May 2023.

Background

2. As agreed in the paper presented in May 2023, we have worked successfully with subject matter experts and programme leads to define the interventions and metrics required for monitoring our system performance for phase one. These being:
   - Reduction in Avoidable/Premature Mortality
   - Increase in Life Expectancy
   - Emergency Admissions
   - Prevalence of long-term conditions
3. The dashboard, reflecting high-level strategic outcomes, has been integrated and is now accessible to all partners via SharePoint.

Key Achievements and challenges for Phase One

- Identification and Alignment of Key Metrics for phase one: collaborative work with public health colleagues and subject matter experts has resulted in the successful listing of metrics required to measure high-level and cohort-specific outcomes.
- Data Integration and Baseline Establishment: Whilst we have integrated elements of the data, we still require outcome targets in order to support the system to identify whether our plans are sufficiently ambitious and delivering.
- Stakeholder Engagement: Continuous engagement and buy-in has been secured across various groups, with widespread support for the direction of the approach. An outcomes technical group is in place that will progress outcome measurements.

4. The achievement of stage one demonstrates our commitment to an integrated approach to PHM Outcomes Monitoring. By maintaining a balanced perspective between preserving the current framework and selectively integrating new ideas, we are on track to create a robust system that supports our mission to provide services that are safe, effective, and equitable. Our continued collaboration, adaptability, and shared vision will be vital in reaching our goal by March 2024, whilst also giving the system the necessary data it needs, not just

to deliver this framework, but to also understand and gain assurance that we are improving the health and wellbeing outcomes of our population.

5. To continue to meet the next phase of our trajectory we propose the following:
    - Ongoing Evaluation of Existing Framework: Continue with the "running refresh" approach, maintaining constant evaluation and updates to ensure that the existing framework remains aligned and relevant to the Integrated Care System Strategy and Joint Forward Plan.
    - Subject Matter Expert Groups: Input from relevant groups within the system to identify and contribute the most impactful interventions and cohort specific outcomes so that these can be integrated into the outcomes dashboard.
    - Clear Communication and Collaboration: Foster clear communication with all stakeholders, explaining the rationale behind the chosen approach and ensuring collaborative decision-making.

Next Steps

- Phase 2 (November 2023): Continue working with programme leads to finalise metrics for interventions and specific outcomes.
- Phase 3 (January 2024): Identify and integrate data sources into GP Repository for Clinical Care, working closely with providers and digital teams.
- Phase 4 (March 2024): Finalise and launch the PHM Outcomes Dashboard on SharePoint, accessible to all partners.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/09/2023
Paper Title:	**Strategic Planning and Integration Committee Highlight Report**
Paper Reference:	ICB 23 039
Report Author:	Committee Secretariat
Report Sponsor:	Jon Towler, Committee Chair
Presenter:	Jon Towler, Committee Chair

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

Summary:

This report presents an overview of the work performed at the Strategic Planning and Integration Committee meetings held on 3 August 2023 (extraordinary meeting) and 7 September 2023 and provides assurance that the Committee is effectively discharging its delegated duties. The report will highlight key messages for the Board's attention and, where applicable, provide the Committee's agreed level of assurance gained from the items received. For information, the report also includes the high-level operational risks being overseen by the Committee

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:

Appendix A – Description of committee assurance levels
Appendix B – High-level operational risks being overseen by the Strategic Planning and Integration Committee
Appendix C – Patient and Public Engagement Annual Report

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

Report Previously Received By:
Not applicable.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Strategic Planning and Integration Committee Highlight Report

Meeting Dates:	**3 August 2023 (extraordinary meeting) and 7 September 2023**
Committee Chair:	**Jon Towler, Non-Executive Director**

Assurances received: (descriptions of assurance levels are provided at appendix A)

Item	Summary	Level of assurance
Working with People and Communities Update	Members received a progress update on the activities that had taken place between 1 April 2023 and 31 August 2023 to implement the System's approach to working with people and communities. The update also outlined the areas of focus for quarter three to further develop and embed the approach. To provide a greater level of assurance going forward, future progress updates would include details of the work being undertaken in collaboration with provider coproduction teams, highlight the links to the engagement work carried out through the Place-Based Partnerships and draw out the outcomes that had been delivered in response to feedback received through the citizen intelligence and co-production approach. A copy of the Patient and Public Annual Report is provided at Appendix C.	**Adequate Assurance**

Other considerations:

Decisions made:
The Committee:

- Ratified an urgent decision made by the Committee's Chair and Chief Executive on 11 July, utilising the Committee's emergency powers. The request had been to approve investment equating to £819,615 in several tobacco dependency models across maternity, inpatient and mental health services, utilising non-recurrent NHS England Long Term Plan tobacco dependency funding.
- Endorsed the approach suggested in regard to development of future proposals for tobacco dependency across maternity, inpatient and mental health services. A paper regarding recurrent funding for tobacco services would be developed and presented to a future meeting. The proposal would align with the Nottingham and Nottinghamshire Tobacco Declaration.
- Approved disestablishment of the Primary Medical Services Contracting Sub-Committee (PMSCSC) and the establishment of a managerial-led operational oversight and decision-making panel in its place.
- Approved the allocation of £140,000 to establish and carry out evaluation of the Health Inequalities Innovation and Investment Fund (HIIIF) overall and individual schemes.
- Approved release of approximately £2.5m of HIIIF slippage in 2023/24 to support wider financial pressures.
- Approved spend from the Health Inequalities Innovation and Investment Fund against the following schemes.
  - Severe and Multiple Disadvantage (SMD) Infrastructure and Delivery Model
  - County Integrated SMD Clinical Team
  - Integrated Neighbourhood Teams: Bassetlaw
  - Integrated Neighbourhood Teams: Mid-Nottinghamshire
  - Integrated Neighbourhood Teams: South-Nottinghamshire
  - Co-designed Community Hypertension Case Finding
  - Family Mentor Programme
  - Childhood Vaccinations and Immunisations in Nottingham City
  - Obesity in Children and Young People
- Approved the Nottingham and Nottinghamshire ICB Value Based Clinical Commissioning Policy

- Approved the adoption of a single 'prior approval' process to ensure that the ICB has assurance of compliance on agreed policies/access approaches for all registered patients.
- Approved the adoption of ongoing policy compliance monitoring to support implementation of the ICB Value Based Clinical Commissioning Policy.
- Approved the procurement for a new All-Age Suicide and Self Harm Service.
- Approved ICB discretion to be applied to the awarding of points for the Primary Care Network Direct Enhanced Service (DES) Investment and Impact Fund (IIF) 2022-2023 AC-02 indicator.
- Ratified an urgent decision made by the Committee's Chair and the ICB's Deputy Chief Executive (acting as the Chief Executive, in line with the ICB's Constitution) on 25 August 2023 utilising the Committee's emergency powers. This was to approve a direct award to Ross Care for the provision of Wheelchair Services for children, young people and adults for the period 1 September 2023 until 31 March 2025, with an annual contract value of £1,238,905 (with annual inflationary uplifts).

Matters of interest:

The Committee also:

- Received a paper that outlined progress to develop oversight arrangements for the implementation of the Joint Forward Plan. Members considered the approach to inform future system strategy and plan development and noted support for the establishment of a system transformation group as a unifying oversight mechanism for all transformational initiatives. Members stated the importance of having a clear set of terms of reference to ensure clarity of responsibilities, particularly in relation to decision-making. Members also noted that this topic would be considered at the Board's next development session.
- Were advised that work was being undertaken across the East Midlands to consider the alignment of regional fertility policies. Members were supportive of this but raised concerns on the impact that this may have on work the ICB needs to do to align its existing local policies. An update specific to the progress of the local work was requested for the next meeting.
- Received a paper that outlined the current provider selection and decision-making process and noted the expected introduction of the NHS Provider Selection Regime and the plans for contracts due to expire before 30 September 2024. A further update on the NHS Provider Selection Regime would be shared at the December meeting.

- Received an update on the progress that has been made across the mental health transformation programme, along with the risks and mitigating actions for each transformation area.
- Received an update on the alignment of contracting arrangements for Locked Rehabilitation provision to facilitate integrated system pathway transformation.
- Received a highlight report from the Primary Medical Services Contracting Sub-Committee from its meeting on 12 July 2023.
- Received a paper that outlined the risks relating to the Committee's remit. A focussed discussion on the high scoring risks would take place at the October meeting.

Appendix A – Description of Committee Assurance Levels

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

Appendix B – High-level Operational Risks Being Monitored by the Strategic Planning and Integration Committee.

Risk Ref.	Risk Description	Current Score
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)
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)

Appendix C

NHS
Nottingham and Nottinghamshire
Integrated Care Board

Working with People and Communities

Annual Report

July 2022 – March 2023

NHS Nottingham and Nottinghamshire Integrated Care Board

Table of Contents

1 Foreword

Nottingham and Nottinghamshire Integrated Care Board (ICB) was established on 1 July 2022, so this is the first report on how the new organisation has worked with people and communities over the last year. The establishment of ICBs across England has meant new ways of working for NHS and social care organisations, and new opportunities to deliver more responsive, integrated, care for citizens and patients. It has also meant a chance to refresh and improve the pre-existing arrangements for listening to our local population, to ensure that the health and care services are delivering in the way that they need and expect.

I am committed to working every day to make sure that we are listening in a systematic and meaningful way to the 1.2m people who live in Nottingham and Nottinghamshire, and I am pleased that this report clearly highlights how we have delivered on the legal duties placed on the NHS, and beyond that, maximised the ways that we are citizen-led in our work. We have been able to take the learnings from the last few years of the Covid-19 response, to enhance the ways that we are reaching and listening to our most deprived communities and citizens, who might be furthest away from accessing mainstream health and care.

Since the establishment of the ICB, our Strategy for Working with People and Communities has been adopted, formed of two distinct approaches: that of Citizen Intelligence and Coproduction. This is underpinned by our Public Involvement and Engagement Policy.

Of course, strategies and policies are only as good as the delivery which follows them, so it is really pleasing to report that some of our flagship initiatives and projects have made real progress this year. The full report includes more detail about our many projects and activities, but the following work has, in particular, hugely enhanced our understanding of the way that residents interact with our health and care services, enabling us to make them better in the future.

This has been an important and formative year for the whole of our Integrated Care Board and for our approach to working with people and communities. The basics are now in place, and as we move forward collaboratively, across the whole public sector, we have the best chance to truly hear from our population in a meaningful way. We are committed to making both our ambitious plans a reality, and ensuring our citizens have opportunities to contribute to the decisions that we make.

We hope you find this report valuable and insightful and would welcome your comments on how we can further improve our approach and reporting for next year's activities. Please get in touch using the contact details included in this report.

Alex Ball Director of Communications and Engagement
Nottingham and Nottinghamshire ICB

I have been an Independent Lay Advisor of the ICB and have helped to set up the forums for best patient and citizen engagement within the new system. The overall objectives have been to enhance our understanding of the communities we serve, capture relevant insights that help to reduce health inequalities, and bring fresh opportunities to strengthen our coproduction work with people and communities.

This has been a rewarding challenge and good progress has been made in three key areas.

The Voluntary, Community and Social Enterprise Alliance (VCSE) has quickly become a powerful body representing the all-important, multifaceted organisations that are the beating heart of engagement. Representatives from a wide range of voluntary organisations, large and small have an equal voice with all parties committed to act as the focal point for the sector, to liaise with commissioners and other stakeholders encouraging dialogue, co-design and collaboration with the consistent aim of improving health and well-being outcomes for residents.

The Citizen Intelligence Advisory Group has also been formed bringing together Healthwatch, place-based representatives and local authority officers to act as a critical friend on the ICB and ICS partners' approaches to delivering patient and public involvement in all their work programmes. This is a huge challenge, and we hope to see major progress in this forum in the coming months.

The foundations of patient engagement in our new system working are solid and we can all expect great progress next year.

Sue Clague
Independent Lay Advisor

2 Introduction

2.1 About us

NHS Nottingham and Nottinghamshire Integrated Care Board (formerly Nottingham and Nottinghamshire Clinical Commissioning Group and Bassetlaw Clinical Commissioning Group) is responsible for commissioning (planning and buying) healthcare services that meet the needs of local people. To do this well we have to ensure the voice of our citizens is at the heart of what we do, so that we can understand the health problems that affect people living in Nottingham and Nottinghamshire, and commission services that will deliver the most benefit to these populations.

The ICB also has a 'convening' role for the Nottingham and Nottinghamshire Integrated Care System (ICS), to support the collaborative and joint working of all partners within the ICS. This means working jointly with partners including the Local Authorities, the Voluntary, Community and Social Enterprise sector and other anchor institutions within our area, to deliver on the ICS's strategic ambitions. Consequently, whilst much of the work described in this report relates to the work of the ICB, it also has a bearing on – and relevance to – the wider work of the ICS.

We serve a population of just over 1.2m people, covering urban and rural areas. We have some of the country's most deprived communities, and there are significant health inequalities between our most affluent and most deprived areas.
Our goal is to ensure that everyone living in Nottingham and Nottinghamshire has the best possible health and wellbeing they can. To achieve this, we work alongside our partners and our communities to provide people with access to quality healthcare, as well as reducing the health inequalities that exist today.

2.2 Our statutory duties

The main duties on NHS bodies to make arrangements to involve the public are set out in Section 14Z45 of the National Health Services Act 2006, as amended by the Health and Care Act 2022:

The integrated care board must make arrangements to secure that individuals to whom the services are being or may be provided, and their carers and representatives (if any), are involved (whether by being consulted or provided with information or in other ways):
a) in the planning of the commissioning arrangements by the integrated care board,
b) in the development and consideration of proposals by the integrated care board for

changes in the commissioning arrangements where the implementation of the proposals would have an impact on:

- *the manner in which the services are delivered to the individuals (at the point when the service is received by them), or*
- *the range of health services available to them, and*

c) in decisions of the integrated care board affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact."

The ICB requires assurance that the legal duties for public involvement are being delivered effectively, and that the Working with People and Communities Strategy is being delivered in line with statutory guidance.

The report covers our activity for the period 1 July 2022 – 31 March 2023.

3. Our commitment to working with people and communities

The ICB is committed to putting people at the heart of all that we do by consistently listening to, involving and collectively acting on, the experience and aspirations of local people and their communities. This is clearly set out in our Constitution and supported by our Public Involvement and Engagement Policy which describes the ICB's approach to ensure public involvement and engagement in the development, implementation and review of health and care policies and services across the statutory organisation.

The Director of Communications and Engagement and Chief Nurse jointly lead on the two elements of our overall approach to working with people and communities and the importance which is placed upon this work is underlined by the fact that both of these roles report directly to the Chief Executive.

One of the ICB's Board Committees (Strategic Planning and Integration (SPI) Committee) has responsibility for scrutinising arrangements for public involvement and consultation in line with the ICB's statutory responsibilities. This includes overseeing the development and delivery of the ICB's public involvement and engagement strategy, ensuring the diversity of the population is effectively considered, including those who experience the greatest health inequalities as well as reviewing and scrutinising how people's voices and experiences across providers and partners are coordinated and heard. The SPI Committee regularly reports to the Board on progress on this work.

3.1 Overview

Our overall approach to working with people and communities is formed of two key elements, that are closely aligned and complementary but are different disciplines with different techniques and arrangements.

- ·Citizen Intelligence. A process of actively listening to citizens to understand their experiences of health and care services to enable a focus on areas that need improvement or changes. An ongoing cycle of activities that generate genuine citizen insights to guide the work of transformation and commissioning.
- Coproduction. A way of working that includes people who use health and care services, carers and communities in equal partnership; and which does this at the earliest (and all) stages of service design, development and evaluation.

3.2 Citizen Intelligence

Our framework for generating qualitative and quantitative citizen intelligence involves a number of mechanisms of equal value, ensuring we are fully inclusive and have a strong focus on health inequalities, enabling the involvement of people and communities. For example:

- We scope and review existing research, data and evidence to ensure we are maximising what we know and identifying gaps in our knowledge.
- Our targeted engagement work helps us to bridge the gap in our understanding of people and communities' health and care needs and aspirations. Some examples include the work that we've done on the Integrated Care Strategy and Tomorrow's NUH.
- We meet regularly with our Health Scrutiny Chairs, MPs and Councillors which helps us hear the concerns and aspirations of communities in a systematic way.
- We work closely with our Place Based Partnerships to understand trends based on geography and to understand who uses services, what views we have already heard, which voices may be missing and how to reach those groups.
- Our Voluntary, Community and Social Enterprise (VCSE) Alliance and other forums outlined in this report allow us to hear from those who are experiencing the greatest health inequalities.
- We use forums like the ICS Partners Assembly to hear directly from our citizens and their representatives and feed these insights into our Integrated Care Partnership.

3.3 Coproduction

The ICB is committed to embed coproduction within all elements of system design and delivery, including transformational activity, commissioning activity, service/system redesign and quality improvement.

We want to empower and enable people to be involved in the co-design and co-commissioning of our system and services in a meaningful way, as a powerful voice, alongside those of professionals in the system.

Our coproduction work builds upon best practice from across our local health, local authority, and voluntary sector partners, and through coproduction with people with lived experience, in an equal partnership. Throughout 2022, the ICB was one of ten sites to develop and embed coproduction through the NHSE Experience of Care Team programme, and the work builds upon this national learning. We also celebrated our approach as a finalist in the NHS England and Academic Health Science Network's Innovation Awards 2022.

The ICB Coproduction team have been established, with funding support from Small Steps Big Changes (SSBC), who have provided resources and shared learning as part of their legacy for the system. The role of this team is to ensure that the ICB meets its Coproduction objectives, by supporting the ICB's strategic and project level remit for Coproduction, and by providing administration of the System Wide Coproduction Network and ICB Strategic Coproduction Group.

During 2022-23, the ICB coproduction activity was focused on establishing the infrastructure and resources needed to support ongoing and new coproduction approaches and help embed a new routine and strategic approach to creating a culture of coproduction within the ICB.

The ICB Coproduction Strategy has been developed in coproduction with people with lived experience and in partnership with system partners and endorsed by the ICB Quality and People Committee. This forms part of the ICB Working with People and Communities Strategy. The ICB Coproduction Strategy sets out the aims around coproduction for the organisation and contains our coproduced Coproduction Values and Principles.

Since the establishment of the ICB, our Strategy for Working with People and Communities has been adopted, formed of two distinct approaches: that of Citizen Intelligence[1] and Coproduction[2]. This is underpinned by our Public Involvement and Engagement Policy[3]. Full assurance was provided by the former Nottingham and Nottinghamshire ICS Board in March 2022. The strategy was also reviewed and endorsed as part of an NHS England led peer review process.

3.4 Our principles

The principles that guide the work of Nottingham and Nottinghamshire are based on the ten principles set out by NHS England:

1. We will work with, and put the needs of, our citizens at the heart of the ICS.
2. We will prioritise reaching out to those communities affected by inequalities who are less likely to be heard.
3. We will use community development approaches that empower people and communities, making connections to social action.
4. We will work with Healthwatch and the voluntary, community and social enterprise
5. sector as key transformation partners. .We will redesign models of care and progress system priorities in partnership with staff, people who use health, care and support services and unpaid carers
6. We will understand our community's experience and aspirations for health and care.
7. We will systematically capture and report community intelligence that includes findings drawn from a citizen's panel, VCS partners, statutory sector partners and networks at Place and neighbourhood level.
8. We will use insight gathered through a range of engagement approaches to inform decision-making.
9. We will develop a culture that enables good quality community engagement to be embedded
10. We will systematically provide clear and accessible public information about vision, plans, progress and outcomes to build understanding and trust amongst our citizens.

4 Governance and assurance

This section describes the structures and processes that support working with people and communities, including the responsible leads and how working with people and communities happens at different layers across the Nottingham and Nottinghamshire system.

[1]Working-with-people-and-communities-strategy.pdf (healthandcarenotts.co.uk)
[2]Nottingham-and-Nottinghamshire-ICB-Coproduction-Strategy-2022-to-2024.pdf
[3] https://notts.icb.nhs.uk/wp-content/uploads/sites/2/2022/04/ENG-001-Public-Involvement-and-Engagement-Policy-v1.2.pdf

4.1 Nottingham and Nottinghamshire ICB arrangements

Progress on the delivery of the Working with People and Communities strategy is formally reported to the ICB Board through our Strategic Planning and Integration Committee. The Working with People and Communities Annual Report will be presented to the ICB Board in September 2023, with the full Annual Report.

The roles and responsibilities of different governance structures that support working with people and communities, including responsible leads can be found below:

Role	Responsibility
ICB Board	The ICB Board has overall accountability for public involvement and engagement, including the Working with People and Communities Strategy. They also have responsibility for ensuring that the views of the public are appropriately considered in decision making.
Strategic Planning and Integration Committee	The Strategic Planning and Integration Committee is responsible for assuring the ICB Board in regard to its statutory duties for patient and public involvement.
Citizen Intelligence Advisory Group (see Appendix 1)	The CIAG will ensure that all proposals to change and improve healthcare services in Nottingham and Nottinghamshire are developed with appropriate and sufficient citizen and service user involvement and citizen intelligence and insights from patients, staff, carers and public that tell us what matters to them are taken on board and have influenced decision making.
Strategic Coproduction Group	The Strategic Coproduction Group will ensure that strategic decisions and planning around the ICB and ICS coproduction approach includes people with lived experience as an equal partner. The group will advise on system design, delivery, and commissioning.

Director of Communications and Engagement	The Director of Communications and Chief Nurse have joint responsibility for sponsoring the ongoing development and implementation of this policy. They also oversee the teams that supports the organisation in its duties and ambitions to work with and hear from people and communities.
Chief Nurse	

Figure 1 gives an overview of the two-way flow of information across Neighbourhood, Place and System, demonstrating how working with people and communities takes place at each of these levels.

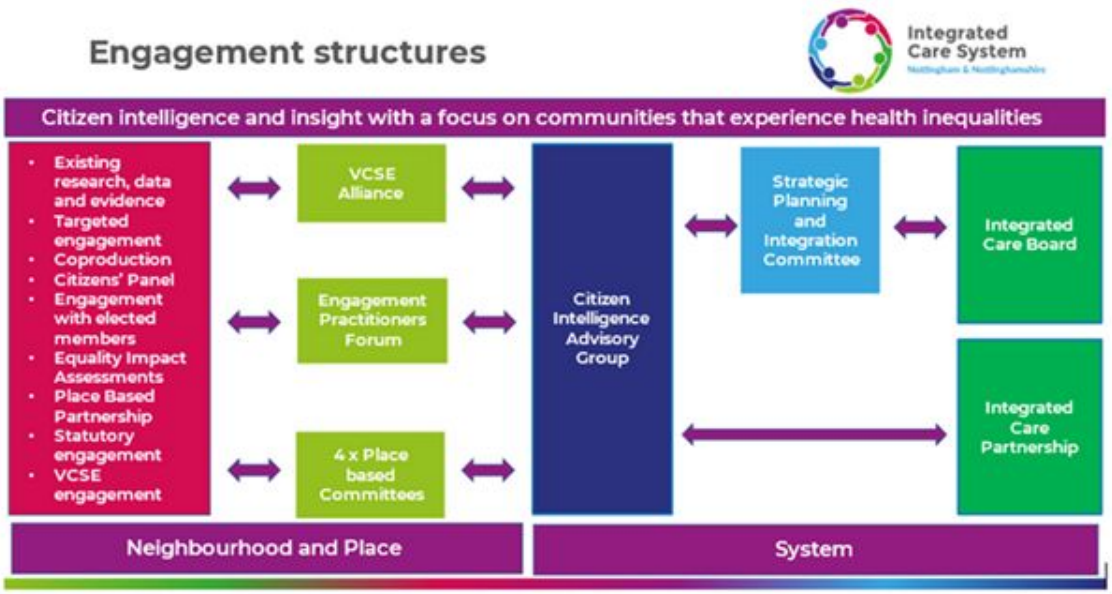


Figure 1. Nottingham and Nottinghamshire ICS engagement structures

Photo by Marketing Nottingham

4.2 Coordinating how we listen to people and communities

4.2.1 ICS Engagement Practitioners Forum

We know that a lot of great work is happening on the ground to hear from people and communities locally, but we knew we needed to do more to better coordinate activity and avoid duplication. The ICS Engagement Practitioners Forum provides a platform for all system partners who. Work with people and communities, to work collaboratively, share resources, knowledge and expertise, to maximise existing knowledge and insights. The Forum aims to maximise collective resources so that listening to our citizens happens in the most efficient way possible – avoiding duplication of public resources and enabling citizens to have their voice heard once, which can then be used for multiple purposes. A “do once” philosophy, as well as a default approach of sharing insights, is the guiding principle.

There are currently more than 35 engagement professional members representing NHS Trusts, Healthwatch Nottingham and Nottinghamshire, Local Authorities, Police, Coproduction Representatives, Colleagues, East Midlands Academic Health Science Network and Community and Voluntary Sector organisations (see Appendix 2).

4.2.2 Voluntary, Community and Social Enterprise (VCSE) Alliance

Nottingham and Nottinghamshire have a rich and diverse Voluntary, Community and Social Enterprise sector, and working as equal partners with this sector is an integral part of the ICB’s approach to listening to our communities. It is therefore great news that the VCSE Alliance has now been fully established and integrated into the system’s strategic decision-making processes. The Alliance currently has 57 members, with representation from both the ‘umbrella’ CVS organisations, who support the small and medium sized members of the sector, and also larger

regional and national organisations such as, Framework, Alzheimer's Society, Active Notts, Framework, Self Help UK, Royal Air Forces Association, Trussell Trust, Active Notts and Stroke Association (see Appendix 3). The Alliance is already well on its way to becoming an integral part of the way that the system works – acting as a sounding board, a voice for marginalised communities and a source of new ideas and initiatives. The fact that the Chair of the Alliance is a formal member of the system's Integrated Care Partnership, further underlines the importance that is being placed on working with this sector.

Nottingham and Nottinghamshire VCSE Alliance is made up of:

- Local representatives of national and regional VCSE organisations working countywide to provide services to citizens.
- A collective of the Community and Voluntary Services (CVSs) and other infrastructure organisations.

This means that the VCSE Alliance will draw in both smaller VCSE organisations via their CVS "umbrella" organisations, as well as the local representatives of larger charities (for example, Framework, Alzheimer's Society, Active Notts, Framework, Self Help UK, Royal Air Forces Association, Trussell Trust, Active Notts and Stroke Association.). This two-pronged approach ensures the voice of smaller community organisations isn't lost against those of bigger providers and means they can all have real influence at system level, working towards the consistent aim of improving health and well-being outcomes for residents. To date, we have over 65 members representing over 50 organisations.

4.2.3 ICS Partners Assembly

The ICB coordinates on behalf of the system as twice-a-year public conference which we call the Partners Assembly. This attracts more than a hundred voluntary sector leaders, patient and citizen representatives, civic partners and others. The Assembly has been used to explore topics and approach for the system's Integrated Care Strategy and also the ICB's Joint Forward Plan. Reports and funding from the Assembly are shared widely, including to the Integrated Care Partnership.

4.2.4 Healthwatch Nottingham and Nottinghamshire

The Nottingham and Nottinghamshire area has long benefit from a single Healthwatch organisation, jointly committed by Nottingham City Council and Nottinghamshire County Council. With the establishment of the ICB and the dissolution of the two CCGs, there is now a one-to-one relationship between the ICB and Healthwatch locally. Healthwatch have refreshed their strategic approach and restructured their team in the recent period and the ICB is now working with Healthwatch to ensure appropriate representation on key bodies and meetings. Healthwatch are represented on CIAG, the VCSE Alliance, Engagement Practitioners Forum and Place-Based Partnership Boards that cover our four Places. Healthwatch are also involved directly in the work on Tomorrow's NUH (as described below) and played a key part in the development of the Integrated Care Strategy.

5 Putting our Working with People and Communities Strategy into practice

This section describes some of the key work programmes that has taken place in partnership with people and communities.

5.1 Major Service Reconfiguration

5.1.1 Tomorrow's NUH

Nottingham University Hospitals (NUH) is one of the hospital trusts identified as part of the Government's New Hospitals Programme – meaning there is an opportunity to secure considerable capital investment in its hospitals. This would also mean the potential relocation or reconfiguration of how services are provided to our population.

As part of our ongoing and continuous listening to our local communities regarding these proposals, a third period of engagement was undertaken in February and March 2023, following on from activity in November/December 2020 and March 2022. This now means that we have heard from over 3,000 residents, patients, and other interested parties – enabling us to take on board feedback on the proposals: right from their formative stage, through specific design, and onto detail, including the name of key buildings and facilities. All of this will stand us on firm foundations ahead of a future public consultation.

A range of different methods were used to engage with patients and the public during February and March 2023, to understand their views:

- Key groups and communities were identified through an extensive stakeholder mapping database undertaken by the ICB Engagement Team. An invitation was sent to these stakeholders, offering a member of the Programme Team to attend community/groups meetings, provide presentations and obtain feedback. In addition, the Programme Team attended public events that were already arranged to specifically speak to citizens about Tomorrow's NUH.

- Members of the public, staff and stakeholders were invited to complete an online

survey about the proposals. The survey was circulated electronically to individuals and groups whose details were held on our stakeholder database, and paper surveys and other languages were available on request.

- Social media was also employed to support the engagement, with the ICB Facebook platform being used to promote this engagement activity.

- Internal communications were used to underpin the key messaging for the engagement and to encourage ICB staff to take part in the survey. Information was disseminated through the organisational staff briefing.

A copy of our engagement report can be found here.

A Stakeholder Reference Group has also been established to ensure best practice engagement in the Tomorrow's NUH proposals. This is chaired by Healthwatch Nottingham and Nottinghamshire, with patient representatives and volunteers as the core members of this important forum. This group forms a significant part of ensuring that patients' views are at the heart of all decision making on this significant investment project.

5.2 Targeted Engagement on Service Change

5.2.1 Interpretation and Translation Services

In April 2022 the ICB Engagement Team engaged with patient, patient advocates and GP Practice staff who had accessed Interpretation and Translation Services, to enable consultations with patients whose first language was not English.

During the engagement 56 individuals responded via a survey (translated and hard copy versions provided) one to one interview and focus groups. We heard from Healthwatch, community group representatives, Nottingham City GP practice managers, a local community trust, and from members of a local community group.

We wanted to understand the priorities for those accessing the Interpretation and Translation Service and views on introducing criterion for accessing the services. We also wanted to understand whether preferences for telephone or face to face interpreting services were required to understand the experiences of both patients and primary care staff.

The recommendations developed as an outcome of the engagement activity have fed into and shaped the service specification and procurement questions set. The ICB Engagement Team was also invited to be involved in the procurement of the services and to evaluate the tenders received (April - May 2023), to ensure that patient and public feedback was considered throughout.

5.3 Frontline service delivery

5.3.1 Notts Alone

Local mental health leads sought to understand the current experiences and feedback of people with lived experience, carers, and professionals, with regards to accessing information on adult mental health services, in Nottingham and Nottinghamshire. This engagement will help inform the production and expansion of the NottAlone website, to enable an all-age, single point of access, for mental health information and support, and highlight any other avenues for consideration when promoting local mental health services.

People with lived experience, carers and professionals were invited to provide their feedback via a survey (either online or hard copy), telephone interviews, participate in online focus group, inviting the engagement team to attend their community groups or to get involved via a coproduction group.

The engagement commenced on 2 September 2022 and finished on 30 October 2022. A total of 249 surveys were completed. A further 170 people were engaged via one-to-one conversations or community group discussions, hosted either by the ICB Engagement Team or in the community.

A full copy of the report and an infographic to highlight key findings can be accessed here.

A coproduction group has been established to ensure that the website will be fully accessible and public facing whilst taking into account the findings from the engagement work.

6 How we've used insight and data

This section describes some examples of how we've used different sources of insight (aligned to our Citizen Intelligence framework) to understand peoples needs and inform decision making.

6.1 Reconfiguration of Acute Stroke Services

In July 2020 temporary changes to Acute Stroke Services at Nottingham University Hospitals Trust to centralise the services in line with the Covid-19 pandemic response resulted in the alignment of service provision with regional and national recommendations such as the local Clinical and Community Services Strategy review of stroke services. This review was underpinned by strong patient and public involvement with stroke survivors forming part of the work alongside staff and clinicians, and the Stroke Association supporting a number of patient engagement sessions.

Insight and engagement to explore the potential opportunities and benefits of a permanent service change involved reviewing a range of evidence related to three areas:

- Clinical effectiveness and quality
- Impact on other clinical services
- Citizen intelligence and insight.

The relocation of the Hyperacute & Acute Stroke Service geographically aligned the service to equipment, interrelated services and the Emergency Department therefore eliminating significant delays in patients receiving the required treatment for an optimal outcome following a stroke.

The impact on clinical services showed no measurable difference before or after moving the NUH Stroke service to QMC or significant growth to stroke medicine during this time period and therefore moving Stroke services to QMC did not result in a change in activity.

Both stroke rehabilitation community providers, the Nottingham CityCare Community Stroke Team and the South Nottinghamshire Community Stroke Team, provided positive feedback to the relocation, as well as aligning to national targets the move also had the potential to reduce the number of deaths due to stroke and potentially increasing collaboration and allowing more interventional approaches.

We heard from people through many activities including two online surveys, targeted engagement with diverse and ethnic communities undertaken by Healthwatch, feedback from events and social media posts, patient case studies and patient and carer feedback.

The evidence base for the management of stroke clearly showed that the assessment

and treatment for a person who has had a stroke is time critical to ensure the best patient outcomes and reduces the occurrence of disability or death. The relocation of the stroke service maximised the opportunity to provide timely assessment and treatment to patients and had support from patients and the public to co-locate emergency care services together on one site. Following endorsement from the Health Scrutiny Committees the temporary location of stroke services was made permanent.

6.2 Maternity and Neonatal Redesign

Nottingham University Hospitals proposed changes to expand their neonatal and maternity services and sought £29.6m capital funding for investment in neonatal and maternity services at the QMC. This would provide an additional 21 neonatal cots (from 17 to 38) and eight additional maternity beds, enabling the Trust to provide sufficient capacity to meet the requirements of the Neonatal Critical Care Review (NCCR), and the recent Getting It Right First Time (GIRFT) report.

The proposals were shared by the Nottingham and Nottinghamshire Clinical Commissioning Group with the Nottingham City Council Adult Health and Social Care Committee and Nottinghamshire County Council Health Scrutiny Committee, in November 2021. It was agreed that targeted engagement would be appropriate to support the planned service move.

Working in partnership with Nottingham University Hospitals NHS Trust (NUH), we engaged with community groups, women and families, health and social care professionals and the wider public, to understand views and experiences of neonatal services within Nottingham and Nottinghamshire, as well as bordering counties, where families may access the NUH sites.

The ICB Engagement Team used various approaches to gather feedback including:

- Administering an online survey for citizens to complete.
- Hosting a webinar for citizens. This session was recorded and shared on the NHS Nottingham and Nottinghamshire YouTube channel.
- Attendance at forums in Newark and Sherwood and Mansfield, who were meeting either virtually or in a community socially distanced setting, to gather face-to-face feedback.

A copy of the final report can be found here.

On Monday 20 February 2023, NUH was given the go ahead to expand the neonatal intensive care unit at the QMC, increasing the number of intensive, high dependency and special care cots from 17 to 38. The neonatal unit at City Hospital will become a ‘Local Neonatal Unit’, where babies can continue to receive high dependency and special care and be managed in intensive care for up to 48 hours, before being

transferred to the QMC for longer term care where needed.

7 Equality and inclusion when working with our diverse communities

This section describes the principles that enable us to effectively hear from the diverse communities living in Nottingham and Nottinghamshire. It also provides some examples of how we have proactively reached out to groups who are most often excluded from (or less represented in) health services and involvement opportunities, such as people from inclusion health groups, people with a learning disability and people whose first language is not English.

7.1 Equality and inclusion principles

We tailor our engagement methods and messages according to the needs of our communities to maximise opportunities to hear from the diverse people living in Nottingham and Nottinghamshire. We make sure that our meetings and events are designed to meet the needs of individuals and communities and enhance access and participation. For example, we source British Sign Language (BSL) and language interpreters at events, provide easy read versions of documents as well as providing information in other languages.

7.2 Working with Empowerment for Heya

The ICB Engagement Team supported a successful funding application by the community group Empowerment for Heya, for the 2022 East Midlands Academic Health Science Network Public Involvement Fund. This group is for all Arab Women who have recently moved to the UK and lack personal and social networks, resulting in social isolation. The group were successfully awarded funding to provide host workshops for their community group on four key areas:

- Registering with a GP/GP access
- Accessing healthcare services in the UK
- Maternity and breastfeeding/chestfeeding
- First aid

Over time, it was noted that additional sessions would also be beneficial for the group, including:

- Healthy lifestyles
- Mental health
- Menopause
- Children's vaccinations
- CPR training

To date, the engagement team have coordinated two workshop sessions for Heya. The first session on Healthy Lifestyles focused on weight management, nutrition and raising awareness of the Better Start Programme. This session was delivered in partnership with Your Health Your Way, This Girl Can, Small Steps Big Changes and colleagues within Public Health. A second workshop then took place on pregnancy and breastfeeding/chestfeeding, which was delivered by a Specialist Midwife from Sherwood Forest Hospitals NHS Foundation Trust. This session also provided the group with the opportunity to have their say and get involved in the naming of a new facility for women, children and families, as part of the Tomorrow's NUH programme.

For these sessions to meet the needs of Heya members, we secured female clinicians to speak to the group, and ensured that sufficient time was allowed for live translation. Further sessions are being coordinated for Heya and are planned to take place from May 2023 onwards.

7.3 Coproduction in Personalised Care – My Life Choices

Personalised care is one of the five major, practical changes to the NHS, as set out in the Long-Term Plan, in recognition that a one-size-fits-all health and care system simply cannot meet the increasing complexity of people's needs.

Through personalised care, people can have more control and choice when it comes to the way their physical and mental health care is planned and delivered and be actively involved in the decision-making process by speaking up on things that matter and are most important to them.

This shift from ‘what is the matter with you’ to ‘what matters to you’ empowers people to take control of their own health and wellbeing, supporting prevention and health inequalities agendas.

The comprehensive model of personalised care supports the delivery of this shift by bringing together six, evidence-based components, each of which is defined by a standard set of practices, including:

a. Shared decision making
b. Personalised care and support planning
c. Enabling choice, including legal rights to choice
d. Social prescribing and community-based support
e. Supported self-management
f. Personal health budgets and integrated personal budgets (health and social care funded)

The heart of personalised care is about working with people to support individuals to achieve outcomes. It is an evidence-based approach where every interaction is outcome focussed, based on what matters to the person and want they want to achieve. There is much evidence that this person-centred, holistic approach supports individuals to achieve improved outcomes in relation to health and wellbeing.

A coproduction approach for Personalised Care has been developed over the past 6 years and is an exemplar in the model for a strategic approach to coproduction.

The dedicated Coproduction Group for personalised care is the My Life Choices group. The group ensures that the voice of people with lived experience is integral to the development and delivery of personalised care, supporting the necessary need for culture change within the ICB and wider system, it has a direct link through membership to the wider ICB Strategic Coproduction Group. My Life Choices work in partnership with the Personalised care team and our health and care system to raise the voice of people to strategically shape and influence decisions about personalised care. Five members are trained lived experience Coaches for National Voices Improvement CORE20PLUS5 and four members have completed the NHSE peer leadership course. They provide oversight to transformation and improvement activity; co-design resources for the system; actively promote personalised care within their networks, at system events and meetings, and at national boards; and support recruitment. Patient Information Forum and the Patients Association worked with the ICB to look at ways of making it easier for patients to take part in shared decision-making.

They delivered a coproduction programme with the My Life Choices panel of local people and the ICB Personalised Care Team and developed and implemented patient information to support people with hip, knee and joint pain to make treatment decisions. This report, developed with input from My Life Choices, outlines the key findings and recommendations.
It also shares the co-produced resources developed throughout the project.

This work has been recognised by NHS England and shared nationally through its Personalised Care Bulletin.

7.4 Working with our diverse communities through our Community and Voluntary Services

Nottingham and Nottinghamshire's local Community and Voluntary Service (CVS) organisations work to promote connectivity, dispel isolation, and address loneliness thereby increasing community involvement and generating valuable citizen insight. They are trusted within their communities and are therefore well placed to hear from people and communities who may not engage with statutory services, amplifying the voice of those experiencing the greatest health inequalities. The following case studies demonstrate the work that is being undertaken.

Case Study: Community drop-in sessions in Ashfield
(Led by Ashfield Voluntary Action)

Health and wellbeing events targeting people experiencing homelessness, requiring housing support, or otherwise vulnerable have been held in Ashfield at Sutton Christian Fellowship. Colin Bozward, who runs the service, highlighted the importance of the sessions:

"The drop-in was a really positive step for our service users. They feel like they are on the bottom rung of the ladder, and nobody cares about them. This sends out the message that they do matter. The second visit resulted in twenty people having vaccines. There have also been other health benefits. One man who had been stabbed had his dressing replaced, was given additional dressings and advice on wound care. He was absolutely over the moon. Also, a local GP has now agreed to come along to one of our drop-ins to invite our service users to sign up to the Practice as many are not registered. This would not have happened without this first step."

Case study: Addressing race health inequalities in Nottingham (Led by Nottingham CVS)

In Nottingham City, a significant proportion of the population identifies as being a part of an ethnic community. Nottingham CVS has supported the Race Health Inequalities Working Group who have developed a Race Maturity Matrix, which is being piloted by Nottingham Place Based Partnership. The matrix is a strength based, self-assessment tool for increasing equality and tackling racism at organisation and system level. The tool was coproduced with Black and Asian-led organisations and people with lived experience.

Nottingham CVS have also been part of the Vaccination Inequalities Steering Group. Working with Majority Black Led Churches, volunteers were deployed to provide insight to the Steering Group to support the development and implementation of vaccination hesitancy strategies with Black Caribbean Communities. Over 1,500 people shared their views.

Case Study: Supporting people living in areas of high deprivation (Led by Mansfield CVS)

People who are homeless may experience digital exclusion from online engagement activities. Mansfield CVS's approach enables those who are homeless and digitally excluded to have access to engagement opportunities by providing access to offline resources and events.

Over the past 12 months, Mansfield CVS have focussed on listening to residents of the Bellamy Road Estate, where the population has a wide range of health inequalities and high numbers of people living in poverty and classed as homeless. Health and Wellbeing and Vaccination Sanctuary events were co-designed with the Bellamy Tenants and Residents, and Friends of Bellamy groups where health checks have taken place, referrals for support are made and people have an opportunity to ask questions about health and wellbeing. The following feedback from a staff member showcases the importance of the work undertaken:

"We were able to make every contact count, discussing health issues and guiding citizens to see health professionals, asking vulnerable citizens to follow up health advice and supporting a young couple in food poverty but with multiple disadvantage"

8 Demonstration of how the ICB has worked with partner organisations

This section describes some examples of how we have worked in partnership partners to design services collaboratively.

8.1 Vaccination conversations development workshops

The ICB Engagement Team worked closely with colleagues in Public Health and the Vaccination Services Team to design, promote and deliver Vaccination Conversations Development Workshops. These workshops were targeted at trusted community representatives with the aim of improving their confidence in having conversations about the Covid-19 vaccinations, following the principles of Making Every Contact Count (MECC).

Three sessions were offered over the period of August to September 2022 and were attended by 30 representatives from the Nottingham City Community Champions Programme and representatives from various community and voluntary sector organisations. Two additional sessions were specifically requested to be delivered to the teams that host the Health and Wellbeing Hubs across Nottingham City and Nottinghamshire County and by Newark and Sherwood Community and Voluntary Services, for the community representatives within their area. A resource pack and feedback forms were shared with all attendees following the sessions. These indicated high levels of confidence in talking about the Covid-19 vaccinations and signposting to information about the vaccinations, following the workshop.

8.2 Patient Participation Group Coproduction and Development Sessions

Working with Mid-Nottinghamshire Locality Team, Ashfield Voluntary Action, Mansfield Community and Voluntary Service (CVS) and Newark and Sherwood CVS, the ICB Engagement Team hosted a series of coproduction sessions with experienced Patient Participation Group (PPG) members. The purpose of these sessions was to create a Development Workshop on recruitment and maintenance of an effective PPG, so that this could be shared across Nottingham and Nottinghamshire.

Three coproduction sessions took place between November 2022 and January 2023, to develop the content for the workshop and to update an existing resource pack which could be shared with practices and PPGs. The final development workshop was hosted on 28 February 2023, with 34 people attending, representing both Primary Care staff and PPG members. The workshop was co-delivered with experienced PPG members, Practice Managers, Newark and Sherwood CVS, and colleagues within the ICB, who all shared their insights and experiences to help those who are struggling with their groups.

Feedback on the PPG Coproduction and Development Sessions

"This meeting has been so beneficial for myself, feeling a little overwhelmed as this will be my first PPG and I am starting from scratch." **PPG Member**

"I am also starting a PPG from scratch so this has been amazing." **PPG Member**

"A really interesting and valuable session." **Practice Manager**

Further work with PPGs is currently being planned with an initial review being undertaken to understand the status of PPGs across Mid-Nottinghamshire.

8.3 Maternity Voices Partnership

Coproduction has been underway on the development of the new Maternity Voices Partnership (MVP) Group, following a review of the existing MVP group. The aim of the coproduction is to restructure the existing MVP group (the existing group will continue to run for the duration of the coproduction) and develop a new model that works and decide the infrastructure needed to support that. The review and coproduction work will take place over 12 months. Members of the group are coproducing how their group will operate in the future. The development will look at membership, volunteer management, engagement approaches, feedback loops, communication, the MVP work programme, finance, and reimbursement and looking at the overarching infrastructure.

An MVP is a part of a national approach, and the local Nottingham MVP works to review and contribute to the development of maternity services in Nottingham and Nottinghamshire. It brings together the staff who commission and provide maternity services with the women, birthing people and families who use those services. The MVP is coordinated by a service user chair or leadership team, including people who are independent with lived experience. All members of the partnership take responsibility for the development and delivery of an agreed workplan.

Membership includes midwives, health visitors, doctors and managers, women, birthing people, and families from a diverse range of backgrounds and members of the wider community such as birth workers and charities specialising in mental health, supporting refugees, etc.

The members work together as equals, recognising that each person brings a different set of experiences, skills and resources that will contribute to the strength of the partnership as a whole. It is intended that anyone who works, has used or supported others in using maternity services in our area can choose to get involved in the Nottingham & Nottinghamshire MVP.

MVP volunteers have been working with Sherwood Forest Hospital on coproducing an updated process for enabling partners and families to stay overnight with birthing people to provide greater support. This has also led to the purchase of appropriate furniture to allow a comfortable stay.

Volunteers have also worked with NUH maternity colleagues in co-creating a new video for birthing people around the expectations when discharged from care.

With focus on safety across maternity units being critical, volunteers are working as members of the Ockenden Learning Review and working with both providers in

ensuring that relevant, easy to fund and easy to understand information is available on provider webpages. Volunteers are supporting in co-creating updated information.

8.4 Piloting a Citizens' Panel in Nottingham

The Citizens' Panel pilot is being delivered in Nottingham to add to our existing methods of engaging local people and is another way that is enabling us to listen the views of our citizens. The Panel is a standing group of citizens, representative of the overall population, who have volunteered to give regular feedback on specific topics. The Panel adds value by identifying local priorities and consulting on specific issues that affect our communities. Benefits include the ability to track trends in opinion, targeted work with particular communities focussing on health inequalities, and the ability to focus on specific ICS priorities at various points in the year.

The implementation of the Citizens' Panel has been undertaken in line with NHS England guidance and informed by a literature review undertaken by academic partners at the University of Nottingham Business School. Further desktop research was undertaken by the ICB Engagement Team and additional support provided by an external subject matter expert.

The ICB Engagement Team continue to work in partnership with Nottingham CVS, Healthwatch Nottingham and Nottinghamshire, Nottingham Trent University, University of Nottingham Business School, CityCare, NUH and other Nottingham Place representatives to grow the Panel membership.

A mapping exercise with recent census data has been undertaken to ensure that the pilot panel is as representative of the Nottingham City population as possible, with an aim of 800 members. Effective stakeholder engagement software is being utilised, with the ability to monitor demographics and to help identify those segments of the population with lower take-up.

Regular, meaningful engagement with Citizens' Panel members will ensure there is clarity and consistent feedback about how their views have shaped the provision of services and how it has contributed to improvements and change therefore demonstrating how we have turned this data into action.

The official launch date of the Panel was in September 2022, with two system-wide engagement surveys issued in November 2022 and February 2023. The Panel currently has 99 members, featuring strong representation from our diverse communities. The engagement team's collaboration with Nottingham City Council and partnership with the Voluntary, Community and Social Enterprise Alliance will aid panel member recruitment and generate strong links with groups and communities, including those who we are yet to hear from and experiencing the greatest health inequalities.

8.5 Green spaces social prescribing

Green social prescribing is a way of connecting people to nature-based activities and green groups, projects, and schemes in their local community for support with health and wellbeing. Often this will be through a referral from a Link Worker based at a GP practice or another primary care professional. Green buddies are people who help people take part in the Green Space activities.

A recent system coproduction activity took place to co-design the Green Buddy model. This involved people with lived experience coming together to codesign different aspects of the model, which included:

- The appropriate pathways to link referrers/providers and buddies
- Role descriptions of the buddies
- Green buddy and host organisation
- Training/support/resource needs
- Add on to existing volunteer roles or new roles

A series of sessions were held, where people came along to share their experiences of befriending and insight about the different topics. The collective group was split into smaller groups during the sessions and fed back into the main group. This was then used to create the resources needed for the Green Buddies.

9 Sharing learning and good practice examples

This section describes key programmes that have gone well for Nottingham and Nottinghamshire ICB.

9.1 Developing Nottingham and Nottinghamshire Integrated Care Strategy

The development of Nottingham and Nottinghamshire's Integrated Care Strategy has been one of the earliest testing grounds for our refreshed and enhanced approach to working with people and communities.

Using a two-step approach, a desktop research exercise was first undertaken to understand the needs of our citizens and how these can be met, and to understand the communities we need to involve, and gaps in our knowledge that could form the basis of our involvement work.

The second stage involved a number of listening activities, to test the findings from the desk research, explore gaps in our knowledge, and test the emerging content of the Integrated Care Strategy and the Vision and purpose for our ICS. A key principle of these activities was to allow citizens the opportunities to shape and inform the Strategy, and to ensure we didn't ask for citizen intelligence we already had.

The ICS Assembly was a core mechanism for involving people and communities in the development of the Integrated Care Strategy, which was attended by 161 partners from across our ICS, including representation from NHS, Local Authority, Voluntary, Community and Social Enterprise, citizens and patients (see Appendix 4).

This was complemented by:

a. One virtual and three in-person briefings to MPs and councillors
b. Two virtual public events
c. Development of an online survey, which was shared with the Citizens' Panel
d. Attendance at the Nottinghamshire County Council Shadow event (targeted engagement with children and young people)
e. Listening to feedback from members of our VCSE Alliance
f. Working with the ICS Engagement Practitioners Forum, to identify existing events and opportunities to hear from our citizens

The work undertaken with people and communities in the development of our Strategy has been a flagship piece of work, identified as an exemplar by the Department of Health and Social Care.

The involvement report can be found here.

9.2 Progressing our approach by working with existing local coproduction groups

One of the key ethos of our coproduction approach is the desire to utilise the existing knowledge and experience about coproduction already within the system. We do this by working closely with system coproduction experts from our partner organisations and the system wide coproduction groups that we had a relationship with already.

