NHS
Nottingham and Nottinghamshire

Integrated Care Board Meeting Agenda (Open Session)

Thursday 08 September 2022 09:00 – 11:50

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

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

Principles:

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

Values:

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

	Item	Presenter	Type	Time
Introductory items				
1.	Welcome, introductions and apologies	Kathy McLean	Verbal	09:00
2.	Confirmation of quoracy	Kathy McLean	Verbal	
3.	Declaration and management of interests	Kathy McLean	Paper	
4.	Minutes from the meeting held on: 01 July 2022	Kathy McLean	Paper	
5.	Action log and matters arising from the meeting held on: 01 July 2022	Kathy McLean	Paper	
Leadership				
6.	Chair's Report	Kathy McLean	Paper	09:05
7.	Chief Executive's Report	Amanda Sullivan	Paper	
Health inequalities and outcomes				
8.	Urgent and Emergency Care: Winter Planning	Lucy Dadge	Paper	09:35
9.	Elective Recovery Plan	Lucy Dadge	Paper	
10.	Maternity Services Update	Rosa Waddingham	Paper	
Assurance and system oversight				
11.	Highlight Report from the Finance and Performance Committee	Stephen Jackson	Paper	10:45
12.	Financial Plan, Opening Budgets and Capital Resource Use Plan	Stuart Poynor	Paper	
13.	Integrated Performance Report	Stuart Poynor Rosa Waddingham Dave Briggs Lucy Dadge	Paper	

Governance and risk

14.	Board Assurance Framework	Lucy Branson	Paper	11:30

Closing items

15.	Questions from the public relating to items on the agenda	Kathy McLean	Verbal	11:40
16.	Any other business	Kathy McLean	Verbal	

Confidential Motion:

The Board will resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1[2] Public Bodies [Admission to Meetings] Act 1960)

Date and time of next Board meeting held in public: 10 November 2022 at 9:00 (Arnold Civic Centre)

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	08/09/2022
Paper Title:	**Declaration and management of interests**
Paper Reference:	ICB 22 015
Report Author:	Lucy Branson, Associate Director of Governance
Report Sponsor:	Kathy McLean, ICB Chair
Presenter:	Kathy McLean, ICB Chair
Recommendation(s):	The Committee is asked to **RECEIVE** this item.

Summary:

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

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

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

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

Appendices:

Appendix A: Extract from the ICB's Register of Declared Interests for members of the Board.

Appendix B: Managing Conflicts of Interests at Meetings.

Board Assurance Framework:
To be confirmed in line with the development of the Board's Assurance Framework.

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

Report Previously Received By:
Not applicable to this report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Register of Declared Interests

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

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

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

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

Name	Current position(s) held in the ICB	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To:	Action taken to mitigate risk
ADAMOU, Marios	Non-Executive Director	South West Yorkshire Partnership NHS Foundation Trust	Employed as a Consultant Psychiatrist	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ADAMOU, Marios	Non-Executive Director	Marios Adamou LTD - providng eductional and advisory services	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ADAMOU, Marios	Non-Executive Director	University of Huddersfield	Visiting Professor			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ADAMOU, Marios	Non-Executive Director	National Institute for Health and Care Research	Member of Health Technology Assessment Prioritisation Committee			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
BRIGGS, David	Medical Director	British Medical Associaton	Member		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Mid Nottinghamshire and Greater Nottingham Lift Co (public sector)	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Valley Road Surgery	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Nottingham Schools Trust	Chair and Trustee			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Care Workers Union	Director (not remunerated)			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Cleaners Union	Director (not remunerated)			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Nottingham Business Improvement District (BID)	Non-Executive Chair		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Nottingham High School	Governor		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Portland College	Governor		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.

Name	Current position(s) held in the ICB	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To:	Action taken to mitigate risk
JACKSON, Stephen	Non-Executive Director	Marketing Nottingham	Non-Executive Director		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Derbyshire Health United CIC	Non-Executive Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	IBC Ltd (currently inactive)	Joint Owner and Chief Executive Officer	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LIM, Dr Kelvin	Primary Care Partner Member	Primary Integrated Community Services	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LIM, Dr Kelvin	Primary Care Partner Member	NEMS	Shareholder	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LIM, Dr Kelvin	Primary Care Partner Member	Church Walk Medical Services	Shareholder	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LIM, Dr Kelvin	Primary Care Partner Member	Eastwood Primary Care Centre	GP Partner	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MALEY, Caroline	Non-Executive Director	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
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	Treetops Hospice	Spouse is a trustee of Treetops Hospice				✓	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	NHS Employers	Chair of the national negotiation committee for Staff and Associate Specialists on behalf of NHS Employers		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Care Quality Commission (CQC)	Occasional Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Public Sector Consultancy	Senior Clinical Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS England/Improvement	Lay Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NEMS Healthcare Ltd	Spouse is shareholder				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS Providers Board	Trustee		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
POYNOR, Stuart	Director of Finance	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable

Name	Current position(s) held in the ICB	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To:	Action taken to mitigate risk
ROBINSON, Paul	NHS Trust and NHS Foundation Trust Partner Member	Sherwood Forest Hospitals NHS Foundation Trust	Chief Executive	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
SULLIVAN, Amanda	Chief Executive	Hillview Surgery	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
TOWLER, Jon	Non-Executive Director	Sherwood Medical Practice	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
TOWLER, Jon	Non-Executive Director	Major Oak Medical Practice, Edwinstowe	Family members are registered patients				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
TOWLER, Jon	Non-Executive Director	YPO - a publicly owned central purchasing body based in Wakefield, Yorkshire. It is owned and governed by a consortium of county, metropolitan and borough councils in Yorkshire and the North West England. It provides a wide range of resources and services to schools, councils, charities, emergency services, and other public sector organisations.	Independent Director	✓				01/07/2022	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.
WADDINGHAM, Rosa	Director of Nursing	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
WILLIAMS, Melanie	Local Authority Partner Member	Nottinghamshire County Council	Corporate Director for Adult Social Care and Health	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.

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.
NEWHAM, Anne-Maria	Deputy Partner Member	Nottinghamshire Healthcare NHS Foundation Trust	Interim Chief Executive Officer	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
NEWHAM, Anne-Maria	Deputy Partner Member	Nurture Care	Senior Advisor on Board		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ROYLES, Dean	Interim People and Culture SRO	KPMG	Associate	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ROYLES, Dean	Interim People and Culture SRO	Healthcare People Management Association	President		✓			01/07/2022	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
01/07/2022 09:30-11:30
GF-04, Sir John Robinson House

Members present:

Dr Kathy McLean	Chair
Professor Marios Adamou	Non-Executive Director
Dr Dave Briggs	Medical Director
Melanie Brooks	Local Authority Partner Member
Lucy Dadge	Director of Integration
Stephen Jackson	Non-Executive Director
Stuart Poynor	Director of Finance
Amanda Sullivan	Chief Executive
Jon Towler	Non-Executive Director
Rosa Waddingham	Director of Nursing

In attendance:

Lucy Branson	Associate Director of Governance
Sue Wass	Corporate Governance Officer (minutes)

Apologies:

Dr John Brewin	NHS Trust/Foundation Trust Partner Member
Dr Kelvin Lim	Primary Care Partner Member
Caroline Maley	Non-Executive Director
Paul Robinson	NHS Trust/Foundation Trust Partner Member
Catherine Underwood	Local Authority Partner Member

Cumulative Record of Members' Attendance (2022/23)

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

Name	Possible	Actual	Name	Possible	Actual
Stephen Jackson	1	1	Rosa Waddingham	1	1
Kelvin Lim	1	0			

Introductory items

ICB 22 001 **Welcome, introductions and apologies**

Kathy McLean welcomed members to the inaugural meeting of the Board. A round of introductions was undertaken and apologies were noted as above.

ICB 22 002 **Confirmation of quoracy**

The meeting was confirmed as quorate.

ICB 22 003 **Declaration and management of interests**

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

ICB establishment and governance arrangements

ICB 22 004 **Establishment of NHS Nottingham and Nottinghamshire Integrated Care Board**

Kathy McLean introduced the item, highlighting that this was a historic day, which signalled a step change in health and social care policy. Integrated Care Systems (ICSs) were now established on a statutory basis as partnerships of organisations to plan and deliver joined up health and care services in order to improve the lives of people who live and work in their areas. Locally, these new arrangements would see a strengthening of existing joint working and collaborations to enable each and every citizen of Nottingham and Nottinghamshire to enjoy their best possible health and wellbeing.

This inaugural meeting of the Board of NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) was primarily to receive, endorse or approve the suite of documentation to bring into effect the ICB's governance arrangements.

Lucy Branson was invited to present the content and the proposals contained within the report. The following key points were highlighted:

a) The Integrated Care Board (ICB) Establishment Order 2022 came into effect on 1 July 2022, bringing into effect the ICB's Constitution and Standing Orders.

b) The Constitution and the Standing Orders were based on a national template designed to meet the legislative requirements set out within the Health and Care Act 2022. The Constitution had been developed following lengthy consultation with system partners and subsequently approved by NHS England.
c) Moving forward, the Board is able to endorse changes to the Constitution, but these would be subject to the approval of NHS England.
d) It is important that members are familiar with the content of the Constitution and Standing Orders, which are appended to the paper and include arrangements for discharging functions, demonstrating accountability, making decisions, managing conflicts of interests, and for public involvement.
e) The Constitution also set out the ICB's formal partner trusts who would need to agree the ICB's joint plans and be party to any joint financial duties.
f) An annual performance assessment would be conducted by NHS England on how well the ICB was discharging its statutory duties.

At this point Melanie Brooks left the meeting.

g) The ICB has automatically taken on delegated responsibility from NHS England for primary medical services functions on 1 July 2022. The associated Delegation Agreement is appended to the report for information and would be signed by the Chief Executive and returned to NHS England to formalise the delegation.
h) This delegation gave ICBs a greater flexibility than in previous delegations to CCGs, including financial flexibilities and the ability to onward delegate.
i) As part of the agreement, responsibility for the management of primary medical services complaints had been delegated to the ICB from 1 July; however, it would be operationally transitioned from NHS England over a three-month period.
j) The ICB's Constitution was supported by a Governance Handbook, containing the terms of reference for the Board's committees and sub-committees, the Standing Financial Instructions and the Scheme of Reservation and Delegation, as well as guidance for for members of the public in relation to the ICB's meetings that are held in public, including how members of the public can ask questions of the Board.
k) The Board and committee structure is illustrated on page 5 of the Governance Handbook. Initial terms of reference for each of the committees and sub-committees had been designed to ensure that the four core aims of the ICS were embedded across all committees. The delegated primary medical services functions were also

embedded in relevant terms of reference. It was anticipated that the terms of reference will require further review and refinement as system arrangements evolve and mature.

l) The Board is required to approve the appointment of the Chairs for its Committee, which are proposed as set out in the report.

m) The ICB Chair is required to approve all individuals appointed as members of any committees or sub-committees that exercise the ICB's commissioning functions to confirm that individuals could not be regarded as undermining the independence of the health service because of their involvement with the private healthcare sector or otherwise. This is relevant to the Strategic Planning and Integration Committee and its Primary Care Contracting Sub-Committee and a process to satisfy this requirement will be implemented following approval of the terms of reference.

n) The ICB has the flexibility to include committee members who were not Board members or ICB employees. The Quality and People Committee and Finance and Performance Committee, both included Non-Executive Director membership from system partners. The Strategic Planning and Integration Committee would also include membership from Local Authority partners.

o) The ICB has greater flexibility in its ability to delegate responsibility for the exercise of its functions. However, these flexibilities are subject to secondary legislation and statutory guidance yet to be published.

p) Work is ongoing to establish an ICS Partners Reference Group to support the work of the Board. Once established, the Reference Group will meet to discuss and influence the development of key strategies, plans and system developments.

q) The ICB's Constitution and other national guidance set out a number of lead roles for Board members. Those relating to Non-Executive Directors are set out in the paper for Board approval. Other Board-level roles, as assigned by the Chair and Chief Executive, are detailed within the paper for information.

r) A robust due diligence process has been undertaken to ensure the safe transfer of the property and staff of NHS Bassetlaw CCG and NHS Nottingham and Nottinghamshire CCG to the ICB. No significant issues had been highlighted as part of this work and appropriate arrangements had been put in place to ensure the preservation of organisational memory and a safe handover from the assurance committees of the outgoing CCGs.

s) Considerable work had been completed to ensure a complete suite of corporate policies was in place for the ICB from 1 July. A full list of the proposed policies is appended to the report, with all policies available to board members for review. Members' attention was drawn to the policies that would be owned by the Board. Other policies would be owned by the appropriate Committees, as outlined within the ICB's Scheme of Reservation and Delegation.

t) A small number of commissioning policies remained unaligned from the former CCGs, due to the timescale required to consult on potential changes. Alignment of the policies would be completed by the end of the year and would be overseen by the Strategic Planning and Integration Committee. However, this means that for a short period of time a differential policy position would be in place in relation to restricted services and access to fertility treatments in line with the former CCG policies.

u) The ICB was required to appoint an external auditor. A meeting of the Auditor Panel was scheduled for 1 July for this purpose. Due to the required timescales for making this appointment, the use of emergency powers was proposed, to be exercised by the Chair and Chief Executive in line with the ICB's Standing Orders.

The following points were raised in discussion:

v) Progress towards the establishment of the Citizen Intelligence Advisory Group was queried, and in particular its membership and reporting mechanisms. It was noted that the Group was in the process of being established and membership was not yet finalised. It would influence the work of the Board and the Integrated Care Partnership. Members of the Board would be invited to attend meetings of the Group. The Chair requested clarity on the Executive lead on the Board for this function and it was agreed that a progress update would be provided at the September meeting.

w) The committee and sub-committee terms of reference were welcomed, and it was recognised that it would be important to continue to challenge arrangements to test what was different to previous arrangements. The proposed starting point presented a safe set of arrangements that will evolve over the coming months. In particular, an assessment of risks versus opportunities would need to be undertaken.

x) Regarding the work undertaken on the property and staff transfer schemes, members noted the positive working relationships between the former CCGs that had enabled this work to be undertaken so

effectively, and the positive developing relationship with the Doncaster and Bassetlaw NHS Trust.

y) The work to develop the ICB's policies was praised and updates against the work to finalise alignment of the commissioning policies requested for a future meeting.

At this point, it was noted that the meeting was no longer quorate as Melanie Brooks was not able to return to the meeting. Members present agreed that the meeting should proceed, and due to the nature of the items being considered, Board 'approvals' would be ratified by use of emergency powers as provided for within the ICB's Standing Orders.

ACTION: Amanda Sullivan to provide an update on the establishment of the Citizen Intelligence Advisory Group at the September Board Meeting.

The Board:

- **RECEIVED** the Constitution and Standing Orders, as approved by NHS England.
- **RECEIVED** the Primary Medical Services Delegation Agreement from NHS England to the ICB.
- **APPROVED** the Governance Handbook, including the Standing Financial Instructions and Scheme of Reservation and Delegation.
- **APPROVED** the appointment of Committee Chairs set out in paragraph 13c) of the paper.
- **APPROVED** the appointment of the Board level roles set out in paragraph 17a) and 17b) of the paper.
- **ADOPTED** the organisational policies listed at Appendix F to the paper.
- **ENDORSED** the use of emergency powers by the Chair and Chief Executive to make an urgent decision to appoint the ICB's external auditor.

ICB 22 005 Establishment of the Nottingham and Nottinghamshire Integrated Care Partnership

Amanda Sullivan presented the item and highlighted the following key points:

a) Work had been undertaken for some time on the development of proposals to establish a statutory Integrated Care Partnership (ICP), as required by the Health and Social Care Act 2022, and thanks were given to local authority partners, who had led this work.

b) The ICP would be the 'guiding mind' of the health and care system, providing a forum for NHS leaders and local authorities to come together with stakeholders from across the system and community.

c) The ICP would lead on creating an integrated care strategy and outcomes framework for the system, building on Joint Strategic Needs Assessments and Joint Local Health and Wellbeing Strategies to cover both the health and social care needs of the local population and address the wider determinants of health and wellbeing.

d) Membership would comprise five nominations from each of the local authorities and the ICB and would include citizen representatives and senior representatives from each of the four Place-Based Partnerships. It would be chaired by the ICB's Chair, supported by two vice chairs, who were the Chairs of the City and County Health and Wellbeing Boards.

e) Initial terms of reference and the appointment of the ICB's members to the ICP was appended to the report for approval. These would also be presented to the Full Council Meetings of both local authorities during July 2022 in order to establish the ICP.

The following points were raised in discussion:

f) Members noted the challenge of drafting an integrated care strategy by the end of the calendar year, taking assurance that working relationships with local authority partners were good and well-established.

g) Discussing citizen engagement, members queried how the ICP would ensure its approach would include citizens from traditionally hard to reach communities. It was noted that the approach would use place-based partnerships, the voluntary and community sectors, local Healthwatch and the local authorities' well-established neighbourhood engagement routes to draw on a range of networks and forums to gain insights for the development of the strategy.

h) Members queried why there was no ICB non-executive membership of the ICP. It was noted that the initial intention was to keep membership as small as possible to ensure a 'manageable' arrangement. However, the terms of reference would be kept under review as work progressed.

i) An update on progress would be provided at the September Meeting.

The Board:

- **APPROVED** the establishment of the Nottingham and Nottinghamshire Integrated Care Partnership, on the basis of the initial terms of reference presented.
- **APPROVED** the appointments of the ICB's members of the Integrated Care Partnership.

Leadership, strategy and planning

ICB 22 006 Chair's Report

Kathy McLean presented the item and highlighted the following points:

a) This was a moment of great change for the NHS and the local care system, with a genuine opportunity to bring together partners to make a tangible improvement to the health of the citizens of Nottingham and Nottinghamshire and to address long-standing health inequalities.

b) The ICB had four clear aims; to improve outcomes, tackle inequalities, enhance value for money and support broader social and economic development. These would be at the heart of everything the ICB did, and upon which the ICB's success would be measured.

c) The area of Bassetlaw was now formally part of the Nottingham and Nottinghamshire ICS.

d) The achievement of the former clinical commissioning groups was acknowledged; their unfaltering commitment to leading the pandemic response over the past two years was specifically recognised.

e) The coming months will see the development of an integrated care strategy for the system and a joint forward plan for the ICB and its NHS trust and foundation trust partners.

The Board:

- **RECEIVED** the report.

ICB 22 007 Chief Executive's Report

Amanda Sullivan presented the item and highlighted the following points:

a) The report provided a description of Nottingham and Nottinghamshire ICS and its vision, values and collective ambitions. This was an exciting opportunity to build on the strong partnership working that had been developed in previous years, and accelerated by the response to the pandemic, to work towards common objectives and a single vision.

b) The existing Memorandum of Understanding (MOU) with NHS England and the ICS had been rolled forward for the first quarter of 2022/23. During July 2022, NHS England would work with ICBs to agree and finalise an MOU for 2022/23. The new MOU would transition more towards system oversight.

c) As the MOU would require the agreement of the ICB during the summer period, it was proposed that the Chief Executive agreed the MOU, and for the Board to formally approve the MOU at its September 2022 meeting; members were requested to endorse this approach.

The Board:

- **RECEIVED** the report and **ENDORSED** the proposed approach to finalising arrangements with NHS England for system oversight in 2022/23.

ICB 22 008 Business deliverables for 2022/23

Stuart Poynor presented the item and highlighted the following points:

a) The report detailed proposed business deliverables that had been developed to support performance against the four core aims of ICS during 2022/23, along with the emerging monitoring and reporting arrangements being put in place to assure delivery.

b) They covered national NHS operational planning priorities for 2022/23, together with additional local deliverables, aligned to three broad areas; ‘Managing today’, ‘Making tomorrow better’ and ‘ICS Development’.

c) An ICB Executive Director had been identified to lead each of the proposed business deliverables and would be accountable to the Board for delivery. Consistent with the established ICS distributed leadership approach, several deliverables also identified ICS System Leads who had system responsibility for delivery.

d) Work was progressing to ensure that detailed delivery and milestone plans were in place for each deliverable, and to establish progress monitoring and reporting arrangements. A detailed position against

each of the business deliverables would be reported to the September 2022 meeting of the Board.

The following points were made in discussion:

e) Members were supportive of the inclusion of system partners in line with the agreed distributed leadership model.

f) A focus on a small number of key objectives that had the potential to make a tangible difference was supported; members suggested that they should be mapped to the aims of the ICS, which was agreed.

g) Noting that many of the deliverables were predicated on strong partnership working, members noted the need for the ICB's leadership team to escalate any issues to the Board.

The Board:

- **ENDORSED** the proposed business deliverables for 2022/23 in line with the ICB's ambitions.

ICB 22 009 Delegation of functions from NHS England to ICBs

Lucy Dadge presented the item and highlighted the following points:

a) Functions in relation to primary medical services had been previously delegated to CCGs, and ICBs automatically took on these delegated functions on 1 July 2022.

b) The report provided an overview of the future delegation of additional NHS England functions, namely pharmacy and optometry services, primary and secondary dental services, and some specialised services, from 1 April 2023.

c) A delegation application was required to be submitted by the ICB by mid-September 2022 for pharmacy, optometry and dental services. This would be presented for consideration at the Board's September meeting.

d) Commissioning expertise for specialised services would be retained within the NHS England national and regional teams in 2022/23, increasingly facing towards ICBs from 2023/24. It was envisaged that circa 65 of 150 specialised services were suitable for delegation, either to the local, sub-regional or regional levels.

e) There were clear population health management and efficiency benefits to ICBs managing these delegated functions and examples of how this could be achieved were provided.

f) Work was ongoing on the operating models and associated governance, financial and workforce implications.

The following points were made in discussion:

g) Members sought assurance that the ICB was clear on how these services could be transformed to provide improved outcomes. It was noted that delegation would bring improved flexibility at the local level to simplify and join up fragmented pathways. Initially a small number of pathways would be targeted to drive transformational change. There was also an opportunity to build on the relationships with community pharmacists, formed during the pandemic.

h) Members highlighted the resource implications on the ICB workforce of the move towards greater delegation of services and it was noted that this would be recorded on, and monitored via, the ICB's Assurance Framework.

The Board:

- **RECEIVED** the report and **ENDORSED** the proposed approach to finalising the workforce and operating models for future delegated functions, as detailed in the report.

ICB 22 010 Emergency Preparedness, Resilience and Response (EPRR) Incident Response Plan

Lucy Dadge presented the item and highlighted the following points:

a) As part of the transition to new statutory arrangements, the ICB had become a category one responder as per duties set out in the Civil Contingencies Act 2004. The report provided assurance regarding the ICB's readiness to take on these responsibilities from 1 July 2022.

b) The ICB's Incident Response Plan, which had been developed in consultation with system partners required the approval of the Board and was appended to the report.

c) The ICB had consulted with, and received input from system partners and NHS England, on the Incident Response Plan and it had been tested through a desk top exercise. There would be an ongoing assurance process overseen by the Audit and Risk Committee.

d) A dedicated briefing session had been arranged to support Non-Executive Directors in understanding the duties and responsibilities of the ICB as a category one responder.

The following points were made in discussion:

e) It was noted that the pandemic was currently a level three, regionally controlled incident.

f) Members queried the resource implications of being a category one responder and it was noted that the Executive Team would keep this under consideration.

The Board:

- **APPROVED** the Incident Response Plan.

Closing items

ICB 22 011 **Questions from the public relating to items on the agenda**

No questions were raised; however it was observed that improvements could be made to the information published to enable easier location of the building where the meeting was being held.

ICB 22 012 **Any other business**

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

Date and time of next Board meeting held in public: 8 September 2022 at 9:00 (Room GF-04, Sir John Robinson House)

NHS
Nottingham and Nottinghamshire

ACTION LOG for the Integrated Care Board meeting held on 01/07/2022

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
Green	01/07/2022	ICB Establishment	To provide an update on the establishment of the Citizen Intelligence Advisory Group at the September Board Meeting.	Amanda Sullivan	08/09/2022	Update provided in the Chief Executive's Report at item 7 on the agenda.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	08/09/2022
Paper Title:	**Chair's Report**
Paper Reference:	ICB 22 018
Report Author:	Dr Kathy McLean, ICB Chair
Report Sponsor:	Dr Kathy McLean, ICB Chair
Presenter:	Dr Kathy McLean, ICB Chair
Recommendation(s):	The Board is asked to **RECEIVE** this item for information.

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

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:
Appendix A – Indicative 2022/23 work programme for the Board.

Board Assurance Framework:
To be confirmed in line with the development of the Board's Assurance Framework.

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

Applicable Statutory Duties:	
Duties regarding public involvement and consultation	Yes
Public sector equalities duties	Yes

Report Previously Received By:
Not applicable for this report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Chair's Report

Together We Are Notts - System Event

On Thursday 7 July, we held our Together We Are Notts: Building our Integrated Care System Together event. This brought people together from across our system including NHS, local authority, and voluntary and community organisations.

During the event we took the opportunity to reflect upon our journey so far, and our ambitions for leading the way to a successful integrated system. I spoke about how we can use this opportunity to pool our expertise, experience and efficiencies across acute, community and primary care so everyone benefits equally.

You can see some of the highlights on the ICB's Twitter feed.

The team are putting in place arrangements for the coming year and will be in touch soon with a save the date for our next event in November.

Update on Integrated Care Partnership arrangements

Arrangements for the Nottingham and Nottinghamshire Integrated Care Partnership have been agreed by the Integrated Care Board, Nottingham City Council and Nottinghamshire County Council with a first meeting on 16 September.

The Integrated Care Partnership is a statutory committee jointly formed between the Integrated Care Board and the two upper-tier local authorities. The ICP will be the 'guiding mind' of the health and care system, providing a forum for NHS leaders and Local Authorities to come together with important stakeholders from across the system and community.

I will be the chair for the Integrated Care Partnership working closely with two Vice-Chairs; Councillor John Doddy, Chair of the Nottinghamshire Health and Wellbeing Board, and Councillor Adele Williams, Chair of the Nottingham Health and Wellbeing Board. In our first meeting we will be discussing the approach to developing an Integrated Care Strategy for the system on how the health and wellbeing needs of the population in the Integrated Care System area will be met. Statutory Guidance was published by the Department of Health and Social Care on 29 July 2022 and is available here: Guidance on the preparation of integrated care strategies - GOV.UK (www.gov.uk). The strategy will be evidence based, setting out system wide priorities to improve health and reduce disparities, and based on assessed need.

Meetings of the ICP will be held in public and associated papers will be available a week before each meeting here: Our Integrated Care Partnership - NHS Nottingham and Nottinghamshire ICS - NHS Nottingham and Nottinghamshire ICS (healthandcarenotts.co.uk)

To support the development of the Integrated Care Strategy, the ICP will engage with a wider assembly of partners, at least once a year, comprising people who rely

on care and support, unpaid carers, the full range of social care and NHS providers, the voluntary and community sector, local professional committees (e.g. optical and pharmaceutical committees), the Office of the Police and Crime Commissioner, etc. Plans are underway for a first event of the Integrated Care System Partners Assembly on 25 October, which I look forward to telling you more about soon.

Stakeholder mapping

We remain committed to ensuring that all system partners can continue to support the work of the Integrated Care System and its ongoing development. As part of confirming the new structures for the Integrated Care System we have mapped stakeholder involvement across all aspects of the new system arrangements. This has been shared with system partners during August and will continue to iterate to ensure that we are engaging as many people as possible in the Integrated Care System.

As well as the Integrated Care Partnership and Integrated Care System Partners Assembly mentioned above, I will be establishing an Integrated Care System Reference Group to ensure the engagement of key colleagues in system business. This group will meet informally to provide a space for thought leaders to come together and shape key system business. Future workshops for the group might include health inequalities, and the development of places.

Initial Board Work Programme

Good governance practice dictates that Boards should be supported by an annual work programme that sets out a coherent cycle of business for the next year of meetings. The annual work programme is a key mechanism to ensure the full breadth of the Board's role can be discharged, balancing agenda time appropriately between key strategic priorities and ensuring appropriately timed governance oversight, scrutiny and transparency.

Recognising that 2022/23 is an atypical year for the ICB, being its first nine months of establishment, an indicative work programme has been developed that will be subject to ongoing review and change over the coming months as new ways of working evolve and embed. This is provided for information and feedback at Appendix A.

Board Work Programme 2022/23

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

Core aims:

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

Principles:

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

Values:

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

Agenda item (and purpose)	1 July	8 Sept	10 Nov	12 Jan	9 Mar
Leadership					
Chair's Report To present a summary briefing for Board members of the Chair's reflections, actions and activities since the previous Board meeting. As appropriate, this will include updates on key governance developments, and on an annual basis this will include a review of the skills, knowledge and experience of Board members (when taken together) to ensure the Board can effectively carry out its functions. *Item sponsor: Kathy McLean, Chair*	✓	✓	✓	✓	✓
Chief Executive's Report To present a summary briefing on recent local and national developments and areas of interest for Integrated Care Boards (ICBs) and the wider Integrated Care system (ICS). As appropriate, the report may also include specific items requiring approval or for noting by Board members. In particular, updates regarding Covid-19 prevalence and the vaccination programme will be included. *Item sponsor: Amanda Sullivan, Chief Executive*	✓	✓	✓	✓	✓

Agenda item (and purpose)	1 July	8 Sept	10 Nov	12 Jan	9 Mar
Health inequalities and outcomes					
Business Deliverables for 2022/23 To set out the proposed business deliverables for the ICB during 2022/23 to ensure work programmes are progressing in line with the ICB's ambitions ahead of relevant strategies and plans being approved. In-year progress reporting will be delivered via the Integrated Performance Report. *Item sponsor: Stuart Poynor, Director of Finance*	✓	-	-	-	-
Service Transformation Updates To present strategic updates on a range of priority areas; focussing on actions being taken to support system resilience, tackle inequalities, improve outcomes and integrate services, highlighting relevant citizen stories. Updates will include the role of Primary Care Networks, Place-based Partnerships and the Provider Collaborate, as appropriate. For future years, these updates will focus on meeting the priorities within the Integrated Care Strategy and Joint Forward Plan.					
• Urgent and Emergency Care *Item sponsor: Lucy Dadge, Director of Integration*	-	✓	-	-	-
• Planned Care *Item sponsor: Lucy Dadge, Director of Integration*	-	✓	-	-	-
• Maternity Services *Item sponsor: Rosa Waddingham, Director of Nursing*	-	✓	-	-	-
• Mental Health Services *Item sponsor: Lucy Dadge, Director of Integration*	-	-	✓	-	-
• Children and Young People Services *Item sponsor: Lucy Dadge, Director of Integration*	-	-	✓	-	-
• Primary Care *Item sponsor: Dave Briggs, Medical Director*	-	-	✓	-	-
• Community Services *Item sponsor: Lucy Dadge, Director of Integration*	-	-	-	✓	-
• Personalised Care *Item sponsor: Rosa Waddingham, Director of Nursing*	-	-	-	✓	-
• Preventative Care *Item sponsor: Dave Briggs, Medical Director*	-	-	-	✓	-
Digital and Data To present a strategic update on the delivery of the ICS Public-Facing Digital Services Strategy and the ICS Data, Analytics, Information and Technology (DAIT) Strategy *Item sponsor: Dave Briggs, Medical Director*	-	-	✓	-	-

Agenda item (and purpose)	1 July	8 Sept	10 Nov	12 Jan	9 Mar
Environmental Sustainability To present a strategic update on the delivery of the ICS Green Plan. *Item sponsor: Stuart Poynor, Director of Finance*	-	-	✓	-	-
People and Culture To present a strategic update on the delivery of the ICP People Plan. *Item sponsor: Rosa Waddingham, Director of Nursing*	-	-	-	✓	-
Integrated Care Strategy and ICS Outcomes Framework To receive the Nottingham and Nottinghamshire Integrated Care Strategy, as developed and approved by the Nottingham and Nottinghamshire Integrated Care Partnership. *Item sponsor: Lucy Dadge, Director of Integration*	-	-	-	✓	-
Joint Forward Plan To present the ICB's Joint Forward Plan for approval (prepared with partner NHS trusts and NHS foundation trusts) setting out how the ICB will exercise its functions over the next five years. *Item sponsor: Lucy Dadge, Director of Integration*	-	-	-	-	✓
Joint Capital Resource Use Plan To present the ICB's Joint Capital Resource Use Plan for approval (prepared with partner NHS trusts and NHS foundation trusts). *Item sponsor: Stuart Poynor, Director of Finance*	-	-	-	-	✓
Estates To present a system-wide estates strategy for approval. *Item sponsor: Stuart Poynor, Director of Finance*	-	-	-	-	✓
Tomorrow's NUH Programme To present the pre-consultation business case for approval. *Item sponsor: Lucy Dadge, Director of Integration*	-	-	-	-	✓
Local Joint Health and Wellbeing Strategies To review the steps the ICB has taken to implement the Joint Local Health and Wellbeing Strategies. *Item sponsor: Dave Briggs, Medical Director* **Please note: This item is shown for completeness but will be presented in May 2023.**	-	-	-	-	-

Agenda item (and purpose)	1 July	8 Sept	10 Nov	12 Jan	9 Mar
Highlight Reports from the Strategic Planning and Integration Committee To present highlight reports from the Strategic Planning and Integration Committee, which will include regular updates in relation to areas of ongoing system development. The first formal meeting of the Committee will be in September 2022, so reporting to the Board will commence from November 2022. Ratified minutes from Committee meetings will be published on the ICB's website, redacted as appropriate. *Item sponsor: Jon Towler, Non-Executive Director and Chair of the Strategic Planning and Integration Committee*	-	-	✓	✓	✓
Assurance and system oversight					
Highlight Reports from the Quality and People Committee, Finance and Performance Committee and Audit and Risk Committee To present highlight reports from each of the Board's assurance committees. The first formal meetings of the committees will start from July 2022, so reporting to the Board will commence from September 2022. Ratified minutes from Committee meetings will be published on the ICB's website, redacted as appropriate. *Item sponsors:* • *Professor Marios Adamou, Non-Executive Director and Chair of the Quality and People Committee* • *Stephen Jackson, Non-Executive Director and Chair of the Finance and Performance Committee* • *Caroline Maley, Non-Executive Director and Chair of the Audit and Risk Committee*	-	✓	✓	✓	✓
Financial Plan and Annual Budgets To present the system financial plan and ICB annual budgets for approval. Due to this being the ICB's first part-year of establishment, items will cover both the 2022/23 and 2023/24 years. *Item sponsor: Stuart Poynor, Director of Finance*	-	✓	-	-	✓
Integrated Performance Report To present progress against the key performance targets across quality, service delivery, finance, workforce and health inequalities, and to note key developments and actions being taken to address performance issues. *Item sponsor: Stuart Poynor, Director of Finance*	-	✓	✓	✓	✓

Agenda item (and purpose)	1 July	8 Sept	10 Nov	12 Jan	9 Mar
Board Assurance Framework To present the opening, mid-year and year-end position of the Board Assurance Framework. This will include annual approval of the ICB's strategic risks. *Item sponsor: Amanda Sullivan, Chief Executive*	-	✓	✓	-	✓
Emergency Preparedness, Resilience and Response (EPRR) Incident Response Plan To describe the ICB's readiness to take on category one responder status in line with the Civil Contingencies Act, and to present the ICB's Incident Response Plan for approval. *Item sponsor: Lucy Dadge, Director of Integration*	✓	-	-	✓	-
Annual Assurance Reports To present a range of assurance reports for the Board's information, including those relating to: • Meeting the Public Sector Equality Duty • Patient and Public Engagement • Learning from Lives and Deaths: People with a Learning Disability and Autistic People (LeDeR) • Adult and Children's Safeguarding Arrangements • Promotion of Research and Use of Research Evidence • Emergency Preparedness, Resilience and Response (EPRR) • Information Governance Arrangements (SIRO Report) *Item sponsor: Relevant Executive Directors* **Please note: Dependent on available Board agenda time, these reports may be received without presentation or discussion, unless requested otherwise by Board members. All such reports will have been reviewed and scrutinised by the relevant Board Committee.**	-	-	✓	✓	✓
Governance and risk					

Agenda item (and purpose)	1 July	8 Sept	10 Nov	12 Jan	9 Mar
Establishment of NHS Nottingham and Nottinghamshire Integrated Care Board To establish and bring into effect the ICB's governance arrangements, including: • Receipt of the ICB's Constitution and Standing Orders, as approved by NHS England. • Receipt of the Primary Medical Services Delegation Agreement from NHS England to the ICB. • Approval of the ICB's Governance Handbook, including the Standing Financial Instructions and Scheme of Reservation and Delegation, and adoption of the ICB's organisational policies. • Appointment the ICB's external auditor. *Item sponsor: Kathy McLean, Chair*	✓	-	-	-	-
Establishment of NHS Nottingham and Nottinghamshire Integrated Care Partnership To approve the establishment of the Nottingham and Nottinghamshire Integrated Care Partnership, based on the initial terms of reference presented and approve the appointments of the ICB's members of the Integrated Care Partnership. *Item sponsor: Amanda Sullivan, Chief Executive*	✓	-	-	-	-
Organisational Risk Report To present routine updates on the management actions in place to mitigate all major risks, following scrutiny by the Board's Committees. *Item sponsor: Amanda Sullivan, Chief Executive*	-	-	✓	✓	✓
Annual Effectiveness Review of Board Committees To present the outcome of the annual review of the effectiveness of Board committees, following consideration by the Audit and Risk Committee. *Item sponsor: Kathy McLean, Chair* **Please note: This item is shown for completeness but will be presented in May 2023.**	-	-	-	-	-

Development Session Work Programme

Topic	13 Oct	8 Dec	9 Feb
Joint Session with NUH Board	✓		
System Oversight Arrangements	✓		
System Risk Management Arrangements (incl. consideration of ICB Risk Appetite)		✓	
Anchor Organisation Approach		✓	
Joint Forward Plan			✓

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	08/09/2022
Paper Title:	**Chief Executive's Report**
Paper Reference:	ICB 22 019
Report Author:	Amanda Sullivan, Chief Executive
Report Sponsor:	Amanda Sullivan, Chief Executive
Presenter:	Amanda Sullivan, Chief Executive
Recommendation(s):	The Board is asked to: • **RECIEVE** this item for information. • **RATIFY** the urgent decisions made during July and August 2022 using the Board's emergency powers.

