Integrated Care System Board
Meeting held in public

Friday 12 July 2019, 09:00 – 12:00
Rufford Suite, County Hall, Nottingham

AGENDA

	Time	Agenda Items	Paper	Lead	Action
1.	09:00	Welcome and Introductions:	Verbal	Chair	To note
2.	09:05	Conflicts of Interest	Verbal	Chair	To note
3.	09:10	Minutes of 13 June 2019 ICS Board meeting and action log	Paper A1-2	Chair	To agree
4.	09:15	Patient Story – End of Life Care	Paper B1	Carl Ellis	To discuss
Outcomes Framework, Prevention and Inequalities					
5.	09:30	ICS Outcomes framework	Paper C1-2	Wendy Saviour	To discuss
Strategy and System Planning					
6.	10:00	ICS Strategy / Five Year Plan: IM&T, digitalisation and analytics	Paper D	Andrew Haw	To agree
7.	10:15	Update from ICPs: • City – to discuss • South – to note • Mid – to note	Paper E	Ian Curryer	To discuss
8.	10:20	Review of available resource for ICP and PCN development	Paper F	Amanda Sullivan	To agree
Short break					
Oversight of System Resources and Performance Issues (including MoU)					
9.	10:40	Performance deep dive – Cancer	Paper G1-3	Richard Mitchell	To discuss
10.	11:00	ICS Integrated Performance Report - Finance, Performance & Quality. Escalated issues: • Urgent Care System delivery	Paper H1-3	Wendy Saviour / Helen Pledger	To discuss

	Time	Agenda Items	Paper	Lead	Action
		• Mental Health OAPs • Financial Sustainability • Cancer Services Delivery • MOU Review Letter			
11.	11:15	ICS Financial Framework - ICP Plans for Flexible Transformation Funding	Paper I1-4	Helen Pledger	To agree
Governance					
12.	11:30	Revised ICS Board Assurance Framework and Risk Register	Paper J	Elaine Moss	To agree
12:00 Close					

Date of the next meeting:
8 August 2019, 9:00 – 12:00, Rufford Suite, County Hall

Integrated Care System Board meeting
Thursday 13 June 2019, 09:00 – 12:00
Rufford Suite, County Hall, Nottingham
Meeting held in public

Draft minutes

Present:

ICS Board members	ORGANISATION
Amanda Sullivan	Accountable Officer, Nottinghamshire CCGs
David Pearson	ICS Chair
Eric Morton	Chair, Nottingham University Hospitals NHS Trust
John Brewin	Chief Executive, Nottinghamshire Healthcare NHS FT
John MacDonald	Chair, Sherwood Forest Hospitals NHS FT
Jon Towler	Lay Member, Nottinghamshire CCGs
Melanie Brooks	Corporate Director Adult Social Care and Health, Nottinghamshire County Council
Richard Mitchell	Chief Executive, Sherwood Forest Hospitals NHS FT

In Attendance:

Alex Ball	Director of Communications and Engagement, Nottinghamshire ICS
Alison Wynne	Director of Strategy and Transformation, Nottingham University Hospitals Trust
Andy Haynes	Clinical Director, Nottinghamshire ICS
Colin Monckton	Director of Strategy and Policy, Nottingham City Council
Deborah Jaines	ICS Deputy Managing Director
Helen Pledger	Finance Director, Nottinghamshire ICS
Nicole Atkinson	Clinical Lead from Greater Nottingham Clinical Chair, Nottingham West CCG
Richard Stratton (up to and including Item 9.)	Clinical Lead from Greater Nottingham GP, Belvoir Health Group
Rebecca Tryner	Business Support Officer, Nottinghamshire CCGs (Minutes)
Thilan Bartholomeuz	Clinical Lead from Mid Nottinghamshire Clinical Chair, Newark and Sherwood CCG
Wendy Saviour	ICS, Managing Director
Cllr. Eunice Campbell-Clark	Chair, Nottingham City Health and Wellbeing Board
Cllr. Tony Harper	Chair, Nottinghamshire County Council Adult Social Care and Health Committee
Cllr. Steve Vickers	Chair, Nottinghamshire County Health and Wellbeing Board

Chris Schofield / Sajidah Munir / Nick Page (for Item 4.)	CS – Nottinghamshire Healthcare NHS FT SM – Former patient NP – General practitioner
Duncan Hanslow/Angela Potter (for Item 7.)	Programme Directors Nottinghamshire ICS Clinical Services Strategy Workstream
Mike Hannay and Suzanne Horobin (for Item 6.)	East Midlands Academic Health Science Network
Dr Stephen Shortt (for Item 9.)	Clinical Chair, Rushcliffe CCG

Apologies:

Dean Fathers	Chair, Nottinghamshire Healthcare NHS FT
Elaine Moss	Chief Nurse, Nottinghamshire CCGs and ICS
Gavin Lunn	Clinical Lead from Mid Nottinghamshire Clinical Chair, Mansfield and Ashfield CCG
Ian Curryer	Chief Executive, Nottingham City Council
Richard Henderson	Chief Executive, East Midlands Ambulance Service
Tom Diamond	ICS, Director of Strategic Planning
Tracy Taylor	Chief Executive, Nottingham University Hospitals Trust
Sheila Wright	Non-Executive Director Nottinghamshire Healthcare NHS FT

1. **Welcome and introductions**

Apologies received as noted above. DP welcomed all present to the meeting, particularly the new members of the Board; Cllr. Eunice Campbell-Clark, Cllr. Steve Vickers and Cllr. Tony Harper.

DP thanked the outgoing Board members, Anthony May (now represented by Melanie Brooks), Cllr. Stuart Wallace, Cllr. Sam Webster and Cllr. John Doddy, for their contributions to the Board.

2. **Conflicts of Interest**

No conflicts of interest in relation to the items on the agenda were declared.

3. **Minutes of 9 May 2019 and Action log**

The minutes of the ICS Board meeting held on 9 May 2019 were agreed as an accurate record of the meeting by those present. The action log was noted.

4. **Patient story – Persistent Physical Symptoms. Primary Care Psychological Medicine**

Chris Schofield, Sajidah Munir and Nick Page joined the meeting to present on the Persistent Physical Symptoms Service.

CS outlined the Persistent Physical Symptoms Service, which had been running as a pilot across Rushcliffe CCG. Members heard a powerful patient story which illustrated how the service had had a positive impact on the outcomes of a patient with complex persistent physical symptoms. In addition to the impact seen by patients and their families, the service also facilitated greater GP and patient understanding, reduced ED attendances and emergency admissions and realised financial savings.

TB noted that it was helpful to bring successful services and schemes, such as this, through the ICS Board as there was potential to roll them out across other PCNs, subject to the demand drivers of the local population.

The ICS Board noted the patient story and thanked Chris Schofield, Sajidah Munir and Nick Page for their presentation.

Outcomes Framework, Prevention and Inequalities

5. Personalised care – lessons learnt and sustainability

AS reported on the actions being taken to ensure that personalisation was sustainably included within commissioning plans. A piece of work was being progressed with Nottingham Trent University to develop a mechanism for benefits realisation for looked after children leaving care, which will be incorporated into plans for a shared children commissioning service to ensure provision going forward. This will either be led by the Joint Childrens and Young People Hub or the CCG Commissioning Team.

Joint work between the CCG and Nottinghamshire County Council was being taken forward to develop a toolkit around personalisation. In 2019/20 there will also be an increase in personal budgets across fast track packages of care for children with complex needs.

Strategy and System Planning

6. ICS and East Midlands Academic Health Science Network – innovation and research

Mike Hannay attended the meeting to present an opportunity for the ICS to further collaborate with the East Midlands Academic Health Science Network (EMAHSN) to embed a more consistent and strategic approach to research and innovation. Members noted the EMAHSN's portfolio of projects and those that were deployed, partially deployed or not deployed across Nottinghamshire.

The Board discussed the presentation and noted the following:

- The requirement for the ICS Board to sponsor and encourage the adoption and implementation of existing innovations

- The importance of understanding which innovations will help the ICS to address the current workforce challenges
- The need to fully understand the full revenue consequences of the innovations
- The need for the ICS to set the direction of travel for innovation and clearly direct ICPs to deliver.

AH agreed to coordinate an information exchange with representatives from the EMAHSN, ICPs and other interested parties, to take oversight of the proposed innovations and fully understand any impact on workforce and associated costs.

The Board agreed in principle to support the full deployment of innovations across the ICS, subject to the outcomes of the information exchange.

ACTIONS:
AH to coordinate an information exchange with representatives from the EMAHSN, ICPs and other interested parties, to take oversight of the proposed innovations and fully understand any impact on workforce and associated costs.
AH to provide an update on progress to the ICS Board in August 2019.