This to date has included representation from community groups including a personalised Care coproduction group My Life Choices a national exemplar strategic coproduction group supporting the universal personalised care programme, Small Steps Big Changes, Healthwatch, Parent Carer Forums and a local authority coproduction group Our Voice from Nottinghamshire County Council. We also coproduced with our system partners in secondary care services including Nottingham University Hospitals Trust and our mental health trust Nottinghamshire Healthcare Trust and coproduction experts from Nottingham City Council and Nottinghamshire County Council; and representation from ICB commissioning and Quality and Transformation functions, colleagues within Place Based Partnerships and the Voluntary sector through the Nottinghamshire Community Voluntary Service (NCVS).

The role of the lived experience people coproducing with us was to develop the coproduction model and strategy content, provide a check and challenge on the coproduction strategy and model and to enable us to make the content meaningful and language used accessible for the public. They shared their perspectives and opinions on the coproduction approaches, as many of the group were members of other coproduction groups, they had experience of contributing to the development of approaches and representing groups of voices.

10 Communications, social media and marketing

This section describes some of our communications activity that has supported the ICB's work with people and communities.

10.1 Overview

We believe that a key enabler of our work is building and maintaining an ongoing relationship with people and communities, enabling a two way dialogue. This includes:

- Producing regular newsletters for system partners, so that they are aware of the work that is being done in this area.
- Producing a monthly stakeholder update.
- Sharing final reports with those who were involved in generating citizen intelligence as part of bespoke programmes of work, including direct distribution and publication on our website.

- Proactively briefing and updating (both verbally and in written form) Members of Parliament.
- Informally meeting with the Chairs of Nottingham Adult Health and Social Care Committee and Nottinghamshire Health Scrutiny Committee monthly.
- Providing regular verbal and written updates to Healthwatch.

10.2 Targeted Lung Health Check

Over 30,000 past and current smokers have already been invited to a lung health check in Mansfield and Ashfield, which is helping to identify lung cancer at an earlier stage. Since April 2021, past and current smokers between the age of 55 and 74 in Mansfield and Ashfield have been invited to an NHS lung health check in a drive to improve earlier diagnosis of lung cancer and save more lives.

With one of the highest mortality rates for lung cancer in England, Mansfield & Ashfield is one of 43 places across the country to complete the Targeted Lung Health Check programme which is now being rolled out across Nottingham City.
The initiative has seen more than 16,000 past and current smokers aged 55 to 74 coming forward for a lung health check-up, which has resulted in a 20 percent increase in lung cancer diagnosis in the area - 60 percent of lung cancers identified were at an early stage.

The campaign involved:

- paid for social media posts targeted to our audience group
- tram stop and bus advertising
- promotional materials displayed in GP practices, local supermarkets, car parks, faith groups, children's centres, libraries, health and wellbeing hubs, churches and Scout huts
- engagement with local community groups
- production of translated materials (leaflets and posters) into 9 different languages

The programme has recently received a performance scorecard from Inhealth for Mansfield and Ashfield and Clifton. We are currently at a 73% uptake rate, whereas nationally the uptake rate is around 40%.

10.3 Covid-19 Vaccination Autumn Booster Campaign

Throughout the Autumn Booster Covid-19 Vaccination campaign the objective was to maximise uptake of the vaccine in all eligible cohorts while supporting the inequalities work and increase the uptake of covid in specific demographic groups.

The campaign ran from September 2022 – February 2023 and in total 65% of eligible citizens received the vaccine. A further breakdown shows 85% of over 65s received the vaccine.

Key inputs included:

- A suite of assets, materials and advertising so we could share our messaging with the public
- Advertising set up across the city and county – billboards, bus sides, bus shelters, local magazine and newspapers, radio adverts (community radio stations), SEO.
- Translating materials into seven different local languages.
- We looked at previous campaign data to help us understand specific areas and people to target – we utilised our advertising in these areas.
- Advertising pop up clinics in low uptake areas by posting leaflets through doors, advertising in community magazines and working with community representatives to share the message.
- Creating three social media toolkits – which were shared with partners and used across all channels
- Working with local media on broadcast opportunities and media releases which reached 947,389 people
- Social media advertising and organic posts totalling in 161,474 people reached.
- Liaised with communications partners throughout the programme to share information and encourage support across all channels
- Working with public health and partners to target areas of inequality, we created engagement material such as posters, leaflets and digital screens for venues to use to promote the events – for example health and wellbeing event at B&Q, visits to colleges and homeless settings and community pop up clinics in low uptake areas.

Overall, the campaign reached more than 1.6 million people and we were either higher or in line with the national average uptake for each cohort. Key relationships have also been made with public health and community champions which will help with future campaigns and reaching more diverse audiences.

11 Future planning

This section presents an outline of key activity planned for the next financial year.

11.1 Coproduction

The aims for the first two years of this programme are to coproduce and cocreate:

- A Coproduction Strategy, setting out the approach to coproduction over the next two years, and containing our coproduced Coproduction Principles and Values for the ICB to work to, and embed, within working practice.
- A Coproduction infrastructure of an ICB Strategic Coproduction Group and a System Coproduction Network.
- Support resources and a Toolkit to enable Coproduction - with tailored resources for staff, people with lived experience and the public.

11.1.1 ICB Strategic Coproduction Group

Building on the agreed ICB Coproduction strategy, our new ICB Strategic Coproduction Group will be central to how coproduction in the ICB will be delivered. The group will ensure that strategic decisions and planning around the ICB and ICS coproduction approach includes people with lived experience as an equal partner. The group will advise on system design, delivery, and commissioning, will be involved in key priority work across the system and will report into ICB Board.

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

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

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

a. Encourage the adoption of the Coproduction Values and Principles as set out in the ICB Coproduction Strategy within the ICB and wider system by having oversight of the ICB Coproduction activities taking place, providing a steer to success, identifying areas for further development, removing barriers to coproduction, and holding the ICB to account for genuine coproduction approaches being adopted
b. Provide oversight and scrutiny to the ICB and ICP to ensure that coproduction activity to support the delivery of the Integrated Care Strategy is being undertaken effectively.
c. Provide oversight and scrutiny on coproduction progress within the 10 system transformation programmes.

11.1.2 Coproduction Network

Our current focus and continuing into 2023-24 will be the coproduction and development of a system wide Coproduction Network. It is anticipated that the network will have a wide-ranging membership open to the wider system and it will be a space to share coproduction approaches and insights so that system best practice can be collated and shared.

Our Coproduction Network will be key to building relationships and best practice support about coproduction approaches across our system.

11.2 Citizen Intelligence

Our ambition is that our Citizen Intelligence approach is fully embedded across all system partners so 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.

To actualise this ambition, during 2023/2024 we will:

- Review existing Community Insights Hubs in other systems. Our Community Insights Hub will be a key resource for capturing and reporting community intelligence that includes findings drawn from all system partners including statutory sector, VCSE, Healthwatch, citizens' panel and networks at Place and neighbourhood level.
- Deliver insight reports on citizen and service user intelligence and insight to the Integrated Care Partnership.
- Deliver reports on citizen and service user intelligence and insight to the ICB Board, on a specific issue, linked to the work programme.
- Expand the Citizens' Panel, increasing the number of members.
- Continue to develop and embed the VCSE Alliance. The Hewitt Review has suggested that membership should be extended to faith groups and our focus will be on this.
- Deliver the formal public consultations for major service change programmes.
- Produce and collate resources that enable the generation of citizen intelligence

12 Working with People and Communities: How to get involved

It is important for us to hear people's comments, ideas and suggestions about health and care services in Nottingham and Nottinghamshire, so we know what we're doing well and where we could do better.

Please visit our website to find out how people and communities can get involved in the work of Nottingham and Nottinghamshire ICB or call or text 07385 360071.

13 Appendices

Appendix 1: Citizen Intelligence Advisory Group (CIAG) membership
Appendix 2: Engagement Practitioners Forum: organisations represented
Appendix 3: VCSE Alliance: organisations represented
Appendix 4: ICS Partners Assembly October 2022: organisations in attendance

13.1 Appendix 1: Citizen Intelligence Advisory Group (CIAG) membership

Organisation/Speciality/Role
Healthwatch Nottingham and Nottinghamshire representative
Chair of the Voluntary, Community and Social Enterprise Alliance
Place representatives • South Nottinghamshire • Nottingham • Mid Nottinghamshire • Bassetlaw
A health inequalities expert
Local Authority Officers • Nottingham City Council • Nottinghamshire County Council
ICB Engagement Team representative
ICB Co-Production Team representative
ICB System Analytics Intelligence Unit representative
ICB Research and Evidence representative

13.2 Appendix 2: Engagement Practitioners Forum: organisations represented

- Alzheimer's Society
- Ashfield Voluntary Action
- Bassetlaw Community and Voluntary Service
- Bassetlaw Place Based Partnership
- Doncaster and Bassetlaw NHS Foundation Trust
- East Midlands Academic Health Science Network
- East Midlands Ambulance Service
- Gedling Borough Council
- Healthwatch Nottingham and Nottinghamshire
- Mansfield Community and Voluntary Service
- Mid Nottinghamshire Place Based Partnership
- Newark and Sherwood Community and Voluntary Service
- NHS Nottingham and Nottinghamshire ICB (Engagement, Coproduction and Research)
- Nottingham City Council
- Nottingham CityCare
- Nottingham Community and Voluntary Service
- Nottingham Trent University
- Nottingham University Hospitals Trust (including Research Team)
- Nottinghamshire County Council
- Nottinghamshire Healthcare Trust
- POhWER
- Police and Crime Commissioners Office
- Rushcliffe Community and Voluntary Sector
- Self Help UK
- Sherwood Forest Hospitals Trust
- University of Nottingham

13.3 Appendix 3: VCSE Alliance: organisations represented

- Active Health Coach
- Active Partners Trust
- Age UK Nottingham and Nottinghamshire
- Alzheimer's Society
- Ashfield Voluntary Action
- Bassetlaw Action Centre
- Bassetlaw Citizens Advice
- Bassetlaw Community and Voluntary Service
- British Liver Trust
- Canal & River Trust
- Children’s Bereavement Centre
- Dementia UK and Admiral Nursing
- Enable
- Framework
- Health Alliance Group (BHAG) CIC
- Healthwatch Nottingham and Nottinghamshire
- Homestart Nottingham
- Improving Lives
- Ladybrook Enterprise
- Mansfield Citizens Advice
- Mansfield Community and Voluntary Service
- Newark and Sherwood Community and Voluntary Service
- Nottingham City Council
- Nottingham Citycare Partnership
- Nottingham Community and Voluntary Service
- Nottingham Focus on Wellbeing
- Nottingham Mencap
- Nottingham Trent University
- Nottinghamshire Deaf Society
- Nottinghamshire Disabled People’s Movement
- Nottinghamshire Mind
- NSPCC
- Opus music
- Parkinson’s UK
- POhWER
- Royal Air Forces Association
- Royal Voluntary Service
- Rural Community Action Nottinghamshire
- Rushcliffe Community and Voluntary Service
- Self Help UK
- S.H.E UK (Supporting, Healing, Educating)
- Sherwood and Newark Citizens Advice

- Stroke Association
- Sustrans (sustainable transport)
- The Centre Place - LGBT+ Service Nottinghamshire
- The Helpful Bureau
- Trussell Trust

13.4 Appendix 4: ICS Partners Assembly October 2022: organisations in attendance

- ABL Health
- AL-Hurraya
- Alzheimer's Society
- Ashdale Care home
- Ashfield Voluntary Action
- Aurora Wellbeing Centres
- Barnsley Premier Leisure
- Bassetlaw Action Centre
- Bassetlaw Community and Voluntary Service
- Bassetlaw District Council
- Bassetlaw Hospital
- Bassetlaw Place Based Partnership
- Beaumond House Hospice
- Bespoke Health & Social Care
- British Lung foundation Durban House Community hub
- British Red Cross
- Carers Roadshows
- Carlton, Gedling and District U3A
- Castle Healthcare
- Children's Bereavement Centre
- Defence Medical Welfare Service
- Citizens Advice (Newark and Sherwood)
- D2N2 Local Enterprise Partnership
- Diagnostics
- Disability Involvement Group (DIG)
- Doncaster & Bassetlaw NHS Foundation Trust
- Double Impact services
- East Midlands Academic Health Science Network
- East Midlands Chamber
- Fire and Rescue Service
- Fosse Healthcare
- Freshwater Communications and engagement - External Provider
- Gedling Borough Council
- GP, Victoria & Mapperley Practice
- Gypsylife
- Healthwatch Nottingham and Nottinghamshire
- Heya in Nottingham
- Hucknall Stakeholder group

- Insight Healthcare
- Insight IAPT
- Inspire Learning
- Keep Our NHS Public
- KS Healthcare Consultancy Ltd working with Primary Care Direct
- Ladybrook Enterprises Ltd
- Larwood Health Partnership
- Liberty Leisure Limited, Broxtowe Borough Council
- Mansfield Community and Voluntary Service
- Mansfield District Council
- Mid Nottinghamshire Locality Team - Integrated Care Board
- Mid Notts Place Based Partnership
- More Leisure Community Trust
- Musters Medical Practice
- My Life Choices
- NEMS Community Benefit Services
- Newark & Sherwood Community Voluntary Service
- NHS Business Services Authority
- NHS England
- NHS Nottingham and Nottinghamshire ICB
- Nottingham and Nottinghamshire ICS
- Nottingham City Council
- Nottingham City GP Alliance
- Nottingham City Place Based Partnership
- Nottingham CityCare Partnership
- Nottingham Community and Voluntary Service
- Nottingham Community Housing Association
- Nottingham University Hospitals NHS Trust
- Nottingham Womens Centre
- Nottinghamshire County Council
- Nottinghamshire Deaf Society
- Nottinghamshire Deaf Wellbeing Action Group
- Nottinghamshire Healthcare Foundation Trust
- Nottinghamshire Local Dental Committee
- Nottinghamshire Mind
- OASIS Community Centre/The EDGE
- One Nottingham
- Parkinson's UK
- Patient and Public Voice
- Patient Participation Group
- Primary Integrated Community Services

- Retford and Villages PCN
- Roselea Care Homes Ltd
- Royal Voluntary Services
- Rushcliffe Borough Council
- S.H.E UK (Supporting, Healing, Educating)
- Self Help UK
- Sherwood Forest Hospitals NHS Foundation Trust
- Skills for Care
- Small Steps Big Changes
- Solsken Limited
- The Centre Place (Talkzone / LGBT+ Notts)
- The Helpful Bureau
- Torkard Hill Medical Centre Patient Group
- Trent Bridge Community Trust
- Truly Care Services
- Voluntary and Community Sector Learning Skills Consortium

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/09/2023
Paper Title:	**East Midlands Joint Committees' Highlight Report**
Paper Reference:	ICB 23 040
Report Author:	Committee Secretariat
Report Sponsor:	Amanda Sullivan, Chief Executive
Presenter:	Amanda Sullivan, Chief Executive

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

Summary:

The East Midlands Joint Committees have been 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.
This report provides an overview of the meetings held by the Committees on 20 June 2023 and aims to provide assurance that the Committees are effectively discharging their delegated duties.

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:

None.

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 highlight report.

Report Previously Received By:
Not applicable.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

East Midlands Joint Committees' Highlight Report

Meeting Date:	**20 June 2023**
Committee Chair:	**David Sissling, Chair of NHS Leicester, Leicestershire and Rutland ICB**
ICB Members	**Amanda Sullivan, Chief Executive (voting)** **Kathy McLean, ICB Chair (discretionary)**

Item	Summary
Meeting of the NHS East Midlands Joint Committee for Specialised Services	
1. Formalisation of the Joint Committee	The Committee confirmed the revised appointments to the core (Executive) and discretionary (Non-Executive) membership of the Committee and noted the continued appointment of David Sissling (Chair of NHS Leicester, Leicestershire, and Rutland Integrated Care Board [ICB]) as the Chair of the Committee. The Committee discussed the opportunity of extending standing invitations to further NHS England colleagues in support of the Committees' duties and agreed an action to explore this further in advance of the meeting in August.
2. Specialised Services (Developing Future Commissioning Arrangements, Clinical Engagement, Priority Setting)	The Committee received an update as to how NHSE and the ICBs will work to support the development of future commissioning arrangements, clinical engagement, and the setting of commissioning priorities through the establishment of a multi-year plan. Focus was placed on effective engagement inclusive of early clinical leadership. The Committee noted the update.
3. Midlands Acute Specialised Commissioning Groups Update	The Committee received an update on the work being undertaken through the Group and the draft Terms of Reference for the Group. With regard to the Terms of Reference, these were approved in principle with a request to further define trigger points for escalation

Item	Summary
	between the Group and Committee. The Committee noted the update and requested the next update provided a focus on quality management and strategic risk.
4. Neonatal Services in the East Midlands: Regional Priority Overview	The Committee received this report as the first in its schedule of deep dives aimed at strengthening the knowledge and understanding of the Committee, Neonatal Critical Care being one of four key priority pathways in the Midlands. The report noted that NHSE have taken steps to work collaboratively with ICBs to develop a plan that focused delivery 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 NHSE and discussed the need to develop the process of enhancing collective insight to shape future plans.
5. Midlands Acute Specialised Commissioning: Schedule of Deep Dives	The Committee received a proposal for the schedule of Deep Dives. This proposal is based upon the Priority Pathways agreed as part of the regional commissioning planning processes. The Committee approved the schedule as proposed
6. Role of Delegated Commissioning Group and Joint Committees	The Committee received a presentation on the role of the National Delegated Commissioning Group and its alignment to the regional joint committees. The Committee agreed for Matt Day (NHS England Regional Director Specialised Commissioning, Health and Justice) to be the interim East Midlands representative to allow for further understanding of the requirements.
Meeting of the NHS East Midlands Integrated Care Boards' Joint Committee	
7. Primary Care Assurance Report	The Committee received an assurance report from the Tier 2 Committee meeting held on 11 May 2023. Key matters for escalation were presented as part of the report. The Committee considered specific challenges around dental access and community pharmacy provision, and the approach to financial risk sharing across the region. The Committee were assured by the content of the paper.

Item	Summary
8. Primary Care Delegated Services Financial Plan 2023/24	The Committee received the proposed plan for 2023/24. The Committee agreed that the plan provided a pragmatic approach to this year but that future years should be focused upon mitigating inequalities in provision and access, noting the risk share proposal that would see funds aligned to committed and anticipated expenditure within the East Midlands and the wider Midlands region. The Committee approved the Plan.
9. East Midlands Intermediate Minor Oral Surgery Procurement	The Committee received a proposal with regard to the procurement of Intermediate Minor Oral Surgery services. The proposal had been developed by the Tier 2 Group and escalated to the Committee for approval. The Committee sought assurance with regard to process, quality, outcomes, and the proposed next steps. An included options appraisal and associated risk profile had been informed by legal opinion. The Committee were not assured and so did not approve the proposal, requesting further consideration by Tier 2 and for a refined proposal to be brought back to a subsequent meeting. The Committee asked for Tier 2 to undertake a lessons learnt appraisal
10. NHS Midlands 111 Procurement and Contract Award	The Committee received an update on the Midlands 111 procurement process and contract award. The Committee were asked to consider the proposed role it would play in decision making and the aligned asks of the individual ICBs. The committee took assurance of the processes being undertaken and supported the intention for it to receive delegated authority from the ICB Boards.
11. NHS 999/11 Update – Governance and Oversight Arrangements	The Committee received an update on the proposed collaborative governance and oversight arrangements for NHS 999/111 services in 2023/24 and discussed the potential for linking the existing work to the Joint Committee arrangements. It was agreed that a full options appraisal should be presented to the next meeting in August.
12. Developing the East Midlands Office	The Committee received an outline proposal for the establishment of an East Midlands Office whose role would be to co-ordinate and drive forward both sub-regional and regional

Item	Summary
	collaboration. The Committee approved the proposal in principle, requesting further work be done in defining the roles and responsibilities and how it added value to collaboration, linkages between it and existing resource working across systems and the consideration of communications.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/09/2023
Paper Title:	**Quality and People Committee Highlight Report**
Paper Reference:	ICB 23 041
Report Author:	Committee Secretariat
Report Sponsor:	Marios Adamou, Committee Chair
Presenter:	Marios Adamou, Committee Chair

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

Summary:

This report presents an overview of the work performed at the Quality and People Committee meeting held on 19 July 2023 and provide assurance that the Committee is effectively discharging its delegated duties. The report will highlight key messages for the Board's attention and, where applicable, provide the Committee's agreed level of assurance gained from the items received. For information, the report also includes the high-level operational risks being overseen by the Committee.

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:

Appendix A – Description of committee assurance levels
Appendix B – High-level operational risks being overseen by the Quality and People Committee.

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 highlight report.

Report Previously Received By:

Not applicable.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Quality and People Committee Highlight Report

Meeting Date:	**19 July 2023**
Committee Chair:	**Marios Adamou, Non-Executive Director**

Assurances received: *(descriptions of assurance levels are provided at Appendix A)*

Item	Summary	Level of assurance
1. System Quality Scorecard and Exception Report	The format of the report had developed in line with members' previous comments and the feedback confirmed that the new version was easier to navigate. The report included the Integrated Performance Report for quality, exception reports on specific areas of quality where there are concerns and quality updates for information. In particular, members' discussion focused on Learning Disabilities and Autism (LDA), Infection Prevention and Control (IPC), the Vaccination Programme and the Patient Safety Incident Response Framework (PSIRF) implementation. It was reported that the first LDA monthly system performance meeting with NHS England had occurred in June 2023 and that a peer review was due to take place to support improvements on inpatient performance and autism pathways. With regard to the Vaccination Programme, members noted the stark differences in uptake across Nottingham and Nottinghamshire and were informed that an engagement plan to address health inequalities was in development to address this. The discussion on PSIRF highlighted that implementation had been inconsistent across the system to date, with outstanding actions remaining around the recruitment of Patient Safety Partners. It was noted that the ICB Board had received the Special Educational Needs and Disability (SEND) action plan and a detailed progress report on this would be presented to the Committee in January 2024.	**Partial Assurance**

Item	Summary	Level of assurance
	It was agreed that due to the challenges highlighted in the report, a level of partial assurance should be given.	
2. System Workforce Scorecard and Exception Report	The report provided an update on delivery of the system workforce plan for 2023/24. Challenges remain around staff retention and the use of bank staff to address operational pressures. It was accepted that current workforce plans are driven by national requirements and the financial envelope. It would be the task of the ICS Workforce Planning and Risk Group to look at overlaying what is required within the Nottingham and Nottinghamshire system, such as population health needs, in addition to the national requirements. Members noted that the next report would provide further information regarding general practice and that future work would address areas more difficult to recruit to, such as mental health and the Care Home sector. It was agreed that due to the challenges highlighted within the report, a level of limited assurance should be given.	**Limited Assurance**
3. Agency usage and spending deep dive	The report informed members of the workforce position in respect of agency usage; the focus being to understand the root causes behind high agency usage, with regards to people. Whilst some financial information was provided for context, it was noted that the Finance and Performance Committee would focus on the expenditure and finance elements. The next steps identified in the report included the development of a dashboard to provide greater clarity on the workforce position, including comparisons against plan and more detailed data analysis. The ICS Agency Reduction Group would continue to scrutinise actions being taken by each provider and there would be an ongoing focus on agency utilisation. High agency usage in non-clinical staff groups would also be a focus as a result of the data highlighting significant spending by Nottingham University Hospitals Trust in this area.	N/A

Item	Summary	Level of assurance
	Members agreed that the next priority would be to examine the drivers of the position and the impact on patients. It was felt that currently, workforce plans were primarily driven by the requirement to achieve financial balance and did not adequately reflect quality and safety. It was agreed that there was more to do to create a system view that would enable the sharing of learning across providers and a full understanding of the staff numbers/skill mix required. In summary, the report provided a comprehensive update on the current state but did not give a sense of the desired state and the actions required to achieve it. It was agreed that the report would be received for information (rather than assurance) on this occasion and that a more detailed report, reflecting the committee's discussion, would be presented at the September meeting.	

Other considerations:

Decisions made:
The Committee: • **Approved** the ICB's Complaints and Enquiries Policy and Mental Health Capacity Act 2005 Policy. • **Agreed** an extension of three months to the existing Equality, Diversity and Inclusion (EDI) Policy to enable further work needed to ensure it reflects the key actions included in NHS England's EDI Improvement Plan. • **Approved** a corroborative statement for inclusion in the Quality Account for Woodthorpe Hospital.

Matters of interest:
• An additional report was presented to members for discussion highlighting concerns related to quality that could impact on delivery of safe and effective care. It was anticipated the report would sit alongside provider Quality Risk Profiles and act as a mechanism to escalate system quality concerns.

- The Committee's routine risk report underwent a significant review following feedback at the previous meeting on the number of risks included and the ability to give the necessary attention to those with a high score. A new approach had therefore been developed which included a 'part A' focussed on a selected risk or risks with a score of 15+ for a period of greater than 12 months. The focus on this occasion was two risks related to Nottingham University NHS Trust (NUHT). Members were supportive of the new format and agreed that this should continue going forward. High-level risks currently being monitored by the Committee are provided for information at Appendix B.

Appendix A – Description of Committee Assurance Levels

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

Appendix B – High-level Operational Risks Being Monitored by the Quality and People Committee.

Risk Ref.	Risk Description	Current Score
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). This risk is further exacerbated by industrial action, during which flow, out of the emergency department and hospital, slows.	**High** 20 (I4 x L5)
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)
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. This may lead to poor patient experience, adverse clinical outcomes and/or patient safety issues for the population of Nottingham and Nottinghamshire.	**High** 16 (I4 x L4)
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)
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)

Risk Ref.	Risk Description	Current Score
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)
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 outcomes and/or patient safety issues for the population of Nottingham and Nottinghamshire.	**High** 16 (I4 x L4)
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)
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)
ORR129	If Nottingham and Nottinghamshire ICS do 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)
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)

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/09/2023
Paper Title:	**Quality and People Performance Report**
Paper Reference:	ICB 23 042
Report Author:	Diane-Kareen Charles, Deputy Director of Nursing Philippa Hunt, Chief People Officer
Report Sponsor:	Rosa Waddingham, Director of Nursing
Presenter:	Rosa Waddingham, Director of Nursing

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

Summary:

The purpose of this report is to present a summary of progress against compliance and commitment targets as required for 2023/24. The report includes progress and exception reports for areas of concern covering quality and people.

Further detail on the areas outlined within this report can be found in the full Integrated Performance Report (IPR), which is included within the Board papers for information at item 19 on the agenda.

The full IPR includes a scorecard on page 4, 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 table has also been provided at the end of this report (page 8) 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 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 current performance in relation to quality and workforce matters across the ICB.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:

None.

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

Report Previously Received By:
The content of this report has been previously scrutinised by the Quality and People Committee.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Quality and People Performance Report

Quality

1. The following paragraphs highlight the key messages regarding the latest performance against quality targets. More detail can be found within the quality scorecard on page 5 and exception reports on pages 13 to 32 of the full IPR.
2. Based on National Quality Board guidance, there is one NHS provider subject to intensive surveillance: **Nottingham University Hospitals NHS Trust (NUH)**. A system-wide Improvement Oversight and Assurance Group (IOAG) is in place, which includes oversight of partnership support and mutual aid arrangements. In July 2023, IOAG noted areas of progress and acknowledged that additional focus would be helpful in embedding the People First Strategy; continuing the work around Equality, Diversity and Inclusion; and providing further detail around the progress and performance of the Maternity Improvement Plan.
3. One NHS provider is subject to enhanced surveillance: **Nottinghamshire Healthcare NHS Foundation Trust (NHT)**. The Quality Improvement Group (QIG) approach has been refreshed to accommodate ongoing challenges in oversight of Care Quality Commission actions. NHT has been requested to conduct a review of open actions and provide a status and achievement trajectory for the next meeting.
4. 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) A Schedule is in place for LMNS assurance based on NHS England guidance and local intelligence. An NUH Ockenden Insight Visit was held on 31 July, led by the LMNS with attendance from NHS England regional team. There was a positive outcome from the visit with noticeable improvements since the last visit in June 2022, particularly regarding the teams working and training together and the impact on workplace culture. Early feedback was provided on the day and a full report is to be shared before the end of August.
    b) A LMNS Quarterly Oversight and Assurance Panel was undertaken on 11 July for assurance against the three-year delivery plan and Ockenden deliverables. This was an initial meeting to set up future ways of working and the key lines of enquiry that will be reviewed during the remaining quarterly panels. The NHS England regional team has set up a meeting with our LMNS in September to confirm future reporting arrangements that will inform quarterly oversight arrangements.

c) Two Maternity Independent Senior Advocates have been appointed to support women, birthing people and families navigate the health system and provide advocacy when there are concerns about care. These are independent roles sat within the Local Maternity and Neonatal System structure, working with local providers.

5. **Learning Disability and Autism**: In July 2023 we had one admission from the community into a mental health bed and an admission from the prison pathway directly into a secure bed. Since April 2023, we have had five admissions, which means there is a risk of not meeting the end of year target for adult inpatients of 37 individuals. Use of the Dynamic Support Register (DSR) means we continue to perform strongly in preventing admissions, with 83 adults and 117 children and young people currently on the DSR. Challenges remain around timely Care, Education and Treatment Reviews, which are being mitigated locally by the appointment of a focussed case manager. Annual Health Check performance remains on target.

6. A Local Government Association Learning Disability and Autism Peer Review was undertaken on 28 to 30 June 2023, with a focus on inpatient performance and the autism pathway. Findings included key areas of strength (with a particular mention on the strong partnership approach across the system), as well as areas requiring more focus. An action plan has been developed with all partners to address areas of challenge and will be overseen by the Learning Disability/Autism Executive Partnership Board.

7. **Special Educational Needs and Disabilities (SEND)**: The local area inspection outcome report for the Nottinghamshire County Partnership was published on Tuesday 16 May 2023. A local improvement programme has been established to improve the experiences and outcomes of children and young people with SEND, with a focus on the Nottinghamshire Local Area Partnership, however work to improve integration and waiting times in our jointly commissioned pathways will be undertaken across the system. Timeliness of both Education Health and Care Plans and access to health services have improved since the inspection in January due to increased capacity.

8. **Children and Young People**: A children and young people quality summit is planned for November to review multiple areas of increased demand, including Looked After Children, statutory reviews for health assessments backlogs, children in inappropriate settings, and Child and Adolescent Mental Health Services and SEND. In all areas deep dives have been undertaken. Relevant providers have mitigation and recovery plans in place and are working at pace, with the ICB focusing on solutions.

9. **Infection Prevention and Control**: Issues around microbiologist capacity are being resolved. System work to align reporting around Healthcare Acquired Infections (HCAIs) continues. The data now reflects one total ICB data set

including sub location. HCAI breaches for C.difficile; E.coli; Klebsiella BSI; Pseudomonas BSI were reported in May 2023. There has been ongoing contribution from the ICB to work with the regional NHS England team, with a focus on reducing regional and local HCAI cases. Local system work to review the leg ulcer pathway is planned, with the aim to reduce the need for antibiotics that may contribute to C.difficile cases. The current climate of increased occupied beds and inability to fully implement deep cleaning programmes remains on secondary care risk registers. A deep dive into HCAI performance and oversight is planned for the September meeting of the ICB's Quality and Performance Committee.

10. **Care Sector**: there has been a recent increase in residential care home closures due to poor quality care delivery. At the present time there is no current risk to the system in relation to residential care home capacity. Partnership working with local authorities, the Care Quality Commission, social workers and health partners to share data and support training, and regular quality visits to services, based on quality intelligence and risk rating continues.

People and Culture

11. The following paragraphs highlight the key messages regarding the latest performance against people and culture targets. More detail can be found within the workforce scorecard on page 12 and exception reports on pages 58 to 70 of the full IPR.

12. **NHS Agency spend:** A system wide Senior Agency Reduction Working Group is in place; however the month four position shows an increase in usage, with a year to date overspend. Improved understanding of the various drivers contributing differently to each trust position is informing trust action plans. The forecast position on spend remains below the ceiling target. 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 2023/24 Operational Plan. Greater pace and impact will be needed to reduce the cost to 3.7% of the pay bill (currently at 5.3%). Focus has been on reducing use of off framework agencies in all three Trusts with exit strategies in place across clinical service areas. An added focus of understanding use of agency for non-clinical services has identified areas where standardisation of approach could be applied across trusts in areas difficult to recruit such as hard facilities management (trade) roles as well as strategies for grow your own through apprenticeship routes. Recruitment of a Deputy Director of People with a focus on resourcing, due to take up post next month, will enable increased capacity to look at drivers thematically to determine collaborative interventions including joint procurement approaches on digital platforms such as e-rostering, as one example.

13. **Turnover/retention**: The workforce report within the Integrated Performance Report predominantly focuses on the three acute, community and mental health trusts within the system, reporting on the July 2023 position against the Operational Plan for 2023/24. The collective position shows the trusts are above plan on substantive staff (521.3 whole time equivalent (WTE)). This is alongside an improvement in the increased use of bank and reduced use of agency staff. Bank usage was 131.1 WTE above plan and agency usage was 82.1 below plan.
14. Growth in substantive WTEs (521.3 WTE) continues, which presents a positive picture, but the continued use of agency staff raises a concern as does the impact on the pay bill position. Growth seen is in additional capacity in ward areas above establishment. Clarity on vacancy positions needs further work as a different methodology to determine is applied in each trust.
15. 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. An improvement in turnover has been seen: NHCT below plan at 14.5%, NUH below plan at 11.4% with SFH meeting its target of 8%.
16. 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.
17. **Vacancy rates:** further work in this area is required, as a different methodology to determine the rate is applied in each trust.
18. **Sickness absence**: An improvement in sickness absence has been seen with all trusts operating at planned levels for this period, as submitted in the operational plan, 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 in post next month will add capacity to focus 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.
19. The overall picture for workforce against plan, as now discussed at the People and Culture Planning, Performance and Risk Group, is concerning. The above plan total workforce comprising substantive, agency and bank and the on-plan sickness absence should be delivering much greater levels of productivity than is being reported.

20. Industrial action has had an impact but not to the extent that has been anticipated.

21. Work is needed to understand why there is such variance from the Operational Plan submitted in May, and what needs addressing as we move towards system operational planning for 2024/25 and more generally as we look to build a ‘one workforce’ plan for Nottingham and Nottinghamshire.

22. **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.

23. 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 submitted for regional/national scrutiny which includes a consolidation of the programmes for GPs and GPNs 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%. The system is taking part in the national roll out of the pilot with a further survey to be completed in the autumn.

24. 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.

25. 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.

26. The Primary Care Workforce Group is aligning workforce development plans to meet the Primary Care Strategic objectives, reporting into the recently re-established Primary Care Strategy Delivery Group as well as into the People and Culture governance. The Primary Care Workforce Group has a focus on creating a sustainable primary medical services workforce but will begin to gain a baseline understanding of Pharmacy, Optometrist and Dentistry workforce positions noting the fragility of Dentistry at this time.

Table 1: Non-Compliant Performance Areas – Recovery Overview

Programme Area	Performance Metric	Latest Performance	Recovery Trajectory
Quality	LDA Inpatients	As of 31 July 2023 Adult commissioned by ICB is 12 against a plan of 14 inpatients. Adult commissioned by NHSE is 34 against a plan of 30 inpatients. CYP commissioned by NHSE is four against a plan of three inpatients.	As at 31 July 2023, there are currently 46 adult inpatients against a target of 44. There has been one admission from the community into a mental health bed and one admission from the prison pathway directly into a secure bed. There has been one ICB discharge along with a transfer between security levels for one individual (ICB to MSU). ICB performance is ahead of target (12 inpatients against a target of 14) and IMPACT performance is behind target (34 inpatients against a target of 30). Secure beds are an area of focus in the peer review action plan. Revised forecasts were agreed with NHSE, with the aim to achieve 37 adult inpatients by March 2024 and a plan to achieve 27 inpatients by March 2025. There is a good level of confidence that the system will meet the 37 adult inpatient target by March 2024. Findings from the LDA Peer Review (28-30 June 2023) are being developed into an action plan with partners which will be presented to the LDA Executive Board in September. This will address the areas of challenge identified, including a focus on secure settings and length of stay.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/09/2023
Paper Title:	**Nottingham and Nottinghamshire Integrated Care System People Plan: Strategic Delivery Update**
Paper Reference:	ICB 23 043
Report Author:	Philippa Hunt, Chief People Officer
Report Sponsor:	Rosa Waddingham, Director of Nursing
Presenter:	Rosa Waddingham and Philippa Hunt

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

Summary:

This paper provides assurance of the process that has been used to develop the delivery plans for the Integrated Care System (ICS) People and Culture work stream.

The paper provides and update for the Board on our ICS People and Culture Plan, our priorities and progress. It describes the direction of travel, the infrastructure and governance processes that have been introduced, the implications of a sustainable solution of building on non-recurrent funding and working in the wider context of a developing Integrated Care System (ICS).

Finally, the paper identifies the four ICS People priorities for the next six months:

1. Developing a People and Culture Function
2. Workforce - through the scaling people services vanguard
3. Supporting inclusion and belonging for all, and creating a great experience for staff
4. Agency reduction.

Recommendation(s):

The Board is asked to **receive** the report for assurance regarding the progress against delivery of the strategic function of People and Culture.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	The people and culture work has designed so that the system can as a result of having the right numbers of workforce with the right skills in the right location deliver improved outcomes in population health and healthcare – this will be achieved through the 'one workforce' approach.
Tackle inequalities in outcomes, experience and access	Having a representative workforce, of the population served will lead to greater informed care reduce inequalities and improved experience and access – because of our supporting inclusion and belonging for all, creating a great experience for staff.

How does this paper support the ICB's core aims to:	
Enhance productivity and value for money	The people and culture work has designed so that the system can as a result of having the right numbers of workforce with the right skills in the right location deliver improved outcomes in population health and healthcare – this will be achieved through the 'one workforce' approach. There is a direct impact on the productivity in system.
Help the NHS support broader social and economic development	Having a representative workforce, of the population served will lead to greater informed care reduce inequalities and improved experience and access. We recognise that within the system our staff are also our citizens so there is an opportunity to directly impact on this aim.

Appendices:
Appendix A – People and Culture Delivery matrix

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): Risk 7: People and Culture – Failure to ensure sufficient capacity and capability within the local workforce.

Report Previously Received By:
This paper has not been reported through the Quality and People Committee, but reflects a number of papers and discussions in that forum.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Nottingham and Nottinghamshire ICS People Plan: Strategic Delivery Update

Introduction

1. This paper is structured to give the Board insight and assurance of the process that has been used to develop the delivery plans for the ICS People and Culture work.

2. The paper sets out the starting point for an ICS People and Culture Plan, describes the direction of travel, the infrastructure and governance processes that have been introduced, the implications of a sustainable solution of building on non-recurrent funding and working in the wider context of a developing integrated care system and highlights the four priorities.

People and Culture ambition for our Integrated Care System and development of a delivery plan

3. The ultimate ambition is to create “One Workforce”, a system wide approach to growing and supporting the workforce for the future. As described in the Integrated Care Strategy and defined in the Joint Forward Plan, there are four ambitions that will be delivered 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 & Culture Plan & delivery process	Governance & delivery plans	Establishing a sustainable deliver team	One workforce becomes a reality	Population health (PH) needs drive plans	Aligned PH, education & training and workforce plan	✓	✓	✓
Resourcing including retention	Scope and develop plans for shortage skill areas	System attraction & retention approach	Expand digital solutions	Operational system recruitment hub	Review evaluate and further consolidate	✓	✓	✓
Strategic workforce planning	Agree scope and scale with SAIU	Work with partners on a common SWP approach	Establish a common approach to productivity measurement	Further support service transformation	Review evaluate and seek further opportunities	✓	✓	✓
Delivering the Future of HR	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	✓	✓	✓

Fig 1: People & Culture outlined delivery within the ICS Joint Forward Plan

4. The ambitions for people and culture outlined in the Joint Forward Plan informed the four priorities for 2023/4.
    1. Developing a system people and culture function.
    2. One workforce - supported by the scaling up vanguard.
    3. Supporting inclusion and belonging for all, creating a great experience for staff.
    4. Agency reduction.

Included at Appendix A is the people and culture delivery matrix.

Delivery against priorities

Priority One - Developing a People and Culture Function

5. Since the last update to Board the Chief People Officer has been recruited and has been in post for six months.
6. A People and Culture team has been created that is formed of three pillars. The focus has been on the third pillar to give sufficient planning and delivery resource for the ICS.
    - **ICB People and Culture Team**: this team will play a fundamental role in the Running Cost Allowance work and the Operating Model and is an ICB focussed team.
    - **People and Culture, Programmes and Assurance Team**: this is a system partnership with reporting and assurance processes in place, with a focus on the oversight of the delivery of the ICS People priorities and long-term plan.
    - **ICS People and Culture Delivery Team**: to enable the ICS to develop a "One Workforce" approach, that delivers the ICS Strategy, Joint Forward Plan and ambitions of the Provider Collaborative. and includes a partnership approach to delivery including the ICB, three providers, Nottingham City and Nottinghamshire County Councils, Primary Care and Voluntary Care Sector(s).
7. Developing the People and Culture function is now almost complete and therefore the priority will change to focus on delivery.

Priority Two – One workforce supported by the scaling people services vanguard.

8. Since the last update we have introduced a new governance approach and have refreshed the People and Culture Steering Group membership. The Steering Group is now co-chaired by the ICB Chief Nurse and the Chief Executive of Nottingham Healthcare Foundation Trust (who is the Provider Collaborative People Senior Responsible Officer). In addition, the new People and Culture Planning, Performance, and Risk Group provides oversight of ICS workforce plan delivery in the system.
9. This refreshed governance approach is helping us develop a one workforce approach by a focused approach on:
    - The planned workforce needed to deliver the ICS strategy and improve health outcomes for our population.

- The factors effecting workforce productivity. Despite significant increases in the numbers in the workforce, productivity is lower than before the pandemic.
- How we can improve workforce planning. This tends to be short term and driven by operational targets and does not address the need for strategic workforce and education planning at a system level planning, informed by population health projections.

10. In addition, during July and August, the ICB submitted a bid as part of a national competitive process to become a vanguard for the region on the scaling people services programme. We were delighted to learn that Nottingham and Nottinghamshire's bid was successful.
11. There is significant opportunity to release capacity and benefit from financial economies of scale, enabling greater focus on the more strategic and transformational aspects of the Long-Term Workforce Plan. The wider benefits of scaling are significant and include:
    - Improved employee and patient experience.
    - Improved access to people services.
    - Increased quality and resilience across services.
    - Recurrent cost savings and productivity efficiencies across the sub functions of people services.
    - Reduced errors through automation and streamlined processes.
    - Reduced time spent by managers and staff on transactional activities leading to increased capacity to care.
12. The ICB had already set out its ambitions in the Joint Forward Plan, to delivering the future of HR, the professionalisation and standardisation of HR policies, procedures, and practices across the ICS, as a vanguard we will receive £250,000 to accelerate this work.
13. Creating the 'one workforce', now supporting by the vanguard status will continue to be a priority.

Priority Three – Supporting inclusion and belonging for all, creating a great experience for staff.

14. Since the last update to the Board, NHS England has published its equality, diversity and inclusion improvement plan that prioritises six high impact actions to address the widely known intersectional impacts of discrimination and bias.
15. We are developing a system wide approach to delivering on all aspects of the People Promise that focuses on system wide staff safety and health, physical and mental health wellbeing and supporting flexible working, promoting a fully inclusive culture that actively addresses racism.

16. We have a specialist that was one of the first appointments to the ICS People and Culture delivery team (point 6) who is driving forward:

    - Co-production of the Workforce, Race, Equality and Inclusion to create an anti-racist, compassionate and inclusive working culture for the system.
    - Work on support for international staffing (one of the six high impact actions)
    - Piloting for the region the Getting to Equity Program
    - Focusing on freedom to speak up. NHS England has asked that all NHS trusts adopt the policy and apply the guidance and improvement tools provide assurance to their public boards by the end of January 2024.

17. Continuing to support inclusion and creating a great system in which to work will continue to be a priority, both for organisations and as a system. Participation in the getting to equity program will provide a basis for further board objective setting and development.

Priority Four – Agency reduction

18. Since the last update to the Board all providers have submitted operational plans in line with national guidance to reduce agency spending across the NHS to 3.7% of the total pay bill in 2023/24.

19. Agency usage is not only more expensive than bank or substantive staff, the evidence would also indicate lower productivity and quality of care.

20. Providers have not been able to achieve the plans for reductions, operational issues including industrial action have meant that agency usage has been necessary in some instances to ensure safe staffing is maintained.

21. An agency reduction group, chaired by the Director of Finance at Sherwood Forest Hospitals Foundation Trust, has been introduced to both understand the root causes underlying continued agency use, and to offer support re solutions to reduce both usage and rates.

22. This group feeds in the People and Culture planning, performance, and risk group (point 8).

23. Given the challenges faced by systems agency remains a priority.

Summary

24. Focused delivery on the four priorities, addressing our workforce challenges and supporting our people we will directly enable us to:

    - 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.

Appendix A: People and Culture Delivery Plan 2023-24

Q1 April - June	Q2 July - Sept	Q3 Oct - Dec	Q4 Jan - March
Recruit ICS People Roles There is sufficient non recurrent funding to support the recruitment to a single host organisation recruiting on a secondment basis **Refresh Governance** People and Culture Group ¼ Refresh PCIC Introduce People Performance Group **Build upon existing programs** Care 4 Notts & academy work **Co-produce detailed delivery plans** Resourcing – inc. retention Leadership, Talent & OD ED&I Wellbeing & engagement	1. A system wide approach to growing the workforce for the future, including the **development of a health and care recruitment hub**. In the next year we will explore opportunities to develop a single health and care recruitment hub. A program will be initiated to scope the potential programme of work, efficiencies, timeframes, and resources required to implement a range of options. This is likely to include: a. Leading on joint recruitment, **enabling deployment and sharing of staff** to respond to service needs. b. Address issues related to system working, **a consistent approach to hosted roles** and employment, **risk sharing**, data sharing and intra operability issues of related workforce systems and data. c. Recommending collaborative approaches to recruitment **under an ICS brand.** d. The program could include benchmarking and **exploring opportunities in future years** across the ICS and the wider D2N2 Local Enterprise Partnership 2. Building the work under the umbrella of **Care For Notts and existing academies** 3. A system wide approach to delivering on all aspects of the People Promise that focuses on system wide **staff safety and health, physical and mental health wellbeing and supporting flexible working**, promoting a **fully inclusive culture that actively addresses racism** 4. Focus on collaboration and progress towards an **Integrated Occupational Wellbeing service/program**, bringing good practice from provider organisations. **5. Retaining people** across all professions and workforce groups, and at all career stages – establishing collaborative approaches to enable People to learn and work flexibly across the system **and delivery of an ICS system induction**.		

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/09/2023
Paper Title:	**Finance and Performance Committee Highlight Report**
Paper Reference:	ICB 23 044
Report Author:	Committee Secretariat
Report Sponsor:	Stephen Jackson, Committee Chair
Presenter:	Stephen Jackson, Committee Chair

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

Summary:

This report presents an overview of the work performed at the Finance and Performance Committee meeting held on 26 July 2023 and provides assurance that the Committee is effectively discharging its delegated duties. The report will highlight key messages for the Board's attention and, where applicable, provide the Committee's agreed level of assurance gained from the items received. For information, the report also includes the high-level operational risks being overseen by the Committee

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:

Appendix A – Description of committee assurance levels
Appendix B – High-level operational risks being overseen by the Finance and Performance Committee

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 highlight report.

Report Previously Received By:
Not applicable.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Finance and Performance Committee Highlight Report

Meeting Date:	**26 July 2023**
Committee Chair:	**Stephen Jackson, Non-Executive Director**

Assurances received: *(descriptions of assurance levels are provided at appendix A)*

Item	Summary	Level of assurance
1. System Finance Report	The report included detailed analysis of the financial performance for the system for month three against a breakeven plan. A deficit position was reported with the majority of overspend attributed to Nottingham University Hospitals Trust (NUH). A discussion ensued regarding the phasing of the 2023/24 plans, particularly with regard to efficiencies. The original plan had described the delivery of efficiencies in equal parts over twelve months; however, it was now noted that delivery was likely to be phased towards the end of the financial year. As such, a decision had been taken to build more risk into the forecast position, which had streamlined risk.	**Limited Assurance**
2. ICB Financial Recovery Plan	This was the first time the report had been produced following a full meeting cycle of the recovery panels, which had enabled a more up-to-date position. The report assumed delivery of all plans by year end. Since the previous meeting there had been positive progress in identifying savings opportunities and the focus had shifted to delivery. Members encouraged a review of non-essential services for potential disinvestment to be progressed. Members expressed particular concern in regard to a lack of grip and control around agency spend and the risk this posed to delivery of the overall financial position.	**Limited Assurance**

Item	Summary	Level of assurance
3. ICB Finance Report	The report included detailed analysis of the financial performance for the system for month three against a breakeven plan. The risk associated with a £56m efficiency target was highlighted. Members discussed the risk of increased prescribing costs as this had been flagged as a national issue. Potential solutions to alleviate the situation were being investigated. Members noted that there was a significant level of risk associated with the plan and encouraged a review of uncommitted allocations with a view to offsetting an element of this.	**Partial Assurance**
4. Capital Resource Use Planning	The report outlined the ICS capital envelope for 2023/2024, progress to date and risks to delivery. Discussion focused on the increased industry lead times and the subsequent impact this had on the pace of delivery of capital projects. Additional steps to improve oversight and grip on the delivery of capital schemes were explained, along with the inter-dependency of delivery of programmes and delivery of other aspects of the wider financial plan, such as efficiency savings. It was explained that a proposal was in development to be brought to a future meeting. This would suggest that the Provider Collaborative take on responsibility for planning, prioritisation and management of the ICS capital envelope. Members were supportive of this, noting that the ICB would remain accountable for the distribution of the capital envelope.	**Limited Assurance**
5. Service Delivery Performance Report	The report described the key areas of risk and improvement since the previous report; however, the position was mainly unchanged. A revised set of metrics had been published by NHSE and would be reflected in local reporting from the next meeting in September. A discussion took place surrounding the role of various system forums in overseeing improvement plans in regard to performance. Non-executive members felt	**Limited Assurance**

Item	Summary	Level of assurance
	that a greater understanding of the role of such groups would be beneficial, and an action was agreed to seek this outside of the meeting. A discussion ensued regarding the overall trajectory of performance and the waiting list, which had not improved at the rate the Committee had hoped. Whilst all the necessary steps were being taken to improve, members were concerned that more needed to be done.	
6. Thematic Service Delivery Review: Elective Waits	The report was the third in a programme of deep-dive reviews into service delivery areas. It outlined the priorities for improvement, which included elimination of 78+ week waits, achievement of maximum 65 week waits by March 2023 and work to increase elective activity over 105% of the 2019/20 baseline. Members discussed the effectiveness of the Planned Care Board and System Oversight Group and agreed to discuss this further as part of the Committee's action to further understand the role of system groups (see section 5 of this report).	**Partial Assurance**
7. National Digital Maturity Assessment	The report outlined the context of the ICB (self-assessment) submission against the national Digital Maturity Assessment Framework, the outcome of the submission and the work undertaken to use feedback to shape the ICB digital priorities for the coming twelve months. The priorities also aligned to the Integrated Care Strategy, What Good Looks Like (WGLL) digital framework, national short-term priorities for digital and the ICS Digital Strategy. Whilst the self-assessment had been scored as amber or red against each criteria, members noted that improvements had been made since then and were assured that work would continue to further improve maturity.	**Partial Assurance**
8. Green Plan	The report described the approach and progress made to date against the System work to achieve carbon net zero by 2024 as well at the NHS target to achieve 80% carbon net zero by 2028. Noting that the targets were net, discussion focused on exploration of	**Adequate Assurance**

Item	Summary	Level of assurance
	opportunities that would offset carbon emissions and deliver associated cost savings. The difficulty in modelling a trajectory for delivery was noted as a risk, however members were pleased that the Nottingham and Nottinghamshire System had been recognised as an advanced system with regards to the approach taken to achieve carbon net zero.	