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. The report also includes items for formal ratification following the exercise of the Board's emergency powers for urgent decisions.

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

Appendices:
Appendix A: Embedding Citizen Voice in Nottingham and Nottinghamshire Integrated Care System.

Board Assurance Framework:
To be confirmed in line with the development of the Board's Assurance Framework.

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

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

Report Previously Received By:
Not applicable to this report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Chief Executive's Report

System status and planning

Critical incident declared

1. Following continued and unprecedented pressure on services, the Nottingham and Nottinghamshire healthcare system declared a critical incident on 26 July 2022. This action was taken in order to maintain safe services for our patients and manage emergency care services. It was stood down at the earliest opportunity on 1 August 2022. This was following swift and extraordinary effort by our health and care teams.
2. Through system working there has been an easing of pressures as a result of additional actions. However, a critical incident is an indication of the pressure the system is facing, with continuing significant levels of patients with Covid-19 infections and other conditions, paired with staff sickness levels, annual leave and difficulties in discharging patients.
3. Staff at the front line remain under significant pressure in their efforts to provide safe care and patients and members of the public will continue to be asked to use services wisely to ensure those patients with the greatest need can access care and support.

Autumn vaccination programme

4. Following the updated advice from the Joint Committee of Vaccination and Immunisation, the NHS has set out plans for the next phase of the Covid-19 vaccination programme. An Autumn booster jab will be offered to everyone aged 50 and over as well as those who are at highest risk from serious illness. This includes pregnant women and people with long-term health conditions, as well as frontline health and social care workers.
5. Extensive planning for the rollout is underway in Nottingham and Nottinghamshire and the National Booking Service is set to open on 5 September to over 75s and frontline health and social care workers, with jabs being administered from 12 September. As with previous vaccination phases, the oldest and most vulnerable will be called forward first. Once the most vulnerable have booked an appointment, the remaining eligible groups will then be contacted.
6. Flu vaccines will also be available to everyone aged over 50 from September, ensuring protection against two dangerous diseases as we head towards the Autumn and Winter. These will be available to book via community pharmacies and general practice.

Collective actions that the NHS will need to take to mitigate health and humanitarian impacts of the rising cost of living

7. Initial discussions are taking place on how we can further support our workforce and citizens during these unprecedented times of rising food, fuel, energy and living costs, which could have both short and long-term impacts on our health and wellbeing. We have already established the partnerships and collaboratives across our system for the provision of core NHS and social care services, we now need to identify how we work together with wider partners to support people with the rising costs of living, alongside our existing commitments.

ICB updates and developments

Use of emergency powers for urgent decisions

8. Since the ICB's establishment on 1 July 2022, the Board's urgent decision-making arrangements (as defined in the ICB's Standing Orders) have been exercised on several occasions. This has been necessary due to exceptional circumstances, including the inaugural meeting of the Board not being quorate and the timing of the ICB's establishment. **The following decisions are now presented to the Board for formal ratification**:

9. At the Board's meeting on 1 July 2022, following discussion with the Board members present, the ICB Chair and Chief Executive approved:

   a) The ICB's Governance Handbook, Standing Financial Instructions and Scheme of Reservation and Delegation.

   b) The appointment of Committee Chairs set out in paragraph 13c) of paper ICB 22 004, Establishment of NHS Nottingham and Nottinghamshire Integrated Care Board.

   c) The appointment of the Board level roles set out in paragraph 17a) and 17b) of paper ICB 22 004, Establishment of NHS Nottingham and Nottinghamshire Integrated Care Board.

   d) The establishment of the Nottingham and Nottinghamshire Integrated Care Partnership, based on the initial terms of reference presented.

   e) The appointment of the ICB's members of the Integrated Care Partnership.

   f) The ICB's Incident Response Plan.

   g) The appointment of KPMG as the ICB's External Auditor, following a recommendation from the ICB's Auditor Panel.

10. In August 2022, the emergency powers were used to approve recurrent expenditure of £8 million for a system-wide 'Discharge to Assess' (D2A) model to expedite discharge of patients confirmed to be medically safe for transfer

from hospital settings. The approval was given by the ICB Chair and Chief Executive, following consultation with the Vice Chair and Director of Integration.

Embedding the citizen voice

11. NHS England has recently released new statutory guidance for Integrated Care Boards, NHS trusts and foundation trusts to support them in meeting their public involvement legal duties and the new 'triple aim' of better health and wellbeing, improved quality of services and the sustainable use of resources.

12. The guidance sets out how working with people and communities supports the wider objectives of integration including population health management, personalisation of care and support, addressing health inequalities and improving quality. It supports organisations to build collaborative and meaningful partnerships that start with people and focus on what really matters to our communities. The guidance can be found at https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/.

13. Following a request for further information made at the July Board meeting, an update on progress to establish local arrangements can be found at Appendix A.

NHS England Oversight Framework 2022-23 and Memorandum of Understanding

14. NHS England has recently published their Oversight Framework for this financial year. The Framework provides a consistent monitoring framework for NHS organisations, with flexibility to support different system delivery and governance arrangements and sets out the oversight role of Integrated Care Boards in leading on the oversight of NHS provider organisations within their system. The framework will support ICBs and NHS England to work together and develop proportionate and locally tailored approaches to oversight. The Framework can be accessed at https://www.england.nhs.uk/wp-content/uploads/2022/06/B1378_NHS-System-Oversight-Framework-22-23_260722.pdf.

15. In support of these oversight arrangements, Integrated Care Boards and NHS England are required to agree a Memorandum of Understand (MOU). This will set the principles which underpin how they will work together to discharge their duties to ensure that people across the system have access to high quality, equitable health and care services, outline the delivery and governance arrangements across the ICB and its NHS partner organisations and how the ICB and NHS England will work together to address development-specific needs across the ICS. At the Board meeting in July, it was agreed that the

ICB's Chief Executive would progress these arrangements with NHS England during August. The final version of the MOU will be shared with the Board at its meeting in November 2022.

Clinical Commissioning Group Annual Reports and Accounts 2021/22

16. Prior to their disestablishment on 30 June 2022, NHS Bassetlaw Clinical Commissioning Group (CCG) and NHS Nottingham and Nottinghamshire CCG submitted their Annual Reports and Accounts (ARAs) for the period of 1 April 2021 to 31 March 2022. The purpose of these reports is to provide key organisational details and the audited financial statements in line with the Department of Health and Social Care reporting requirements. The requirements include an assessment of performance during the reporting period, details as to how key statutory duties have been discharged and a governance statement that describes how governance, risk management and decision-making arrangements have operated over the year.

17. For this period, both organisations reported achievement of their statutory financial duties, received Head of Internal Audit Opinions providing significant assurance and had no significant control issues to report. As expected, both reports also reference the continued focus on the Covid-19 pandemic, along with the work undertaken to prepare for closedown of the CCGs and the ICB's establishment. The ARA 2022-23 for NHS Bassetlaw CCG can be accessed here, and the ARA for NHS Nottingham and Nottinghamshire CCG can be accessed here.

18. ARAs will also need to be submitted for the final three months of CCG operation (1 April 2022 to 30 June 2022). As the ICB has assumed responsibility from the CCGs for approving these, the key details and assurances required to do so were provided by the CCGs' Accountable Officers to the ICB's Chief Executive, Chair and Audit and Risk Committee Chair as part of the CCG handover process. A detailed report on the ARA timescales and process will be provided to the Audit and Risk Committee at its meeting in September 2022.

Nottingham and Nottinghamshire ICS Digital Charter Agreement

19. Digital is a key enabler to improve the quality and sustainability of our health and care services. Several collaborative digital projects, products and services have been created and operated over the past years. In many cases, this has required each project to create a separate agreement to bind the relevant parties together.

20. As we expect many new digital projects in the future, it is not sustainable to expend legal resource on creating a new agreement for every initiative.

Therefore, a single Digital Charter has been developed that covers the principles, responsibilities, and behaviours common to all digital initiatives and projects. By creating an overarching set of principles, it is then made easier for each new project to create their own annex to this Charter to deal with their specific needs.

21. Signatories to the Charter are Nottinghamshire Healthcare Foundation Trust, Nottingham University Hospitals Trust, Sherwood Forest Hospitals Foundation Trust, Nottingham and Nottinghamshire Integrated Care Board, Nottingham City Council and Nottinghamshire County Council.

Partner Updates

New Chief Executive of Nottinghamshire Healthcare NHS Foundation Trust

22. Nottinghamshire Healthcare has announced that Ifti Majid will become Chief Executive following the retirement of John Brewin. Ifti is currently the Chief Executive of Derbyshire Healthcare NHS Foundation Trust, and he also holds several national roles including Chair of the NHS Confederation's Mental Health and Learning Disabilities Network, and Co-Chair of the BME Leadership Network. Ifti will join the Trust later in the year, with Anne-Maria Newham, Executive Director of Nursing, acting as Interim Chief Executive until that point.

New Chair of East Midlands Ambulance Service (EMAS)

23. Following the departure of EMAS Chair Pauline Tagg MBE, NHS England has recruited a new Chair, Karen Tomlinson. Karen joined EMAS as a Non-Executive Director in August 2014. She has worked in most healthcare settings throughout her career within the NHS, starting as a nurse, and progressing to various senior management posts including Executive Nurse, Deputy Chief Executive and Director of Operations. Karen has been a Specialist Advisor with the Care Quality Commission since 2014 and led the implementation of the North Nottinghamshire Covid Programme during 2020/2021.

£1.14 billion Devolution Deal for the East Midlands

24. The Government has confirmed that a £1.14 billion devolution deal is on offer for the East Midlands, covering Derbyshire, Nottinghamshire, Derby and Nottingham. The four city and county council leaders have signed up to work on this deal with the Government, which will provide the region with a guaranteed income stream of £38 million per year over a 30-year period and make an East Midlands combined authority one of the biggest in the country.

25. The deal is one of the first of a new type of combined authority, requiring new legislation from central government. As well as the £1.14 billion, it includes an

extra £16 million for new homes on brownfield land, and control over a range of budgets like the Adult Education Budget, which could be better tailored to the needs of people in our communities.

26. This would be a level 3 deal, which offers the most local powers and funding. It would also mean a new elected regional mayor, whose role would be to look at major issues affecting the whole region, give the area more of a voice and take advantage of local knowledge and expertise. Further work is underway to work on the details of the deal, with a detailed proposal planned for consultation with residents, businesses, and other organisations later this year.

Covid-19 Vaccination Programme Reward and Recognition Event

27. The Nottingham and Nottinghamshire programme won two awards at the Covid-19 Vaccination Programme Reward and Recognition Event held by NHS Midlands on 12 July 2022. The Vaccination Centres and Roving Service won the Best Collaboration Award for work to deliver the vaccine into communities through vans, buses, pop-up clinics and door-to-door vaccines.

28. The roving service has delivered more than 6,000 vaccines in the community and this has been achieved through collaboration with Nottingham City Council and Nottinghamshire County Council as well as partners across the city and county. Work to help educate the public on the Covid-19 vaccine through special Q&A clinics won the Community Engagement Award.

Health and Wellbeing Board updates

29. The Nottinghamshire County Health and Wellbeing Board's meeting on 27 July 2022 was cancelled and the next meeting is due to be held on 7 September 2022. The papers for this meeting will be published on Nottinghamshire County Council's website here: https://www.nottinghamshire.gov.uk/care/health-and-wellbeing/health-and-wellbeing-board.

30. The Nottingham City Health and Wellbeing Board met on 27 July 2022. The meeting received an update on the delivery of the Joint Health and Wellbeing Strategy; a report on the road map to a place-based collaborative commissioning plan, a Speech, Language and Communication Strategy; and a substance abuse Joint Strategic Needs Assessment.

31. Four ICB representatives were welcomed onto the Board: Dr Dave Briggs, Medical Director, Lucy Dadge, Director for Integration, Dr Hugh Porter, Clinical Director, Nottingham City Place-Based Partnership and Michelle Tilling, City Locality Director.

32. The papers and minutes from the meeting are published on Nottingham City Council's website here: https://committee.nottinghamcity.gov.uk/ieListMeetings.aspx?CId=185&Year=0.

National Updates

Establishment of a new NHS England

33. NHS England Chief Executive Amanda Pritchard has written to colleagues to update them on the establishment of a new NHS England. The NHS England Board, working with colleagues at Health Education England and NHS Digital, has agreed the purpose for the new organisation: to lead the NHS in England to deliver high-quality services for all. This will be achieved by:

    a) Enabling local systems and providers to improve the health of the populations they serve and reduce health inequalities.

    b) Making the NHS a great place to work, where our people can make a difference and achieve their potential.

    c) Working collaboratively to ensure our healthcare workforce has the right knowledge, skills, values, and behaviours to deliver accessible, compassionate care.

    d) Optimising the use of digital technology, research, and innovation; and

    e) Delivering value for money and increased productivity and efficiency.

34. Amanda's message is:

    "*Placing integrated care systems (ICSs) on a statutory footing from 1 July was a significant moment for the NHS. It means NHS England must now change the way we work and how we support leaders in local systems and providers to deliver our shared core purpose of high-quality services for all. We must create the space to allow systems to lead locally, working alongside our seven regions.*

    This means we need to reduce the size of NHS England and be rigorous about what we do, only undertaking activity at national and regional level, where it is necessary to do so. We need to simplify how we work across the new organisation and how we work with the wider NHS. And, as the NHS recovers from the pandemic, and the economic position across the country is tighter, we must also ensure our resources are used as effectively and efficiently as possible.

    In designing the new NHS England, we will reset what activity NHS England undertakes. We will review which functions we can delegate to ICSs. Where we can, we will build on the delegation of direct commissioning functions and explore what other functions can be delegated or transferred locally. We will also work with you to identify how we can best enable sustainable improvement in the services and care the NHS provides. We will do all this in close partnership

with you, delivering on the commitment to genuine co-creation that I have made.

This will mean a significant change for NHS England. We expect that, by the end of 2023/24, the new single organisation will be at least 30%, and up to 40%, smaller than the current combined size of NHS England, Health Education England, and NHS Digital. We will take account of any vacancies we have."

Department of Health and Social Care Guidance

35. The Department of Health and Social Care has recently published further statutory and non-statutory guidance on a several aspects relating to the development of Integrated Care Partnerships (ICPs) and integrated care strategies. Also included is guidance on the role of Health and Wellbeing Boards and how health overview and scrutiny committees should operate within integrated care systems to ensure they continue to be locally accountable to their communities.

    a) Health and Wellbeing Board Guidance – Engagement Document: guidance on the role of Health and Wellbeing Boards following the implementation of ICBs and ICPs, for further engagement.

    b) Integrated Care Strategy Guidance: statutory guidance for ICPs on the preparation of integrated care strategies.

    c) Expected Ways of Working between ICPs and adult social care providers: provides guidance on how integrated care providers and adult social care providers are expected to work together.

    d) HOSC Principles: this sets out the expectations on how Health Overview and Scrutiny Committees should work with ICSs to ensure they are locally accountable to their communities. It is an explanation of their role under the new statutory framework and highlights the continued importance of scrutiny.

Covid 19 Public Inquiry

36. On 21 July 2022 the Chair of the UK Covid-19 Inquiry, Baroness Heather Hallett, gave an opening statement and set out how the Inquiry will function. The Chair acknowledged the very wide scope of the terms of reference and how, as a consequence, she will need to focus on the key issues.

37. The Chair also acknowledged the importance of undertaking and concluding work as soon as possible to learn lessons for any future pandemics. Health inequalities will be a key theme to be explored. The Inquiry will proceed on a modular basis, producing regular reports following the conclusion of each module. The first three modules are to be opened this year, with preliminary

hearings before the end of 2022 and substantive public hearings in late Spring 2023.

a) Module One will examine the resilience and preparedness of the United Kingdom.

b) Module Two will be split into two parts, UK-wide and national. The first part will look at the core political and administrative governance and decision-making for the UK. This will include the initial UK response to the pandemic and will address central government decision-making.

c) Module Three will examine the impact of Covid, and of the governmental and societal responses to it, on healthcare systems generally and on patients, hospital and other healthcare workers and staff. Among other issues, it will investigate healthcare systems and governance, hospitals, primary care (including GPs and dentists), the impact on NHS backlogs and non-Covid treatment, the effects on healthcare provision of vaccination programmes and Long Covid diagnosis and support.

NHS Receipt of the George Cross

38. On behalf of 1.5 million NHS colleagues in England, on 12 July 2022, Chief Executive of NHS England Amanda Prichard, received the George Cross from Her Majesty The Queen in recognition of the incredible dedication, courage, compassion, and skill shown by NHS staff – from nurses and doctors to porters, cleaners, therapists, and countless other roles – over more than seven decades, particularly in the face of the Covid pandemic.

Social Partnership Forum – Partnership Agreement

39. The Department of Health and Social Care has recently published a policy paper between the Department of Health and Social Care, NHS Employers, NHS trade unions, NHS England, and Health Education England. It will be used to discuss, debate, and involve partners in the strategic development and implementation of policy and strategy where there are implications for the healthcare workforce.

40. Its aim is to create an environment where partners can have honest and open conversations, listening to staff voices and working with them to co-create changes that will benefit both staff and patients. The full paper can be found at https://www.gov.uk/government/publications/social-partnership-forum-partnership-agreement-2022/social-partnership-forum-partnership-agreement

Direct and Indirect Health Impacts of Covid 19 in England: Emerging Omicron Impacts

41. The Department of Health and Social Care, in collaboration with the Office of National Statistics, has recently published a paper providing a high-level overview of the short-term and long-term health harms that have arisen as a consequence of Covid-19 Omicron infections in terms of morbidity and mortality and also the indirect impacts arising through behavioural changes and health system pressures. The key findings are summarised below:

    a) Mortality and morbidity: infection rates with Omicron have surpassed previous peaks, over a sustained period. However, the numbers dying or requiring hospitalisation due to Omicron have been much lower compared to the first wave of infections and the Alpha wave.

    b) An estimated 2 million people were experiencing Long Covid (self-reported) as of 1 May 2022. High numbers of acute Covid-19 cases since the emergence of the Omicron variant have led to increased Long Covid prevalence.

    c) There has been no discernible increase in the number of Covid-19 positive patients in critical care beds during the Omicron wave of infection. However, increases in staff absence may have led to increased pressure in critical care.

    d) Primary care: appointments and referrals were resilient during the Omicron wave of infection. However, lower overall activity across the pandemic has led to ‘missing’ appointments and referrals. A proportion of these may return in the future with patients being in a worse state of health, whilst others will not return for a variety of reasons. During the pandemic there has been a reduction in the diagnosis of new conditions compared to pre-pandemic trends. Whilst the reported incidence of some conditions has returned to pre-pandemic trends, other conditions are still persistently below the pre-pandemic trend.

    e) Staff infections: there has been a wave of NHS staff absences due to Omicron, similar to that seen during the wave of infections caused by the Alpha variant but lower than the first wave of infection. This continues to put pressure on the NHS.

    f) Secondary care: supply constraints during the Omicron wave of infection have led to longer waits for elective and emergency patients. Elective activity remains below the levels delivered prior to the pandemic. Whilst it has been more resilient during the Omicron wave of infection compared to previous waves, there were reductions in activity in December 2021 and January 2022, with activity not returning to pre-Omicron levels until February 2022.

g) Mental health: the number of referrals and people in touch with mental health services are above pre-pandemic levels and children's mental health needs continue to grow.

h) Social care: adult social care has long-lasting pressures pre-dating Covid-19, including workforce pressures. In many cases these have been exacerbated by the pandemic and may lead to indirect health impacts. It is possible that Covid-19 may have had an impact on access to social care.

i) Economic impacts: impacts from Omicron have been smaller compared to those seen during previous waves of infection. Unemployment, which would be a negative driver of long-term health, did not spike following the end of furlough, though non-Covid-19 pressures mean that the wider economic climate remains fragile.

42. The full report can be found at https://www.gov.uk/government/publications/direct-and-indirect-health-impacts-of-covid-19-in-england-emerging-omicron-impacts/direct-and-indirect-health-impacts-of-covid-19-in-england-emerging-omicron-impacts

National Director for Emergency Planning and Incident Response

43. Dr Mike Prentice has been appointed National Director for Emergency Planning and Incident Response (EPRR). He will lead the Resilience team, which includes EPRR, Potential Incident Investigation Preparation and Recovery, and the National Operations Centre. Mike joined the NHS England team at the start of 2020 on secondment from his previous role as Regional Medical Director in the North East and Yorkshire.

Appendix A – Embedding Citizen Voice in Nottingham and Nottinghamshire Integrated Care System

Introduction

1. Good progress is being made in establishing the ICB's structures and systems for working with people and communities. We have received positive feedback from NHSE on our overall approach and are on track with delivery of key elements including: Citizens' Panel, ICS Engagement Practitioners Forum, ICB Citizen Intelligence Advisory Group (CIAG) and the Voluntary, Community and Social Enterprise (VCSE) Alliance.

Working with people and communities: Citizen Intelligence Strategy

2. As part of the NHSE assurance process, the ICS Citizen Intelligence Strategy was reviewed by the national Public Participation and System Partnership teams, regional engagement leads and peer reviewers from an ICB in another region. The feedback received was overwhelmingly positive, describing the strategy as: "*very thorough with useful supporting visuals and extensive knowledge of working with people and communities, providing a lot of confidence in the overall approach*". The areas for development including publication of a summary version and clarification of the unique role of the VCSE sector are being acted on.

Citizens' Panel

3. The Citizens' Panel pilot is being delivered in Nottingham City to add to our existing methods of engaging local people and will be a further way that we can listen to the views of our citizens. The panel will add value by identifying local priorities and consulting on specific issues that affect our communities. Benefits of the panel include the ability to track trends in opinion, targeted work with particular groups focussing on health inequalities and the ability to focus on specific ICS priorities at various points in the year.
4. The Engagement Team continue to work closely with key stakeholders such as Nottingham CVS, Healthwatch Nottingham and Nottinghamshire, Nottingham Trent University, University of Nottingham Business School, CityCare, NUH and other Place representatives to establish the Panel.
5. A mapping exercise with recent census data is underway to ensure that the pilot panel will be as representative of the Nottingham City population as possible with an aim of 800 panel members. Effective stakeholder engagement software has been sourced with the ability to carefully monitor demographics and to identify those segments of the population with lower take-up.

6. A comprehensive communications plan has been drafted and will be implemented in line with panel recruitment. The official launch date of the Panel is 5 September, with the first engagement survey being issued in November. The survey schedule will be developed in conjunction with the ICS Engagement Practitioners Forum.

ICS Engagement Practitioners Forum

7. The ICS Engagement Practitioners Forum will provide a platform for all system partners working with people and communities to work collaboratively, share resources, knowledge and expertise and maximise existing knowledge and insights. The Forum will aim 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 be used for multiple purposes. A “do once” philosophy as well as a default approach of sharing insights should be the guiding principle.
8. An informal introduction session took place on 21 July, with representation from Bassetlaw Place, Mid-Notts Place, East Midlands Health Academic Science Network, NUH, Nottinghamshire Healthcare and Healthwatch Nottingham and Nottinghamshire. Apologies were received from colleagues representing EMAS, SFHT, Nottingham CityCare, Nottinghamshire County Council, Nottingham City Council and Nottingham CVS. Follow-up discussions are scheduled with those organisations to ensure that they are involved in the work going forward.
9. The key discussion points were regarding the draft Terms of Reference, members aspirations and hopes for the group and priority projects. Members were also keen to understand the wider system engagement structures.
10. The first formal meeting will take place on 14 September.

ICB Citizen Intelligence Advisory Group (CIAG)

11. The CIAG will be a group of experts in the fields of research/insight/engagement working across the system, to provide assurance and challenge that the appropriate work is being done to listen to and involve our citizens. This group will have a link to the ICP and ICB Board:
12. The ICP will, as part of its role as the ‘guiding mind’ of the ICS in line with the expectation that “*a strong and effective ICS will have a deep understanding of all the people and communities it serves*”, receive reports summarising intelligence and insights gathered from citizens and communities over the period preceding each meeting of the ICP.

13. The Quality and People Committee will be responsible for assuring the ICB in regard to its statutory duties for patient and public involvement.

14. An informal introduction session with members is scheduled on 21 September with the first formal meeting taking place on 13 October.

Voluntary, Community and Social Enterprise (VCSE) Alliance

15. We have been working with an external consultant who was tasked with developing a model for how the VCSE sector could provide the ICS with intelligence and insight from the groups and communities they work with via a single point of contact. A Task and Finish Group with representatives from the six Community Voluntary Services (CVSs) across the ICS was established to provide support guidance and feedback via monthly meetings. The primary recommendation was to establish a Nottingham and Nottinghamshire VCSE Alliance which is made up of:

    a) Local representatives of national and regional VCSE organisations working countywide to provide services to citizens

    b) A collective of the CVSs and other infrastructure organisations.

16. This means that the VCSE Alliance will draw in both smaller VCSE organisations via their CVS “umbrella” organisations and also the local representatives of larger charities (for example, Framework, Alzheimer’s Society etc.). This two-pronged approach ensures the voice of smaller community organisations isn’t lost against those of bigger providers; that by being represented by strong, collaborative CVSs and infrastructure organisations within a wider VCSE Alliance, they can have real influence at system level, allowing the needs of the community to be heard.

17. To date, we have secured the membership of Active Notts, Framework, Self Help UK, Royal Air Forces Association, Trussell Trust, Active Notts and Stroke Association. Further meetings are scheduled over the coming weeks with Alzheimer’s Society, Age UK Nottingham and Nottinghamshire and Parkinson’s UK. The focus now is to secure membership of organisations who support children and young people.

18. An informal introduction session with members is scheduled on 8 September with the first formal meeting taking place on 4 October.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	08/09/2022
Paper Title:	**Urgent and Emergency Care: Planning for Winter**
Paper Reference:	ICB 22 020
Report Author:	Caroline Nolan, System Delivery Director Urgent Care
Report Sponsor:	Lucy Dadge, Director of Integration
Presenter:	Lucy Dadge, Director of Integration
Recommendation(s):	The ICB is asked to **RECEIVE** this item.

Summary:

The Urgent and Emergency Care system continues to be under intense pressure with long delays and bottlenecks impacting acutely unwell patients accessing our services. This pressure is expected to intensify in Winter 2022, when services and our staffing are likely to be stretched further.

The winter letter from NHS England (NHSE) *Increasing capacity and operational resilience in urgent and emergency care ahead of winter* sets out the core objectives and key actions for operational resilience for all Health and Care systems. The system has plans underway for all the priorities, as detailed in this paper.

As a system we are trying to mitigate these risks and challenges and ensure our Elective Recovery Programme continues as planned. All system partners are engaged in developing mitigation plans for winter, and scenario planning based on predicted levels of demand.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	The urgent and emergency care system is continuing to provide access to urgent and emergency care and is developing winter mitigation plans.
Tackle inequalities in outcomes, experience and access	System partners are working together to ensure that access is consistently available across the urgent and emergency care system and ensure that we support patients to access the right service at the right time which is most appropriate to their needs.
Enhance productivity and value for money	All transformation and winter mitigation schemes are impact assessed to ensure we deliver productivity improvement and best value.
Help the NHS support broader social and economic development	Alignment of Urgent and Emergency Care with Elective Recovery requirements, informed by a system approach to demand and capacity planning across health and social care. Population Health Management at place informs service planning based on population need.

Appendices:

Appendix 1 – Extract from NHSE Letter *Increasing capacity and operational resilience in urgent and emergency care ahead of winter* August 2022

Board Assurance Framework:
To be confirmed in line with the development of the Board's Assurance Framework.

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

Report Previously Received By:
The Nottingham and Nottinghamshire ICS Urgent and Emergency Care Delivery Board has operational oversight responsibility for all areas covered within this report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Urgent and Emergency Care: Planning for Winter

Introduction

1. Throughout 2022 there has been significant pressure on urgent and emergency care (UEC) services across the health and care system. This has resulted in bottlenecks in flow from one point of care to the next and delays in people accessing their next stage of care. This has impacted acutely unwell patients in ambulance services, emergency departments and hospital flow particularly for discharge.
2. There have also been delays in community and social care services, with people spending longer than needed in care homes or community services. To provide care most effectively for our population, every part of the pathway needs to be optimised, preventing hospital attendances and admissions, managing hospital assessment, diagnostic, treatment, and discharge processes optimally, ensuring that people who require further support can move into services as promptly as possible.
3. This pressure is expected to intensify in Winter 2022 when services are likely to be stretched further. The winter letter from NHS England *Increasing capacity and operational resilience in urgent and emergency care ahead of winter* (August 2022) sets out the core objectives and key actions for operational resilience for all Health and Care systems. An extract from this letter is provided at Appendix 1, and this paper details the system plans underway for each of these priorities.
4. The management of emergency demand and flow is vital to protect resources for delivery of elective services for high priority patients as well as delivering in full the elective service recovery plan.
5. The system has worked up UEC transformational schemes and is continuing to develop winter mitigation plans to deliver enough capacity to meet likely demand scenarios in our acute hospitals and community health and care services.

Operational Planning and Resilience management

6. The Integrated Care System (ICS) Surge and Escalation Plan will be operational throughout winter to oversee and manage UEC pressures.
7. Capacity and demand planning is an integral part of the surge and escalation plan to ensure demand scenarios and mitigation plans to meet predicted levels of acute demand and community health and care needs are in place.

8. The ICB UEC team maintain real time oversight of operational pressures at provider and system level, monitor escalation and galvanise provider response including requests for mutual aid.
9. The established and recently reviewed Operational Pressures Escalation Levels (OPEL) reporting and escalation tools will continue to ensure appropriate provider and system level response. This includes a more diligent focus on OPEL 3 actions by all providers to avoid escalation to OPEL 4 levels.
10. The rhythm of daily reporting and oversight, through system calls and escalation management including out of hours will continue throughout the winter period. In the event of emergency demand exceeding system resource EPRR Incident Response arrangements will be enacted.
11. Nottingham and Nottinghamshire ICS Urgent and Emergency Care Delivery Board will continue to provide oversight of winter planning and resilience.

Services Supporting Admission Avoidance

12. The Urgent and Emergency Care Board oversees transformation plans to reduce both attendance at emergency departments and admissions into hospital. The impact of these schemes on demand and capacity has been quantified and contributes to ICS mitigations. Schemes include non-conveyance, urgent community response, virtual wards, respiratory schemes and enhanced care home support.
13. All transformation schemes across the ICS are currently being reviewed and challenged to identify high impact actions which should be prioritised and accelerated.
14. The virtual wards system offer includes step up virtual ward capacity in the community which will reduce the need for admission to hospital for specific cohorts of patients including frailty and respiratory conditions.
15. Our Urgent Community Response is well established, receiving 800 referrals a month, of which 350 meet the clinical requirements to be responded to within 2 hours. Nottingham and Nottinghamshire is achieving 95% of this target against a national target of 70%. There are still some workforce challenges, and the ICS is running a rolling recruitment programme and skill mixing across community teams in line with the UCR technical guidance.
16. The ambulance non-conveyance work programme continues to support and progress schemes that maximise the crew's ability to keep patients in their usual place of residence.
17. As a system we have a significant programme of work around Enhanced Health in Care Homes this includes the recent national bid to support the increase of

hydration in care homes, rolling out MDT training for care home staff and falls management.

Maintaining Acute Flow

18. Following recent regional and national steer the ICS Navigation group is leading two key pieces of work to support acute and specifically Emergency Departments (ED) flow. This includes consideration of collocated UTCs (urgent treatment centre) and a SPA (single point of assessment) to ensure our public reach the right place first time. Proposals are being pulled together collaboratively by system partners and our citizens will be engaged appropriately as clinical thinking develops. Current services will be aligned and integrated to provide a streamlined service offer within available resources.
19. Virtual wards will also support acute flow and capacity as plans are now entering the mobilisation phase. Step down virtual wards from acute trusts will reduce the length of stay for specific patient cohorts and provide additional capacity for acute care over winter and beyond. This requires new collaborative arrangements between providers and is a key element of capacity expansion over the winter and beyond.
20. Ambulance pre handover improvement trajectories have been agreed ICS wide for the elimination of over two-hour pre handovers, a reduction in over 60-minute pre handovers and improvement on the average pre handover time.

Discharge Schemes

21. Patients are spending longer in hospital and community settings than they need to, with significant backlogs for patients waiting for home care services.
22. The ICS remains committed to delivering an effective model of discharge to assess (D2A). Investment of £8.6 million has been approved, following submission of a collaborative business case by system partners.
23. This investment will allow for an equitable pathway 1 (services in individuals usual place of residence) offer across the ICS. This will improve outcomes for our population, facilitate reduction in the current medically safe for transfer (MSFT) numbers and a reduction in utilisation of interim bed capacity.
24. All system partners are actively engaged in the 100-day D2A challenge which is supporting us to fast-track priorities across the discharge pathway, including mobilising three transfer of care hubs.
25. Whilst changes detailed above are embedded the system will retain interim bed capacity that has been utilised since winter 2021/22 at a rate to maintain discharge flow.

26. Ongoing work with both councils to develop the home care market to support reduction of backlogs in patients waiting for longer term home care service continues.

Demand and Capacity

27. As part of 2022/23 winter preparations the ICS Demand and Capacity Group has established a programme of work to develop demand scenarios and mitigation plans.

28. Two scenarios have been modelled; Nominal state – this is based on a continuation of current run rate / pressures. Challenging Winter – based on an extremely challenging winter considering flu trends in the Southern Hemisphere, Covid 19 infection trends, current run rates and variances against plan.

29. In parallel a systematic process across Health and Care is in progress to capture potential mitigations. These will be prioritised for implementation following review of potential impact, value for money and deliverability in time for winter.

30. Each prioritised mitigation is being worked up into a more detailed plan confirming milestones, risk adjusted impact, KPIs and costings. The first draft has been completed and will be used as a tracking tool.

31. The mitigations aim to meet acute hospital capacity requirements identified in the challenging winter scenario to improve flow and reduce reliance on interim beds.

Communications

32. The ICS will be implementing a winter communications strategy to support the public to minimise pressures on urgent and emergency services including the Help Us Help You campaign. Learning from the recent critical incident will be embedded.

Conclusion

33. The plan takes account of likely demand scenarios, measures in place for operational oversight, and additional capacity through transformation and winter mitigation schemes. The three major remaining risks are detailed below:

    a) Unplanned sickness and recruitment challenges impacting workforce availability; most notably in clinical posts in acute and community services and the home care sector.

b) A simultaneous rise in Covid 19 and influenza cases risks putting previously unseen levels of pressure on acute, primary care and community services.

c) Consequences of the rising cost of living and heating and food poverty on the immediate health of our population. This is difficult to predict and quantify and will depend on wider measures that are taken.

34. As the plan details, measures to plan for and mitigate these risks as fully as possible are underway to minimise the impact for our patients, our workforce, and our services.

Appendix 1

Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter NHS England, August 2022

The following is an extract from the NHS England letter:

Core objectives and key actions for operational resilience

Our collective core objectives and actions are to:

1) Prepare for variants of COVID-19 and respiratory challenges, including an integrated COVID-19 and flu vaccination programme.
2) Increase capacity outside acute trusts, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.
3) Increase resilience in NHS 111 and 999 services, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.
4) Target Category 2 response times and ambulance handover delays, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.
5) Reduce crowding in A&E departments and target the longest waits in ED, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.
6) Reduce hospital occupancy, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.
7) Ensure timely discharge, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the ‘100-day challenge’.
8) Provide better support for people at home, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	08/09/2022
Paper Title:	**Elective Recovery Plan**
Paper Reference:	ICB 22 021
Report Author:	Lisa Durant, System Delivery Director Planned Care, Cancer and Diagnostics
Report Sponsor:	Lucy Dadge, Director of Integration
Presenter:	Lucy Dadge, Director of Integration
Recommendation(s):	The ICB is asked to **RECEIVE** this item.

Summary:

Our system Elective Recovery Plan aims to reduce current waiting times and sustain timely access to elective or non-urgent care. As a direct result of the Covid-19 Pandemic there are significant backlogs of patients waiting for elective care across all NHS providers.