7. Draft Acute, Community and Primary Care Clinical Services Strategy

NA, DH and AP presented the Draft Acute, Community and Primary Care Clinical Services Strategy.

The presentation outlined the approach to the development of the strategy, alignment with other ICS work programmes and the high level clinical model, which was predicated on a health continuum throughout the lifespan with a focus on prevention. So far six services have been prioritised for detailed consideration and development. Next steps will include the undertaking of further service reviews to cover the breadth of service areas in the ICS. Transformation proposals will be expected from each of these reviews to include the system level impact on capacity, demand and finance.

The Board discussed the strategy and noted the following:

- The need to build momentum and demonstrate that progress was being made, acknowledging that some pieces of work will take longer to complete
- The importance of ensuring consistency with best practice and embedding successful innovations across the Nottingham and Nottinghamshire system
- The need for those engaged in the development of the strategy to ensure that the patients benefits of the proposed changes were clearly articulated.

The ICS Board supported the proposed next steps noting the importance of identifying some key priorities to now take forward at pace.

8. Draft Primary Care Strategy

NA presented the Draft Nottingham and Nottinghamshire ICS Primary Care Strategy, which responded to the Long Term Plan and formed part of the process for the

allocation of General Practice Forward View funding. The final draft of the strategy will be submitted to NHS England and NHS Improvement (NHSE/I) on 19 June 2019.

The Board noted that a working group had been established to undertake further work on the strategy, particularly in relation to primary care workforce, population health management, finance and the commissioning intentions for primary care.

The Board suggested that the case for change section be strengthened to be more explicit around the areas that will be a main focus for patients, such as access, and to aim for 100% engagement from primary care clinicians as this will be one of the keys to successful Primary Care Networks.

The ICS Board supported the draft Primary Care Strategy and agreed for WS and AS to oversee the sign-off process ahead of submission on 19 June 2019.

ACTIONS:
ICS Board Members to feedback any comments on the draft Primary Care Strategy to ICS@nottscc.gov.uk by 5.00pm on 14 June 2019.

9. Confirmation of the Primary Care Network Configurations for Nottingham and Nottinghamshire

Stephen Shortt joined the meeting to support the discussion around the Primary Care Network (PCN) Configurations for Nottingham and Nottinghamshire.

NA presented a paper which outlined the confirmed PCNs for Nottingham and Nottinghamshire, the PCN Clinical Directors and the rationale behind the different PCN configurations. NHS England guidance on the establishment of PCNs had been emergent with guidance on potential models being issued up to and including May 2019. Work was ongoing to support the development of the PCN Network Agreement DES, which had to be enacted by 30 June 2019. All PCNs across the country will go live on 1 July 2019.

Discussion took place and the Board noted:

- Further clarity was required around the arrangements for linking the development of PCNs to the transformation agenda at an ICP level
- The need to ensure that larger PCNs across Nottingham and Nottinghamshire worked and had clinical representation and visible operational arrangements at a neighbourhood level
- The importance of recognising that PCNs were not focussed solely around general practice and will support neighbourhoods through provision of broader community services
- The requirement to develop a communications plan to clearly articulate to citizens and staff across health and social care services what PCNs are

The ICS Board supported the PCN configurations and newly appointed Clincal Directors for each PCN for Nottingham and Nottinghamshire and noted the next steps for development of the PCNs.

10. Local priorities for inclusion in the 19/20 MoU with NHS England & Improvement

WS introduced a report that provided an update on progress since the May 2019 meeting of the Board and a further iteration of local priorities for inclusion in the 2019/20 MOU, which also included national deliverables.

The ICS Board agreed with the proposed local priorities for inclusion in the 2019/20 ICS MOU and noted that the MOU will be agreed locally with the regional NHS England and NHS Improvement team.

ACTIONS:
DJ to circulate the outline of the national MOU to ICS Board members.

11. CCG Merger Plan

AS presented a report on the proposed merger of the six Nottingham and Nottinghamshire CCGs. The NHS Long Term Plan contained a confirmation of the direction of travel for CCG configurations into a single Strategic Commissioner CCG for each ICS area. In addition to this, there is a requirement for commissioners and regulators to make a 20% running cost reduction. Whilst the running cost reduction was separate to the formal merger, the merger provided an opportunity to consolidate the costs of running an organisation.

WS highlighted the challenge to get all partners signed up to the new arrangements for strategic commissioning. WS assured the Board that this should not deplete the focus at ICP and PCN level. When establishing the single CCG commissioner, some of the capacity and capabilities that currently sit within CCGs will be aligned to the ICPs and PCNs.

MB and CM confirmed Local Authority support for the proposed merger, which will provide a stronger platform for commissioning.

The ICS Board noted the application to commence the process to merge by April 2020 and the commencement of the stakeholder consultation on the proposed merger by 21 May 2019. In addition to this, the ICS Board agreed to write collectively as ICS leaders to the Accountable Officer of the CCGs to confirm the ICS's support for the proposed merger.

ACTIONS:
AB to draft a letter of support for the proposed CCG merger on behalf of the ICS Board.

12. Update from Mid Nottinghamshire ICP

RM introduced a paper that provided an update on Mid-Nottinghamshire ICP progress over the last month. The Mid-Nottinghamshire ICP Board met earlier in the week and agreed a way forward around the ICP transformation funding, received an update on the End of Life Care Collaboration and held a discussion around health inequalities.

The Mid-Nottinghamshire ICP had signed up to delivering ten high level priorities in 2019/20 and RM and Rachel Munton, Independent Chair of the ICP Board, will provide an update on progress against these priorities at the end of quarter one.

The ICS Board noted the Mid-Nottinghamshire Integrated Care Provider Update.

13. 2019/20 System Operational Plan (NHS)

HP presented a paper that provided an update on the changes included in the May 2019 submission of the 2019/20 Operational Plan for finance, activity and operational performance.

The Board noted that the ICS was required to submit a draft Elective Care Transformational Plan for 2019/20 to NHS England and NHS Improvement. A draft plan was required by end June 2019 and final plan by end July 2019. In addition to this, the ICS was also required to submit an Urgent Care Transformational Plan for 2019/20 with similar timescales for submission. HP proposed that the ICS Board delegate oversight and delivery of the Transformational Plans to the ICS Planning Group.

The ICS Board noted the changes to the System Operational Plan and that further work was underway to develop Transformational Plans to meet the 2019/20 savings and efficiency requirement. The ICS Board also noted that the NHS Operational Plan would be consolidated with Local Authority Plans to present an overall system position for 2019/20.

The ICS Board agreed that the ICS Planning Group would oversee the development of and approve the 2019/20 Elective Care and Urgent Care Transformation Plans.

Oversight of System Resources and Performance Issues (including MoU)

14. ICS Integrated Performance Report - Finance, Performance & Quality.

HP presented the June 2019 Integrated Performance Report for information.

JT suggested that, since cancer performance appeared to be an emerging risk and was a key element within the ICS MOU, that a deep dive on cancer performance was undertaken and the findings presented to the ICS Board in July 2019.

The ICS Board noted the June 2019 Integrated Performance Report and supported the suggestion to undertake a deep dive on cancer performance.

ACTIONS:
HP to arrange for a deep dive on cancer performance to be undertaken and present the findings to the July 2019 meeting of the ICS Board.

15. Mental Health Deep Dive

AS presented the Mental Health Performance Deep Dive Report noting the current position in relation to children and young peoples' access standards, children and young peoples' eating disorder access standards, early intervention in psychosis, improving access to psychological therapies and reducing out of area placements.

The Board noted there was much improved system visibility of the key issues and shared working arrangements had also improved. There was still a significant amount of work to be undertaken and a requirement to ensure parity of esteem around mental health and physical health.

JB outlined the actions that were being taken to improve performance, which included: re-structuring internal processes to ensure alignment of oversight and performance, working with Health Education England (HEE) to get support for an in-house CBTp training course to be accredited and work to improve staffing levels.

The Board discussed the report and noted the following:

- It is a national requirement to reduce out of area placements to zero by 2021
- Nottinghamshire Healthcare NHS FT was working closely with commissioners to re-define the local mental health specification
- Whilst Nottinghamshire Healthcare NHS FT performed well in the national community and mental health survey, the national staff survey results were not as positive. The Trust's CQC rating had recently slipped to "requires improvement" and work was being taken forward to address this
- The Trust was working with NHS England and NHS Improvement around workforce retention

The ICS Board noted the report, supported discussions taking place with HEE/NHS England to determine if the in-house CBTp training course could be accredited and approved the next steps outlined within the report.

Governance

16. ICS Board Revised Governance Arrangements

DP introduced a report which set out the issues that needed to be discussed and resolved in the near term and an updated version of the Terms of Reference. In order to not increase the size of the Board, it was suggested that non-executive directors or elected members take a role as sponsors for key issues.