Other considerations:

Decisions made:
No decisions were required at the meeting.
Matters of interest:
The Committee: • Received an overview of work undertaken to develop a clearly outlined description of digital responsibility for the Integrated Care Board, Integrated Care System and Primary Care. Progress against the draft ICS and ICB Digital Plans was highlighted, and it was noted that these would be presented at the September 2023 Committee meeting. • Received the Committee's routine risk report detailing operational risks pertaining to the Committee's responsibilities. The high-level risks from this report are provided for information at Appendix B.

Appendix A – Description of Committee Assurance Levels

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

Appendix B – High-level Operational Risks Being Monitored by the Finance and Performance Committee.

Risk Ref.	Risk Description	Current Score
ORR105	Continued over-reliance on non-recurrent (one-off) funds / mitigations by the ICB to temporarily offset recurring (year on year) pressures may result in further deterioration in the ICB's recurrent underlying financial position for 2023/24.	**High** 16 (I4 x L4)
ORR106	There is a potential risk that NHS Nottingham and Nottinghamshire ICB may not meet its statutory financial duties for 2023/24.	**High** 16 (I4 x L4)
ORR107	There is a potential risk that the Nottingham and Nottinghamshire system, as a collective, may not meet its agreed year-end financial position outlined within the 2023/24 financial plan. As well as potential reputational risks for the ICS, this may significantly impact the extent to which the system is able to create financial 'headroom' to focus on the transformation of services.	**High** 16 (I4 x L4)
ORR108	Continued over-reliance on non-recurrent mitigations to manage the system's 2023/24 financial position may result in further deterioration in the system's underlying financial position (UDL). The UDL may also be impacted by non-delivery of required 'cash releasing' productivity, efficiency, and transformation plans.	**High** 16 (I4 x L4)
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)
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)

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/09/2023
Paper Title:	**Finance, Service Delivery and Health Inequalities Performance Report**
Paper Reference:	ICB 23 045
Report Author:	Sarah Bray, Associate Director of Performance and Assurance
Report Sponsor:	Stuart Poynor, Director of Finance Lucy Dadge, Director of Integration Dave Briggs, Medical Director
Presenter:	Stuart Poynor, Director of Finance Lucy Dadge, Director of Integration

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

Summary:

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

Further detail on the areas outlined within this report can be found in the full Integrated Performance Report (IPR), which is included within the Board papers for information at item 19 on the agenda.

The full IPR includes a scorecard on page 4, 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 table has also been provided at the end of this report (pages 9-10) 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

How does this paper support the ICB's core aims to:	
	well' while tackling long waits, will support patients to return to work where possible.

Appendices:

None.

Board Assurance Framework:

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

- Risk 1: 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 10: Financial Sustainability – Establishing a shared culture of financial stewardship may not ensure financial sustainability across the system.

Report Previously Received By:

The content of this report has been previously scrutinised by the Finance and Performance Committee.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Finance, Service Delivery and Health Inequalities Performance Report

Finance

1. The following paragraphs summarise the financial position at month four. More detail can be found within the finance scorecard on page 11 and exception reports on pages 54 to 57 of the full IPR.

2. **Revenue finance**: At the end of month four, the NHS system reported a £41.6 million deficit position, which is £27.6 million adverse to plan. The adverse variance is experienced across all system providers – £20.0 million deficit in Nottingham University Hospitals NHS Trust (NUH), £1.0 million in Sherwood Forest Hospitals NHS Foundation Trust (SFH) and £4.7 million at Nottinghamshire Healthcare NHS Foundation Trust (NHT). The ICB is reporting a deficit position of £1.9 million at the end of month four.

3. The main drivers of the July 2023 adverse variance are:

    a) External factors (industrial action and inflation) - £4.5 million

    b) Prescribing and Continuing Healthcare (CHC) pressures (ICB) - £6.4 million

    c) Planned actions not delivered including efficiencies, covid spend reduction and urgent and emergency care (UEC) escalation beds remaining - £14.7 million

    d) Increasing run rates compared to 2022/23 - £18.6 million of which:

        - £8.5 million relates to pay pressures (substantive staffing increases);
        - £5.2 million increased agency costs (due to increased acuity, high staff absence and off-framework agency rates); and
        - £4.9 million of non-pay pressures relating to drugs, premises and independent sector activity.

    e) Offsetting mitigations/balance - £16.6 million

4. At month 4, the reported total system forecast was a break-even position against the break-even plan submitted.

5. **Capital finance**: The system capital envelope is underspent by £3.6 million to the end of month four. 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.

6. **Agency**: NHS England has set a 2023/24 agency cap of £68.7 million for NHS Nottingham and Nottinghamshire ICS. Agency plans are to spend £62.9 million. At month 4, the forecast is to spend £65.6 million which will be £3.1

million under the agency cap. Year-to-date £32.2 million has been spent which is £8.6 million adverse to plan.

7. **Efficiency and productivity plans**: Efficiency and productivity plans are being actively managed but year to date delivery is heavily reliant on non-recurrent solutions.

Service delivery

8. The following paragraphs highlight the key messages regarding the latest performance against service delivery targets. More detail can be found within the service delivery scorecards on pages 6 to 10 and exception reports on pages 33 to 53 of the full IPR.

9. **Urgent care**: The challenges in discharging patients from acute episodes of care continue, which impacts acute and mental health services. These issues are exposed within the medically safe for discharge (MSFT) and length of stay measures.

10. Discharge pressures continue to impact the front door of emergency departments as reported through the high levels of people waiting over 12 hours in Accident and Emergency and increased delays in handover from ambulances into emergency departments. In July, there were 1,927 hours lost through ambulances waiting to handover patients to hospitals in Nottinghamshire, which limits capacity to respond to calls within a timely manner. The full IPR describes some of the key actions being put in place to improve ambulance handover times.

11. Accident and Emergency performance for the system overall remains an area of concern for the Performance Oversight Group. Performance against the 4-hour target was above planned levels in July at 62.6% against a plan of 62.3%, but there is significant variation in waiting times within the system and a high volume of patients exceeding a 12 hour wait from a decision to admit being made to being admitted into an available bed.

12. Within the system, there remains a high volume of patients that have been declared medically safe for transfer. The latest position is 252 patients against a plan of 214 patients. There have been improvements in the position, but it remains in excess of the required level. Within the Nottinghamshire system it is recognised that home care capacity is a significant constraint with other system capacity often used to help decongest the acute wards; this is often out of alignment with the ‘home first’ principles. At system-level there is a System Discharge Board in place to enable focus on addressing these issues.

13. Virtual Ward capacity has grown from 58 beds to 88 beds; however this remains below the plan of 189 for August. The increase is due to 30 IV antibiotic therapy virtual ward beds at SFH now being part of the system

capacity. Work continues to release more capacity for step up virtual ward beds with our community providers which will bring the system closer to plan achievement. Utilisation of the stated capacity remains at a high level.

14. **Planned care**: As a system, the ICS performs relatively well regionally for elective care delivery. However, industrial action continues to be a significant challenge for the system and the wider NHS.

15. The end of August position for 78-week waits was 67 patients, of which 45 are due to capacity, 20 are due to complexity and two patients have exercised their choice to be treated at a later date.

16. The industrial action increased the month end forecast of 78-week waiters by 30 patients, of which 23 were driven by the junior doctor strikes and seven by consultant strikes.

17. Ear, nose and throat and spinal services in particular have been impacted by the industrial action, as this occurred on the specific days of the week when these theatre lists should have taken place. There is currently a level of risk for patients waiting over 78 weeks at the end of September. A specialty led forecast is being developed for the end of September position.

18. Capacity has been sourced in principle for adult and paediatric spinal cases, which will be offered to long waiting patients locally.

19. The latest weekly ICB data for the cancer backlog volume is week ending 27/08/2023, with 437 patients against a plan of 364 patients. NUH has 361 patients against a plan of 305 and SFH has 76 patients against a plan of 59. 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 that are received after day 62 of the pathway. These patients directly increase the backlog volume.

20. Changes to cancer waiting time standards have been agreed between NHS England and the Department of Health and Social Care and will come into effect from 1 October 2023. In 2018, the then Prime Minister asked NHS England to lead the first review of cancer waiting times standards in almost ten years. This review aimed to make sure that they were appropriately aligned with modern clinical practice and also considered the recommendations of the 2015 Independent Cancer Taskforce. The changes include the removal of the two-week wait standard in favour of a focus on the Faster Diagnosis Standard, and the rationalisation of existing standards into three core measures for the NHS:

    a) The 28-day Faster Diagnosis Standard (target of 75%).

    b) One headline 62-day referral to treatment standard (target of 85%).

    c) One headline 31-day decision to treat to treatment standard (target of 96%).

The faster diagnosis standard will rise to 80% in 2025/26 to take into account the £2.3 billion of investment in extra diagnostic capacity over the current spending review period. Providers will continue to be able to track time to 'first seen' (the current two-week wait standard) in both local and national datasets for the purposes of managing different phases of the pathway, and NHS England will continue to publish the current data breakdowns for the standards.

21. Within diagnostics, 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.

22. The position for June is positive with the diagnostic waiting list and backlog volumes being below planned volumes. However, there is significant variation in the volume of patients waiting and waiting times by modality and provider level within the system. A detailed review of performance is undertaken at the Diagnostic Board, which includes tracking of the position against the recovery trajectories. Additional mobile capacity will be implemented during the third quarter of 2023/24 as part of the development of the community diagnostic centres. Insourcing, mutual aid and recruitment are taking place to increase capacity in Echocardiography.

23. A deep dive meeting was held with NHS England on 22 August to enable a granular discussion around the challenges impacting activity delivery and the actions underpinning improvements. The meeting was positive and demonstrated that the system is well positioned to meet diagnostic trajectories.

24. **Mental health**: As a programme, mental health performs well, with improvements being made across many service areas. However, there are a few areas that have been experiencing declining performance, including Talking Therapy waits between first and second treatment, Talking Therapy Recovery Rates, and Dementia Diagnosis rates.

25. Areas that consistently fail the target, and which are unlikely to achieve the targeted levels, have improvement plans in place to progress towards delivery. These include Talking Therapies Access, Out of Area Placements, Health Checks for people with severe mental illness, Perinatal access and Children and Young People Eating Disorders.

26. The volume of patients entering Talking Therapies services remains significantly below plan. The waiting time for a talking therapy first appointments has reduced and now achieves the required standard. However, the waiting time between the first and second treatments is significantly higher than the planned level, with 44.9% of patients waiting more than 90 days between treatments rather than a maximum of 10%. This has arisen as the new provider has focused on ensuring patients were undertaking their initial appointment, the focus is now progressing to the second treatments. Local data is showing an improvement in this and is forecasted to improve at the end of

the third quarter of 2023/24, when the majority of inherited patients will have completed their treatment.

27. Children and Young People 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 therefore have a significant impact on the overall level of compliance. Any patients who are not seen within the four weeks as expected, are all individually reviewed to determine the reason for the delay, of which patient choice is a significant factor. 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 is scheduled to be operational by September 2023.

28. The volume of out of area placements remains at a high level. Admission rates were within expected levels for both male and female patients. However, demand for inpatient beds routinely exceeds capacity, which results in around five patients each day being supported by the crisis teams or delayed discharges in other healthcare settings e.g., Emergency Department, acute physical health wards, as well as section 136 suites. Continual demand has also required some patients to be cared for outside of Nottinghamshire.

29. **Primary care and community**: The volume of GP appointments in July was 7.5% above the planned level. The percentage of appointments held face to face remains relatively consistent with previous months at 70.6%. GP appointments within two weeks data shows that 77.8% of appointments were offered within two weeks in July 2023.

30. There were 5,957 adult patients waiting for community services at NHT and 5,230 adult patients waiting at Nottingham CityCare at the end of June 2023. Across both community providers, the largest waiting list is for the musculo-skeletal service, which has 3,831 patients waiting. There are 100 adult patients waiting more than 52 weeks, which span several services. The largest cohorts with patients waiting more than 52 weeks are community nursing services (continence service) with 41 patients and podiatry and podiatric services with 40 patients.

31. The volume of patients waiting over 13 weeks (national ambition) reduced from May to June and has continued to reduce into July. However, for the continence service, there are 58% of patients waiting over the national ambition. High levels of demand, combined with staff sickness have been the key drivers impacting the position. Work is ongoing to improve productivity via reducing ‘so not attends’ and aligning operating models between the clinic locations. The forecast is for the service to recover by December 2023 based on stable referral demand. The position will continue to be tracked closely via routine reporting and formal contract meetings.

32. Within the podiatry service, recruitment is underway to fill two theatre optimisation posts. Additional weekday and weekend sessions are planned to begin in September, which will contribute towards expected recovery by December 2023.

Health Inequalities

33. The following paragraphs highlight the key messages regarding the latest performance against health inequalities targets. More detail can be found within the health inequalities exception reports on pages 70 to 76 of the full IPR.

34. The Health Inequalities Innovation and Investment Fund (HIIF) has gone through the final stages with nine schemes being approved. The schemes sit across three areas of focus for health inequalities, including Severe Multiple Disadvantage, Best Start in Life and Integrated Community Working.

35. Through the process, funding has been approved to support evaluation of both the HIIF overall and the individual schemes.

Table 1: Non-Compliant Performance Areas – Recovery Overview

Programme Area	Performance Metric	Latest Performance	Recovery Trajectory
Urgent Care	12 Hour Breaches	811 in Jul 23 against a target of zero.	Providers are planning 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 from decision to admit to admission.
Planned Care	Long Waits +104 & +78 weeks	104ww – confirmed position was 1 patient at end of August 2023 78ww – 67 patients at the end of August 2023	The current forecast for the end of September is being developed. However, there are risks to delivery 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, 34% of patients waited 6 weeks or more for a diagnostic test in June 2023.	The recovery trajectories are being achieved. The activity level remans less than 1% below the planned level.
Mental Health	NHS Talking Therapies	Access levels remain low at 5275 patients against a plan of 8009 at May 23 (3 month rolling position).	The service continues to achieve and exceed the 6 week (89.2%) and 18 week (99.5%) waiting time standards. The provider has now achieved full staffing establishment. The provider has also implemented a marketing and engagement plan, which include the launch of the NHS Limbic digital assistant as an online referral tool, use of digital tablets by community engagement team to make live referrals, promotional campaigns including a pharmacy bag campaign and digital campaign and partnership pack distribution and attendance at events. Access levels are expected to recover in Q3.

Programme Area	Performance Metric	Latest Performance	Recovery Trajectory
	Out of Area Placements	300 at May 23 against a zero national target	Performance is 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	4615 at July 23 against a plan of 7029	An additional Health Improvement Worker is being recruited for Nottingham City to support City East PCN who have the largest SMI register and the lowest performance. They are expected to be in post by November and will increase performance against the check due to providing additional capacity. A small Peer Support Worker Team has been recruited to provide additional support to City PCNs from September.
Community Services	Community Waiting List Volume	Position for patients aged 0-17 is 2,117 patients against a plan of 1,938. For patients aged 18+ the position is 11,187 against a plan of 8,351.	The volume of long waiting patients is planned to reduce within podiatry and continence services resulting in achievement of the 13-week waiting time standard by December 2023. This will be closely monitored via the contract meetings.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/09/2023
Paper Title:	**Risk Management Policy**
Paper Reference:	ICB 23 046
Report Author:	Lucy Branson, Associate Director of Governance Siân Gascoigne, Head of Corporate Assurance
Report Sponsor:	Rosa Waddingham, Director of Nursing
Presenter:	Lucy Branson, Associate Director of Governance

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

Summary:

The purpose of this paper is to present the updated Risk Management Policy for approval, which includes the ICB's revised approach to risk appetite.

The ICB has an overarching narrative risk appetite statement; this was initially agreed by the ICB Board at its inaugural meeting on the 1 July 2022. At this time, it was acknowledged that risk management arrangements would continue to evolve and develop over the next 12 months, and it was recognised that a full review of the ICB's approach to risk appetite would be needed.

The ICB's revised approach to risk appetite has been developed over the past six months. The narrative risk appetite statement has been strengthened with the addition of a risk appetite matrix, which outlines five risk appetite levels and corresponding risk tolerance scores. This visually represents the organisation's willingness to take risks, providing a clear framework to align five levels of risk appetite to quantitative risk tolerance bandings.

Work has been undertaken to initially 'test' the proposed risk appetite against the ICB's current risk profile and a programme of work identified to embed risk appetite within the organisation's business as usual activities. It is recognised that the ICB's risk appetite may need to be reviewed during the course of the year to ensure it is truly reflective of how the organisation operates.

Consideration has also been given to how system risk appetite may be approached; recognising there continues to be much national and regional debate as to how this could be taken forward.

Recommendation(s):

The Board is asked to **approve** the Risk Management Policy, noting the work undertaken to develop and strengthen the ICB's risk appetite statement.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	The ICB's risk management arrangements are a structured way of identifying and mitigating risks that may prevent the achievement of the ICB's core aims.

How does this paper support the ICB's core aims to:	
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: Application of the ICB's risk appetite to current, 'live' operational risks B: Alignment of risk appetite across system partners C: Risk Management Policy

Board Assurance Framework:
The Risk Management Policy describes the organisation's strategic risk management arrangements. The ICB's 14 strategic risks are managed by an established control framework and planned assurances, captured within the Board Assurance Framework.

Report Previously Received By:
The ICB's current Risk Management Policy was approved by the Board in July 2022.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Risk Management Policy

Introduction

1. The Board approved the ICB's Policy at its inaugural meeting on 1 July 2022 which included an initial narrative risk appetite statement. At this time, it was acknowledged that risk management arrangements would continue to evolve and develop over the next 12 months, particularly in relation to the management of 'system risks', and it was recognised that a full review of the ICB's approach to risk appetite would be needed. As such, it was agreed that the Risk Management Policy would be scheduled for review in early 2023/24.
2. Work has been undertaken over the past six months to further develop the ICB's risk appetite statement and the purpose of this paper is to present an updated Risk Management Policy for the ICB for approval following completion of this work.

Approach

Development of risk appetite

3. Risk appetite refers to an organisation's willingness and capacity to take on risks in the pursuit of its aims and objectives. It outlines the level of risk the organisation is comfortable with, which helps guide decision-making and strategy development.
4. The ICB's approach to risk appetite has been developed over the past six months. The narrative risk appetite statement has been strengthened with the addition of a risk appetite matrix, which outlines five risk appetite levels and corresponding risk tolerance scores.
5. The narrative statement describes the level of risk the organisation is comfortable with and the boundaries within which risk-taking should occur. This is complemented by the matrix, which visually represents the organisation's willingness to take risks, providing a clear framework to align five levels of risk appetite to quantitative risk tolerance ranges.
6. The narrative statement is outlined in section 6.3 of the Risk Management Policy (page 12, Appendix C) and the risk appetite matrix is provided at section 6.4 (page 13, Appendix C) of the Policy.
7. Work has also been undertaken to identify, and define, eight risk domains. The 'classification' of risks into one of the eight domains enables the organisation to proactively determine the level of mitigation required in line with its 'appetite' (or willingness) to take risk in these areas. This enables the organisation to prioritise resource more effectively when managing risks.
8. The table at section 7.2 of the Risk Management Policy (page 13, Appendix C). outlines the target risk score range across eight risk domains (e.g. the minimum

and maximum level of risk the ICB is willing to accept reflective of its risk appetite). A target risk score will be agreed for each risk and mitigating actions identified as appropriate.

9. This work has been undertaken across a number of key stages, as outlined below:

    a) Discussions at a Board development session on 9 February 2023, which included a review of the ICB's risk landscape, case studies and breakout sessions where Board members' appetite for risk was considered across three scenarios:

        - The successful delivery of an urgent and emergency care system;
        - Formal delegation to Place (or Provider Collaboratives); and
        - The movement of a system to focus on prevention.

    b) A further session was held with the ICB's Non-Executive Directors on 7 June 2023 to develop the risk domains, assess the appropriateness of the risk tolerance ranges, and 'test' the application of the proposed risk appetite matrix against a selection of 'live' risks held in the Operational Risk Register.

    c) A session was held with the ICB's Executive Management Team on 31 July 2023 to review the proposed risk appetite approach, risk domains and the 'assigned' risk appetite levels applied across each of the risk domains.

10. Alongside these sessions, work has been undertaken to review national best practice, as well as local approaches to risk appetite by system partners across the Nottingham and Nottinghamshire ICS. Consideration has been given to all these elements when developing the ICB's risk appetite.

<u>Application of risk appetite</u>

11. Initial work has commenced to apply the ICB's risk appetite levels, and target risk scores, retrospectively to current risks that are held within the ICB's Operational Risk Register. Analysis undertaken at the time of writing, is provided at Appendix A. This identified that the majority of the current risks are above their tolerated risk appetite level.

12. A programme of work has been developed over the remainder of the financial year to introduce the ICB's risk appetite into business-as-usual activities. This includes:

    a) The enhancement of risk reporting to the Board and its committees, through the analysis of the number of 'live' operational risks which fall within/outside their risk appetite tolerance range. Focused risk reviews will

be undertaken on those risks which consistently sit outside the ICB's risk appetite.

b) Refinement of the target risk scores for the ICB's strategic risks within its Board Assurance Framework; which will strengthen the focus and scrutiny of the prioritisation of resources to address any 'gaps' in control and/or assurances as part of Executive-led Targeted Assurance Reports to the Audit and Risk Committee.

c) A workshop will be held with the ICB's Executive and Senior Leadership Teams to 'socialise' the ICB's risk appetite levels and introduce officers to the concept of these having to be embedded within operational decision-making. This will coincide with work being taken to develop Board and committee front sheet templates to ensure authors proactively consider the ICB's risk appetite when making decisions.

13. It is recognised that the ICB's risk appetite, and process to apply it, will take time to implement and likely evolve over the next year. The above work will continue to 'test' the application of the ICB's risk appetite to determine whether this is at the correct level, in line with how the ICB operates in practice. This may result in a need to review or reassess risk appetite levels as we move into 2024/25.

System risk appetite

14. An area of ongoing local, regional and national debate is the concept of system (ICS) risk appetite. Two documents have recently been published in relation to system risk management (*NHS England System Risk Management Principles* and the *HfMA System Risk Management: Key considerations for evolving arrangements*[1]). Both documents describe system risk maturity levels, recognising that systems will be at different points of development of system risk arrangements dependent on how closely organisations had worded prior to ICB establishment.

15. Although there is no explicit definition of system risk appetite within these documents, reference is made to it across the four maturity levels. For example, a 'level 1' system is one where there is '*no established ICB risk appetite'*, a 'level 2' has '*an ICB only focused risk appetite'*, a 'level 3' system refers to '*risk appetite focussing on the ICB's role as a member and leader of risk within the ICS'* and a 'level 4' makes reference to '*a single aligned approach to risk appetite across the ICS'*.

16. In line with the level 3 approach described above, it is proposed that, for an interim period, the ICB's risk appetite is applied to the system risks captured within the Operational Risk Register. This recognises that, although system risk management arrangements are collective across all partners, they are naturally

[1] system-risk-management8ac625ce1ab7692cb427ff0000b8cb05.pdf (hfma.org.uk)

led by the ICB, in line with its system assurance and oversight role. This will continue to be revisited over time, in line with national best practice, and has been identified as a priority area of focus by the ICS Risk Management Leads Network. This will ensure that we are working collectively with our partners on the best approach to system risk appetite.

17. It is also important to note that, as part of the development of the ICB's risk appetite matrix, an exercise has been undertaken to review this in line with system partners' risk appetites. It is important to note that a 'like for like' assessment was unable to be undertaken given individual organisations' different approaches or definitions of risk domains, however, informed assumptions were able to be made across areas. Detail is provided at Appendix B.

Risk Management Policy

18. The ICB's Risk Management Policy has been updated to include the risk appetite approach, as described in this paper, as well as reference being strengthened as to how risk arrangements within the ICB interface with key elements of the Integrated Care System (ICS) and ICS system partners (e.g., system risk management arrangements).

19. The full Policy is provided at Appendix C, however, as a reminder, it outlines the whole risk management architecture (roles, responsibilities and reporting structure) and sets out:

    a) The ICB Board's commitment to, and leadership of, the total risk management function;

    b) How risk management will be integrated into organisational culture and be key to all business decision-making processes, including collective risk management with ICS system partners;

    c) The roles and responsibilities of individuals and committees in respect of both operational and strategic risks; and

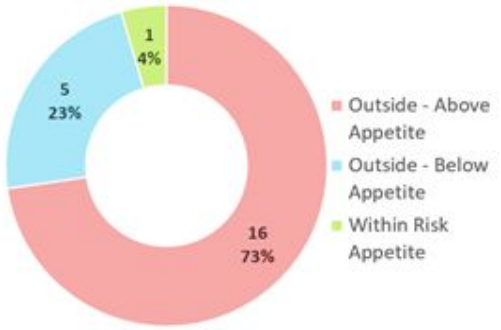
    d) The processes in place to ensure the systematic identification, assessment, evaluation and control of risks; for both strategic and operational risk management, including arrangements for the Operational Risk Register and Board Assurance Framework.

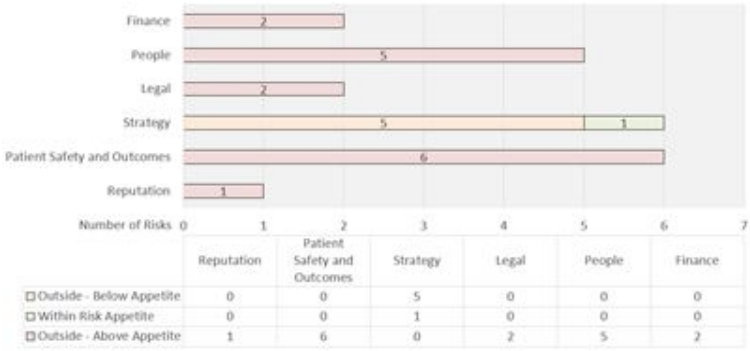
Appendix A: Application of the ICB's risk appetite to current, 'live' operational risks

As highlighted in the paper, work has been undertaken to 'test' the proposed risk appetite against existing risks within the Operational Risk Register. Each individual risk has been mapped against a risk domain (risk domains are applied based on the main 'cause' of the risk) and analysis undertaken of whether the current risk score is above, within or below the proposed risk appetite level.

ICB 'corporate' operational risks

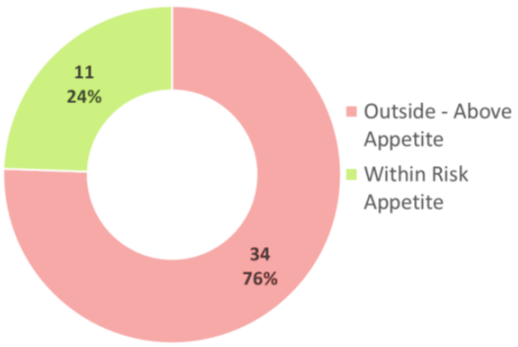
There are currently 22 ICB corporate risks on the Operational Risk Register; 16 (73%) of which have a current risk score greater than the tolerated range (i.e. above risk appetite), one (4%) is within its risk appetite and five (23%) are below. Meaning that the majority of the ICB's risk profile is at a greater level of risk than the organisation is willing to tolerate.

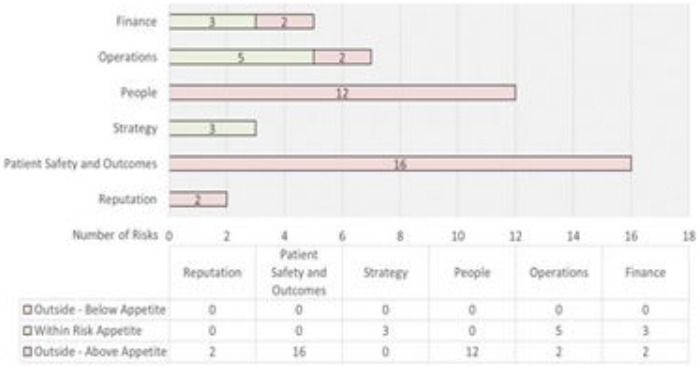




System operational risks

There are currently 45 system risks on the Operational Risk Register. If we were to apply the ICB's risk appeite to these; 34 (76%) have a current risk score greater than the tolerated range (i.e. above risk appetite) and 11 (24%) are within their risk appetite.





Appendix B: Alignment of risk appetite across system partners

An exercise has been undertaken to review individual system partners' risk appetite statements when developing the ICB's proposed approach. This proved challenging given each statutory partner takes a different approach; including how risks are categorised, how risk appetite levels are defined, as well as its application (i.e., some apply risk appetite levels to risk domains and others to their strategic objectives); however, general conclusions were able to be drawn (as outlined in Table 1).

It should be noted Nottinghamshire County Council, East Midlands Ambulance Service NHS Trust and Nottingham CityCare do not have risk appetites matched to categories within their respective Risk Management Policies and, as such, do not appear in the below tables.

Table 1 provides an 'at a glance' view of risk appetite levels using a homogenized colour rating to allow ease of comparison of the ICB's risk appetite levels to system partners. Further detail by individual organisation is provided at **Table 2**.

Risk Category	ICB Proposed Risk Appetite	NUH	SFHT	Notts HC	Bassetlaw Hospital	City LA
Social and Economic Development	Open (8 to 15)					**Environmental** Averse (1 to 5) Cautious (6 to 10)
Finance	Open (8 to 15)		**Finance** Cautious (8 9)	**Finances** Open (12,15,16)	**Finance / Value for Money** Open (8 to 12)	**Financial** Averse (1 to 5) Cautious (6 to 10)
People	Cautious (4 to 10)	**People** Moderate (8 to 12)	**Staff Harm** Minimal (4 to 6)		**People** Open (8 to 12)	**Workforce** Cautious (6 to 10) Open (11 to 15)
Patient Safety and Outcomes	Averse (1 to 5)	**Our Population Health Outcomes Potential** Moderate (8 to 12) **Patient** Cautious (4 to 6)	**Patient Harm Public Harm** Minimal (4 to 6)	**Quality** Cautious (Moderate 8,9, Impact Score of 5) Open (12,15,16)	**Quality** Open (8 to 12)	**Customer / Citizen** Cautious (6 to 10) Open (11 to 15) Optimistic (16 to 20)
Reputation	Averse (1 to 5)		**Reputation/Regulatory Action** Cautious (8 9)	**Reputation** Cautious (Moderate 8,9, Impact Score of 5) Open (12,15,16) Seek (20,25)	**Reputation** Seek (15 to 25)	**Reputation** Averse (1 to 5) Cautious (6 to 10)
Legal	Averse (1 to 5)		**Reputation/Regulatory Action** Cautious (8, 9)	**Compliance/Regulatory** Cautious (8 to 10)	**Regulatory/Compliance** Minimal (1 to 3)	**Legal / Legislation Health and Safety** Averse (1 to 5) Cautious (6 to 10)
Operations	Open (8 to 15)	**Places Performance** Cautious (4 to 6)	**Services** Cautious (8, 9)			**Service / Project / Programme Delivery Physical Assets** Cautious (6 to 10) Open (11 to 15) Optimistic (16 to 20)
Strategy	Eager (15 to 20)			**Innovation** Open (12,15,16) Seek (20,25)	**Innovation** Open (8 to 12)	**Opportunity Partnership Engagement** Cautious (6 to 10) Open (11 to 15) Optimistic (16 to 20)

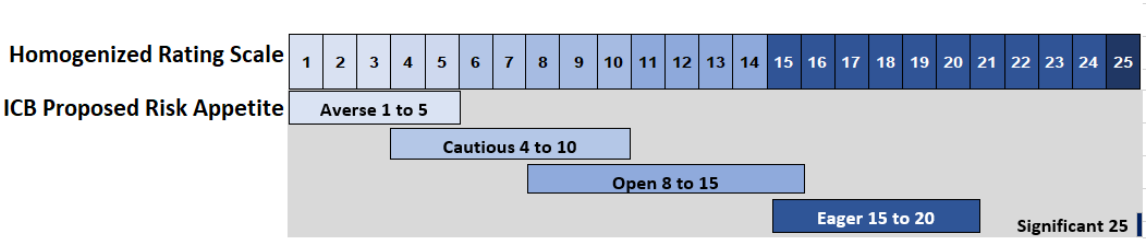


Table 2

Within the below table, the coloured boxes depict the statutory partners' risk appetite applied to their defined risk domains. The colour and risk appetite level are as described within their respective Risk Management policies. The blue arrows depict the ICB's quantitative risk tolerance bands, in line with the ICB's proposed risk appetite levels. As highlighted above, this is not a 'like for like' comparison given each organisation has a different approach.

	Target 'Risk Score' Range (Impact x Likelihood = Risk Score)																								
Risk Domains / Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Nottingham University Hospitals																									
People								Moderate																	
Our Population Health								Moderate																	
Outcomes Potential								Moderate																	
Patient				Cautious																					
Places				Cautious																					
Performance				Cautious																					
Sherwood Forest Hospitals																									
Patient harm				Minimal																					
Public harm				Minimal																					
Staff harm				Minimal																					
Services								Cautious																	
Reputation / regulatory action								Cautious																	
Finances								Cautious																	
Nottinghamshire Healthcare																									
Financial / Value for Money														Open											
Compliance / Regulatory						Cautious *																			
Innovation														Open							Seek				
Quality						Cautious *								Open											
Reputation						Cautious *								Open							Seek				
Bassetlaw																									
Reputation															Seek										
Finance / Value for Money								Open																	
Regulatory / Compliance	Minimal																								
Innovation								Open																	
Quality								Open																	
People								Open																	
Nottingham City Council																									
Financial	Averse					Cautious																			
Customer / Citizen						Cautious				Open										Optimistic					
Health and Safety	Averse					Cautious																			
Environmental	Averse					Cautious																			
Legal / Legislation	Averse					Cautious																			
Workforce						Cautious				Open															
Physical Assets						Cautious				Open										Optimistic					
Partnership Engagement						Cautious				Open										Optimistic					
Reputation	Averse					Cautious																			
Service / Project / Programme Delivery						Cautious				Open										Optimistic					
Opportunity						Cautious				Open										Optimistic					

ICB Proposal		
ICB Risk Domain	ICB Risk Appetite	Risk Tolerance (i.e. Target Risk Score Range*)
People	Cautious	4 to 10
Patient Safety and Outcomes	Averse	1 to 5
Patient Safety and Outcomes	Averse	1 to 5
Patient Safety and Outcomes	Averse	1 to 5
Operations	Open	8 to 15
Operations	Open	8 to 15
Patient Safety and Outcomes	Averse	1 to 5
Patient Safety and Outcomes	Averse	1 to 5
People	Cautious	4 to 10
Operations	Open	8 to 15
Reputation / Legal	Averse	1 to 5
Finance	Open	8 to 15
Finance	Open	8 to 15
Legal	Averse	1 to 5
Strategy	Eager	15 to 20
Patient Safety and Outcomes	Averse	1 to 5
Reputation	Averse	1 to 5
Reputation	Averse	1 to 5
Finance	Open	8 to 15
Legal	Averse	1 to 5
Strategy	Eager	15 to 20
Patient Safety and Outcomes	Averse	1 to 5
People	Cautious	4 to 10
Finance	Open	8 to 15
Patient Safety and Outcomes	Averse	1 to 5
Legal	Averse	1 to 5
Social and Economic Development	Open	8 to 15
Legal	Averse	1 to 5
People	Cautious	4 to 10
Operations	Open	8 to 15
Strategy	Eager	15 to 20
Reputation	Averse	1 to 5
Operations	Open	8 to 15
Strategy	Eager	15 to 20

NHS
Nottingham and Nottinghamshire
Integrated Care Board

Risk Management Policy

September 2023 – September 2026

CONTROL RECORD				
Reference Number GOV-001	**Version** 1.10	**Status** Draft	**Author(s)** Associate Director of Governance Head of Corporate Assurance	
			Sponsor Director of Nursing	
			Team Corporate Assurance	
Title	Risk Management Policy			
Amendments	Further detail in relation to the ICB's risk appetite and target risk score included in sections 4.1; 6.4; 7.2 and 7.3.			
Purpose	The purpose of this policy is to ensure that robust arrangements for risk management are embedded across the ICB and to ensure an agreed risk appetite and approach to risk tolerance.			
Associated Documents	Nottingham and Nottinghamshire ICB's Board Assurance Framework; Nottingham and Nottinghamshire ICB's Operational Risk Register; Nottingham and Nottinghamshire ICB's Fraud Risk Register.			
Superseded Documents	Risk Management Policy v1.5			
Audience	All employees and appointees of the Nottingham and Nottinghamshire ICB and any individuals working within the ICB in a temporary capacity.			
Equality Impact Assessment	Complete (see Appendix F)			
Approving Body	ICB Board		**Date approved**	September 2023
Date of Issue	TBC			
Review Date	TBC			
This is a controlled document and whilst this policy may be printed, the electronic version available on the ICB's document management system is the only true copy. As a controlled document, this document should not be saved onto local or network drives.				

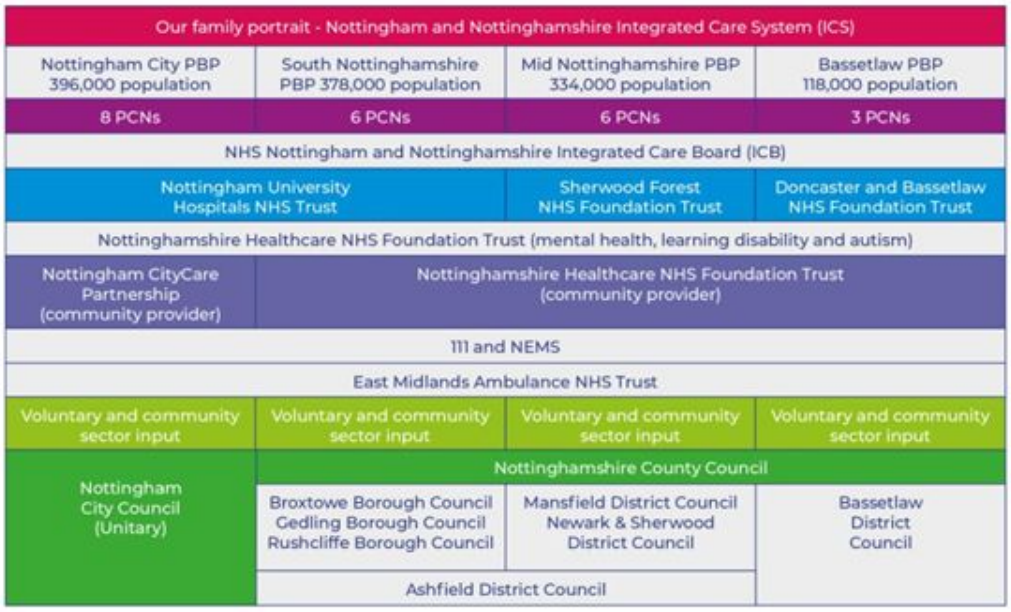
NHS Nottingham and Nottinghamshire Integrated Care Board (ICB)'s policies can be made available on request in a range of languages, large print, Braille, audio, electronic and other accessible formats from the Communications Team at nnicb-nn.comms@nhs.net

Contents

1. Introduction

1.1. This policy applies to NHS Nottingham and Nottinghamshire Integrated Care Board, hereafter referred to as 'the ICB.'

1.2. The ICB is a statutory organisation which forms part of the wider Nottingham and Nottinghamshire Integrated Care System (ICS). Whilst this policy outlines risk management arrangements for the statutory ICB, it is important that these arrangements work in partnership with other key parts of the ICS family.



1.3. The management of risk across organisational boundaries, e.g. system risk management, is complex. Governance models should allow sovereign organisations to manage their own risks independently, whilst enabling a strong and holistic partnership approach to risk management to support the delivery of system priorities.

1.4. Risk should be an important feature within the different parts of the system architecture e.g. Place Based Partnerships (PBPs), Provider Collaboratives and health and care providers. Partnership working can often lead to potential issues regarding risk ownership and accountability. As such, it is important that there are clear inter-relationships regarding the management and ownership of risks between these different elements.

1.5. The ICB recognises that risk management is an essential business activity that underpins the achievement of its objectives. A proactive and robust approach to risk management can:

- Reduce risk exposure through the development of a 'lessons learnt' environment and more effective targeting of resources.
- Support informed decision-making to allow for innovation and opportunity.
- Enhance compliance with applicable laws, regulations and national guidance.
- Increase stakeholder confidence in corporate governance and ability to deliver.

1.6. Risk is accepted as an inherent part of health care. Likewise, uncertainty and change in the evolving healthcare landscape may require innovative approaches that bring with them more risk. Therefore, it is not practical to aim for a risk-free or risk-averse environment; rather one where risks are considered as a matter of course and identified and managed appropriately.

1.7. This policy has been developed to ensure that risk management is fundamental to all of the ICB's activities and understood as the business of everyone. The policy has adopted the following principles of risk management as set out in the ISO 31000: 2018 standard[1].

Principle	Description
Integrated	Risk management is an integral part of all organisational activities.
Inclusive	Appropriate and timely involvement of stakeholders enables their knowledge, views and perceptions to be considered. This results in improved awareness and informed risk management.
Structured and comprehensive	A structured and comprehensive approach to risk management contributes to consistent and comparable results.
Customised	The risk management framework and process are customised and proportionate to the organisation's external and internal context related to its objectives.
Dynamic	Risks can emerge, change or disappear as an organisation's external and internal context changes. Risk management anticipates, detects, acknowledges and responds to those changes and events in an appropriate and timely manner.
Best available information	The inputs to risk management are based on historical and current information, as well as on future expectations. Risk management explicitly takes into account any limitations and uncertainties associated with such information and expectations. Information should be timely, clear and available to relevant stakeholders.
Human and cultural factors	Human behaviour and culture significantly influence all aspects of risk management.
Continual improvement	Risk management is continually improved through learning and experience.

[1] ISO 31000 helps organisations develop a risk management strategy to effectively identify and mitigate risks, thereby enhancing the likelihood of achieving their objectives and increasing the protection of their assets. https://www.iso.org/iso-31000-risk-management.html

1.8. This policy demonstrates the ICB's commitment to its total risk management function. It sets out the ICB's risk architecture (roles, responsibilities, communication and reporting arrangements) and describes how risk management is integrated into governance arrangements, key business activities and culture, both internally within the ICB and with health and care system partners.

2. Purpose

2.1. This policy describes the ICB's approach to the management of strategic and operational risks across the statutory organisation. It also references how risk arrangements within the ICB will interface with key elements of the Integrated Care System (ICS) and ICS system partners (e.g. system risk management arrangements).

2.2. The purpose of this guidance is to encourage a culture where risk management is viewed as an essential process of the ICB's activities. It provides assurance to the public, patients and partner organisations that the ICB is committed to managing risk appropriately.

3. Scope

3.1 This policy applies to all employees and appointees of the ICB and any individuals working within the ICB in a temporary capacity (hereafter referred to as 'individuals').

4. Definition of Risk Management Terms

4.1 The following terms are used throughout this document:

Term	Definition
Assurance	Evidence that controls are working effectively. Assurance can be internal (e.g. committee oversight) or external (e.g. internal audit reports).
Assurance Framework	A (Board) Assurance Framework is a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect. The Assurance Framework document is the key source of evidence that links the organisation's strategic objectives to risk, controls and assurances and the main tool a Board should use in discharging its responsibility for internal control.[2]
Controls	The measures in place to control risks and reduce the impact or likelihood of them occurring.
Integrated Care Board (ICB)	The ICB is the statutory NHS organisation within the ICS which holds responsibility for NHS functions and budgets.

[2] NHS Governance, Fourth Edition 2017 (HfMA)

Term	Definition
Integrated Care Partnership (ICP)	The ICP is a statutory committee which brings together all ICS system partners to produce a health and care strategy.
Integrated Care System (ICS)	The ICS is a partnership that brings together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of the population.
Initial risk score	The numerical assessment of the risk (impact vs. likelihood) prior to considering any additional mitigating controls and/or actions.
Corporate risks	Operational risks which relate to the delivery of the ICB's statutory duties, functions and/or objectives.
Current (or Residual) risk score	The numerical assessment of the risk (impact vs. likelihood) after taking into consideration any mitigating controls and/or actions.
Operational Risk Register (ORR)	A tool for recording identified 'live' operational risks and monitoring actions against them. The ORR captures both ICB 'corporate' operational risks and system operational risks.
Operational risk management	Risk management processes which focus on 'live' operational risks which the organisation is potentially facing. It relies upon the identification of risks, which are 'dynamic' in nature and are managed via additional mitigations. Operational risk management processes are centred around the Operational Risk Register.
Operational risks	These risks are by-products of day-to-day business delivery. They arise from definite events or circumstances and have the potential to impact negatively on the organisation and its objectives. Operational risks include corporate risks (those which directly relate to the ICB's objectives/duties) and system risks (those which relate to the delivery of system priorities).
Place-Based Partnerships (PBPs)	Place-based partnerships are collaborative arrangements formed by the organisations responsible for arranging and delivering health and care services in a locality or community.

Term	Definition
Risk	There are many definitions of risk, but this policy has adopted the definition set out in ISO 31000 in that a risk is the *'effect of uncertainty on objectives'.* The effects can be negative, positive or both. It is measured in terms of impact and likelihood.
Risk appetite	The total amount and type of risk that an organisation (the ICB) is willing to take in order to meet its strategic objectives. A range of appetites exist for different risk domains, and these may change over time.
Risk assessment	An examination of the possible risks that could occur during an activity.
Risk culture	The values, beliefs, knowledge and understanding of risk, shared by a group of people with a common intended purpose.
Risk logs	Risk logs are a tool for capturing operational level risks at team/directorate/place/project-level which may impact on the delivery of local objectives. Examples of risk logs may include: • Directorate/Team specific Risk Logs; • Project Risk Logs; • Transformation Programme Risk Logs.
Risk management	The arrangements and activities in place that direct and control the organisation with regard to risk.
Risk mitigation	How risks are going to be controlled in order to reduce the impact on the organisation and/or likelihood of their occurrence.
Risk profile	The nature and level of the threats faced by an organisation.
Risk treatment	The process of selecting and implementing suitable measures to modify the risk.
Strategic objectives	Strategic objectives describe a set of clear organisational goals that help establish priority areas of focus. Whilst broad and directional in nature, they need to be specific enough that their achievement can be assured, and progress measured. They should have direct alignment with the (Board) Assurance Framework and the ICB's performance management processes.

Term	Definition
Strategic risk management	Risk management processes which support the achievement of the organisation's strategic objectives. It focuses on the proactive identification of 'high level' risks which are managed by an established control framework and planned assurances. Strategic risk management processes are centred around the (Board) Assurance Framework.
Strategic risks	Potential, significant risks that are pro-actively identified and threaten the achievement of strategic objectives.
System risk management	The collective identification, assessment and mitigation of operational risks where improved outcomes can be achieved by system partners working together through shared accountability arrangements. System risk management does not replace risk management infrastructures in place within each ICS system partner; system risk management arrangements complement organisational risk management arrangements; they do not replace them.
System risks	• An operational risk that requires more than one system partner to manage; and/or • An operational risk that is not unique to a single system partner.
Target risk score	The numerical level of risk exposure that the ICB is prepared to tolerate following completion of all the mitigating actions.
Three lines of defence model	A risk governance framework that splits responsibility for operational risk management across three functions. Individuals in the first line own and manage risk directly. See Appendix E.

The diagram below summarises the differences between strategic and operational risks. Further detail is provided at Appendix A.

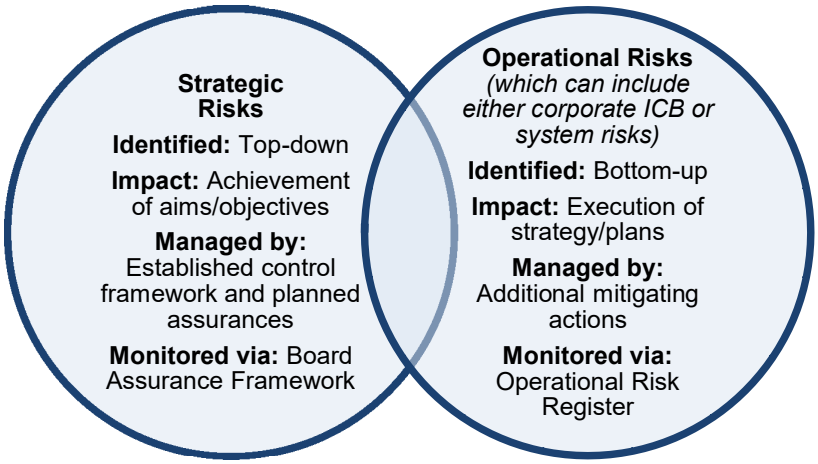


Figure 1 – The two types of risks

5. Roles and Responsibilities

Roles	Responsibilities
Forums	
Integrated Care Board	The Board has overall accountability for risk management and, as such, needs to be satisfied that appropriate arrangements are in place and that internal control systems are functioning effectively. The Board determines the ICB's risk appetite and risk tolerance levels and is also responsible for establishing the risk culture.
Audit and Risk Committee	The Audit and Risk Committee provides the Board with assurance on the effectiveness of the Board Assurance Framework and the robustness of the ICB's operational risk management processes. The Committee's role is not to 'manage risks' but to ensure that the approach to risks is effective and meaningful. In particular, the Committee supports the Board by obtaining assurances that controls are working as they should, seeking assurance about the underlying data upon which assurances are based and challenging relevant managers when controls are not working, or data is unreliable.
ICB Committees	Committees are responsible for monitoring operational risks related to their delegated duties* as outlined within their respective Terms of Reference. This will include monitoring the progress of actions, robustness of controls and timeliness of mitigations. They are also responsible for identifying risks that arise during meeting discussions and ensuring that these are captured on the Operational Risk Register.
Individuals	
Chief Executive	The Chief Executive has responsibility for maintaining a sound system of internal control that supports the achievement of the ICB's policies, aims and objectives, whilst safeguarding public funds and assets.
Director of Nursing	The Director of Nursing is the executive lead for corporate governance and risk and assurance systems across the ICB. This includes promoting the ICB's risk culture within the Executive Team, wider directorates and across system partners.
ICB Non-Executive and Partner Members	As members of the Board and committees, Non-Executive Members will ensure an impartial approach to the ICB's risk management activities and should satisfy themselves that systems of risk management are robust and defensible.