Work is being undertaken across the system to reduce elective and cancer backlogs, increase diagnostic provision and increase elective capacity. The system continues to make good progress in these areas; however, there are interdependencies in the context of urgent care demand and associated pressures across health and social care due to increased levels of Covid-19, staff sickness absence and staff vacancies.

Information on current performance and trend analysis against all elective care performance indicators is described in section 7.3 of the Board's Integrated Performance Report to this meeting.

In parallel clinical transformation is focussed on the needs of the patient to offer more personalised care in a timely manner. We have good system wide engagement with strong clinical leadership and management support to sustain performance improvement.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	By reducing waiting times for patients requiring non urgent elective care. Placing the patient at the centre of transformational change offering personalised care with shared decision making.
Tackle inequalities in outcomes, experience and access	Our approach to whole system transformation and end to end pathway redesign complements the role of Place Based Partnerships and local priorities. In addition, providing GPs with specialist advice and guidance and alternatives to acute based care will enable access to the right service first time.
Enhance productivity and value for money	Utilising productivity opportunities informed by national programmes creating additional capacity to sustain performance and meet future demand.
Help the NHS support broader social and economic development	Alignment of Urgent and Emergency Care with Elective Recovery requirements, informed by a system approach to demand and capacity planning across health and social care. Population Health Management at place informs service planning based on population need.

Appendices:
Appendix 1 – Summary of national elective waiting time targets.

Board Assurance Framework:
To be confirmed in line with the development of the Board's Assurance Framework.

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

Report Previously Received By:
The Nottingham and Nottinghamshire ICS Planned Care Board has operational oversight responsibility for all areas covered within this report.

Are there any conflicts of interest requiring management?
No

Is this item confidential?
No

Elective Recovery Plan

Introduction and background information

1. In Nottingham and Nottinghamshire elective care is predominantly provided by Nottingham University Hospitals NHS Trust (NUH), Sherwood Forest NHS Foundation Trust (SFH) and community providers.
2. Elective waiting lists have grown as all NHS providers were initially required to cease non-urgent elective care as a national response to the Covid-19 pandemic. Capacity has since been further constrained due to the requirement for additional infection prevention and control procedures (IPC) and social distancing. However, these restrictions are now lifted.
3. The annual operating plan submitted in June 2022 required the system to develop an Elective Recovery Plan to deliver the national elective waiting time targets summarised in Appendix 1. National direction to achieve this ambition was received in February 2022 (Coronavirus » Delivery plan for tackling the COVID-19 backlog of elective care (england.nhs.uk)) with specific guidance to: increase elective capacity, ensure early diagnosis to prioritise treatment, transform elective care, and provide information to support patients with shared decision making. Sustainable performance improvement requires a combination of direct action to eliminate long waits, increased productivity, and system transformation.
4. The Elective Recovery Plan is supported by the ICS Clinical Executive Group (CEG) and was agreed by the ICS Planned Care Board in April 2022; the Planned Care Board now oversights delivery of the plan.
5. The system continues to make good progress however, there are interdependencies in the context of urgent care demand and associated pressures across health and social care due to increased levels of Covid-19, staff sickness absence and staff vacancies. The system is working together to analyse and mitigate the impact of this using local and national trends to predict future demand and capacity requirements.
6. This report describes work being undertaken across the system to reduce elective and cancer backlogs, increase diagnostic provision and increase elective capacity. Information on current performance and trend analysis against all elective care performance indicators is described in section 7.3 of the Board's Integrated Performance Report to this meeting.

Reducing elective and cancer backlogs

7. The system has successfully eliminated waits of 104 weeks other than exceptional cases of complexity and patient choice. We aim to eliminate all 104

week waits due to complexity from the end of September 2022. Trajectories to eliminate waits of over 78 weeks are being finalised at service level. Performance is reviewed and action agreed on a weekly basis with progress reported to the ICS Planned Care Board.

8. Actions include:
    a) Additional weekend operating lists.
    b) Independent Sector Providers (ISPs); contracts with three main ISPs have been increased to enable transfers from NUH and SFH in addition to offering patients a choice of provider at the point of referral.
    c) Mutual aid between SFH and NUH if clinically appropriate and if the patient chooses an alternative hospital. In addition, a small number of patients have been offered and accepted elective care outside of the system.
    d) Increasing day case provision where clinically appropriate.
9. All patients are clinically prioritised in line with national guidance from the Royal College of Surgeons. Cancer patients and urgent elective cases are prioritised appropriately. Current performance against the 62-day cancer waiting times target is below plan however this is an improving position. A detailed review of cancer capacity and demand is underway and provider trajectories are being finalised.

Increasing diagnostic provision

10. Increasing diagnostic provision is fundamental to reducing the elective backlog and earlier cancer diagnosis. Options are being scoped to develop Community Diagnostic Centres (CDCs) in line with national policy to increase diagnostic provision in community settings away from acute hospitals. The differential population health need is being assessed to ensure a reduction in health inequalities with consideration of the impact and benefit for patients, workforce requirements and financial implications.
11. A diagnostic performance improvement plan has been agreed by SFH and NUH with specialty level trajectories and action plans to April 2023, with an overall trajectory to achieve 95% of diagnostic waits under six weeks by end of March 2025. Performance against the cancer 28-day faster diagnosis standard is already strong. Workforce constraints have been the main limiting factor in current performance against diagnostic waiting times. Recruitment is underway and improvement noted. It is anticipated that whilst CDCs will contribute to increased provision detailed workforce plans are required to address future recruitment and training needs.

12. Performance improvement and CDC planning is overseen by the ICS Diagnostic Programme Board with progress reported into the ICS Planned Care Board.

Increasing elective capacity

13. Providers are required to increase elective activity to 104% of pre-Covid levels, which generates income via the Elective System Recovery Fund (ESRF). This is a short-term measure to reduce elective backlogs therefore providers need to increase capacity and productivity for future sustainability.
14. National guidance recommends separating elective activity away from urgent care demand where possible, and there may be opportunity to access national capital monies to develop an Elective Hub on the City campus at NUH, providing additional capacity away from the Emergency Department.
15. The Elective Hub will complement earlier changes to locate colorectal and hepatobiliary services at the City campus from October 2022 to enhance capacity ahead of winter. Analysis is underway, including population health need, the benefit and impact on patients, together with the financial implications. Robust workforce planning will be an essential component to ensure sustained service delivery. SFH and NUH are working together to consider options that benefit the wider population and address workforce challenges. In addition, SFH are increasing day case activity at Newark to complement existing services at Kings Mill Hospital.
16. Productivity opportunities to increase capacity can be drawn from the national High Volume Low Complexity Programme (HVLC) and the Getting it Right First time Programme (GIRFT) data, alongside potential improvements in theatre productivity. The HVLC programme is focussed on six specialties: Ophthalmology, Ear, Nose and Throat (ENT), General Surgery, Musculoskeletal (MSK) including spinal surgery, Urology and Gynaecology.
17. GIRFT data has been reviewed with clinical and managerial leads to inform the respective improvement programmes within SFH and NUH. There are some differences in opportunities due to the nature of service provision; however, there are also similarities across the HVLC programme and learning to share. A process is underway to confirm opportunities which informs local action plans owned at specialty level. Current plans include:
    a) One stop clinics in Ophthalmology and other specialties ‘see and treat’.
    b) Review of roles to make best use of allied health professionals and other staff.
    c) Improved theatre utilisation by means of scheduling and flow to enable more cases per theatre session.

d) Workforce planning.

18. Support has been offered by NHS England regarding theatre utilisation and a series of deep dive reviews with the GIRFT team is underway. This is aligned with the existing outpatient transformation programme which seeks to increase virtual outpatients, expand advice and guidance and offer Patient Initiated Follow Up (PIFU) in line with planning requirements, supported by digital technology.

19. Work is underway with Place Based Partnerships (PBPs) to optimise referrals, supporting GPs to access alternatives to face to face outpatient appointments, aligned to the needs of the local population.

System transformation

20. The approach to clinical transformation is centred around the patient and informed by a local assessment of population need with an ambition to improve health outcomes, reduce health inequalities with more personalised care. This will increasingly link to the emerging role and priorities of PBPs. The specific programmes of work currently underway are Eye Health and MSK.

21. The Eye Health programme is established and is widely considered an optimum future model with shared clinical leadership and project management in place. There are good examples of tangible changes based on end-to-end pathway redesign aligned to GIRFT findings. The impact on activity and capacity in 2022/23 is driven by increased community-based follow ups, improved quality of referrals, increased capacity using an ophthalmology diagnostic hub and increased theatre productivity. There may be further opportunities across this programme.

22. The MSK programme has recently been re-established and has clinical leadership in place with good provider engagement. Immediate action to reduce backlogs has been required however clinical leads are now keen to address wider MSK transformation opportunities building on the Eye Health model. This will include review and implementation of HVLC and GIRFT recommendations, standardisation of MSK pathways to improve access and reduce unwarranted variation, access to community-based care, implementation of MSK link worker roles to support a personalised approach to care and shared decision making with patients.

Conclusion and next steps

23. It is essential to address long waiting times and to increase elective activity in line with all national planning requirements. Risk factors have been assessed and include urgent care pressures, seasonal influenza and further Covid related

demand, which may also impact our workforce and staffing. Actions to mitigate risk can be summarised as follows:

a) Maximise productivity opportunities, implement and model the impact.

b) Build on a system wide approach to transformation to address health inequalities with a personalised approach to care, aligned to PBP priorities.

c) Develop business cases for the Elective Hub and CDCs with system partners, informed by population need and appropriate patient and public engagement.

d) Develop workforce plans and recruitment to address future requirements.

e) Delivery of Elective Recovery plans supported by strong clinical and managerial leadership.

Appendix 1

Elective waiting times	
July 2022	Eliminate waits of 104+ weeks
March 2023	Eliminate waits of 78+ weeks
March 2024	Eliminate waits of 65+ weeks
March 2024	Hold or reduce waiting list size to the September 2021 level
March 2025	Eliminate waits of 52+ weeks
Diagnostic waiting times	
March 2025	95% of patients receiving diagnostic tests within six weeks. Stepped improvement trajectory requirement: 75% by March 2023 85% by March 2024
Cancer waiting times	
March 2023	Return the number of people waiting 62 days or more from urgent referral to pre pandemic levels
March 2024	75% patients urgently referred by their GP with suspected cancer are diagnosed or have cancer ruled out within 28 days. The Faster Diagnosis Standard was introduced in Q3 2021/22.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	08/09/2022
Paper Title:	**Maternity Services Update**
Paper Reference:	ICB 22 022
Report Author:	Danni Burnett, Deputy Chief Nurse
Report Sponsor:	Rosa Waddingham, Director of Nursing
Presenter:	Rosa Waddingham, Director of Nursing
Recommendation(s):	The Board is asked to **RECEIVE** this item.

Summary:

This paper outlines our system response to the fifteen immediate and essential actions (IEAs) contained in Donna Ockenden's Report following the review commissioned into maternity care failings at Shrewsbury and Telford NHS Trust.

This update report is presented in two parts. The first details how we are working as a system across Nottingham and Nottinghamshire to meet the Ockenden requirements and delivering transformation plans to improve safety in our maternity services. Led through the Local Maternity and Neonatal Services (LMNS), system partners have collaborated on significant work to evolve the LMNS perinatal governance structure, strengthening effectiveness and support of timely identification and escalation of safety and quality concerns ensuring clear oversight of services delivered across our system. Progress has continued across the system against all Ockenden IEA domains, and focus continues to ensure further progress which is monitored though the LMNS and supported by all partners.

Secondly, recognising that the Nottingham and Nottinghamshire maternity system is affected by the challenges at Nottingham University Hospitals NHS Trust (NUH), the ICB has been working closely with NUH, NHS England and wider system partners to oversee improvements in the services, providing capacity to support, as well as continuing to provide scrutiny and challenge to the improvement plans. Although improvements are being made against a comprehensive Maternity Improvement Plan (MIP), it is widely acknowledged that the pace is nowhere near where we want it to be for local women and their families. The scale of improvement required will take time and has been further compounded by operational demands and response to the pandemic. That said, there are areas of improvement which are detailed in the paper and work continues to further accelerate improvements.

We welcome the review of NUH maternity services chaired by Donna Ockenden, which started on 1 September 2022 and will give further opportunity to support the families involved in maternity services at NUH have their voices heard and provide valuable learning to support the rapid improvement in quality in these services to benefit our citizens. All system partners are fully committed to both supporting this review and implementing the findings at pace, alongside the other recommendations and plans outlined in this report.

Improving the quality of care delivered at NUH's maternity services and ensuring high-quality maternity services within our system remains a clear priority for the ICB and all system partners.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	This report outlines activity undertaken in relation to maternity safety, improvement and transformation in Nottingham and Nottinghamshire to improve the outcomes and experiences of local women and their families accessing maternity care.
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 – Refreshed System Quality Group Governance Arrangements.

Board Assurance Framework:
To be confirmed in line with the development of the Board's Assurance Framework.

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

Report Previously Received By:
This paper is a further update and amalgamation of papers received by the Quality and People Committee, and the system Quality Assurance and Improvement Group where the system progress against Ockenden recommendations and the improvements at NUH were discussed. Noting that pace of change needs to improve, and improvements need to be sustainable. It was also agreed (and reflected in our priorities and business deliverables) that the delivery of safe, effective and high-quality maternity services remains a priority.

Are there any conflicts of interest requiring management?
No

Is this item confidential?
No

Maternity Services Update

Introduction and background

1. A review was commissioned into maternity care failings at Shrewsbury and Telford NHS Trust. An interim Donna Ockenden Report was published in December 2020 containing seven immediate and essential actions (IEAs) which aligned with existing maternity safety improvement and assurance measures (including SBLCBv2, the Maternity Incentive Scheme and Each Baby Counts). All Trusts providing maternity services in England were asked to assess their current position against the seven IEAs:

   a) Enhancing safety

   b) Risk assessment throughout pregnancy

   c) Listening to women and families

   d) Staff training and working together

   e) Managing complex pregnancy

   f) Monitoring fetal wellbeing

   g) Informed consent

2. The final Ockenden report builds upon the foundations of the initial seven IEAs and concludes with a revised list of 15 IEAs, as follows:

IEA1 Workforce planning and sustainability	IEA9 Preterm birth
IEA2 Safe staffing	IEA10 Labour and birth
IEA3 Escalation and accountability	IEA11 Obstetric anaesthesia
IEA4 Clinical governance (leadership)	IEA12 Postnatal care
IEA5 Clinical governance (investigations and complaints)	IEA13 Bereavement care
IEA6 Learning from maternal deaths	IEA14 Neonatal care
IEA7 Multidisciplinary training	IEA15 Supporting families
IEA8 Complex antenatal care	

3. This update report is presented in two parts. The first details how we are working as a system across Nottingham and Nottinghamshire to meet the Ockenden requirements and other transformation plans to improve safety in our maternity services, including details of the partnership and oversight arrangements in place.

4. The second part details the challenges we face as a system in supporting the implementation of the Ockenden requirements and pays special regard to the maternity improvement programme in place within Nottingham University Hospitals NHS Trust (NUH).

Part one

5. Nottingham and Nottinghamshire maternity safety, improvement and transformation is co-ordinated through the Nottingham and Nottinghamshire Local Maternity and Neonatal System (LMNS) with both NUH and Sherwood Forest Hospitals NHS Foundation Trust (SFH) having executive membership on the LMNS Executive Partnership Board which reports through the System Quality Group (previously known as the Quality Assurance and Improvement Group) into the ICB Quality and People Committee.

6. The LMNS is a partnership collaborative established to oversee the development and implementation of a local vision for transforming maternity services based on the principles of Better Births, the NHS Long Term Plan, the National Neonatal Review (Better Newborn Care), and more recently the Ockenden recommendations across the system.

7. Led by the LMNS, quality and safety of maternity services now has system visibility and ownership. Whilst NUH has an Improvement Oversight and Assurance Group (IOAG) in place it is essential that the system sustains the level of rigour and support, not just for services delivered at NUH, but beyond.

8. Over the past year significant work has taken place to evolve the LMNS perinatal governance structure and associated meetings. The overarching aim has been to strengthen effectiveness and support timely identification and escalation of safety and quality concerns in line with the Perinatal Quality Surveillance Model.

9. The LMNS Perinatal Surveillance Quality Group (PSQG) is intrinsic to system oversight. Key highlights are shared with the LMNS Executive Partnership Board and into the System Quality Group. The LMNS has established a Serious Incident Shared Governance Group which meets alternate weeks having oversight of all Maternity Serious Incidents. This group is chaired by the ICB, attended by all system partners, representatives from NHS England, and the Lincolnshire LMNS offering a sphere of clinical practice and independence.

10. Also reporting into the PSQG is the LMNS Quality Outcomes Dashboard Sub-group (DSG) the purpose of which is to ensure that the LMNS dashboard data is regularly scrutinised for key themes that require either escalation or general sharing. The LMNS Quality and Outcomes Dashboard provides an overview of the Local Maternity and Neonatal System performance against a defined set of indicators across a broad range of maternity, neonatal and associated services and was developed over 2021/2022.

11. Progress has continued across the system against all Ockenden IEA domains, and focus continues to ensure plans are delivered. The LMNS Programme Management Office team are working with both maternity providers to formulate and agree a plan for delivery of the entire set of Ockenden recommendations since the publication of the final report on 30 March 2022. Oversight of this plan will be through the LMNS transformation programme, which reports into system quality arrangements. Information on the local partnership and oversight arrangements in place and the progress made against the Ockenden IEAs can be found here. The next Ockenden Evidence Review Panel is scheduled for September 2022.

12. The Maternity Voices Partnership (MVP) is an NHS working group that aims to review and improve maternity services by putting the experiences of women and their families at the centre. The Nottingham and Nottinghamshire MVP is multidisciplinary in nature bringing together representatives from organisations involved in maternity care and local women and their families. There is commitment from the ICB to ensure more user voice is fed into all service delivery and patient experience. There is also a need to recognise the importance of the Neonatal specialism and that other LMNSs have created Neonatal Voices Partnerships. As of 1 September 2022, the MVP contract will transfer to the ICB and to ensure independence is retained, the function will be hosted as part of the Coproduction Team not within the LMNS PMO Team. Scheduled activities such as MVP Board meetings, social media campaigns, and recruiting new volunteers whilst supporting existing ones will continue. There will also be a refreshed infrastructure to ensure commitment to support the system to:

    a) Implement a Neonatal Voice Partnership.

    b) Support providers to achieve the recommendations outlined with Ockenden.

    c) Implement and incorporate recommendations from the NHS England national review of MVP.

    d) Increase coproduction activities and opportunities.

    e) Increase diversity of service user voice.

Part two

13. NUH maternity services have been subject to enhanced surveillance since Autumn 2020 in response to quality concerns, with increased scrutiny and support provided by the former CCG, CQC, NHS England and the LMNS in agreeing, monitoring, and delivering a Maternity Improvement Plan. A CQC inspection of NUH in 2021 resulted in ‘Requires Improvement’ overall, with ‘Inadequate’ for maternity services. In March 2022 an unannounced CQC

inspection of NUH maternity services resulted in additional concerns being raised, specifically about the timeliness of initial review on arrival to maternity triage and the execution of maternal observations on the postnatal ward. There are concerns about the pace and scale of progress against the NUH Maternity Improvement Plan, further evidenced at both the Nottinghamshire County Health and Social Care Scrutiny Committee in January 2022, and Nottingham City Health and Adult Social Care Scrutiny Committee in February and March 2022.

14. The Nottingham and Nottinghamshire maternity system is potentially adversely affected by the challenges at NUH, and the ICB has been working closely with NUH, NHS England and wider system partners to oversee improvements in the services, providing capacity to support, as well as continuing to provide scrutiny and challenge to the improvement plans.

15. An **NUH Improvement Oversight and Assurance Group (IOAG)** has been established. This group combines partners from across the ICS and is co-chaired between the ICB and NHS England's regional team, overseeing the Trust's response to all quality and governance concerns currently present at NUH. The IOAG and relationship with wider system quality governance arrangements is illustrated in Appendix A. The IOAG meets monthly with membership from the Care Quality Commission (CQC), Health Education England (HEE), Healthwatch Nottingham and Nottinghamshire, General Medical Council (GMC), Nursing and Midwifery Council (NMC) as well as calling on key members of the Trust's leadership team to provide updates and information.

16. The group has significant focus on maternity services whilst ensuring that Trust-wide interdependent improvement work, such as culture and inclusion, has complete read across in terms of aims and objectives. The group's aim is to: provide support and challenge to drive continued improvement in quality and safety; provide collective oversight and assurance of progress; and ensure sustained progression of improvement actions.

17. Although improvements are being made, it is widely acknowledged that the pace is nowhere near where we want it to be for local women and their families. The scale of improvement required will take time and has been further compounded by operational demands and response to the pandemic. That said, there are areas of improvement and support to build upon these continues, as described in paragraphs 18 to 24 below.

18. **Ockenden Immediate and Essential Actions (IEAs):** nine out of 12 clinical priorities are now compliant with three partially compliant. Partial compliant elements include:

    a) Staff training and working together.

b) Implementing consultant-led labour ward rounds twice daily over 24 hours and seven days per week.

c) Risk assessment throughout pregnancy and monitoring fetal well-being – implementation of the saving babies lives bundle.

19. These elements align to the concerns raised in the most recent CQC report and demonstrate a good awareness of the areas still requiring work. The LMNS has undertaken a robust review of the evidence against the IEAs ahead of the data submission and report confidence against the data. Evidence on the progress of the three partial compliant elements are due to be reviewed at a September LMNS Panel.

20. **Savings Babies Lives Care Bundle (SBLCBv2):** Maternity Service at NUH has now completed Safety Action 3 (Raising Awareness of reduced fetal movement). All other elements need further work to reach full implementation:

    a) Training gaps have been identified in elements one, two and four.

    b) A comprehensive rolling audit plan is required to identify key areas for improvement, continuous learning and to evidence compliance with SBLCB and CNST safety action six.

    c) The Trust continues to work with data analysts to improve data quality.

    d) Scan software is updated to include <3rd centile to align to SBLCB.

21. The LMNS and East Midlands Clinical Network continue to provide support and oversight of areas requiring improvement.

22. **Maternity Improvement Plan:** 43% of the actions have been completed and 8% are now indicated as embedded. The Trust now has a review process in place via the Maternity Improvement Group, to review all the actions and associated evidence. The improvement plan is being updated based on the findings from the latest CQC inspection report.

23. **Workforce:** NUH has a forward plan and funding is in place. Focus on engagement with staff to retain. Preceptorship packages for newly qualified midwives are being reviewed. Concerns around medical staffing due to sickness and delayed starts for new staff. Since December 2021, the maternity services have reported that safe staffing has been met 84.2% of recorded episodes. This has impacted on the home birth offer; however 1:1 care has been provided in labour 96.8% (recorded since 20 December 2021).

24. **System Insight Visits** to the maternity services also show many areas of positive change:

    a) A robust Professional Midwifery Advocate (PMA) service in place, which is well supported by the Director of Midwifery. The new PMA-run Birth Reflection Service has positive utilisations and has supported as part of birth experiences. PMA service has also created an end-to-end care offer

for staff involved in Serious Incident (SI) investigations has been created to provide support and guidance to promote staff wellbeing.

b) Significant progress in completion of fetal monitoring competency packages >95%.

c) Maternity audit strategy now in place with evidence of feedback to staff.

d) Improving staff engagement via a range of communication approaches.

e) Approach to skill mix and different roles such as the support from Registered Nurses on postnatal wards and additional administrative staff for community teams.

f) 'Job Planning' for emergency and out-of-hours obstetric cover is good to cover high risk areas, including triage and cover for twice-daily ward rounds.

g) A range of new roles are being created which have the potential to really make the changes required to steer NUH maternity services to a safe service.

Summary

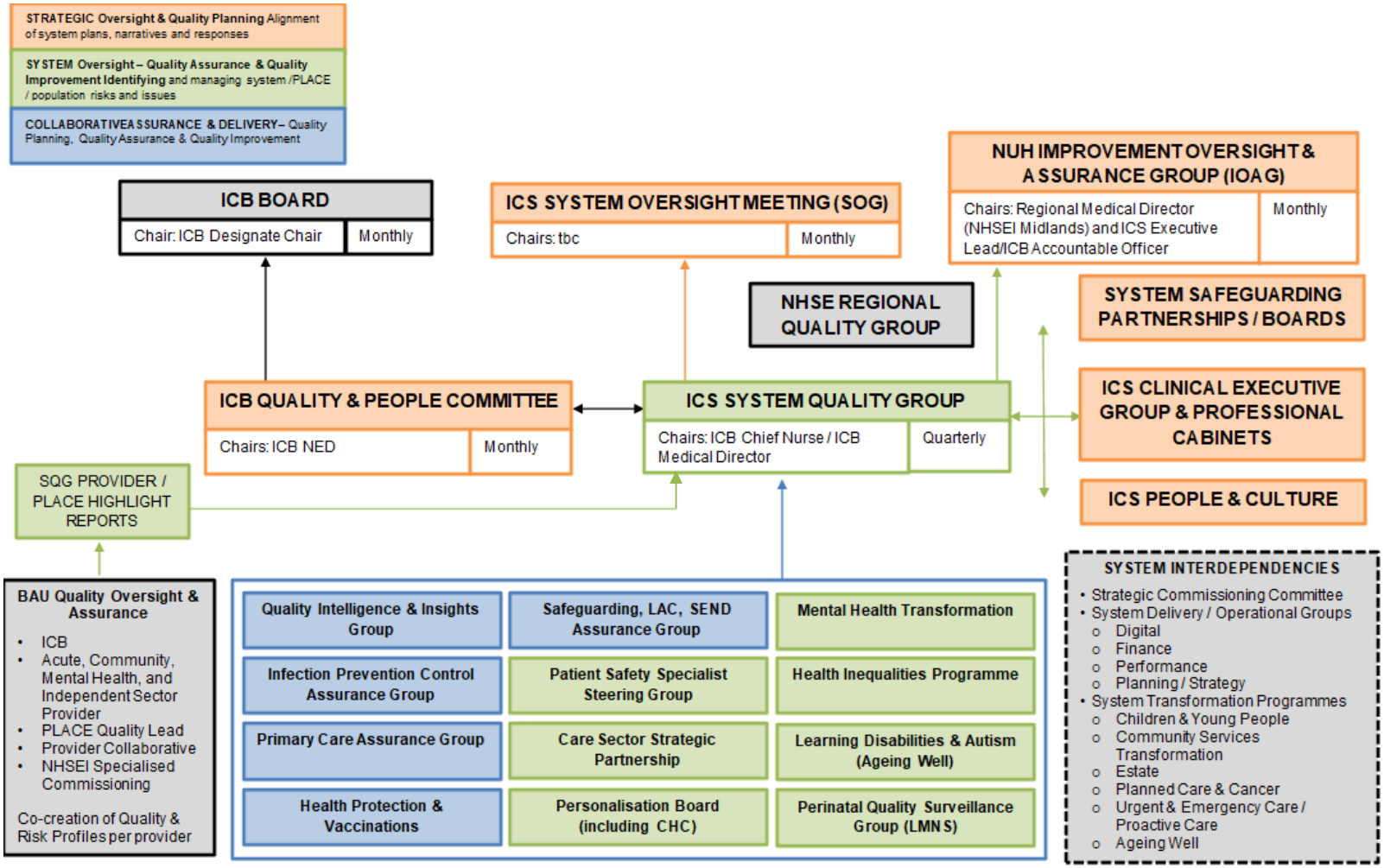
25. This briefing is not exhaustive; however, it provides some detail on the changes and actions being taken by the ICB, NUH and all system partners through the LMNS to oversee and support the necessary improvements so babies, women and their families get the safe, effective, and personalised care that they deserve.

26. Following the announcement of Donna Ockenden to chair a new review, Donna visited families in Nottingham on 11 July 2022. The new review into maternity services at NUH has commenced on 1 September 2022 and will run for eighteen months. The Terms of Reference for the Ockenden NUH Review are yet to be confirmed.

27. The ICB welcomes the review of NUH maternity services chaired by Donna Ockenden, which will give further opportunity to support the families involved in maternity services at NUH have their voices heard and provide valuable learning to support the rapid improvement in quality in these services to benefit our citizens.

28. We are fully committed to both supporting this review and implementing the findings at pace, alongside the other recommendations and plans outlined in this report. Improving the quality of care delivered at NUH's maternity services, and high-quality maternity services within our system remains a clear priority for the ICB and all system partners.

Appendix A – Refreshed System Quality Group Governance Arrangements



NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	08/09/2022
Paper Title:	**Highlight Report from the Finance and Performance Committee**
Paper Reference:	ICB 22 023
Report Author:	Jo Simmonds, Head of Corporate Governance
Report Sponsor:	Stephen Jackson, Non-Executive Director (Chair of the Finance and Performance Committee)
Presenter:	Stephen Jackson, Non-Executive Director (Chair of the Finance and Performance Committee)
Recommendation(s):	The Board is asked to **RECEIVE** the report for assurance.

Introduction:

This report presents an overview of the Finance and Performance Committee meeting on 27 July 2022. In particular, the report aims to provide assurance that the Committee is effectively discharging its delegated duties and to highlight key messages for the Board's attention. The minutes of the meeting will be published on the ICB's website once ratified.

Board members are asked to note that the format of committee highlight reports is still under development with the ICB Chair and Committee Chairs. Feedback from members on future reporting requirements is welcome as part of this process.

Overview of the meeting:

The following items were **ENDORSED**:

1. **Capital funding and capital expenditure plans for 2022/23** – the Committee supported the proposed plans for 2022/23 for onward submission to the ICB Board for approval. The proposed next steps for capital planning and the development of a capital prioritisation process for larger schemes were approved by the Committee, subject to approval of the plans by the Board.
2. **2022/23 Annual Financial Plan and Opening Budgets** – members were provided with a detailed update on the 2022/23 draft financial plans, noting that these covered the full financial year so had been submitted by the former CCGs as part of the system plan submission to NHS England in June. Members supported recommendations to endorse the opening budgets and annual financial plan for onward submission to the Board for approval.

The following items were **APPROVED**:

3. **General Practice (GP) IT Futures Procurement** – Members were advised of the mandated requirement to procure 'foundation' clinical systems for General Practice and the approach taken by CCGs nationally to put in place bridging agreements to fulfil the requirement to date. In Nottingham and Nottinghamshire, these agreements are nearing expiry and a truncated procurement had recently concluded to ensure new arrangements are in place until 31 March 2024, during which time a full procurement

will be undertaken. Members were satisfied with the robustness of the process undertaken and approved the award of contracts to the recommended suppliers.

4. **Committee Annual Work Programme (AWP) 2022/23** – Members approved the final AWP, which was built on a detailed discussion of the Committee's requirements at its development session in June.

The following items were **RECEIVED**:

5. **Integrated Performance Report (IPR)** – As this was the inaugural meeting of the Committee, members had a comprehensive discussion on the purpose and format of the IPR, with a particular focus on the specific role of the Committee in scrutinising this. It was noted that work was underway to develop the report further and it would continually evolve to meet the requirements of the ICB.
6. **System Finance Report** – Members received a detailed analysis of the financial performance of the system, including an overview of risks within the financial forecast. At the end of month three, the system is reporting a £25.8 million deficit, which is £0.7 million adverse to plan. The Committee was informed of the national expectation that all healthcare systems deliver a breakeven position, and the Nottingham and Nottinghamshire ICS is one of five systems with a planned deficit. Members were advised that partner organisations are committed to achieving the system's financial plan.
7. **ICB Finance Report** – the report outlined the financial position for the former CCGs up until their disestablishment on 30 June 2022. Members were informed that NHS England allocation adjustments had been made against the ICB allocation to ensure a balanced position for each organisation in their final accounts.

It is intended that future highlight reports will indicate levels of assurance for items discussed at meetings. A summary of all high-level operational risks being oversighted by the Committee will also be provided.

Key messages for the Board:

- The Committee's discussion on the format and content of the IPR (detailed in section 5).
- The concerns raised on the risks surrounding the financial position of the ICB and wider system (detailed in section 6).

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	08/09/2022
Paper Title:	**Financial Plan, Opening Budgets and Capital Resource Use Plan**
Paper Reference:	ICB 22 024
Report Author:	Marcus Pratt, Programme Director – ICS Finance Ian Livsey, Assistant Director of Finance
Report Sponsor:	Stuart Poynor, Director of Finance
Presenter:	Stuart Poynor, Director of Finance
Recommendation(s):	The Board is asked to **APPROVE:** • The system capital resource plan for 2022/23 and distribution of capital resources to the ICS provider organisations. • The ICB 2022/23 Capital Plan. • The ICB 2022/23 Opening Budgets.

Summary:

The purpose of this report is to present the System Capital Resource Plan 2022/23 and planned distribution of capital resources to ICS provider organisations, the ICB's 2022/23 Capital Plan and the ICB's opening budgets for approval. These items were endorsed by the Finance and Performance Committee at its meeting in July 2022.

The ICS Capital Resource Plan describes the capital funding available to the system across the three-year period 2022/23 to 2023/25, a proposal on how these funds will be distributed and recommended next steps.

The ICB Annual Finance Plan and Opening Budgets provides an update on the 2022/23 draft financial plans, which formed part of the Nottinghamshire ICS system plan submission to NHS England on 20 June 2022. This item also requests approval for the ICB opening budgets aligned to the financial plan.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	The ICS's revenue and capital plans are used to enable and support the delivery of all core aims, including improving outcomes, tackling inequalities, enhancing productivity, and supporting broader social and economic development.
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 – Breakdown of the capital envelope
Appendix B – Updates to the ICB Capital Plan

Board Assurance Framework:
To be confirmed in line with the development of the Board's Assurance Framework.

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

Report Previously Received By:
ICB Finance and Performance Committee – 27 July 2022. All recommendations within this paper were endorsed for approval.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Financial Plan, Opening Budgets and Capital Resource Use Plan

Introduction

1. The purpose of this report is to present the System Capital Resource Plan 2022/23 and planned distribution of capital resources to ICS provider organisations, the ICB's 2022/23 Capital Plan and the ICB's Opening Budgets for approval. These items have been reviewed and endorsed by the Finance and Performance Committee at its meeting in July 2022.

Integrated Care System Capital Resource Plan 2022/23 to 2024/25

2. The ICS has been working within a system-wide capital envelope since 2019/20. Each year since that point the ICS is provided with a capital resource envelope for use across the three provider organisations and is expected to plan and deliver capital expenditure within available resources.
3. To enable longer-term planning, systems have been provided with a three-year envelope for 2022/23 to 2024/25. For the Nottingham and Nottinghamshire system the envelope values are:
    - 2022/23 - £85.3 million
    - 2023/24 - £82.6 million
    - 2024/25 - £82.6 million
4. The envelope available to the system is calculated based on several factors, including depreciation values (less private finance initiative (PFI) and finance lease payments) generated by the providers, gross asset values within the system and backlog maintenance requirements.
5. In addition to the capital envelope, NHS England has made available several other sources of funding for national initiatives. Some are bespoke to Nottingham, such as the National Rehabilitation Centre, and others are generic across the NHS, for example, community diagnostic centres.

2022-25 Capital Envelope – Allocation Approach

6. Capital requirements across our provider organisations are significantly higher than the funding available. In recent years the envelope has been mainly used to address operational priorities on an annual basis such as equipment replacement, IT upgrades and backlog maintenance priorities. Larger strategic priorities have tended to be funded by targeted national funding as it becomes available.

7. To meet the core aims of the ICB, consideration of how our limited capital resources can be used requires a different approach, which will support the development of system capital priorities. To support the development of 2022/23 to 2024/25 plans, the following broad approach has been taken:

   a) Agreed prior-year precommitments are the first call on the capital envelope. This includes any slippage or unexpected cost increases. Note that slippage in plans were particularly high in 2021/22 due to Covid and Brexit related supply issues.

   b) Approximately 50% of capital envelope to be used to address operational priorities, using an agreed assessment of need across the provider organisations.

   c) National funding to be used to support strategic priorities where possible, for example, capital to support elective recovery.

   d) Remaining funding to be used to address larger strategic schemes, prioritised at a system level.

8. Utilising this approach and the ensuing distribution by organisation, a breakdown of the capital envelope is provided for information at **Appendix A**.

Risks within the Capital Plan

9. The following are the key risks to delivery of the capital plan:

Risk	Mitigations
Clarity is required over the ability of the ICS to broker funding between funding streams; i.e., allowance to use Community Diagnostic Centre (CDC) funds to support the ICS capital envelope with an equal and opposite transaction in the following years.	To discuss and agree the approach to system brokerage of capital funding with NHS England regional team, including confirmation of funding available for Community Diagnostic Centres.
High levels of inflation may lead to uncertainty in planning and escalating costs during delivery.	The continued approach to robust monthly monitoring and collective management of capital through the ICS Finance Directors' Group to quickly address any changes to capital plans.
There remains potential for slippage in capital schemes in year. To ensure funding is utilised to best effect contingencies may be required.	The continued approach to robust monthly monitoring and collective management of capital through the ICS Finance Directors' Group to

Risk	Mitigations
	quickly address any changes to capital plans. Continue to develop business cases for larger capital schemes on a consistent basis with a recognition of how these address ICB core aims, business deliverables and system risks should a scheme not be funded.
Process for prioritisation of strategic capital schemes remains under development. There is a risk that this delays capital investment if it does not proceed at pace.	The continued approach to robust monthly monitoring and collective management of capital through the Finance Directors' Group to quickly address any changes to capital plans Continue to develop business cases for larger capital schemes on a consistent basis with a recognition of how these address ICB core aims, business deliverables and system risks should a scheme not be funded.
Available capital funding is insufficient to address all the systems capital priorities. This may lead to operational risks being realised where schemes cannot be progressed.	Continue to develop business cases for larger capital schemes on a consistent basis with a recognition of how these address ICB core aims, business deliverables and system risks should a scheme not be funded.