The ICS Board agreed the proposed changes to the Terms of Reference and agreed that non-executive directors or elected members could take a role as sponsors for key issues outlined within the report.

DP informed members that he was not available to attend the next meeting of the ICS Board and JT will therefore chair the meeting.

Time and place of next meeting:
12 July 2019, 09:00 – 12:00
Rufford Suite, County Hall

ICS Board Action Log (July 2019) **Item 3. Enc. A2**

ID	Action	Action owner	Date Added	Deadline	Action update
B136	To meet with system planning leads to agree the approach to developing the implementation plans for the MH Strategy that are to be delivered by ICPs working with PCNs. These need to reflect the requirements of the long term plan. These implementation plans are to be reviewed at the Board's strategic planning session in June.	John Brewin and Lucy Dadge	15 March 2019	29 July 2019	Item scheduled for discussion at the 8 August ICS Board meeting
B158	To work with Lyn Bacon and Nicky Hill to give further consideration to how the LWAB links to the ICS and the resource requirements for the workforce workstream	Wendy Saviour	09 May 2019	31 July 2019	Discussions underway.
B168	To coordinate an information exchange with representatives from the EMAHSN, ICPs and other interested parties, to take oversight of the proposed innovations and fully understand any impact on workforce and associated costs.	Andy Haynes	13 June 2019	8 August 2019	Discussions underway and item added to workplan for August Board

ID	Action	Action owner	Date Added	Deadline	Action update
	To provide an update on progress to the ICS Board in August 2019.				
B157	To provide further detail to the ICS Board on the impact of the initiatives in the People and Culture Strategy.	Lyn Bacon/Nicky Hill	09 May 2019	30 September 2019	Item to be presented at the September Board.

ENC. B1

Meeting:	ICS Board
Report Title:	Patient Story – End of Life Care
Date of meeting:	Friday 12 July 2019
Agenda Item Number:	4
Work-stream SRO:	Richard Mitchell
Report Author:	Carl Ellis
Attachments/Appendices:	Enc. B2. End of Life Care Together

Report Summary:

End of life care is a process of advance care planning for patients perceived to be in the last 12 months of life. In South Nottinghamshire, Nottingham City and Mid-Nottinghamshire, our aim is to identify everyone who would benefit from the advance care planning process to describe their future care needs, record these needs and provide care packages that focus on symptom management, carers support and psychological needs.

The presentation will provide an example from Mid-Nottinghamshire to show how collaborative working from palliative care providers is adding value to the delivery of end of life care, supporting patients to be cared for in their preferred place of care.

Action:

☒ To receive
☐ To approve the recommendations

Recommendations:

Key implications considered in the report:

Financial	☐	
Value for Money	☒	
Risk	☐	
Legal	☐	
Workforce	☐	
Citizen engagement	☐	
Clinical engagement	☐	
Equality impact assessment	☐	

Engagement to date:

Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
☐	☐	☐	☐	☐
Performance Oversight Group	**Clinical Reference Group**	**Mid Nottingham-shire ICP**	**Nottingham City ICP**	**South Nottingham-shire ICP**
☐	☐	☒	☐	☐

Contribution to delivering the ICS high level ambitions of:

Health and Wellbeing	☒
Care and Quality	☒

Finance and Efficiency	☒
Culture	☐

Is the paper confidential?

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

Integrated Care System
Nottingham & Nottinghamshire

ICS Board, 12 July
Item 5, Enc. C2

ICS System Level Outcomes Framework

Draft Reporting Prototype Version 2.7

Integrated Care System Board

11 July 2019

Integrated Care System
Nottingham & Nottinghamshire

Introduction, purpose and approach

Introduction

The Nottingham and Nottinghamshire ICS has developed a system level outcomes framework that all partners across the system will work together to jointly deliver, in recognition that such a framework is a core component of a successful Integrated Care System.

When done well, measuring success:

- Shows that outcomes for citizens are being achieved across the system;
- Focuses plans and informs priorities through clearly articulated key performance indicators; and
- Supports organisations to work as one health and social care system to deliver impact and continually improve

Purpose

The purpose of the Nottingham and Nottinghamshire ICS System Level Outcomes Framework is to provide a clear view of our success as an Integrated Care System in improving the health, wellbeing and independence of our residents and transforming the way the health and care system operates (quality and efficiency).

The Framework sets out the short, medium and long term outcomes the whole ICS will work together to achieve, and supports strategic planning by ensuring system improvement priorities and investment enable achievement of the outcomes.

In April 2019 the Board agreed to receive a proposed prototype to support the presentation and operationalisation of the Framework.

Approach

Against the triple aims of Improving Health and Wellbeing, Improving Independence, Care and Quality, and Improving Effective Resource Utilisation the ICS System Level Outcomes Framework identifies a total of ten aspirations. Against these 28 outcomes have been defined to demonstrate delivery and achievement, monitored through 73 measures (the appropriateness of these measures will be kept under constant review).

Domain 1: Health and Wellbeing

- 4 aspirations
- 12 outcomes
- 29 measures

Domain 2: Independence, Care and Quality

- 3 aspirations
- 8 outcomes
- 24 measures

Domain 3: Effective Resource Utilisation

- 3 aspirations
- 8 outcomes
- 20 measures

Initially it is proposed reporting frequency to the ICS Board is monthly on a rotational basis for each of the three domain areas, thereby ensuring each is discussed by the Board on a quarterly basis. Timeframes over which measures will change will vary and this will be reflected in the reporting, frequency of reporting to the Board will be subject to ongoing review.

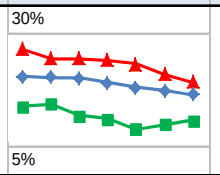
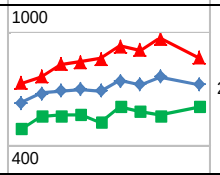
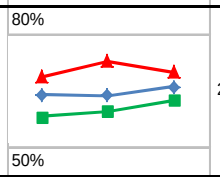
One outcome from each of the three domains is presented in the prototype to illustrate how reporting will operate. The data included will be subject to further scrutiny and refinement following approval of the reporting prototype.

Integrated Care System
Nottingham & Nottinghamshire

Domain: Improving Health and Wellbeing

Ambition: Our people and families are resilient and have good health and wellbeing

System Level Outcome: Reduction in illness and disease prevalence

System Level Outcomes	Measures	Data Frequency	Better to be high or low	Draft ICS Aspiration[1] at			Latest Data				Trend		
				Year 1	Year 3	Year 5	Actual		Level	Period	Start	Profile	End
Reduction in illness and disease prevalence	Smoking prevalence in adults	Annual	↓	16.1%	15.7%	14.9%	Highest Total ICS Lowest	19.4% 16.3% 9.7%	Borough	2017	2011		2017
	Admission episodes for alcohol-related conditions (Rate per 100,000 population)	Annual	↓	703	669	632	Highest Total ICS Lowest	881 721 583	Borough	2017/18	2008/09		2017/18
	Percentage of adults (aged 18+) classified as overweight or obese	Annual	↓	66%	64%	62%	Highest Total ICS Lowest	70.7% 66.2% 62.2%	Borough	2017/18	2015/16		2017/18

1 - Calculation of aspirations employ a pragmatic working approach that will require refinement and subsequent engagement with the Board and ICS community. The aspiration shown is based on improvement relative to the identified peer group using the principle that there will be steady improvement over time

Integrated Care System
Nottingham & Nottinghamshire

Domain: Improving Health and Wellbeing

Ambition: Our people and families are resilient and have good health and wellbeing

System Level Outcome: Reduction in illness and disease prevalence

(Measure rationale, indicator construction and indicator publication are set out in Appendix)

Smoking Prevalence in Adults (18+)

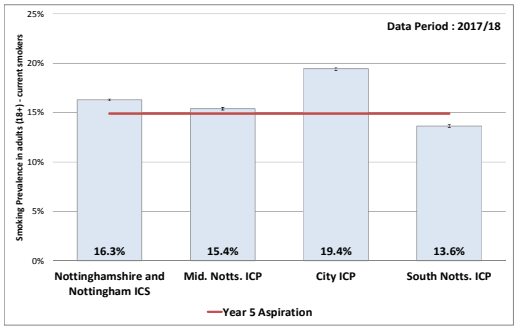
System Priority to deliver

- Prevention and Wider Determinants of Health
  - Tobacco and related harm

Aspiration:

- 3 year – Lower than E. Midlands (15.7%)
- 5 Year - Lower than England (14.9%)

Current performance:



Delivery headlines:

- Tobacco report presented to CRG providing framework and action plan supporting existing Public Health activity
- Wider comms plan/campaign completed for tobacco

Risk to delivering aspiration	Green

Admission episodes for alcohol-related conditions (Rate per 100,000 Population)

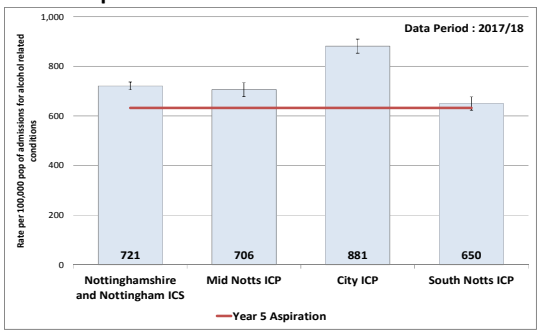
System Priority to deliver

- Prevention and Wider Determinants of Health
  - Alcohol related harm

Aspiration:

- 3 Year – Lower than E. Midlands Rate (669)
- 5 Year – Lower than England (632)

Current performance:



Delivery headlines:

- Ongoing implementation of action plan: funding secured through PHE to support alcohol harm reduction and 'Housing First'; IBA training resources being rolled out; high volume service user business case/model developed, e-learning tool developed
- Barriers to implementation in two areas of the action plan; brief advice and case management of high volume service users.