Roles	Responsibilities
Associate Director of Governance (supported by the Corporate Assurance Team)	The Associate Director of Governance leads on the implementation of corporate governance and risk and assurance systems across the ICB. This includes the development, implementation and co-ordination of the ICB's risk management activities and provision of training and advice in relation to all aspects of this policy.
Executive Directors	Executive Directors are responsible for ensuring effective systems of risk management are in place, and commensurate with this policy, within their respective Directorates. This includes promoting the ICB's risk culture and ensuring all senior leaders, within their respective Directorates, have a robust understanding of the organisation's risk management arrangements.
Senior Leadership Team (including Associate/Deputy Directors)	Members of the Senior Leadership Team are responsible for leading risk management arrangements within their Teams, which includes, but is not limited to, ensuring that: • Risk Logs are in place to support delivery of team, place and project/programme objectives; • Operational risks are appropriately escalated from Risk Logs to the Operational Risk Register; • Mitigating actions are in place to manage risks in line with the ICB's risk appetite statement; and • Staff are suitably trained in relation to risk management.
Senior Information Risk Owner (SIRO)	The SIRO takes ownership of the ICB's information risks and acts as advocate for information risk on the Integrated Care Board.
Risk Owners	Risk owners are responsible for ensuring robust mitigating actions are identified and implemented for their assigned risks. In relation to system risks, risk 'owners' are responsible for co-ordinating mitigating actions across relevant system partners.
Individuals	All individuals are responsible for complying with the arrangements set out within this policy and are expected to: • Routinely consider risks when developing business cases, commencing procurements or any other activity which could be impacted by unexpected events (undertaking specific risk assessments as necessary). • Ensure that any operational risks they are aware of are captured on the Operational Risk Register or Directorate/Team Risk Logs as appropriate.

** Risks cannot always be addressed in isolation from each other. Risks may have different facets (e.g. finance and quality) and management actions may impact on different areas of the ICB. Where this is the case, a pragmatic approach will be taken, and risks may be scrutinised by more than one committee.*

6. Risk Appetite

6.1. Good risk management is not about being risk averse, it is also about recognising the potential for events and outcomes that may result in opportunities for improvement, as well as threats to success.

6.2. A 'risk aware' organisation encourages innovation to achieve its objectives and exploit opportunities and can do so in confidence that risks are being identified and controlled by senior managers.

6.3. The ICB Board has agreed to the following narrative risk appetite statement:

Nottingham and Nottinghamshire ICB's Risk Appetite Statement
The Board of NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) recognises that long-term sustainability and the ability to improve quality and health outcomes for our population, depends on the achievement of our strategic objectives and that this will involve a willingness to take and accept risks. It may also involve taking risks with our strategic partners in order to ensure successful integration and better health services for the people of Nottingham and Nottinghamshire. The ICB will endeavour to adopt a ***mature*** approach to risk-taking where the long-term benefits could outweigh any short-term losses, in particular when working with strategic partners across the Nottingham and Nottinghamshire system. However, such risks will be considered in the context of the current environment in line with the ICB's risk tolerance and where assurance is provided that appropriate controls are in place, and these are robust and defensible. The ICB will seek to ***minimise*** risks that could impact negatively on the health outcomes and safety of patients or in meeting the legal requirements and statutory obligations of the ICB. We will also seek to ***minimise*** any risks that may impact on our ability to demonstrate high standards of probity and accountability. In view of the changing landscape, the ICB's risk appetite will not necessarily remain static. The ICB's Board will have the freedom to vary the amount of risk it is prepared to take, depending on the circumstances at the time. It is expected that the levels of risk the ICB is willing to accept are subject to regular review. *1 Good Governance Institute Risk Appetite for NHS Organisations – definition of '**mature**' is confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.* *2 Good Governance Institute Risk Appetite for NHS Organisations – definition of '**minimal'** is preference for ultra-safe delivery options that have a low degree of inherent risk.*

6.4. The above is further supplemented with an ICB risk appetite matrix. This matrix describes five levels of risk appetite the organisation is willing to take; from averse (taking little or no risk) to significant (taking lots of risk).

Risk Appetite Level	Description	Risk Tolerance (i.e. Target Risk Score Range*)
Averse	**Preference for ultra-safe delivery** options that avoid or minimise risk as much as possible.	**1-5**
Cautious	**Preference for safe delivery** options that have a low degree of inherent risk and may only have limited potential for reward.	**4-10**
Open	**Willing to consider all potential delivery options** while also providing an acceptable level of reward (and Value for Money).	**8-15**
Eager	**Seek to be innovative** and to choose options offering potentially higher business rewards with greater uncertainty (i.e. despite greater inherent risk).	**15-20**
Significant	**Confident in setting high levels of risk appetite** because controls, forward scanning and responsiveness systems are robust.	**25**

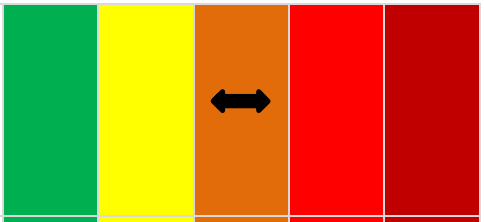
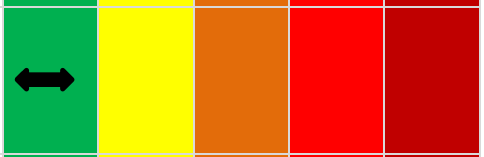
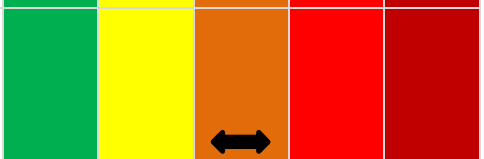
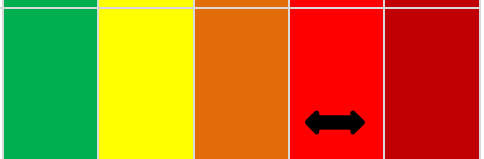
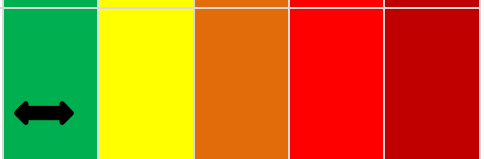
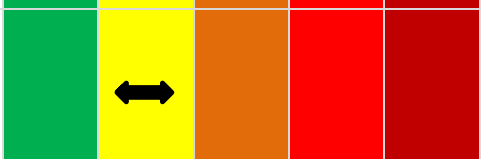
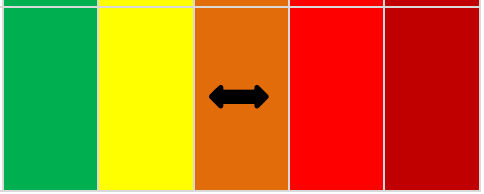
**It should be noted that there is some crossover on the risk tolerance ranges as the scores are dependent on whether the impact or likelihood score is higher (i.e. I1 x L5) is averse vs. (I5 x L1) is cautious.*

7. Risk Tolerance

7.1. Whilst risk appetite is about the pursuit of risk, risk tolerance is concerned with the level of risk that can be accepted (e.g. it is the minimum and maximum level of risk the ICB is willing to accept reflective of the risk appetite statement above).

7.2. The below table outlines the target risk score range across eight risk domains; the target risk score being the acceptable level of risk that is able to be tolerated by the ICB. A target risk score will be agreed for each risk and mitigating actions identified as appropriate.

Risk domain	Risk appetite level	Target risk score range				
		1-5	4-10	8-15	15-20	25
Legal: Risks arising from a legal event occurring that may result in a liability, loss or a failure to take appropriate measures to meet legal or regulatory requirements.	*Averse*					

Finance: Risks associated with financial decision-making where there may be the potential for higher-than-expected value for money, financial gains and/or positive outcomes.	*Open*	
Reputation: Risks arising from adverse events that may lead to damages to reputation and or destruction of trust and relations.	*Averse*	
Operations: Risks associated with the establishment of innovative systems and processes which may improve operational efficiency and/or effectiveness, leading to favourable outcomes (such as the delivery of strategies and plans).	*Open*	
Strategy: Risks associated with identifying and pursuing strategies which could lead to improvements, opportunities for growth or may contribute positively to the achievement of aims and objectives.	*Eager*	
Patient Safety and Outcomes: Risks arising from adverse events, incidents and/or performance resulting in unintended or unexpected harm occurring.	*Averse*	
People: Risks associated with innovative decision-making which may improve performance, foster collaboration and/or enhance staff well-being.	*Cautious*	
Social and Economic Development: Risks relating to decisions or events which may have favourable social, ethical and/or environmental outcomes.	*Open*	

7.3. It is recognised that some risks are unavoidable and will be out of the ICB's ability to mitigate to a tolerable level. Where this is the case, the focus will move to the controls in place to manage the risks and the contingencies planned should the risks materialise.

8. Strategic Risk Management

8.1. Strategic risks are high-level risks that are pro-actively identified and threaten the achievement of the ICB's strategic objectives and key statutory duties. Strategic risks are owned by members of the Executive Management Team and are outlined within the ICB's **Board Assurance Framework (BAF).** The ICB will work with system partners across the ICS to ensure alignment of strategic risks, where appropriate and/or relevant to do so.

8.2. The Assurance Framework provides the Board with confidence that the ICB has identified its strategic risks and has robust systems, policies and processes in place (*controls*) that are effective and driving the delivery of their objectives (*assurances*). Sources of assurance incorporate the three lines of defence, as referenced in Appendix E. It provides confidence and evidence to management that '*what needs to be happening is actually happening in practice.'*

8.3. The Assurance Framework plays a key role in informing the production of the Annual Governance Statement and is the main tool that the Board should use in discharging overall responsibility for ensuring that an effective system of internal control is in place.

8.4. The Board approves the strategic risks (opening position) during the first quarter of the financial year, following agreement of the strategic objectives. The Board reviews the fully populated Assurance Framework bi-annually to affirm that sufficient levels of controls and assurances are in place in relation to the organisation's strategic risks.

8.5. The Assurance Framework is reviewed and updated by Executive Directors and the Head of Corporate Assurance Team throughout the year. This involves a review of the effectiveness of controls and what evidence (internal or external) is available to demonstrate that they are working as they should (assurances). Any gaps in controls or assurances will be highlighted at this point and actions identified.

8.6. The Audit and Risk Committee receives a rolling programme of targeted assurance reports which, over a 12-month period, covers all the ICB's strategic objectives (the full Assurance Framework). This enables a focussed review on specific sections of the Assurance Framework and allows for robust discussions on the actions in place to remedy any identified gaps in controls and assurances.

9. Operational Risk Management

9.1. Operational risks are 'live' risks the organisation is currently facing which are by-products of day-to-day business delivery. They arise from definite events or circumstances and have the potential to impact negatively on the organisation and its objectives.

9.2. Operational risk management relies upon reactive identification of risks, which are 'dynamic' in nature. Operational risks are managed via additional mitigations and are captured on the ICB's **Operational Risk Register**.

9.3. The Operational Risk Register is the central repository for all ICB operational risks. Whilst risks will feature across several of the ICB's processes, it is important that these are captured centrally to provide a comprehensive log of prioritised risks that accurately reflects the ICB's risk profile.

9.4. The Operational Risk Register reflects operational risks relevant to the ICB as a corporate body (operational risks associated with delivery of the ICB's statutory duties) and operational risks associated with the delivery of system objectives/priorities (operational risks associated with the delivery of transformation programmes, for example).

9.5. The Operational Risk Register contains details of the risk, the current controls in place and an overview of the actions required to mitigate the risk to the desired level. A named individual (risk owner) is given responsibility for ensuring the action is completed by the chosen due date.

10. Risk Logs

10.1. Risk logs are used to record operational risks at **individual team, directorate and programme/project-level.**

10.2. Risk logs should be used to record operational risks which are not considered significant enough to be captured on the ICB's Operational Risk Register. Such risks are identified in line with the Place/programme/team/Directorate-level objectives which have been set. A Risk Log template is in place and accessible from the Corporate Assurance Team by email: notts.corporateassurance@nhs.net

10.3. Whilst a fundamental part of the ICB's risk management arrangements (ensuring and demonstrating that project-level and/or team-level risks are being actively identified and managed), risk logs do not require the same level of management as the Operational Risk Register or Assurance Framework and, therefore, the oversight and scrutiny for team level risk logs is the responsibility of the relevant senior manager(s) (e.g., member of the Senior Leadership Team) to establish this. It may, for example include routine consideration of Risk Logs at project and/or team meetings.

10.4. When risks are added to a risk log, consideration should be given to the key elements of the risk. The risk review checklist can be used to support this exercise. See Appendix D for details.

10.5. When identified risks are considered to have the potential to directly impact the achievement of ICB objectives, these must be escalated from risk logs and captured on the Operational Risk Register. The Head of Corporate Assurance and Operational Risk Manager can offer support and guidance regarding risk escalation.

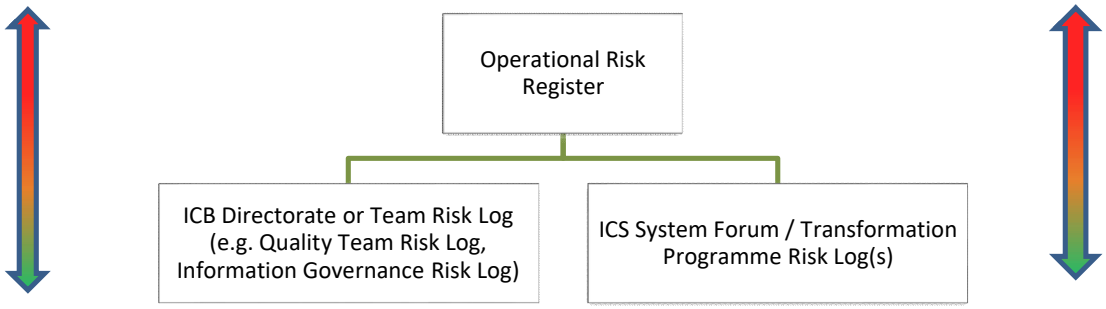


Figure 2 - Risk Log and ORR process

11. Risk Management Processes

Risk Assessments

11.1. Risk assessments can be undertaken at the start of any activity and provide a helpful means of anticipating 'what could go wrong' and deciding on preventative actions. For specific risk assessments relating to workplace safety (e.g. use of display screen equipment, lone working, maternity, etc.), please refer to the ICB's health and safety policies.

Risk Identification

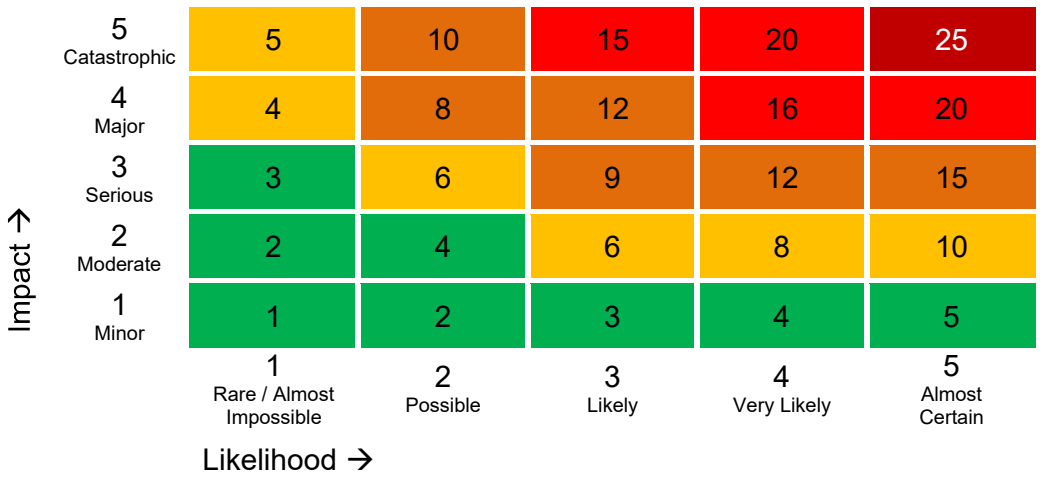
11.2. Operational risks (those which require adding to the Operational Risk Register) may be identified through an assortment of means, for example by risk assessments, external assessments, audits, complaints, during meetings and through horizon-scanning. For example, any medium (or higher) risks identified within internal or external audit reports are captured within the Operational Risk Register.

11.3. The ICB, its Committees, and system forums, all have a key role in the identification of risks in response to information presented to, and discussions held, at each meeting. A standing agenda item is included for every meeting to determine if there are any new risks that need to be considered for the Operational Risk Register.

11.4. Regular meetings are held with Executive Directors, members of the Senior Leadership Team, as well as operational, clinical and risk leads within ICS system partners, to discuss new or evolving risks within their respective portfolios/teams. This may include corporate or system risks.

Risk Evaluation

11.5. Risks are evaluated by defining qualitative measures of impact and likelihood, as shown in the risk scoring matrix, shown in Appendix C, to determine the risk's RAG rating. Risk scores can be subjective; therefore, the scores will be subject to review by senior managers and/or the responsible committee.



11.6. **Risk Treatment**

Risk treatment (also known as risk control) is the process of selecting and implementing measures to mitigate the risk to an acceptable level. Once risks have been evaluated, a decision should be made as to whether they need to be mitigated or managed through the application of controls (as described using the 'four T' risk treatment model below).

Treatment	Description
Terminate	Opt not to take the risk by terminating the activities that will cause it (more applicable to project risks).
Treat	Take mitigating actions that will minimise the impact of the risk prior to its occurrence and/or reduce the likelihood of the risk occurring.
Transfer	Transfer the risk, or part of the risk, to a third party.
Tolerate	Accept the risk and take no further actions. This may be due to the cost of risk mitigation activity not being cost effective or the impact is so low it is deemed acceptable to the organisation. Risks which are tolerated should continue to be monitored as future changes may make the risk no longer tolerable.

11.7. Most operational risks should have the ability to reduce in impact and/or likelihood and the relevant risk treatment must be performed to mitigate risks to an acceptable level in line with the ICB's risk appetite. High and extreme operational risks (those scoring 15 or above) which are not deemed to be treatable will be highlighted to the Board as part of routine risk reporting.

Management and Reporting of Risks

11.8. The following categories of risk grading provide a high-level view of management and reporting requirements. Expected management of risks at each grading has been designed in consideration of the ICB's risk appetite.

- The **ICB** will oversee all risks with an overall score of 15+ (e.g. any high and/or extreme operational risks from the Operational Risk Register; both ICB and system risks) at each of its meetings.
- **Committees** will oversee all risks relevant to their remit with an overall score of 6+ (e.g. medium rating and upwards; both ICB and system risks) from the Operational Risk Register at each of their meetings.
- **System (ICS) forums** will receive reports relating to system risks that fall within their remit to enable them in their duties to oversee the identification and management of system operational risks at each of their meetings.
- The **Audit and Risk Committee** will receive bi-annual risk management updates, including the full Operational Risk Register, which will enable any risk themes and trends to be reviewed; ensuring any multiple, similar risks of a minimal impact and likelihood are not ignored. This will support their duty to provide the Board with assurance on the robustness and effectiveness of the ICB's risk management processes.

	Very Low (1-5)	Low (4-10)*	Medium (8-15)*	High (15-20)	Extreme (25)
Level of risk	An acceptable level of risk that can be managed at directorate / team / project level (recorded in Risk Logs).	An acceptable level of risk that can be managed at directorate / team / project level (recorded in Risk Logs). **A risk could score 8-10 and be 'Low' if the 'Impact' score is low.*	A generally acceptable level of risk but corrective action needs to be taken (e.g. new risk at score 6+ or escalated from Risk Log(s) to ICB Operational Risk Register). **A risk could score 8-10 and be 'Medium' if the 'Impact' score is high.*	An unacceptable level of risk which requires senior management attention and corrective action.	An unacceptable level of risk which requires urgent Executive and senior management attention and immediate corrective action.
Add to ICB Operational Risk Register?	No.	No.	Yes, with quarterly progress updates (as a minimum).	Yes, with bi-monthly progress updates (as a minimum).	Yes, with monthly progress updates (as a minimum).

	Very Low (1-5)	Low (4-10)*	Medium (8-15)*	High (15-20)	Extreme (25)
Oversight and scrutiny	Risk Logs to be reviewed in relevant Team/Directorates Meetings or system forum.	Risk Logs to be reviewed in relevant Team/Directorates Meetings or system forum.	ICB Risk Register (full or relevant extracts) to be reviewed by the relevant committee(s) at each meeting. System risks will be reported to the relevant system forum.	ICB Risk Register (full or relevant extracts) to be reviewed by the relevant committee(s) at each meeting. System risks will be reported to the relevant system forum.	All red/high risks on the ICB Operational Risk Register to be highlighted to the ICB Board.

12. Performance Risks

12.1. The ICB monitors the system performance against key delivery priorities via a separate, but parallel, process to the ICB's risk management arrangements.

12.2. To minimise duplication, failures to achieve performance standards are not routinely identified as specific risks on the ICB's Operational Risk Register. This should not indicate its absence from the organisation's overall risk profile and poor performance from a risk perspective will be referenced as necessary when reporting externally on risks (e.g., in the Annual Governance Statement).

12.3. The consistent non-delivery of performance standards will be assessed to ensure that any specific risks this poses to the ICB's functions and/or system priorities (e.g., a detrimental impact on health outcomes, patient safety or patient experience) are identified and captured on the Operational Risk Register.

13. Interface with ICS Partner Risks (System Risk Management)

13.1. The Integrated Care System has agreed a working definition of system risk management as "the collective identification, assessment and mitigation of risks where improved outcomes can be achieved by system partners working together through shared accountability arrangements".

13.2 System risk management does not replace organisational risk management requirements but is complementary. Organisations are equal partners within the system, so there is no escalation to the system level and there is a collective responsibility on all system partners for managing system risks. System risks are scored in relation to their potential impact on overall system deliverables and priorities, not individual organisations.

13.3 Processes to identify, evaluate, monitor and report operational system risks follow those outlined within section 11 of this Policy; however, the criteria for a system risk, and further detail on system risk management, is outlined in the below paragraphs.

13.4. An operational risk is determined to be a system risk when it meets the following criteria:

- A risk that requires more than one system partner to manage; and/or
- A risk that is not unique to a single system partner.

13.5. System risks can be identified in the following ways:

- Through individual discussions with system partner senior responsible officers, operational leads and clinical colleagues, when updating existing risks or through other general risk awareness raising discussions;
- Through discussions at system forums;
- Through discussions with system partner risk leads at local Risk Management Network meetings; and
- As reported by internal audit, as a result of system-wide audit reviews.

13.6. System risks will be managed by system partners working together through collective accountability arrangements.

13.7. System risks are captured on the ICB's Operational Risk Register. The use of the Operational Risk Register as the source risk register for system risks enables matrix reporting of relevant system risks across ICS oversight and operational groups, as appropriate. System partner representatives are responsible for feeding back on system risk discussions into their respective organisations.

13.8. Ownership of system risks is defined as the individual responsible for co-ordinating and facilitating overall progress against mitigating actions; they are not responsible for delivering all the mitigating actions themselves.

13.9. As system working arrangements mature and embed, it is likely that system risk management processes will evolve.

14. Management of Issues

14.1 Issues are not routinely recorded on the ICB's Operational Risk Register as they are managed via the organisation's performance management framework. However, senior leads/managers may use discretion as to whether local issues are captured on individual risk logs.

14.2 Known issues are an important mechanism to determine if there are any new risks needed to be identified, and captured, within the ICB's risk management arrangements. Head of Corporate Assurance and Operational Risk Manager can provide further support and guidance on the management of issues.

15. Fraud Risk Assessment

15.1. The Government Functional Standard 013: Counter Fraud “Management of counter fraud, bribery and corruption activity” has applied to NHS organisations since April 2021. The standard is part of a suite of standards that promotes consistent and coherent ways of working across government, and provides a stable basis for assurance, risk management and capability improvement.

15.2. The NHS Counter Fraud Authority (NHSCFA) is a health authority charged with identifying, investigating and preventing fraud and other economic crime within the NHS. The NHSCFA requires the organisation to undertake a local risk assessment to identify fraud, bribery and corruption risks and to ensure these are recorded and managed in line with its risk management policy.

15.3. A separate fraud risk register will be maintained by the ICB and reported to the Audit and Risk Committee once a year (as a minimum), to coincide with the Counter Fraud annual planning process.

16. Confidentiality

16.1. Where risks are not deemed to be in the public interest, they will be clearly marked as confidential on the Operational Risk Register and reported to the ICB during its closed session. This should be for a time-limited period only and risk owners and committees are responsible for agreeing when confidentiality no longer applies.

17. Communication, Monitoring and Review

17.1. The policy will be published and maintained in line with the ICB’s Policy Management Framework.

17.2. The policy will be highlighted to new staff as part of the local induction process and made available to all staff through the ICB’s internal communication procedures (and internet/intranet sites).

17.3. The ICB’s Audit and Risk Committee will review the effectiveness of this policy, and its implementation, via bi-annual risk management update reports and monthly targeted assurance reports.

17.4. The ICB will review the risk appetite on an annual basis.

17.5. Internal Audit will report on the implementation of this policy as part of the annual Head of Internal Audit Opinion work programme.

18. Staff Training

18.1. The Corporate Assurance Team will proactively raise awareness of the policy across the ICB and provide ongoing support to committees and individuals to enable them to discharge their responsibilities. Members of the Corporate Assurance Team can be contacted for formal training at team meetings (or other forums) by email: notts.corporateassurance@nhs.net

18.2. The Corporate Assurance Team intranet page is under development and will include bite size training on risk management topics. This can be accessed at: https://nhs.sharepoint.com/sites/52R_Intranet/SitePages/Who%27s%20Who/Nursing/Corporate-Assurance-Team.aspx

18.3. Any individual who has queries regarding the content of the policy, or has difficulty understanding how this relates to their role, should contact the ICB's Corporate Assurance Team by email: notts.corporateassurance@nhs.net

19. Equality and Diversity Statement

19.1 NHS Nottingham and Nottinghamshire ICB pays due regard to the requirements of the Public Sector Equality Duty (PSED) of the Equality Act 2010 in policy development and implementation, as a commissioner and provider of services, as well as an employer.

19.2 The ICB is committed to ensuring that, the way we provide services to the public and the experiences of our staff does not discriminate against any individuals or groups based on their age, disability, gender identity (trans, non-binary) marriage or civil partnership status, pregnancy or maternity, race, religion or belief, gender or sexual orientation.

19.3 We are committed to ensuring that our activities also consider the disadvantages that some people in our diverse population experience when accessing health services. Such disadvantaged groups include people experiencing economic and social deprivation, carers, refugees and asylum seekers, people who are homeless, workers in stigmatised occupations, people who are geographically isolated, gypsies, Roma and travellers.

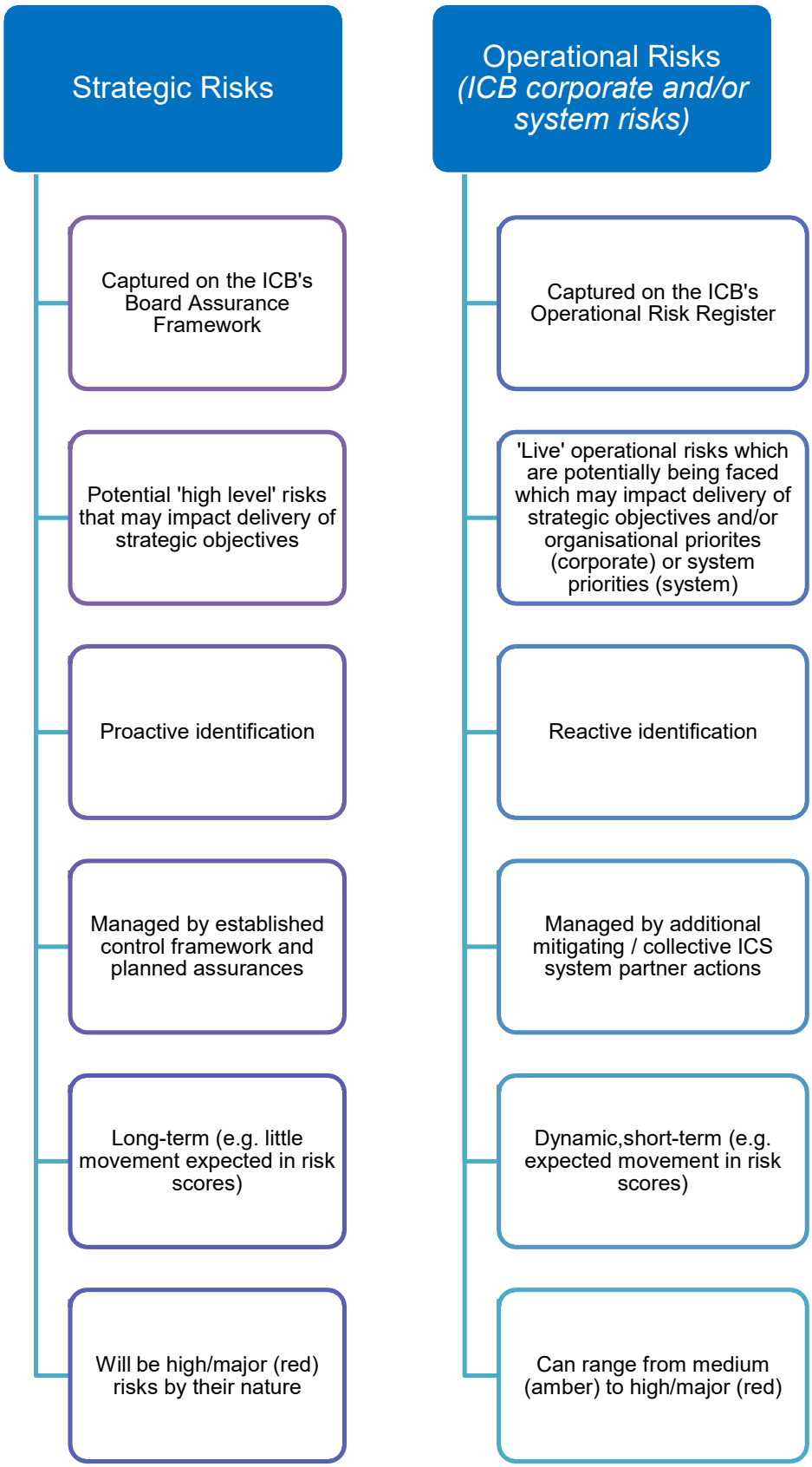
19.4 As an employer, we are committed to promoting equality of opportunity in recruitment, training and career progression and to valuing and increasing diversity within our workforce.

19.5 To help ensure that these commitments are embedded in our day-to-day working practices, an Equality Impact Assessment has been completed for, and is attached to, this policy.

20. References

- Assurance Frameworks, (2012). HM Treasury.
- A Risk Practitioners Guide to ISO 31000:2018, (2018). The Institute of Risk Management.
- Board Assurance: A toolkit for health sector organisations, (2015). NHS Providers.
- The Orange Book: Management of Risk – Principles and Concepts, (2020).
- Risk Appetite & Tolerance, (2011). The Institute of Risk Management.
- NHS Audit Committee Handbook, (2018). Healthcare Financial Management Association
- NHS Governance Handbook, (2017). Healthcare Financial Management Association
- Risk Appetite for NHS Organisations: A matrix to support better risk sensitivity in decision taking. (2012). The Good Governance Institute.
- Good Governance Institute (GGI).

Appendix A: Characteristics of Strategic and Operational Risks



Appendix B

Risk Identification Guidance

The purpose of this guidance is to support staff in identifying operational risks that may require entry on to their local risk logs and/or for escalation to the ICB's Operational Risk Register. Further guidance on identifying risks can be provided by contacting the Corporate Assurance Team by email: **notts.corporateassurance@nhs.net**

The general definition of a risk is "*the effect of uncertainty on objectives"* and it is the responsibility of all staff to:

- Identify risks at the conceptual stage of projects, as well as throughout the life of the project.
- Routinely consider risk within any planning, procurement or other ICB business and system activities.
- Ensure that any **operational** risks they become aware of are captured on local risk logs and/or the ICB's Operational Risk Register (dependent on score).

Operational risks are defined as by-products of the day-to-day running of an organisation. They arise from definite events or circumstances and have the potential to impact negatively on the organisation and its objectives. The objective which may not be achieved needs to be considered in the risk wording.

Good practice for articulating risks to use the is as follows:

CAUSE: '*As a result of* ….' (what will cause the risk to occur?)
EVENT: *'There is a risk ….*' (what can go wrong?)
EFFECT: *'Which may lead to ….*' (what will be the consequence/effect if the risk were to materialise?)

Training on writing risk statements can be requested from the Head of Corporate Assurance. Guidance documents are also available on the Corporate Assurance Team's Intranet page. Risk Log templates are also available.

Categorise the risk using the categories in one of the eight risk domains (see para 7.2) and use the risk scoring matrix in Appendix C to calculate what the risk is at the moment (before any actions have been implemented). You then need to consider the controls you have in place to manage this (e.g. contract monitoring arrangements) and any additional actions that may be needed to mitigate the risk to an acceptable level.

Appendix C

Risk Scoring Matrix

Table 1A: Impact Score (I) Guidance

Impact Score	1 Minor	2 Moderate	3 Serious	4 Major	5 Catastrophic
Guidance	Minor impact on objective/s.	Moderate impact on objective/s.	Serious impact on objective/s.	Major impact on objective/s.	Catastrophic impact on objective/s.
	Day to day operational challenges.	Temporary restriction to service delivery with limited impact on stakeholder confidence.	Short term failure to deliver key objectives with temporary adverse local publicity.	Medium term failure to deliver key objectives with ongoing adverse publicity or negative impact on stakeholder confidence.	Continued failure to deliver key objectives with long term adverse publicity or fundamental loss of stakeholder confidence.

Table 1B: Impact Score (I) Further Guidance broken by Risk Domain

Risk Domains	1 Minor	2 Moderate	3 Serious	4 Major	5 Catastrophic
Finance May include, but not limited to, risks linked to: • Finance • Procurement • Claims	• Small loss. • Risk of claim remote.	• Loss of 0.1–0.25 per cent of budget. • Claim less than £10,000.	• Loss of 0.25–0.5 per cent of budget. • Claim(s) between £10,000 and £100,000.	• Uncertain delivery of key objective. • Loss of 0.5–1.0 per cent of budget. • Purchasers failing to pay on time. • Claim(s) between £100,000 and £1 million.	• Non-delivery of key objective • Loss of >1 per cent of budget. • Failure to meet specification • Slippage. • Loss of contract/ payment by results. • Claim(s) >£1 million.

Appendix C

Risk Domains	1 Minor	2 Moderate	3 Serious	4 Major	5 Catastrophic
Legal May include, but not limited to, risks linked to: • Statutory duty • Inspections • Information Governance • Governance / Probity • Compliance • Safeguarding • EPRR	• No or minimal impact or breach of guidance/ statutory duty.	• Breach of statutory legislation. • Reduced performance rating if unresolved.	• Single breach in statutory duty. • Challenging external recommendations/ improvement notice.	• Enforcement action. • Multiple breaches in statutory duty. • Improvement notices. • Low performance rating. • Critical report.	• Multiple breaches in statutory duty. • Prosecution. • Complete systems change required. • Zero performance rating. • Severely critical report.
Operations May include, but not limited to, risks linked to: • Capacity • Demand • Primary Care	• Day to day operational challenges.	• Temporary restriction to service delivery with limited impact on stakeholder confidence.	• Short term failure to deliver key objectives with temporary adverse local publicity.	• Medium term failure to deliver key objectives with ongoing adverse publicity or negative impact on stakeholder confidence.	• Continued failure to deliver key objectives with long term adverse publicity or fundamental loss of stakeholder confidence.
• Service/ business interruption • Digital	• Loss/ interruption of >1 hour.	• Loss/ interruption of >8 hours.	• Loss/ interruption of >1 day.	• Loss/ interruption of >1 week.	• Permanent loss of service or facility.
• Business Projects • Planning • Delivery • Commissioning • Partnership working	• Insignificant cost increase / schedule slippage. • Key 'political' target is being achieved and impact prevents improvement.	• <5 per cent over project budget. • Schedule slippage. • Key 'political' target is being achieved but impact reduces performance marginally below target in the near	• 5–10 per cent over project budget. • Schedule slippage. • Key 'political' goal is marginally below target or is soon projected to deteriorate beyond acceptable limits or	• Non-compliance with national 10–25 per cent over project budget. • Schedule slippage. • Key 'political' target not being achieved, and impact prevents	• Incident leading >25 per cent over project budget. • Schedule slippage. • Key objectives not met. • Key 'political' target is not being achieved

Appendix C

Risk Domains	1 Minor	2 Moderate	3 Serious	4 Major	5 Catastrophic
		future or performance currently on target, but there is no agreed plan to meet the target.	there is an agreed plan, but it does not yet meet the rising target.	improvement, or substantial decline in performance trend.	and the impact further deteriorates the position.
Patient Safety and Outcomes • Quality • Medicines • Pharmacy • Patient Experience • Health Outcomes • Health Inequalities	• Peripheral element of treatment or service suboptimal • Informal complaint/ • Inquiry.	• Overall treatment or service suboptimal. • Formal complaint stage 1. • Local resolution • Single failure to meet internal standards. • Minor implications for patient safety if unresolved. • Reduced performance rating if unresolved.	• Treatment or service has significantly reduced effectiveness. • Formal complaint stage 2. • Local resolution (with potential to go to independent review). • Repeated failure to meet internal standards. • Major patient safety implications if findings are not acted on.	• Non-compliance with national standards with significant risk to patients if unresolved. • Multiple complaints/ independent review. • Low performance rating. • Critical report.	• Unacceptable level or quality of treatment/ service. • Gross failure of patient safety if findings not acted on. • Inquest / ombudsman inquiry. • Gross failure to meet national standards.
People May include, but not limited to, risks linked to: • Workforce • Human resources / Organisational Development • Staffing / Competence	• Short-term low staffing level that temporarily • Reduces service quality (< 1 day).	• Low staffing level that reduces the service quality.	• Late delivery of key objective / service due to lack of staff. • Unsafe staffing level or competence (>1 day). • Low staff morale. • Poor staff attendance for mandatory training.	• Uncertain delivery of key objective / service due to lack of staff. • Unsafe staffing level or competence (>5 days). • Loss of key staff. • Very low staff morale. • No staff attending mandatory training.	• Non-delivery of key objective / service due to lack of staff. • Ongoing unsafe staffing levels or competence. • Loss of several key staff. • Staff unable to attend mandatory training on ongoing basis.

Appendix C

Risk Domains	1 Minor	2 Moderate	3 Serious	4 Major	5 Catastrophic
Reputation May include, but not limited to, risks linked to: • Reputation • Adverse publicity • Engagement	• Rumours. • Potential for public concern.	• Local media coverage – short-term reduction in public confidence. • Elements of public expectation not being met.	• Local media coverage – • long-term reduction in public confidence.	• National media coverage with <3 days service well below reasonable public expectation.	• National media coverage with >3 days service well below reasonable public expectation. • MP concerned (questions in the House). • Total loss of public confidence.
Social and Economic Development May include, but not limited to, risks linked to: • Environmental	• Minimal or no impact on the environment.	• Minor impact on environment.	• Moderate impact on environment.	• Major impact on environment.	• Catastrophic impact on environment.
Strategy May include, but not limited to, risks linked to: • Transformation	• Insignificant cost increase/ schedule slippage. • Key 'political' target is being achieved and impact prevents improvement.	• <5 per cent over project budget. • Schedule slippage. • Key 'political' target is being achieved but impact reduces performance marginally below target in the near future or performance currently on target, but there is no agreed plan to meet the target.	• 5–10 per cent over project budget. • Schedule slippage. • Key 'political' goal is marginally below target or is soon projected to deteriorate beyond acceptable limits or there is an agreed plan, but it does not yet meet the rising target.	• Non-compliance with national 10–25 per cent over project budget. • Schedule slippage. • Key 'political' target not being achieved, and impact prevents improvement, or substantial decline in performance trend.	• Incident leading >25 per cent over project budget. • Schedule slippage. • Key objectives not met. • Key 'political' target is not being achieved and the impact further deteriorates the position.

Appendix C

Table 2: Likelihood Score (L)

Category	Likelihood Scoring				
Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare / Almost Impossible**	**Possible**	**Likely**	**Very Likely**	**Almost Certain**
Frequency / How likely is it to happen?	Event very rare, only occur in exceptional circumstances. Less than 20% chance of event happening.	The event may occur at some time. 21% - 40% chance of event happening.	The event is likely to occur at some time. 41% - 60% chance of event happening.	The event will occur in most circumstances. 61% - 80% chance of event happening.	This event is expected to occur in most circumstances. 81% to 99% of chance of this occurring.

Appendix C

Table 3: Impact (I) x Likelihood (L) Risk Matrix

Appendix D

Risk Review Checklist

Element	Guidance	Findings (with prompts)
Risk Description	Think about the reader when formulating the description, a clear and concise description helps the reader to understand what the risk is. A description includes: **CAUSE:** 'As a result of ….' (what will cause the risk to occur?) **EVENT:** 'There is a risk ….' (what can go wrong?) **EFFECT:** 'Which may lead to ….' (what will be the consequence/effect if the risk were to materialise?)	*Q: Does the description follow the above format?*
Controls	A control is a process, policy, device, or action that acts to minimise risk and describes what is in place to reduce or manage the risk. **PLEASE REMEMBER PLANNED ACTIONS ARE NOT CONTROLS**	Q: Are any controls identified? Q: Are your controls up to date?
Gaps in Control	It is essential you consider what controls may be missing (not recorded) that would help to manage the risk.	Q: For all instances of negative assurance, do you have a corresponding ACTION to close the gap in control.
Actions	An action will exist where you have a gap in control and completion of actions should provide assurance, strengthen existing controls, or add new controls. All gaps in control and gaps in assurance require an ACTION to close the gap.	Q: Are you confident the actions will be delivered and on time? Q: Is the action owner the right action owner? Q: Is the action owner aware they have this action assigned to them?
Initial Risk Score	This was the score evaluated when the risk was first recorded.	Q: Are you confident the initial risk score was reflective of the risk when recorded?
Current Risk Score	It is essential to consider the likelihood of the consequence being realised (see risk description - **EFFECT:** *'Which may lead to ….*') in light of the existing controls and assurances.	Q: Does the current score consider all the controls and assurances? Q: Have you used the risk scoring guidance? Q: Have you evaluated the evidence to quantify the risk?

Appendix E

Three Lines of Defence Model

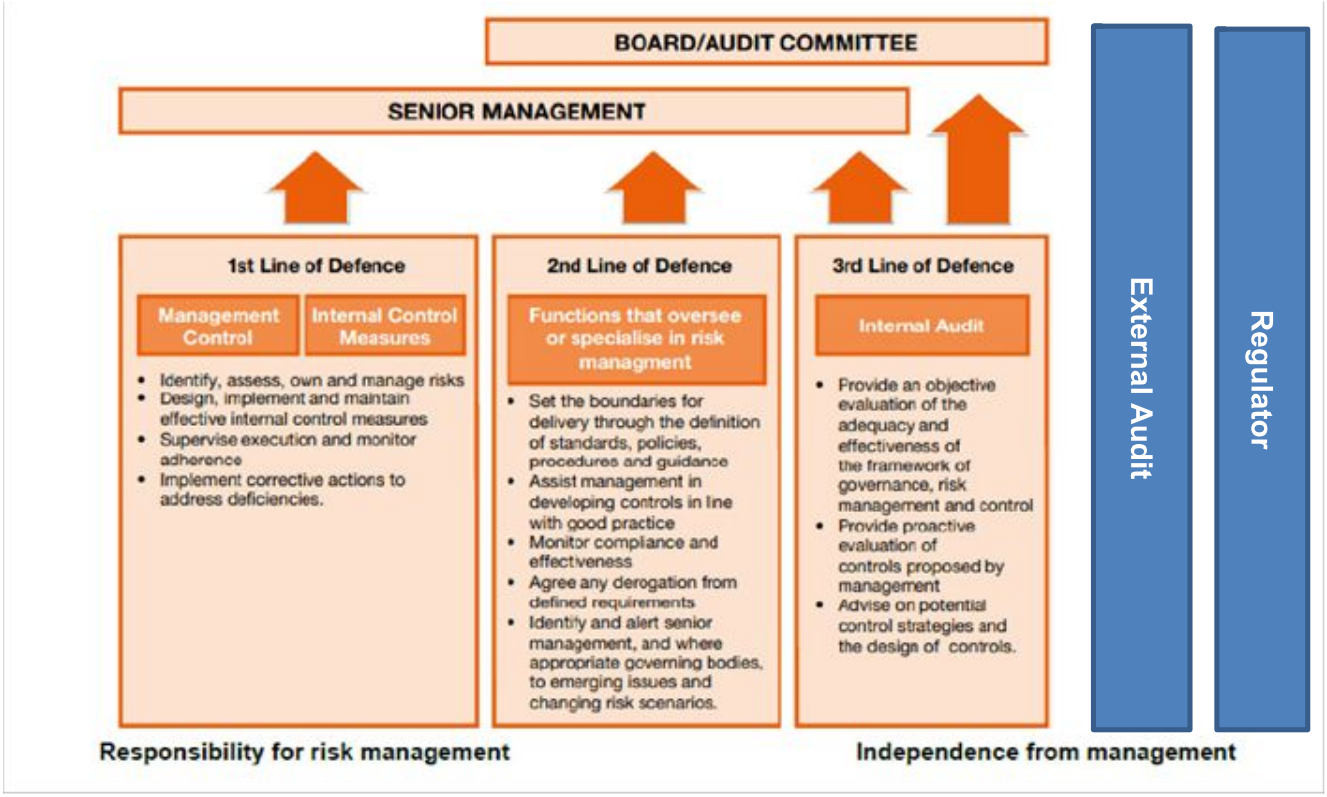


Figure 3 - Three Lines of Defence Model

Everyone in the organisation has some responsibility for risk management. The “three lines of defence” model provides a simple and effective way to help delegate and coordinate risk management roles and responsibilities within and across the organisation.

1. First line of defence

1.2 Under the “first line of defence,” management have primary ownership, responsibility and accountability for identifying, assessing and managing risks. Their activities create and/or manage the risks that can facilitate or prevent an organisation’s objectives from being achieved.

1.3 The first line ‘own’ the risks and are responsible for execution of the organisation’s response to those risks through executing internal controls on a day-to-day basis and for implementing corrective actions to address deficiencies.

1.4 Through a cascading responsibility structure, managers design, operate and improve processes, policies, procedures, activities, devices, practices, or other conditions and/or actions that maintain and/or modify risks and supervise effective execution.

1.5 There should be adequate managerial and supervisory controls in place to ensure compliance and to highlight control breakdown, variations in or inadequate processes and unexpected events, supported by routine performance and compliance information.

Appendix E

2. Second line of defence

2.1. The second line of defence consists of functions and activities that monitor and facilitate the implementation of effective risk management practices and facilitate the reporting of adequate risk related information up and down the organisation. The second line should support management by bringing expertise, process excellence, and monitoring alongside the first line to help ensure that risks are effectively managed.

2.2. The second line should have a defined and proportionate approach to ensure requirements are applied effectively and appropriately. This would typically include compliance assessments or reviews conducted to determine that standards, expectations, policy and/or regulatory considerations are being met in line with expectations across the organisation.

3. Third line of defence

3.1. Internal audit forms the organisation's "third line of defence." An independent internal audit function will, through a risk-based approach to its work, provide an objective evaluation of how effectively the organisation assesses and manages its risks, including the design and operation of the "first and second lines of defence."

3.2. It should encompass all elements of the risk management framework and should include in its potential scope all risk and control activities.

3.3. Internal audit may also provide assurance over the management of cross organisational risks and support the sharing of good practice between organisations, subject to considering the privacy and confidentiality of information.

4. External / Fourth line of defence

4.1. Sitting outside of the organisation's own risk management framework and the three lines of defence, are a range of other sources of assurance that support an organisation's understanding and assessment of its management of risks and its operation of controls.

4.2. The tend to be external independent bodies such as the external auditors and regulators.

4.3. External bodies may not have the existing familiarity with the organisation that an internal audit function has, but they can bring a new and valuable perspective. Additionally, their outsider status is clearly visible to third parties, so that they can not only be independent but be seen to be independent.

Adapted from HM Treasury Orange Book - More information is available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/866117/6.6266_HMT_Orange_Book_Update_v6_WEB.PDF

Appendix F: Equality Impact Assessment

Overall Impact on: **Equality, Inclusion and Human Rights** **[Select one option]**	**Positive ☐ Neutral ☒** **Negative ☐ Undetermined ☐**

Name of Policy, Process, Strategy or Service Change	Risk Management Policy	**Date of Completion**	August 2023
EIA Responsible Person Include name, job role and contact details.	Sian Gascoigne, Head of Corporate Assurance Email: sian.gascoigne@nhs.net		
EIA Group Include the name and position of all members of the EIA Group.			
Wider Consultation Undertaken State who, outside of the project team, has been consulted around the EIA.	None		
Summary of Evidence Provide an overview of any evidence (both internal and external) that you utilised to formulate the EIA. E.g., other policies, Acts, patient feedback, etc.	Equality Act 2010		

For the policy, process, strategy or service change, and its implementation, please answer the following questions against each of the Protected Characteristics, Human Rights and health groups:	What are **the actual, expected or potential positive impacts** of the policy, process, strategy or service change?	What are the **actual, expected or potential negative impacts** of the policy, process, strategy or service change?	What **actions have been taken** to address the actual or potential **positive and negative impacts** of the policy, process, strategy or service change?	What, if any**, additional actions should be considered** to ensure the policy, process, strategy or service change is as inclusive as possible? Include the **name and contact details** of the person responsible for the actions.	**Impact Score**
Age	There are no actual or expected positive impacts on the characteristic of Age.	There are no actual or expected negative impacts on the characteristic of Age.	None.	None.	3
Disability[1] (Including: mental, physical, learning, intellectual and neurodivergent)	There are no actual or expected positive impacts on the characteristic of Disability.	There are no actual or expected negative impacts on the characteristic of Disability.	None.	None.	3
Gender[2] (Including: trans, non-binary and gender reassignment)	There are no actual or expected positive impacts on the characteristic of Gender.	There are no actual or expected negative impacts on the characteristic of Gender.	None.	None.	3
Marriage and Civil Partnership	There are no actual or expected positive impacts on the characteristic of Marriage and Civil Partnership.	There are no actual or expected negative impacts on the characteristic of Marriage and Civil Partnership.	None.	None.	3

Pregnancy and Maternity Status	There are no actual or expected positive impacts on the characteristic of Pregnancy and Maternity Status.	There are no actual or expected negative impacts on the characteristic of Pregnancy and Maternity Status.	None.	None.	3
Race[3]	There are no actual or expected positive impacts on the characteristic of Race.	There are no actual or expected negative impacts on the characteristic of Race.	None.	None.	3
Religion and Belief[4]	There are no actual or expected positive impacts on the characteristic of Religion or Belief.	There are no actual or expected negative impacts on the characteristic of Religion or Belief.	None.	None.	3
Sex[5]	There are no actual or expected positive impacts on the characteristic of Sex.	There are no actual or expected negative impacts on the characteristic of Sex.	None.	None.	3
Sexual Orientation[6]	There are no actual or expected positive impacts on the characteristic of Sexual Orientation.	There are no actual or expected negative impacts on the characteristic of Sexual Orientation.	None.	None.	3
Human Rights[7]	There are no actual or expected positive impacts on the characteristic of Human Rights.	There are no actual or expected negative impacts on the characteristic of Human Rights.	None.	None.	3
Community Cohesion and **Social Inclusion**[8]	There are no actual or expected positive impacts on the characteristic of	There are no actual or expected negative impacts on the characteristic of	None.	None.	3

	Community Cohesion and Social Inclusion.	Community Cohesion and Social Inclusion.			
Safeguarding[9] (Including: adults, children, Looked After Children and adults at risk or who lack capacity)	There are no actual or expected positive impacts on the characteristic of Safeguarding.	There are no actual or expected negative impacts on the characteristic of Safeguarding.	None.	None.	3
Other Groups at Risk[10] of Stigmatisation, Discrimination or Disadvantage	There are no actual or expected positive impacts on the characteristic of Other Groups at Risk.	There are no actual or expected negative impacts on the characteristic of Other Groups at Risk.	None.	None.	3

Additional Narrative
Provide additional evidence and narrative about the positive, negative, and neutral impacts of the proposal on the equality, inclusion and human rights elements detailed above.
You should consider:
• Three elements of Quality (safety, experience and effectiveness)
• Intersectionality
• Impact of COVID-19
• Access to Services
  ○ Physical
  ○ Written communication
  ○ Verbal communication
• Digital Poverty
• Safeguarding
• Dignity and Respect
• Person-centred Care
	Here you should add additional detail or explanation around the positive, negative, and neutral impact of the proposals on the above protected characteristic and health inclusion groups. To address this, you should consider the barriers to accessing or using the service, including the mitigations to respond to these.	