Next Steps

10. In addition to implementing the actions described in section 9, work will also commence to develop a capital prioritisation process to ensure best value from remaining capital resources. This will:

    a) Use the ICB's Strategic Decision-Making Framework (once approved) as a basis for prioritisation.

    b) Include a capital workshop approach to ensure that key stakeholders understand the proposals and risks being addressed through each of the projects.

    c) Consider the system wide governance requirements for prioritisation.

2022/23 Annual Financial Plan and Opening Budgets

11. The 2022/23 draft financial plans formed part of the Nottingham and Nottinghamshire system plan submission to NHS England on 20 June 2022. The plans cover the 12 months of the financial year; the first three months for the former CCGs (NHS Bassetlaw CCG and NHS Nottingham and Nottinghamshire CCG) and the remaining nine months as the ICB.

12. Allocations for 2022/23 have been provided on a system wide basis. This has required an ICS system wide approach to splitting the allocation between the two former CCGs for the first three months.

13. This is a balanced financial plan for the full 12-month period. It requires a £36.96 million (3.7%) efficiency requirement. The plan to deliver this efficiency is in development and not yet fully identified (£4.6 million unidentified). The financial plan includes investment to deliver the Mental Health Investment Standard (MHIS).

14. In line with the agreed financial framework across the system, the main provider contracts within the system remain on a ‘block’ contract basis. Elective recovery funding (ERF) is again available to the system. The bulk of the ERF activity and associated funding sits with Nottingham University Hospitals NHS Trust (NUH) and Sherwood Forest Hospitals NHS Foundation Trust (SFH). A small element of ERF funding sits with the ICB, this has associated risk if the respective activity is not undertaken.

15. The CCGs received £2.018 million ‘business as usual’ capital funds which will now become the ICB capital plan. A plan to utilise the full allocation has been drawn up in conjunction with estates, primary care, and IT colleagues.

Allocations, Business Rules and Planning Assumptions

16. The allocation for 2022/23 is a system wide allocation based on the recurrent allocation received in H2 2021/22 (October – March). A convergence adjustment (reduction) had been applied nationally to all (former) CCGs as a step towards fair share allocations. Growth has been applied at a system level on an agreed basis.

17. Non-recurrent Covid funds have been made available to the system, albeit at circa 50% of the level received in the last financial year. Finally, non-recurrent funds for service development funds (SDF) have been notified and built into the plan with associated and matched expenditure. The total allocation of £2280.9 million can be broken down as follows:

    - Programme costs £2063.1 million
    - Delegated primary care costs £195.7 million
    - Running costs £22.1 million

18. The national planning guidance sets out finance assumptions and business rules. Those assumptions and rules are detailed below, showing what is included in the Financial Plan:

    - Minimum 0.5% contingency, where affordable*.
    - Remain within the running costs allocation.
    - Achievement of the Mental Health Investment Standard.
    - Plan for minimum Better Care Fund contribution.
    - Plan to spend delegated primary care allocation in full.

    **At this stage the contingency of 0.5% is not included in the plan as it is not considered affordable.*

19. The planning assumptions used in the planning model are those generally set by the planning guidance from NHS England.

Key Planning Outputs

20. The 2022/23 draft Financial Plan:

    - Delivers an in-year financial breakeven.
    - Has an underlying deficit of circa £26.1 million, with an aim to reduce in line with system expectations.
    - Requires £36.96 million efficiency savings (excluding block contracts, 3.7%).

Risks and Mitigations

21. The main risk is the level of efficiency savings required. In total there is an efficiency program of £36.96 million to be delivered and at this stage there is a shortfall in the plan to deliver this (by £4.6 million).

22. Prescribing: the plan includes a level of growth for prescribing, at the same time no specific investment has been built in for new medications that are expected to be available during the financial year.

23. East Midlands Ambulance Service (EMAS) Contract: The plan includes a minimum-only level of growth in line with planning assumptions. There is currently a risk share arrangement in development with EMAS. The current assessment is that this should not have an overall material impact on the ICB position but should be kept under review.

24. The plan includes funding for the delivery of the 104% ERF activity target. As noted above there is a risk that required activity levels may not be achieved.

25. Continuing healthcare costs (CHC), whilst inclusive of inflationary pressures and growth, remain a risk to the financial position given that the nature of CHC packages are low-volume and high cost.

26. In line with previous years, residual budget on delegated primary care, balance sheet flexibility and slippage on non-recurrent allocations will be key areas of mitigation. Some of which will need working up.

2022/23 Opening Budgets

27. The 2022/23 draft opening budgets, by programme heading are shown below. Further work is required to fully allocate efficiency savings to Programme budgets. The 12-month budget is split into the three months CCG(s) budget and a nine-month ICB budget.

£000	Full Year Plan	Q1 Nottingham & Nottinghamshire CCG	Q1 Bassetlaw CCG	Q2 to 4 NHS Nottingham ICB
Allocation	**2,280,619**	**526,036**	**54,885**	**1,699,698**
Acute Services	1,186,756	281,180	26,300	879,276
Community Services	190,603	43,431	3,986	143,185
Mental Health Services	238,549	51,324	5,979	181,245
Primary Care Contracting	195,678	43,876	5,377	146,425
Prescribing	184,111	40,632	5,396	138,083
Other Primary Care Services	45,132	9,651	1,305	34,175
Continuing healthcare	139,059	30,642	4,123	104,294
Other Contracts	70,331	16,374	1,413	52,545
Corporate Non-Running Costs	22,664	5,308	358	16,998
Programme Reserves	10,238	1,361	56	8,821
Unallocated Efficiency	-16,970	-2,348	0	-14,622
Running Costs	21,107	4,898	618	15,591
ICS system surplus (to be redistributed)	-6,320	0	0	-6,320
Planned Expenditure	**2,280,938**	**526,328**	**54,912**	**1,699,698**
Adjustments for Q1 outturn	0	-1,903	259	1,644
Planned Expenditure	**2,280,938**	**524,425**	**55,171**	**1,701,342**

Capital

28. £2.018 million has been allocated for ‘business as usual’ capital in 2022/23. The programme was previously considered and approved by the former CCGs. There have been (minor) updates to some of the schemes, which have been reflected in the table provided at **Appendix B**. This will now be the 2022/23 ICB capital plan against which performance is to be monitored.

Appendix A

ICS Approach to Capital Envelope Distribution

ICS Capital Envelope £'m	2022/23	2023/24	2024/25
Notified Envelope	**85.3**	**82.6**	**82.6**
Operational Pre-commitments	35.2	3.4	0.0
Strategic Pre-commitments	33.0	23.8	19.2
Operational Priorities	27.7	41.8	41.8
Disposals	-0.8	-3.2	-5.0
Total Planned Spend	**95.0**	**65.9**	**56.0**
Variance to Envelope - Before Strategic Priorities	**-9.7**	**16.7**	**26.6**

Community Diagnostic Centres (CDC) - National Programme	2022/23	2023/24	2024/25
Indicative Funding	13.6	5.3	5.3
Assumed Expenditure Profile	2.0	9.6	12.1
Net CDC Position	**11.6**	**-4.3**	**-6.8**

Funds remaining to prioritise against larger schemes	**1.9**	**12.4**	**19.8**

Indicative value of larger schemes developed	**12.4**	**62.4**	**47.4**

Organisational Distribution of Spend

ICS Envelope £'m	2022/23	2023/24	2024/25
NUH	59.8	42.6	40.9
SFH	11.8	9.3	9.1
NHT	23.4	14.0	6.0
CDCs			
NUH	0.0	0.0	12.1
SFH	2.0	9.6	0.0
Planned spend before larger schemes	**97.0**	**75.5**	**68.1**

Appendix B – Updates to schemes in the Capital Plan

CCG	Category	Scheme	2022/23 £000
Notts	GPIT	Remote working	125
Notts	GPIT	Hardware refresh	158
Notts	CCG IT	Meeting room kit	40
Notts	CCG IT	Hardware refresh	20
Notts	GPIT	WLAN refresh	200
Bassetlaw	GPIT	Hardware replacement	233
Bassetlaw	GPIT	Equipment for additional GP requirements due to growtl	40
Bassetlaw	GPIT	Equipment for additional staffing engaged through addit	30
Bassetlaw	GPIT	Newgate development GPIT equipment	0
Bassetlaw	GPIT	Bassetlaw GPIT transition capital costs	240
Bassetlaw	PC estates	Kilton Forest	100
Notts	PC estates	Rise Park	22
Notts	PC estates	Forest Medical	160
Notts	PC estates	Roundwood Surgery	11
Notts	PC estates	Deer Park	0
Notts	PC estates	Broad Oak	31
Notts	PC estates	Elmswood Surgery(Sherwood Health Centre)	21
Notts	PC estates	Beechdale (JRB)	69
Notts	PC estates	Orchard Surgery	59
Notts	PC estates	Torkard Hill MC	6
Notts	PC estates	Ivy Medical Group	9
Notts	PC estates	Peacock Practice	14
Notts	PC estates	West Bridgford HC	15
Notts	PC estates	Woodlands Medical Practice (reserve)	14
Notts	PC estates	Bridgeway Practice (reserve)	0
Notts	PC estates	To be confirmed – out to liaison with practices	401
Total			**2018**

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	08/09/2022
Paper Title:	**Integrated Performance Report**
Paper Reference:	ICB 22 025
Report Author:	Sarah Bray, Associate Director of Performance and Assurance
Report Sponsor:	Stuart Poynor, Director of Finance
Presenter:	Stuart Poynor, Director of Finance
Recommendation(s):	The Board is asked to **RECEIVE** the Integrated Performance Report.

Summary:

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

Quality:

a) Learning Disability and Autism, inpatient and health checks (page 13)
b) Maternity (page 15)
c) Infection prevention and control (page 16)

Service Delivery:

a) Urgent Care – flow through and out of hospital with high ambulance handover and patient 12 hour waits, high levels of patients with long stays in hospital and not transferred out of acute care when medically safe (page 20)
b) Elective Activity – rising waiting lists and 52 week waits (page 24) and difficulties in increasing and sustaining higher levels of planned activity (page 25)
c) Cancer – 62-day performance and 62-day backlogs (page 27)
d) Diagnostics – diagnostic waiting list and six week waits (page 28)
e) Mental Health – CYP Eating Disorders and Out of Area Placements (page 33)
f) Community – high levels of community waiting lists (page 35)

Finance:

a) Year to date performance is off plan at month four (page 37)
b) Financial risks have been identified and are being actively managed (page 38)

Workforce:

a) Agency – high levels of agency are still being required across the system (page 42)
b) Vacancies – the system is holding higher levels of vacancies than planned (page 44)
c) Sickness Absence – the system has higher levels of staff absence than planned (page 44)

Health Inequalities have also been included to provide a current overview of the main areas of inequalities by ethnicity and deprivation which are being targeted by the system (page 48-49) and detail relating to the five key areas of focus and actions being taken (page 50).

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

Appendices:
Appendix 1 – Full Integrated Performance Report September 2022

Board Assurance Framework:
To be confirmed in line with the development of the Board's Assurance Framework.

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

Report Previously Received By:
Elements of this report has been previously considered by the ICB Finance and Performance Committee.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Integrated Performance Report

Executive Summary

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

Quality (Rosa Waddingham)

2. The IPR Appendix 1 provides detail in relation to delivery against quality plan requirements and trajectories across Learning Disability and Autism, Personalisation and Co-Production, Maternity and Infection Prevention and Control (see Appendix 1 IPR pages 12-16).

3. There are two areas of enhanced surveillance within the system which have a system-wide quality assurance group (QAG) in place:

    a) Nottingham University Hospitals NHS Trust (NUH) remains under enhanced surveillance with specific quality assurance programmes for Maternity, ED and Leadership.

    b) The Nottinghamshire Healthcare NHS Foundation Trust (NHFT) QAG continues as part of their organisational-wide improvement. The outputs from the recent CQC Well-Led visit are pending. Further bespoke support is in place regarding sub-contracted services at Priory Arnold.

4. **Financial risk associated with the COVID-19 programme** is an area of focus. The recent changes in the payment mechanism from a reclaim to a cost per item have been further complicated by a national requirement to attribute H1 overspends to H2 budgetary allocations. Following a detailed financial analysis, this forecasts an overspend of up to £3 million for the programme for H1. This forecast is currently under review and is likely to reduce. A series of cost improvements are being implemented. The Notts programme is not an outlier in this position and the issue remains at regional and national level.

5. **Capacity and availability of the care sector workforce** (clinical and non-clinical) and the fundamentals of care remain a focus. Home care remains one of the biggest risks nationally and locally, with capacity and availability of the workforce (clinical and non-clinical) remaining the focus. ICB and Local

Authority teams are working with potential providers to ensure they can enter the healthcare market and provide safe care to our patients. Providers are struggling to recruit and retain staff due mainly to financial reasons i.e., due to the cost of living, including fuel costs. The ICB has concluded a procurement exercise which offers agencies a higher rate based on complexity of the patient and rurality. Nottinghamshire County Council will uplift from September all contracted Home Care and Supported Living hourly rates by £1 per hour. Nottingham City Council are currently in discussion around how best to support the home care market. Development of a Market Management Group has taken place and the group has agreed to produce a system market management integrated strategic commissioning plan for home care.

6. System partners continue to work closely with NUH and regulators in relation to **Maternity Services**, in order to oversee and support improvements. There is additional focus on addressing the serious incident backlog and workforce planning. The ICB is preparing to support the independent review of maternity services led by Donna Ockenden (see Appendix 1 IPR page 15).

7. The **Local Maternity and Neonatal System (LMNS) programme remains under enhanced surveillance** due to capacity concerns to transform services in line with requirements given operational pressure and demands. The focus remains on implementing the Ockenden recommendations and the development of Maternity Voices Partnership (MVP), with final updated LMNS deliverables (incorporating final Ockenden and East Kent recommendations) expected from NHS England in Autumn (see Appendix 1 IPR page 15).

8. The **Learning Disability/Autism (LDA) Partnership programme remains under enhanced surveillance** due to adult inpatient numbers, rapid response to the Five Eyes recommendations, and increased host commissioner responsibilities. A key focus remains on adult inpatient admission prevention work across the partnership, with a review underway to monitor readmission rates for individuals moved into community settings to inform future commissioning activity. The system is currently achieving the children and young people inpatient target with two in the system (one under target) (see Appendix 1 IPR page 13).

9. **Infection Prevent and Control and Hospital Acquired Infections (HCAIs)** remain an area of focus, due to breaches against plan positions across a range of the new reduction targets; further information has been requested which will be reviewed at the system meetings that have been established (see Appendix 1 IPR page 16).

Service Delivery (Stuart Poynor)

10. The system is failing to meet the majority of the operational planning targets for 2022/23 across service performance (see Appendix 1 pages 6-9). The SPC

charts indicate that whilst there are some areas of improvement, the position is not likely to return to within the set control levels within the year across many of the areas (see Appendix 1 Page 18). The system is taking specific actions against each area to target further improvements during the year as outlined below.

11. **Urgent Care demand and pressures** continue to be high across the system. Difficulties with the ability to flow patients through the acute system is contributing to patients waiting longer on ambulances or in the ED department. Harm reviews are undertaken across this cohort of patients which is overseen through the System Quality Group.

12. **System Flow** is a key driver in the deteriorating performance of electives and cancer as well as the urgent care position outlined above. This is due to difficulties in discharging patients from the acute episode of care into an alternative setting, such as community, social or home care, lead to patients remaining in acute beds longer than is necessary which prevents other patients from accessing the hospital. The systems Medically Safe for Transfer volumes and patients in acute beds longer than 21 days are significantly higher than planned levels (see Appendix 1 page 21). The system triggered a critical incident during at the end of July due to the pressures in the system. A range of actions have been or are being put in place to address the main causes of the delays:

    a) Accelerated Discharge events including Mental health.

    b) Focused reviews on patients in beds LOS.

    c) Interim Care home placements and additional capacity has continued through the summer to support pathway 1 patients awaiting packages of care.

    d) Discharge to assess business case has been agreed.

    e) 100 Day Discharge Challenge has been instigated by NHS England to ensure the position is improved ahead of the winter period. By 30 September all trusts and systems are to have a full understanding of the 10 initiatives and associated tier support offer available from NHS England to assist with implementation, and to ensure the appropriate infrastructure is in place to focus on the implementation of the initiatives. This will be led by the System Ageing Well Group, reporting into the ICS Urgent and Emergency Care Delivery Board.

13. **Elective Care:** Activity remains below planned levels and waiting lists continue to increase due to capacity pressures arising from urgent care demand, staff absences and IPC restrictions which remained in place between April and May. This position improved during June as all elective capacity was restored and staffing absences improved. However, during July and August there have been periods of significant urgent care demand, which has impacted the volume of

non-urgent elective activity that providers have been able to undertake. A critical incident was announced on 27 July due to significant numbers of Covid patients in hospitals alongside high demand for urgent care services. There were difficulties in discharging patients due to a lack of capacity across the care sector as well as staff absences due to Covid, which caused a significant strain on the system.

14. The ICB is robustly managing the patients potentially waiting 104 weeks, at the end of July 2022 there were 85 patients against the plan of 52. This will continue to be a focus area as the system moves to focus on those waiting over 78 weeks. Mutual aid across the acute system and independent sector providers continues based on equity of waits. Any cancelled operations are being clinically reviewed daily. To increase elective capacity building works on modular wards and theatres at City Hospital are progressing at pace, which are expected to open in Autumn 2022, and potential service relocation of colorectal and HPB to City from Autumn 2022 is undergoing engagement with stakeholders.

15. **Cancer:** The volume of two-week wait referrals have been higher than pre-Covid levels by at over 120% since January 2021. Whilst it is a positive position for patients in that missing cancer referrals during covid appear to have come forward, the high level of demand is causing pressure in some services. Issues then relating to capacity such as for Radiology are leading to patients being seen beyond the day 14 target, such as across Breast and Urology. However, additional clinics and increased levels of diagnostic activity are being undertaken which means that some patients, whilst unfortunately waiting longer than 14 days for their initial consultation are receiving a timely diagnosis within 28 days. Note that across all tumour sites, performance for the system against the Faster Diagnosis Standard was 76.7% in June against the 75% national standard.

    The increased levels of demand are also impacting upon the volumes waiting on the cancer pathway, as can be seen with the increased volumes of patients waiting over 62 days. The latest published position for the 62day cancer backlog relates to June 2022, which highlights that there were 497 patients against a plan of 353 patients waiting beyond 62 days. The position is tracked weekly using provisional data, which shows that at week ending 14 August the system backlog was 461 patients. This is a gradually improving position. Individual specialty action plans and trajectories have been created to monitor the backlog position and the system aims to still deliver the year end planned position of 265 patients. The main areas of risk relate to urology, gynaecology and lower GI, as these have higher volumes of referrals, and the responsibility to prioritise higher priority cancers over long wait lower priority cancers.

16. **Diagnostics:** Across all modalities there is an increasing waiting list for the system. The two modalities with most significant backlogs are MRI and

Echocardiology. Significant improvements have been being made across MRI at NUH, seeing a waiting list reduction of 1500 patients since January 2022. Echocardiology remains an area of significant concern across both providers. NUH and SFH are insourcing staff to provide further capacity as well as offering weekend working to existing staff to increase capacity levels further. NHS England have offered support to the system to secure further improvements in performance and has been provided with a diagnostic recovery trajectory for 2022-2025.

17. **Mental Health:** Increased numbers of patients continue to access services. Internal waits and +90day LOS significant concern as the trust is struggling to discharge patients out of the hospitals, due to lack of care home placements and delayed CHC packages. MADE events continue to take place to identify potential immediate solutions, and demand–capacity modelling has been supported to enable strategic view of medium-longer term requirements. Additional capacity to support OAPs has been delayed, however Sherwood Oaks is now expected to open for patients from September. This was delayed from November 2021 due to additional capital works required.

18. **Primary Care:** The number of GP appointments is below prior year levels by 8% in June 2022 and is below plan. The majority of patients are being seen same and next day. The system continues to offer a blended model, with 65% of appointments being delivered face to face, and home visits continue to increase. Capacity and demand pressures remain high

19. **Community Care:** Waiting list flow of data to enable routine monitoring against the operational plans is being progressed across performance teams. A potential discrepancy with the operational plan values is being addressed with the trusts.

Finance (Stuart Poynor)

20. **Year To Date position**: At the end of month four the NHS System reported a £27.8 million deficit position, £0.4 million adverse to plan. The combined (former) CCG position reported an aggregate £1.5 million favourable variance, and net provider position reported £1.9 million adverse variance. The main drivers of the deficit related to covid costs, efficiency shortfalls and urgent care capacity above planned levels.

21. The forecast position remains breakeven against £17 million deficit plan, however there are significant risks to delivery, particularly relating to Elective Services Recovery Fund (ESRF), covid, efficiency and urgent care capacity.

22. **Financial risks:** The system has undertaken a full review of risks with potential impact upon the system financial position in year. These have been assessed and allocated a risk status, which is summarised below. Further detail is provided on page 40 in Appendix 1, with exception reports on pages 37-40.

Identified Risk	Risk Assessment	Rationale for Risk Assessment	Appendix 1 Page
Urgent Care	High Risk	Due to the level of additional investment required to facilitate discharges	40
Efficiency Programme	High Risk	Due to size of target and phasing of delivery	38
Covid	High Risk	Due to operational outlook and continued waves	37
ESRF	Moderate Risk	It has been confirmed there will be no ESRF clawback in H1, however there is a significant step up required in elective activity for Q3 & Q4 to deliver the planned recovery position.	38
Additional System Risk / investment Review	Moderate Risk	Process in place to manage but there may be some residual commitments that cannot be mitigated through this process	
Early Adopter CDC revenue income	Moderate Risk	Funds remain unconfirmed but communication remains positive with regional and national team	
Vaccination Programme	Moderate Risk	Further understanding of funding mechanism required	
Out of Area Contracting	Moderate Risk	May need regional support to finalise this position. There is a potential issue as Bassetlaw crosses regional boundaries.	

23. **Capital**: The system capital envelope is underspent by £8.1 million to the end of month four (mainly relating to slippage on NUH's additional theatres/ward plans) and forecasting to spend the full £89.6 million by the end of the financial year.

24. **Agency**: NHS England has introduced an agency cap £54.6 million for Nottingham and Nottinghamshire ICB, current forecast is that the ICB will exceed the agency cap by £8.4 million

Workforce (Rosa Waddingham)

25. The workforce report predominantly focuses on the three acute community and mental health trusts within the system reporting on the July 2022 position. Substantive WTE is -2.7% (787.77 WTE) below plan with Bank use 15.5% (336.7 WTE) above plan as is Agency usage at 28% (240.2 WTE) above plan (see Appendix 1 Page 42).

26. Primary Care General Practice data including the ARRS position is presented at a high level showing indicative workforce numbers against the 2022-23 plan for June 2022. Detailed workforce positions in general practice are limited by the current data collection limitations of NWRS. The system is working with the

national development team in NWRS to improve standardisation through clear definitions of data capture and consideration of local agreements to increase the utilisation of NWRS functionality.

27. Development work is in progress to capture the current social care and care home workforce position. The last reported position dates back to March 2021. Workforce data collection and reporting developments are being refined following presentation at the People and Culture Group in August 2022.

28. Sickness absence in the acute, community and mental health trusts has increased over recent months linked to an increase in Covid related absences with daily reported positions of 7.3% all sickness and 2% Covid related. The 12-month rolling average position for each Trust has also risen to a position of 6.7% sickness which is higher than the pre-Covid levels needed to be achieved of 4.7%. Wellbeing plans remain in place in all organisations with the Staff Support Hub engaging with all partners on increasing the awareness and access to the services available.

29. Substantive vacancies in the acute, community and mental health trusts has reduced slightly to 12.7%, 4.0% above target position within the Operational Plan. This position will be informed by changes to establishment made in April therefore presenting a false indicator for the number of actual vacancies. There are working groups in place for HCSW, International Recruitment, midwifery and nurse retention. Retention is a key focus with a system retention lead recruitment in progress.

30. The People Diagnostic phase 1 was completed at the end of July with recommendations developed and agreed around the governance, structure and resources to deliver the 10 domains of the People Function. We intend to build upon the diagnostic to co-create with system partners the ICB People structure and strengthen the People and Culture Group governance, maximising and aligning the people and culture resource already in the system.

Health Inequalities (Dave Briggs)

31. The Health Inequalities plan has been developed with equity as a core principle and will be presented for final sign off during October and November.

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

Chappell Room, Arnold Civic Centre 09:00-31/08/22

NHS
Nottingham and Nottinghamshire

Nottingham & Nottinghamshire Integrated Care Board

Integrated Performance Report

Reporting Month: June 2022

Board Month: September 2022

Integrated Performance Report 2022/23 – Report Contents

NHS Nottingham and Nottinghamshire

Introduction

This report presents progress against the key performance targets, across quality, service delivery, finance and workforce, and to note key developments and actions being taken to address performance issues. Where appropriate, information is provided for total Nottingham and Nottinghamshire population, and total provider responsibilities for those providers geographically located within Nottinghamshire, Sherwood Forest Hospitals (acute), Nottingham University Hospitals (acute) and Nottinghamshire Healthcare NHS Trust (mental health). The indicators included in the Board IPR are reviewed annually and are based on the system operational plan for 2022/23, compliance and commitment targets, and any additional key local and national measures.

The intention is that each ICS Oversight Group, which is led by an ICB Executive Lead, will propose a level of assurance following the discussion of the reported metrics based upon the ICS Assurance Escalation Framework (page 52) which will support the escalation of issues to the ICB Board. This will develop and embed as an approach over the next few months.

Service Delivery and workforce areas have adopted a new reporting approach using Statistical Process Control (SPC) charts, further detail relating to SPC is included on page 54 of the report for reference to aid the review of the performance report tables included in the report. The aim of the SPC charts is to provide richer information relating to whether a service is improving or deteriorating based on trend (variation icons) and the likelihood of the system plan or target being met (assurance icons).

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

The full detail of the performance measures which the ICB is required to deliver, are provided across a series of functional score cards on pages 5 –11. These provide an overview of the areas which are and are not delivering as planned. The SPC icons provide an indication of the improvement or deterioration in the position as well as an indication of whether the current process or performance levels will achieve the required level in future.

Exception reports by functional area, detailing the areas of concern, actions being taken to address the current issues, and assurance as to whether these actions will impact upon and improve the position, are provided on pages 13 – 50.

NHS Nottingham and Nottinghamshire

1. ICB Scorecard by ICS 4 Aims – Reporting @ July 2022/23

AIM-01 Improve Outcomes in Population Health and Healthcare

ID	Key Performance Indicators	Date	Plan	Actual	In Month	Variation	Assurance
	Quality						
	LD&A Annual Health Checks	22-23 Q2	25%	16%		-	-
	Total LD&A Inpatients	Jul-22	51	53		-	-
	No. Personal Health Budgets	21-22 Q4	5800	5271		-	-
	HCAIs	tbd	-	-		-	-
	Flu Vaccinations	tbd	-	-		-	-
	Maternity	tbd	-	-		-	-
	Urgent Care						
	12 hour breaches	Jul-22	0	709			
	Handover delays > 60 minutes	Jul-22	0	193			
	Length of Stay > 21 days	Jul-22	237	394			

AIM-03 Improving the Effective Utilisation of Our Resources

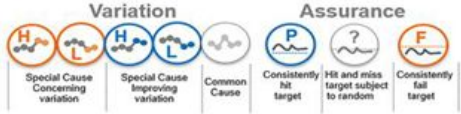
ID	Key Performance Indicators	Date	Plan £m	Actual £m		Variance £m	FOT £m
	Delivery against system plan	Jul-22	-27.4	-27.8		-0.4	0.0
	Efficiency Target	Jul-22	23.0	21.1		-1.9	0.0
	ESRF Income	Jul-22	13.0	17.4		4.4	-0.2
	Agency Spend	Jul-22	19.6	27.6		-8.0	-8.4
	MHIS	Jul-22	62.7	61.9		-0.8	0.0
	Capital Spend	Jul-22	22.5	14.4		-8.1	0.0

AIM-04 Support Broader Social and Economic Development

ID	Key Performance Indicators	Date	Plan	Actual	In Month	Variation	Assurance
	Provider Substantive Staffing	Jul-22	31,453	31,243			
	Provider Bank Staff	Jul-22	1,552	1,888			
	Provider Agency Staff	Jul-22	837	1,078			
	Provider Staff Vacancy Rate	Jun-22	8.7%	12.9%			
	Provider Staff Absence Rate	Jun-22	4.6%	5.9%			
	Primary Care Workforce	May-22	-	3396			-

AIM-02 Tackle Inequalities in Outcomes, Experience and Access

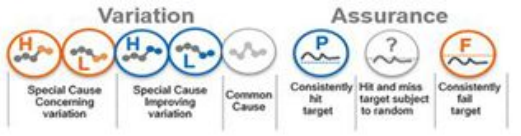
ID	Key Performance Indicators	Population Date	Population Plan	Population Actual	In Month	Variation	Assurance	Provider View Plan	Provider View Actual	In Month	Variation	Assurance
	Planned Care											
	Total Waiting lists	Jun-22	-	117678			-	99763	112733			
	Patients Waiting >104 weeks	Jun-22	-	68			-	38	87			
	Cancer 62 Day Backlog	Jun-22	-	-		-	-	353	497			
	Cancer Faster Diagnosis	Jun-22	75.0%	76.4%				75.0%	76.7%			
	OP Remote Delivery	Jun-22	25.0%	22.6%				25.0%	22.7%			
	Childrens Wheelchair Provision	Q12022/23	91.6%	68.9%				-	-		-	-
	Community											
	Community Waits - Adult	Jun-22	3754	9141				-	-		-	-
	Virtual Wards	From Nov 2022						-	-		-	-
	Primary Care											
	GP Appointments	Jun-22	527,046	481,888				-	-		-	-
	NHS App	Jun-22	60%	48%				-	-		-	-
	Mental Health											
	IAPT Access	May-22	8984	7995				-	-		-	-
	CYP Access	May-22	13300	17550				-	-		-	-
	Out of Area Placements	May-22	0	485				-	-		-	-
	SMI Physical Health Checks	Jul-22	3750	3424				-	-		-	-
	Health Inequalities - Prevention											
	NHS Digital WM Referrals	Jun-22	627	208		-	-	-	-	-	-	-
	NHS Inpatient % Smokers Offered Tobacco Treatment	Jun-22	1111	1051		-	-	-	-	-	-	-



NHS Nottingham and Nottinghamshire

2. Quality Scorecard

Quality Scorecard	Latest Period	Population			Variation	Assurance	Exception Report
		Plan	Actual	Variance			
Learning Disability & Autism							
LD&A Inpatients Rate Adults - ICB	Jul-22	14	15 ✖	1	-	-	Page 13
LD&A Inpatients Rate Adults - NHSE	Jul-22	34	36 ✖	2	-	-	
LD&A Inpatients Rate CYP - NHSE	Jul-22	3	2 ✔	-1	-	-	
LD&A Annual Health Checks	22-23 Q2	25%	16.0% ✖	-9.0%	-	-	
Personalisation							
No. of Personal Health Budgets	21-22 Q4	5800	5271 ✖	-529	-	-	Page 14
No. PCN funded social prescribing link workers	21-22 Q4	54	68 ✔	14	-	-	
No. Social prescribing referrals into link workers	21-22 Q4	8377	8988 ✔	611	-	-	
No. active PCSPs in place	21-22 Q4	24000	40207 ✔	16207	-	-	
Personalised Care Institute Training	May-22	596	210 ✖	-386	-	-	
Maternity							
No. stillbirths per 1000 total births	tbc	-	-	-	-	-	Page 15
No. neonatal deaths per 1000 live births	tbc	-	-	-	-	-	
Hospital Acquired Infections							
MRSA	tbc	-	-	-	-	-	Page 16
CDI	tbc	-	-	-	-	-	
Ecoli BSI	tbc	-	-	-	-	-	
Klebseilla BSI	tbc	-	-	-	-	-	
Pseudomonas BSI	tbc	-	-	-	-	-	



NHS Nottingham and Nottinghamshire

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

Urgent Care Scorecard	Latest Period	Population			Variation	Assurance	Latest Period	Provider			Variation	Assurance	Exception Report
		Plan	Actual	Variance				Plan	Actual	Variance			
Urgent Care Access													
Extended Access Primary Care Appointments Booked	Jun-22	9717	7363	✖ -2354	L	?		-	-	-	-	-	
111 Calls referred into an SDEC Service		-		tbc	-	-		-	-	-	-	-	
Ambulance Conveyances (%)	Jul-22	55.2%	50.6%	✔ -4.6%	L	F		-	-	-	-	-	
Ambulance Conveyances (Vol.)	Jul-22	8652	8025	✔ -627	L	?		-	-	-	-	-	Page 20
A&E Attendances v 19/20 (%)	Jun-22	100%	106.3%	✖ 6.3%	H	?	Jul-22	100%	105.9%	✖ 5.9%		?	
% Unheralded Patients attending A&E		-	-	-	-	-	Jun-22	-	70.1%	-	H	-	
NEL Admissions v 19/20 (%)	Jun-22	100%	99.4%	✔ -0.6%		?	Jun-22	100%	101.6%	✖ 1.6%		?	
Urgent Care - Acute Discharges and Out of Hospital													
% patients medically safe to transfer from acute setting		-	-	-	-	-	Aug-22	73	216	✖ 143	H	F	
Length of Stay > 21 days		-	-	-	-	-	Jul-22	237	394	✖ 157	H	F	
No. Patients utilising Virtual Ward		-	-	tbc	-	-		-	-	-	-	-	
2 Hour Urgent Care Response Contacts	Jun-22	357	396	✔ 39		P		-	-	-	-	-	Page 21
2 Hour Urgent Care Response %	Jun-22	-	96.00%										
Community Crisis - 2 Hour Urgent Care Response %		-		tbc				-	-	-	-	-	
Social Care / Home Care Packages		-		tbc		-		-	-	-	-	-	
Urgent Care - Compliance													
Ambulance (mean) Response Times Cat 1 (Notts Only)	Jul-22	0:07:00	00:08:49	! 00:01:49		F		-	-	-	-	-	
Ambulance (mean) Response Times Cat 2 (Notts Only)	Jul-22	0:18:00	00:56:42	✖ 00:38:42		F		-	-	-	-	-	
Hospital Handover Delays > 60 Minutes		-	-	-	-	-	Jul-22	0	193	✖ 193	H	F	Page 22
12 Hour Breaches ED		-	-	-	-	-	Jul-22	0	709	✖ 709	H	F	
12 Hour Breaches as % NEL		-	-	-	-	-	Jun-22	2%	4.9%	✖ 2.9%	H	?	

'tbc' - A number of metrics require additional data flows directly from the trusts, these are being arranged to enable monitoring of the planning metrics from next month.