Risk to delivering aspiration	Amber

Percentage of adults (aged 18+) classified as overweight or obese

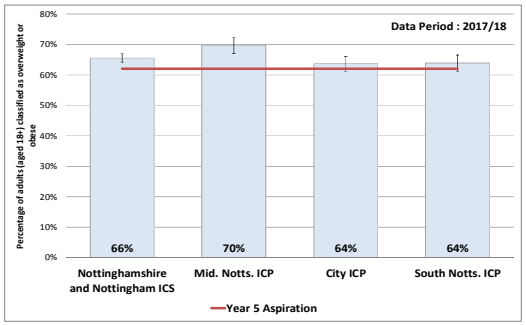
System Priority to deliver

- Prevention and Wider Determinants of Health
  - Diet and nutrition

Aspiration:

- 3 Year – Lower than East Midlands (64%)
- 5 Year – Lower than England (62%)

Current performance:



Delivery headlines:

- Plans to be developed that will include systematic and aligned approach across tiers 1 – 4 for weight management and consistent messages across the system for diet and nutrition

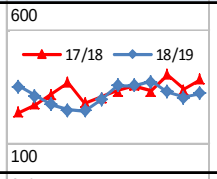
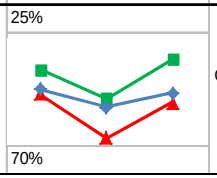
Risk to delivering aspiration	Amber

Integrated Care System
Nottingham & Nottinghamshire

Domain: Independence, Care and Quality

Ambition: Our people will have equitable access to the right care at the right time in the right place

System Level Outcome: Increase in appropriate access to primary and community based health and care services

System Level Outcomes	Measures	Data Frequency	Better to be high or low	Draft ICS Aspiration[1] at			Latest Data				Trend		
				Year 1	Year 3	Year 5	Actual		Level	Period	Start	Profile	End
Increase in appropriate access to primary and community based health and care services	Number of delayed transfers of care for medically fit patients	Monthly	↓	299	278	247	Highest Total ICS Lowest	385 309 265	LA	Mar-19	Apr-17		Mar-19
	Proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement/ rehabilitation services	Quarterly	↑	83%	90%	95%	Highest Total ICS Lowest	86.7% 80.0% 78.0%	LA	Q4 2018-19	Q4 2016-17		Q4 2018-19

1 - Calculation of aspirations employ a pragmatic working approach that will require refinement and subsequent engagement with the Board and ICS community. The aspiration shown is based on improvement relative to the identified peer group using the principle that there will be steady improvement over time

Integrated Care System
Nottingham & Nottinghamshire

Domain: Independence, Care and Quality

Ambition: Our people will have equitable access to the right care at the right time in the right place

System Level Outcome: Increase in appropriate access to primary and community based health and care services *(Measure rationale, indicator construction and indicator publication are set out in Appendix)*

Number of delayed transfers of care for medically fit patients (Rate per 100,000 Population)

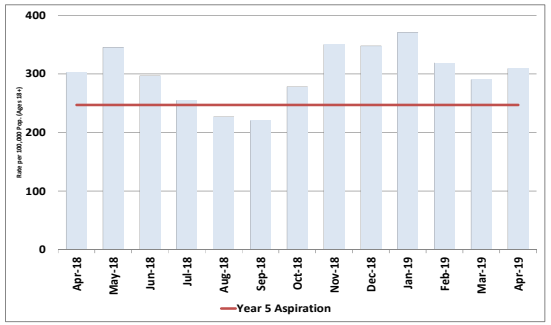
System Priority to deliver:

- Urgent and Emergency Care
  - Effective integrated discharge

Aspiration:

- 3 year - Delivery of trajectory milestone
- 5 Year – Better than England Average (247)

Current performance:



Delivery headlines:

- Collaborative working continues to take place across Nottinghamshire, with urgent care teams sharing good practice around Discharge to Assess pathways and DTOC actions.
- The care home capacity tracker is now part of a mandated national NHSE rollout. This will enable families and advocates to make faster decisions around care home placements

Risk to delivering aspiration	Red

Proportion of older people (65 and older) still at home 91 days after discharge from hospital into reablement/rehab services

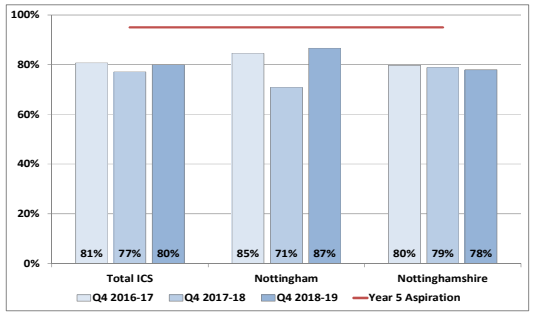
System Priority to deliver:

- Urgent and Emergency Care
  - Effective integrated discharge

Aspiration:

- 3 year – Exceed best Region Nationally (90%)
- 5 Year – Achieve 95%

Current performance:



Delivery headlines:

- Demand for social care continues to increase, and includes an increasing number of those people who have higher, more complex care needs
- County Council - work in 2018/19 to promote short term services to help people recover, recuperate and maximise independence included additional investment in the reablement service and the continuation of the Home First Response Service, a short-term rapid response service for people who need social care support to remain at or return home

Risk to delivering aspiration	Amber

% improvement in waiting times and waiting for treatment

Barriers to reporting:

There is wide variation in the types of services provided by Community Providers across the County, which directly influences the waits or response times for patients
For example, Short waits for Urgent care services (e.g. 2 hours in Call for Care) against a 13 week for a planned care service

Where similar services are provided across the county, the service specifications adhered to may vary
For example, up to 18 weeks wait for MSK in County, but 4 weeks within Nottingham City

Measure needs further refinement

Integrated Care System
Nottingham & Nottinghamshire

Domain: Resource Utilisation

Ambition: Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population

System Level Outcome: Sustainable teams with skill mix designed around our population and mechanisms to deploy them flexibly to respond to care and support needs

System Level Outcomes	Measures	Data Frequency	Better to be high or low	Draft ICS Aspiration[1] at			Latest Data				Trend		
				Year 1	Year 3	Year 5	Actual		Level	Period	Start	Profile	End
Sustainable teams with skill mix designed around our population and mechanisms to deploy them flexibly to respond to care & support needs	Staff responding to the question "I often think about leaving this organisation" (Q23a)[2]	Annual	↓	28%	25%	20%	Highest Total ICS Lowest	44.6% 30.1% 24.3%	Provider	2018	2018	50% 20%	2018
	Staff responding to the question "I will probably look for a job at a new organisation in the next 12 months." (Q23b)[2]	Annual	↓	19%	15%	10%	Highest Total ICS Lowest	34.9% 21.1% 16.4%	Provider	2018	2018	40% 10%	2018
	Staff responding to the question "As soon as I can find another job, I will leave this organisation" (Q23c)[2]	Annual	↓	13%	10%	5%	Highest Total ICS Lowest	26.5% 14.9% 11.8%	Provider	2018	2018	30% 10%	2018
	Percentage of Bank Staff spend (core)	Monthly	↓	6%	5%	3%	Highest Total ICS Lowest	0.0% 6.4% 0.0%	Provider	Sep-18	Apr-18	10% 0%	Sep-18
	Percentage of Agency Staff spend (core)	Monthly	↓	0.4%	0.3%	0.2%	Highest Total ICS Lowest	0.0% 0.5% 0.0%	Provider	Sep-18	Apr-18	2% 0%	Sep-18
	Percentage of Vacancy Staff spend (core)	Monthly	↓	16%	13%	10%	Highest Total ICS Lowest	0.0% 18.9% 0.0%	Provider	Sep-18	Apr-18	25% 10%	Sep-18