Positive Impact	Neutral Impact	Negative Impact	Undetermined Impact	Equality Impact Score Total	39
56 to 50	49 to 36	35 to 22	21 to 14		

Positive	Neutral	Negative	Undetermined
4	3	2	1

1. **Disability** refers to anyone who has: "…a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities…" (Equality Act 2010 definition). This includes, but is not limited to: mental health conditions, learning disabilities, intellectual disabilities, neurodivergent conditions (such as dyslexia, dyspraxia and dyscalculia), autism, many physical conditions (including HIV, AIDS and cancer), and communication difficulties (including d/Deaf and blind people).

2. **Gender**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: "A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex."

3. **Race**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: A person's colour, nationality, or ethnic or national origins. This also includes people whose first spoken language is not English, and/or those who have a limited understanding of written and spoken English due to English not being their first language.

4. **Religion and Belief**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: Religion means any religion and a reference to religion includes a reference to a lack of religion. Belief means any religious or philosophical belief and a reference to belief includes a reference to a lack of belief.

5. **Sex**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: A reference to a person who has a particular protected characteristic and is a reference to a man or to a woman.

6. **Sexual Orientation**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: Sexual orientation means a person's sexual orientation towards persons of the same sex, persons of the opposite sex or persons of either sex.

7. The **Human Rights Act 1998** sets out the fundamental areas that everyone and every organisation must adhere to. In relation to health and care, the most commonly applicable of the Articles within the Human Rights Act 1998 include: Article 2 Right to Life, Article 5 Right to Liberty and Security, Article 8 Right to Respect of Private and Family Life, and Article 9 Freedom of Thought, Conscience and Religion.

8. **Community Cohesion** is having a shared sense of belonging for all groups in society. It relies on criteria such as: the presence of a shared vision, inclusion of those with diverse backgrounds, equal opportunity, and supportive relationships between individuals. **Social Inclusion** is defined as the process of improving the terms of participation in society, particularly for people who are disadvantaged, through enhancing opportunities, access to resources, voice and respect for rights (United Nations definition). For the EQIA process, we should note any positive or negative impacts on certain groups being excluded or not included within a community or societal area. For example, people who are homeless, those from different socioeconomic groups, people of colour or those from certain age groups.

9. **Safeguarding** means: "…protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care. Safeguarding children, young people and adults is a collective responsibility" (NHS England definition). Those most in need of protection are children, looked after children, and adults at risk (such as those receiving care, those under a DoLS or LPS Order, and those with a mental, intellectual or physical disability). In addition to the ten types of abuse set out in the Health and Care Act 2022, this section of the EQIA should also consider PREVENT, radicalisation and counterterrorism.

10. **Other Groups** refers to anyone else that could be positively or negatively impacted by the policy, process, strategy or service change. This could include, but is not limited to: carers, refugees and asylum seekers, people who are homeless, gypsy, Roma and traveller communities, people living with an addiction (e.g., alcohol, drugs or gambling), people experiencing social or economic deprivation, and people in stigmatised occupations (e.g., sex workers).

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/09/2023
Paper Title:	**Remuneration Committee Highlight Report**
Paper Reference:	ICB 23 047
Report Author:	Committee Secretariat
Report Sponsor:	Jon Towler, Committee Chair
Presenter:	Jon Towler, Committee Chair

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

Summary:

This report presents an overview of the meetings held by the Remuneration Committee meetings held on 5 June and 24 July 2023. The report aims to provide assurance that the committee is effectively discharging its delegated duties and highlight key messages for the Board's attention.

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:

Appendix A: High-level operational risk being monitored by the Remuneration Committee

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 highlight report.

Report Previously Received By:

Not applicable.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?
No.

Remuneration Committee Highlight Report

Meeting Dates:	**05 June and 24 July 2023**
Committee Chair:	**Jon Towler, Non-Executive Director**

Summary of discussions and decisions made:

At these meetings, the Committee:

- Approved Chief Executive, Executive Director and VSM pay awards for 2022 and 2023, in line with national direction. This included approving the remuneration for two new roles in the Integration Directorate (created from the current establishment).
- Approved existing pay rates for Clinical Advisors and Clinical Reviewers that transferred from NHS England to the ICB (as the host employing organisation) on 01 July 2023, pending a detailed review to be concluded by 31 March 2024.
- Approved the disestablishment of the Human Resources Executive Sub-Committee and supported the establishment of an executive-led HR Steering Group. This was agreed following a review of the arrangements which concluded that the work of the Sub-Committee had transpired to be mostly concerned with overseeing and directing the day-to-day operational delivery of HR arrangements in place across the ICB. An executive-led HR steering group will be established in its place, with the Remuneration Committee receiving comprehensive workforce assurance reports to ensure ongoing fulfilment of its formal HR responsibilities and oversight of HR risks. There is currently one high-scoring risk within the Committee's responsibilities, which is provided for information at Appendix A.
- Discussed the proposed approach to ICB succession planning but asked for clarity regarding required investment and the inclusion of measures of success to the process. The approach to individual talent management would be confirmed once expected guidance had been published nationally.

The Committee also received:

- Updates on existing employee relations matters; and
- An update on the Chair and Chief Executive Appraisal framework from NHS England. Further clarity would be sought regarding any further reporting requirements to the Remuneration Committee.

Appendix A – High-level Operational Risk Being Monitored by the Remuneration Committee

Risk Ref.	Risk Description	Current Score
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)

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/09/2023
Paper Title:	**Integrated Performance Report**
Paper Reference:	ICB 21 048
Report Author:	Sarah Bray, Associate Director of Performance and Assurance
Report Sponsor:	Stuart Poynor, Director of Finance
Presenter:	N/A – Item for information only

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.

The report provides further detail on the narrative reports presented at items 13 and 16.

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	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:

Integrated performance Report

Board Assurance Framework:

Not applicable

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.

NHS
Nottingham and Nottinghamshire

Nottingham & Nottinghamshire Integrated Care Board

Integrated Performance Report

Reporting Month: July/August 2023

Board Month: September 2023

Integrated Performance Report 2023/24 – Report Contents

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 2023/24, compliance and commitment targets, and any additional key local and national measures.

The intention is that each ICS Oversight Group, which is led by an ICB Executive Lead, will propose a level of assurance following the discussion of the reported metrics based upon the ICS Assurance Escalation Framework (page 80) which will support the escalation of issues to the ICB Board.

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 81 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. At the end of month four, the NHS System reported a £41.6 million deficit position, which is £27.6 million adverse to plan. The adverse variance is experienced in the all the system providers. Industrial action from Junior Doctors and Consultants has significantly constrained the elective activity 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 13 – 77.

NHS Nottingham and Nottinghamshire

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

AIM-01	Improve Outcomes in Population Health and Healthcare						
ID	Key Performance Indicators	Date	Plan	Actual	In Month	Variation	Assurance
	Quality						
	LD&A Annual Health Checks	Jul-23	1156	1143	✗	-	-
	LD&A Inpatients - ICB	Jul-23	14	12	✓	-	-
	LD&A Inpatients - NHS England	Jul-23	30	34	✗	-	-
	LD&A Inpatients - CYP (NHSE)	Jul-23	3	4	✗	-	-
	No. Personal Health Budgets	Q1 23/24	2175	2538	✓	-	-
	No. stillbirths per 1000 total births	Jun-23	8.4	3.9	✓	-	-
	No. neonatal deaths per 1000 live births	Jun-23	5.2	5.1	✓	-	-
	MRSA	Jul-23	0	0	✓	-	-
	CDI	Jul-23	22	17	✓	-	-
	Ecoli BSI	Jul-23	72	85	✗	-	-
	Klebseilla BSI	Jul-23	21	24	✗	-	-
	Pseudomonas BSI	Jul-23	6	11	✗	-	-
	% Over 65s Flu Vaccinations	Feb-23	-	82.1%	-	-	-
	Planned Care						
	Extended Waits > 78 weeks	Jun-23	0	60	✗		
	Urgent Care						
	12 hour delays from arrival in ED	Jul-23	0	811	✗		
	Handover delays > 60 minutes	Jul-23	0	704	✗		
	Length of Stay > 21 days	Jul-23	398	377	✓		

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	Jul-23	-14.0	-41.6		✗ 27.6	✓ 0.0
	Efficiency Target	Jul-23	34.9	29.8		✗ -5.1	✓ 2.0
	ERF Income	Jul-23	36.4	36.4		✓ 0.0	✓ 0.0
	Agency Spend	Jul-23	-	32.2		-	✓ 3.1
	MHIS	Jul-23	-	67.9		-	✓ 0.0
	Capital Spend (Plan)	Jul-23	29.0	25.4		✓ -3.6	✗ 5.0

AIM-04	Support Broader Social and Economic Development						
ID	Key Performance Indicators	Date	Plan	Actual	In Month	Variation	Assurance
	Provider Substantive Staffing	Jul-23	30,354	30,706	✗		
	Provider Bank Staff	Jul-23	1,812	1,944	✗		
	Provider Agency Staff	Jul-23	1,049	967	✓		
	Provider Staff Turnover	Jul-23	12.5%	8.0%	✓	-	-
	Provider Staff Sickness Absence	Jul-23	5.4%	5.2%	✓	-	-
	Primary Care Workforce*	Jun-23	3539	3604	✗		

* Quarterly target figures requested in the Operational Plan Submission

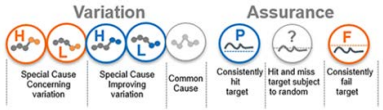
AIM-02	Tackle Inequalities in Outcomes, Experience and Access												
		Population						Provider View				
ID	Key Performance Indicators	Date	Plan	Actual	In Month	Variation	Assurance	Plan	Actual	In Month	Variation	Assurance
	Planned Care											
	Total Waiting lists	Jun-23	124545	137602	✗			115637	132440	✗		
	Patients Waiting >65 weeks	Jun-23	1929	1031	✓			887	944	✗		
	Referral to Treatment Pathway +18 weeks	Jun-23	-	44611	-	-	-	-	49384	-	-	-
	Elective Value Weighted Activity	To be included in future reports										
	Outpatient Follow-up Reductions	Jun-23	58602	64548	✗			70430	61504	✓		
	Diagnostics +6 weeks Wait	Jun-23	10780	8278	✓			9637	9207	✓		
	Cancer 2 week waits	Jun-23	-	-	-			93%	89%	✗		
	Cancer 31 Day First Treatment	Jun-23	96%	90%	✗			96%	88%	✗		
	Cancer 62 Day Performance (85%)	Jun-23	85%	65%	✗			85%	62%	✗		
	Cancer 62 Day Backlog	Jun-23	-	-	-	-	-	390	373	✓		
	Cancer Faster Diagnosis	Jun-23	75%	78%	✓			75%	78%	✓		
	Urgent Care											
	Ambulance Cat 1 Response (mean)	Jul-23	00:07:00	00:07:48	✗			-	-	-	-	-
	Ambulance Cat 2 Response (mean)	Jul-23	00:18:00	00:31:01	✗			-	-	-	-	-
	ED 4 hour waits	Jul-23	-	-	-	-	-	62.3%	62.6%	✓	-	-
	% Beds Occupied with no criteria to reside	-	-	-	-	-	-	-	-	-	-	-
	% Bed Occupancy	Jul-23	-	-	-	-	-	91.02%	90.20%	✗	-	-
	Community											
	Community Waits - Adult	Jun-23	8351	11187	✗			-	-	-	-	-
	Community Waits - CYP	Jun-23	1938	2117	✗			-	-	-	-	-
	Primary Care											
	GP Appointments	Jul-23	555052	596524	✓			-	-	-	-	-
	GP Appointments < 14 days (85%)	Jul-23	85%	78%	✗			-	-	-	-	-
	% Units of Dental Activity	To be included in future reports						-	-	-	-	-
	NHS App	Jul-23	60%	53%	✗			-	-	-	-	-
	Mental Health											
	Talking Therapies Access	May-23	8009	5275	✗			-	-	-	-	-
	Talking Therapies Recovery Rate	May-23	50%	49%	✗			-	-	-	-	-
	Dementia Diagnosis Rates	Jun-23	67%	70%	✓			-	-	-	-	-
	Perinatal Access	May-23	1298	1180	✗			-	-	-	-	-
	Individual Placement Support Access	Jun-23	282	495	✓			-	-	-	-	-
	EIP < 2 weeks referral	May-23	60%	84%	✓			-	-	-	-	-
	CYP Access	May-23	15800	17740	✓			-	-	-	-	-
	Out of Area Placements	May-23	0	300	✗			-	-	-	-	-
	SMI Physical Health Checks	Jul-23	7029	4615	✗			-	-	-	-	-
	SMI Access to Community Services	May-23	14000	13890	✗			-	-	-	-	-
	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 – July 2023	Latest Period	Plan	Actual	Variance	Exception Report
Learning Disability & Autism					
LD&A Inpatients Rate Adults - ICB	Jul-23	14	12	-2	Section 01
LD&A Inpatients Rate Adults - NHSE	Jul-23	30	34	4	
LD&A Inpatients Rate CYP - NHSE	Jul-23	3	4	1	
LD&A Annual Health Checks	Jul-23	1156	1143	-13	
Personalisation					
No. of Personal Health Budgets	Q1 23/24	2175	2538	363	Section 02
No. Social prescribing referrals into link workers	Q1 23/24	3927	3703	-224	
No. active PCSPs in place	Q1 23/24	7500	6092	-1408	
Maternity					
No. stillbirths per 1000 total births	Jun-23	8.4	3.9	-4.5	Section 04
No. neonatal deaths per 1000 live births	Jun-23	5.2	1.1	-4.1	
Hospital Acquired Infections					
MRSA	Jul-23	0	0	0	Section 07
C-Diff	Jul-23	22	17	5	
Ecoli BSI	Jul-23	72	85	-13	
Klebseilla BSI	Jul-23	21	24	-3	
Pseudomonas BSI	Jul-23	6	11	-5	



NHS Nottingham and Nottinghamshire

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

Pre-Hospital Flow Volumes

Population							Provider						
Name	Latest Period	Plan	Actual	Variance	V	A	Name	Latest Period	Plan	Actual	Variance	V	A
EMAS Calls - ICB Population	Jul-23	25272	22620	✓ -2652			EMAS Calls - ICB Provider	-	-	-	-		
111 Calls Answered - ICB Population	Jun-23	-	29385	-			111 Calls Answered - ICB Provider	-	-	-	-		

Pre-Hospital - Alternatives to ED

Name	Latest Period	Plan	Actual	Variance	V	A	Name	Latest Period	Plan	Actual	Variance	V	A
Urgent Care Response (UCR) - ICB Population	Jun-23	286	1363	✓ 1077			Urgent Care Response (UCR) - ICB Provider	-	-	-	-		
UCR Response % - ICB Population	Jun-23	70.0%	96.1%	✓ 26.1%			UCR Response % - ICB Provider	-	-	-	-		

Front Door - Flow Volumes

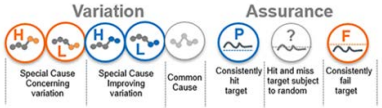
Name	Latest Period	Plan	Actual	Variance	V	A	Name	Latest Period	Plan	Actual	Variance	V	A
Ambulance Conveyances to ED (Vol)	Jul-23	8762	7648	✓ -1114			Ambulance Conveyances to ED (Vol)	-	-	-	-		
Ambulance Conveyances to ED (%)	Jul-23	51.2%	51.2%	✗ 0.0%			Ambulance Conveyances to ED (%)	-	-	-	-		
Total A&E Attendances - ICB Population	Jun-23	-	38041	-			Total A&E Attendances - ICB Provider	Jun-23	33143	33698	✗ 555		

In-Hospital Flow

Name	Latest Period	Plan	Actual	Variance	V	A	Name	Latest Period	Plan	Actual	Variance	V	A
Total NEL admissions - ICB Population	Jun-23	-	10755	-			Total NEL admissions - ICB Provider	Jun-23	12102	11348	✓ -754		
NEL Conversion Rate from ED Atds - %	-	-	-	-			NEL Conversion Rate from ED Atds - %	-	-	-	-		
SDEC % of Total Admissions - ICB Population	-	-	-	-			SDEC % of Total Admissions - ICB Provider	Jun-23	33.0%	34.0%	✓ 1.0%		
% Bed Occupancy - ICB Population	-	-	-	-			% Bed Occupancy - ICB Provider	Jul-23	-	90.2%	-		

Flow out of Hospital

Name	Latest Period	Plan	Actual	Variance	V	A	Name	Latest Period	Plan	Actual	Variance	V	A
Number of MSFT > 24 Hours	-	-	-	-			Number of MSFT > 24 Hours	Jul-23	214	252	✗ 38		
No Criteria to Reside	Jun-23	328	446	✗ 118			No Criteria to Reside	Jun-23	328	332	✗ 4		
Length of Stay > 21 days	-	-	-	-			Length of Stay > 21 days	Jul-23	398	377	✓ -21		
Pthy 0 - Discharges Home	Jul-23	7173	10431	✓ 3258			Pthy 0 - Discharges Home	-	-	-	-		
Pthy 1 - Disch home w/ hlth and/or social care	Jul-23	1212	829	✗ -383			Pthy 1 - Disch home w/ hlth and/or social care	-	-	-	-		
No. Patients utilising Virtual Ward	Jul-23	155	55	✗ -100			No. Patients utilising Virtual Ward	-	-	-	-		



3a. Service Delivery Scorecard - Urban Care Compliance

NHS Nottingham and Nottinghamshire

Population

EMAS Performance Compliance

Name	Latest Period	Plan	Actual	Variance	V	A
Ambulance (mean) resp time Cat 1 (Notts)	Jul-23	00:07:00	00:07:48	✗ 00:00:48		
Ambulance (mean) resp time Cat 2 (Notts)	Jul-23	00:18:00	00:31:01	✗ 00:13:01		
% Cat 2 waits below 40 minutes (Notts)	Jul-23	90.0%	61.8%	✗ -28.2%		
Ambulance resp time Cat 3 - 90th Centile *	Jul-23	02:00:00	05:27:25	✗ 03:27:25		
Ambulance resp time Cat 4 - 90th Centile *	Jul-23	03:00:00	04:17:18	✗ 01:17:18		

Acute Performance Compliance

Name	Latest Period	Plan	Actual	Variance	V	A
Hospital Handover Delays > 30 Minutes	Jul-23	-	2523	-		
Hospital Handover Delays > 60 minutes	Jul-23	-	715	-		
Ambulance Total Hours Lost	Jul-23	-	2038:31:06	-		
A&E 4hr % Perf (All)	-	-	-	-		
12 Hour Breaches ED	-	-	-	-		
12 Hour Breaches as % ED Atds	-	-	-	-		

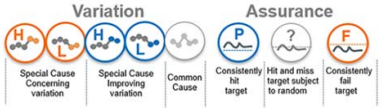
Provider

EMAS Performance Compliance

Name	Latest Period	Plan	Actual	Variance	V	A
Ambulance (mean) resp time Cat 1 (Notts)	-	-	-	-		
Ambulance (mean) resp time Cat 2 (Notts)	-	-	-	-		
% Cat 2 waits below 40 minutes (Notts)	-	-	-	-		
Ambulance resp time Cat 3 - 90th Centile *	-	-	-	-		
Ambulance resp time Cat 4 - 90th Centile *	-	-	-	-		

Acute Performance Compliance

Name	Latest Period	Plan	Actual	Variance	V	A
Hospital Handover Delays > 30 Minutes	Jul-23	-	2359	-		
Hospital Handover Delays > 60 minutes	Jul-23	0	704	✗ 704		
Ambulance Total Hours Lost	Jul-23	-	1927:19:53	-		
A&E 4hr % Perf (All)	Jul-23	62.3%	62.6%	✓ 0.4%		
12 Hour Breaches ED	Jul-23	0	811	✗ 811		
12 Hour Breaches as % ED Atds	Jul-23	2.0%	2.4%	✗ 0.4%		



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	Jun-23	124545	137602	✗ 13057		
Incomplete RTT pathways >52 Wks	Jun-23	5329	4570	✓ -759		
Incomplete RTT pathways >65 Wks	Jun-23	1929	1031	✓ -898		
Incomplete RTT pathways >78 Wks	Jun-23	0	69	✗ 69		

Provider

Name	Latest Period	Plan	Actual	Variance	V	A
Total Waiting List Size	Jun-23	115637	132440	✗ 16803		
Incomplete RTT pathways >52 Wks	Jun-23	3220	4374	✗ 1154		
Incomplete RTT pathways >65 Wks	Jun-23	887	944	✗ 57		
Incomplete RTT pathways >78 Wks	Jun-23	0	64	✗ 64		

Elective Recovery - Activity

Population

Name	Latest Period	Plan	Actual	Variance	V	A
Total Referrals	Jun-23	-	27823	-		
Total Ordinary Electives	Jun-23	2216	2078	✗ -138		
Total Daycases	Jun-23	13589	14395	✓ 806		
Total Outpatients 1st (Spec Acute)	Jun-23	27549	26908	✗ -641		
Total Outpatients FUp (Spec Acute)	Jun-23	58602	64548	✓ 5946		
Total Diagnostic Activity	Jun-23	38616	32412	✗ -6204		

Provider

Name	Latest Period	Plan	Actual	Variance	V	A
Total Referrals	Jun-23	-	25073	-		
Total Ordinary Electives	Jun-23	2897	2041	✗ -856		
Total Daycases	Jun-23	14090	13606	✗ -484		
Total Outpatients 1st (Spec Acute)	Jun-23	28253	23950	✗ -4303		
Total Outpatients FUp (Spec Acute)	Jun-23	70430	61504	✗ -8926		
Total Diagnostic Activity	Jun-23	32835	32509	✗ -326		

Elective Recovery - Productivity & Transformation

Population

Name	Latest Period	Plan	Actual	Variance	V	A
Total Outpatients - Virtual(%)	Jun-23	25.0%	18.0%	✗ -7.0%		
Patient Initiated Fups (%)	-	-	-	-		
Advice and Guidance (% of 1st OP)	Jun-23	32	30	✗ -2		
Completed Adm RTT Pathways	Jun-23	5826	4889	✗ -937		
Completed Non-Adm RTT Pathways	Jun-23	25208	25531	✓ 323		

Provider

Name	Latest Period	Plan	Actual	Variance	V	A
Total Outpatients - Virtual(%)	Jun-23	25.0%	18.6%	✗ -6.4%		
Patient Initiated Fups (%)	Jun-23	5.0%	5.1%	✓ 0.1%		
Advice and Guidance (% of 1st OP)	Jun-23	-	24	-		
Completed Adm RTT Pathways	Jun-23	6440	4360	✗ -2080		
Completed Non-Adm RTT Pathways	Jun-23	23657	23687	✓ 30		

Diagnostic Recovery

Population

Name	Latest Period	Plan	Actual	Variance	V	A
Total Diagnostic Activity	Jun-23	38616	32412	✗ -6204		
Diagnostic Waiting List	Jun-23	28409	25000	✓ -3409		
Diagnostic Backlog	Jun-23	10780	8278	✓ -2502		
Diagnostics +6 Wks	Jun-23	37.9%	33.1%	✓ -4.8%		

Provider

Name	Latest Period	Plan	Actual	Variance	V	A
Total Diagnostic Activity	Jun-23	32835	32509	✗ -326		
Diagnostic Waiting List	Jun-23	27869	26645	✓ -1224		
Diagnostic Backlog	Jun-23	9637	9207	✓ -430		
Diagnostics +6 Wks	Jun-23	34.6%	34.6%	✓ 0.0%		

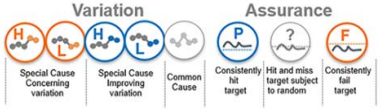
Cancer Recovery

Population

Name	Latest Period	Plan	Actual	Variance	V	A
Cancer 2ww %	-	-	-	-		
Cancer - Faster Diag Std 28 Days	Jun-23	75.0%	77.8%	✓ 2.8%		
Cancer - No. 1st Definitive Treatments	Jun-23	-	543	-		
Cancer - No.receiving 1st Trt <31 days %	Jun-23	96.0%	89.5%	✗ -6.5%		
Cancer - No. patients waiting <62 days %	Jun-23	85.0%	64.6%	✗ -20.4%		
Cancer - 62 day backlog	-	-	-	-		

Provider

Name	Latest Period	Plan	Actual	Variance	V	A
Cancer 2ww %	Jun-23	93.0%	89.4%	✗ -3.6%		
Cancer - Faster Diag Std 28 Days	Jun-23	75.0%	78.1%	✓ 3.1%		
Cancer - No. 1st Definitive Treatments	Jun-23	-	655	-		
Cancer - No.receiving 1st Trt <31 days %	Jun-23	96.0%	87.6%	✗ -8.4%		
Cancer - No. patients waiting <62 days %	Jun-23	85.0%	62.0%	✗ -23.0%		
Cancer - 62 day backlog	Jun-23	390	373	✓ -17		



NHS Nottingham and Nottinghamshire

3c. Service Delivery - Mental Health Scorecard

Population

Mental Health - Talking Therapies (Previously IAPT)

Name	Latest Period	Plan	Actual	Variance	V	A
Talking Therapies - Referrals	May-23	-	2670	-		
Talking Therapies- 1st Treatment <6 Weeks	May-23	75.0%	89.2%	✓ 14.2%		
Talking Therapies- 1st Treatment <18 Weeks	May-23	95.0%	99.5%	✓ 4.5%		
Talking Therapies - Entering Treatment (3mth)	May-23	8009	5275	✗ -2734		
Talking Therapies- >90 Days 1st & 2nd Treatment	May-23	10.0%	44.9%	✗ 34.9%		
Talking Therapies- Recovery Rate (3mth Rolling)	May-23	50.0%	49.0%	✗ -1.0%		

Mental Health - Adult Mental Health

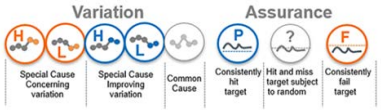
Name	Latest Period	Plan	Actual	Variance	V	A
Adult MH IP Discharges - % Fup 72 hours	Apr-23	80.0%	80.0%	✓ 0.0%		
Inappropriate OAP Bed days	May-23	0	300	✗ 300		
Rate per 100,000 Older Adult MH LOS > 90 Days	Apr-23	8	6	✓ -2		
SMI Health Checks	Jul-23	7029	4615	✗ -2414		
Access SMI +2 Contacts Community MH Services	May-23	14000	13890	✗ -110		
Dementia Diagnosis	Jun-23	66.7%	70.2%	✓ 3.5%		

Mental Health - Access

Name	Latest Period	Plan	Actual	Variance	V	A
Perinatal Access % (12 month rolling)	May-23	10.0%	9.1%	✗ -0.9%		
Perinatal Access - Volume	May-23	1298	1180	✗ -118		
Individual Placement Support	Jun-23	282	495	✓ 213		
Early Intervention in Psychosis (EIP)	May-23	60.0%	83.6%	✓ 23.6%		

Mental Health - Children & Young People

Name	Latest Period	Plan	Actual	Variance	V	A
CYP - New Referrals	May-23	-	1810	-		
CYP Eating Disorders - Routine Ref Perf (Qtr)	May-23	95.0%	83.0%	✗ -12.0%		
CYP Eating Disorders - Urgent Ref Perf (Qtr)	May-23	95.0%	100.0%	✓ 5.0%		
CYP Access (1+ Contact) (12 Mth Rolling)	May-23	15800	17740	✓ 1940		



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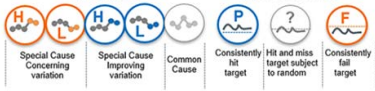
3d. Service Delivery – Primary & Community Scorecard

Population						
Primary Care and Community Recovery						
Name	Latest Period	Plan	Actual	Variance	V	A
Total Appointments	Jul-23	555052	596524	✔ 41472		
% Face to Face Appointments	Jul-23	-	70.6%	-		
% Same Day Appointments	Jul-23	-	41.9%	-		
% Pts able to book within 2 Weeks	Jul-23	-	77.8%	-		
Number of NHS App Registrations	Jul-23	60.0%	52.8%	✘ -7.2%		
Community Waiting List (0-17 years)	Jun-23	1938	2117	✘ 179		
Community Waiting List (18+ years)	Jun-23	8351	11187	✘ 2836		



4. Finance - Scorecard

Integrated Care System
Nottingham & Nottinghamshire

Indicator Measure	YTD Variance £m's			YE FOT Variance £m's			RAG	
	Plan	Acts	Variance	Plan/ Ceiling/ Envelope	FOT	Variance	YTD	FOT
Financial Sustanability (Variance from b/e)	-14.0	-41.6	**-27.6**	0.0	0.0	**0.0**		
Financial Efficiency Vs Plan	34.9	29.8	**-5.1**	192.7	194.7	**2.0**		
Achievement of MHIS		67.9		207.2	207.2	**0.0**		
Agency Spend Vs Ceiling		32.2		68.7	65.6	**3.1**		
Agency Spend - on framework compliance	100%	91%	**-9%**					
Agency Spend - price cap compliance	100%	59%	**-41%**					
Capital Spend Vs System Envelope	29.0	25.4	**-3.6**	100.6	105.7	**5.0**		
Elective perf not achieved above 105% target	36.4	36.4	**0.0**	102.6	102.6	**0.0**		

- £41.6m deficit experienced to end of month 4, which is £27.6m adverse to plan.
- The adverse variance is experienced in the all the system providers - £20m deficit in NUH, £1m in SFH and £4.7m at NHT.
- The ICB is reporting a deficit position of £1.9m as at month 4.
- At M4, the reported total system forecast was a break-even position against the break-even plan submitted.
- The ICB is forecasting spend to £207.2m MHIS target, which delivers achievement of the MHIS, with £67.9m spend to the end of month 4.
- Agency spend YTD is £32.2m. The forecast at M4 is £3.1m under the agency cap. The total agency plan is £5.8m below the system's agency ceiling.
- The system is reporting a 91% (YTD) of shifts being filled by agency as being compliant with on framework rules with 9 being off framework & non-compliant.
- The system is reporting a 59% (YTD) of shifts being filled by agency as being compliant with the price cap rules with 41% being non-compliant.
- The system has spent £25.4m of its capital envelope which is £3.6m 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.
- All ERF income including stretch targets at NUH & SFH is assumed to plan as per NHSE guidance at M4.

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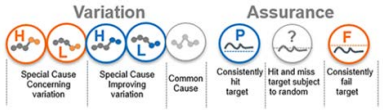
Nottingham and Nottinghamshire

5. Workforce - Scorecard

	Key Performance Indicators	Date	Plan	Actual	Variance
Workforce	Total WTE Substantive Workforce	Jul-23	30353.6	30705.9	352.3
	Bank Staff	Jul-23	1812.4	1943.5	131.1
	Agency Staff	Jul-23	1049.3	967.2	-82.1
	12 Month Rolling Average Sickness Absence %	Jul-23	5.40%	5.21%	-0.19%
	12 Month Rolling Average Staff Turnover %	Jul-23	12.50%	8.00%	-4.50%
	Total WTE Primary Care Workforce *	Jun-23	3539	3604	65
	* Quarterly target figures requested in the Operational Plan Submission				



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Quality

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

- 01 - Exception Report Learning Disability & Autism
- 02 - Exception Report Personalisation
- 03 - Exception Report Co-Production
- 04 - Exception Report Maternity
- 05 - Exception Report Vaccinations
- 06 - Exception Report Patient Safety
- 07 - Exception Report Infection Prevention & Control
- 08 - Exception Report Adult & Children Safeguarding
- 09 - Exception Report Looked After Children
- 10 - Exception Report Special Educational Needs and Disabilities
- 11 - Exception Report Children & Young People Additional Vulnerabilities

Reporting Period: 01 July 23 – 31 July 23

NHS Nottingham and Nottinghamshire

Quality Scorecard

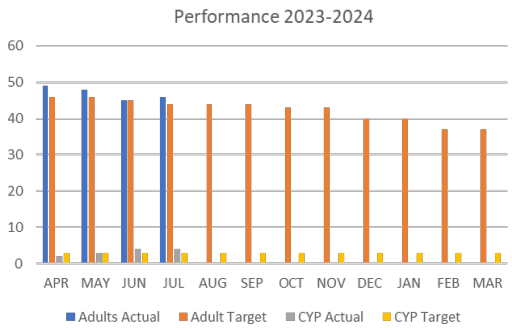
Quality Scorecard – July 2023	Latest Period	Plan	Actual	Variance	Exception Report
Learning Disability & Autism					
LD&A Inpatients Rate Adults - ICB	Jul-23	14	12	**-2**	Section 01
LD&A Inpatients Rate Adults - NHSE	Jul-23	30	34	**4**	
LD&A Inpatients Rate CYP - NHSE	Jul-23	3	4	**1**	
LD&A Annual Health Checks	Jul-23	1156	1143	**-13**	
Personalisation					
No. of Personal Health Budgets	Q1 23/24	2175	2538	**363**	Section 02
No. Social prescribing referrals into link workers	Q1 23/24	3927	3703	**-224**	
No. active PCSPs in place	Q1 23/24	7500	6092	**-1408**	
Maternity					
No. stillbirths per 1000 total births	Jun-23	8.4	3.9	**-4.5**	Section 04
No. neonatal deaths per 1000 live births	Jun-23	5.2	1.1	**-4.1**	
Hospital Acquired Infections					
MRSA	Jul-23	0	0	**0**	Section 07
C-Diff	Jul-23	22	17	**5**	
Ecoli BSI	Jul-23	72	85	**-13**	
Klebseilla BSI	Jul-23	21	24	**-3**	
Pseudomonas BSI	Jul-23	6	11	**-5**	

01. Exception Report Learning Disability & Autism

NHS Nottingham and Nottinghamshire

Learning Disability and Autism (LD&A)

LD&A Inpatient



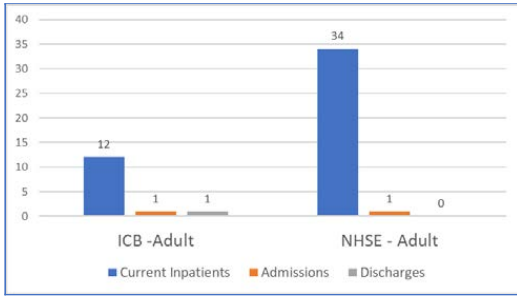
Data Cut-Off Date: 31/07/2023

Explanatory Note/Insight Analysis and Assurance:

Adult Inpatient Trajectories: Our current adult inpatient number stands at 46, which is 2 above trajectory. For the month of July we have had 1 admission from the community into a MH bed and 1 admission from the prison pathway directly into a secure bed. There has been 1 ICB discharge along with a transfer between security levels for 1 individual (ICB to MSU).

Children & Young People Inpatient Trajectories: In total there are 4 CYP in an inpatient setting which means we are now 1 above trajectory. A late admission notification for June increased our June total to 5. There has been 1 admission following a full community CETR for acute psychosis and an additional CYP admission for re-feeding in context of an Eating Disorder. There has also been 3 CYP discharges during July back to the family home/community setting.

LD&A Adult Inpatient Movements

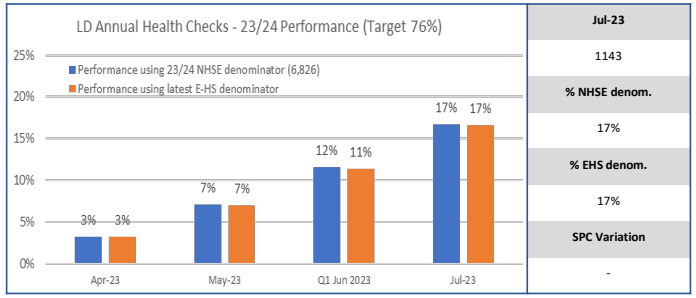


Jul-23
46
Admissions
2
Discharges
1
SPC Variation
-

Data Cut-Off Date: 31/07/2023

Explanatory Note/Insight Analysis and Assurance:
During July there were 2 admissions and 1 discharge.

LD Annual Health Checks



Jul-23
1143
% NHSE denom.
17%
% EHS denom.
17%
SPC Variation
-

Data Cut-Off Date: 31/07/2023

Explanatory Note/Insight Analysis and Assurance: There have been 1143 health checks completed to date, putting performance at 17% . Though slightly below plan, performance mirrors July 2022 data (16%) but will be closely monitored to ensure that The ICS is on track to achieve the end of year target of 76%.

LeDeR

2022-23
34
Target
58
Assurance
-
SPC Variation
-

Data Cut-Off Date: 31/06/23

Explanatory Note/Insight Analysis and Assurance: 19 LeDeR Reviews received in Quarter 1. These reviews have been allocated to reviewers for completion, no reviews from this quarter have yet been signed off, all are currently within the 6th month completion date. Q2 data will be available in October

01. (continued) 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 remains on adult inpatient performance with monthly NHSE system performance meetings in place. Both adult and child inpatient numbers are above plan. Also the LDA Peer Review action plan is currently in development to address areas of challenge.

Current Position

Exceptions for this month:
We are experiencing increased scrutiny from NHSE region on inpatient performance, despite achieving target for June 2023. Work is being undertaken with NHSE region to ensure that the information and narrative shared at the monthly performance meetings give NHSE the assurance they require to show there is a plan to meet year end target in place. The Chief Executive is being briefed on performance to ensure full oversight and planning underway for a line by line Minsterial review of inpatients with the Chief Exec as agreed at Select Committee in July.

LGA Learning Disability & Autism Peer Review was undertaken 28-30 June 2023 with a focus on inpatient performance and the autism pathway to identify areas for improvements to improve outcomes for people with LDA. Findings included key areas of strength (with a particular mention on the strong partnership approach across the system) as well as areas requiring more focus. An action plan has been developed with all partners to address areas of challenge and will be overseen by the LDA Executive Partnership Board.

Inpatient performance
As at 31st July 2023, there are currently 46 adult inpatients against a target of 44. There has been 1 admission from the community into a Mental Health bed and 1 admission from the prison pathway directly into a secure bed. There has been 1 ICB discharge along with a transfer between security levels for 1 individual (ICB to MSU). ICB performance is ahead of target (12 inpatients against a target of 14) and IMPACT performance is behind target (34 inpatients against a target of 30). Secure beds are an area of focus in the peer review action plan.

In total there are 4 CYP in an inpatient setting which means we are now 1 above trajectory, but there has also been 3 CYP discharges during July back to the family home/community setting which shows the pathway being used appropriately for short stay interventions.

Dynamic Support Register: We have 246 people on our register who we are actively being supported by our community MDT (129 adults and 117 cyp). Since the inception of the adult DSR (Nov 2022) there have been 42 people that have been discharged from the register (26 adults and 16 cyp), demonstrating strong performance by the ICS operational teams on the ground. However, increasing level of need and the increasing numbers of people being identified on the DSR is creating a challenge for the system in terms of health and social care service capacity issues. This is being picked up via service reviews being undertaken by commissioners.

Actions Being Taken & Next Steps

Next Monthly System Performance Meeting scheduled 16 August 2023 with NHSE region

Finalisation of LDA Peer Review action plan to address areas of challenge, including a focus on secure settings and length of stay

Risks & Escalations

The current position in the delay to receive neurodevelopmental assessments means the resulting impact on CYP and adults not receiving support remains a concern.

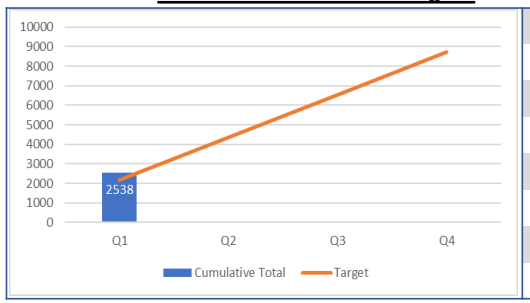
Content Author: Amy Callaway | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

02. Exception Report Personalisation

NHS Nottingham and Nottinghamshire

Personalisation

Personalised Health Budgets



Q1 23-24
2538
2023/24 Plan
8700
Assurance
-
SPC Variation
-

Data Cut-Off Date: 30/06/2023

Explanatory Note/Insight Analysis and Assurance: on track to achieve the end of year targets

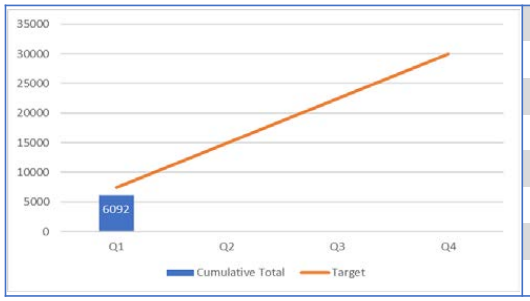
Referrals to Link Workers

Q1 23-24
3703
2023/24 Plan
15,706
Assurance
-
SPC Variation
-

Data Cut-Off Date: 30/06/2023

Explanatory Note/Insight Analysis and Assurance: on track to achieve the end of year target

Personalised Care & Support Plans

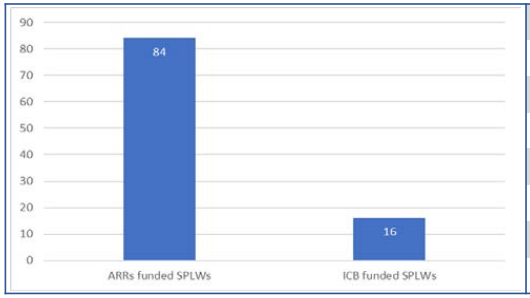


Q1 23-24
6092
2023/24 Plan
30,000
Assurance
-
SPC Variation
-

Data Cut-Off Date: 30/06/2023

Explanatory Note/Insight Analysis and Assurance: Actions in place to support delivery (see next slide)

Number of Social Prescribing Link Workers & Funding Source



Q1 23-24
100
2023/24 Plan
N/A
Assurance
-
SPC Variation
-

Data Cut-Off Date: 30/06/2023

Explanatory Note/Insight Analysis and Assurance: Already exceeded target for year

02. (continued) Exception Report Personalisation

NHS Nottingham and Nottinghamshire

Personalisation

System Quality Group Assurance – Significant Assurance

Rationale for assurance level: The progress position against quarter 1 for Year 2023/2024 as reported on previous slide shows we are on track to achieve the end of year targets with work required on Personalised Care and Support Plans.

Current Position

Exceptions for this month:
The Personalised Care Strategic Oversight Group has been reviewed and refreshed with updated Terms of Reference that focus on delivery of the Joint Forward Plan being delivered, along with the 2023/2024 targets.

Personalised Care and Support Plans
The graph on the previous slide shows that we are below target at the end of quarter 1. A Project Manager in the team is doing focussed work to share and scale up the 'About Me' as section 1 of a Personalised Care and Support Plan this includes;
1. Digitalising the 'About Me' as a key enabler to scaling up plans and this work is being completed with Digital Notts. The working group continues to build momentum, with Digital Notts mocking up a first phase text only 'About Me' using the PRSB standard data set - this is awaiting sign off from the working group members. Test sites for first phase of testing the 'About Me' have been identified at SFH children's epilepsy service, Dementia Communication & Support Project and NUH Older Persons inpatients along with some interest from the trusts hospice to be followed up.
2. Easy Read - About Me work with SPLAT and Mencap - Easy read document has gone out to the day centres members for feedback from carers and family on the questions and the ease of completing the document.
3. Health Inequalities & Obesity Projects are beginning to use the 'About Me' and Personalised Care & Support plans with people who meet the criteria for the projects who may be eligible for a PHB. The Personalised Care approaches will be completed within a template in the individuals clinical record on System One.

Emergency Department Social Prescribing (NUH)
The ED Social Prescribing Service's bid was unsuccessful at the HIIF panel, and the service will close on August 24th. This was originally funded through winter pressures funding. The HIF bid was unsuccessful due to lack of data and evaluation. Lack of data and evaluation is an ongoing challenge within personalised care approaches and social prescribing. The impact of social prescribing will be an area of focus for this year.

Workforce
Limited Governance and Leadership exists to support the Personalised Care team to increase the number of people trained in Personalised Care PCI accredited, as it is not one of the 3 agreed priority areas of the ICS Learning and Development system workforce group. The Head of Personalised Care is joining the MECC Delivery Group to align and join up key messages and training on MECC and Support Self-Management to demonstrate how the training can support the identified priority area.

Annual Health Checks
Limited progress has been made due to the limited capacity of Primary Care to engage in this work. Proposal will be taken to Septembers Strategic oversight Group to continue the work under way with partners with capacity, but to stand down any new work and utilise Project Manager resource for other priorities including expanding Personalised Care and Support Plans.

Actions Being Taken & Next Steps

- Finalise and agree the ToR of the Personalised Care Strategic Oversight Group and membership and agree the priority areas for Personalised Care
- Meeting with Urgent and Emergency Care SROs to consider how personalised care can support system challenges.
- 360-degree audit to commence to provide an independent assurance opinion on the governance structure that supports social prescribing and evidence that supports the Social Prescribing Maturity Framework.

Risks & Escalations

Emergency Department Social Prescribing (NUH)
The impact of losing this service will be significant and a paper is being escalated via NUH Deputy Director of Integration. This will also be shared with Personalised Care Strategic Oversight Group
Commissioning and planning for Personalised Care
Recognition of the system financial challenges, but more clarity needed over system appetite to fund personalised care, as scaling up will be at risk without a clear commissioning plan. The Head of Personalised Care and Clinical Lead are meeting with the Director of Strategy and Reconfiguration to agree how to address this issue, including a proposal to have a Standard Operating Procedure for the Commissioning and Contracts teams to ensure funding is allocated to Personalised Care and the team can collaborate and support commissioners, quality and contract teams. This includes agree quality measures that are standard and measured against.
Workforce
Senior Leadership support within the People Plan is required for Personalised Care approaches training as a key enabler for system change – this will be escalated to the Personalised Care Strategic Oversight Group.
Annual health checks
Escalation will be made at Septembers Personalised Care Strategic Oversight Group to ensure clear and agreed direction on priorities and resource capacity across system partners

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

03. Exception Report Co-Production

NHS Nottingham and Nottinghamshire

Co-Production

System Quality Group Assurance – Significant Assurance

Rationale for assurance level: The Strategic Coproduction Group continues to develop as a group and is having a dedicated development session in September 2023, the group are developing their workplan and are identifying priorities of focus. The Coproduction Toolkit has been created on the NHS Futures platform, initial content has been created which is to be user tested before wider roll out and full promotion. The establishment and promotion of the Coproduction Network and its supporting infrastructure is the focus of the next quarter. 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:

National Coproduction Week activities: July 2023 – The Team curated a week of events for system staff and people with lived experience for national coproduction week, the content of the events that took place was informed by conversation with staff across the system. The aim of the week was to raise the profile of coproduction and the Coproduction Team and build relationships with the wider system. The sessions included Coproduction approaches in Local Maternity & Neonatal Systems (LMNS), Coproduction approaches for Service Improvement, Coproduction with an Equality and Diversity focus and skills around facilitation delivered by the Engagement Team. Feedback from the week has been positive and will be used to develop next year's activities.

Work continues to develop the Coproduction Toolkit, the Toolkit is hosted on the NHS Futures platform and initial resources are available, user testing is taking place before wider promotion of the resource. The approach to populating the Lived Experience section of the toolkit which will include tools for supporting lived experienced members to feel empowered and supported to engage with coproduction is in the planning phase and will be a focus for the next quarter. The Toolkit also includes links to external coproduction resources from the system and national NHS bodies like NHS England.

Focused activity is underway to support developing greater coproduction within the Nottinghamshire Partnership SEND improvement programme. This also includes linking the broader work through to the existing System work, ensuring shared learning and identification of support/tools for inclusion within the Toolkit development,

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 the group.

The development of a whole system assessment is provisionally planned to start August 2023.

Actions Being Taken & Next Steps

- Scoping and establishing the infrastructure to support the Coproduction Network launch.
- User Testing and roll out of the Coproduction Toolkit
- Involvement in SEND coproduction workstream to support achievement of actions by providing Coproduction best practice

Risks & Escalations

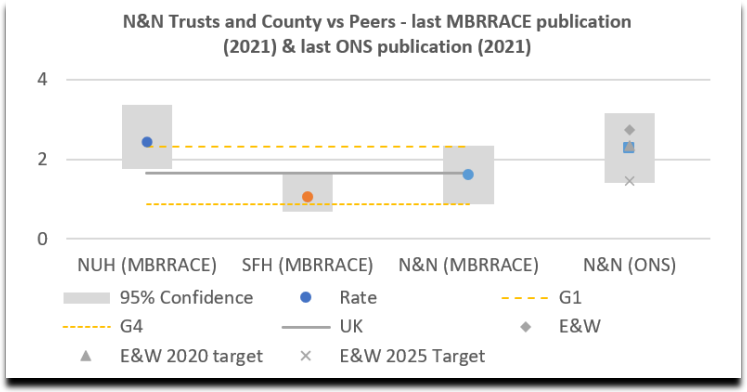
None

04. Exception Report Maternity

NHS Nottingham and Nottinghamshire

Local Maternity & Neonatal System (LMNS)

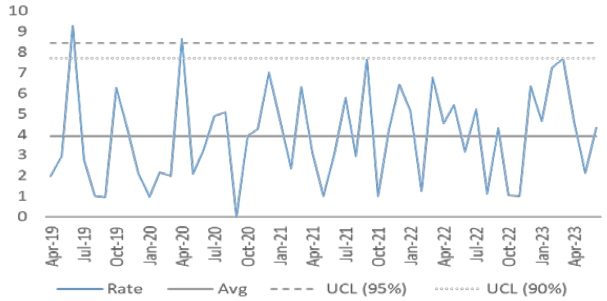
N&N Trusts and County vs Peers – last MBRRACE publication (2021) & last ONS publication (2021)



Data Cut-Off Date: 31/07/23

Explanatory Note/Insight Analysis and Assurance: - New MBRRACE figures for 2021 comparators were brought in last month and show SFH and N&N roughly aligned to their comparators with NUH being elevated. National trajectory shows more progress is needed in order to achieve the 2025 ambition.