NHS Nottingham and Nottinghamshire

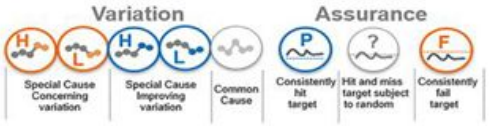
3b. Service Delivery Scorecard - Planned Care Recovery

Elective Scorecard	Latest Period	Population			Variation	Assurance	Latest Period	Provider			Variation	Assurance	Exception Report
		Plan	Actual	Variance				Plan	Actual	Variance			
Elective Recovery - Total Waiting List & Long Waits													
Total Waiting List Size	Jun-22	-	117678	-		-	Jun-22	99763	112733	12970			Page 24
Incomplete RTT pathways >52 weeks	Jun-22	-	5251	-		-	Jun-22	3768	4707	939			
Incomplete RTT pathways >78 weeks	Jun-22	-	835	-		-	Jun-22	1044	889	-155			
Incomplete RTT pathways >104 weeks	Jun-22	-	68	-		-	Jun-22	38	87	49			
Elective Recovery - Activity													
Total Referrals	Jun-22	26700	24618	-2082			Jun-22	23618	22935	-683			Page 25
Total Ordinary Electives	Jun-22	1647	1925	278			Jun-22	1933	1984	51			
Total Daycases	Jun-22	11247	12914	1667			Jun-22	12393	12156	-237			
Total Outpatients - First Appointments	Jun-22	35314	24333	-10981			Jun-22	25534	22283	-3251			
Total Outpatients - Follow Ups	Jun-22	74220	59001	-15219			Jun-22	57090	58572	1482			
Total Diagnostic Activity	Jun-22	37653	34390	-3263			Jun-22	32871	30580	-2291			
Elective Recovery - Productivity & Transformation													
Total Outpatients - Total Virtual (%) 25%	Jun-22	25%	23%	-2%			Jun-22	25%	23%	-2%			Page 26
Patient Initiated Follow ups - %	-	-	-	-	-	-	Jun-22	5.0%	4.1%	-0.9%			
Advice & Guidance - % of 1st OP	Jun-22	16	28	12			-	-	-	-	-	-	
Total Outpatient F/Up v 2019/20 Activity (%) 25% Reduction	Jun-22	75.0%	94.7%	19.7%			Jun-22	75.0%	114.1%	39.1%			
Completed admitted RTT pathways	Jun-22	5250	4782	-468			Jun-22	5153	4515	-638			
Completed non-admitted RTT pathways	Jun-22	22263	21209	-1054			Jun-22	21000	20239	-761			
Diagnostic Recovery													
Diagnostic Activity	Jun-22	37653	34390	-3263			Jun-22	32871	30580	-2291			Page 28
Diagnostic Waiting List	Jun-22	-	29831	-		-	Jun-22	-	26156	-		-	
Diagnostic Backlog	Jun-22	-	11881	-		-	Jun-22	-	11110	-		-	
Diagnostics + 6 Weeks	Jun-22	1%	39.8%	38.8%			Jun-22	1%	42.5%	41.5%			
Cancer Recovery													
Cancer Referrals	Jun-22	-	3824	-			Jun-22	-	4222	-		-	Page 27
Cancer - Faster Diagnosis Standard 28 days	Jun-22	75.0%	76.4%	1.4%			Jun-22	75.0%	76.7%	1.7%			
Cancer - No. 1st Definitive Treatments	Jun-22	545	507	-38			Jun-22	672	559	-113			
Cancer - No. patients receiving 1st treatment < 31 days (%)	Jun-22	96%	84%	-12.4%			Jun-22	96%	82%	-13.9%			
Cancer - No. patients waiting < 62 days (%)	-	-	-	-	-	-	Jun-22	85%	48%	-37.0%			
Cancer - 62 day backlog	-	-	-	-	-	-	Jun-22	353	497	144			

NHS Nottingham and Nottinghamshire

3c. Service Delivery - Mental Health Scorecard

Mental Health Scorecard	Latest Period	Population			Variation	Assurance	Exception Report
		Plan	Actual	Variance			
Mental Health - Improving Access to Psychological Therapies							
IAPT - Referrals	May-22	-	3645	-	H	-	Page 30
IAPT - 1st Treatment <6 Weeks	May-22	75%	78.1%	✓ 3.1%	L	P	
IAPT - 1st Treatment <18 Weeks	May-22	95%	100%	✓ 5.0%	H	P	
IAPT - Entering Treatment 3 Months	May-22	8984	7995	✗ -989	H	F	
IAPT - >90 Days between 1st and 2nd Treatment	May-22	10%	10.5%	! 0.5%	H	?	
IAPT - Recovery Rate (3 months rolling)	May-22	50%	52.4%	✓ 2.4%	H	?	
Mental Health - Adult Mental Health							
Adult MH Inpatient Discharges - % F Up 72 hours	Apr-22	80%	87%	✓ 7.0%	H	?	Page 31
Inappropriate OAP Bed days	May-22	0	485	✗ 485	H	F	
Rate per 100,000 Older Adult MH LOS > 90 Days	Apr-22	11	12	✗ 1.25	H	?	
SMI Health Checks	Jul-22	3750	3424	✗ -326	H	F	
Access SMI +2 Contacts Community MH Services	Apr-22	11854	12190	✓ 336		P	
Dementia Diagnosis	Jun-22	69%	68.9%	✗ -0.4%		?	
Mental Health - Access							
Perinatal Access % (12 month rolling)	May-22	9.3%	7.3%	✗ -2.0%	H	F	Page 32
Perinatal Access - Volume	May-22	828	935	✓ 107	H	?	
Individual Placement Support	Jun-22	225	360	✓ 135		?	
Early Intervention in Psychosis (EIP)	May-22	60%	73%	✓ 13.0%	L	P	
Mental Health - Children & Young People							
CYP - New Referrals	Mar-22	-	2190	-	H	-	Page 33
CYP Eating Disorders - Routine Referral Performance (Qtr)	Jun-22	95%	71%	✗ -23.9%	L	F	
CYP Eating Disorders - Urgent Referral Performance (Qtr)	Jun-22	95%	91%	✗ -3.7%	H	F	
CYP Access (1+ Contact)	May-22	13300	17550	✓ 4250	H	P	



3d. Service Delivery – Primary & Community Scorecard

Primary Care and Community Scorecard	Latest Period	Population			Variation	Assurance	Exception Report
		Plan	Actual	Variance			
Primary Care and Community Recovery							
Total Appointments	Jun-22	527,046	481,888	✖ -45,158			Page 35
Percentage of Face to Face Appointments	Jun-22	-	66%	-			
Percentage of Same Day Appointments	Jun-22	-	43%	-			
Number of NHS App Registrations	Jun-22	60%	48%	✖ -12%			
Community Waiting List (Patients aged 0-17 Years)	Jun-22	576	1785	✖ 1209			
Community Waiting List (Patients aged 18+ Years)	Jun-22	3754	9141	✖ 5387			

NHS
Nottingham and Nottinghamshire

4. Finance - Scorecard

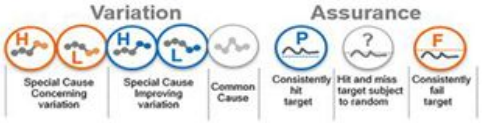
		YTD Variance £m's			FOT Variance £m's			RAG	
Financial Duties	**Measure**	**Plan**	**Acts**	**Variance**	**Plan**	**FOT**	**Variance**	**YTD**	**FOT**
NHS System (Breakeven)	**(Deficit)/Surplus**	**-27.4**	**-27.8**	**-0.4**	**-16.9**	**-16.9**	**0.0**	🔴	🔴
Capital (within Envelope)	**Spend against plan**	22.5	14.4	**8.1**	89.6	89.6	**0.0**	🟢	🟢
MHIS (meeting target)	**Spend against plan**	62.7	61.9	**-0.8**	188.1	188.1	**0.0**	🔴	🟢
Agency (spend within Cap)	**Spend against plan**	19.6	27.6	**-8.0**	54.6	63.0	**-8.4**	🔴	🔴

		YTD Variance £m's			FOT Variance £m's			RAG	
Drivers of the (Deficit)/Surplus	**Measure**	**Plan**	**Acts**	**Variance**	**Plan**	**FOT**	**Variance**	**YTD**	**FOT**
COVID Spend	**Delivery against plan**	12.3	14.9	**-2.6**	17.8	18.9	**-1.1**	🔴	🔴
NHS Efficiencies	**Delivery against plan**	23.0	21.1	**-1.9**	102.7	102.7	**0.0**	🔴	🟢
ERF Income	**Delivery against plan**	13.0	17.4	**4.4**	53.7	53.4	**-0.2**	🟢	🔴

NHS
Nottingham and Nottinghamshire

5. Workforce - Scorecard

Workforce Scorecard	Latest Period	Total Provider			Variation	Assurance	Exception Report
		Plan	Actual	Variance			
Total Provider Workforce							
Total Provider Workforce	Jul-22	31,453	31,243	-210			
Total Provider Substantive	Jul-22	29,065	28,277	-788			Page 42
Total Provider Bank	Jul-22	1,552	1,888	337			
Total Provider Agency	Jul-22	837	1,078	241			
Total Primary Care Workforce	May-22	-	3,396	-			Page 43
Key Workforce Performance							
Total Provider Turnover Rate % (12 month rolling)	Jun-22	11.0%	13.5%	2.5%			
Total Provider Sickness Absence Rate %	Jun-22	4.6%	5.9%	1.3%			Page 44
Total Provider In-Month Vacancy Rate %	Jun-22	8.7%	12.9%	4.2%			



NHS
Nottingham and Nottinghamshire

6: Quality

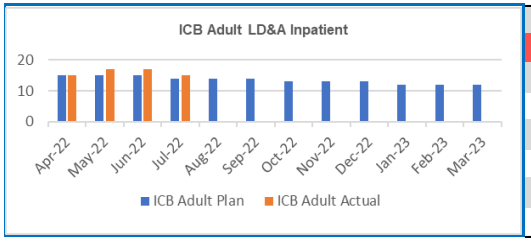
ICS Aim 1: To improve outcomes in population health and healthcare

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

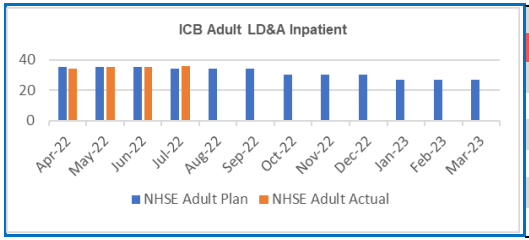
6.1 - Improving Quality of Services – Exception Report Learning Disability & Autism

NHS Nottingham and Nottinghamshire

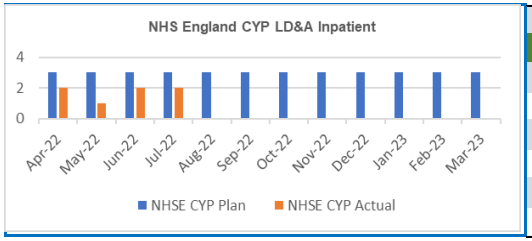
Learning Disability and Autism



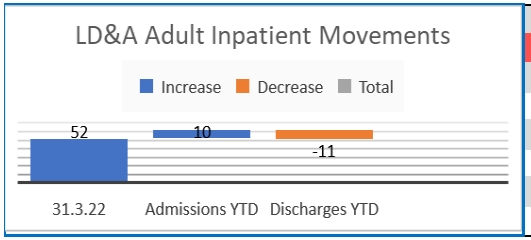
Jul-22
15
2022-23 Plan
14
Assurance
-
SPC Variation
-



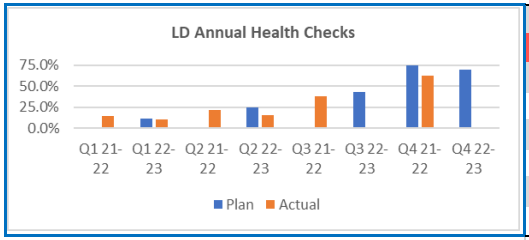
Jul-22
36
Target
34
Assurance
-
SPC Variation



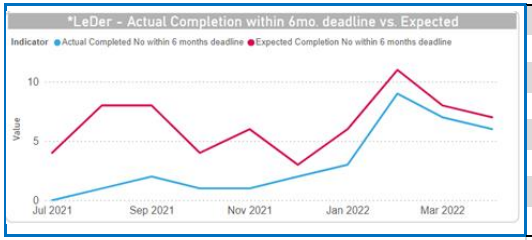
Jul-22
2
Target
3
Assurance
-
SPC Variation
-



Jul-22
-1
2022-23 Plan
-4
Assurance
-
SPC Variation
-



22-23 Q2
16%
Target
25%
Assurance
-
SPC Variation
-



Jun-22
tbc
Target
tbc
Assurance
-
SPC Variation
-

Current Position

LDA&A Inpatients ICB: Currently over target for ICB inpatient target (15 against target of 14) and over target for the secure inpatient target (36 against target of 34). Despite 2 discharges in July for ICB inpatients, there has been 1 secure inpatient admission. Total admissions for this financial year are in line with initial forecasting of 2 admissions per month.

LD&A Inpatients Children & Young People (CYP) (NHS England): Currently achieving target with 2 in the system (1 under target). There was 1 'discharge' in July as a young person transferred to adult inpatients, and 1 admission.

Annual Health Checks (AHC): As at 28 July there have been 1,152 health checks completed in 2022/23 across the ICS (equating to 16% - this is a 2% increase compared to this time last year). 414 health checks (19%) have been completed for the priority cohort across the ICS (those that did not receive an AHC in 21/22). The City Exemplar Pilot continues to see significant results in uptake in the 14-25 years BAME cohort, with increases in uptake by 42% for people identifying as Black/African/Caribbean/Black British and 33% Asian/Asian British.

Actions

LDA&A Inpatients: system partners are strengthening the capacity across the partnership to support with the prevention of inappropriate admissions. A review is being undertaken to monitor readmission rates for individuals moved into community settings to inform future commissioning activity. To develop the Community Market, a draft accommodation strategy has been developed by the County Council, with plans in place for City Council development to create one strategy and approach across the ICS for the development of specialist provision that meets needs. The admission avoidance workstream and Children & Young People workstream are to focus on updating and embedding the Dynamic Risk Register/development of the community wraparound service to disrupt admissions.

LeDeR: Internal and external capacity has been developed. A LeDeR Local Area Coordinator has been recruited to and starts in post in August 2022 which will provide focused capacity.

Annual Health Checks: Scoping work is taking place to expand to support all 14–25-year-olds regardless of ethnicity.

Quality Group Assurance - Limited Assurance

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

Quality Improvement: safe & well learning / actions are part of monthly case management meetings. Key themes identified (obesity, communication with family, quality of life issues) are being incorporated into transformation activity. All patients identified as benefitting from an Independent Life Plan have been allocated to a reviewer for the life plan to be completed.

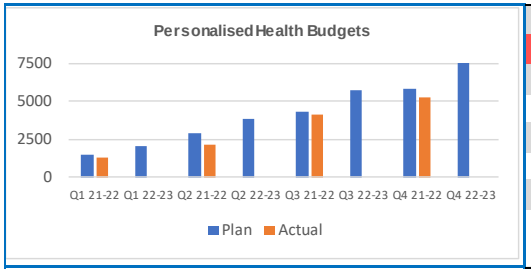
Workforce: Partnership working with Local Authority and voluntary sector colleagues is being developed to address workforce challenges. Discussions are taking place about creating new Learning Disability nurse placement opportunities in social care settings, with Higher Education institutions (HEIs), Skills for Care and Nottingham Alliance Training Hub (NATH) involved.

Learning Disabilities Mortality Review (LeDeR): Risk to completing all reviews within the 6-month timeframe due to capacity within the ICB Case Management Team.

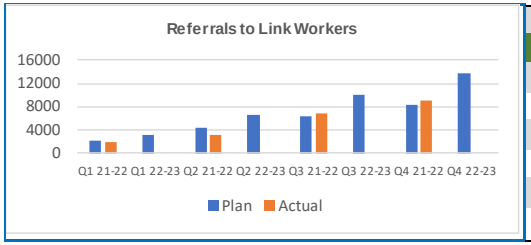
6.2- Improving Quality of Services – Exception Report Personalisation & Co-Production

NHS Nottingham and Nottinghamshire

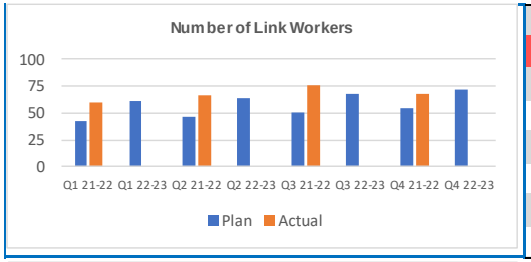
Personalisation



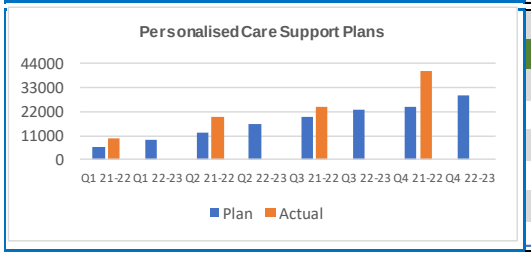
21-22 Q4
5271
2021-22 Plan
5800
Assurance
SPC Variation



21-22 Q4
8988
2021-22 Plan
8377
Assurance
SPC Variation



21-22 Q4
68
2021-22 Plan
54
Assurance
SPC Variation



21-22 Q4
40207
2021-22 Plan
24000
Assurance
SPC Variation

System Quality Group Assurance - Partial Assurance

The Finance plan has been approved by the Personalised Care Strategic Oversight Group for 2022/23.

A Project Manager post to support social prescribing and community development will be hosted by Nottingham Community and Voluntary Service (CVS), to build on the test and learn Green space programme. A social prescribing survey has been completed: 93% of the respondents said they would recommend it; 62% said their situation had improved; 29% reported improved mental health; and 71% reported what they valued most was time with a link worker to understand their concerns.

Integrated personalised commissioning
Collaborative commissioning: a single, strategic approach to governance and operating model is agreed and in place for joint commissioning. This provides a framework and principles to take forward the work to review the process with health and social care on joint funded budgets.

Learning labs are to be established to agree a system vision and plan for home based support to provide greater personalisation and choice. Community Catalysts diagnostic reports on market position will inform the labs.

Co-Production

System Quality Group Assurance - Full Assurance

- ICB Coproduction Strategy: a draft has now been endorsed by the ICS Coproduction Steering Group and Working Group and is being scheduled to be taken to the appropriate ICB governance meeting, as well as the Integrated Care Partnership for system partner endorsement and sign up. This forms part of the Working with People and Communities Strategy.

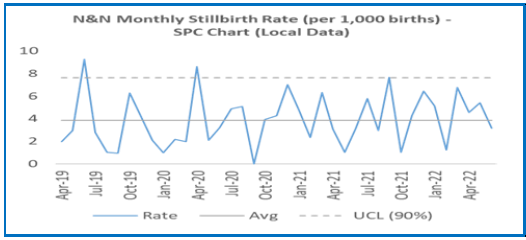
- Coproduction Support Resources (Toolkit): engagement and development is underway and discussions are in place to support coproduction training as part of staff induction, to support the culture change across the system.

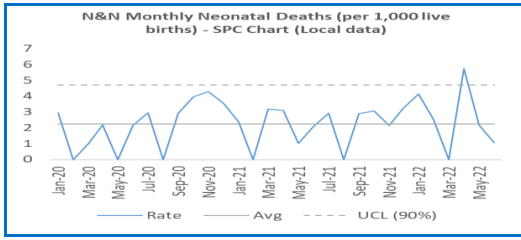
- Coproduction Team: activity continues to focus on the establishment of the Coproduction Team, which has been jointly funded with Small Steps Big Changes (SSBC).

6.3 - Improving Quality of Services – Exception Report Maternity

NHS Nottingham and Nottinghamshire

Local Maternity & Neonatal System





Continuity of Carer

To note - the LMNS CoC Plan confirms that Nottingham and Nottinghamshire will pause CoC until safe staffing levels are in place

-

Summary

Nottingham University Hospitals (NUH) maternity: The ICB continue to work closely with NUH, Care Quality Commission (CQC) and NHS England and NHS Improvement (NHSEI) to oversee improvements in maternity services. NUH maternity continue to be impacted by staff shortages (vacancies and sickness) across midwifery and obstetrics.

Ockenden Oversight: Ockenden Evidence Reviews and Insight Visits have been scheduled. BirthRate+ workforce reviews are underway at both Trusts.

LMNS Deliverables: Awaiting further guidance on Ockenden and East Kent recommendations (due Autumn). Equity Plan is on track for September submission and will inform foundations of the whole programme

Coproduction: Detailed transition planning with Healthwatch is underway as the Maternity Voices Partnership (MVP) contract is brought in-house for development. A new MVP development post is being developed to sit within the new ICB Coproduction Team.

Perinatal Quality Surveillance: NUH continue to work with the regional perinatal team and ICB quality and commissioning leads to identify improvement needs in relation to Saving Babies Lives Care Bundle (SBLCBv2) compliance. Positive feedback was received following the July review, which confirmed compliance with Action 3 of the bundle. Continued work is underway to ensure alignment with the East Midlands Neonatal Operational Delivery Network (ODN) in relation to the reporting and oversight of neonatal deaths, with a joint focused report to be presented to the LMNS and NUH Oversight Group in October.

Digital: The Maternity Information System Replacement (MISR) programme continues the system-wide work to deliver the new maternity system (Badgernet). Substantial progress has been made in understanding and aligning Trust processes to the new system (and understanding where warranted variation may be needed). Further focus has been given to staff training, including the need for post go-live support where further funding has been provided, to ensure that the new system is embedded. Work is underway looking at digital exclusion and engagement with the ICB Digital Notts team to learn from their engagement work and develop solutions to support service user uptake and use of the digital opportunities that Badgernet provides.

Development of a coproduced LMNS website to communicate with women and families effectively (LMNS): A website gap analysis was completed by the Maternity Voices Partnership lay chair in May 2022. Work underway to ensure the LMNS website communicates effectively with all women and families via the development of the MVP model, and alignment with Best Start digital developments to support effective communication to women and families.

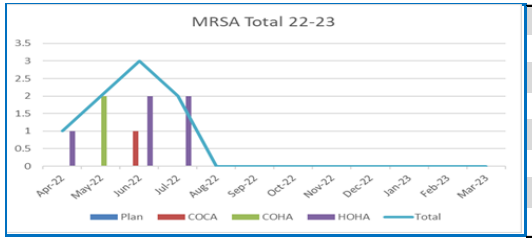
Quality Group Assurance - Limited Assurance

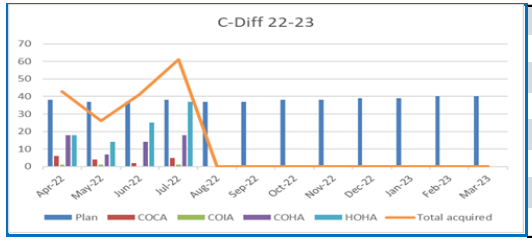
Enhanced Surveillance due to capacity concerns to transform services in line with requirements, given operational pressures and workforce challenges. Focus remains on safety, Ockenden, and planning guidance submission.

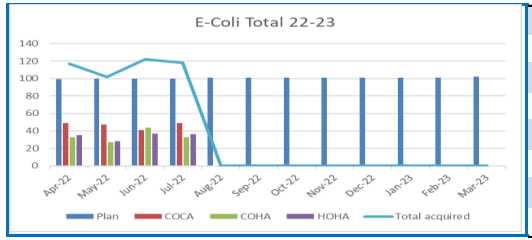
6.4 - Improving Quality of Services – Exception Report Infection Prevention & Control

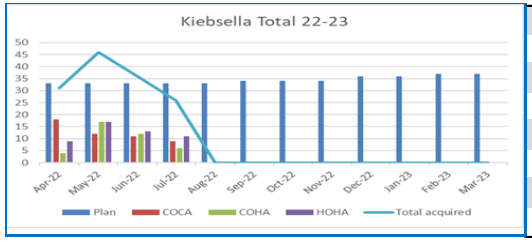
NHS Nottingham and Nottinghamshire

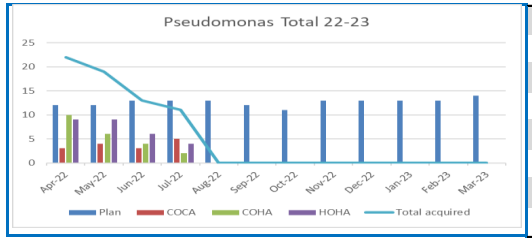
Infection Prevention and Control

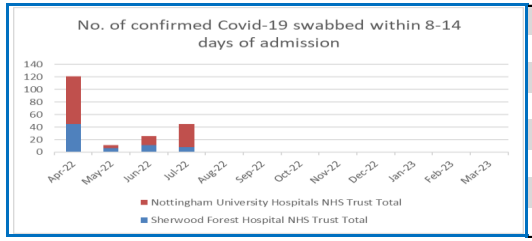












Summary

June 22 Healthcare Associated Infections (HCAI) data

-**MRSA bloodstream infection (BSI)**: ICB 2 cases (Sherwood Forest Hospitals Trust/City GP community case) breached month/year-end target with 2/0. Sherwood Forest Hospitals Trust (SFHT) breached month/year-end target 1/0.

-**CDI:** ICB met month plan 19/22, SFHT breached month plan 8/7; NUH breached month plan 14/8, individual case reviews are in place to identify lapses in care. Nationally cases are increasing.

-**E.coli BSI:** ICB breached month plan 80/79, SFHT breached month plan 14/8, NUHT breached month plan 28/22.

-**Klebsiella BSI:** ICB breached month plan 23/21, SFHT breached month plan 3/1, NUHT met month plan 10/11.

-**Pseudomonas BSI**: ICB breached month plan 8/7, SFHT met month plan 1/1, NUHT met month plan 4/5.

COVID-19

-COVID-19 case rates are increasing at a national, regional and local level with BA.2 being the dominant strain with monitoring of BA.4/BA.5. This is not impacting on ITU admissions.

-COVID-19 outbreaks and staff related absence is increasing across the system as community rates increase. The relaxation in national IPC guidance including a reduction in use of masks is considered a contributory factor.

Actions

MRSA BSI: Post infection reviews are in progress.

CDI: A system wide and regional group supports with reduction actions needed.

E.coli BSI: System and regional meetings are in place to support with reduction actions.

Klebsiella BSI: System and regional meetings are in place to review and plan actions needed to reduce BSI with urinary source.

Pseudomonas BSI: System and regional meetings are in place to review and plan actions needed to reduce BSI with urinary source

COVID-19: themes and learning are shared across the system. There are no new themes to report.

Monkeypox: UKHSA lead on Monkeypox. IPC support with local planning as cases slowly increase.

Quality Group Assurance - Partial Assurance

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

Infection Prevention & Control (IPC) Teams:

-IPC teams continue to update plans in line with new IPC guidance and the NHSEI principles as part of recovery work.

-Testing plans are in place to support with elective care and IPC derogation process is in place to support discharge and flow.

-Work to progress system workforce planning is progressing; IPC recruitment remains challenging across the system

-HCAI reduction meetings are in place along with planned regional NHSEI meetings.

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 July 2022/23

July 2022		Assurance: Pass	Assurance: Hit & Miss	Assurance: Falling Below
Variation	Special Cause - Improvement	CYP Access (1+ Contact) IAPT < 18 weeks	78 Week Waits (Provider) Ordinary Electives (Population) Daycases (Population) Advice & Guidance (Population) Cancer 1st <31 days (Provider) IAPT Recovery Adult MH - 72 Hour Follow Ups Primary Care Appointments RTT Admitted (Population) Diagnostics Activity (Provider) Total Appointments	**PIFU (Provider)** **IAPT Treatments (Access)** **SMI Physical Health Checks** **Perinatal Access % and Volume** **CYP Eating Disorders - Urgent** **Ambulance Conveyances %** **NHS App Registrations**
	Common Cause - Random	Adult SMI +2 Contacts Community Individual Placement Support Early Intervention Psychosis 2 Hour Urgent Care Response	104 week waits (Provider) OP Virtual (Population) RTT Non-Admitted (Population) Referrals (Population) Cancer FDS (Provider) Dementia Diagnosis NEL Admissions Outpatient Fups (Population)	**Outpatient 1st (Population)** **Ambulance Response Cat 1** **Ambulance Response Cat 2** **Cancer 1st Treatments (Provider)**
	Special Cause - Concern	IAPT <6 weeks	Total Waiting List (Provider) OP Fup 25% Reduction (Population) Cancer 62 Day Backlog (Provider) IAPT <90 days 1st to 2nd Older Adult MH >90 day LOS A&E Attendances 12 Hour Breaches % NEL	**Diagnostic 6 Week Waits (Provider)** **Cancer 62 Performance (Provider)** **CYP Eating Disorders - Routine** **12 hour Breaches ED** **Community Waiting Lists** **Medically Safe for Transfer** **Length of Stay >21 days** **Hospital Handover Delays > 60 minutes** **Out of Area Placements**

Items for escalation based on the indicators Falling short of the target or unstable ("Hit and Miss") and showing Special Cause for concern are as follows:

Electives:
- Patient Long Waits (page 24)
- Outpatient Activity (page 25 and 26)
- Cancer 62 Day Performance & Backlog (page 27)
- Diagnostics Activity & Waits (page 28)

Mental Health:
- IAPT Access (page 30)
- SMI Physical Health Checks (page 31)
- Out of Area Placements & Older Adult LOS (page 31)
- Perinatal Access % and Volume (page 32)
- CYP Eating Disorders (page 33)

Community:
- Community Waiting Lists (page 35)

Urgent Care:
- A&E Attendances (page 20)
- Length of Stay > 21 days (page 21)
- Ambulance Performance (page 22)
- 12 Hour Breaches ED (page 22)

The Matrix supports the Board to identify areas of risk and concern, as well as areas of improvement, across the range of service delivery requirements. For example, the orange bottom right box consolidates all of the areas which have deteriorating performance levels and are unlikely to achieve the required positions based on current performance levels. These, and other areas of deterioration, or areas expected to falling below requirements have been included as exception reports.

7.2 Service Delivery
Urgent Care Performance

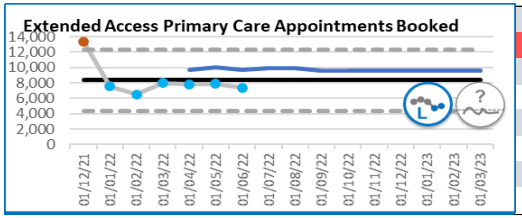
7.2a – Urgent Care Access Exception Report
7.2b – Discharges and Out of Hospital Exception Report
7.2c – Urgent Care Compliance Exception Report

7.2a- Streamline Urgent Care – Exception Report : Access

NHS Nottingham and Nottinghamshire

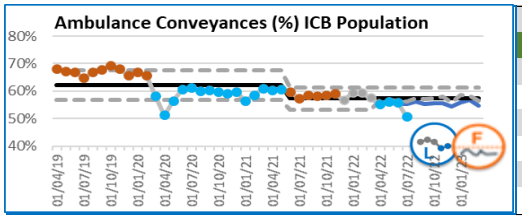
Urgent Care

Urgent Care - Access

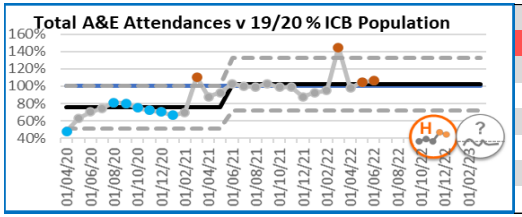


Jun-22
7363
2022-23 Plan
9717
Assurance
Flip
SPC Variation
Improving - Low

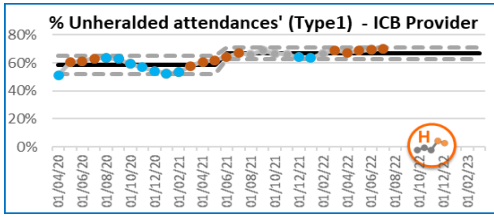
SDEC Service	Date
To be provided in future reports	2022-23 Plan
	Assurance
	SPC Variation



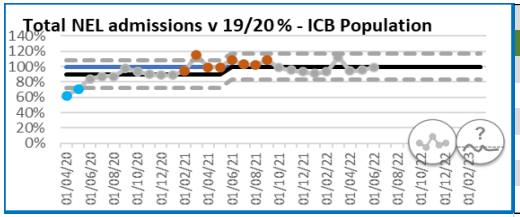
Jul-22
50.6%
2022-23 Plan
55.2%
Assurance
Fail
SPC Variation
Improving - Low



Jun-22
106.3%
2022-23 Plan
100%
Assurance
Flip
SPC Variation
Concerning - High



Jul-22
70.13%
Target
-
Assurance
-
SPC Variation
Concerning - High



Jun-22
99.4%
2022-23 Plan
100%
Assurance
Flip
SPC Variation
Common Cause

Summary

GP Extended Access - is below the planned levels and remaining along a flat trajectory - therefore common cause variation. Significant increases are needed to deliver to the planned levels.

Ambulance Conveyences continue to reduce as % towards planned levels, with sustained improvements since pre-covid levels.

A&E and NEL activity plans were required to be set at 100% of pre-covid levels, with no growth included. The system is operating at increased levels to these planning assumptions, which is continuing to cause additional pressure on the acute urgent care system.

Unheralded Attendances continue to increase triggering a special cause-high alert.

Actions

A&E - NUH Paediatric ED will be back in place from 31st August following estates work. This will release the Lynn Jarrett Unit to support same day emergency care once again.

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

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

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

Wound care follow up pathway pilot has been agreed with community providers and GP practice nurse leads.

An Acute Respiratory Care Unit proposal at NUH sites is progressing through the system.

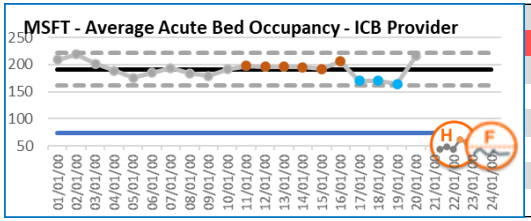
POG Assurance - Limited Assurance

Activity levels continue to be above planned levels into the front door of urgent care. Additional clarity is needed in relation to the Extended Access Primary Care Booked appointments, as to additional actions being taken to improve the position.

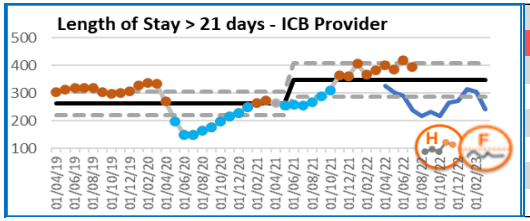
7.2b - Streamline Urgent Care – Exception Report: Discharges and Out of Hospital Provision

NHS Nottingham and Nottinghamshire

Urgent Care - Acute Discharges & out of hospital provision

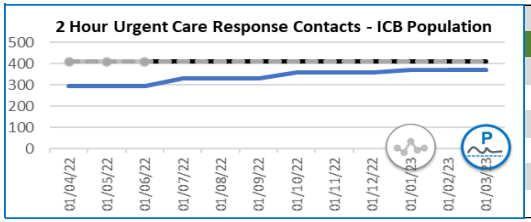


Aug-22
216
2022-23 Plan
73
Assurance
Fail
SPC Variation
Concerning - High

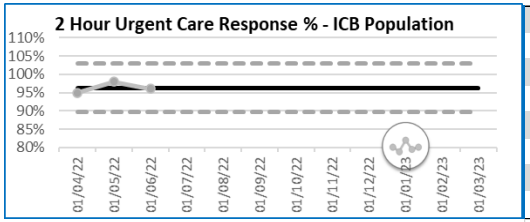


Jul-22
394
Variance Type
237
Assurance
Fail
SPC Variation
Concerning - High

No. Patients utilising Virtual Ward	Date
	2022-23 Plan
To be provided in future reports	
	Assurance
	SPC Variation



Jun-22
396
2022-23 Plan
357
Assurance
Pass
SPC Variation
Common Cause



Jun-22
96%
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause

Social Care / Home Care Packages	Date
	2022-23 Plan
To be provided in future reports	
	Assurance
	SPC Variation

Summary

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

LOS >21 days - Special Cause High Alert as there are significantly more patients in acute hospitals with lengths of stay of over 21 days than planned levels and also pre-covid. 17.6% of all available acute beds are currently occupied by +21 day patients as at 1st August 2022. As well as the impact from the issues of flow out of the hospitals, patients are entering the system with increased acuity for emergency presentation and deconditioned presentations for elective care which lengthens recovery time and therefore period to discharge.

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

Actions

MSFT Actions - Daily system partner calls continue to be held to maximise use of all available capacity and determine additional actions which are able to be undertaken. An additional 160 P1 interim beds have been opened, however these obviously require actively monitoring and sourcing of packages of care, so does impact on health and social care capacity. Sciensus are providing additional P1 capacity in the city, averaging 80 home visits per day. System partners are working to identify additional interim capacity from Q3 onwards, as the Discharge to Assess business case is being finalised later than planned

LOS - a system led review of current long waits is to be undertaken to provide further clarity as to the specific drivers for these waits, and indentify high impact actions to reduce these long lengths of stay in future months.

Virtual Wards - are being expanded to provide new pathways for frailty, respiratory and IVs. Data flows are being introduced to enable monitoring against the system plans submitted.

Urgent Community Response - continues to build additional capacity. Data flows are being introduced to enable monitoring against the system plans submitted.

POG Assurance - Low Assurance

The additional capacity being planned for within the Discharge to Assess business case will be implemented later than planned due to delays in finalising the business case. The final costing and proposals are now due to be finalised by the end of Q2.

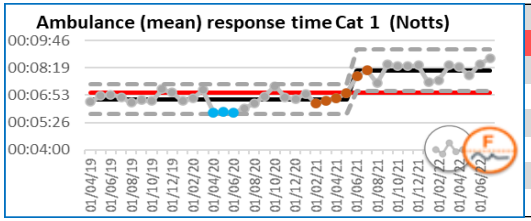
NHS England has launched a **"Discharge 100 day challenge**" requiring systems to deliver against 10 initiatives, in the first 100 days of the ICB. Focused senior leadership is required, and there should be consistent and appropriate oversight of discharge performance from trust boards and the ICB. The aim is for the position to have improved ahead of the winter period. NHS England will undertake a launch meeting with each system to determine the appropriate level of tiered support required to successfully implement the initiatives.