1 - Calculation of aspirations employ a pragmatic working approach that will require refinement and subsequent engagement with the Board and ICS community. The aspiration shown is based on improvement relative to the identified peer group using the principle that there will be steady improvement over time.
2 - Trend data is unavailable as Q23 was newly added to the 2018 staff survey

Integrated Care System
Nottingham & Nottinghamshire

Domain: Resource Utilisation
Ambition: Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population
System Level Outcome: Sustainable teams with skill mix designed around our population and mechanisms to deploy them flexibly to respond to care and support needs
(Measure rationale, indicator construction and indicator publication are set out in Appendix)

Staff responding to the question "I often think about leaving this organisation" (Q23a)

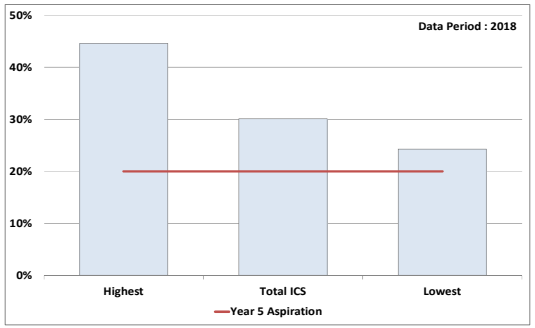
System Priority to deliver:

- IC S People and Culture Strategy
  - Retaining skills and experience in our system

Aspiration:

- 3 year – Reduce to 25%
- 5 Year – Reduce to 20%

Current performance:



Staff responding to the question "I will probably look for a job at a new organisation in the next 12 months." (Q23b)

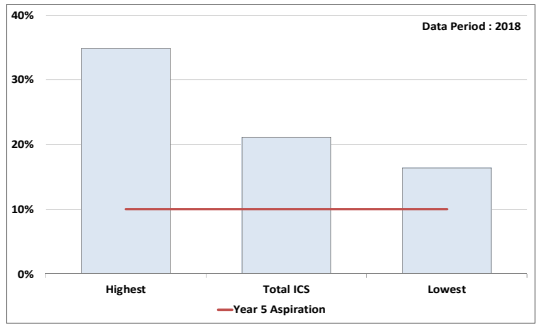
System Priority to deliver:

- IC S People and Culture Strategy
  - Making our health & care system the best place to work

Aspiration:

- 3 year – Reduce to 15%
- 5 Year – Reduce to 10%

Current performance:



Staff responding to the question "As soon as I can find another job, I will leave this organisation" (Q23c)

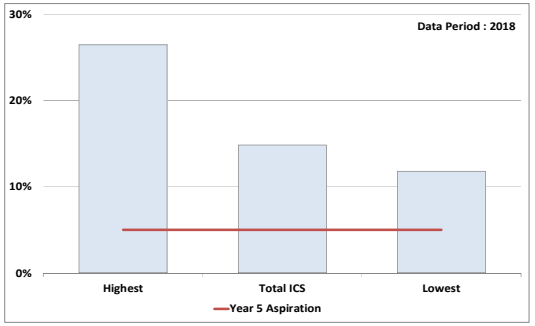
System Priority to deliver:

- IC S People and Culture Strategy
  - Attracting & retaining people to deliver care

Aspiration:

- 3 year – Reduce to 10%
- 5 Year – Reduce to 5%

Current performance:



Delivery headlines:

- HR & OD Collaborative action plan to improve health and wellbeing of our staff
- Development underway of flexible employment options to enable streamlined movement around our systems with portability of training
- Data and analysis of flow of people between Notts employers , net losses to other ICSs and address causes
- Analysis of loss of staff in first year of employment and early retirement at end of career to develop retention schemes & support

Risk to delivering aspiration	Amber

Integrated Care System
Nottingham & Nottinghamshire

Domain: Resource Utilisation
Ambition: Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population
System Level Outcome: Sustainable teams with skill mix designed around our population and mechanisms to deploy them flexibly to respond to care and support needs
(Measure rationale, indicator construction and indicator publication are set out in Appendix)

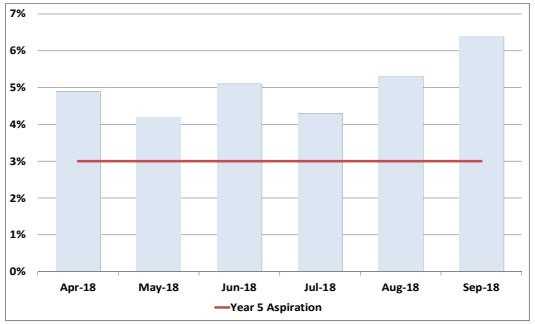
Percentage of Bank Staff (core)

System Priority to deliver:

- IC S People and Culture Strategy
  - Reducing reliance on temporary staff

Aspiration:
3 year – Reduce to 5%
5 Year – Reduce to 3%

Current performance:



Delivery headlines

- HR & OD Collab action plan to shift agency staff onto system bank registers and support them into substantive employment over time
- Developing enhanced offer to bank workers to attract them away from agency work into local employment options
- Scoping potential for collaborative bank across the system to optimise utilisation of temporary staff resources

Risk to delivering aspiration	Amber

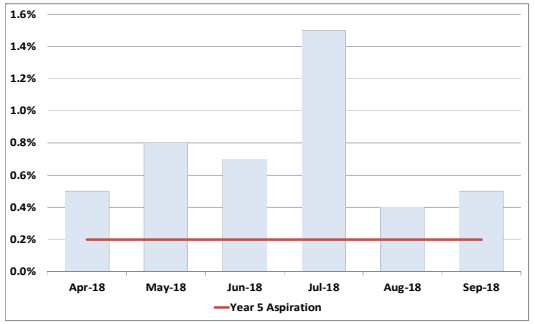
Percentage of Agency Staff (core)

System Priority to deliver:

- IC S People and Culture Strategy
  - Reducing reliance on short term, agency staff

Aspiration:
3 year – Reduce to 0.3%
5 Year – Reduce to 0.2%

Current performance:



Delivery headlines

- Action plan in development to attract agency workers onto our local bank staff registers through enhanced offer & flexible working models
- Exploring potential opportunities for market management working in partnership with other ICSs

Risk to delivering aspiration	Amber

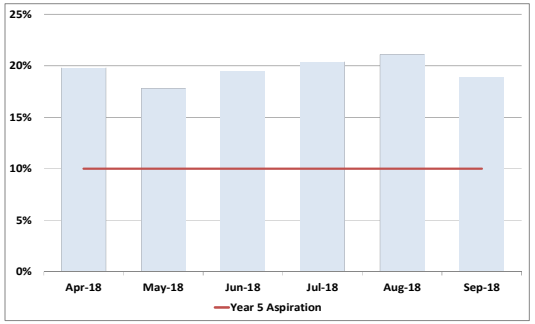
Percentage of Vacancy Staff (core)

System Priority to deliver:

- IC S People and Culture Strategy
  - Attracting substantive staff into vacancies and reducing reliance on temporary staff use

Aspiration:
3 year – Reduce to 13%
5 Year – Reduce to 10%

Current performance:



Delivery headlines

- Collaborative working to recruit to business critical staff groups where we are recycling between Notts employers rather than bringing in additional capacity
- Promotion of Nottinghamshire as a place to work through careers events, ambassadors, innovative development opportunities
- Notts Talent Academy to attract people into health & care careers

Risk to delivering aspiration	Amber

Integrated Care System
Nottingham & Nottinghamshire

Appendix

Integrated Care System
Nottingham & Nottinghamshire

Health and Wellbeing

Our people and families are resilient and have good health and wellbeing

Outcome: Reduction in illness and disease prevalence

Smoking Prevalence in Adults (18+)

Rationale:

- Smoking causes 17% of deaths in people aged 35 and over.
- Smoking reinforces health inequalities – people in more deprived areas are more likely to smoke and less likely to quit.
- Men and women in most deprived groups have more than double death rate from lung cancer compared with those in least deprived.
- Smoking prevalence in Nottingham is statistically significantly higher than the England level (19.4% and 14.9% respectively)
- Smoking prevalence in Nottinghamshire (15.1%) is similar to that of England

Indicator construction:

- Numerator: The number of persons aged 18+ who are self-reported smokers in the Annual Population Survey. The number of respondents has been weighted in order to improve representativeness of the sample.
- Denominator: total number of respondents aged 18+ from the Annual Population Survey.
- Source: Annual Population Survey

Indicator publication:

- Annual - last updated Mar 19

Admission episodes for alcohol-related conditions (Rate per 100,000 Population)

Rationale:

- Analysis of 67 risk factors for death and disability found alcohol is 3rd leading factor
- Alcohol has been identified as a causal factor in more than 60 medical conditions.
- There is a high prevalence of co-morbidity in those attending mental health services and both drug and alcohol treatment services.
- Excessive alcohol consumption is a major cause of preventable premature death.
- The impact of harmful drinking and alcohol dependence is much greater for those in the lowest income bracket and those experiencing the highest levels of deprivation.
- *Local position to be added*

Indicator construction:

- Numerator: Admissions to hospital where the primary diagnosis is an alcohol related condition, or a secondary diagnosis is an alcohol-related external cause.
- Source: Hospital Episode Statistics (HES)
- Denominator: ONS Mid-year estimates
- Source: ONS

Indicator publication:

- Annual - Data is published up to 1 year after the indicator date, so data published in 2019 relates to 2017-18

Percentage of adults (aged 18+) classified as overweight or obese

Rationale:

• Obesity is a priority area for Government. The Government's "Call to Action" on obesity (published Oct 2011) included national aspirations relating to excess weight in adults, which is recognised as a major determinant of premature mortality and avoidable ill health.