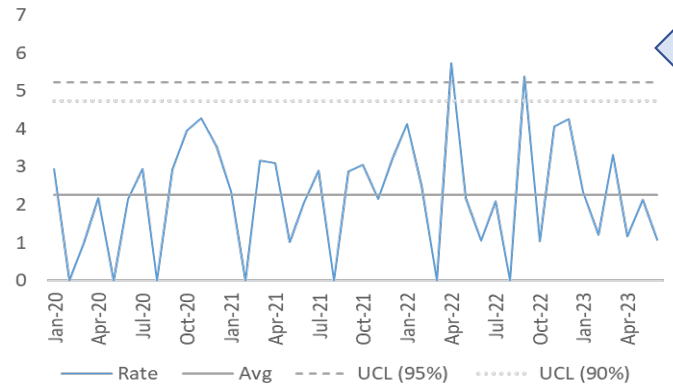
N&N Monthly Stillbirth Rate (per 1,000 live births) – SPC Chart (local data)



Data Cut-Off Date: 31/07/23

Explanatory Note/Insight Analysis and Assurance: - NNICB remains within 5% of the UK average for perinatal mortality, however this is increasing nationally - MBRRACE mortality rates 2021

N&N Monthly Neonatal Deaths (per 1,000 live births) – SPC Chart (local data)



Data Cut-Off Date: 31/07/23

Explanatory Note/Insight Analysis and Assurance: - Neonatal deaths continue to be rigorously scrutinised through perinatal mortality reporting and review. Recent updates have seen the threshold of concern metric for NUH (based on 12 month rolling figures) to be reduced. The first 6 months of '23 has just over half of the NNDs that '22 had (7 versus 13).

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: 31/07/23

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 undertaken on 31st July which triangulates assurance.

04. 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 continued LMNS assurance based on NHSE guidance and local intelligence.

Current Position

Exceptions for this month:

An NUH Ockenden Insight Visit was held on 31 July, led by the LMNS with attendance from NHSE region. There was a positive outcome from the visit with noticeable improvements since the last visit in June 2022, particularly regarding the teams working and training together and the impact on workplace culture. Early feedback was provided on the day and a full report is to be shared before the end of August.

LMNS Quarterly Oversight and Assurance Panel undertaken 11 July for assurance against 3 year delivery plan & Ockenden deliverables. This was an initial meeting to set up future ways of working and the key KLOE's that will be reviewed during the remaining quarterly panels. NHSE Region have set up a meeting with our LMNS in September to confirm future reporting arrangements which will inform quarterly oversight arrangements.

Actions Being Taken & Next Steps

Publication of NUH Ockenden Insight Visit Report due 25th August.

Deliverables confirmation session with NHSE region in September

LMNS PMO has active membership at Women's Hub working group to align strategies and approaches

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.

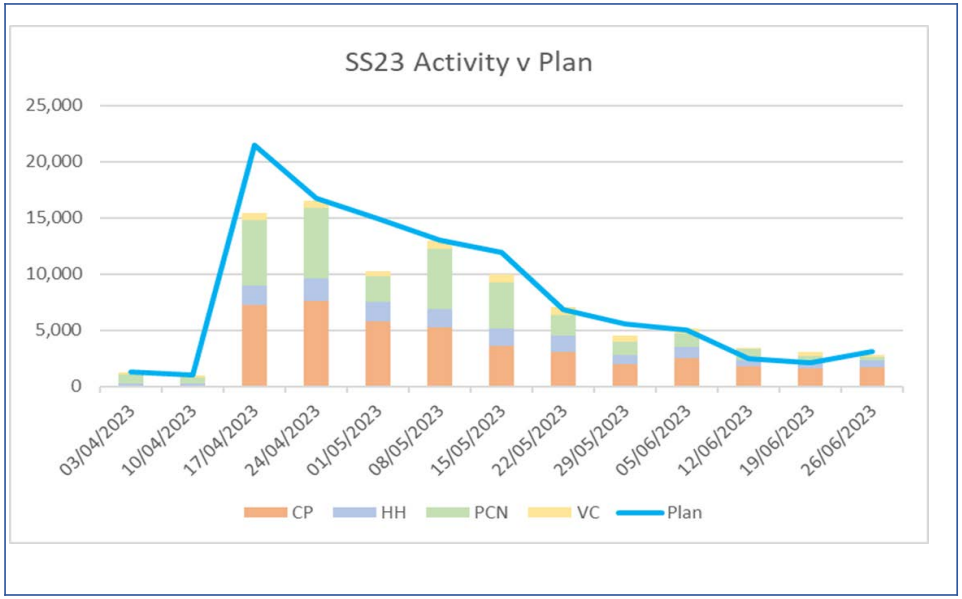
05. Exception Report Vaccinations

NHS Nottingham and Nottinghamshire

Vaccinations

COVID Spring Booster Campaign Performance - ended 30 June 2023

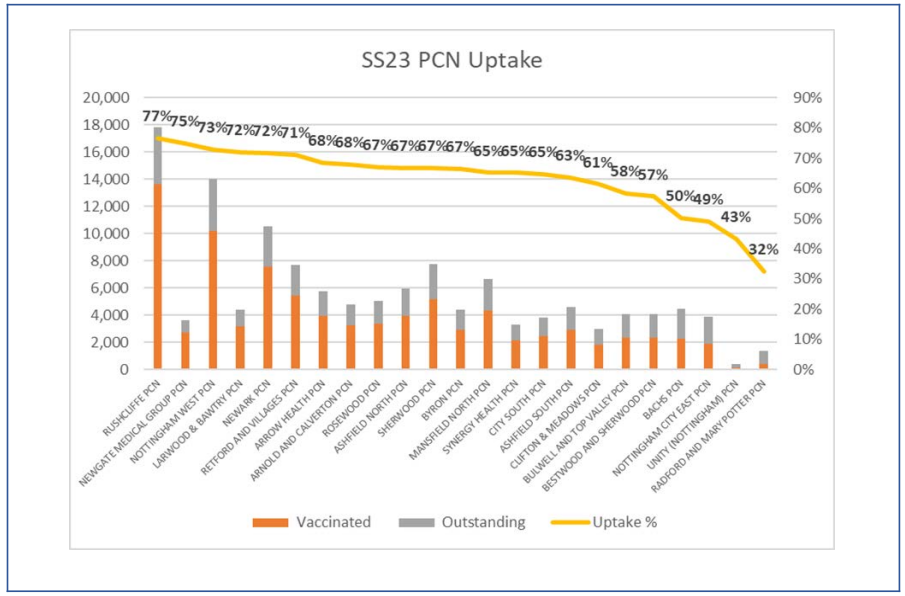
SS23 Activity v Plan



Data Cut-Off Date: 30/06/23 (end of campaign)

Explanatory Note/Insight Analysis and Assurance: Total Vaccinations 93.902
First doses 406
Second doses 651
Third doses 5
Booster dose 92,840

SS23 PCN Uptake



Data Cut-Off Date: 30/06/23 (end of campaign)

Explanatory Note/Insight Analysis and Assurance: Eligible Population 131,597
Booster dose 88,658
Uptake 67.4%

Significant variation between PCNs from Rushcliffe 77% to Radford and Mary Potter 32%

05. (continued) Exception Report Vaccinations

NHS Nottingham and Nottinghamshire

Vaccinations

System Quality Group Assurance – Partial Assurance

Rationale for assurance level: Uptake for the spring booster 67%, this is 1% less than the national assumption of 68%. Awaiting responses from CPs and PCNs regarding op-in / opt-out for Autumn/Winter 23 programme.

Current Position

Exceptions for this month:

Autumn/Winter covid-19 vaccination programme:

- https://www.gov.uk/government/news/jcvi-advises-on-eligible-groups-for-2023-autumn-booster
- JCVI advises that for the 2023 autumn booster programme, the following groups should be offered a COVID-19 vaccine:
  - residents in a care home for older adults
  - all adults aged 65 years and over
  - persons aged 6 months to 64 years in a clinical risk group, as defined in tables 3 and 4 of the COVID-19 chapter of the Green book
  - frontline health and social care workers
  - persons aged 12 to 64 years who are household contacts, as defined in the Green book, of people with immunosuppression
  - persons aged 16 to 64 years who are carers, as defined in the Green book, and staff working in care homes for older adults

- System letter – released 11th August and circulated via SVOC
- Non-primary care contract is awaiting clearance, ops note will be shared to identify core changes
- Combined covid and flu schedules, references to delivery models have been removed, focus on core cohorts instead
- **Start date 2 October – Care Homes for flu and covid**
- **Start date 7 October – all cohorts for flu and covid**
- Training materials not expected until 28 September – this is very late, all regions pushed for an earlier date
- 15th December will be a hard stop to end the Programme
- NBS will be closed from 14 December
- Systems can continue covid into January to target inequalities (unclear if this will need to be pre-planned at this stage or not, to be confirmed) End date would be 31 January

Actions Being Taken & Next Steps

- Clinics to cater for severely immunosuppressed and newly immunosuppressed will continue over Summer 2023 following national mandate for continued primary vaccination offer from 1 July 2023 to start of autumn campaign for newly severe immunosuppressed. Process, pathway and service offer in place to account for this requirement
- Covid-19 vaccination workforce for end of June and the start of the Autumn programme reviewed:
  - Preparation and planning of workforce ready for Autumn/Winter 23 phase underway
- Covid and Flu vaccine equity steering group planning for autumn outreach and inequalities started
- Wider immunisation and vaccination strategy meeting in place with partners from NHSE, PH and ICB
- Work underway with system partners to develop a Nottingham and Nottinghamshire MMR eradication plan

Risks & Escalations

Guidance for Autumn/Winter flu/covid-19 programme encourages co-administration of covid-19 and flu vaccinations. Opt-in/opt-out returns from PCNs by 23rd August which will help with planning capacity and demand.

06. Exception Report Patient Safety

NHS Nottingham and Nottinghamshire

Patient Safety

System Quality Group Assurance – Limited Assurance

Rationale for assurance level: All partners continue to make progress towards PSIRF with draft plans now being prepared and recruitment underway for patient safety partners. There are clearer updates now being shared with executive colleagues and the PSIRF implementation group, and partnership working noted to support training roll out.

Current Position

Exceptions for this month:

ICB PSIRF position outstanding actions:
- Recruitment of two patient safety partners (PSP) from the local population by end Q2
- Establish system forum for PSPs
- Submit ICS PSIRP to System Quality Group (September)

Partner Quality Assurance & Improvement Group (PQAIG)
- Updates received from both system quality improvement groups (tissue viability and falls)
- Partners discussed proposed approaches to transition from STEIS to PSIRF (options appraisal)
- QRPs for Q1 were presented in draft and updates agreed for submission to System Quality Group in September.

Never Events; Section 28 (PFD); CQC inspections & reports
One Never Event at NUH – wrong site surgery.
One PFD issued to NUH -7 July 2023. NICE guidance not followed, and poor communication between teams.
One PFD issued to NHT. Issued 26 July 2023. Incident date July 2022. Delays relating to emergency response and escalation of care.
A CQC oversight Board has been established at NHT to oversee all outstanding CQC actions and progress against.

Actions Being Taken & Next Steps

ICS Patient Safety Incident Response Policy in draft with stakeholder input requested.

Meeting with regional patient safety leads on 17 August 2023 for stocktake against Patient Safety Strategy.

ICS Patient Safety Specialists network development session planned for 14 September 2023, supporting by EMAHSN Patient Safety Collaborative.

First meeting of NHT CQC Oversight Board scheduled 16 August.

Risks & Escalations

NUH Quality & Safety Oversight Group (QSOG) - Concerns were raised at the July meeting around patients experiencing long waits in ED and being exposed to additional harm as a result of this. This links with ongoing improvement work through the national improvement programme
https://www.england.nhs.uk/nhsimpact/integrated-urgent-and-emergency-care-improvement/

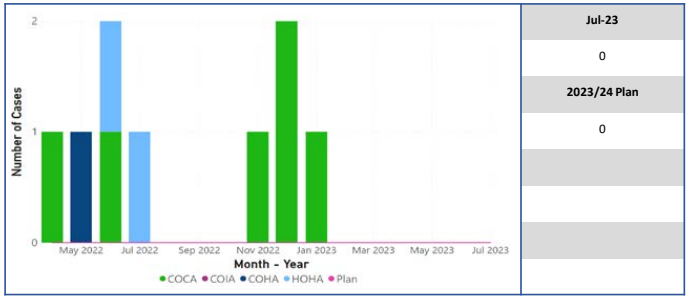
Content Author: Penny Cole | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

07. Exception Report Infection Prevention & Control

NHS Nottingham and Nottinghamshire

Infection Prevention and Control

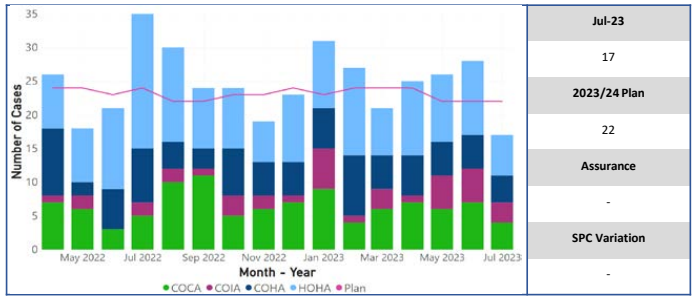
HCAI Data 22-23 – MRSA Bloodstream Infections



Jul-23
0
2023/24 Plan
0

Data Cut-Off Date: 16/08/2023

HCAI Data 22-23 – C-Diff



Jul-23
17
2023/24 Plan
22
Assurance
-
SPC Variation
-

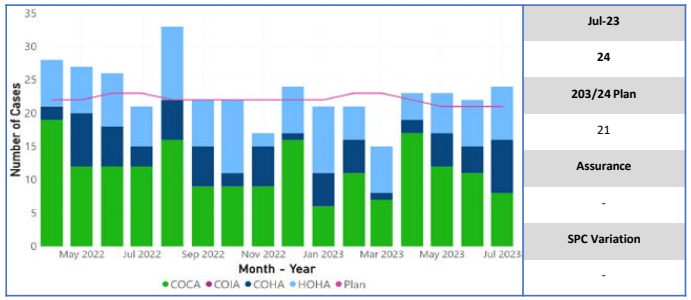
Data Cut-Off Date: 16/08/2023

HCAI Data 22-23 – E-coli Bloodstream Infections

Jul-23
85
2023/24 Plan
72
Assurance
-
SPC Variation
-

Data Cut-Off Date: 16/08/2023

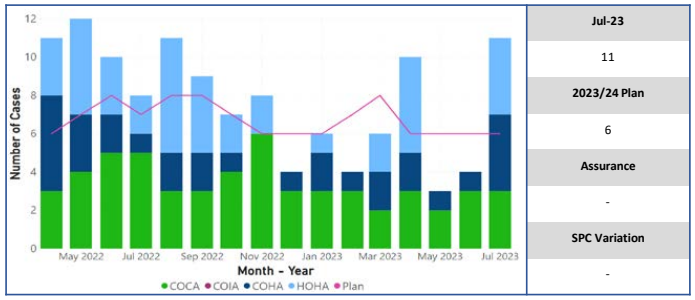
HCAI Data 22-23 – Klebsiella Bloodstream Infections



Jul-23
24
203/24 Plan
21
Assurance
-
SPC Variation
-

Data Cut-Off Date: 16/08/2023

HCAI Data 22-23 – Pseudomonas Bloodstream Infections



Jul-23
11
2023/24 Plan
6
Assurance
-
SPC Variation
-

Data Cut-Off Date: 16/08/2023

07. Exception Report Infection Prevention & Control

NHS Nottingham and Nottinghamshire

Infection Prevention and Control

System Quality Group Assurance – Partial Assurance

Rationale for assurance level: 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. Some progress has been made in secondary care regarding deep clean programmes, this remains reliant on reduced bed occupancy to implement fully.

Current Position

Exceptions for this month:

- Winter planning. NEMS are to support with antiviral prophylaxis prescribing and flu management in care homes 23-24 with an extension of the contract to include Bassetlaw. The lack of a swabbing team over winter 23-24 remains a gap this work is led by EPRR.
- There has been an increase in the reporting of post operative infections relating to private provider procedures resulting in patients being admitted to NUHT. The need to review reporting mechanisms has been highlighted to contracting, quality team and Medical Director. There may be a gap in current reporting processes to capture these type of events as not all are infection related.
- HCAI targets remain challenging.

System position for July 2023

***C.difficile* infections**
ICB met plan with 17/22 cases
NUHT breached plan 10/8 cases (6 HOHA)
SFHT breached plan 5/4 (4 HOHA)

***E.coli* BSI**
ICB breached plan 85/72 cases (52 COCA)
NUHT breached plan 34/21

***Klebsiella* BSI**
ICB breached plan 21/20 cases (8 COCA)

Pseudomonas BSI
ICB breached plan 11/6 (3 COCA)

Actions Being Taken & Next Steps

- EPRR are finalising elements of the service specification with NEMS in readiness to support with flu management , this will include cover for Bassetlaw for the first time. The gap left after decommissioning of the swabbing service has been highlighted to EPRR lead as no provision in place winter 23-24
- IPC focus remains on monitoring HCAI rates, preventing avoidable infections and taking actions that address learning from patient reviews where a lapse in care is identified.
- System focus plan to review the leg ulcer pathway with an aim to reduce admissions and need for repeated antibiotics that are considered contributory to *C.difficile* infection
- Link professional workshops and training
- Improved blood culture taking/training to reduce contamination rates
- Public Health requested to support with a focus on wider prevention and population health to support reducing non healthcare associated bacteraemia
- Work to determine community rates and to use benchmark data to review the ICB position with other comparator ICB.
- Attendance at regional NHSE HCAI collaborative meetings, regional IPC support
- Secondary care services are progressing with deep clean programmes.

Risks & Escalations

- Inability to fully progress 'deep cleaning programmes' in secondary care due to bed pressures. This is improving but is not fully resolved.
- The challenge to meet HCAI targets particularly *E.coli* BSI and *C.difficile*.
- Increase in reporting of patients with post operative infections and admission following initial care from private providers and need for improved reporting processes to capture these events including those non infection related. .

08. Exception Report Adult & Children Safeguarding

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 partners are being met. Where concerns have been raised around specific issues, the ICS Safeguarding Public Protection and Assurance Group are monitoring and actioning these issues. No specific risks require escalation but there are some key messages to share.

Current Position

Exceptions for this month:

- The ICB Safeguarding Team are supporting the ICB Mid Notts CHC Team to identify and risk assess patients who we are fully funding support for at home who may be subject to a community DoLs. This work is now required to avoid a breach of the MCA 2005 and avoid unlawfully depriving people of their liberty.
- All providers continue to report pressure around the impact of increasing MARAC cases and the strain this is putting on the individual teams.
- Following the implementation of new People in a Position of Trust (PIPOT) guidance in NUH & NHCFT they have seen an increase in staff allegations as well as reports of staff as survivors of Domestic Abuse.
- Supporting people with SMD in the community to gain access to community services (inc. GP practices in the North of the County) is being highlighted by the teams as a major issue. Staff are conflicted with supporting the patient and manging their own safety at work .
- Bassetlaw GP practices have raised that they require further support in relation to safeguarding and discussions are being held as to how that can be managed.
- NUH report changes to their internal governance structure which does not align with the intercollegiate document for safeguarding
- Members agreed to develop an ICS Safeguarding strategies with the group for learning and discussion
- 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 date has been confirmed.
- The ICB is fully engaged in the NCSCP Improvement Board work and business plan developments for the partnership and is due for sign off at the next Business meeting and plans developed to implement work identified..
- The ICB is fully engaged in the NSCP business development plan which continues to be developed for the next SAIG meeting
- C&YP in crisis/inappropriate settings continues to be challenging impacting on safeguarding concerns for individual C&YP & providers. There continues to be escalations when required to safeguarding professionals.
- In the last month a Child Safeguarding rapid review commenced which has identified learning related to faltering growth and working with large families.

Actions Being Taken & Next Steps

- Multi-agency task & finish group to be developed to look at safeguarding and access to services for complex patients in the community.
- Designated Nurse for Childrens reviewing Bassetlaw GP support with AD for Childrens safeguarding
- PIPOT & DA to be agenda for next meeting to allow for deep dive into this area.

Risks & Escalations

None to raise

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

09. Exception Report Looked After Children

NHS Nottingham and Nottinghamshire

Looked After Children (LAC)

System Quality Group Assurance – Limited Assurance

Rationale for assurance level: The statutory health assessments for looked after children are significantly delayed which could have an impact on children.

Current Position

Exceptions for this month:

The current summary position for the statutory IHAs and RHAs to note are:

- The ICB's commissioning team not requiring a recovery plan for IHAs from DBTH and SFH due to their current performance.
- The performance of IHAs for NUH has continued to be a concern and a comprehensive recovery plan was not submitted to the ICB commissioners therefore this is now going through senior contracting. Various solutions have been discussed one including NUH sub-contracting to a private provider (the ICB is aware some other areas have taken this option). The ICB has asked for a trajectory on recovery.
- The NHCT nursing team's recovery plan is showing improvements in RHAs month on month moving from 25% in timescales in January to over 60% in July; if staffing capacity is maintained this is expected to continue to improve but it is recognised both by the ICB and NHCT that there will be a plateau and that additional capacity is likely to be required which is currently been scoped. The ICB has asked for a trajectory.
- The ICB with has met with both LA Public Health commissioners for the 0-19 years services with NHCT LAC nursing team to establish the wrap around offer for all looked after children, further work on describing this is been taken forward.
- There is a review of NHCT 0-19 voice of the child role which is a part of the LAC universal provision.
- A LAC workshop has been planned for September which aims to consider what is required for future commissioning and provision for a child in care's journey through the health service from entering care to leaving care.
- The new NHSE National Data Set for LAC quarter 1 has been submitted, NHSE has said this is a must do but also learning in the years 1 & 2. There were limitations in submission which forms the learning and development required.

Risks & Escalations

- There is a review of NHCT 0-19 voice of the child role which is a part of the LAC universal provision.
- A LAC workshop has been planned for September which aims to consider what is required for future commissioning and provision for a child in care's journey through the health service from entering care to leaving care.
- The new NHSE National Data Set for LAC quarter 1 has been submitted, NHSE has said this is a must do but also learning in the years 1 & 2. There were limitations in submission which forms the learning and development required.

Risks & Escalations

There are no new risks

The existing 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.

10. Exception Report Special Educational Needs and Disabilities

NHS Nottingham and Nottinghamshire

Special Educational Needs & Disabilities (SEND)

System Quality Group Assurance – Limited Assurance

Rationale for assurance level:

- The Children and Families Act 2014 places statutory responsibilities on ICB and health partners to respond to, ensuring the experiences and outcomes for vulnerable children and young people with SEND 0–25-year-olds and their families are improved.
- The SEND Joint local area inspection outcome, undertaken by Ofsted and the Care Quality Commission, was published 16 May 2023. The outcome informed widespread and/or systemic failings, leading to significant concerns about the experiences and outcomes of children and young people with SEND which the Nottinghamshire local area partnership, must address urgently.

Current Position

Exceptions for this month:

- Ministerial letter received to confirm that there will be no formal improvement notice served on the Nottinghamshire Local area, although this remains dependent on progress.
- The Nottinghamshire SEND Priority Action Plan (PAP) has been approved by the Ofsted and CQC inspectors. Work being undertaken for improvements will include Nottingham City partners to ensure a system wide approach.
- Awaiting approval from the Department of Education (DfE) for a proposal submitted by the SEND leader's partnership, to receive input from Research & Improvement for SEND Excellence partnership (RISE), led by the Council for Disabled, to progress improvement required.
- NHSE SEND regional leads requested Key Lines of Enquiries to be returned for clinical interventions required to be delivered within education settings, including special schools. Associated with ongoing challenges related to delegated healthcare tasks and funding provision to meet the complex physical health needs of CYP in education settings. National leads are exploring the challenges, development guidance to support management
- As at, the end of July 2023, the number of SEND Tribunals 'Extended Appeals' raised against health; 6 Open, 1 Closed.
    - Themes include; Sensory Intergration and mental health provision and content of EHC plans linked to quality assurance or absence of information obtained at the time of the EHC assessment. Parent/Carers are increasingly commissioning independent practitioners for assessments resulting in recommendations for provision that may not be accessible via existing commissioned arrangements

Actions Being Taken & Next Steps

- Partners are working to progress the Nottinghamshire SEND Priority Action PAP at pace.
- A project officer for children's commissioning and transformation team has been appointed and will commence in September. The role is SEND focussed and to support work across the priority action areas for joint commissioning arrangements to support improvements for waiting times and pathways to access support.
- SAIU and commissioners are approval to recruit or reallocate resource to support improvements work required, as part of the PAP.
- Review of current Tribunal 'Extended Appeal' pathway for ICB management and participation from health service providers.
- Roll out of Quality Assurance and Multiagency Audits Framework and resources. to strengthen organisation management of EHC process and support for practitioners contributing to assessments and improve quality of EHC Plans.

Risks & Escalations

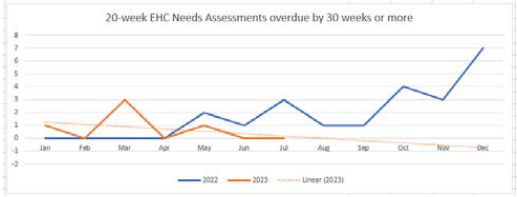
- Identification of ICB lead for the data intelligence enabling workstream to respond to the SEND inspection outcome recommendations for areas of improvement.
- Further Ofsted report for a Nottinghamshire secondary school has identified risks in relation to effective safeguarding.
- Reported delays from NUH and SFH community paediatric services responding to their statutory responsibilities for EHC process. Impact; poor outcomes for CYP with SEND and/or potential increase for 'extended appeals' being raised. Leading to financial and reputational damage.

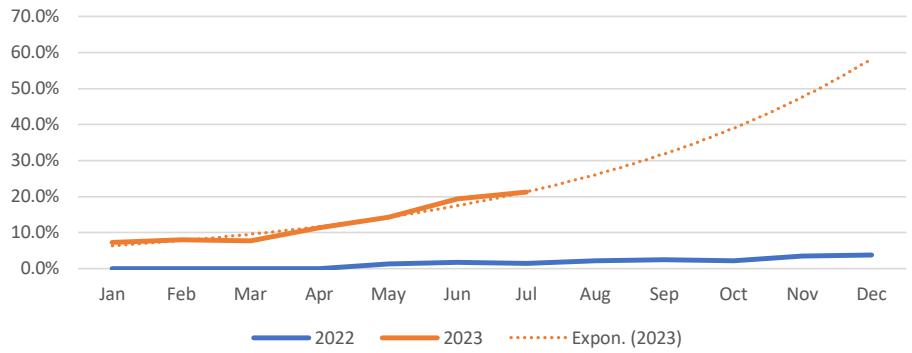
10. SEND Improvement Programme
Monthly Spotlight Report – SEND Partnership Improvement Board 24 August 2023

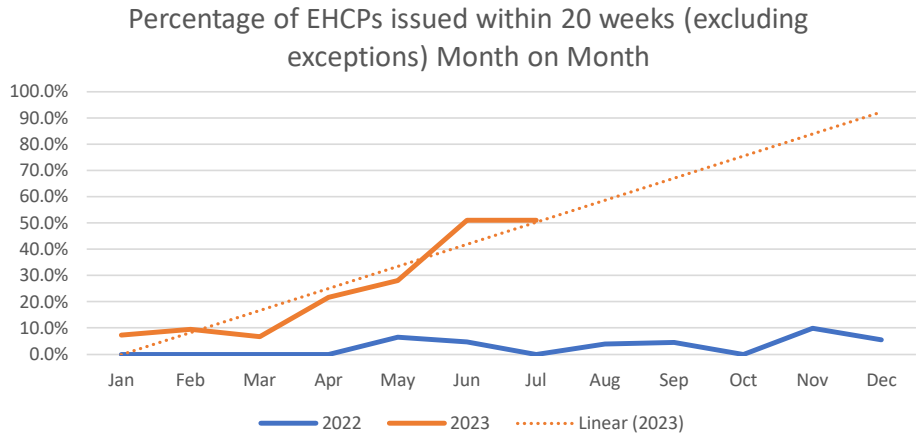
Priority Area 1:	**Leaders, NHS Nottingham and Nottinghamshire Integrated Care Board and education, health, and care providers should cooperate to urgently identify, assess and provide for the needs of children and young people with SEND. This includes assessment of needs, timely issuing of EHC plans and holistic oversight of these plans through annual reviews.**

Impact & Trajectories:

20-week EHC Needs Assessments overdue by 30 weeks or more	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total Jan to July
2022	0	0	0	0	2	1	3	1	1	4	3	7	6
2023	1	0	3	0	1	0	0						5







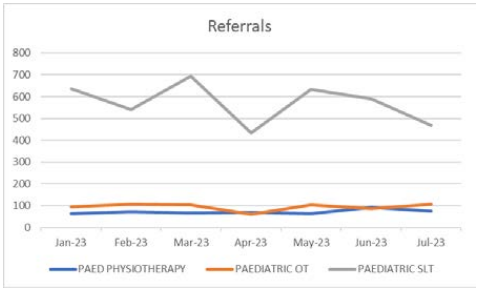
Content Author: Cathy Burke | **Exec Lead: Rosa Waddingham** | **System Oversight: System Quality Group** | **ICB Committee: Quality & People Committee**

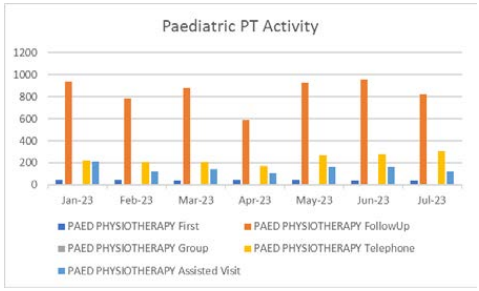
10. SEND Improvement Programme
Monthly Spotlight Report – SEND Partnership Improvement Board 24 August 2023

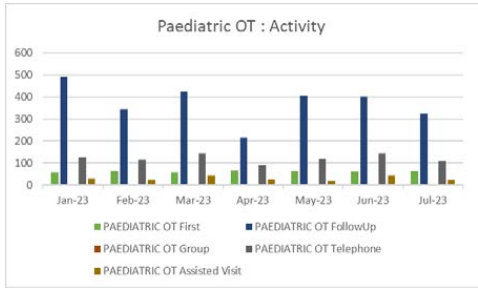
NHS Nottingham and Nottinghamshire

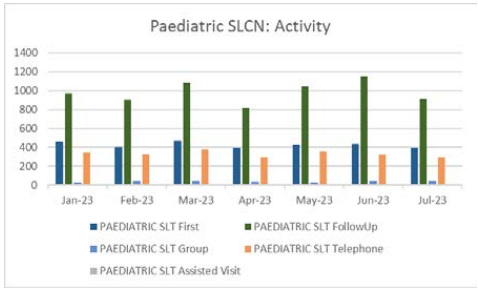
Priority Area 2:	Leaders, including commissioners and providers, should act urgently to identify and address the delays and gaps in access to some health services, particularly speech and language therapy, neuro-developmental pathways and equipment services. They should also ensure that they use available performance data to identify where gaps exist and whether actions taken to address these are effective.

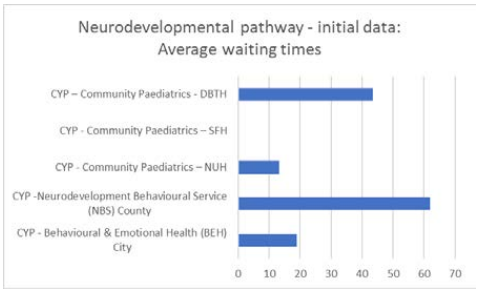
Impact & Trajectories:

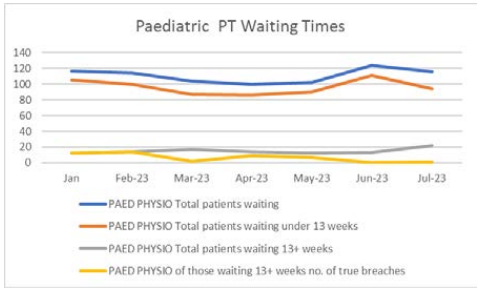


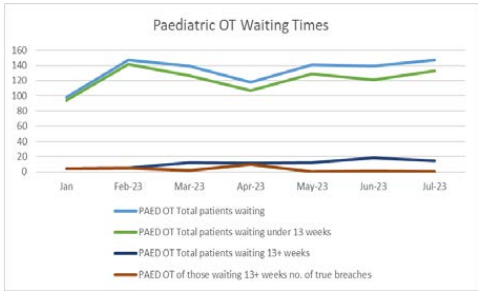


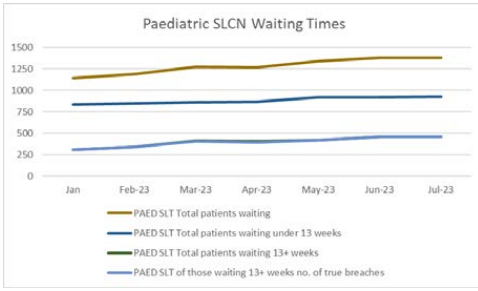












11. Exception Report Children and Young People Additional Vulnerabilities

NHS Nottingham and Nottinghamshire

Children and Young People Additional Vulnerabilities

System Quality Group Assurance – Limited Assurance

Rationale for assurance level: There are increasing numbers of CYP presenting with complex behavioural, mental health and autism related needs where there is no clear route for provision or pathways for care. This is concerning for those aged 14 years and over and specifically for 17 year olds, where provision is delayed and transition planning is limited due to the differences in assessment and provision in children's and adult services. Escalation in these cases take significant resource in terms of being placed in inappropriate settings, time for silver and gold level escalation meetings and funding to meet the extraordinary needs that cannot be met with existing commissioned services.

Current Position

Exceptions for this month:

D2N2 joint presentation at the Midlands CYP Transformation Board 3 August 2023 to outline the challenges of cyp in inappropriate settings and areas where we have been able to work together.

Draft role description for support for the cyp in inappropriate settings pathway in development

Draft ICS pathway in development

Transition scoping work commenced across the ICS

Actions Being Taken & Next Steps

Discussion around a C&YP Summit-being led by Deputy Chief Nurses

Weekly multi-agency meeting to discuss C&YP known to be in inappropriate settings continues

NHSE Mental Health Lead for the Midlands is to raise the issue of placement and setting availability with the national team

Risks & Escalations

There are two risks on the corporate risk register ORR 005 and ORR 128

There is high financial risk to manage care provision outside of current commissioned services to meet the high level, individual needs

There is high risk to health and wellbeing and safeguarding for cyp who are not managed in appropriate settings

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 August 2023/24

Nottingham and Nottinghamshire

August 2023		Assurance: Pass	Assurance: Hit & Miss	Assurance: Falling Below
Variation	Special Cause - Improvement	2Hr Urgent Care Response (Pop) Talking Therapies <6 weeks Perinatal Access Volume Early Intervention Psychosis CYP Eating Disorders - Urgent	Ambulance Response Cat 1 (Pop) Ambulance Response Cat 2 (Pop) Ambulance Response Cat 3 (Pop) 52 Week Waits (Pop) 65 Week Waits (Pop) Diagnostic Backlog (Prov)	% Cat 2 waits below 40 minutes 52 Week Waits (Prov) 65 Week Waits (Prov) 78 Week Waits (Pop & Prov) Cancer 2ww % (Prov) SMI Health Checks Perinatal Access % CYP Eating Disorders - Routine NHS App Registrations
	Common Cause - Random	2Hr Urgent Care Response % (Pop) P0 - Discharges Home (Pop) Talking Therapies <18 weeks Dementia Diagnosis	EMAS Calls (Pop) (Pop) Amb Conveyance to A&E Vol & % (Pop) A&E Attendances (Prov) NEL Admissions (Prov) Length of Stay >21 days Ambulance Response Cat 4 Hospital Handover Delays > 60 mins A&E 4hr % (Pop) 12 Hour Breaches % Ed Atts (Prov) Ordinary Electives (Pop) Daycases (Pop & Prov) Outpatient 1st (Pop & Prov) Outpatient Fups (Pop & Prov) Total Diagnostic Activity (Prov) PIFU (Prov) RTT Admitted (Pop & Prov) RTT Non-Admitted (Pop & Prov) Total Diagnostic Activity (Prov) Diagnostic Waiting List (Pop & Prov) Diagnostic Backlog (Pop) Diagnostic 6 Weeks % (Pop & Prov) Cancer FDS (Pop & Prov) Cancer 62 Backlog (Prov) Talking Therapies Recovery Rate Adult MH - 72 Hour Follow Ups Older Adult MH >90 day LOS Individual Placement Support Total Appointments	MSFT >24Hours (Prov) P1 - Discharges Home H&SC (Pop) Patients Using Virtual Wards (Pop) 12 Hour Breaches Actual (Prov) Ordinary Electives (Prov) Total Diagnostic Activity (Pop) Advice & Guidance (Pop) Total Diagnostic Activity (Pop) Cancer 1st <31 days % (Pop & Prov) Cancer 62 Day % (Pop & Prov) Inappropriate OAP Bed Days Adult SMI +2 Contacts Community
	Special Cause - Concern	CYP Access (1+ Contact)	SDEC % of Total Admissions (Prov) No Criteria To Reside (Prov) Total Waiting List (Pop & Prov) Talking Therapies Entering Treatment Talking Therapies <90 days 1st to 2nd Community Waiting Lists Aged 0-17 Community Waiting Lists Aged 18+	No Criteria To Reside (Pop) 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:

Urgent Care
- No Criteria To Reside (Pop) - Page 38

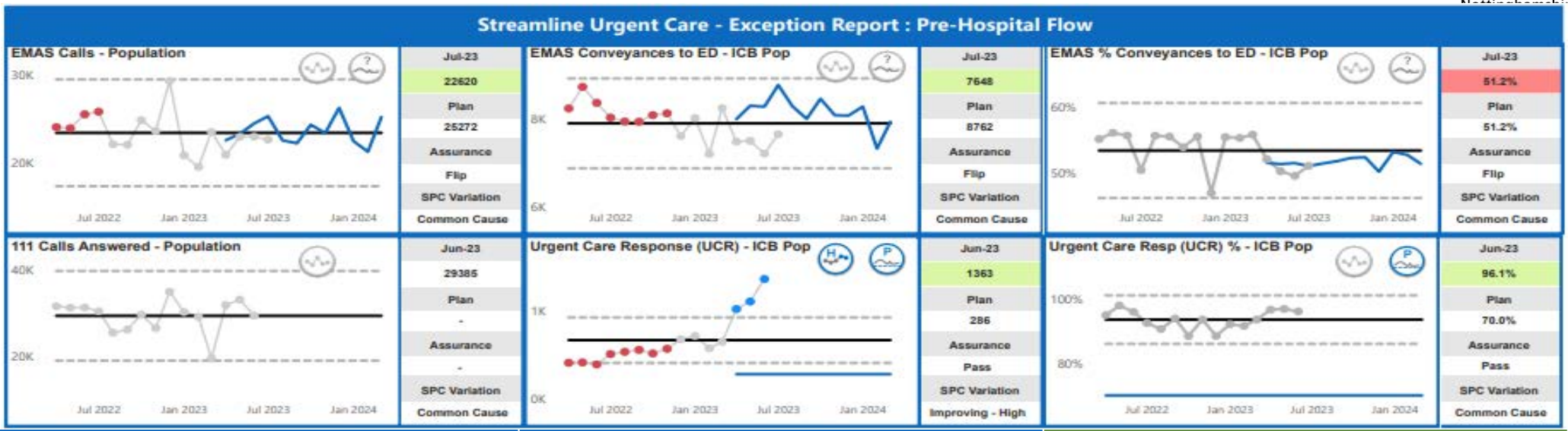
Outpatients
- Total Outpatients - Virtual (Pop & Prov) - Page 44

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 – Exception Report : Pre-Hospital Flow
7.2b – Exception Report : Front Door & In-Hospital Flow
7.2c – Exception Report : Flow Out of Hospital
7.2d – Exception Report: EMAS Performance Compliance (Notts Only)
7.2e – Exception Report : Acute Performance Compliance

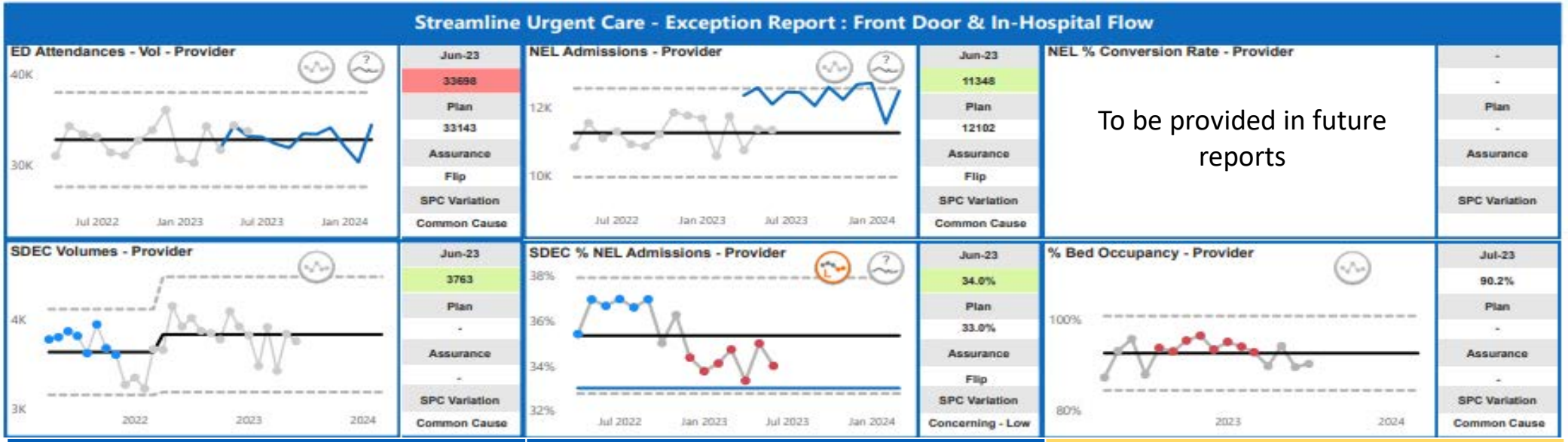
7.2a- Streamline Urgent Care – Exception Report : Pre-Hospital Flow



Summary	Actions	Oversight Level – Routine
EMAS – During July calls received and incidents were both below plan at -9.8% and -0.4% respectively. Conveyances to ED remain under plan for July 2023 and have consistently so for all of 2023/24 so far **111 -** In June 2023, 29,385 calls were answered by the 111 service for Nottingham and Nottinghamshire, in line with the average since April 2021. Ambulance dispositions and ED attendances as call outcomes are consistent over time at 14% and 12% of the answered calls, respectively. The percentage of 111 calls with a clinical triage assessment by DHU was lower than average between March and May 2023. This was due to DHU taking on the service for the West Midlands from March 2023, with a lower-than expected level of clinical resource transferred from WMAS, leading to limited resource for clinical assessment. The percentage has increased to normal levels in June 2023.	**2 Hour UCR** – Work taken place at Nottingham CityCare to better capture UCR activity within the Community Nursing Service. A similar process is taking place at Nottinghamshire Healthcare Trust and is expected to be seen in reporting soon. 2hr standard performance has been maintained. **EMAS** - The ambulance conveyance rate decreased slightly to 51.2% in July 2023, but remains broadly in line with the 2022/23 average position. Work continues around further improvements via the Reducing Conveyance group. Memorandum of Understanding and funding has been signed off by the ICB for a reducing conveyance post.	The proportion of patients conveyed to hospital has reduced over recent months. However, further sustained improvements are required in order to consider a reduction in the oversight level for pre-hospital flow.

7.2b- Streamline Urgent Care – Exception Report : Front Door & In-Hospital Flow

NHS Nottingham and



Summary

A&E and NEL activity plans (ICB Provider) – The volume of attendances to ED is 555 or 1.6% above the plan of 33,143 attendances for the combined NUH and SFH position in June 2023. However, for the same period NEL Admissions are 6.2% or 754 attendances below the planned level. Unheralded Attendances equate to 75% of all ED attendances in July 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.

The NEL plans were increased for 2023/24 to align to a planned reconfiguration of short stay services at NUH. The pathway changes are intended to treat a higher proportion of patients as short stay admissions.

SDEC - 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. Data for June shows that 34% of total admissions are SDEC, which exceeds the 33% target.

Actions

A&E - Work continues to try and 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 continues to take place to further improve patient flow.

Continued focussed work to improve delayed discharges for MSFT patients and pre-MSFT, including understanding why investments are not delivering benefits in terms of reduced MSFT patients, and understand the origin of the rise at SFH. SDEC performance is tracked closely within the Right Place First Time Board.

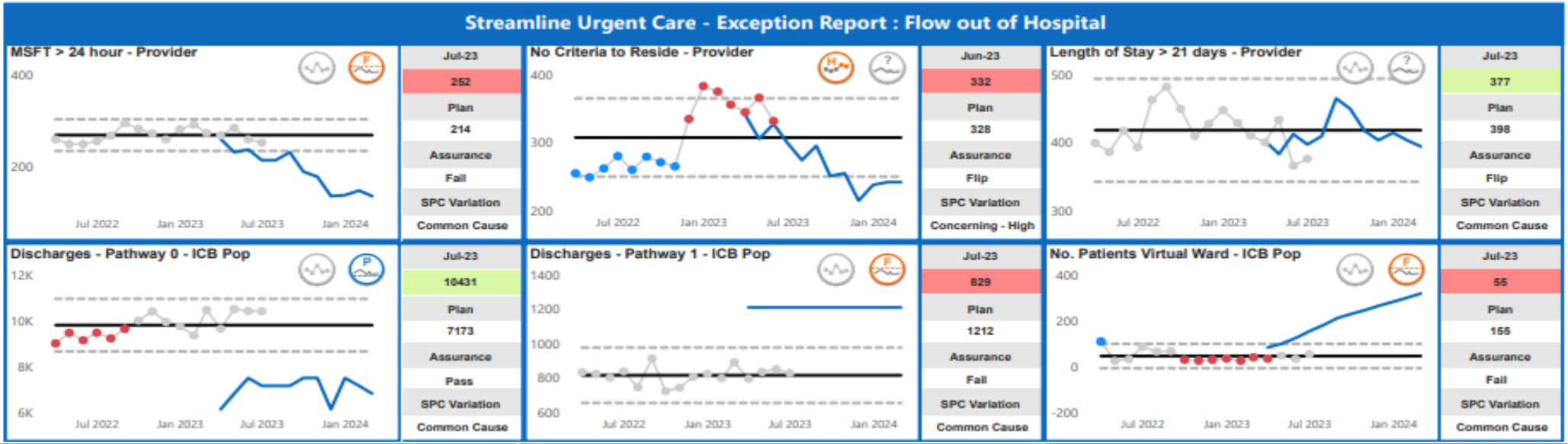
SDEC - Discussions are ongoing around the NEMS and EMAS pathways for SFH Medical SDEC to enable accurate reporting of the activity.

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.

7.2c- Streamline Urgent Care – Exception Report : Flow Out of Hospital

NHS Nottingham and



Summary

Patients Medically Safe to transfer - The number of MSFT >24 patients continues to decrease at NUH. The weekly average has reduced from 210 at the start of March to 137 in the first week of August. At SFH the weekly average has remained at around 100. This is in line with the long-term trend. On Friday 4th August, there were 108 MSFT >24hr patients. Of these 47 were in KMH, 26 at Newark and 35 at Mansfield Community Hospital.

No Criteria to Reside - Patients that no longer meet the criteria to reside is also above the planned level. The latest position for June 2023 is marginally above the planned level with 332 patients against a trajectory of 328 patients. Note that this includes all patients that no longer meet the criteria to reside whereas the MSFT metric includes only patients that have been declared medically safe for a period of 24 hours or more

Discharges pathway 1 – The volume of discharges remains below the planned level. Note that pathway 1 discharges are where the patient is able to return home with support from health and social care. Pathway 0 discharges can be referred to as simple discharge and require no input from health or social care. Pathway 1 discharges have remained at around 250 per week against the 303 per week P1 trajectory. June included 7 days of Industrial action.

Actions

Virtual Wards – Work continues to ensure accurate reporting of Virtual Ward Capacity is recorded to the Foundry System. Providers have been asked to check the accuracy of stated capacity as it is known to be currently under reported in the Foundry System.

Length of stay >21 days – Development of the escalation process for patients with over 14-day length of stay (LOS) that require ongoing support / care from social care but cannot be moved on easily due to available social care capacity is to take place. A weekly alert system for LLoS patients that would be overseen by the LLoS panel members and the flow professional lead in Medicine being created

Discharges – Delays reported along the discharge pathway include – Nottm City patients waiting for reablement and external homecare, Nottm County patients who have been in the service more than 14 days, 21 days or are waiting for ongoing home care, CityCare patients with delayed transfers of care, NHCT patients with delayed discharges form Lings Bar Hospital. Business Case Improvement Trajectory has been refreshed for 23/24 and being monitored alongside recruitment. Review of Pathway 1 model is underway including shared skills / competencies and outcomes which will inform workforce redesign if necessary to align across providers

Oversight Level – Escalated Risk

MSFT – Analysis shows longer term patterns are varying between NUH and SFH. The weekly average at NUH has reduced from 210 in March 2023 to 137 month to date in August 2023. There has not been a reduction over the same period at SFH, the latest data shows a high number of MSFT at Mansfield Community Hospital which stood at 35 on 4th August.

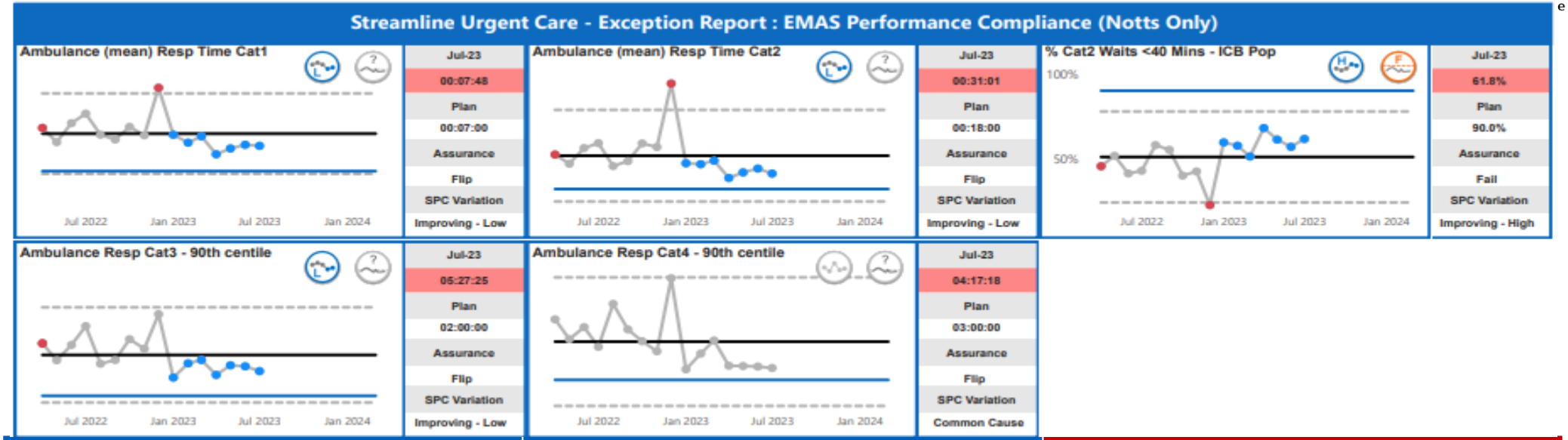
Discharges – All organisations are supplying delay data to help understand bottlenecks across the discharge pathway. Data teams continue to work together to improve this visibility of delays.
The online Transfer of Care (TOC) hub spreadsheets have allowed data to be collected detailing the time to process referrals in the TOC hubs. Analysis has been undertaken to show the time between the hub receiving the referral and the discharge date. This average time is currently 3 days for pathway 1 referrals through the Mid-Notts TOC hub.