The recently established Ageing Well Board will be responsible for D2A, UCR and falls, and will take a lead in the production and progress of the Discharge 100 day challenge.

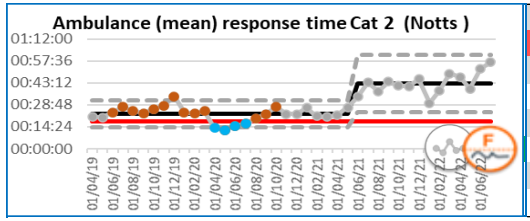
7.2c - Streamline Urgent Care – Exception Report : Compliance

NHS Nottingham and Nottinghamshire

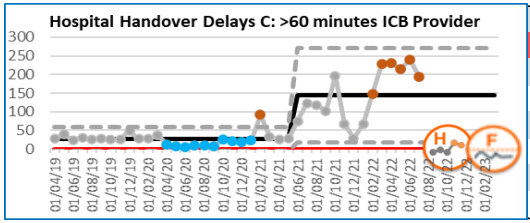
Urgent Care - Performance Compliance



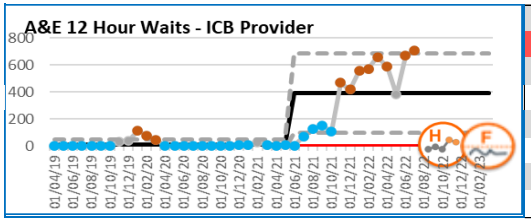
Jul-22
00:08:49
Target
0:07:00
Assurance
Fail
SPC Variation
Common Cause



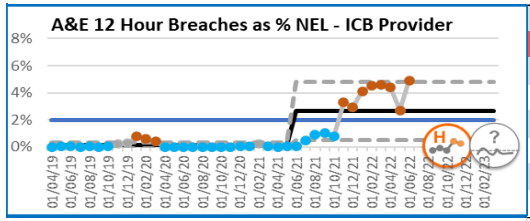
Jul-22
00:56:42
Target
0:18:00
Assurance
Fail
SPC Variation
Common Cause



Jul-22
193
Target
0
Assurance
Fail
SPC Variation
Concerning - High



Jul-22
709
Target
0
Assurance
Fail
SPC Variation
Concerning - High



Jun-22
4.9%
Target
2%
Assurance
Flip
SPC Variation
Concerning - High

Date
2022-23 Plan
Assurance
SPC Variation

Summary

Ambulance Handover Delays >60 minutes: Special cause High alert due to rising numbers snce December 2021. Pre and post handover performance also remain below national targets, with the position deteriorating since May.

Ambulance Response Times: Cat 1 and Cat 2 response times have remained at high levels since June 2021, with common cause variation, and low assurance that the service expected to achieve targets set.

12-Hour Breaches: Continue to trigger special cause alerts due the high volumes of patients waiting more than 12 hours from a clinical decision to admit. Early indications of improvements were made during April and May, however pressures have significantly increased into July, with increased activity and covid presentations.

Actions

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

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

POG Assurance - Low Assurance

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

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

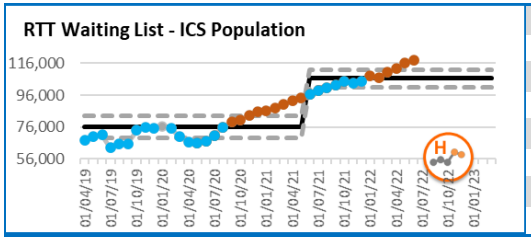
7.3 Service Delivery
Elective Care Performance

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

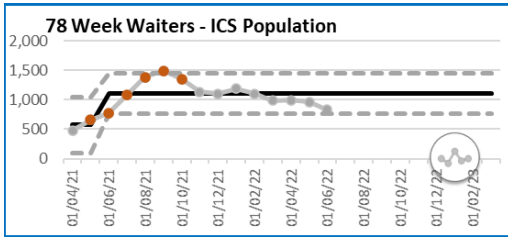
7.3a - Recover Services and Address Backlogs – Exception Report : Elective Waits

NHS Nottingham and Nottinghamshire

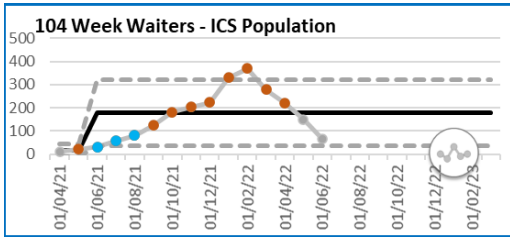
Elective Waits - Total Waiting List and Long Waits



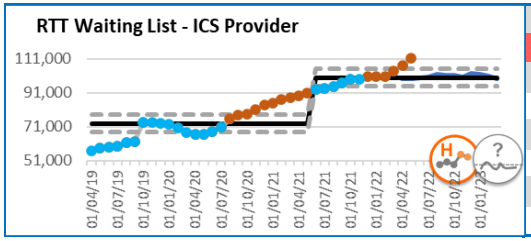
Jun-22
117678
2022-23 Plan
-
Assurance
-
SPC Variation
Concerning-High



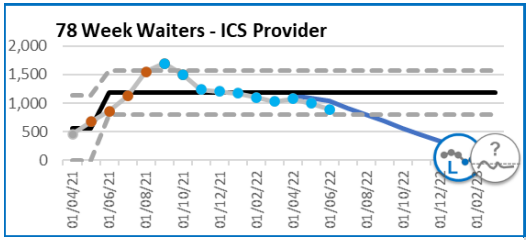
Jun-22
835
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause



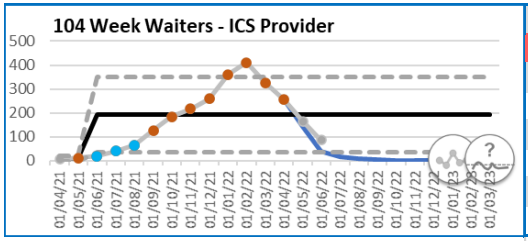
Jun-22
68
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause



Jun-22
112733
2022-23 Plan
99763
Assurance
Flip
SPC Variation
Concerning-High



Jun-22
889
2022-23 Plan
1044
Assurance
Flip
SPC Variation
Improving-Low



Jun-22
87
2022-23 Plan
38
Assurance
Flip
SPC Variation
Common Cause

Summary

Waiting List - ***showing concerning-high variation due to continual deterioration of the position and failure to deliver against the plan*** . A reduction of 12,970 patients is needed to return to plan.

78 Week Waits - ***showing improving - low variation as the position is reducing in line with the plan since a peak in September 2021*** . 78 ww are acheiving the planned level of reductions at June 2022. Note that the plan is to eliminate waits of 78 weeks or more by March 2023.

104 Week Waits - ***showing common cause variation as the position has reduced below the mean*** . The national target is zero 104 week waits by the end of June 2022 except where patients choose to wait. At the end of July, there were 85 patients waiting 104 weeks or more at NUH and SFH. Whilst improvements are being made the rate of progress currently means that the system is not delivering the level of reductions required. The latest weekly data for week ending 21/08/22, shows that there are currently 88 patients waiting 104 weeks or more for treatment at NUH and SFH, compared to a plan of 9. The current forecast risk for the end of August 2022 is 82 patients who are being actively managed to secure appropriate treatment within the 104 weeks, of which 34 patients are exercising choice to be treated at a later date.

Actions

Elective Capacity levels improved during June as all elective capacity was restored and staffing absences improved. However, during July and August there have been periods of significant urgent care demand, which has impacted the volume of non-urgent elective activity that providers have been able to undertake. Staffing pressures due to sickness absence has also impacted upon theatre capacity - further information is included in the Activity section of this report.

Elective Hub - the system operates a system wide elective hub which reviews the current waits of patients across the local NHS trusts as well as commissioned Independent Sector providers. The aim being to ensure equity of waits across the system and that the various providers review patients on assessment of clinical need and prioritisation, and align capacity resource through mutual aid as required. Specialty reviews are also undertaken to provide organisational support where specific issues have arisen. This has been successful with over 600 patients moving between providers since summer 2021.

104 week waits - all patients at risk of breaching 104 week waits are individually contacted by the relevant provider, offered dates for the future and are actively supported while waiting. All actions possible are being taken by the system to ensure patients are treated including offers of transfer in specific cases, should the patient wish to travel for treatment.

POG Assurance - Limited Assurance

Internal Oversight of the **104 position** continues to take place on a daily basis by providers. Weekly meetings with NHSE/I continue to take place to enable a granular discussion to take place around specialty level risks and mitigations. This also includes a review of the 78 week position.

NUH are forecasting to have 49 104 breaches due to complexity (29) and patient choice (20) as at the end of September.

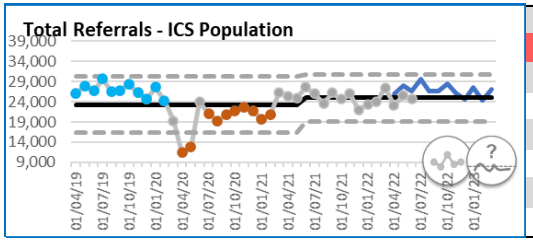
78 Weeks forecasts for the end of March 2023 are being developed, these will take in to account patients that are currently waiting beyond 78 weeks as well as those that will be over 78 weeks at the end of 2022/23, this will also consider the reduction in elective capacity over the winter and the impact this will have on long waiters.

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

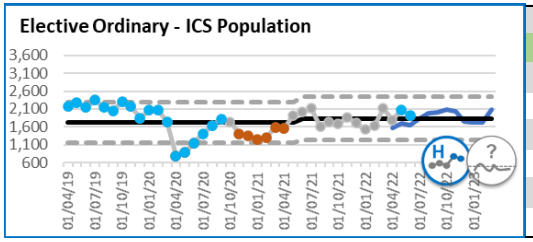
7.3b - Recover Services and Address Backlogs – Exception Report Elective Activity

NHS Nottingham and Nottinghamshire

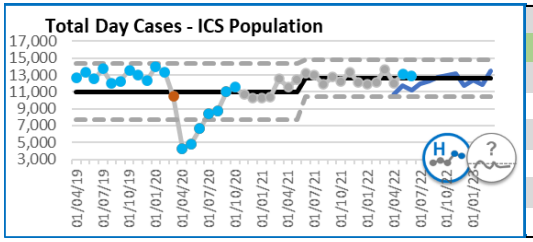
Elective Recovery - Activity



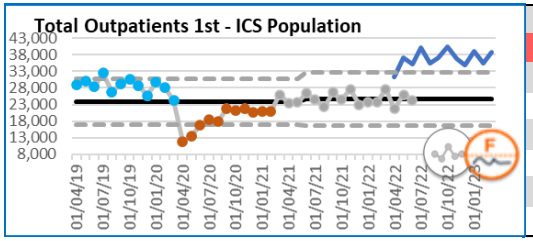
Jun-22
24618
2022/23 Plan
26700
Assurance
Flip
Variation
Common Cause



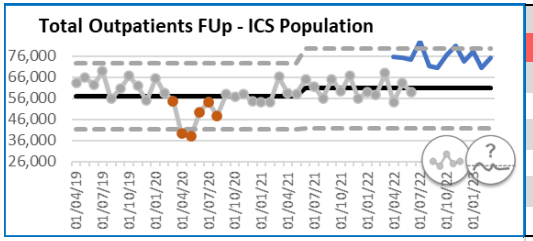
Jun-22
1925
2022/23 Plan
1647
Assurance
Flip
Variation
Improving - High



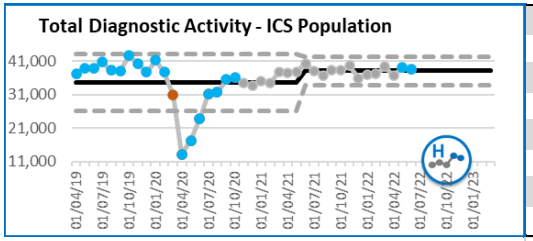
Jun-22
12914
2022/23 Plan
11247
Assurance
Flip
Variation
Improving - High



Jun-22
24333
2022/23 Plan
35314
Assurance
Fail
Variation
Common Cause



Jun-22
59001
2022/23 Plan
74220
Assurance
Flip
Variation
Common Cause



Jun-22
38505
2022/23 Plan
-
Assurance
-
Variation
Improving - High

Summary

These charts compare the June activity level to the operational plan. Where a plan was not required during the planning process run rate has been provided. The charts include activity for the whole ICB population and at all providers (NHS and IS).

Three of the charts (Total Referrals - ICS Population, Outpatient 1st - ICS Population, and Outpatient FUp - ICS Population) show common cause variation as the activity is varying around the mean (black line). This demonstrates that a period of high activity has not able to be sustained due to challenging system conditions, which indicates that it is unlikely that the plan will be delivered. The remaining three charts (Elective Ordinary - ICS Population, Day Case - ICS Population, and Diagnostic Activity - ICS Population) show Improving - High variation, which indicates a period of activity above the mean.

Referrals (Routine, Urgent and 2ww) have increased significantly since April 2020. During 2021/22 referral volumes exceeded 100% of 2019/20 in ten of twelve months. In particular, the growth in 2ww referral volumes has driven the overall position, with volumes routinely being between 120% and 130% of pre-pandemic levels. This is described further within the Cancer Recovery Section of this report.

Actions

Reinstate Elective Capacity - In the first quarter there were a number of significant factors that impacted the volume of elective surgery including staff vacancies, staff absence due to sickness, increased demand for emergency admissions and subsequent bed pressures. As the overall number and acuity of COVID patients reduced mid way through the first quarter, this has allowed the return of elective wards which were allocated to non-elective patients during extreme system pressures.

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

Staffing Capacity:
Absences - the system continues to have high levels of staff absence with levels between 7% to 8% of the acute provider workforce.
Infection Prevention and Control (IPC) restrictions have been eased in line with national guidance, which will support more productive and flexible use of capacity.

POG Assurance - Limited Assurance

Activity remains below planned levels across all areas, except for Elective Ordinary activity, which are patients that require an overnight stay following surgery.

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

System needs to determine the most appropriate way to maximise day case activity and protect elective activity wherever possible.

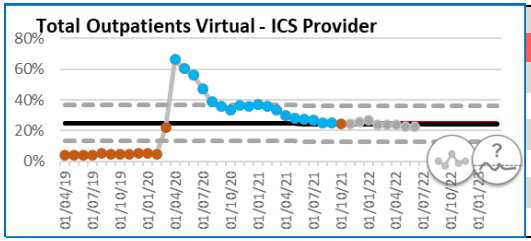
OP 1st Plan at NUH is overstated on Ophthalmology, the ICB Performance and Assurance Team will obtain further detail on the potential scale and impact on delivery against plan for 2022/23.

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

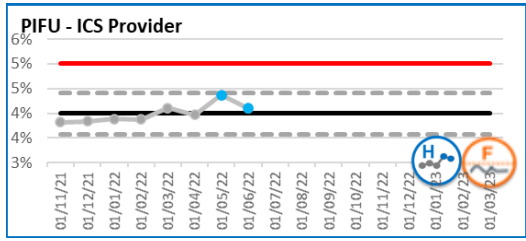
7.3c - Recover Services and Address Backlogs – Productivity & Transformation

NHS Nottingham and Nottinghamshire

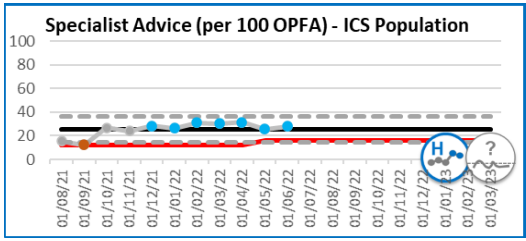
Elective Recovery - Productivity & Transformation



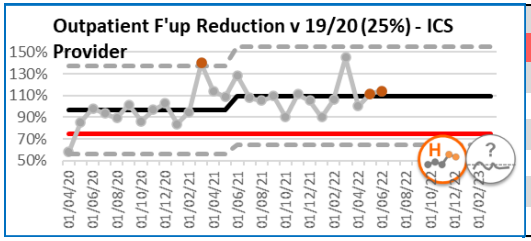
Jun-22
22.7%
Target
25.0%
Assurance
Flip
Variation
Common Cause



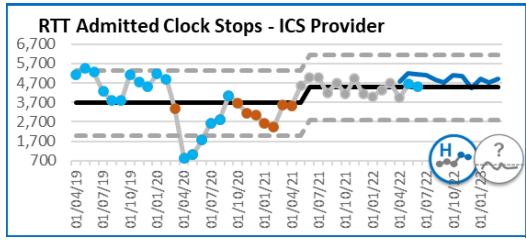
Jun-22
4.1%
March 2023 Target
5.0%
Assurance
Fail
Variation
Improving - High



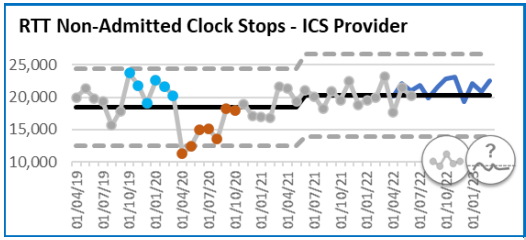
Jun-22
28
March 2023 Target
16
Assurance
Flip
Variation
Improving - High



Jun-22
114%
Target
75%
Assurance
Flip
Variation
Concerning - High



Jun-22
4515
2022-23 Plan
5153
Assurance
Flip
Variation
Improving - High



Jun-22
20239
2022-23 Plan
21000
Assurance
Flip
Variation
Common Cause

Summary

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

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

Outpatient Virtual: ***Common cause variation, 'flip' target delivery as the target is near the mean.*** There is a differential position by provider with NUH at 26% whereas SFH deliver 23% of outpatients virtually.

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.

Admitted and Non-Admitted Clock Stops: ***These charts show common cause or high-improving variation, with activity being delivered around the mean.*** However for the system to be successful in tackling waiting lists, the activity levels need to shift above the upper control limit.

Actions

Advice & Guidance: benchmarking is being undertaken to compare the ICB with other systems to identify any further improvements and learning opportunities for how to maximise this service offer. It is the intention to measure variation at PCN level in utilisation of Advice & Guidance, however this functionality is not yet available within the national dashboard, it is under development and this work will commence when an updated dashboard is published.

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

Outpatient Virtual: NUH and SFH submitted trajectories which show delivery of the 25% national standard by March 2023. Monitoring is in place to track delivery against the agreed plan. SFH identified that some specialties are not reporting all telephone and advice line activity, therefore a virtual core project team has been set up to investiage this and improve the position against the national target.

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, which include, Increases in urgent care demand, Pressures around flow, re-purposing of elective wards , Increases in staff sickness as well as increases in COVID infection rates.

POG Assurance - Limited Assurance

Utilisation of **Advice and Guidance** remains high and the system continues to consistently achieve the national standard. There is confidence that this performance level will continue during the financial year.

PIFU - The current performance level in June 2022 is 4.1%, which exceeds the locally set plan and is on track to exceed the March national standard.

Outpatient Virtual attendance volumes at SFH remain lower than the national standard. The national standard of 25% has not been acheived since May 2021.

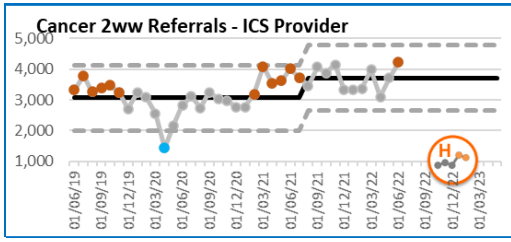
Outpatient Follow-up 25% Reduction: the national 25% reduction will not be delivered as the providers concentrate on treating patients on their current lists. Future service change plans will focus on safely progressing the reductions required.

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

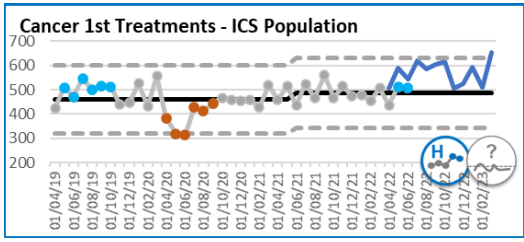
7.3d - Recover Services and Address Backlogs – Exception Report : Cancer

NHS Nottingham and Nottinghamshire

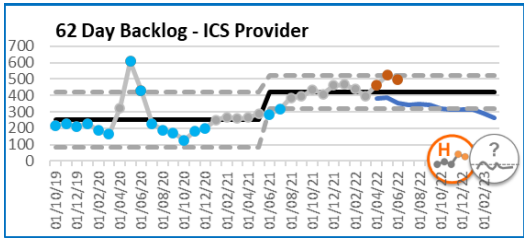
Cancer Recovery - Total Provider View



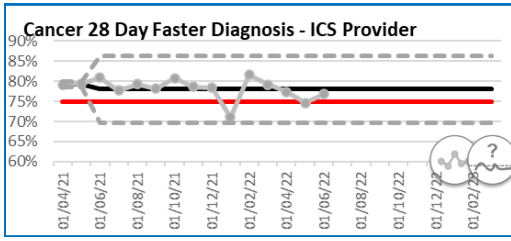
Jun-22
4222
2022/23 Plan
-
Assurance
-
Variation
Concerning - High



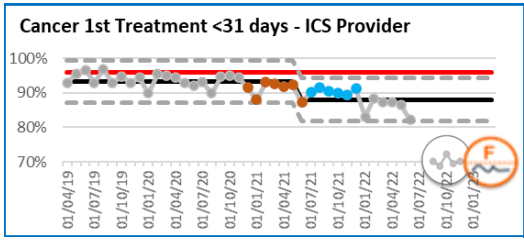
Jun-22
559
2022/23 Plan
672
Assurance
Flip
Variation
Improving - High



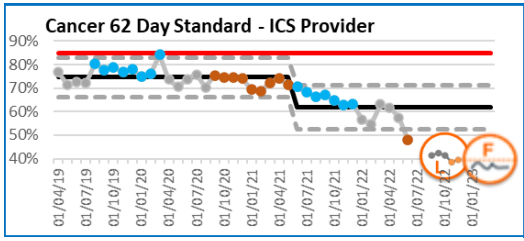
Jun-22
497
2022/23 Plan
353
Assurance
Flip
Variation
Concerning - High



Jun-22
76.7%
Target
75.0%
Assurance
Flip
Variation
Common Cause



Jun-22
82%
Target
96%
Assurance
Fail
Variation
Common Cause



Jun-22
48%
Target
85%
Assurance
Fail
Variation
Concerning - Low

Summary

2ww Referrals: ***Concerning-High variation as the referrals are above the mean,*** with growth in demand being at c120% of pre-pandemic levels since March 2021. This is acros all tumour sites and has increased pressure on services, and impacts all other measures.

28 Day Faster Diagnosis: ***common cause and 'flip' assurance indicate activity remains around the mean and will therefore hit or miss the target*** . Despite increased demand the 28 day FDS continues to be achieved. The N&N system is one of only two systems within the region that consistently achieved the 28 day FDS standard since February 2022.

31 Day & 62 Day Performance: ***Special cause alert as the position is consistently below the mean. As the standard is above the mean there is low levels of assurance that the standard will be achieved*** . The high levels of cancer demand since January 2020 impacted upon performance, this was further reduced from January 2022 as access to theatres, base and critical care beds improved, which supported a greater number of patients waiting over 62 days to be treated.

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

Actions

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

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

To address the 62 day backlog, NUH have held Internal meetings with all tumour site leads and clinical leads which have enabled discussion around reviewing approaches to follow ups; 'testing' pathways; and options to address staffing issues. 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. NHSEI have also been asked to share any insights on forecast methodology models from other areas, due to the complexity of the cancer pathway.

POG Assurance - Limited Assurance

Following development of the NUH specialty level plans, the underlying assumptions which were linked to system level conditions fundamentally changed. As an example, the impact of COVID was more material than planned, the sickness levels of staff were greater than forecast and the impact of non-elective pressures were more servere than expected. Therefore, ***the backlog increased materially during April and May 2022, a small reduction has been seen in June. The latest weekly data for week commencing 21/08/22 is 472 patients against a plan of 349 patients.***

The system is still aiming to deliver to the March 2023 plan of 265 patients.

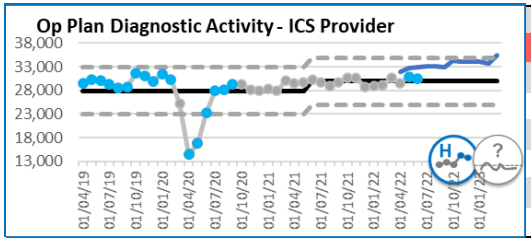
The weekly 104 week waiter meetings that take place with NHSE/I have been expanded to enable a discussion to take place around plans to reduce the 62 day cancer backlog.

62 day standard performance is expected to remain at lower levels during the time period that longer waiting patients are progressed through to treatment, as the target count is as treatments are undertaken rather than as a picture of current patients waiting.

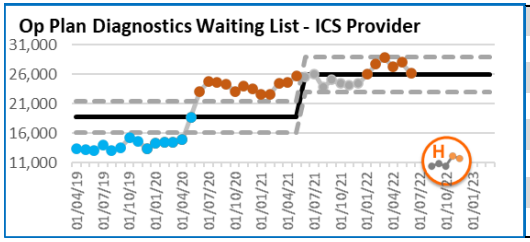
7.3e - Recover Services and Address Backlogs – Exception Report: Diagnostics

NHS Nottingham and Nottinghamshire

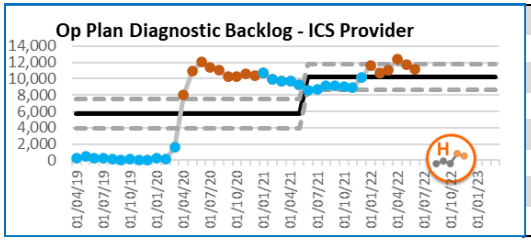
Diagnostics Recovery - Total Provider View



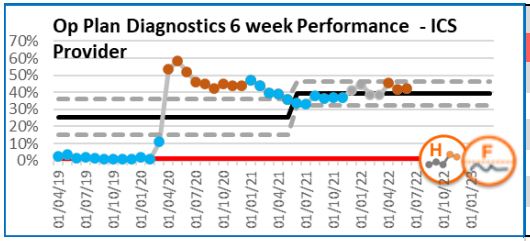
Jun-22
30580
2022-23 Plan
32871
Assurance
Flip
Variation
Improving - High



Jun-22
26156
2022-23 Plan
-
Assurance
-
Variation
Concerning - High



Jun-22
11110
2022-23 Plan
-
Assurance
-
Variation
Concerning - High



Jun-22
42.5%
2022-23 Plan
1.0%
Assurance
Fail
Variation
Concerning - High

Diagnostic Modality - Highlighted Modalities are included in the OP Plan

ICS Provider	Waiting List	Backlog	%
MRI	5,870	3,183	54.2%
Computed Tomography	3,230	632	19.6%
Non-obstetric ultrasound	7,706	2,190	28.4%
Barium Enema	0	0	
DEXA Scan	1,910	551	28.8%
Audiology	1,036	716	69.1%
Echocardiography	6,313	3,607	57.1%
Cardiology - Electrophysiology	0	0	
Neurophysiology	292	70	24.0%
Sleep studies	1,264	657	52.0%
Urodynamics	160	45	28.1%
Colonoscopy	1,152	586	50.9%
Flexi sigmoidoscopy	477	273	57.2%
Cystoscopy	411	67	16.3%
Gastroscopy	1,409	639	45.4%
Total - All Modalities	**31,230**	**13,216**	**42.3%**
Total - Plan Modalities	**26,157**	**11,110**	**42.5%**

Summary

Backlog and diagnostics waiting list: ***showing concerning - high alerts due to values above the mean, however the waiting list and backlog reduced in June 2022.***

Diagnostic activity: ***overall varies month on month due to common cause variation, however the positon does vary by modality and provider. The 'flip' assurance indicates that the plan levels are unlikely to be achieved.***

Diagnostic 6 week performance for plan modalities: June at 42.5% with the 6 week backlog decreasing to 11,110 patients.

MRI: challenging at NUH, however the position has continued to improve week by week since January 2022. The waiting list has reduced by around 2100 patients, with the backlog reducing by around 1500 patients between January and June 2022. Mutual aid has been provided by SFHT during this time.

Echocardiology: The latest data for week ending 21/08/22 shows that Echocardiography is performing at around 56% for SFH and NUH. After a period of rapid increase, the backlog and waiting list are now showing signs of reduction

Actions

Echocardiology - NUH have secured locum staff and are working weekends to meet demand, these efforts have supported the backlog to stabalise and reduce

Mutual Support - is in place with NUH supporting SFHT with ultrasound.

Refinement of the demand and capacity modelling analysis is being undertaken to inform the CDC Business Case, which will be submitted during Q2 2022/23. The business case will support the development of a single CDC within the Mid Nottinghamshire area that will align to the minimum specification national specification. This will provide additional CT, MRI, Non-Obstetric Ultrasound and X-Ray capacity. It will also provide endoscopy, physiological measurements for respiratory and cardiolgy as well as additional pathology capacity.

Providers routinely monitor the current position against modality level recovery trajectories. Copies of the trajectories have been received from service leads at the local providers, which will be monitored through the Diagnostics Board.

POG Assurance - Limited Assurance

The total waiting list and backlog is showing signs of stabilisation across the key 15 modalities.

Diagnostics data for week ending 21/08/22 illustrates that the system has a challenging long waiters position for MRI, Echcardiography, Gastroscopy, Flexi-Sygmoidoscopy and Colonoscopy. In each of these five modalities, at least 50% of patients were waiting more than six weeks for a diagnostic test.

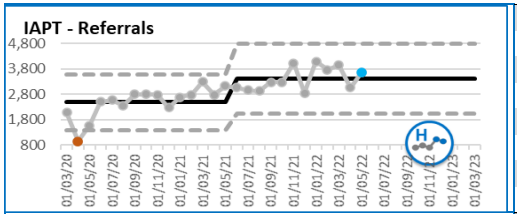
7.4 Service Delivery Mental Health Performance

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

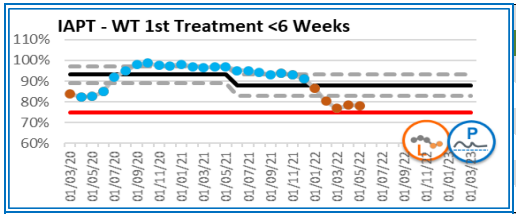
NHS Nottingham and Nottinghamshire

Mental Health

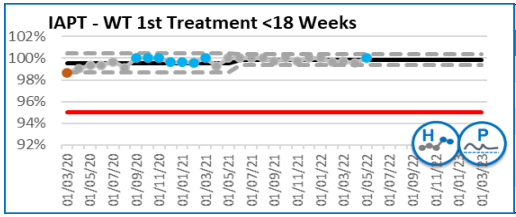
Mental Health - Improving Access to Psychological Therapies



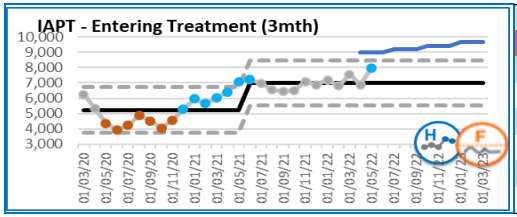
May-22
3645
2022-23 Plan
-
Assurance
-
SPC Variation
Common Cause



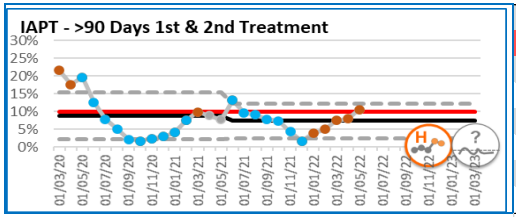
May-22
78%
Target
75%
Assurance
Pass
SPC Variation
Concerning - Low



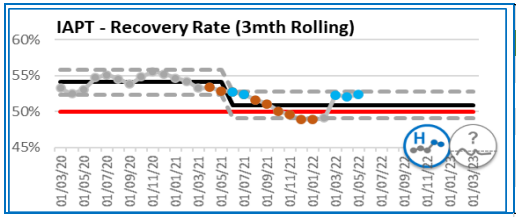
May-22
100%
Target
95%
Assurance
Pass
SPC Variation
Improving - High



May-22
7995
2022-23 Plan
8984
Assurance
Fail
SPC Variation
Improving - High



May-22
11%
Target
10%
Assurance
Flip
SPC Variation
Concerning - High



May-22
52%
Target
50%
Assurance
Flip
SPC Variation
Improving - High

Summary

- IAPT referrals continue to increase, triggering special cause - high alert.
-Treatment numbers (3-month) rolling average are at the mean, which is below planned levels, 7995 against 8984 plan.

The service continues to achieve and exceed **waiting time standards**, however there has been a sustained reduction in treatments within 6 weeks, triggering a special cause - low alert. It is probable that this will move below standard for April reporting. This is largely due to a 16% increase in referrals between Q3 and Q4,m as well as high levels of covid staff absence (18% at one provider). This has resulted in reduced appointments available, and doubled appointment cancellations across that provider.

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

There has been an improvement in the **recovery standard**, with achievement in March 2022. The downward trend had reflected a reported increase in complexity of presentations, however in March 2022, 70% of patients showed reliable improvement upon completing treatment.

Actions

Key actions to increase performance over the next quarter include:
Access - Focus on service promotion, community advertising and engagement and strengthening links with localities and PCNs. This includes continuing with service promotion and awareness raising through social media animations, videos and blogs, monthly newsletters, community advertising and attendance at community events.
Waiting Times - A continued focus on staff wellbeing, supervision and caseload management including training and drop-in support sessions. Ongoing recruitment to increase capacity, including 14 trainees commenced April, agency and affiliates.
- The wider roll out of NHS Limbic will improve online access, support appropriate signposting ensuring that clinical capacity is used most appropriately and additional support to patients while they are waiting to reduce drop-out rates, and thus supporting the access and recovery standards.
Recovery - targeted support for staff with lower recovery rates including refresher training, review of case suitability and data quality and processes.
Inequalities - A continued focus on inequalities to include the roll out of online offers in different languages and the commencement of community engagement workers, with a primary focus on BAME communities and older adults.

POG Assurance - Partial Assurance

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

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

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

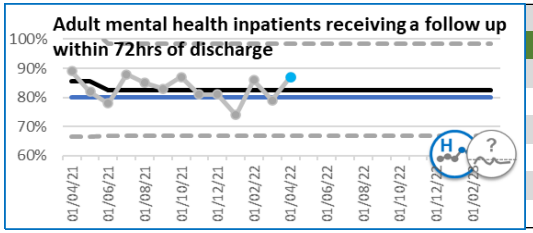
Recovery against the 6 week waiting time standard is expected by September 2022.

Staff sickness rates had seen some improvement during June 2022, however these are starting to rise again with the rising cases of covid in the community.

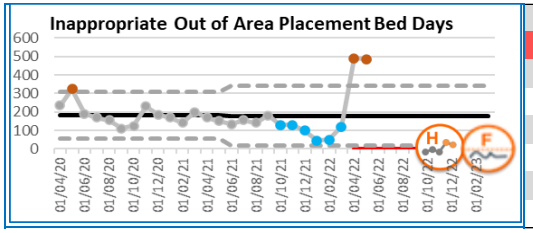
7.4b - Recover Services and Address Backlogs – Exception Report: Mental Health - Adult Services

NHS Nottingham and Nottinghamshire

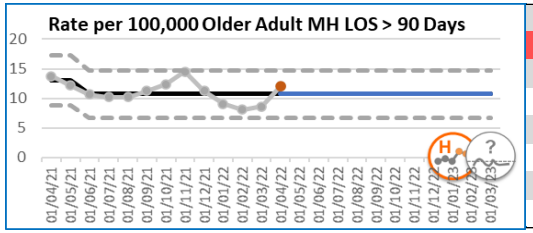
Mental Health - Adult Mental Health



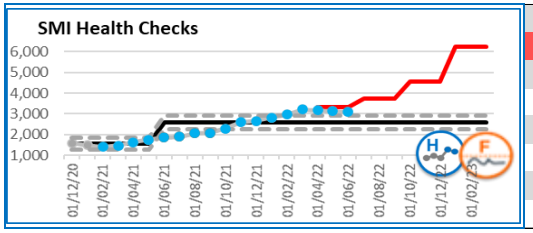
Apr-22
87%
Target
80%
Assurance
Flip
SPC Variation
Improving - High



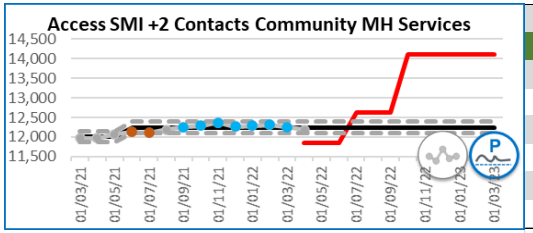
May-22
485
2022-23 Plan
0
Assurance
Fail
SPC Variation
Concerning - High



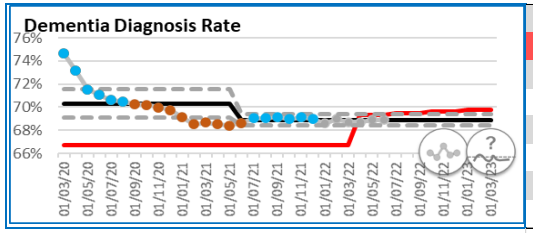
Apr-22
12
Target
11
Assurance
Flip
SPC Variation
Concerning - High



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



Apr-22
12190
2022-23 Plan
11854
Assurance
Pass
SPC Variation
Common Cause



Jun-22
68.9%
Target
69.3%
Assurance
Flip
SPC Variation
Common Cause

Summary

72 Hour Follow Ups - this target is near the mean therefore is likely to hit and miss the target.

OAPs - Placements out of area have significantly decreased from April 2022, local data reports 485 as at May 2022. This has been driven by increased demand for inpatient admissions, acuity and complex patient delays in discharge from the acute setting.