Indicator construction:

• Numerator: Number of adults 18+ with a BMI classified as overweight, calculated from the adjusted height and weight variables. Adults are defined as overweight (including obese) if their body mass index (BMI) is greater than or equal to 25kg/m2.
•Source: Active Lives Survey, Sport England
•Denominator: Number of adults aged 18+ with valid height and weight recorded
•Source: Active Lives Survey, Sport England

Indicator publication:

- Data is published up to 2 year after the indicator date, so data published in 2019 relates to 2017-18

Integrated Care System
Nottingham & Nottinghamshire

Independence Care and Quality

Our people will have equitable access to the right care at the right time in the right place

Outcome: Increase in appropriate access to primary and community based health and care services

Number of delayed transfers of care for medically fit patients (Rate per 100,000 Population)

Rationale:

- Significant impact on outcomes for our patients and service users

Indicator construction:

- A delayed transfer of care (DTOC) from NHS-funded Acute or Non-Acute care occurs when an adult (18+ years) patient is ready to go home and is still occupying a bed. The value is shown the number of days delayed as a rate per 100,000 patients.

Indicator publication:

- Providers submit this data monthly as part of their monthly SitRep Delayed Transfers of Care statutory return. The return is split by Local Authority and Acute or Non-Acute care.

Proportion of older people (65 and older) still at home 91 days after discharge from hospital into reablement/rehab services

Rationale:

- Delaying and reducing the need for care and support
- Readmissions are linked to worse outcomes for our people and their future health and wellbeing
- Provides an indication of a successful outcome of care given and reduction in readmissions
- Demonstrates a potential increase of care being provided closer to home and/or in the community

Indicator construction:

- The data that is recorded for this measure is citizens over the age of 65 (as at the 31st March) who have completed a period of re-ablement, where their route of access into the service was from a hospital setting.
- 91 days after the discharge date from hospital the patient is contacted to see whether they are still at home.

Indicator publication:

- Local Authorities submit this data annually as part of their SALT statutory return. Locally, the data is collected throughout the year but only the data submitted as part of Statutory Returns could currently be guaranteed to be available to benchmark with other Local Authorities.

Integrated Care System
Nottingham & Nottinghamshire

Effective Resource Utilisation: People and Culture

Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population

Outcome: Our system has sustainable teams with skill mix designed around our population

Staff responding to the Q23 survey question

Rationale:

- This provides an indication of the sustainability/stability of staff that can be analysed down to service area and aggregated locally to give a 'temperature check' at different levels of the system.

Indicator construction:

- Numerator: The total number of positive staff survey responses.
- Denominator: The total number of staff survey responses.
- Source: www.nhsstaffsurveys.com

Indicator publication:

- Annual - last updated Feb-19

Integrated Care System
Nottingham & Nottinghamshire

Effective Resource Utilisation: People and Culture

Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population

Outcome: Our system has sustainable teams with skill mix designed around our population

Percentage of Bank Staff (core)

Rationale:
- High use of temporary staff via established banks or agency indicates fragile teams and service areas either due to high vacancy levels or sickness absence.

Indicator construction:
- Numerator: The number of bank staff currently employed.
- Denominator: The total number of WTE staff currently employed.
- Source: Provider organisation data

Indicator publication:
- Collected for a 6 month period April 2018 - September 2018

Percentage of Agency Staff (core)

Rationale:
- High use of temporary staff via established banks or agency indicates fragile teams and service areas either due to high vacancy levels or sickness absence.

Indicator construction:
- Numerator: The number of agency staff currently employed.
- Denominator: The total number of WTE staff currently employed.
- Source: Provider organisation data

Indicator publication:
- Collected for a 6 month period April 2018 - September 2018

Percentage of Vacancy Staff (core)

Rationale:
- Indicator of sustainability and stability of teams especially where there are long term, difficult to fill vacancies for business critical staff.

Indicator construction:
- Numerator: The number of substantive staff vacancies
- Denominator: The total number of WTE staff currently employed.
- Source: Provider organisation data

Indicator publication:
- Collected for a 6 month period April 2018 - September 2018

Integrated Care System
Nottingham & Nottinghamshire

Analytical Contributors

- Robert Taylor - Head of Performance and Information, CCG
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- Ian Bates - Public Health Intelligence Analyst
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- Fraser White - Principal Analyst, CCG
- Stuart Baxter, Data Analyst, CCG
- Victoria Myers - Senior Performance Business Partner, Nottinghamshire County Council
- Emma Stow – Nottingham City Council

ENC. C1

Meeting:	ICS Board
Report Title:	The Nottingham and Nottinghamshire ICS System Level Outcomes Framework Reporting Prototype
Date of meeting:	12 July 2019
Agenda Item Number:	5.
Work-stream SRO:	Wendy Saviour
Report Author:	Tom Diamond/Elaine Varley
Attachments/Appendices:	Enc. C2. Annex A – System Level Outcomes Framework Prototype Version 2.7

Report Summary:

In April 2019 the Board agreed the updated ambitions and outcomes within the System Level Outcomes Framework, and agreed to receive a prototype for reporting delivery against the outcomes in the Framework.

The purpose of this paper is to:

a. Update the Integrated Care System (ICS) Board Members on the continued development of the Nottingham and Nottinghamshire ICS System Level Outcomes Framework.
b. Present the initial reporting prototype for discussion that, once final, will be used as the format for reporting delivery against the ICS System Level Outcomes Framework to the ICS Board.
c. Highlight the opportunity to establish the level of aspiration for measures across the system.
d. Continue to highlight to the ICS Board the significant analytical capacity and capabilities needed to proceed with this work.
e. Propose the next steps to further develop and operationalise the System Outcomes Framework at Board and across the ICS community.

Development of the Framework continues to be in accordance with the agreed principles and Board agreement to 'learn by doing'. The best available information, resource and analytical capacity have been drawn upon from health and care teams to establish a prototype for reporting delivery of the outcomes, operating within the agreed governance structure.

The Outcomes Framework includes 10 ambitions and 28 system level outcomes monitored through 73 measures that sit within one of three domains: Health and Wellbeing; Independence, Care and Quality; and Effective Resource Utilisation.

To develop the initial prototype for reporting delivery against the Framework, analytical colleagues from across the health and care community were brought together in the short term as part of a 'virtual' team. To operationalise the System Level Outcomes Framework and deliver against the proposed reporting schedule at

future Board meetings the analytical capacity required cannot be underestimated. The focus for this stage of work has been to prioritise getting the initial reporting prototype format right and to understand the opportunities and limitations of the measures. Whilst every effort has been made to increase accuracy the data included will be subject to further scrutiny and refinement following approval of the reporting prototype. Ongoing engagement with the ICS Board, ICPs and PCNs is also essential to discuss and set the level of aspiration for measures across the system.

There are a number of key considerations for ICS Board members following receipt of the Outcomes Framework Prototype. They are:

a. How much time should the Board dedicate to the Outcomes Framework when each domain reports monthly?
b. Does the reporting prototype give sufficient information to inform discussions at the Board, track progress and drive actions?
c. How do Board members want to engage with understanding the methodology used to develop the draft system aspirations for all measures at years 1, 3 and 5 and set the level of aspiration across the system?

Action:
☐ To receive ☒ To approve the recommendations

Recommendations:	
1.	Note the progress to further refine and develop of the Outcomes Framework
2.	Approve the reporting prototype, advising how the Board want to use the framework to drive discussions at Board and across the system
3.	Advise how the Board want to be involved in setting the level of aspiration for measures across the system
4.	Agree the reporting frequency for future Board meetings

Key implications considered in the report:		
Financial	☒	The system outcomes framework will reflect all of these areas.
Value for Money	☒	
Risk	☒	
Legal	☒	
Workforce	☒	
Citizen engagement	☒	
Clinical engagement	☒	
Equality impact assessment	☒	

Engagement to date:				
Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
☒	☒	☒	☒	☒

Performance Oversight Group	Clinical Reference Group	Mid Nottingham-shire ICP	Nottingham City ICP	South Nottingham-shire ICP
☐	☐	☒	☐	☐

Contribution to delivering the ICS high level ambitions of:	
Health and Wellbeing	☒
Care and Quality	☒
Finance and Efficiency	☒
Culture	☒

Is the paper confidential?