Virtual Wards - The plan is to achieve a level of virtual ward 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.

Work continues to resolve issues around assistive technology that would enable more Virtual Ward capacity to become available.

7.2d - Streamline Urgent Care – Exception Report: EMAS Performance Compliance (Notts Only)

NHS Nottingham and e



Summary

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).

2023/24 national Planning Guidance aim was to 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. June 2023's mean time for Category 2 calls for Notts was 35.16 minutes, which compares to 52.32 minutes in June 2022. Nottinghamshire ICB remains lower mean time overall compared to EMAS average. (39 mins 39 secs)

Actions

Monthly meetings between senior operational leads from EMAS, BDGH, NUH, SFH and the Urgent Care Resilience team continue to take place with main-focus of improving ambulance handover performance. Further data has become available to the group which facilitates improved performance monitoring and identifying appropriate actions.

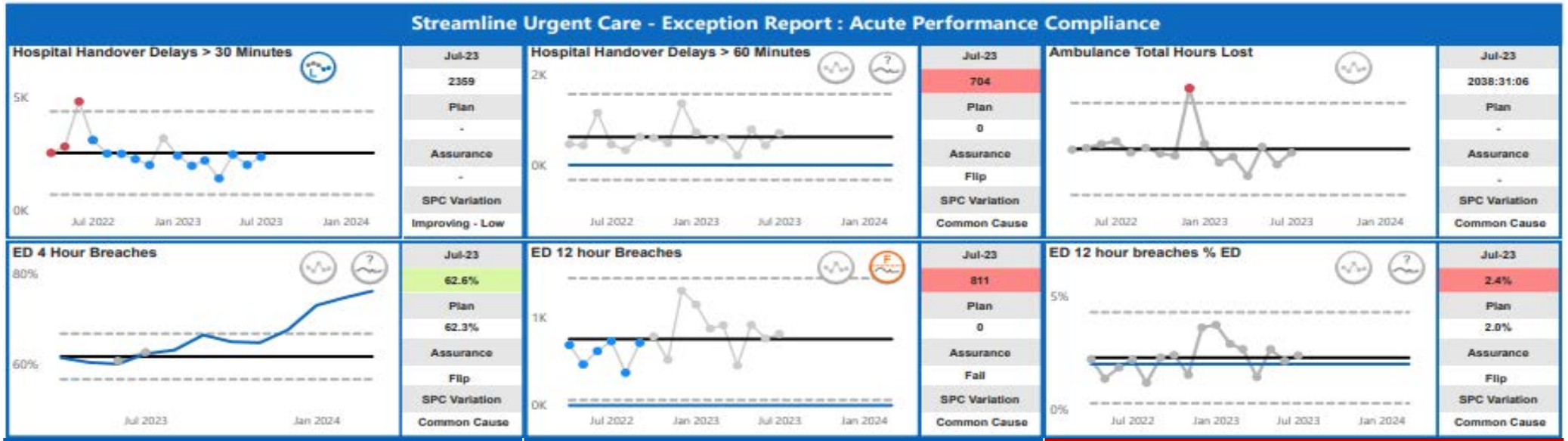
EMAS to align with the triage tool that NHS 111 uses and is likely to result in less Cat 2 activity but more Cat 3 activity. There will be impacts for other urgent care services and pathways across the ICS and EMAS are planning to meet the LMC about this.

Oversight Level – Escalated Risk

The performance level remains a significant concern to the ICB. Response time metrics are routinely above the planned level, but some small improvements are being seen against previous performance levels.

7.2e - Streamline Urgent Care – Exception Report : Acute Performance Compliance

NHS Nottingham and



Summary

Hospital handover delays >60 minutes remain a challenge for the system. In July, there were 704 handover delays during the month against a target of 0. Poor outflow from ED for patients requiring hospital admission results in regular overcrowding in 'majors' department which continues to result in ambulance handover delays as there is no physical space to move patients out of 'first contact' and into the 'majors' department. Consequently, the number of patients waiting in 'first contact' frequently goes above the capacity for the area (three patients at NUH) and therefore ambulance crews experience delays handing over new patients. Provider data illustrates that Ambulance handover times showed a slight decline in July with 32.85% of patients handed over within 15 minutes, 79.95% within 30 minutes and 94.88% within 60 minutes. Analysis of ED patient flow continues to demonstrate a clear association between bed unavailability and ambulance waits.

ED 4 Hour Waits – A&E 4hr performance for July was 62.63% for total provider against a plan of 62.25%. Composed of NUH performance of 50% (plan 47.72%) and SFH 77% (plan 79.21%).

ED 12-hour breaches – remains high for the system, In July, there were 811 breaches against a plan of 0. Challenges around flow through the hospitals impacts this measure.

Actions

Hospital Handover Delays – Providers continue to work very closely with EMAS to reduce handover delays. NUH have commenced an EMAS/ED Clinical Steering Group to review a range of improvement actions. The NUH Command Centre SitRep is shared automatically with EMAS colleagues at intervals throughout the day and night for greater visibility of NUH current position and pressures. The development of a live Microsoft teams chat between Site Operations and EMAS tactical command 24hrs a day has improved both relationships between NUH and EMAS as well as allowing for improved responsiveness to challenges and pressure.

Oversight Level – Escalated Risk

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.

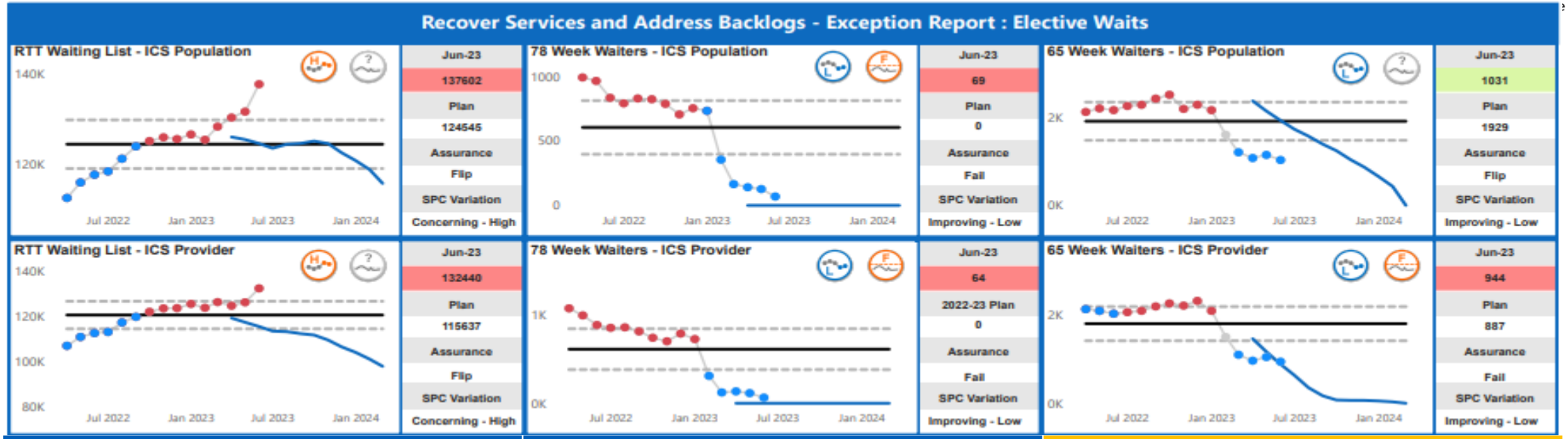
12 Hour waits - Harm reviews are being undertaken and thematic reviews being addressed through the System Quality Group.

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.

7.3 Service Delivery Elective Care Performance

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

NHS Nottingham and



Summary

Waiting List (ICS Provider)- 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 16,803 patients is required to return to the June plan.

78 Week Waits (ICS Provider) - 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 June was 64 against a plan of zero.

65 Week Waits (ICS Provider) - showing special cause low-improving variation as the position remains below the mean. In June, there were 944 patients waiting 65 weeks or more for the system against a plan of 887.

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.

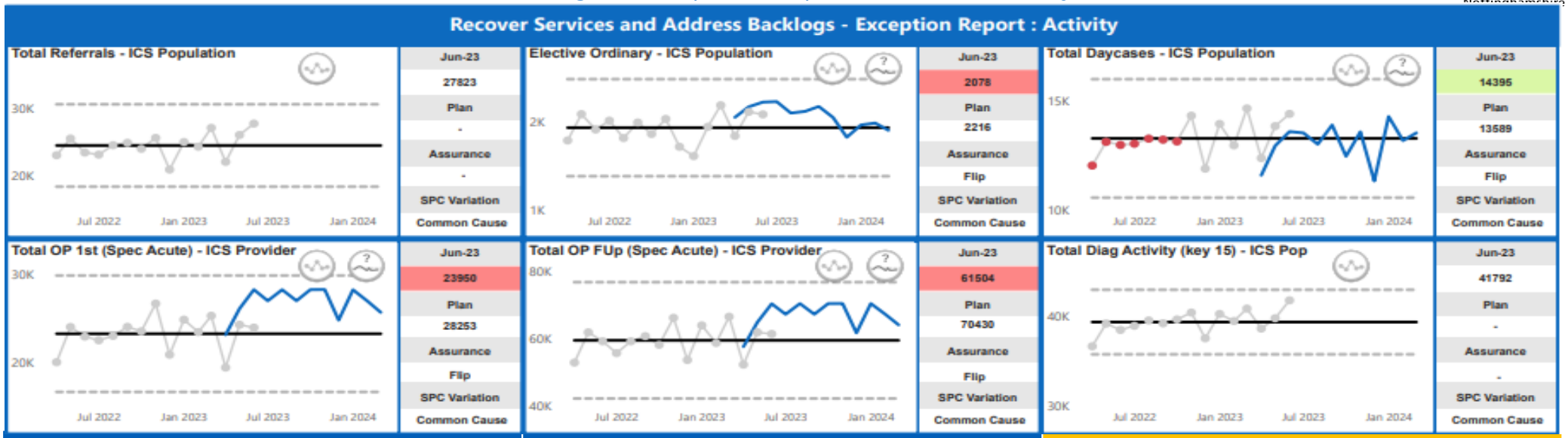
Oversight Level – Enhanced

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 was 67 patients at the end of August (64 at NUH, 3 at SFH). There are capacity challenges for complex ENT patients, due to limited mutual aid capacity locally or nationally. There are also capacity challenges within spinal services for adults and paediatric patients.

There were no 104 week wait breaches for August.

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



Summary

These charts compare the June activity level to the operational plan. The charts include activity for the whole ICB population at all providers including independent sector (ICS Population) or at local providers, NUH and SFHT total trust positions (ICS Provider).

All charts are showing common cause variation, which indicates a period of sustained activity around the mean (the black line). This indicates that there has not been a sustained increase in activity which will be required to deliver to planned levels.

Elective Ordinary admissions, Outpatient First and Outpatient follow up activity levels were below plan in June . The strike action which took place between the 14th and 17th June limited the volume of activity that could be delivered, which was the main constraint relating to activity delivery.

Actions

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

Sourcing Additional Capacity -Fully utilising Independent Sector capacity and identifying mutual aid potential across NHS Providers where clinically appropriate. Over 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.

Oversight Level – Enhanced

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

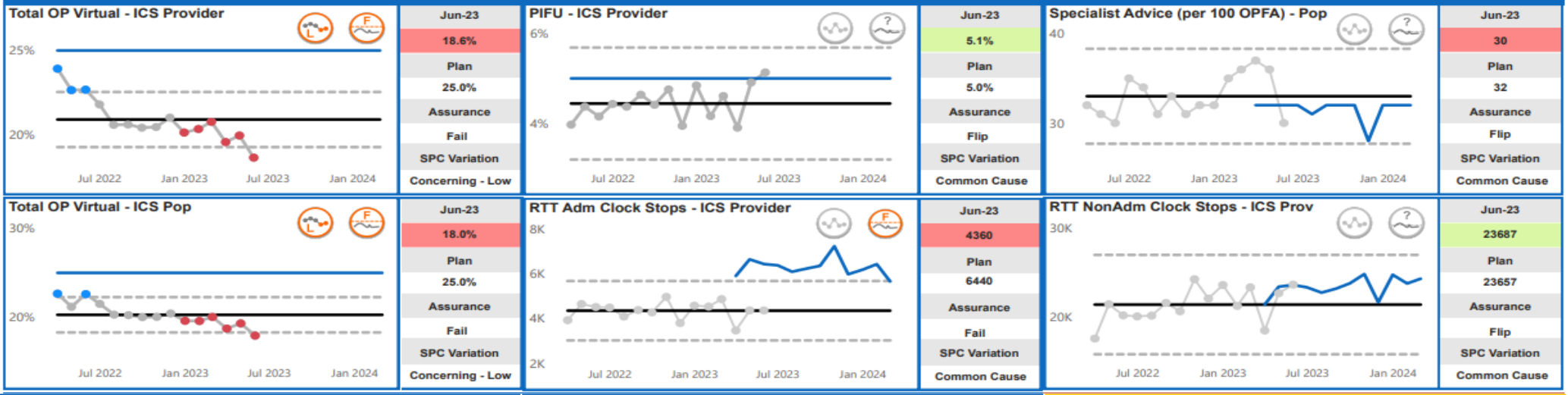
Industrial action continues to impact activity levels, with confirmed strikes scheduled by Consultants on 19th and 20th September. Further strikes by other staff groups remains a key risk.

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



Summary

Outpatient Virtual: Concerning - Low variation, 'flip' target delivery as the target is near the mean. The latest position for the system is 18%, 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 – achieved the plan in June with performance of 5.1% against a 5% plan.
Advice & Guidance Target. The ICS failed to achieve this standard in June 2023, in which the utilisation rate was 30 against a plan of 32.
Admitted and Non-Admitted Clock Stops: These charts show common cause variation, but with a failure alert for admitted clock stops. The admitted clock stops are below plans in June, but Non-Admitted was above the planned level. Increased delivery of admitted activity and therefore stops is required in order to impact 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. Based on national guidance SFH are developing a toolkit to assess suitability and appetite for each speciality to understand current virtual attendance position, potential trajectories, challenges and risks.

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. NUH are working to expand PIFU in a range of specialties.

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 – Enhanced

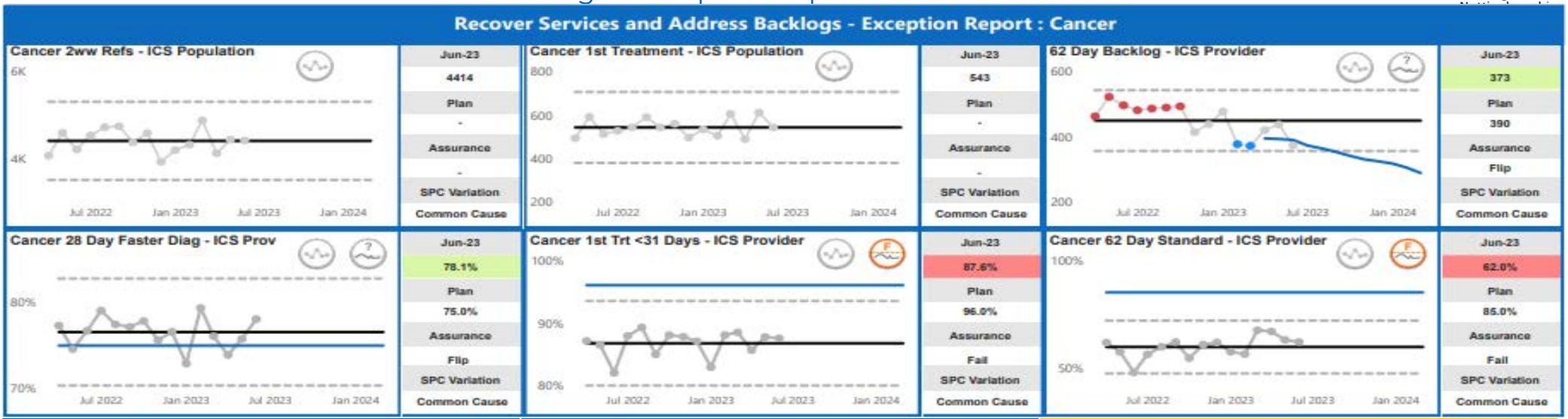
Outpatient Virtual attendance volumes at SFH remain significantly lower than the national standard. However, the trust are working to improve virtual utilisation in specialties with low benchmarks.

Outpatient Follow-up 25% Reduction: the national 25% reduction will not be delivered as the providers concentrate on treating patients on their current lists. Local providers have significant overdue review 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 Referral Optimisation Group to explore variation at PCN and general practice level in order to identify areas that warrant further targeted support.

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



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 June 2023 for the sixth consecutive month, however July is not forecast to achieve due to Industrial Action and capacity issues. NUH failed to meet the 93% standard, with performance deteriorating in June.

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 achieved by providers in June 2023 and is forecast to be achieved in July.

31 Day & 62 Day Performance: Common cause assurance indicates activity remains around the mean and will therefore hit or miss the target. As the performance is significantly below plan, this triggers a 'fail' as it is unlikely to be achieved in the coming months.

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 most 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.
- New processes for 31-day treatment for surgery were rolled out on the 1st July 2023 to meet the new CWT guidance and a review of validation process have been undertaken

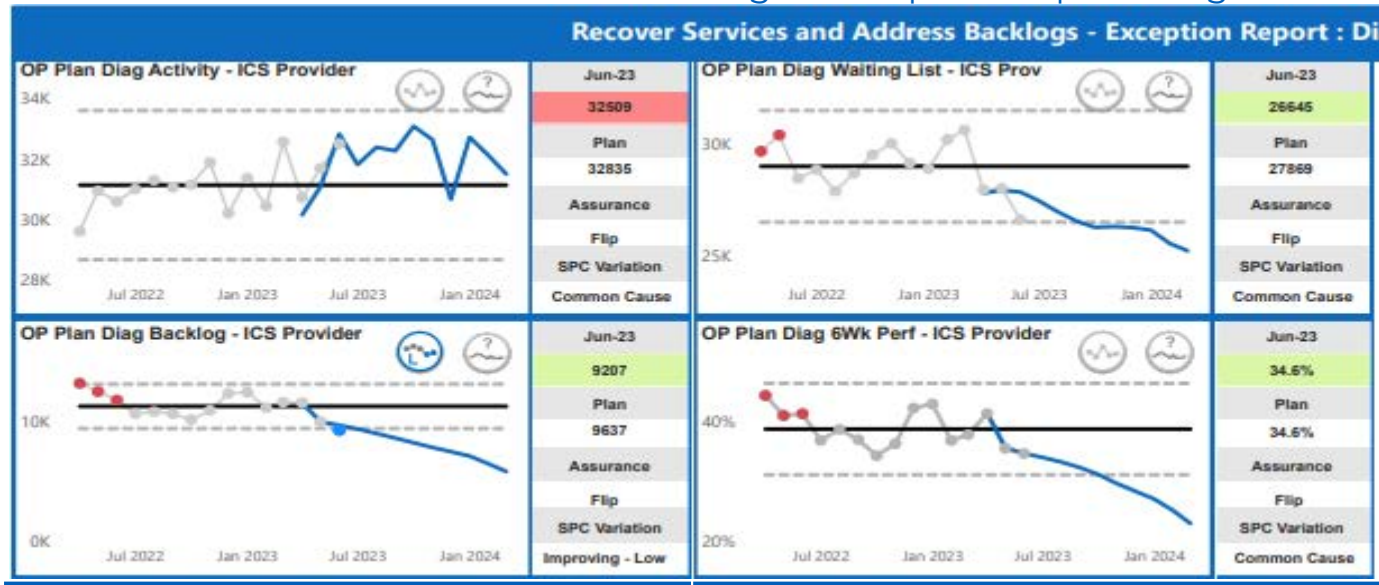
Oversight Level – Enhanced

62 Day Backlog- The latest weekly ICB data for week ending 27/08/23 is 437 patients against a plan of 364 patients. NUH have 361 patients against a plan of 305 and SFH have 76 patients against a plan of 59.

As at 27/08/2023 the proportion of patients waiting over 62 days at NUH is 11.04%, this is above the national position of 8.33%. 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. The forward plan of treatments indicates an improving position in September, but there are key risks around the impact of industrial action.

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



Provider	Waiting List	Backlog	%
MRI	6,166	2,326	37.7%
Computed Tomography	5,144	1,420	27.6%
Non-obstetric ultrasound	6,638	1,137	17.1%
Barium Enema	0	0	
Echocardiography	6,270	3,456	55.1%
Colonoscopy	829	241	29.1%
Flexi sigmoidoscopy	397	175	44.1%
Gastroscopy	1,201	452	37.6%
Total - Plan Modalities	**26,645**	**9,207**	**34.6%**
DEXA Scan	980	129	13.2%
Audiology	1,945	715	36.8%
Cardiology - Electrophysiology	0	0	
Neurophysiology	84	4	4.8%
Sleep studies	841	367	43.6%
Urodynamics	195	65	33.3%
Cystoscopy	375	97	25.9%
Total - All Modalities	**31,065**	**10,584**	**34.1%**

Summary

These charts display the aggregate latest position for MRI, CT, NOUS, Colonoscopy, Flexi-Sigmoidoscopy, Gastroscopy and Echocardiography.

Diagnostic activity, waiting list and 6-week performance: showing as common cause variation as there have not been sustained improvements in the position. However, barring diagnostic activity (which is 1% below plan) all are better than plan at June 2023. The position does vary significantly by modality and provider.
Diagnostic 6-week performance for plan modalities: June at 34.6% with the 6-week backlog decreasing to 9,207 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 2,326 patients at the end of June 2023 but has reduced since January 2023.
Echocardiography: The data for June shows that Echo is performing at 55.1% for the system. Significant pressures remain at SFH for this modality.

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. Recruitment to vacancies is underway. Mutual aid has been agreed within the system of 30 scans per month. Work is taking place to explore in sourcing of 250 scans per month. A revised recovery trajectory is under development to recognise this additional capacity. Longer term solutions around recruitment and the development of the CDC are required to support the service in future.

Oversight Level – Enhanced

Although the plan was not achieved in June (32,509 against a plan of 32,835) the levels of activity improved against the April (30,715) and May (31,698) position.

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.

Recovery trajectories are in place to enable monitoring of waiting list and 6 week waiter volumes. These are closely tracked and reported routinely to the diagnostic board. A deep dive meeting took place on 22nd August with NHSE and system colleagues to enable a granular discussion around the latest performance and position against recovery trajectories. Based on data for April to June, the system is tracking well against these trajectories.

The variation in modality and provider positions is driving the Enhanced level of oversight.

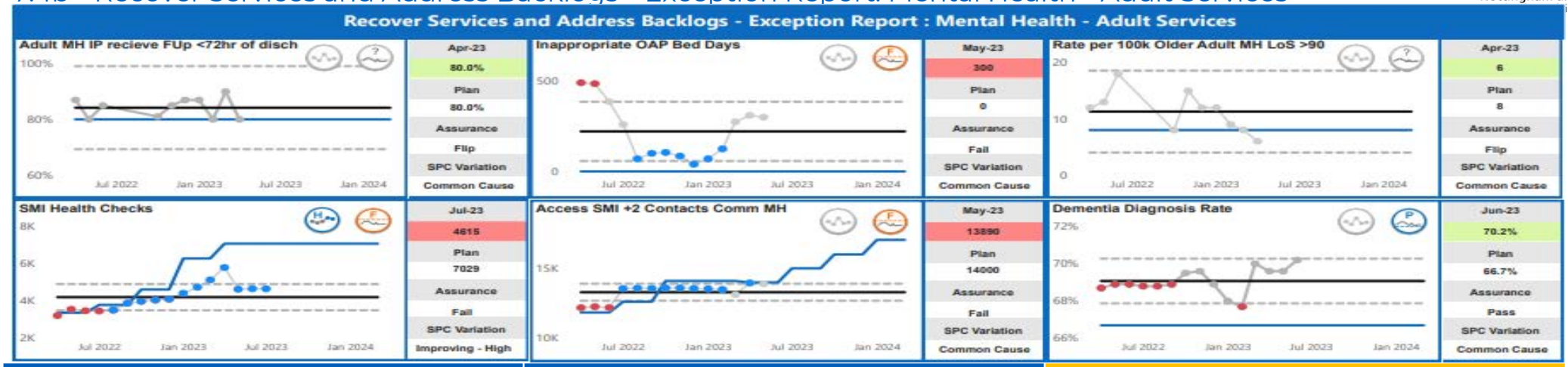
7.4 Service Delivery Mental Health Performance

7.4a – Exception Reports Mental Health NHS Talking Therapies
7.4b – Exception Reports Mental Health Adult Services
7.4c – Exception Reports Mental Health Access
7.4d – Exception Reports Mental Health CYP

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

Summary	Actions	Oversight Level – Enhanced
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 5275 patients entering treatment against a target of 8009. The service continues to achieve and exceed the 6 week (89.2%) and 18 week (99.5%) waiting time standards. Patients **waiting over 90 days** between 1st and 2nd treatments has increased, causing a concerning – high alert in month. **Recovery Rate** failed to achieve the 50% target with performance at 49.0% and has flip assurance and common cause variation.	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: - Increasing referrals- The provider has implemented a marketing and engagement plan, which includes launch of the NHS Limbic digital assistant as an online referral tool, use of digital tablets by community engagement team to make live referrals, promotional campaigns including a pharmacy bag campaign and digital campaign and partnership pack distribution and attendance at events. -Capacity - additional capacity was implemented in March 2023 to mitigate the closing of 2 of the 3 providers which reduced clinical capacity. The impact of this will be when March referrals complete treatment by October 2023. The provider has now achieved full staffing establishment. -Waiting times- As an improved stepped care model is implemented for referrals, the ratio of step 2/step 3 will change and the wait between 1st and 2nd appointment will improve as more patients needs will be met at step 2 which has greater capacity. - Recovery Caseload cleansing, and appropriate case closures of transferred cases has been completed in Q1. The service has commenced using a new supervision framework and weekly drop ins to support staff to maintain the 50% recovery rate. Recovery refresher training and pathway placement training will be rolled out during Q2.	Monthly contract meetings in place to review delivery and performance. Monthly contract executive group to be established from Q3

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 May 2023 has increased to 300. 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 July 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 on track to meet the quarterly trajectory.
Dementia –The ICB continues to exceed the national dementia diagnosis rate standard (70.2%) in June 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 Primary Care Networks (PCNs) is underway during Q2 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. An additional Health Improvement Worker is being recruited for Nottingham City to support City East PCN who have the largest SMI register and the lowest performance. They are expected to be in post by November and will increase performance against the check due to providing additional capacity. A small Peer Support Worker Team has been recruited to improve the access, experience, outcomes and follow ups of the health check. They will provide additional support to City PCNs from September.
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.

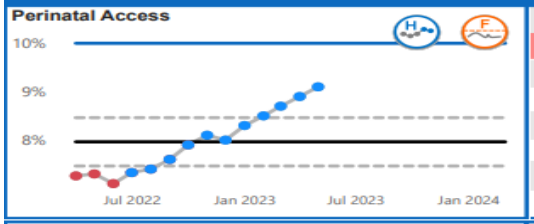
Dementia - An NHSE led audit of MAS took place in February 2023 and the MAS service signed up to the Memory Services National Accreditation Programme (MSNAP) process in November 2022 with results from the self-review published in April 2023. The results from these findings have been embedded into a new 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.

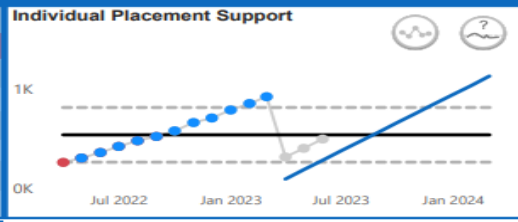
7.4c - Recover Services and Address Backlogs – Exception Report : Mental Health – Access

NHS Nottingham and Nottinghamshire

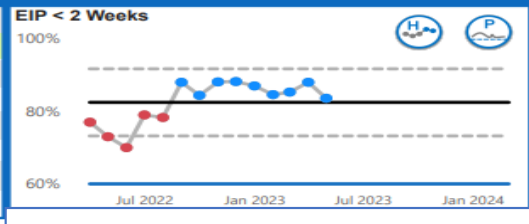
Recover Services and Address Backlogs - Exception Report : Mental Health - Access



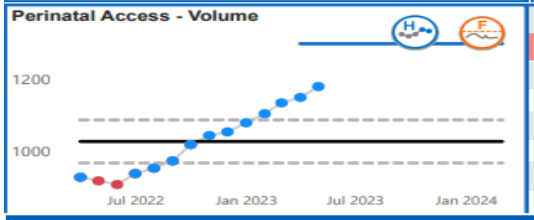
May-23
9.1%
Plan
10.0%
Assurance
Fail
SPC Variation
Improving - High



Jun-23
495
Plan
282
Assurance
Flip
SPC Variation
Common Cause



May-23
83.6%
Plan
60.0%
Assurance
Pass
SPC Variation
Improving - High



May-23
1180
Plan
1298
Assurance
Fail
SPC Variation
Improving - High

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 495 people accessing IPS as of June 2023 against a target of 282.

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 May 2023 shows a slight decrease in performance with 83.6% of patients accessing EIP within 2 weeks, compared to 86.5% in April 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.
•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 is being 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, which is on track. Following this a business case for the South EIP team will be developed with embedded learning from the evaluation. This is expected by end of Q2 2023/24.

Oversight Level – Enhanced

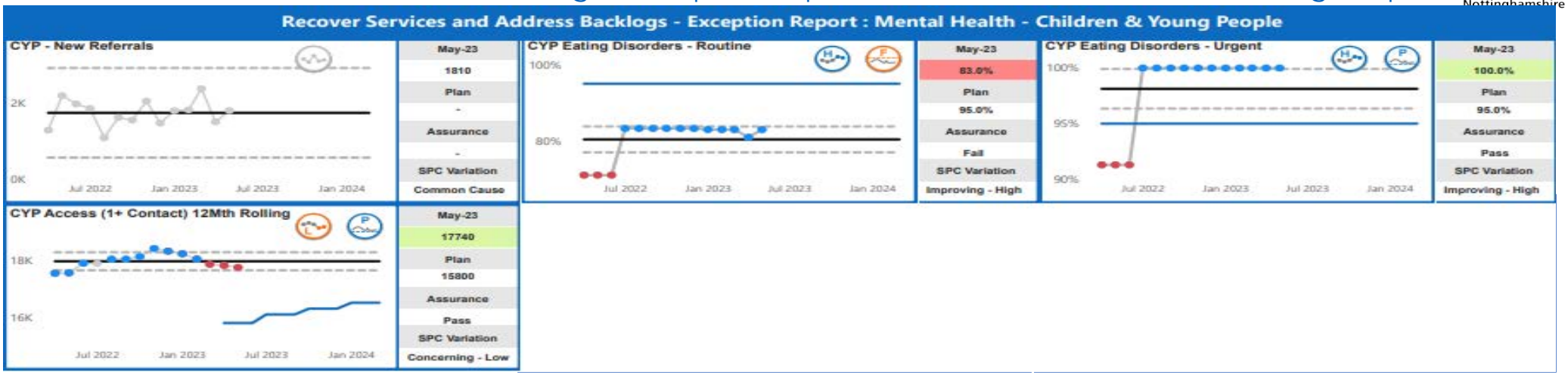
Perinatal - The team is commissioned to meet the LTP ambition. An ICS Perinatal Recovery Action Plan has been developed. The recovery improvement trajectory is March 2024 (12 months rolling performance). Performance against the recovery trajectory will be reviewed monthly.

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



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); 17,740 CYP were recorded as having at least 1 contact in the rolling 12 months ending May 2023 exceeding the annual plan of 16,507. **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 (<1 week)** – Improving - 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: • Reviewing space utilisation to expand access to clinical room availability and where possible. This seems to have rectified the issues previously experienced, however will continue to be monitored. • Continued protected time with Community CAMHs where joint assessments are required (to enable assessment within the routine timeframe). Recovery trajectory for 23/24 has been finalised which will see the delivery of the 95% target for routine referrals in Q4 2023/24.	**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. Provider 'Talkzone' is due to make its first submission this quarter (Q2). The service APTCOO is also preparing for submission (expected within Q3). **CYP Eating Disorder** - Investment plans have been agreed. Assumptions about referral trends have been endorsed by the regional Clinical Network. NHS England Clinical Network recognise slight reductions nationally but note presentations of disordered eating and ARFID are increasing. 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.

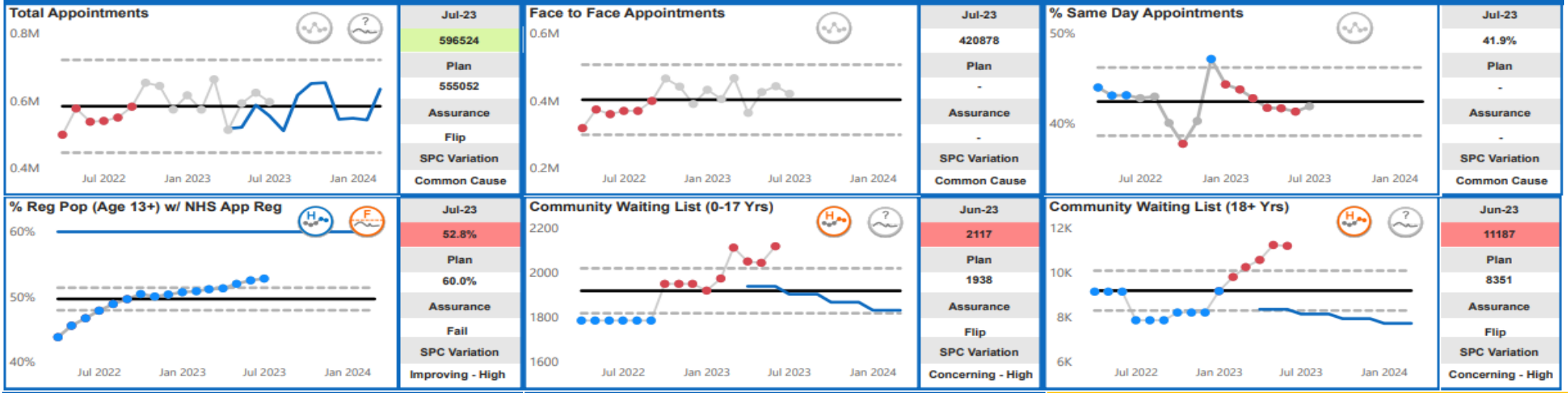
7.5 Service Delivery Primary & Community Performance

7.5a – Exception Reports Primary & Community

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

NHS Nottingham and Nottinghamshire

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



Summary

Total GP Appointments in July were 7.5% above the planned level. The percentage of appointments held face to face remains relatively consistent with previous months at 70.6%. GP Appointments within two weeks data shows that 77.8% of appointments were offered within two weeks in July 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 52.8% in July, however the position continues to increase steadily.

Community Waiting Lists - The June position reports significant pressures on the adult waiting list. The community waiting list for adults has increased gradually from the January position of 9,168 through to the June position of 11,187, however there has been a slight decrease on the May position of 11,227. The waiting list includes NHCT and CityCare community services for Nottingham and Nottinghamshire patients.

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, this appears to be supporting the increased progress towards the target 60% coverage.

Oversight Level – Enhanced

The waiting list for adults has increased gradually from the January position of 9,168 through to the JKune position of 11,187.

In June, there were 5,957 adult patients waiting for services at NHCT and 5,230 adult patients waiting at CityCare. Across both providers, the largest waiting list is for the MSK service, which has 3,831 patients waiting. There are 100 adult patients waiting more than 52 weeks, which span a number of services. The largest cohorts with patients waiting more than 52 weeks are Community nursing services with 41 patients and Podiatry and Podiatric Services with 40 patients.

NHS
Nottingham and Nottinghamshire

8.0 Finance

ICS Aim 3: Improving the Effective Utilisation of Our Resources (Enhance productivity & VFM)

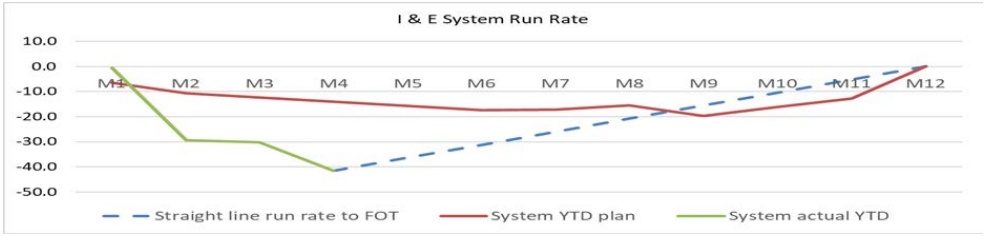
8.1 Month 4 Financial Position

8.2 Organisational Analysis

8.3 Financial Recovery Plans

8.1 - Finance Position - Month 4 2023/24 Key Metrics

- £41.6m deficit at month 4. £27.6m adverse to plan. In-month adverse variance of £9.8m
- Year to date, £14m planned deficit due to efficiency schemes planned for later in the year and profiling of UEC stretch plans.
- The position assumes full coverage of ERF shortfall as per NHSE guidance for month 4, including stretch ERF for the acute providers.
- Drivers of the variance can be analysed as follows
    - External factors (industrial action & inflation) - £4.5m
    - Prescribing & CHC pressures (ICB) - £6.4m
    - Planned actions not delivered including efficiencies, covid spend reduction and UEC escalation beds remaining - £14.7m
    - Increasing run rates compared to 22/23 - £18.6m of which:
        - £8.5m pay pressures at NUH mainly seen in substantive staffing increases.
        - £5.2m increased agency costs at NHT due to increased acuity, high staff absence and off-framework agency rates.
        - £4.9m of non pay pressures relating to drugs, premises and independent sector activity
    - Offsetting mitigations/balance - £16.6m
- All partners continue to forecast to achieve break-even. There are significant risk to the achievement of this position. Current quantification of unmitigated financial risk is £78.8m.
- The nature of the risks remain as described in the plan. Key risks includes inflation, efficiency, urgent care pressures, elective recovery and CDC income.



Month 4 Financial Position Year to date variance £'m	YTD Plan	YTD Actuals	YTD Variance	FOT
NUH	-4.6	-24.6	-20.0	0.0
SFH	-5.1	-6.1	-1.0	0.0
NHT	-4.3	-9.0	-4.7	0.0
N&N ICB	0.0	-1.9	-1.9	0.0
TOTAL	**-14.0**	**-41.6**	**-27.6**	**0.0**

Drivers of Variance £'m	NUH	SFH	NHT	ICB	Total
Planned close of UEC escalation beds not enacted	0	-2.5	0	0	-2.5
Organisational efficiency programmes	-5.6	0	-3.4	0	-9.0
Covid related spend not removed	-3.2	0	0	0	-3.2
NR impact of industrial action	-2.2	-1	0	0	-3.2
Inflation & pay award pressures	0	0	-1.3	0	-1.3
Prescribing pricing pressure	0	0	0	-3.9	-3.9
CHC pressure/S117	0	0	0	-2.5	-2.5
Pay/agency run rate pressures above plan	-8.5	0	-5.2	0	-13.7
Non pay pressures including drugs, premises and IS activity	-4.9	0	0	0	-4.9
Offsetting mitigations/balance	4.4	2.5	5.2	4.5	16.6
TOTAL	**-20.0**	**-1.0**	**-4.7**	**-1.9**	**-27.6**

8.2 - Finance Position – Organisational Analysis

Integrated Care System
Nottingham & Nottinghamshire

By Organisation £'m	YTD Plan	YTD Actuals	YTD Variance	In-month Plan	In- month Actuals	In month Variance	Total FY Plan	FOT	Variance
NUH	-4.6	-24.6	-20.0	0.4	-7.4	-7.8	0.0	0.0	0.0
SFH	-5.1	-6.1	-1.0	-1.3	-1.2	0.1	0.0	0.0	0.0
NHT	-4.3	-9.0	-4.7	-0.8	-1.0	-0.2	0.0	0.0	0.0
N&N ICB	0.0	-1.9	-1.9	0.0	-1.9	-1.9	0.0	0.0	0.0
TOTAL	**-14.0**	**-41.6**	**-27.6**	**-1.7**	**-11.5**	**-9.8**	**0.0**	**0.0**	**0.0**

- £9.8m in month adverse variance leading to a £41.6m year to date deficit, which is £27.6m adverse to plan.
- The position includes £18m of non-recurrent benefits. Much of this was expected later in the year leaving reduced scope for improvement in future months

ICB
£1.9m year to date adverse variance:
- Main driver is price increases in primary care prescribing (£3.9m).
- Pressures also seen in CHC (£1.4m) & S117 (£1.1m).
- Offset by £4.5m other plan movements & NR actions.
- Net likely risk to forecast estimated at £18m.

SFH
£1.0m adverse variance to month 3 arising from:
- £2.5m planned closure of escalation beds not enacted.
- £1.0m industrial action.
- Offset by £2.5m NR benefit from FIP delivery & CDC income assumptions.

NHT
£4.7m adverse variance arising from:
- £3.4m efficiency shortfall.
- £1.3m non-pay inflationary pressures.
- £5.2m agency spend over plan offset by £1.5m recruitment slippage.
- Offset by £3.7m of other NR actions.

NUH
£20.0m adverse variance with key drivers being:
- £8.5m substantive pay run rate increase.
- £3.2m costs previously attributed to Covid not stepped down
- £5.6m efficiency shortfall.
- £2.2m strike pay impact.
- £2.4m Drugs mainly cancer services
- £1.2m independent sector activity above planned levels
- £1.3m Premises (energy, PPM backlog etc.)
- Offset by £4.4m NR actions.

8.3 Financial Recovery Plans

Integrated Care System
Nottingham & Nottinghamshire

On 9 August the ICB received a letter from NHS England expressing concern over the regional and system financial performance, failing financial plans, and the need for additional system-wide action to address this. The letter recognises the key drivers of financial adverse performance as continued reliance on temporary staffing and under-development and non-delivery of efficiency plans.

The letter requests several actions including:

- Expectation for all systems to provide evidence of 'fully-developed' and 'in-delivery' plans for 90% of efficiency programmes by September 2023.
- Granular detail of the financial controls in place, by organisation, across your system, using the national guidance and June planning correspondence as a basis for compliance and consistent application of the rules.
- Development of an in-year financial recovery plan (FRP) with a key focus on these areas of delivery and with a robust and accountable board governance structure in place to oversee delivery.

The ICS has already agreed structures to strengthen the system wide delivery oversight of financial recovery. This will ultimately be through the Financial Recovery Group – a weekly meeting of CEOs and FDs to agree financial recovery actions. This will focus on the areas highlighted by NHSE as well as other areas critical to delivering financial recovery:

- Organisational efficiency –2023/24 plans total £192.8m. Good progress has been made in the development of plans with £177m now recognised as fully developed or in progress. However only 15% of the annual target has been delivered at the end of month 4 and less than half of year to date delivery is recurrent. Work is in train to understand gaps in delivery and trajectories to ensure recurrent delivery from Q3.
- Financial controls - All organisations have reviewed internal financial control environment and governance processes to support delivery of 2023/24 plan with a focus on recruitment and agency controls and clarity on the role of budget managers across the system. A full stocktake of controls against best practice is underway which will be a key element of the forward recovery plan. 360 Assurance are also undertaking an internal audit review of financial controls across systems partners. This will examine compliance against control mechanisms and the effectiveness of established controls.
- Urgent care reform – Delivery of an ambitious UEC pathway transformation and reset is critical in meeting operational requirements and releasing escalation capacity to support elective recovery. The ICS has engaged with PA Consulting who will work as a delivery partner in supporting an urgent care reset. System governance, work programme and timescales have been developed
- Elective recovery – Plans remain ambitious with 115% delivery of 2019/20 levels at NUH required to meet the plan and 111% at SFH. Further capacity is coming on line through Targeted Investment Funding (TIF) but this will need to be supplemented by acute productivity plans to drive more activity within existing staffing levels. NHSE have agreed a mitigation for the impact of industrial action in April reducing the overall target by 2%. Arrangements for the impact of further strikes after April have not yet been communicated.

NHS
Nottingham and Nottinghamshire

9.0 People and Culture

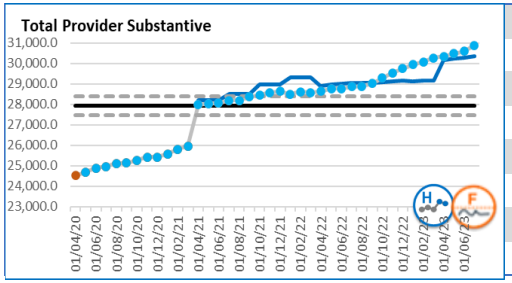
ICS Aims: All 4 (Outcomes, inequalities, productivity and social and economic development)

- 9.1 – Workforce – Exception Report Provider Workforce – Operational Plan v Actual
- 9.2 – Exception Report Provider Turnover & Sickness
- 9.3 – Exception Report Pay Run Rates
- 9.4 – Exception Report Agency Performance
- 9.5 – Social Care Employment Overview
- 9.6 – Social Care Projections
- 9.7 – Care Homes Workforce

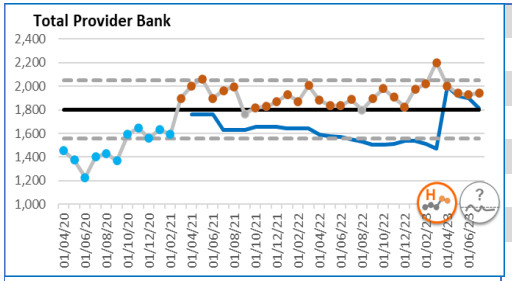
9.1 - Workforce – Exception Report Provider Workforce – Operational Plan v Actual

NHS Nottingham and Nottinghamshire

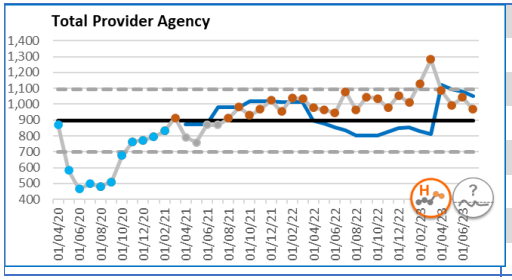
Total ICB Provider Workforce - Operational Plan v Actual 2023/24



Jul-23
30874.9
2023-24 Plan
30353.6
Assurance
Fail
SPC Variation
Improving - High



Jul-23
1943.5
2023-24 Plan
1812.4
Assurance
Fail
SPC Variation
Concerning - High



Jul-23
967.2
2023-24 Plan
1049.3
Assurance
Fail
SPC Variation
Concerning - High

Trust Positions

	NUH			SFH (adjusted for hosted WTE)			NHCT		
	July Planned	July Actual	Variance to Plan	July Planned	July Actual	Variance to Plan	July Planned	July Actual	Variance to Plan
No. Substantive staff	17236.0	17534.3	298.2	4811.8	4791.0	-20.8	8305.8	8380.6	74.9
No. Bank Staff	896.3	881.8	-14.5	511.9	420.1	-91.8	404.2	641.6	237.4
No. Agency Staff	660.5	538.0	-122.6	122.6	121.6	-0.9	266.2	307.6	41.4
Total Workforce	**18792.9**	**18954.0**	**161.2**	**5446.3**	**5332.7**	**-113.6**	**8976.2**	**9329.8**	**353.7**

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.
The Agency Reduction working group will be reviewing the month 4 Agency usage and spend in detail and assessing the impact of trust action plans. The detail is not available to meet the deadline for reports for SOG. Trust action plans are targeted around certain hotspot areas with initial focus on nursing and HCA but now broadened to non-clincial usagehaving positive impacts with reductions in off framework usage, reductions in agency usage. There are apparent differnet drivers for each of the Trusts given teh nature of different service provision but opportunities to standardise approaches across providers.
The appointment of a Deputy Director - Resourcing and System Retention lead will provide additional capacity in looking at the drivers and increased understanding gained at organisational level to ascertain thematics that can be taken forward at a system level 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.

Providers are above plan on substantive supported by improved positions on utilisation of bank staff and agency usage. However, the impact on the pay bill and comparison with 22-23 costs provides an area of concern.

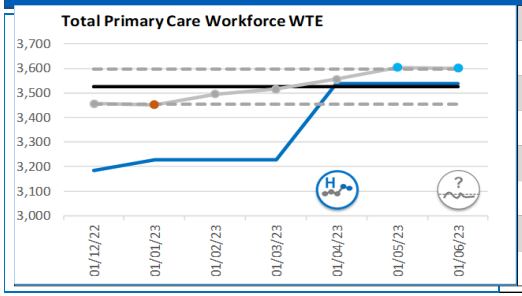
P&C Group Limited Assurance - Further Information Required

Total Providers:
Plans are in place as per submitted operational plan. Improved monitoring of in-year performance in progress has been negatively impacted by national return changes to the PWR . SAIU are devloping the reporting analysis in alignment with Finance given the focus on pay bill and targets around agency usage and spend.

Provider information taken from PWR's and is a count of WTE's.

9.1 - Workforce – Exception Report Provider Workforce – Operational Plan v Actual (con'd)

NHS Nottingham and Nottinghamshire



Jun-23
3604
Target
3539
Assurance
SPC Variation
Improving - High

Total ICB Primary Care Workforce - Operational Plan v Actual 2023/24

Primary Care	Actual Q1	Plan Q1		Plan Q2	Plan Q3	Plan Q4
Nottingham And Nottinghamshire Health And Care STP	As of the end of Jun-23	As at the end of Jun-23	Variance to Plan	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	WTE	Total WTE	Total WTE	Total WTE
Total Workforce	**3601**	**3539**	**62**	**3624**	**3687**	**3731**
GPs excluding GPs in Training Grade	565	574	-9	571	576	570
GPs in Training Grade	227	226	1	254	263	256
Nurses	361	356	5	356	359	359
Direct Patient Care roles (ARRS funded)	582*	546	37	596	634	679
Direct Patient Care roles (not ARRS funded)	271	270	1	272	273	277
Other – admin and non-clinical	1595	1568	27	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

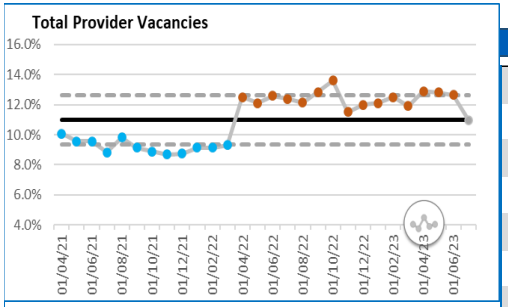
The overall workforce position is being maintained with an established retention/workforce development programme in place for General Practitioners and Practice nurses.
Recruitment continues in to the additional roles but not to the full potential of funding allocations. Training Hub support is being 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 given SDF allocation is now a single pot with no ring-fenced funding for workforce development. The allocation of the system SDF is currently being taken through the Primary Care Strategy Delivery Group and its governance.