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

SMI Physical Health Checks - There had been continued improvement in 2021/22 however this has plateaued in May and June, 42.0% (3,083 checks). The target for 2022/23 increases to 5,592 (6237 including Bassetlaw).

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

Actions

OAPS - Crisis/ Community Support - Crisis Resolution Home Treatment Teams delivering Intensive Home Support and in-reach to wards, however recruitment to some posts remains a challenge. A pilot of daytime Crisis Home provision is being undertaken from Q1 to support admission avoidance and supported discharge from inpatient wards. Inpatients Long Stay reviews have been undertaken, routine reporting established from NHT, MH MADE events held and additional beds to be opened Q3 in the new inpatient unity to support discharge and local capacity.

SMI Health Checks - Recovery Plan actions include: Monitoring against PHSMI LES (live since 1 May 2021) and practice/PCN data to target Health Improvement Workers across primary care, improvements in communication approach of HIW across primary care, scoping on role of VCSE. Nottingham City East PCN focused support to scope and address disparity in access to a health check. A pilot has commenced Q1 2022/23 testing several digital kits to enable point of care testing, funded by NHSE.

Dementia - MAS teams flex staffing and delivery methods including remote consultations, to meet variation in demand across locality to ensure equitable waits across the system. From April 2022 the Integrated Demential Wellbeing Service has enhanced the post diagnostic offer to those diagnosed and their carers, which is a key component of the MSNAP accreditation.

POG Assurance - Limited Assurance

OAPS - Mental Health Crisis and Urgent Care Steering Group meets monthly to review progress against actions. Partnership meetings are also in place to identify any actions that can be taken to alleviate system pressures. **It is not expected that the ICS will achieve the 'nil' target until later in the year.**

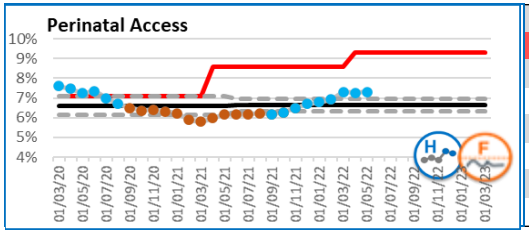
SMI Health Checks - monitoring by practice is undertaken through PHSMI Steering Group, 100% take up of PHSMI LES in 2022/23. Delivery of the standard is integrated into the Community Mental Health Transformation Programme to ensure co-ordination with all service developments, including LMHT and MH Practitioners in PCNs.

Dementia - reconfiguring data systems to accurately record referral to diagnosis. The ICB is took part in an NHS England led Dementia Diagnostic Rate deep dive in Q1 2022/23 to support full understanding of variation. Following this the ICB is working with MAS and data teams to establish a measure of equity in the DDR to be included within reporting from Q2.

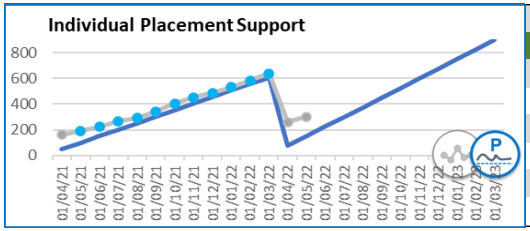
7.4c - Recover Services and Address Backlogs – Exception Report : Mental Health – Access

NHS Nottingham and Nottinghamshire

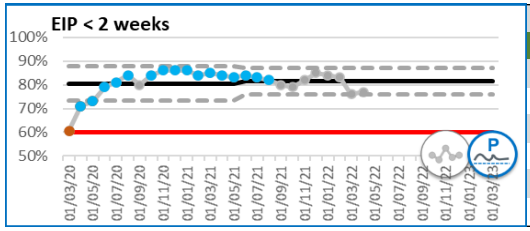
Mental Health - Access



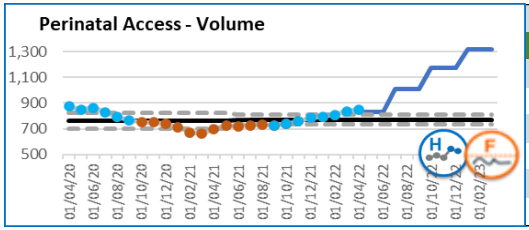
May-22
7.3%
Target
9.3%
Assurance
Fail
SPC Variation
Improving - High



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



May-22
73%
Target
60%
Assurance
Pass
SPC Variation
Common Cause



May-22
935
2022-23 Plan
828
Assurance
Flip
SPC Variation
Improving - High

Early Intervention Psychosis (EIP) Compliance Levels

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

Summary

Perinatal - Performance in May 2022 has remained static at 7.3%, reflecting continued improvement, but remains below the standard of 9.3%. National reporting guidance specifies that only face-to-face and video conferencing contacts contribute to access performance. This resulted in a decline in reportable performance from July 2020 as Covid led to virtual service delivery. Performance has stabilised and shows signs of continual improvement and analysis of local data, including telephone support, demonstrates that more women are accessing support than is reportable nationally.
IPS - The ICS meet and exceeded the 2021/22 IPS access standard. Month 1 is ahead of trajectory and track to achieve the 2022-23 year-end target of 899.
EIP - Access standard consistently exceeding target at ICS Level. Level 3 Overall compliance achieved in September 2021.

Actions

Perinatal - 2-year investment plan to meet the increased access standard and deliverables outlined in the Long Term Plan was agreed in April 2021. Recruitment has taken place and has been phased throughout 2021/22; all additional roles for year 1 have been recruited, with most additional roles for year 2 appointed. The service transformation, which includes an extended period of care, the provision and support to partners, increased access to psychological therapies and the commencement of the maternal mental health pilot (trauma and bereavement service) in January 2022, will have a positive impact on the access target, with increased numbers expected to access the service.
Actions to increase the number of women accessing the service include:
Undertaking promotional activity to increase the number of referrals to the service. This includes a launch of the new trauma and bereavement service which took place on 31 March 2022 and a wider promotion of the expanded service during maternal mental health week in May 2022.
Analysis of DNAs which are high for new assessments, including exploring the functionality of the text messaging reminder service to ensure that the number of missed appointment slots is reduced

POG Assurance - Partial Assurance

Perinatal - An ICS Perinatal Recovery Action Plan has been developed, including an improvement trajectory outlining when the service is expected to achieve the access target. Due to the metric being based on 12-month rolling position, the trajectory will represent a slow but continual improvement. This is monitored through the Perinatal Mental Health Steering Group. ***The access target increases in 2022/23 from 8.6% to 10%, the ICS aim is to achieve the revised target by Q4.***

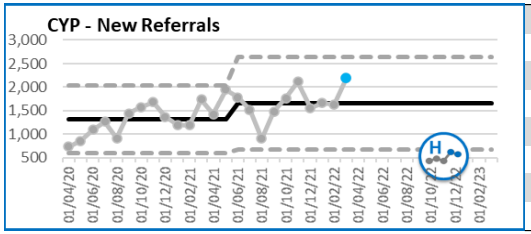
EIP Transformation meetings are in place to review progress against agreed actions, variations across teams and progression through compliance levels.

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

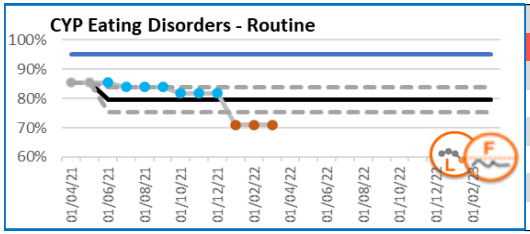
7.4d - Recover Services and Address Backlogs – Exception Report : Mental Health – Children & Young People

NHS Nottingham and Nottinghamshire

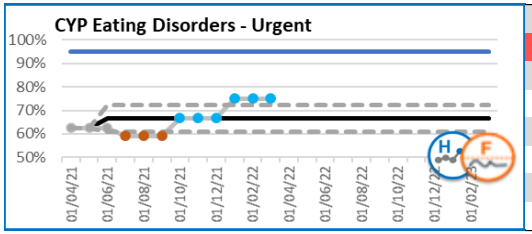
Mental Health - Children & Young People (CYP)



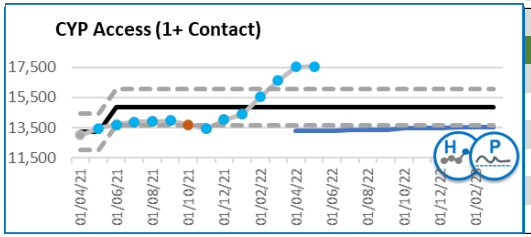
Mar-22
2190
2022-23 Plan
-
Assurance
-
SPC Variation
Improving - High



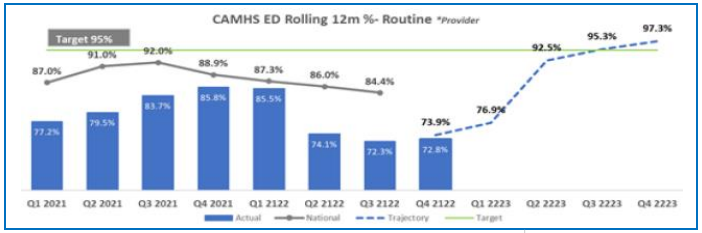
Jun-22
71%
Target
95%
Assurance
Fail
SPC Variation
Concerning - Low

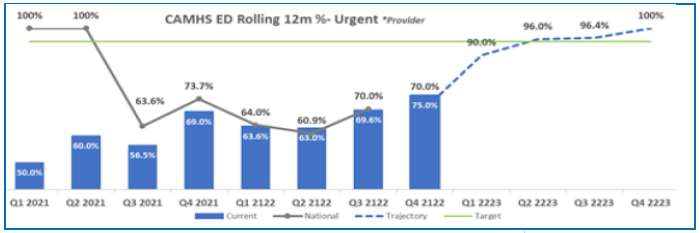


Jun-22
91%
Target
95%
Assurance
Fail
SPC Variation
Improving - High



May-22
17550
2022-23 Plan
13300
Assurance
Pass
SPC Variation
Improving - High





Summary

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

CYP Access (1+ Contact) - The ICS is exceeding the new access target of number of children and young people (CYP) receiving support (1-contact); 17550 CYP were recorded as having at least 1 contact in the rolling 12 months ending May 2022, exceeding the annual plan of 13,300 this financial year. This is reporting a SPC Assurance 'Pass' as the mean is above the plan providing confidence in the delivery of the plan.

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

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

Actions

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

CYP Eating Disorder Service - the ICS reviewed service demand and capacity during 2021/22 with support from the clinical network. However despite investment during 2021/22, a further significant and sustained increase in referrals from September 2020 onwards has continued to lead to pressures within the service and therefore has impacted upon the ability of the service to deliver to the required standards. 2022/23 investment plans have been agreed to further increase capacity in line with these increased referrals levels. Most posts have been recruited to, however there have been some issues with recruitment to the psychology post which is reflective of a national workforce issue. NHT are re-advertising and reviewing psychology resource across the the CAMHS service to ensure it is being use effectively.

POG Assurance - Partial Assurance

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

Investment was agreed for 2022/23 which will enable service expansion and transformation across a range of services.

The ICS remains a high performer for CYP Access.

CYP Eating Disorder - a recovery trajectory has been established based on 200 referrals per annum. It is expected that 'routines' will achieve target in Q3 and 'urgents' will achieve target in Q2. Recovery trajectories provided above.

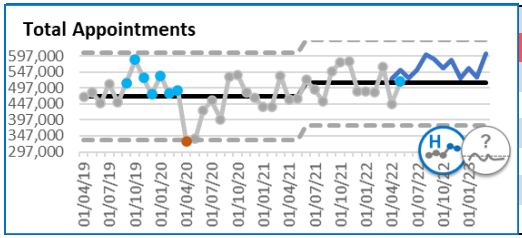
7.5 Service Delivery Primary & Community Performance

7.5a – Exception Reports Primary & Community

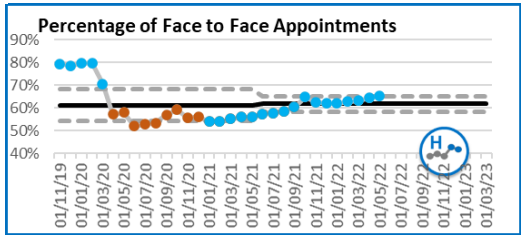
7.5a - Recover Services and Address Backlogs – Exception Report: Primary and Community Recovery

NHS Nottingham and Nottinghamshire

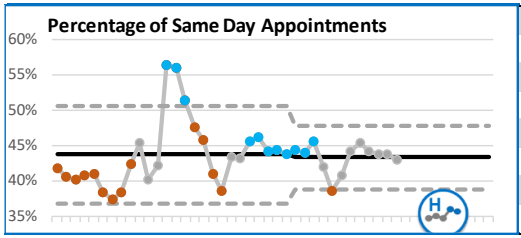
Primary Care and Community Recovery



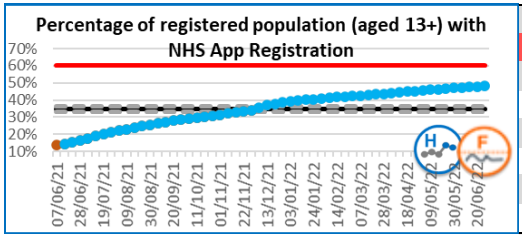
Jun-22
481888
Max Lmit / Target
527046
Assurance
Flip
SPC Variation
Improving - High



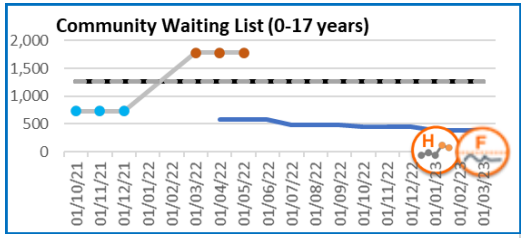
Jun-22
66%
Max Lmit / Target
-
Assurance
-
SPC Variation
Improving - High



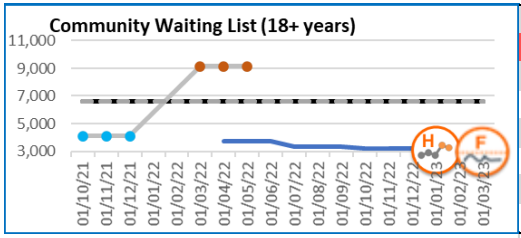
Jun-22
43%
Max Lmit / Target
-
Assurance
-
SPC Variation
Improving - High



Jun-22
48%
Max Lmit / Target
60%
Assurance
Fail
60% by March 2023
Improving - High



Jun-22
1785
Max Lmit / Target
576
Assurance
Fail
SPC Variation
Concerning - High



Jun-22
9141
Max Lmit / Target
3754
Assurance
Fail
SPC Variation
Concerning - High

Summary

Total GP Appointments, are below plan and below prior year levels by 8%. The volume of appointments per working day was similar in June to May (24,625 in May compared to 24,094 in June, which is a 2.2% variance). There was one fewer working day In June than May, which also influences the chart shown above.

The percentage of appointments held face to face continues to increase at 66%, and on the same day continues to deliver around the mean at 43%. There has been a stepped increase in home visits since March 2022.

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

Community Waiting Lists are significantly over the plan submitted to NHS England. This was a new measure for 2022/23 planning. It is understood that the plans may have excluded certain groups of activity, this is being reviewed with NHT and Citycare, and will be reported on in future reports.

Actions

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

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

POG Assurance - Limited Assurance

Further discussions are required with NHT and Citycare to understand the waiting list position for community services. This will be reported at future meetings.

NHS
Nottingham and Nottinghamshire

8.0 Finance

ICS Aim 3: Enhance productivity and VFM

- 8.1 – Month 4 2022/23 Financial Position
- 8.2 – Risks and Plans for Delivery
- 8.3 – System and Organisational focus
- 8.4 – Emerging risks to financial delivery

8.1 - Finance Position Month 4 2022/23 – Key Metrics

		YTD Variance £m's			FOT Variance £m's			RAG	
Financial Duties	**Measure**	**Plan**	**Acts**	**Variance**	**Plan**	**FOT**	**Variance**	**YTD**	**FOT**
NHS System (Breakeven)	**(Deficit)/Surplus**	**-27.4**	**-27.8**	**-0.4**	**-16.9**	**-16.9**	**0.0**		
Capital (within Envelope)	**Spend against plan**	22.5	14.4	**8.1**	89.6	89.6	**0.0**		
MHIS (meeting target)	**Spend against plan**	62.7	61.9	**-0.8**	188.1	188.1	**0.0**		
Agency (spend within Cap)	**Spend against plan**	19.6	27.6	**-8.0**	54.6	63.0	**-8.4**		
		YTD Variance £m's			**FOT Variance £m's**			**RAG**	
Drivers of the (Deficit)/Surplus	**Measure**	**Plan**	**Acts**	**Variance**	**Plan**	**FOT**	**Variance**	**YTD**	**FOT**
COVID Spend	**Delivery against plan**	12.3	14.9	**-2.6**	17.8	18.9	**-1.1**		
NHS Efficiencies	**Delivery against plan**	23.0	21.1	**-1.9**	102.7	102.7	**0.0**		
ERF Income	**Delivery against plan**	13.0	17.4	**4.4**	53.7	53.4	**-0.2**		

Current position & key drivers

- (**£27.8m**) deficit experienced to end of month 4, which is (**£0.4m**) adverse to plan.
- This is made up of a **£1.5m** favourable variance with the ICB (CCGs) and a (**£1.9m**) adverse variance across the providers in the system.

- The main drivers of the system position at M4 are:-
  - COVID (**£2.6m**) mainly at NUH with a large part relating to pay costs where workforce absences due to covid are above planned levels.
  - under-delivery of efficiency plans (**£1.9m**) – this relates to the 3 Providers with (**£1.2m**) of the variance with SFH where all schemes have slipped against the £1.3m YTD plan & (**£0.5m**) relating to NHT mainly in respect of non-pay schemes including estates & premises transformation.
  - urgent care capacity (**£3m**) relating to the two acute hospitals and the inability to close down winter bed base capacity due to being unable to transfer medically fit patients to the community and ED staffing.
  - offset by ERF income **£4.6m** and other **£2.5m** (including the ICB/CCG surplus of **£1.5m** at M4)

- The ICB (CCGs) YTD position is a **£1.5m** favourable variance at month 4 which reflects the CCGs' close-down positions. The ICB (CCGs) is forecasting a break-even position.
- Net provider position is a (**£1.9m**) adverse variance. Main drivers are covid (**£2.9m**), efficiency shortfall (**£1.9m**) and urgent care capacity above planned levels (**£3.0m**). This is offset by **£4.6m** of ESRF income above plan (following confirmation from NHSE/I that there would be no clawback of ESRF at M4) & other various small gains **£1.3m**.

- Forecast remains break-even but there are significant risks to delivery, particularly relating to Elective Services Recovery Fund (ESRF), covid, efficiency and urgent care capacity.

8.2 - Finance Position Month 4 2022/23 – Risks & Plans for delivery

Risks to delivery

- Delivery of the £17m deficit plan requires a stepped change in existing run rates and month on month financial surpluses to be delivered from month 5.
- The proposed trajectories show month 4 spend trajectory is in line with Q1 at £298.6m. Month 5 and month 6 are forecast to show large reductions in spend with levels at £290.4 and £290.8m respectively which will primarily be delivered through reduced covid related backfill and increased efficiencies. These run rates will need to continue to improve recurrently into Q3 and Q4 and deliver an exit run rate that will support a balanced plan into 2023/24.
- Delivery of efficiency programme remains a key risk with 21% (plan 22%) of the required target been delivered at the end of Month 4. All organisations are still forecasting to be on plan but overall the system's programme increases towards the end of the year with delivery of target being 14% in month 5-6, 27% in Q3 and 37% in Q4.
- The system is forecasting to be £0.2m short of the ERF income plan due to out of system contracts. The financial framework around ERF income is unclear in terms of this will be blocked further after M6 or revert to a performance related payment.
- The system's plans expect a sharp decline in COVID spend from July onwards. With potentially further COVID surges expected this remains a real risk in delivery of the forecast position.

Plan to deliver

- The key drivers & risks in current and forecast variances within the financial plan are covid expenditure, efficiency delivery, elective recovery income (ESRF) & spend and urgent care capacity.
- These areas, alongside other areas highlighted by region for significant scrutiny, form the focus of the system recovery plan.
- To address the required run rate change the system have agreed a financial recovery approach with focussed delivery across 7 High Impact Areas.
- Finance Director Senior Responsible Officers from the four ICS organisations are now appointed to work with existing groups to develop and deliver plans to meet the agreed trajectories.
- The 7 impact areas are:-
  - Reductions in covid expenditure
  - Reduce acute urgent care capacity requirements to within planned levels
  - Productivity actions to increase ESRF within existing resources
  - Delivery of 22/23 cash-releasing efficiency programmes
  - Actions to reduce agency expenditure
  - Investment review principles and processes
  - System wide transformation programme development

8.3 - Finance Position Month 4 2022/23 – overall and organisation specific

Key Messages

- **(£27.8m)** deficit experienced to end of month 4, which is (**£0.4m**) adverse to plan.
- The CCGs (N&N CCG & Bassetlaw CCG) variance **£1.6m** positive variance reflects the final close-down position at the end of month 3 and expected that this would have shown break-even in a normal reporting period.
- The ICB Variance is in line YTD (**£0.2m** adverse variance) with offsetting the CCG final position to show a FY breakeven position combining the CCGs & ICB.
- Net provider position is a (**£1.9m)** adverse variance. Main drivers are covid (**£2.9m**), efficiency shortfall (**£1.9m**) and urgent care capacity above planned levels (**£3.0m**).
- This is offset by **£4.6m** of ESRF income above plan following confirmation from NHSE/I that there would be no clawback of ESRF at M4 & other various small gains **£1.3m.**
- Forecast remains break-even but there are significant risks to delivery, particularly relating to ESRF, Covid efficiency and urgent care capacity requirements.

Month 4 Financial Position						
£'ms	YTD plan	YTD Actuals	Variance	Annual Plan	FOT	Variance
NUH	-20.7	-21.3	-0.6	-12.3	-12.3	0.0
SFH	-3.9	-5.2	-1.3	-4.7	-4.7	0.0
NHT	-1.4	-1.3	0.0	0.0	0.0	0.0
ICB	0.2	0.0	-0.2	1.6	0.0	-1.6
CCGs	-1.6	0.0	1.6	-1.6	0.0	1.6
TOTAL	**-27.4**	**-27.8**	**-0.4**	**-16.9**	**-16.9**	**0.0**

NHT

- Small favourable variance against plan overall.
- (**£0.6m**) adverse variance due to efficiency shortfalls offset by investment slippage leading to pay related underspends with COVID on plan.
- Continuing pressures in non-delivery of the recovery plan, cost per case income, agency costs and energy & PFI inflation.

CCGs/ICB

- The CCGs positions reflect a close-down position which includes a final accounts adjustment.
- ICB in month and forecast is on plan (after the CCG's surplus of **£1.6m** has been factored in).
- Continued pressures on continuing healthcare (**£6.6m**) and interim beds supporting hospital discharge (**£3.2m**), acute contracts (IS & outside system NHS activity) (**£1.5m**) offset by favourable variances in primary care and reserves (slippage).

NUH

- Largest driver of adverse variance is pay (**£7.4m**) relating to enhanced bank and overtime rates (**£1.5m**), COVID costs not stepping down (**£2.6m**), non-delivery of recovery plan schemes (**£1.1m**) and (**£2.2m**) other pressures e.g. ED staffing, car parking staff (re-introduction of barriers) and oncology service growth.
- This is offset by positive variance on income **£5m** mainly relating to ERF income above plan and other non-pay benefits.

SFH

- The YTD position is driven by being unable to closedown winter bed base capacity (**£1.35m**) due to being unable to transfer medically fit patients to the community, slippage in the FIP programme (**£1.25m**) seen in Month 4 & COVID pressure of (**£0.3m**)
- However, this is offset by 4/12ths of ERF income being assumed in Month 4 for the YTD position, which is **£1.3m** favourable to the planned phasing YTD & other gains of **£0.3m.**

8.4 - Finance Position Month 4 2022/23 - Finance Emerging Risks to Financial Delivery

Urgent Care - High levels of MSFT have led to a need to maintain winter capacity, introduce enhanced bank rates and open interim community/care beds. This is the key driver of M4 overspend in the provider organisations at around £3m. **High financial risk**

Mitigation: Interim community beds part-mitigated by D2A funding set aside in the plan (at business case stage). G&A bed capacity exercise demonstrates plans in place to mitigate 251 beds through winter at an indicative cost of £5.2m above planned levels

Efficiency Programme - £21.1m delivered at M4, which is £1.9m adverse to plan. Delivery equates to 21% of total target with 79% phased into last eight months of the year. System wide collation of schemes underway including RAG assessment of plans and expected milestones. **High financial risk given size of target and phasing of delivery**

Covid – Off plan at M4 with £14.9m spent against a plan of £12.3m. However plans assume sharp drop off in spend into the later part of Q2 and specifically in Q3/4 (£1.8m each). **High risk given operational outlook**

Elective Services Recovery Fund – Informed by NHSE/I to assume no clawback of ERF income at M4. This equates to the system being £5m above plans with ERF performance having a large planned step-up in delivery in Q2 and Q3. Should we be able to step up plans in Quarters 3 & 4 this could be an opportunity for improvement. **Moderate risk – significant step-up required but shortfalls may be offset by cost reduction to some extent.**

Additional system risk/Investment Review – £7.8m risk included in ICB plans with primary mitigation through investment review and slippage. Initial ICB-led review has proposed investment reduction of £4.8m. Some of this risk will transfer to providers where costs have been committed. Further savings expected from in-year slippage. **Moderate risk – processes in place to manage but there may be some residual commitments that cannot be mitigated through this process.**

Early adopter CDC revenue income – this continues to be assumed at £8.5m in the forecast. No confirmation of income as yet. Working closely with the regional team to resolve. **Moderate risk – funds remain unconfirmed but communication remains positive with regional and national team.**

Vaccination Programme – Emerging risk with move to cost per vaccine model. **Moderate risk – further understanding of funding mechanisms required.**

Out of area contracting – Agreement of growth and ESRF assumptions remains outstanding with neighbouring systems. Notts is a net importer but with the addition of Bassetlaw the net value is relatively small. As long as agreement of growth/ESRF distribution is consistent across boundaries (which is our assumption) then impact will be small. **Moderate risk – may need regional support to finalise this. Potential issue as Bassetlaw crosses regional boundaries.**

Inflationary costs above plan assumptions – Funding built into plans to offset this. Some pressures seen within Notts Healthcare but currently managed within the position. Potential further pressures into winter. **Low risk at this stage.**

NHS
Nottingham and Nottinghamshire

9.0 System Workforce

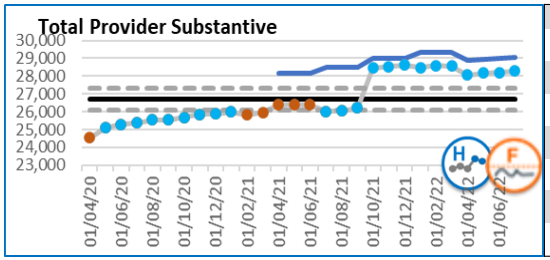
ICS Aims: All 4 (Outcomes, inequalities, productivity and social and economic development)

- 9.1 – Total ICB Provider Workforce
- 9.2– Primary Care Workforce
- 9.3 – Total ICB Provider Workforce KPIs (Vacancy, Turnover & Sickness absence)
- 9.4 – Total ICB Provider Agency & Bank Usage

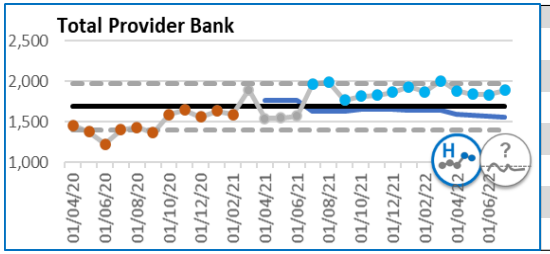
9.1 - Workforce – Total Provider Metrics

NHS Nottingham and Nottinghamshire

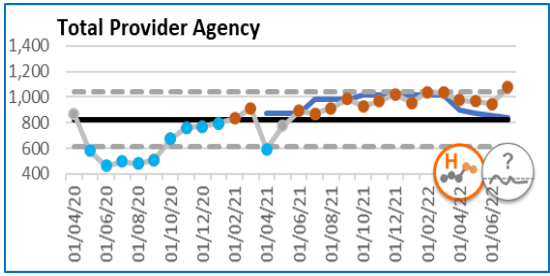
Total ICB Provider Workforce - Operational Plan v Actual 2022/23



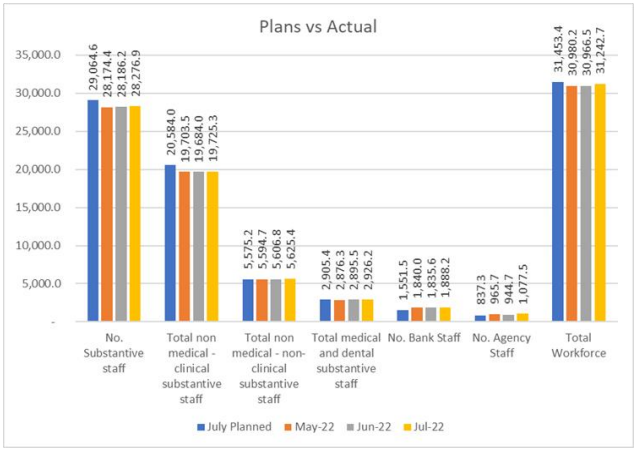
Jul-22
28277
2022-23 Plan
29065
Assurance
Fail
SPC Variation
Improving - High



Jul-22
1888
Target
1552
Assurance
Flip
SPC Variation
Improving - High



Jul-22
945
2022-23 Plan
837
Assurance
Flip
SPC Variation
Concerning - High



Actions

Review of provider recruitment plans as further work needed to recover position on nurse IR targets

Review of provider retention plans, with recruitment to system retention lead in progress to develop oversight, monitoring and support to delivery

Provider Collaborative Resource Group in place with workstreams addressing systems and processes in relation to recruitment, reservist models and development of a Collaborative bank

Joint finance and workforce leads working group developing an understanding of agency usage and spend

Total Provider Current Position

Growth in substantive workforce but below plan

Bank staff utilisation has increased above plan

Agency use increased above plan, continuing run rate seen in quarter 1

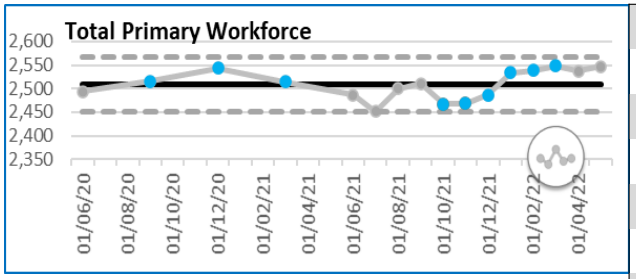
People & Culture Group Assurance - Limited Assurance

Plans are in place with additional interventions put in place which require monitoring to assess impact

9.2 - Workforce – Primary Care Metrics

NHS Nottingham and Nottinghamshire

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



Jun-22
3120
Target
3252
Assurance
SPC Variation
Common Cause

Primary Care- General Practice Nottingham & Nottinghamshire ICS	Baseline Actual Mar-22 wte	2022 Actual Jun-22 wte	Movement wte	2022 Plan Jun-22 wte	Variance with Qte 1 Plan wte
Total Workforce	3089	3120	31	3252	-132
GPs exc Registrars	581	568	-13	584	-16
Nurses	353	353	0	362	-9
Direct Patient Care Roles (ARRS Funded)	333	333	0	384	-51
Direct Patient Care Roles (Non-ARRS Funded)	285	347	62	384	-37
)ther - Admin and no-clinical	1537	1519	-18	1538	-19

Total Primary Care Current Position

Data collection at practice level shows variation sue to unclear definitions on the workforce detail to be recorded. Members of the primary care team are working with the national development team to determine standardisation through clear definitions. The workforce data is therefore indicative data.

Growth in WTE seen but falling below plan

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. The Primary Care Workforce Group has contributed content to the developing Primary Care Strategy with more work to do once clinical models are clearer to assess workforce implications and to develop a workforce plan.

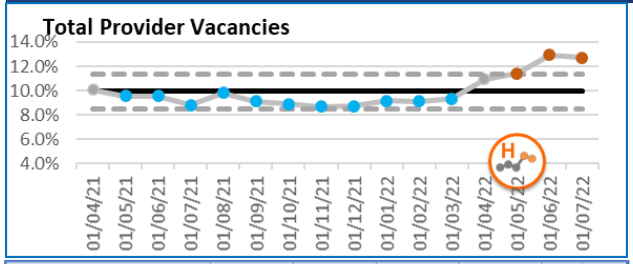
People & Culture Group Assurance – Limited Assurance

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.

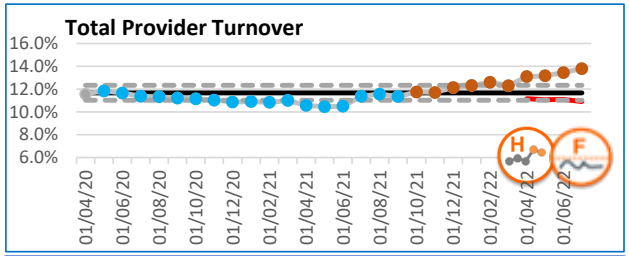
9.3 - Workforce – Key Performance Metrics

NHS Nottingham and Nottinghamshire

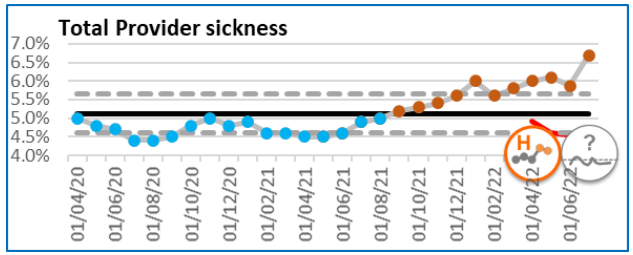
Workforce - Vacancies, Turnover & Sickness Absence



KPI	Latest Period	Target	Actual	Variance	Variation	Assurance
ICS Vacancies	Jul-22	8.7%	12.7%	4.0%		
NHC Vacancies	Jul-22	8.7%	12.9%	4.2%		
NUH Vacancies	Jul-22	8.7%	14.5%	5.8%		
SFH Vacancies	Jul-22	8.7%	4.7%	-4.0%		



KPI	Latest Period	Target	Actual	Variance	Variation	Assurance
ICS Turnover (12 mth)	Jul-22	11.0%	13.8%	2.8%		
NHC Turnover (12 mth)	Jul-22	11.0%	17.5%	6.5%		
NUH Turnover (12 mth)	Jul-22	11.0%	12.9%	1.9%		
SFH Turnover (12 mth)	Jul-22	11.0%	8.7%	-2.3%		



KPI	Latest Period	Target	Actual	Variance	Variation	Assurance
ICS Sickness Absence	Jul-22	4.6%	6.7%	2.1%		
NHC Sickness Absence	Jul-22	4.6%	8.0%	3.4%		
NUH Sickness Absence	Jul-22	4.6%	5.4%	0.8%		
SFH Sickness Absence	Jul-22	4.6%	8.1%	3.5%		

Total Primary Care Current Position

Vacancies:
Slight reduction in vacancies across all three providers in month remaining above plan of 8.7 %

Turnover:
Slight rise in all providers in month remaining above plan of 11.6%

Sickness:
Upturn in sickness absence seen in month aligned to expected covid-19 wave. Daily sit rep positions show this position abating significantly.

Actions

Review of provider recruitment plans, specifically IR.