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

The Nottingham and Nottinghamshire System Level Outcomes Framework

11 July 2019

Introduction

1. The purpose of this paper is to:

    a. Update the Integrated Care System (ICS) Board Members on the continued development of the Nottingham and Nottinghamshire ICS System Level Outcomes Framework.
    b. Present the initial reporting prototype for discussion that, once final, will be used as the format for reporting delivery against the ICS System Level Outcomes Framework to the ICS Board.
    c. Highlight the opportunity to establish the level of aspiration for measures across the system.
    d. Continue to highlight to the Board the significant analytical capacity and capabilities needed to proceed with this work.
    e. Propose the next steps to further develop and operationalise the System Outcomes Framework at Board and across the ICS community.

Background

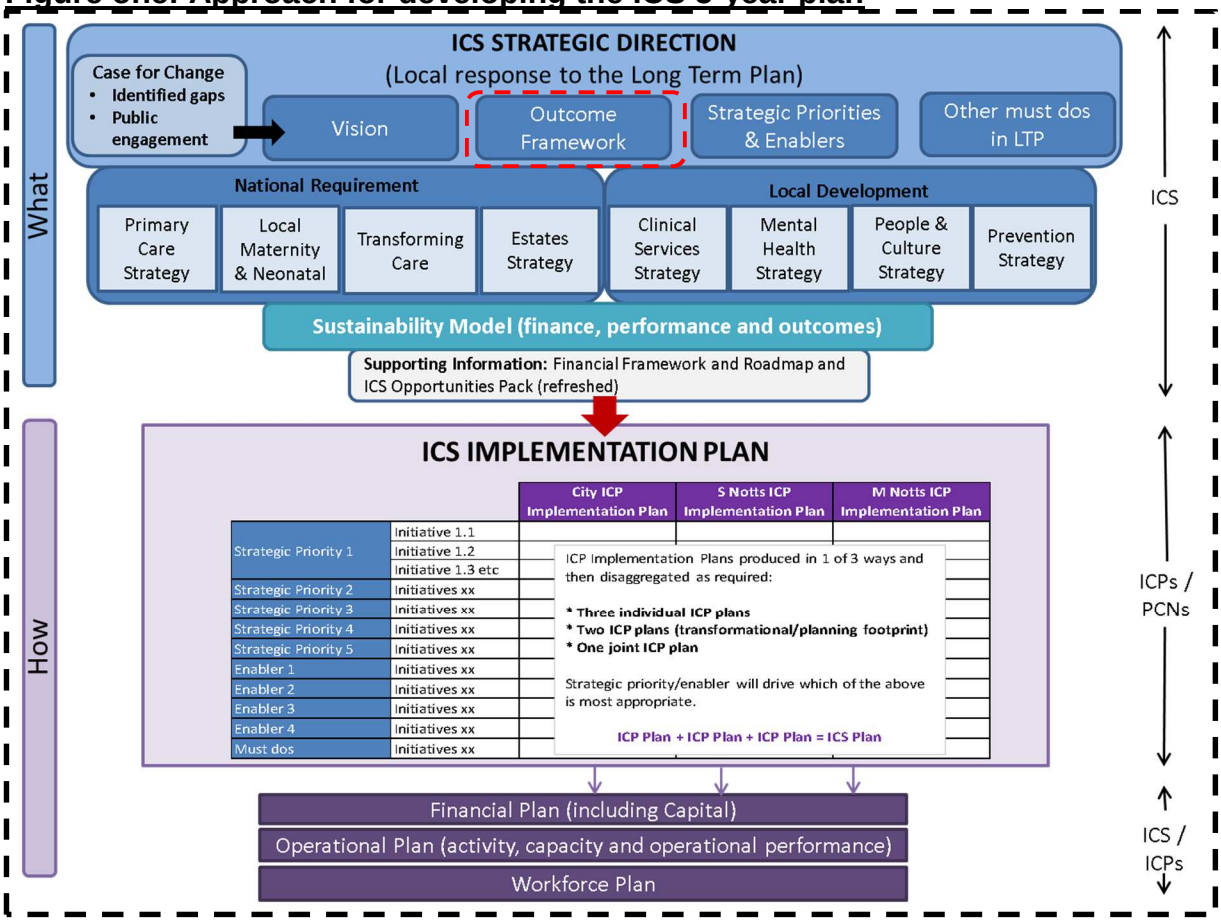
2. In April 2019 the ICS Board agreed the updated ambitions and outcomes within the Framework, and agreed to receive a prototype for reporting delivery against the outcomes in the Framework.

3. Development of the Framework continues to be in accordance with the agreed principles and Board agreement to 'learn by doing'. The best available information, resource and analytical capacity have been drawn upon from health and care teams to establish a prototype for reporting delivery of the outcomes, operating within the agreed governance structure. Engagement on the Framework with partners across the system continues to support its ongoing refinement. The Framework will continue to be built upon to ensure future iterations support the system in the best possible way to focus on the delivery and achievement of outcomes for our populations.

Progress to date

4. The Outcomes Framework has been aligned to the approach for developing the ICS 5-year plan, as shown in Figure one. The ambitions and outcomes within the Framework are driven by the health, wellbeing and need of our populations and is therefore a crucial component of our strategic direction.

Figure one: Approach for developing the ICS 5-year plan



5. Continued engagement with partners across the system, including the CCG Governing Body, ICS Partnership Forum, County Council Chief Executive, Nottinghamshire Healthcare Foundation Trust and Mid Nottinghamshire Integrated Care Partnership (ICP), has highlighted the importance of embedding the Framework across the whole system and organisationally. Feedback consistently conveyed the importance of the need to understand the variation and health inequalities experienced by different groups / communities and geographical areas that contribute to the Nottingham and Nottinghamshire picture as a whole. This reinforces the importance and role of our ICPs and PCN with the Framework to ensure actions to deliver our ambitions are focused in the right areas.

The Outcomes Framework reporting prototype (Annex A)

6. The Outcomes Framework includes 10 ambitions and 28 system level outcomes monitored through 73 measures that sit within one of three domains: Health and Wellbeing; Independence, Care and Quality; and Effective Resource Utilisation.

7. To develop the initial prototype for reporting delivery against the Framework, analytical colleagues from the Clinical Commissioning Group (CCG), Public Health and Social Care were brought together in the short term as part of a 'virtual' team to undertake an assessment of the measures, establish reporting principles to achieve consistency and to take a lead responsibility for populating the measures that sit within the remit of their organsiation against an agreed format. The CCG took the role of coordinating the information to report in a consistent format to establish the reporting prototype. The capacity to achieve this cannot be underestimated and required a certain level of 'goodwill'. Additionally, relevant senior individuals from workforce, finance, estates and ICT were also involved in an assessment of the Effective Resource Utilisation domain measures. The establishment of the Framework reporting prototype and sign off has been in accordance with the previously identified and agreed governance structure for the Outcomes Framework development.

8. The assessment of the measures sought to identify the indicator rationale, definition, construction, reporting period/lag/frequency/boundaries etc. along with any challenges or opportunities with the data. This assessment identified that the measures largely fall into one of the following categories:

    a. Data available and reported frequently e.g. monthly
    b. Data available but reported infrequently e.g. annual and frequency cannot be increased
    c. Data available and reported infrequently e.g. annual and frequency can be increased using local calculations (with the identified capacity and appropriate mandate)
    d. Data available but not currently reported for that intention
    e. Data unavailable and not currently collected
    f. Measure requires refinement to establish a data definition

9. The Framework reporting prototype is designed to capture our delivery against the outcome proxy measures in the Framework to enable an understanding of:

    a. ICS ambition potential calculated at years 1, 3 and 5
    b. The latest validated data reported annually, quarterly or monthly for:

        - The total ICS and, where possible, use local calculations for the 3 ICPs (this is due to data flows and reporting not being aligned to newly emerging structures and is therefore not validated)
        - Our highest/lowest areas across the ICS to highlight the level of variation

c. Trends over time
d. Delivery highlights and risk
e. The ICS Priority and associated strategic initiatives the outcome proxy measure is aligned to.

10. To ensure we achieve a greater level of consistency in reporting the following principles were agreed with analytical teams:

a. Baseline – is established using the most recent period available
b. Aspiration – is based on improvement relative to the identified peer group using the principle that there will be steady improvement over time, (with the exception of mortality and life expectancy which may warrant alternative phasing when those measures are analysed).