P&C Group Limited Assurance - Further Information Required

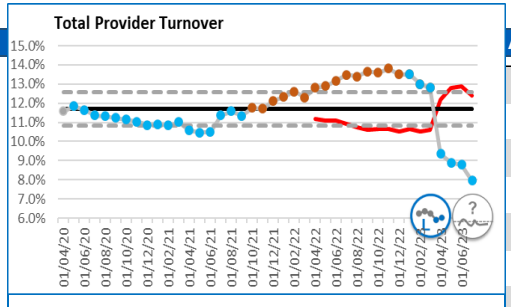
Primary Care - General Practice:
Plans are in place and are effective but more needs to be done to make general practice an attractive offer supporting staff, offering flexibility in working and cultural shift to integrated working.
Leads from the Primary Care Workforce group are engaging with PCN leads to determine next steps in supporting retention and recruitment challenges being experienced.
The establishment of the Primary Care Strategy Delivery Group 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 Provider Workforce –Turnover & Sickness Reports

NHS Nottingham and Nottinghamshire

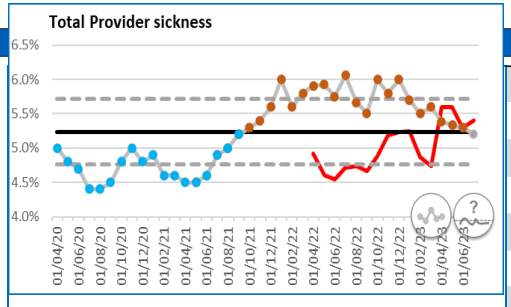


Jul-23	
10.9%	
2023-24 Plan	
Assurance	
SPC Variation	
Concerning - High	



Absence

Jul-23	
8.0%	
2022-23 Plan	
12.5%	
Assurance	
Fail	
SPC Variation	
Concerning - High	



Jul-23	
5.21%	
2022-23 Plan	
5.40%	
Assurance	
Fail	
SPC Variation	
Concerning - High	

Summary

Vacancies have decreased slightly in all providers with a wide variation across providers: 3.5% - 13.9%

Turnover - A positive position seen in Total Providers with Turnover rates below plan for this period.

Sickness levels continue to improve against planned positions and reflect a positive position against a changed baseline of sickness levels post covid.

Actions

Trusts are seeing variation in levels of **vacancies** across the different staff and professional groups, nursing and clinical support remain the highest but are linked to establishment changes made as a result of agreed investments in year. Trusts are also reviewing recruitment capacity to support the recruitment intentions, targeting those services where higher vacancies are being seen. Exit interviews are being conducted and will be linked to staff survey responses. Workforce development such as leadership training, growing new roles and increased capacity to support recruitment areas are in place or being enhanced in Trusts. Increased options around flexible working being piloted. **Turnover** seen in the Total Providers reflects the national position with Nursing contributing in both registered and Health Care Workers categories. Each Trust has completed a retention assessment and are developing action plans working with regional leads on targeted areas. Promotion and work life balance continue to be common reasons for leaving. Flexible working remains a key area of development. A review of this years Staff Survey outcomes will inform system decisions. Trusts continue to review and enhance their **wellbeing plans** including mental health First aiders and Professional Advocate roles. Funding has ceased for system level staff support hub.

People & Culture Group Assurance - Further Information Required

Vacancy positions are informed by varing methodologies across the Trusts - discussion on a standardised approach to be scheduled.
More granular understanding of turnover rates in service areas aligned to vacancies and agency and bank usage to be developed
Plans are in place but more detail is needed to determine if targeted interventions are required. There is more detail provided as part of 23/24 operational plan submissions with plans to review opportunities for collaboration across providers as set out in the Integrated Care Strategy (single recruitment hub and collaborative bank arrangements).

9.3 – Workforce – Pay Run Rates

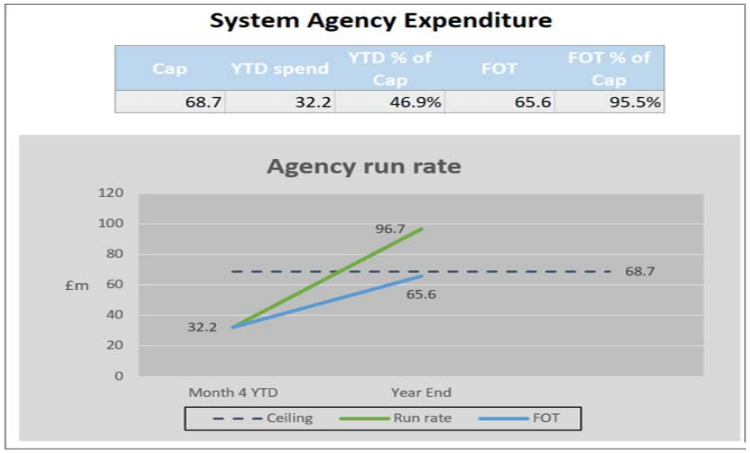
Pay Run Rates

Organisation	Total WTE movement				Breakdown of movement (22/23 Avg M1-11 to 23/24 M4)					
	2022/23 Avg M1-11	2023/24 M4	Growth		Substantive growth / (reduction)		Bank growth / (reduction)		Agency growth / (reduction)	
	WTE	WTE	WTE	%	WTE	%	WTE	%	WTE	%
NUH	17,696	18,954	1,258	7.1%	1,263	7.8%	76	9.4%	(81)	-13.1%
SFH	5,437	5,502	64	1.2%	143	3.0%	(80)	-16.0%	1	1.1%
NHT	9,012	9,330	318	3.5%	236	2.9%	52	8.9%	30	10.7%
Total	**32,145**	**33,786**	**1,640**	**5.1%**	**1,642**	**5.6%**	**48**	**2.5%**	**-50**	**-4.9%**

Organisation	Total £'ks movement				Breakdown of movement (22/23 Avg M1-11 to 23/24 M4)					
	2022/23 Avg M1-11	2023/24 Avg M1-4	Growth		Substantive growth / (reduction)		Bank growth / (reduction)		Agency growth / (reduction)	
	£'ks	£'ks	£'ks	%	£'ks	%	£'ks	%	£'ks	%
NUH	£82,589	£87,914	£5,326	6.4%	£5,384.8	7.2%	£69	2.1%	-£128	-3.1%
SFH	£25,645	£26,220	£575	2.2%	£704.5	3.4%	-£139	-4.5%	£9	0.6%
NHT	£36,251	£37,969	£1,719	4.7%	£666.9	2.1%	£200	8.5%	£851	51.2%
Total	**£144,485**	**£152,104**	**£7,619**	**5.3%**	**£6,756.2**	**5.3%**	**£130**	**1.5%**	**£733**	**10.0%**

- The above tables demonstrate how our 2023/24 workforce and paybill compare to those experienced in 2022/23.
- 2022/23 pay has been normalised for inflation at 4.5% (NHSE figures based on agenda for change uplift).
- This shows a significant increase in pay costs compared to 2022/23. Wtes are 1,640 higher in July than the average of 2022/23 equating to a £7.6m increased real-terms cost.
- The growth is mainly in substantive staffing. Some of this relates to increases in urgent care capacity through 2022/23 but further investigation is required to establish a granular understanding of this growth.
- Although there has been a small reduction in agency staffing, costs have increase significantly, potentially due to increased agency rates.

9.4 – Workforce – Agency Performance



Agency Ceiling & Spend

- Agency spend YTD position is over plan with an adverse YTD variance of £8.6m.
- The system has been provided with an agency cap of £68.7m. The 2023/24 plan is to spend £62.9m, £5.8m below the cap.
- The forecast at M4 is £3.1m under the agency cap & £5.8m over plan.
- Agency as a % of the total pay bill were submitted at 3.7% in line with expected national requirements.
- YTD agency as a total of pay bill is 5.3% with FOT being 3.8%

Agency £'m	Acts 22/23	Plan YTD	Actual YTD	Variance YTD	Plan 23/24	FOT 23/24	Variance FOT
NUH	49.3	13.1	15.9	**-2.8**	35.7	35.7	**0.0**
SFH	18.1	5.7	6.3	**-0.6**	13.0	15.7	**-2.7**
NHT	19.6	4.8	10.1	**-5.3**	14.2	14.2	**0.0**
TOTAL	**87.1**	**23.6**	**32.2**	**-8.6**	**62.9**	**65.6**	**-2.7**
Agency Cap	**54.6**				**68.7**	**68.7**	
(Over)/under Cap £'m	**-32.5**				**5.8**	**3.1**	
(Over)/under Cap %					**8.4%**	**4.5%**	
Total Pay Costs			**608**		**1,721**	**1,725**	
Agency as a % of pay costs			**5.3%**		**3.7%**	**3.8%**	

9.4 – Workforce – Agency performance

NHS Nottingham and Nottinghamshire

Price Cap & On Framework Compliance

- The system is reporting a **59% (YTD**) of shifts being filled by agency as being compliant with the **price cap rules** with 41% being non-compliant.
- Each provider has set quarterly financial improvement trajectories for 2023/24 price cap compliance. The NHSE target is 100% compliance i.e. within price cap rules.
- The system is reporting a **91% (YTD**) of shifts being filled by agency as being **compliant with the framework rules.** The NHSE target is 100% compliance.

	Actuals per month				
Off Framework Compliance	**M1**	**M2**	**M3**	**M4**	**YTD**
NUH	97%	97%	99%	100%	98%
SFH	100%	100%	100%	100%	100%
NHT	81%	80%	80%	84%	81%
SYSTEM	**91%**	**90%**	**90%**	**91%**	**91%**

				Trajectories 2023/24				Actuals per month			
Price Cap Compliance	**Plan Q2**	**YTD M4**	**Var to Q1 Traj**	**Q1**	**Q2**	**Q3**	**Q4**	**M1**	**M2**	**M3**	**M4**
NUH	52%	27%	-25%	47%	52%	57%	62%	26%	27%	27%	29%
SFH	57%	46%	-10%	52%	57%	62%	67%	52%	40%	47%	45%
NHT	92%	94%	2%	88%	92%	95%	98%	95%	94%	94%	92%
SYSTEM		**59%**						**59%**	**58%**	**58%**	**59%**

Use of Non-Medical Admin & Estates £'ms

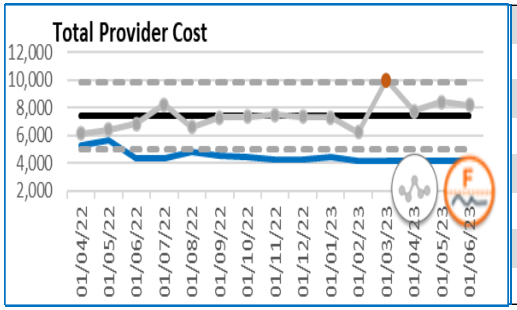
- Agency rules are that Trusts are required to use only substantive or bank workers to fill admin and estates staff.
- Trusts should only use agency workers to fill these shifts where they meet NHSE specific criteria.
- Administration and Estates Agency expenditure accounted for 8.3% of total agency spend and despite agency rules only a small proportion of the total spend was covered by an approved business case.
- At M3 23/24, Midland region administration and estates agency expenditure accounted for 7.0% of total agency costs.
- Nottingham and Nottinghamshire ICB was a significant outlier with a spend accounting for 17.1% of our total agency spend YTD.
- At M4 23/24, the ICB's use of non-medical admin & estates agency spend was 16% of the total agency spend.

	Actual YTD			
Use of Non-Medical Admin & Estates £'ms	**NUH**	**SFH**	**NHT**	**System**
Non-Medical Admin & Estates Agency Spend	5.2	0.1	0.1	5.3
Total Agency Spend	15.9	6.3	10.1	32.2
% use of non-medical estates & agency	**32%**	**1%**	**1%**	**16%**

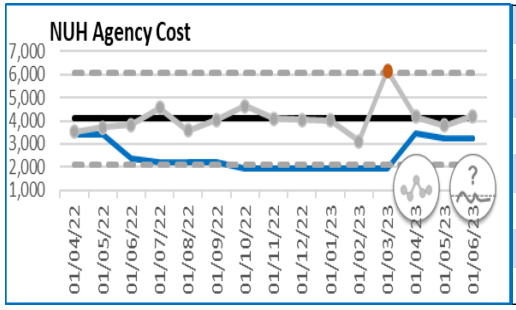
9.4 – Workforce – Exception Report Agency Cost

NHS Nottingham and Nottinghamshire

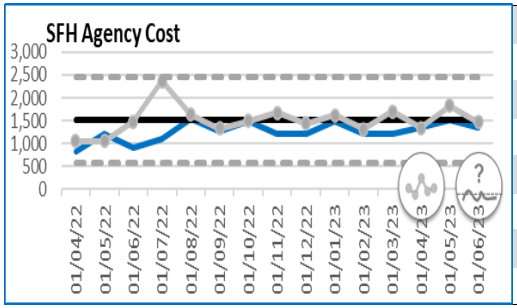
Total Provider Agency Cost



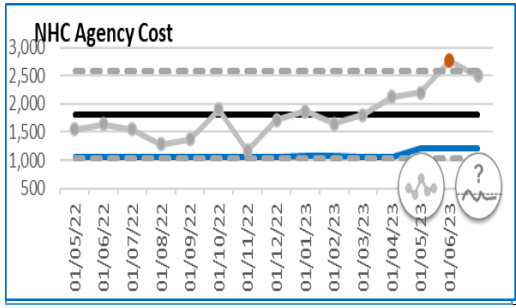
Jun-23
£8,176
Assurance
Fail
SPC Variation
Common Cause



Jun-23
£4,204
Assurance
Fail
SPC Variation
Common Cause



Jun-23
£1,469
Assurance
Flip
SPC Variation
Common Cause



Jun-23
£2,502
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 on substantive, above plan for use of bank staff and above plan for use of agency with high percentage being off framework in Nursing and more so in Healthcare Support Worker staff groups. All three trusts still have on framework above price cap spend so the system is not compliant on the target of 100% within Price cap target.

Actions

Trusts have individual action plans to deliver the expected reduction in agency usage and spend which crosses over recruitment, retention and wellbeing strategies. The Agency Reduction Working Group will review the month e 2 position and actions plans to strengthen the 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.

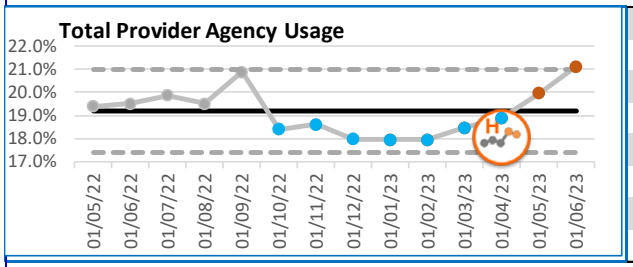
People & Culture Group Assurance - Further Information Required

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

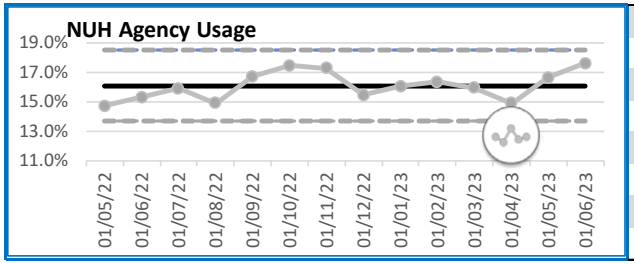
NHS Nottingham and Nottinghamshire

9.4 – Workforce – Exception Report Agency Usage

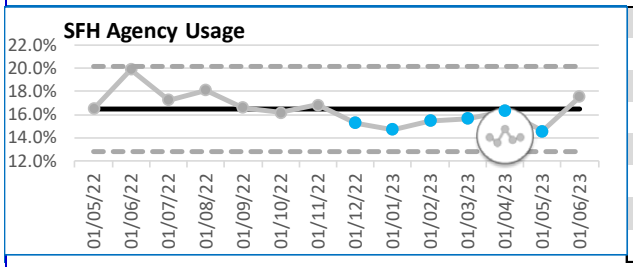
Total Provider Agency Usage



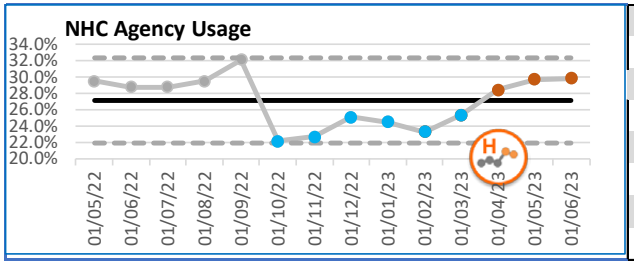
Jun-23
21.12%
2023-24 Plan
-
Assurance
-
SPC Variation
Common Cause



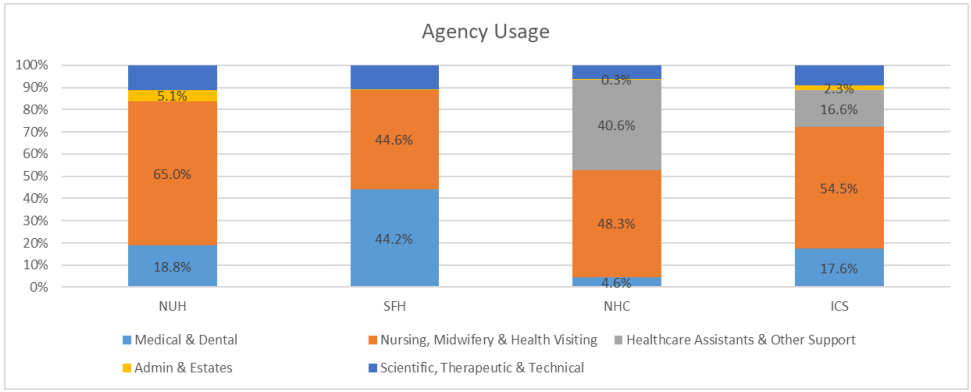
Jun-23
17.60%
2023-24 Plan
-
Assurance
-
SPC Variation
Common Cause



Jun-23
17.55%
2023-24 Plan
-
Assurance
-
SPC Variation
Common Cause



Jun-23
29.82%
2023-24 Plan
-
Assurance
-
SPC Variation
Common Cause



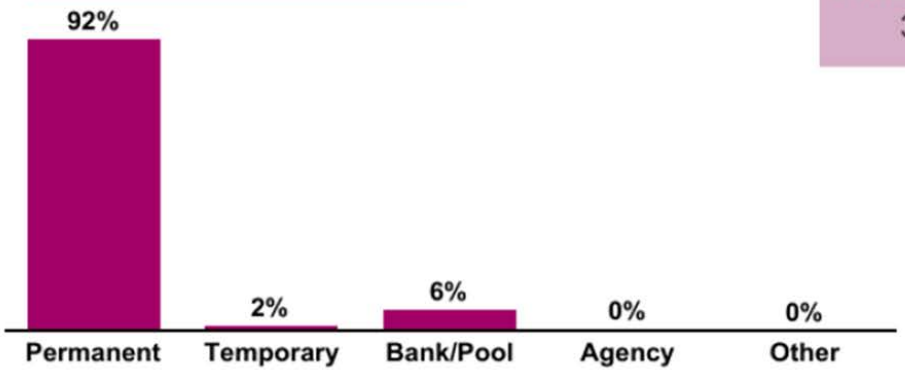
9.5 – Workforce – Social Care Employment Overview

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**)

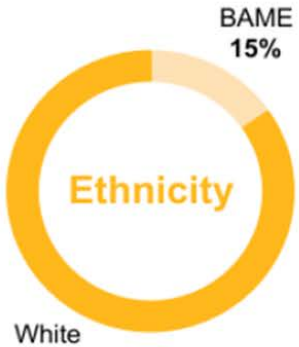
Demographics

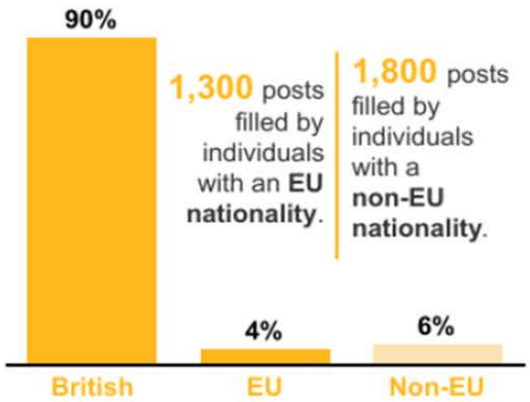
Gender

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

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

Ethnicity and nationality



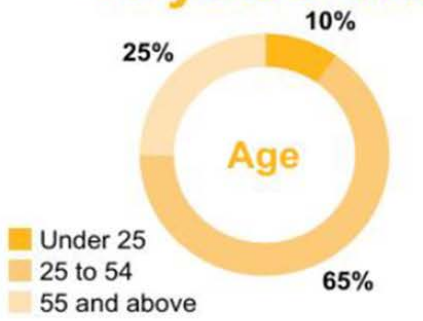


1,300 posts filled by individuals with an **EU nationality**.

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

Age

The average **age** was
43 years old

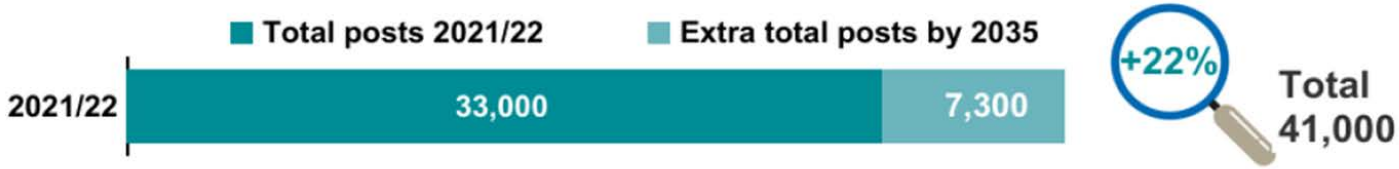


9.6 – Workforce – Social Care Projections

NHS Nottingham and Nottinghamshire Integrated Care System

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.

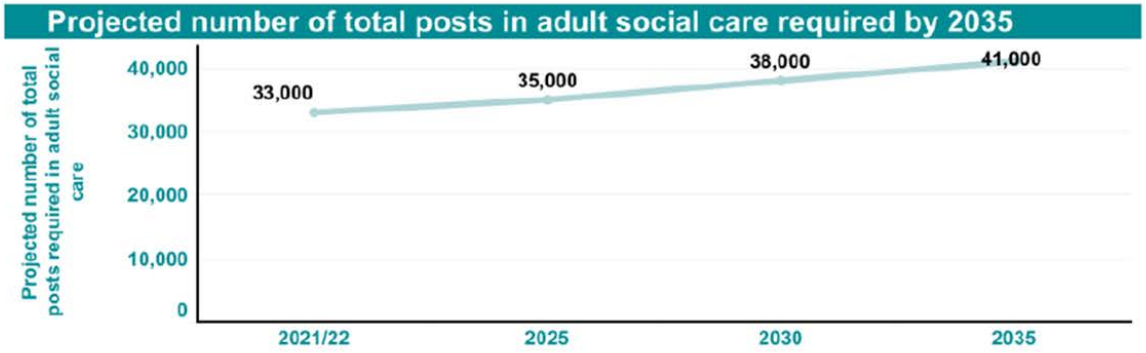


If the adult social care workforce grows proportionally to the projected number of people aged **65 and over** in the population then the number of adult social care filled posts will...

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

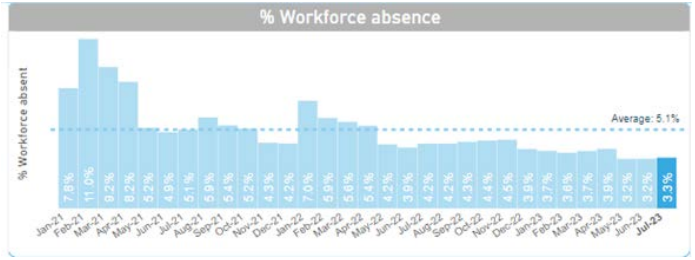


9.7 - Care Homes Workforce

Workforce absence and agency staff

Monthly staff trend: All staff

Aligned PBP	Employed	Absence	%	Agency	%
Bassetlaw	1,591	36	2.3%	160	9.1%
Mid Notts	4,352	157	3.6%	231	5.0%
Nottm City	2,649	87	3.3%	128	4.6%
South Notts	4,620	155	3.4%	216	4.5%
Total	**13,212**	**435**	**3.3%**	**735**	**5.3%**



Care Home workforce absence is a currently 3.3% across all staff groups. This is lower than 5.1% during Jul 21 and 4.2% during Jul 22. For Jul 2023, nursing staff have the lowest reporting with only 8 out of 573 (1.4%) staff absences. Compared with Apr 23 reporting, overall CH staff employed has increased from 12,944 to 13,212 (2.1%).

As reported in Apr 23, Agency staff percentage continues to decrease possibly due to better reporting in the National Capacity Tracker. Work continues to contact services reporting higher numbers of agency staff to ensure correct reporting. Compared with Apr 23 reporting, overall CH agency staff has decreased from 928 to 735 (-20.8%).

SAIU SYSTEM ANALYTICS INTELLIGENCE UNIT

Data and visuals taken from the Care Home & Home Care SIR July 2023 on the SAIU Portal

NHS
Nottingham and Nottinghamshire

10.0 Health Inequalities

ICS Aim 2: Tackle inequalities in outcomes, experience and access

- 10.1 – Health Inequalities Headlines
- 10.1a – Health Inequalities and Innovation Investment Fund Schemes
- 10.2a – Core20+5 Adults
- 10.2b – Core 20+5 Children – CYP Mental Health
- 10.3 – A Neighbourhood Overview
- 10.4 – Access and Experience – Waiting Lists & ED

10.1. - Health Inequalities Headlines

NHS Nottingham and Nottinghamshire

Key Deliverable

Health Inequalities Innovation and Investment Fund (HIIF) – 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.

HIIF Schemes – The schemes approved as part of the fund cover three core areas that align with the ICS Strategy and Joint Forward Plan and will impact on health inequalities. These include Severe Multiple Disadvantaged, Integrated Community Working and Best Start in Life. 10.1a provides more detail in relation to the population need and impact. Schemes include the following:

Severe Multiple Disadvantaged (SMD)	Integrated Community Working	Best Start in Life
• Nottingham City SMD Infrastructure and Delivery Model covering • County Integrated Severe and Multiple Disadvantage Clinical Team	• Integrated Neighbourhood Teams – Bassetlaw • Integrated Neighbourhood Teams – Mid Notts • Integrated Neighbourhood Workiing – South Notts • Co=designed Community Hypertension Case Finding	• Family Mentor Programme • Childhood Vaccs and Imms in Nottingham City • Obesity in Children and Young Poople
SMD is an identified priority and inclusion health group for Nottingham and Nottinghamshire, supported by the Core20+5 framework. The HIIF schemes that have been approved allow for alignment and an integrated approach that fully covers the needs of this population cohort across Nottingham and Nottinghamshire and aligned with Place.	Engagement, co-production and subsequently effectively working at a hyper-local and neighbourhood level allows for a more effective approach to address and impact on health inequalities. Integrated community working directly improves both access and experience recognising the diversity across population cohorts. Working in this way provides considerable benefits across the health and care system including a greater understanding and impact on unmet need, reducing demand on the health and care system and building community resilience. Also, focusing on underlying determinants motivates staff, as their roles combine the clinical and care elements with a more relational approach. In Nottingham, between 17% and 24.1% of the difference in life expectancy between areas of high and low deprivation is a result of modifiable circulatory disease.	Children living in poverty are more likely to have poorer health outcomes including low birth weight, poor physical health, and mental health problems. The health impacts of growing up in poverty are significant and follow children across their lives. The schemes identified target the populations with the greatest inequalities and align with the ambitions in the ICS Strategy and the priority to support children and young people to have the best start in life with their health, development, education and preparation for adulthood.

Funding has also been approved to support the evaluation of the Fund. A working group led by Public Health will take this forward. The proposal includes a framework to allow for ongoing evaluation of the impact of the fund overall as well as evaluation of individual schemes.

10.1.a - Health Inequalities Headlines – Health Inequalities Innovation and Investment Fund Schemes

NHS Nottingham and Nottinghamshire

Severe Multiple Disadvantaged	***Integrated Community Working***	***Best Start in Life***
A national definition and case management structure exists for Severe and Multiple Disadvantage (SMD) which is a combination of three or more disadvantages, including: homelessness, problematic substance use, mental-ill health, domestic and sexual violence and/or abuse, and interaction with the criminal justice system. People experiencing SMD have a dual challenge of being compromised by their circumstances e.g. addiction, homelessness or mental ill-health and barriers e.g. stigma, mistrust, or exclusions due to trauma related behaviour that leave them less able to access preventative healthcare People experiencing SMD and/or with high alcohol dependency are among the most vulnerable within our population in their exposure to poor physical health, mental ill-health, and poor wellbeing. The challenges they face substantially increases their risk of the early onset of chronic health problems, shortened healthy life expectancy and premature death. *NB The ICS has commissioned an exploratory research study relating to the experience of Severe and Multiple Disadvantage (SMD) in ethnically diverse communities in Nottingham City. The research study will also support a better understanding of the definition of SMD locally.* For Nottinghamshire County the funding will provide new clinical capacity in underserved areas with no or insufficient provision. This investment will add to and transform existing fragmentated pieces of clinical provision for those with alcohol dependency and SMD into a dynamic, evidence based integrated offer that will address physical health, mental health and drug and alcohol dependency problems at the same time. In Nottingham City the funding allows for sustainability and the continuation of the integrated model developed through Changing Futures and led by the Place Based Partnership. By taking a MDT and integrated approach individuals will benefit from wider preventative support therefore reducing reactive, repeated and long-term use of emergency care.	Bassetlaw Place Based Partnership (BPBP) aims to develop three Integrated Neighbourhood Teams (INT). By working closely with the Core Access Hubs, the INT will undertake proactive case finding to facilitate the provision of targeted interventions supporting the delivery of person centred holistic approaches with those people in greatest need. For Mid-Notts the funding is over a two-year period to pump prime the development of four INTs. These teams will be focussed on the population health needs of each of the four defined communities / identified neighbourhoods in Mansfield, Ashfield, Newark and Sherwood. The PBP will work with communities through a range of engagement approaches, analysing data, co-designing and co-producing specific interventions as well as understanding what the neighbourhood assets are available in order to build the INTs. South Notts will target four areas with the highest health inequalities which are Eastwood Town, Hucknall Town, Arnold Town and Cotgrave. Integrated neighbourhood working will adopt the 20 minute neighbourhood approach with an ambition to improve health and wellbeing and reduce health inequalities within these communities. The intention is to fully integrate services to meet the health and wellbeing needs of the population, recognising this includes services which impact the wider determinants of health. The community hypertension scheme is a proposal for non-recurrent funding to support the co-design and delivery of an asset-based approach to community hypertension case finding. The approach will be piloted in areas and/or to population cohorts where the key risk factors cluster (e.g. deprivation, black ethnicity, health behaviours) to maximise the potential to impact on health inequalities.	The Family Mentor Programme has been co-produced in Nottingham and is a community-based approach that supports parents from pregnancy through to the first 12 months of a baby's life. Family Mentors are a paid peer workforce of parents, from the local community and employed by local voluntary and community sector (VCS) organisations. Childhood Imms - Childhood immunisation helps to prevent disease and promote child health from infancy, creating opportunities for children to thrive. Reducing inequalities in access to immunisation coverage should allow everyone to have the same opportunities to lead a healthy life, in all age groups. Taking learnings from increasing the uptake for COVID19 vaccinations, the programme is targeted to neighbourhoods with Nottingham City where figures are well below the 95% World Health Organisation target required to sustain elimination of diseases such as measles and rubella. Children and Young People Obesity Scheme - Nationally in 2020/21, the prevalence of obesity in children in the most deprived areas was more than double the value in the least deprived areas. This is true both for children in Reception and in Year 6. In Nottingham City this inequity gap is growing at an even greater rate compared to national average for those from most deprived households and there is an over-representation of Black African and Bangladeshi ethnic groups compared to the national prevalence. Furthermore, a worrying accompanying trend is the corresponding rise in the number of severely obese children who have a comorbidity due to their excess weight such as Type 2 diabetes, sleep apnoea and heart disease.

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	Annual health checks for 60% of those living with SMI	Aug 23	1730	7029	F		3296	1245	5347
2	Uptake of Covid and Flu Vaccine in people with COPD	Aug 23	0%	100%	F	L	50%	33%	66%
3	Reduction of emergency admissions in people with COPD	Aug 23	5%	0%	F	L	6%	1%	10%
4	75% of cancer cases diagnosed at stage 1 or 2 by 2028	Jan 23	50%	75%	F		53%	50%	56%
5	Reach 80% of expected hypertension diagnoses by 2029	Jan 20	74%	80%	F	H	73%	72%	73%
5	Optimal treatment of high risk CVD (QRISK > 20% currently on statins)	Aug 23	75%	80%	?	H	69%	49%	88%

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. Uptake for 22/23 in people with COPD was 65%.
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.

NHS Nottingham and Nottinghamshire

10.2b Tackling Health Inequalities – The 5 in the 'Core20Plus5' – Children

Children and Young People Mental Health – a health equity audit has been carried out to understand equity of access, experience and outcomes for Nottingham and Nottinghamshire children and young people. A health equity audit (HEA) is a process that examines how health determinants, access to health services and related outcomes are distributed across the population. It identifies inequalities in order to ensure health resources are distributed in relation to the health needs of different groups. The health equity audit includes recommendations which are outlined below and are being taken forward by the ICS.

Key Trends and Outcomes:

Since 2019 there has been a gradual increase in the numbers of children and young people attending mental and emotional health services (levels currently exceed those previous to COVID)
There are higher rates of individual service users in Mansfield, Ashfield and Gedling which may be reflective of the services
Therefore, the equity profile considers the demographics of those accessing services with expected usage based on population need/known prevalence of mental health conditions
Age – Those 11-16 have a higher usage than expected need and 6-10 and 20-23 have a lower usage than expected need. The figures for those aged between 6-16 may be due to the role that schools play in supporting referrals.
Ethnicity – The Asian population appears under-represented compared with need. The ratio for the Black population suggests that this group has higher access to services than expected.
Geographical/Local Authority – Bassetlaw shows a significantly higher number of individuals access services than expected. Rushcliffe has fewer individuals than expected accessing services and all other areas, access falls predominantly as expected.
Deprivation - meaningful equity analysis based on deprivation is not possible, as it is not a true analysis of difference between need and service use by deprivation quintile. When looking at age related data it does seem to indicate that usage is higher than expected need in the 20% most deprived.

Recommendations:

1. Areas for Further Examination
Recommendations sit across Public Health, ICB and Providers and include the following:
Areas for further examinations includes the university student cohorts. This work is supported by the Further and Higher Education Mental Health and Suicide Network
2. Data Improvement
Make representations to the relevant national research team for the NHS Digital national survey of prevalence of mental health need in children and young people (0-24) to enhance their data collection
Improve recording of SEND and ethnicity data
Data capture in order to inform equity of access
Clarity on outcomes and relevant measure
3. Addressing Identified Inequities
Work with Place Based Partnerships on local actions in response to the findings
Focused work on children aged 6-10 and those with Asian ethnicity
Providers to identify actions to provide equity of access
4. Engaging with Young People to Promote Action
Use the equity audit to drive forward co-production and shape future services
Work with the local charity MH:2K Group to engage with young people and rpromote action
Drve forward action plans based on you said/we did
5. Dissemination and Promotion of Learning
Hold an ICB?Public Health CPD session to share the findings from the audit and drive forward action

Content Author: Hazel Buchanan	Executive Lead: David Briggs	System Oversight: Health Inequalities Group	ICB Committee: Finance & Performance Committee

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.

10.4 Access & Experience – Elective Recovery and Urgent Care

Waiting Lists and Outpatients

Waiting Lists

Current Waiting List Date Ending - 06/08/2023

IMD Quintile (1 - Very Deprived)	Patients	% Patients	Population Count	% Population
5	23755	17.49%	231,491	18.65%
4	22142	16.30%	198,141	15.96%
3	25689	18.92%	232,825	18.76%
2	26365	19.41%	235,774	19.00%
1	36754	27.06%	342,990	27.63%
Total	**135803**	**100.00%**	**1,241,221**	**100.00%**

Current Waiting List Date Ending - 06/08/2023

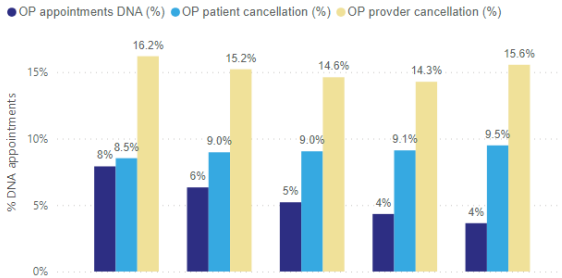
Ethnic Group	Patients	% Patients	Population Count	% Population
White	93878	69.13%	943,760	76.03%
Not stated	30778	22.66%	108,187	8.72%
Asian/Asian British	4412	3.25%	91,540	7.37%
Black/African/Caribbean/ Black British	2593	1.91%	41,614	3.35%
Mixed/Multiple ethnic groups	1876	1.38%	38,839	3.13%
Other ethnic group	2116	1.56%	17,343	1.40%
Total	**135803**	**100.00%**	**1,241,283**	**100.00%**

Summary: The number of patients waiting is highest in Mid Notts and more deprived areas. However, this variation could be explained by differences in specialty. The proportion of patients with longest wait times is higher in less deprived areas, minority ethnic groups and Nottingham City and South Notts ICPs.
Actions: As part of population health framework, NUH is exploring options for an intelligence led personalised model for elective surgery. This will include an understanding of who is over and under represented on waiting list. Supported by elective programmes for eye health, MSK and Patient Facing Digital Work

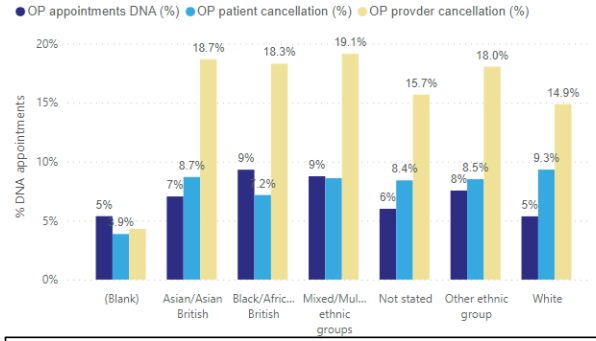
Tables and summary are taken from the ICS SAIU Dashboards

Outpatient Appointments

OP appointment DNA by deprivation quintile



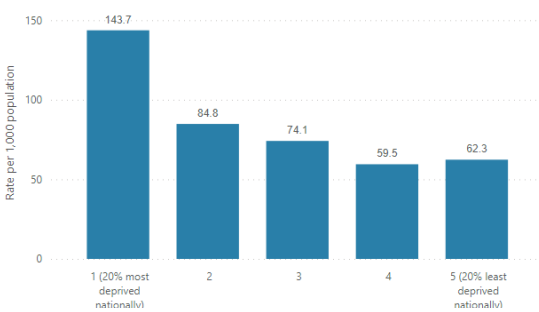
OP appointment DNA by ethnicity



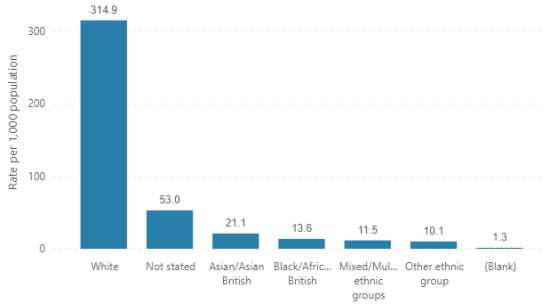
Summary: Age standardised rates of A&E appointments Patient DNA rates are highest in areas of high deprivation, younger age groups and in minority ethnic groups. Nottingham City PCNs have the highest DNA rates. The opposite trend is seen in patient cancellations, where the rate is higher in less deprived areas, older age groups and similar between ethnic groups.
Actions: Referral Optimisation Programme; NUH carrying out regressional analysis to allow for a more informed understanding of where to target efforts.

A&E Attendances

Age standardised rate of A&E attendances by deprivation qui...



Age standardised rate of A&E attendances by ethnicity



Summary: Age standardised rates of A&E appointments are highest in areas of high deprivation , younger age groups and white ethnicity.
Actions: Both Trusts are taking a preventative approach through ED. Will be considered as part of the overall programme of the Urgent Care Reset.

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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 August 2023

NHS Nottingham and Nottinghamshire

Quality of care, access and outcomes

(36 out of 38 metrics populated @25.08.2023)

Lower Quartile Areas:

- Diagnostic activity waiting times - percentage of patients not seen within 6 weeks (ICB)
- Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted (ICB)
- Inpatients with a learning disability and/or autism per million head of population (ICB)
- GP appointments - percentage of regular appointments within 14 days (NNICB)
- Inappropriate adult acute mental health placement out of area placement bed days (NNICB)
- GP appointments - percentage of regular appointments within 14 days (BICB)
- Clostridium difficile infection rate (BICB)

Higher Quartile Areas:

- Total patients waiting more than 65 weeks to start consultant led treatment (ICB)
- Proportion of patients meeting the faster cancer diagnosis standard (ICB)
- Virtual ward - percentage capacity occupied (ICB)
- Number of children and young people accessing mental health services as a % of population (ICB)
- Dementia diagnosis rate (ICB)
- Proportion of patients meeting the faster cancer diagnosis standard (NNICB)
- Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia infection rate (NNICB)
- Women accessing specialist community perinatal mental health services (NNICB)
- Antimicrobial resistance: total prescribing of antibiotics in primary care (NNICB)
- Proportion of patients meeting the faster cancer diagnosis standard (BICB)
- Dementia diagnosis rate (BICB)
- Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia infection rate (BICB)
- Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care (BICB)

Preventing ill-health and reducing inequalities

(7 out of 7 metrics populated @25.08.2023)

Lower Quartile Areas:

- Population vaccination coverage: MMR for two doses (5 year olds) (ICB)

Higher Quartile Areas:

- % of hypertension patients who are treated to target as per NICE guidance (NNICB)

People

(12 out of 14 metrics populated @25.08.2023)

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)

Finance and Use of Resources

(0 out of 4 metrics populated @25.08.2023)

Finance Metrics Identified in NOF:

- MHIS
- Finance Efficiency
- Financial Sustainability
- Agency Cap

Leadership & Capability

(0 out of 0 metric populated @25.08.2023)

There are no ICB Leadership & Capability metrics in the 2023/24 NHSOF

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

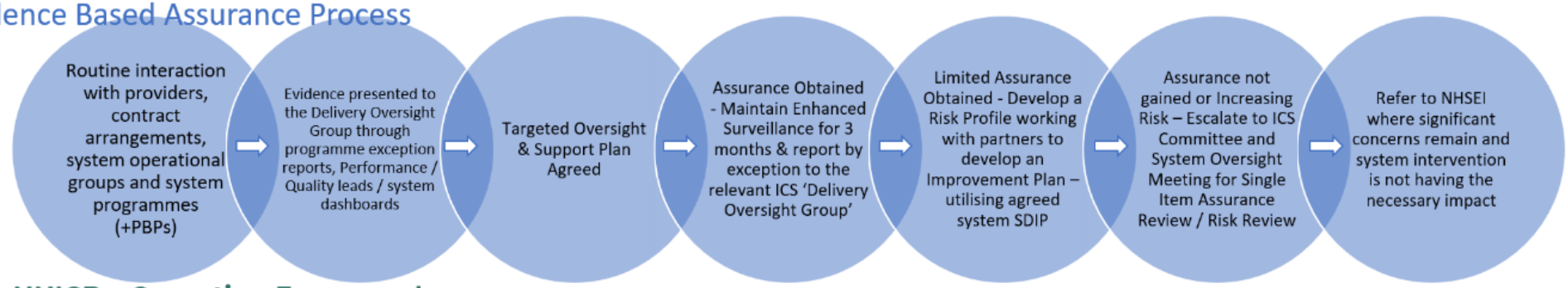
NHS Nottingham and Nottinghamshire

i – ICS Escalation Framework

Each key deliverable programme or oversight group will propose a level of assurance, aligned to **the escalation framework**, following discussion of reported metrics and key milestones at each group. This approach is still being developed and rolled out across the ICB. The 4 levels are as follows:

Oversight Monitoring Level	1. Routine	2. Further Information Required	3. Enhanced	4. Escalated Risk
What does this mean? What is the assessment of risks relating 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 'Delivery Oversight Group' in response to this assessment				
	Actions to be taken by Relevant Delivery 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 'Delivery Oversight Group' until concerns are resolved	Trigger Escalation Single Subject Review/ Deep Dive / Risk Summit

Evidence Based Assurance Process



NNICB – Operating Framework

ii – Key to Variation & Assurance Icons (SPC) and Assurance Escalation Framework

This performance report incorporates Statistical Process Control (SPC) charts, which plot data over time around a centre line (the average). They help us to understand variation which guides us to make appropriate decisions.
The Upper Control Limit (UCL) and Lower Control Limit (LCL) are derived by the variability of the data. It is expected that 99% of data points will fall within the process limits (probability) and SPC are therefore useful to identify / consider how likely it is that the target will be achieved.

The **Variation Icons** are derived from the movement of the actuals, either as an indication of run rate over 6 data points, or against the mean (higher or lower than the mean), showing whether the process is improving, deteriorating or having no significant change.

The **Assurance Icons** are derived from the position of the Lower Control Limit against the plan or standard – and the confidence level that provides as to whether the target or plan is expected to be achieved in the future. If the plan or target is higher than the lower control limit this will indicate 'inconsistent' passing or falling short. If plan or target is lower than the lower control limit this indicates that the target is being consistently passed. If the plan is higher than the higher control limit, this will indicate consistent falling short.

Essentially, the assurance icon is all about the future not the past. We don't need SPC to tell us whether we've hit our target in the past, we know if we have or not and we can report on that as is customary. However that approach doesn't give much assurance about what happens in future. Even if we've consistently missed our target for the past 10 months, what's the likelihood that we will do so again next month? Traditional reporting does not have an answer for that but SPC does. SPC charts allow us to see how the process we are monitoring is behaving. We can therefore use the mean and limits to 'predict' future performance which is what the assurance icon does.

Variation			**Assurance** (capability of meeting target)		
Common Cause - no significant change Up/Down arrow no special cause	**Special Cause** of *concerning* nature or *higher pressure* due to (H)igher or (L)ower values	**Special Cause** of *improving* nature or lower *pressure* due to (H)igher or (L)ower values	Variation indicates ***inconsistent*** passing or falling short of target - random	Variation indicates ***consistently (P)assing*** the target	Variation indicates ***consistently (F)alling short*** of the target

Blue lines on the charts represent the operational plan for 2022/23
Red Lines on the charts represent a required target position

Exception Reporting Rules

'Exception Reports' will be triggered if:

- An 'Orange' Variation icon or a 'Falling' short Assurance icon
- A Special Cause Variation (positive or negative)
- An area of escalation proposed via a sub-committee
- An area of escalation highlighted through the Executive Director from ICS Oversight Groups
- An area of escalation relating to sub-organisational level concerns

Further Reading / other resources
The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://improvement.nhs.uk/resources/making-data-count

iii – Glossary of Terms

NHS Nottingham and Nottinghamshire

Acronym	Meaning	Acronym	Meaning	Acronym	Meaning	Acronym	Meaning
A&E	Accident & Emergency	FD	Finance Director	NEMS	Nottinghamshire Emergency Medical Services	SEG	System Executive Group
A&E	Accident & Emergency Delivery Board	FOT	Forecast Out-Turn	NHP	New Hospitals Programme	SFH	Sherwood Forest Hospitals Foundation Trust
AMH	Anit-Mullerian Hormone	G&A	General & Acute	NHSE	NHS England	SLA	Service Level Agreement
BAU	Business as Usual	GI	Gastro-intestinal (often referred to as Upper GI or Lower GI)	NHT / NHC	Nottinghamshire Healthcare NHS Trust	SMI	Severe Mental Illness
Blaw	Bassetlaw	HEE	Health Education England	NICE	National Institute for Health & Care Excellence	SOF	System Oversight Framework
BLM	Back-log Maintenance	HFID	Hospital First Integrated Discharge	NNICB	Nottingham & Nottinghamshire ICB	SOP	Standard Operating Procedure
CAMHS	Child & Adolescent Mental Health Services	HLE	Healthy Life Expectancy	NRC	National Rehabilitation Centre	SPC	Statistical Process Control
CCG	Clinical Commissioning Group	IAPT	Improving Access to Psychological Therapies	NUH	Nottingham University Hospitals	SRO	Senior Responsible Officer
CDC	Community Diagnostic Centre	IBN	Information Breach Notice	OAPs	Out of Area Placements	TIF	Targeted Investment Fund
CDEL	Capital Departmental Expenditure Limits	ICATT	Intensive Community Assessment & Treatment Teams	OBD	Occupied Bed Days	UEC	Urgent & Emergency Care
CDU	Clinical Decision Making Unit	ICB	Integrated Care Board	OOA	Out of Area	UTC	Urgent Treatment Centre
CHC	Continuing Health Care	ICP	Integrated Care Partnership	OP	Out Patients	WTE	Whole Time Equivalents
CoP	Court of Protection	ICS	Integrated Care System	PBP	Place Based Partnerships	YOC	Year of Care
CT	Computed Tomography	IPC	Infection prevention control	PCIT	Primary Care Information Technology	YTD	Year to Date
CV	Contract Variation	IR	Identification Rules	PCN	Primary Care Networks		
CYP	Children & Younger People	IS	Independent Sector	PFDS	Public Facing Digital Services		
D2A	Discharge to Assess	JSNA	Joint Strategic Needs Assessment	PFI	Private Finance Initiative		
DC	Day Case	KMH	Kings Mill Hospital	PHM	Population Health Management		
DDAT	Digital, Data, Analytics and Technology	LD	Learning Disabilities	PHSMI	Physical Health check for Severe Mental Ill patients		
DHSC	Department of Health and Social Care	LD&A	Learning Disabilities & Autism	PICU	Psychiatric Intensive Care Unit		
DST	Decision Support Tool	LINAC	Linear Accelerator	PID	Project Initiation Document		
DTT	Diagnosis to Treatment Time	LoS	Length of Stay	PIFU	Patient Initiated Follow Ups		
EBUS	Endobronchial Ultrasound	MAS	Memory Assessment Service	POD	Prescription Ordering Direct		
ED	Emergency Department	MHIS	Mental Health Investment Standard	PoD	Point of Delivery		
EIP	Early Intervention Psychosis	MHST	Mental Health Support Team	PTL	Patient Targeted List		
EL	Electives	MNR	Maternity & Neonatal Redesign	QDCU	Queens Day Case Unit		
EMAS	East Midlands Ambulance Service NHS Trust	MOU	Memorandum of Understanding	QMC	Queens Medical Centre		
EMCA	East Midlands Cancer Alliance	MRI	Magnetic Resonance Imaging	R&D	Research & Development		
EMNNODN	East Midlands Neonatal Operational Delivery Network	MSFT	Medically Safe for Transfer	R&I	Research & Innovation		
EOL	End of Life	N&N	Nottingham & Nottinghamshire	RAG	Red, Amber & Green		
ERF	Elective Recovery Funding	NCSO	No Cheaper Stock Obtainable (prescribing)	RTT	Referral to Treatment Times		
ESRF	Elective Services Recovery Funding	NEL	Non-Electives	SDMF	Strategic Decision Making Framework		