Review of Provider Retention plans, appointment of retention lead in progress

Total providers continue to have Wellbeing Plans in operation with targeted support from the Staff Mental Health & Wellbeing Hub in Maternity and ED at NUH.
The Staff Mental Health & Wellbeing Hub has increased its accessibility and offers

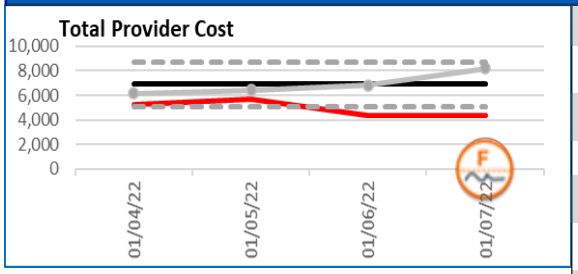
People & Culture Group Assurance – Limited Assurance

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

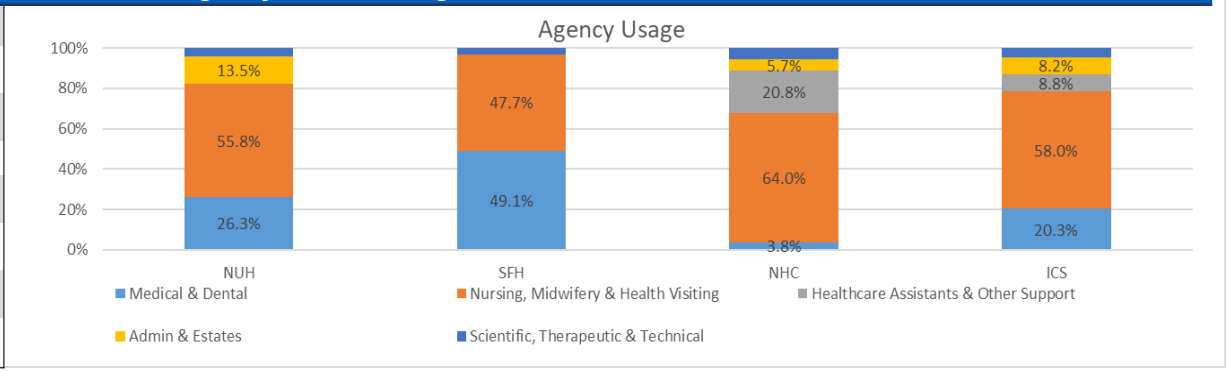
9.4 – Agency & Bank Usage

NHS Nottingham and Nottinghamshire

Total Provider Agency Cost & Usage



Jul-22
£8,215
2022-23 Plan
£4,351
Assurance
Fail
SPC Variation
-



Total Provider Current Position

Agency usage and related spend continues to run above the required run rate to deliver recovery to agency cap levels

Areas of spend varies between providers with overall need being seen in Nursing & Midwifery staff group.

Action

Joint working Group in place with finance and workforce leads with an initial analysis of the usage with additional detail of use on approved framework but above price cap and off framework.

Providers are addressing own internal controls and will work collaboratively on common issues to resolve the position

Correlation around vacancies, turnover and sickness levels will be examined and will feed into further interventions in recruitment and retention plans

People & Culture Group Assurance – Low Assurance

Plans need to be defined a provider and collaborative levels, put into place and measured to assess impact

NHS
Nottingham and Nottinghamshire

10.0 Health Inequalities

ICS Aim 2: Tackle inequalities in outcomes, experience and access

- 10.1 – Embed PHM approach
- 10.2a – Health inequalities dashboard – Metrics by Ethnicity
- 10.2b – Health inequalities dashboard – Metrics by Deprivation
- 10.3 – The 5 in the 'Core20plus5'

10.1 - Embed PHM Approach and Reduce Health Inequalities

NHS Nottingham and Nottinghamshire

10.1.1 The ICS Health Inequalities Group continues to consider and develop equity as a core principle which will be central to the final version of the ICS Health Inequalities Plan alongside the Core20+5 approach. Equity as a core principle will inform the ICS strategy. The Health Inequalities plan will be presented for final sign off during October and November.

10.1.2 The national Core20+5 approach supports the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. Through Place Based Partnership plans, inclusion health groups (PLUS) are identified. Actions are being taken across each of the five clinical areas and in relation to smoking cessation which is across all due to the impact on health inequalities.

10.1.3 Place Based Partnership plans to impact on health inequalities are central to the ICS approach. This includes community champion and engagement programmes which continue to develop following the learning from targeted work to increase the uptake of COVID vaccinations. The community champion and engagement programmes are fundamental and strengthen working with the voluntary sector. are being implemented across and through PBPs are fundamental to the ICS approach to impacting on health inequalities. The ICS Health Inequalities Group received presentations on the progress of these initiatives in the August meeting, with a view to understanding how to provide the strength of knowledge and integration with communities back into provider and ICB planning.

10.1.4 The priorities and action taken through the ICS as an anchor institution are also central to impacting on health inequalities and the wider determinants. During August and September, working groups have been established with all partners in order to inform and establish the priority areas of action.

10.1.5 Equity as a core principle and the Core20+5 approach will be embedded within transformation programmes, supported by clinical and community engagement providing the intelligence required for a targeted approach. The ICS Diabetes Transformation Programme is trialling an equity payment in primary care to support uptake of care processes and treatment targets.

10.1.6 The system continues to progress **prevention programmes**:

- ***ICS Tobacco Dependency Steering Group*** – development of the ICS Tobacco Dependency Strategy, participation in a CLeaR review during Q1 2022/23, which is a deep dive self assessment to inform tobacco control work. Work programmes are underway across maternity, mental health and NHS inpatient services. Through funding from NHSE, a pilot smoking cessation programme is also being implemented specifically for NHS staff, targeting staff groups with higher smoking prevalence.
- ***Nottingham and Nottinghamshire Alcohol Pathways*** group has been established. A priorities work plan has been confirmed which includes alcohol related brain injury as a pathway development. Work has commenced with NUH and Public Health to plan a review of ACT and pathways to community based substance misuse treatment.
- ***Joint Weight Management*** Commissioners meetings between the ICB and Councils have been established and are producing a 2-year roadmap to integrate and align all tiers of commissioning. Service improvements are planned to address long waits for Tier 3 adult service. A proposal has been implemented for personal health budgets in relation to weight management. Children and Young People service development is progressing with consideration of aligning service offers for the whole family approach. Education with PCNs is ongoing to increase the uptake of NHS Digital Weight Management as referrals are below target.

10.2a - Health Inequalities Dashboard – Nottingham and Nottinghamshire Health Inequalities Metrics by Ethnicity

NHS Nottingham and Nottinghamshire

		Ethnicity		
Topic	Metric	Relative Difference in Mean	Trend (2017 - 2021)	Description
Cancer	Cancer morbidity in adults (percent)	0.84	Narrowing	Cancer morbidity in adults is lower in the Black and Asian population compared to the White population. The differences between populations are narrowing overtime.
	Cancer mortality age <75 (per 100,000 pop')	0.72	Steady	Cancer mortality under 75 is lower in the Black and Asian population compared to the White population.
Elderly persons	A&E Attendances age 75+ (per 100,000 pop')	0.91	Widening	A&E attendances over 75 are similar between ethnicity groups.
	Hip fracture NE Admissions age 75+ (per 100,000 pop')	0.51	Narrowing	Hip fracture NE admissions are half as frequent in the Black and Asian population as the White population. The difference between populations is narrowing over time.
H&J Spec Com	Renal morbidity in adults (percent)	1.39	Steady	Renal morbidity in adults is higher in the Black and Asian population compared to the White population,
Healthy people	A&E Attendances in adults (per 100,000 pop')	1.03	Steady	A&E attendances in adults is similar between ethnicity groups.
	All-cause mortality age <75 (per 100,000 pop')	1.10	Narrowing	All cause mortality under 75 is similar between ethnicity groups, differences between groups has narrowed overtime.
	CVD morbidity in adults (percent)	1.11	Steady	CVD morbidity in adults is similar between ethnicity groups.
	Diabetes morbidity in adults (percent)	2.39	Steady	Diabetes morbidity is 2.39 times higher in the Black and Asian population compared to the White population.
	Mortality within 60 days of a stroke (per 100,000 pop')	1.31	Widening	Mortality within 60 days of a stroke is 1.31 times higher in the Black and Asian population compared to the White population. The difference between groups is widening over time.
	Respiratory morbidity in adults (percent)	0.91	Steady	Respiratory morbidity in adults is similar between ethnicity groups.
	T&O Outpatient App. in adults (per 100,000 pop')	0.86	Steady	T&O outpatient appointments in adults are lower in the Black and Asian population compared to the White population.
Maternity & Child	Maternal C-section (per 100,000 pop')	1.65	Widening	Maternal C-section is 1.65 times higher in the Black and Asian population compared to the White population. This difference is widening overtime.
	Maternal post-partum haemorrhage (per 100,000 pop')	1.31	Steady	Maternal post-partum haemorrhage is 1.31 times higher in Black and Asian population compared to the White population.
	Mortality rate for infants aged 0-4 (per 100,000 pop')	9.73	Widening	Mortality rate for infants aged 0-4 is 9.73 times higher in the Black and Asian population compared to the White population. The difference between groups is widening over time.
Mental health	Alcohol related Admissions in adults (per 100,000 pop')	0.31	Widening	Alcohol related admissions are higher in the White population compared to the Black and Asian population. The difference between groups is widening over time.
	IAPT referrals in adults (per 100,000 pop')	0.91	Narrowing	IAPT referrals in adults are similar between ethnicity groups.
	NE Admissions for self-harm age 12+ (per 100,000 pop')	0.43	Widening	Non-elective admissions for self harm aged 12+ are higher in the White population compared to the Black and Asian population. The difference between ethnicity groups is widening over time.
Primary Care	Number of GPs in registered practice (per 1,000 pop')	0.95	Steady	Number of GPs in registered practice are similar between ethnicity groups.
	Number of nurses in registered practice (per 1,000 pop')	0.85	Widening	Number of nurses in registered practice is higher in the White population compared to the Black and Asian population. The difference between groups is widening over time.
	Received first dose of Covid-19 vaccine by 18/07/21 (%)	0.82	N/A	Covid vaccination rates are lower in the Black and Asian population compared to the White population.

The indicators here have been established by the National Commissioning Data Repository (NCDR) which utilises a number of different data sources from across the Healthcare system.

Alongside this data, the ICS local health inequalities dashboard was launched in July 2022. This dashboard presents key metrics aligned to the CORE20Plus5 as well as providing an inequality profile for each area of the ICS.
This information sits alongside the JSNA and other regional and national dashboards. Sub-groups have been established as part of the transformation programme to look at health gain value alongside financial value.

List of ICB Ambitions can be found on the next slide

	Higher Health Inequality in White population
	Higher Health Inequality in Black and Asian population

Data source: *calculations and metrics are from the 'Midlands Health Inequalities Dashboard' available in the 'National Commissioning Data Repository (NCDR)' developed by Arden and Gem. Data sets are obtained from SUS, IAPT, General Practice Workforce and Maternity Services Data Set.*

10.2b - Health Inequalities Dashboard – Nottingham and Nottinghamshire Health Inequalities Metrics by Deprivation

NHS Nottingham and Nottinghamshire

Health Inequalities Metrics				
		Deprivation		
Topic	Metric	RII	Trend (2017 - 2021)	Description
Cancer	Cancer morbidity in adults (percent)	0.97	Steady	Cancer morbidity in adults is similar between most and least deprived populations.
	Cancer mortality age <75 (per 100,000 pop')	2.53	Widening	Cancer mortality under 75 is 2.5 times higher in the most deprived population, and the inequality between groups has been widening over time.
Elderly persons	A&E Attendances age 75+ (per 100,000 pop')	1.86	Steady	A&E attendances over 75 are 1.86 times higher in the most deprived population.
	Hip fracture NE Admissions age 75+ (per 100,000 pop')	1.78	Widening	Hip fracture NE admissions are 1.78 times higher in the most deprived population. The difference between groups has been widening over time.
H&J Spec Com	Renal morbidity in adults (percent)	1.53	Steady	Renal morbidity in adults is higher in the most deprived areas.
Healthy people	A&E Attendances in adults (per 100,000 pop')	1.97	Widening	A&E attendances in adults is higher in more deprived areas and the inequality by deprivation has been widening over time.
	All-cause mortality age <75 (per 100,000 pop')	3.59	Widening	All-case mortality under 75 is 3.59 times greater in more deprived areas, and this inequality is widening over time.
	CVD morbidity in adults (percent)	1.64	Steady	CVD morbidity is 1.64 times greater in more higher areas.
	Diabetes morbidity in adults (percent)	2.37	Steady	Diabetes morbidity is 2.37 times higher in more deprived areas.
	Mortality within 60 days of a stroke (per 100,000 pop')	1.31	Narrowing	Mortality within 60 days of a stroke is 1.31 times higher in the most deprived areas, but the difference between areas has been narrowing over time.
	Respiratory morbidity in adults (percent)	1.76	Steady	Respiratory morbidity in adults is 1.76 times higher in the most deprived areas.
	T&O Outpatient App. in adults (per 100,000 pop')	1.04	Steady	T&O outpatient appointments are similar by deprivations
Maternity & Child	Maternal C-section (per 100,000 pop')	0.97	Steady	Maternal C-section rates are similar by deprivation.
	Maternal post-partum haemorrhage (per 100,000 pop')	0.80	Steady	Maternal post-partum haemorrhage is lower in more deprived population.
Mental health	Alcohol related Admissions in adults (per 100,000 pop')	6.26	Narrowing	Alcohol related admissions are 6.26 times higher in the most deprived populations, but this difference is narrowing over time.
	IAPT referrals in adults (per 100,000 pop')	0.88	Steady	IAPT referrals in adults are lower in more deprived areas.
	NE Admissions for self-harm age 12+ (per 100,000 pop')	3.15	Narrowing	Non-elective admissions for self harm aged 12+ are 3.15 times higher in more deprived areas. The difference between areas is narrowing over time.
Primary Care	Number of GPs in registered practice (per 1,000 pop')	0.86	Steady	Number of GPs in registered practices are higher in less deprived areas.
	Number of nurses in registered practice (per 1,000 pop')	0.94	Steady	Number of nurses in registered practice is similar by deprivation
	Received first dose of Covid-19 vaccine by 18/07/21 (%)	0.78	N/A	Covid vaccination rates are lower in more deprived areas.

Higher Health Inequality in Least Deprived population

Higher Health Inequality in Most Deprived Population

Calculations and metrics are from the 'Midlands Health Inequalities Dashboard' available in the 'National Commissioning Data Repository (NCDR)' developed by Arden and Gem. Data sets are obtained from SUS, IAPT, General Practice Workforce and Maternity Services Data Set.

10.3 Tackling Health Inequalities – The 5 in the 'Core20Plus5'

NHS Nottingham and Nottinghamshire

ICS Smoking Rates: City: 20.6% (2018) County: 14.4% (2019)

	Maternity Ensuring continuity of carer for 75% of women from BAME communities and the most deprived groups		**Severe Mental Illness (SMI)** Ensuring annual health checks for 60% of those living with SMI		**Respiratory** A clear focus on COPD driving uptake of flu, COVID and pneumonia vaccs		**Cancer** 75% of cases diagnosed at stage 1 or 2 by 2028		**Hypertension** To allow for interventions to optimise BP and minimise the risk of M.I. and stroke	
Key Stats	• Maternal mortality is more than 4x higher in black women, 2x higher for mixed ethnicity women and 2x as high for Asian women. Stillbirths and infant mortality are highest amongst Pakistani and Black ethnicities. NUH has a high percentage of BAME mothers. • A higher proportion than the national average of mothers are from the most deprived areas • 15.6% mother present as smokers at time of booking across the ICS, 12.8% self report as smokers at time of delivery - worse than the England average across every district in the ICS.		• People with a SMI on avg have 15 to 20 years shorter life expectancy • Premature mortality in adults with SMI is much higher in Nottingham than the England Average. • Smoking prevalence is 24.5% in Nottingham and 20.7% in Notts. • The ICS is targeted to undertake 6,237 SMI health checks for 2022/23. 12 month performance currently sits at 41% of this target. Although performance has increased since 2021/22, it has plateaued in Q1 2022/23, this is now similar to the regional average but slightly below national average.		• 2% of the total ICS population have a diagnosis of COPD. The highest rates are in Bassetlaw and Mid-Notts. • Nottingham City has the lowest prevalence of COPD but has higher COPD emergency hospital admissions than the rest of the ICS and is higher than the regional and national averages. • Uptake of the flu and covid vaccines is lower in the most deprived areas but also amongst BAME communities, regardless of deprivation quintile. • 33% of COPD patients across the ICS are smokers, 41% of COPD patients in Nottingham City are smokers.		• 20/21 saw an improvement with approx 30% of cancers diagnosed at an early stage. • In Nottinghamshire as whole, under 75s mortality rate from cancer is similar to the England average, however in Mansfield and Ashfield it is significantly worse. • Under 75 mortality rates from cancer in Nottingham City is also significantly worse than the England average and the worst in the East Midlands Region.		• Approximately 14.4% of the N&N population have a hypertension diagnosis. • 64.2% of expected cases have been diagnosed. Target is 80% by 2029. • 71.5% of hypertension cases are treated optimally. Target is 80% by 2029. • Hypertension is more prevalent in areas of higher deprivation in the ICS. Those from Black backgrounds are twice as likely to be diagnosed with hypertension than those from White backgrounds.	
Metrics	1. Continuity of carer for BAME communities. Target 75% by 2022/23 2. Smoking status at time of delivery. Target 6%, England average 9%. 3. Pre-term births. Target 6% by 2025.	**System Level Outcomes** SLO-16 SLO-14 SLO-04 SLO-06 SLO-07 SLO-03	1. Number of Physical health checks completed for people with SMI. Target 6,237 checks for 2022/23. 2. Covid vaccinations given to people with SMI 3. % of patients admitted to hospital under mental health offered tobacco treatment	**System Level Outcomes** SLO-01 SLO-02 SLO-10 SLO-07 SLO-12 SLO-14 SLO-19	1. Number of self management plans in place for COPD Patients 2. Number of referrals to Pulmonary Rehab & number of programmes completed 3. Covid vaccine uptake, Flu Vaccine uptake, Pneumonia vaccine uptake	**System Level Outcomes** SLO-01 SLO-02 SLO-18 SLO-10 SLO-09 SLO-11 SLO-13 SLO-07	1. Lung Health Checks	**System Level Outcomes** SLO-01 SLO-11 SLO-12	1. Expected no. of people to be diagnosed with hypertension. Target 80% by 2029 2. Patients with hypertension optimally treated. Target 80% by 2029 3. Stroke admissions	**System Level Outcomes** SLO-01 SLO-02 SLO-09 SLO-12 SLO-14
Current Attainment	1. 14.4% (3months end of Aug. 21 - Discontinued) 2. 12.8% (May 21 –May 22) 3. 7.6% (March 21 – March 22)		1. 3,435 completed June 21 – June 22 2. 1st Dose: 80.47%, 2nd Dose: 77.42%, Booster: 62.53% 3. N/A – not yet available		1. 73% Self management plans. 66% received annual review 2. 51.2% offered PR. Completion rates in City: 65% County: 65% 3. C: 71.2% (BAME communities low), F: 57.9%, Pn: City: 70.3% / County: 74.2%		1. N/A – Data not yet available		1. 64.2% 2. 71.5% 3. N/A – Data not yet available	

NHS
Nottingham and Nottinghamshire

Appendices

i – ICS Assurance Escalation Framework

ii - Key to Variation and Assurance Icons (SPC)

iii - Glossary of Terms

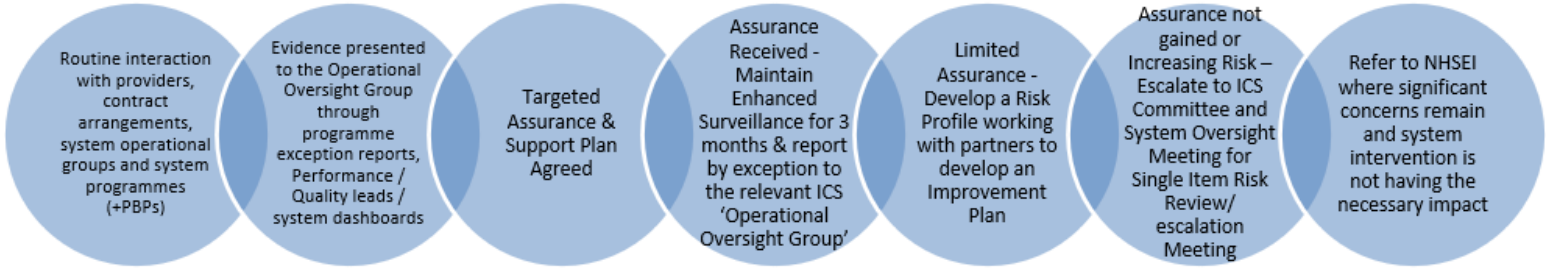
NHS Nottingham and Nottinghamshire

i – ICS Assurance Escalation Framework

Each key deliverable programme or oversight group will propose a level of assurance, aligned to **the assurance escalation framework**, following discussion of reported metrics and key milestones at each group. This approach is still being developed and rolled out across the ICB. The 4 levels are as follows:

Significant Assurance	Partial Assurance	Limited Assurance	No Assurance
1. Routine	2. Further Information Required	3. Enhanced	4. Escalated Risk
What does this mean? What is the assessment of risks to delivery / quality			
No Specific areas of concern identified	Potential for concern. Key milestones not achieved. More information required to determine level of risk	Delivery or quality concerns identified	Serious, specific risk to delivery or quality identified, including where there is a need to act rapidly to protect patients or staff
What actions may be taken by the relevant 'Operational Oversight Group' in response to this assessment			
Actions to be taken by Relevant Operational Oversight Group	Agree route to follow up to gain necessary information to assess risk and agree who will lead	Agree actions, and schedule for discussion at each 'Operational Oversight Group' until concerns are resolved	Trigger Escalation Review/ Deep Dive / Risk Summit

Evidence Based Assurance Process



NHS Nottingham and Nottinghamshire

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)		
	L H	L H	?	P	F
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

NHS
Nottingham and Nottinghamshire

iii – Glossary of Terms

Acronym	Meaning	Acronym	Meaning	Acronym	Meaning	Acronym	Meaning
A&E	Accident & Emergency	FD	Finance Director	NHSE	NHS England	SLA	Service Level Agreement
A&E	Accident & Emergency Delivery Board	FOT	Forecast Out-Turn	NHT / NHC	Nottinghamshire Healthcare NHS Trust	SMI	Severe Mental Illness
AMH	Anit-Mullerian Hormone	G&A	General & Acute	NICE	National Institute for Health & Care Excellence	SOF	System Oversight Framework
BAU	Business as Usual	GI	Gastro-intestinal (referred to as Upper GI or Lower GI)	NNICB	Nottingham & Nottinghamshire ICB	SOP	Standard Operating Procedure
Blaw	Bassetlaw	HEE	Health Education England	NRC	National Rehabilitation Centre	SPC	Statistical Process Control
BLM	Back-log Maintenance	HFID	Hospital First Integrated Discharge	NUH	Nottingham University Hospitals	SRO	Senior Responsible Officer
CAMHS	Child & Adolescent Mental Health Services	HLE	Healthy Life Expectancy	OAPs	Out of Area Placements	TIF	Targeted Investment Fund
CCG	Clinical Commissioning Group	IAPT	Improving Access to Psychological Therapies	OBD	Occupied Bed Days	UEC	Urgent & Emergency Care
CDC	Community Diagnostic Centre	IBN	Information Breach Notice	OOA	Out of Area	UTC	Urgent Treatment Centre
CDEL	Capital Departmental Expenditure Limits	ICATT	Intensive Community Assessment & Treatment Teams	OP	Out Patients	WTE	Whole Time Equivalents
CDU	Clinical Decision Making Unit	ICB	Integrated Care Board	PBP	Place Based Partnerships	YOC	Year of Care
CHC	Continuing Health Care	ICP	Integrated Care Partnership	PCIT	Primary Care Information Technology	YTD	Year to Date
CoP	Court of Protection	ICS	Integrated Care System	PCN	Primary Care Networks		
CT	Computed Tomography	IPC	Infection prevention control	PFDS	Public Facing Digital Services		
CV	Contract Variation	IR	Identification Rules	PFI	Private Finance Initiative		
CYP	Children & Younger People	IS	Independent Sector	PHM	Population Health Management		
D2A	Discharge to Assess	JSNA	Joint Strategic Needs Assessment	PHSMI	Physical Health check for Severe Mental Ill patients		
DC	Day Case	KMH	Kings Mill Hospital	PICU	Psychiatric Intensive Care Unit		
DDAT	Digital, Data, Analytics and Technology	LD	Learning Disabilities	PID	Project Initiation Document		
DHSC	Department of Health and Social Care	LD&A	Learning Disabilities & Autism	PIFU	Patient Initiated Follow Ups		
DST	Decision Support Tool	LINAC	Linear Accelerator	POD	Prescription Ordering Direct		
DTT	Diagnosis to Treatment Time	LoS	Length of Stay	PoD	Point of Delivery		
EBUS	Endobronchial Ultrasound	MHIS	Mental Health Investment Standard	PTL	Patient Targeted List		
ED	Emergency Department	MHST	Mental Health Support Team	QDCU	Queens Day Case Unit		
EIP	Early Intervention Psychosis	MNR	Maternity & Neonatal Redesign	QMC	Queens Medical Centre		
EL	Electives	MOU	Memorandum of Understanding	R&D	Research & Development		
EMAS	East Midlands Ambulance Service NHS Trust	MRI	Magnetic Resonance Imaging	R&I	Research & Innovation		
EMCA	East Midlands Cancer Alliance	MSFT	Medically Safe for Transfer	RAG	Red, Amber & Green		
EMNNODN	East Midlands Neonatal Operational Delivery Network	N&N	Nottingham & Nottinghamshire	RTT	Referral to Treatment Times		
EOL	End of Life	NEL	Non-Electives	SDMF	Strategic Decision Making Framework		
ERF	Elective Recovery Funding	NEMS	Nottinghamshire Emergency Medical Services	SEG	System Executive Group		
ESRF	Elective Services Recovery Funding	NHP	New Hospitals Programme	SFH	Sherwood Forest Hospitals Foundation Trust		

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	08/09/2022
Paper Title:	**Board Assurance Framework**
Paper Reference:	ICB 22 026
Report Author:	Siân Gascoigne, Head of Corporate Assurance
Report Sponsor:	Rosa Waddingham, Director of Nursing
Presenter:	Lucy Branson, Associate Director of Governance
Recommendation(s):	The ICB Board is asked to: • **APPROVE** the ICB's strategic risks to enable the full development of the 2022/23 Board Assurance Framework. • **NOTE** the development timeline and future monitoring and reporting arrangements for the Board Assurance Framework.

Summary:

A fundamental aspect of the ICB's governance structure is the establishment and implementation of sound risk management arrangements. The effective design and embedment of these arrangements will ensure that the Board is kept informed of the key risks facing the ICB, and the wider system, and assured that robust management actions are in place to manage and mitigate them.

At its inaugural meeting on 1 July 2022, the Board approved the ICB's Risk Management Policy and recognised that risk management arrangements will need to continue to be developed throughout the remainder of the financial year. In particular, in relation to the establishment of system risk management arrangements.

This paper presents 15 strategic risks for the ICB for review and approval, which have been identified as a result of an Executive-led exercise to determine the strategic risks to achieving the ICB's four core aims. Once approved, these strategic risks will be used as the basis for developing the full 2022/23 Board Assurance Framework.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	The Board Assurance Framework is a structured way of identifying and mapping the main sources of assurance in support of the achievement of the ICB's four 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: Proposed 2022/23 strategic risks
Appendix B: Alignment of system partner BAF risks
Appendix C: ICB Board Assurance Framework template

Board Assurance Framework:
This paper presents the ICB's strategic risks to enable the full development of the 2022/23 Board Assurance Framework.

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

Report Previously Received By:
Draft ICB strategic risks have been agreed by the Executive Management Team.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Board Assurance Framework

Introduction

1. A fundamental aspect of the ICB's governance structure is the establishment and implementation of sound risk management arrangements. The effective design and embedment of these arrangements will ensure that the Board is kept informed of the key risks facing the ICB and the wider system and assured that robust management actions are in place to manage and mitigate these risks.
2. At its inaugural meeting on 1 July 2022, the Board approved the ICB's Risk Management Policy, including an initial risk appetite statement. At this time, the Policy's fitness for purpose was confirmed, whilst also recognising that risk management arrangements will need to continue to evolve throughout the remainder of the financial year. In particular, the arrangements relating to the management of system risk.
3. This paper presents the ICB's proposed strategic risks for review and approval, which will be used as the basis for the 2022/23 Board Assurance Framework. Recognising that this is an atypical year for the ICB, a timeline for development of the full Board Assurance Framework and future monitoring and reporting arrangements is also included for information.

Background information

4. The ICB's risk management arrangements consist of two key elements; strategic risk management and operational risk management.
5. ***Strategic risk management*** – these processes are centred on the Board Assurance Framework, which is a structured way of identifying and mapping the main sources of assurance in support of the achievement of the ICB's aims/objectives. The Assurance Framework provides the Board with confidence that what needs to be happening is happening in practice. More specifically it enables the Board to:
    a) Gain a clear and complete understanding of the control environments that have been established to manage its strategic risks.
    b) Consider the types of assurance currently obtained and whether they are effective and efficient.
    c) Identify areas where assurance activities are not present or are insufficient (i.e. assurance gaps), or where assurances may be duplicated or disproportionate (i.e. where there is scope for efficiency gains or reduction of duplication of effort).

d) Identify areas where existing controls are failing (i.e. control gaps), and consequently, the risks that are more likely to occur.

6. ***Operational risk management*** – these processes focus on the dynamic identification and management of the operational risks that are currently being faced in relation to the execution of strategies and plans, the delivery of functions, or in meeting statutory duties.

7. Operational risks are recorded and monitored via the ICB's Operational Risk Register (ORR), with oversight and scrutiny of relevant risks being undertaken by the Board's committees in line with their remits. High or extreme operational risks (risk scores 15+) will also be routinely reported to the Board as part of its committees' highlight reports.

8. The Audit and Risk Committee will receive a comprehensive update in relation to the ICB's operational risk management arrangements at its meeting on the 15 September. The paper will provide assurance on the work being undertaken to establish and embed risk management arrangements for the ICB, and the early work that has been undertaken to develop system risk management arrangements. This paper will also incorporate the full ICB Operational Risk Register (ORR) to enable the ICB to formally 'receive' all risks inherited from the former NHS Bassetlaw and NHS Nottingham and Nottinghamshire CCGs.

2022/23 strategic risks

9. An Executive-led exercise has been undertaken to identify the strategic risks to achieving the ICB's four core aims to:

   a) Improve outcomes in population health and healthcare.

   b) Tackle inequalities in outcomes, experience, and access.

   c) Enhance productivity and value for money.

   d) Help the NHS support broader social and economic development.

10. This has identified 15 strategic risks as set out at Appendix A, which also reflect the ICB's statutory duties and its new responsibilities in relation to system working.

11. Early discussions have been held with system partners regarding benefits in aligning strategic risks across organisations, where possible and as appropriate. It is important to recognise that the unitary boards of each statutory NHS partner organisation within the ICS will continue to have their own individual Board Assurance Frameworks, and there may be a differential approach to these by the respective organisations in line with their roles, responsibilities and requirements of individual Boards. Nevertheless, with the move towards more collaborative working, the importance of having some

alignment of key strategic risks across partners is vital for successful system working.

12. An exercise has been undertaken to determine the current level of alignment of strategic risks within the Board Assurance Frameworks for the ICB, Nottingham University Hospitals NHS Trust (NUH), Sherwood Forest Hospitals NHS Foundation Trust (SFH), Nottinghamshire Healthcare NHS Foundation Trust (NHCT) and East Midlands Ambulance Service NHS Trust (EMAS). Engagement with Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust is ongoing.

13. As expected, the narrative of the strategic risks is described in line with the roles and statutory responsibilities of each individual organisation; however, there is a great deal of consistency across the strategic risk 'topics'. There is also some alignment of the highest scoring risk areas. Further detail in relation to this exercise, which has been shared with system partners, is provided at Appendix B.

Next steps and timeline

14. Subject to Board agreement of the ICB's proposed strategic risks, work will now be completed with the Executive risk owners to fully develop the Board Assurance Framework. For information, Appendix C outlines the proposed Board Assurance Framework template and how to read its component parts.

15. The fully developed Board Assurance Framework will be presented to the Board in the form of mid-year and year-end position statements. These will be presented slightly later than in a typical year, given the national deferral of ICB establishment until 1 July. Future Board Assurance Framework reports will summarise movement in the strategic risks using a 'heat map' approach.

16. A programme of Executive-led targeted assurance reports will also be scrutinised by the Audit and Risk Committee in-year. The targeted assurance reports enable a focussed review of specific sections of the Board Assurance Framework and allow for robust discussions on the actions in place to remedy any identified gaps in controls and assurances.

Appendix A – Proposed 2022/23 Strategic Risks

Strategic risk	Risk Owner	Initial Risk Score *(I x L)*
Risk 1: Health Inequalities and Outcomes – Failure to adequately address health inequalities and improve health outcomes for the population of Nottingham and Nottinghamshire.	Medical Director	High (5 x 3)
Risk 2: System Resilience (for Managing Today) – Failure to work effectively across the system to ensure current levels of demand are met across primary, community and secondary care.	Director of Integration	High (5 x 4)
Risk 3: Transformation (for Making Tomorrow Better) – Failure to work effectively across the system to reform and improve services to ensure best possible health outcomes within available resources.	Director of Integration / Medical Director	High (5 x 3)
Risk 4: System Development (for Developing the ICS) – Failure to develop thriving 'Places' and Provider Collaboratives to ensure the best possible health outcomes for the population of Nottingham and Nottinghamshire.	Director of Integration	High (4 x 4)
Risk 5: Quality Improvement – Failure to maintain and improve the quality of services. *For 2022/23, this specifically includes the need to improve the quality of maternity services across the system.*	Director of Nursing	High (5 x 4)
Risk 6: Citizen Voice – Failure to effectively work in partnership with citizens and communities.	Chief Executive	Medium (4 x 3)
Risk 7: People and Culture – Failure to ensure sufficient capacity and capability within the local workforce.	Director of Nursing	High (5 x 4)
Risk 8: Financial Sustainability – Failure to establish a shared culture of financial stewardship to ensure financial sustainability across the system.	Director of Finance	High (4 x 4)
Risk 9: Allocation of Resources – Failure to establish robust resource allocation arrangements across the system (revenue and capital).	Director of Finance	High (5 x 3)
Risk 10: Digital Transformation – Failure to deliver digital transformation and establish effective system intelligence solutions.	Medical Director	High (5 x 3)
Risk 11: Emergency Preparedness, Resilience and Response – Failure to be adequately prepared to respond to major and/or business continuity incidents.	Director of Integration	Medium (5 x 2)
Risk 12: Equality, Diversity and Inclusion – Failure to comply with the general and specific Public Sector Equality Duties.	Director of Nursing	High (5 x 3)
Risk 13: Safeguarding – Failure to safeguard children and vulnerable adults in accordance with legislative and statutory frameworks and guidance.	Director of Nursing	Medium (5 x 2)
Risk 14: Environment Sustainability – Failure to effectively deliver on the green plan.	Director of Finance	Medium (4 x 3)
Risk 15: Research and Evidence – Failure to effectively utilise research and evidence to inform decision-making.	Medical Director	Medium (4 x 3)

Appendix B – Alignment of System Partner BAF Risks

ICB	NUH	SFH	NHCT	EMAS
Health inequalities and outcomes (15)				
People and culture (20)	People (recruitment, retention and training) (20)	Workforce capacity and capability (12)	People and culture (skillset / experience/ equality and diversity) (16)	Workforce (recruitment, training and diversity) (20) / Workforce wellbeing (16) / Development of clinical model (16)
Digital transformation (15)	Infrastructure (physical and digital) (20)		Infrastructure (estate, digital, green plan and capital) (12)	Estate, infrastructure and technology (16)
Quality improvement (20)	Patients (experience and outcomes) (16)	Standards and safety of care (16)	Standards and safety of care (16)	Inability to deliver a safe service (25)
Financial sustainability (16) / Allocation of resources (15)	Financial stability (16)	Financial strategy (16)	Financial sustainability (16)	Financial targets (20) / Financial settlement (20) / Impact of external factors on supply chain costs (12)
Transformation (for making tomorrow better) (15)	Governance and strategy (16)	Working with health partners (6)	Partnership working across health and social care (12)	Transformation of UEC services (9) / Service development (16)
Research and evidence (12)	Research and education (16)	Evidence-based improvement and innovation (9)	Innovation and transformation (8)	

Appendix B – Alignment of System Partner BAF Risks

ICB	NUH	SFH	NHCT	EMAS
System resilience (for managing today) (20)		Demand and capacity (16)		Failure to meet demand and response standards (20)
EPRR (10)		Major incident (12)		Cyber threats / data loss (12)
Environmental sustainability (12)		Environmental sustainability (9)	*See infrastructure risk above	Failure to meet green plan (12)
System development (for developing the ICS) (15)			Commissioning and provider collaborative (12)	Capacity and capability to develop collaboratives with partners (12)
Citizen voice (12)				Stakeholder engagement and quality improvement (16) / Public communication (16)
Equality, diversity and inclusion (15)			*See people and culture risk above	Diversity and inclusion (16)
Safeguarding (12)				

Appendix C – Board Assurance Framework template

How to read the Board Assurance Framework