11. The focus for this stage of work has been to prioritise getting the initial reporting prototype format right and to understand the opportunities and limitations of the measures. Whilst every effort has been made to increase accuracy the data included will be subject to further scrutiny and refinement following approval of the reporting prototype. Ongoing engagement with Board and our places and neighbourhoods is also essential to discuss and set the level of aspiration for measures across the system.

12. One outcome from each of the three domains is presented in the prototype to illustrate how reporting will operate. These are:

Domain	Ambition	System Level Outcome	Measures
Health and Wellbeing	Our people and families are resilient and have good health and wellbeing	• Reduction in illness and disease prevalence	• Smoking prevalence in adults • Admission episodes for alcohol-related conditions • Percentage of adults (aged 18+) classified as overweight or obese
Independence Care and Quality	Our people will have equitable access to the right care at the right time in the right place	• Increase in appropriate access to primary and community based health and care services	• Number of delayed transfers of care for medically fit patients • Proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement/ rehabilitation services • % improvement in waiting times and waiting for treatment

Domain	Ambition	System Level Outcome	Measures
Effective Resource Utilisation	Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population	• Sustainable teams with skill mix designed around our population and mechanisms to deploy them flexibly to respond to care & support needs	• System workforce tracker: vacancies, agency reliance & turnover - monitored 6 monthly from March 2018 baseline • Teams representative of the population we serve (diversity measures, impact of widening participation measures via Talent Academy) • Availability & take up of flexible employment option

Reporting frequency

13. Initially it is proposed reporting frequency to the ICS Board is monthly on a rotational basis for each of the three domain areas, thereby ensuring each is discussed by the Board on a quarterly basis. Taking this structured approach to reporting will ensure the analytical capacity can be best managed.

14. It is recommended that this schedule commence with the Health and Wellbeing domain, reporting to ICS Board in September 2019. Timeframes over which measures will change will vary and this will be reflected in the reporting. Frequency of reporting to the Board will be subject to ongoing review.

Operationalising the framework

15. Analytical capacity and capability is crucial for the ongoing development and refinement of reporting against the ICS System Level Outcomes Framework. The way in which we have worked together as a 'virtual' team to establish the reporting prototype has been successful but its effectiveness is limited by a number of constraints not within the control of the team. The main constraints were:

    a. Timescales as the Outcomes Framework is to be turned around quickly but requires significant large scale change across the whole system;
    b. Capacity as supporting the development of the Prototype was an 'add-on' to existing analytical teams work;
    c. Mandate for the work and where it 'fits' with existing workload and deliverables;
    d. Leadership and support given individuals are effectively working outside of their organisational team.

16. As a consequence, not as many measures are included in the prototype as originally envisaged, but the significant amount of work and time dedicated to get to this stage cannot be undervalued. These constraints have been discussed at length at the Population Health / Population Health Management Steering Group as part of the agreed governance for this work and discussions continue. To operationalise the System Level Outcomes Framework and deliver against the proposed reporting schedule at future Board meetings the analytical capacity required cannot be underestimated. The identification of dedicated sustainable analytical capacity is essential to ensure the continued development of the prototype and subsequent maintenance.

17. At the 12 July ICS Board a paper regarding a system wide strategy for data, analytics, intelligence and digital technology (DAIT) for health and care in Nottingham and Nottinghamshire will also be received. The continued development and refinement of the reporting prototype for the System Level Outcomes Framework is within the scope of this system wide strategy, however this work will need to be completed over a number of months to develop solutions to effectively and efficiently identify and secure long term sustainable capacity and a successful infrastructure to work across organisational teams within the ICS. Therefore, an analytics capacity task and finish group has been established to help resolve some of the challenges the system is currently facing, and will be used to help strengthen and refine the working approach used so far to develop the Framework reporting prototype. However, it should be noted this may not resolve all the issues in the short term while a longer term approach is identified.

18. Further engagement with ICPs is also needed to consider and agree how to practically embed the Framework and analytical capacity across the emerging system as a means of tracking success for their populations. We also need to work more closely with our ICPs to consider and be informed by them how ICP priorities might be shaped by, and aligned to, the achievement of the Outcomes Framework ambitions. This engagement will need to extend to and be replicated with Primary Care Networks.

Key considertaions

19. There are number of key considerations for ICS Board members following receipt of the Outcomes Framework Prototype. They are:

    a. How much time should the Board dedicate to the Outcomes Framework when each domain reports monthly?
    b. Does the reporting prototype give sufficient information to inform discussions at the Board, track progress and drive actions?

c. How do Board members want to engage with understanding the methodology used to develop the draft system aspirations for all measures at years 1, 3 and 5 and set the level of aspiration across the system?

Next steps and key risks

20. The following next steps have been identified:

a. Agree the analytical capacity and approach to move from a prototype to a routine Outcomes Framework report
b. Report the Health and Wellbeing domain of the Outcomes Framework to September ICS Board
c. Establish governance mechanisms to determine the level of aspiration and subsequent pace at which it can be realistically achieved
d. Further refine the measures following their initial assessment to enable reporting on all measures – acknowledging that some measures will need to develop over time as current data availability may be limited or unavailable
e. In the longer term, ensure ability for different system and organisational levels to interpret variations in outcomes locally.

21. The Outcomes Task and Finish Group will continue to meet every three weeks and report into the monthly Population Health/Population Health Management Steering Group.

22. The key risks to the Outcomes Framework are identified as:

a. Capacity to build a fully operational report for the System Level Outcomes Framework at scale and pace that reports against all measures, is managed on an ongoing basis and meets the needs of the whole system
b. Data availability and reporting frequency/boundaries.

Recommendations

The ICS Board is asked to:

1. Note the progress to further refine and develop the System Level Outcomes Framework
2. Approve the reporting prototype, advising how the Board want to use the framework to drive discussions at the Board and across the system
3. Advise how the Board want to be involved in setting the level of aspiration for measures across the system
4. Agree the reporting frequency for future Board meetings.

ENC. D

Meeting:	ICS Board
Report Title:	Developing an ICS Strategy for Data, Analytics, Information and Digital Technology
Date of meeting:	12 July 2019
Agenda Item Number:	6
Work-stream SRO:	Andrew Haynes
Report Author:	Andrew Haw, Tom Diamond
Attachments/Appendices:	None

Report Summary:

At an ICS Board development session on 24 April 2019, the Board agreed five priorities and four enablers, one of which was 'digitalisation, IMT and analytics.' The Board agreed further consideration and work was required on all of the enablers and this paper is a first response to that.

Now is the right time to develop a system wide strategy for Data, Analytics, Intelligence and Digital Technology (DAIT) for several reasons, not least of which is the need to reflect an important contribution to the ICS 5 year plan. Moving forward we expect that the whole ICS will be powered by new insights that are derived from a deeper understanding of the data available to us and more sophisticated methods of manipulating that data to generate those insights, and we need to address the gaps in both capability and capacity in this area.

Previous work has identified that we do not collect all of the data that are required to manage the system, and we need to collaborate across our organisations to rectify that. We know that the Strategic Commissioner will have different information needs from the provider functions (ICPs and PCNs), and a different legal basis for processing data. ICPs will need consistent planning, analysis and modelling support. For each ICP to be entirely self-sufficient in these skills may lead to competition for resources in an already small pool of people with the appropriate skills. Therefore in the first instance we should explore the creation of a single shared function that can support all ICPs. Arguably, with careful system controls, that function could also provide the analytical support for both PCNs and the Strategic Commissioner.

As a community we have made good progress on developing our IT capabilities in support of direct care, but knowledge of what systems are there and how they could be used is perhaps limited, and awareness of impending developments needs to increase.

The proposal, over the next three months, is to develop a collaborative Data, Analytics, Intelligence and Digital Technology (DAIT) strategy for the ICS.

Action:

☐ To receive
☒ To approve the recommendations

Recommendations:

1.	That the scope, approach and the timing are acceptable

2.	That each organisation / partnership can make the time of key stakeholders available
3.	That the proposed staffing and governance arrangements are acceptable
4.	That a new SRO for this work be identified

Key implications considered in the report:		
Financial	☐	
Value for Money	☐	
Risk	☐	
Legal	☐	
Workforce	☐	
Citizen engagement	☐	
Clinical engagement	☐	
Equality impact assessment	☐	

Engagement to date:

Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
☐	☐	☒	☐	☐
Performance Oversight Group	**Clinical Reference Group**	**Mid Nottingham-shire ICP**	**Nottingham City ICP**	**South Nottingham-shire ICP**
☐	☐	☐	☐	☐

Contribution to delivering the ICS high level ambitions of:	
Health and Wellbeing	☒
Care and Quality	☒
Finance and Efficiency	☒
Culture	☒

Is the paper confidential?

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

Developing a System-wide Strategy for Data, Analytics, Intelligence and Digital Technology for Health and Care in Nottingham & Nottinghamshire

12 July 2019

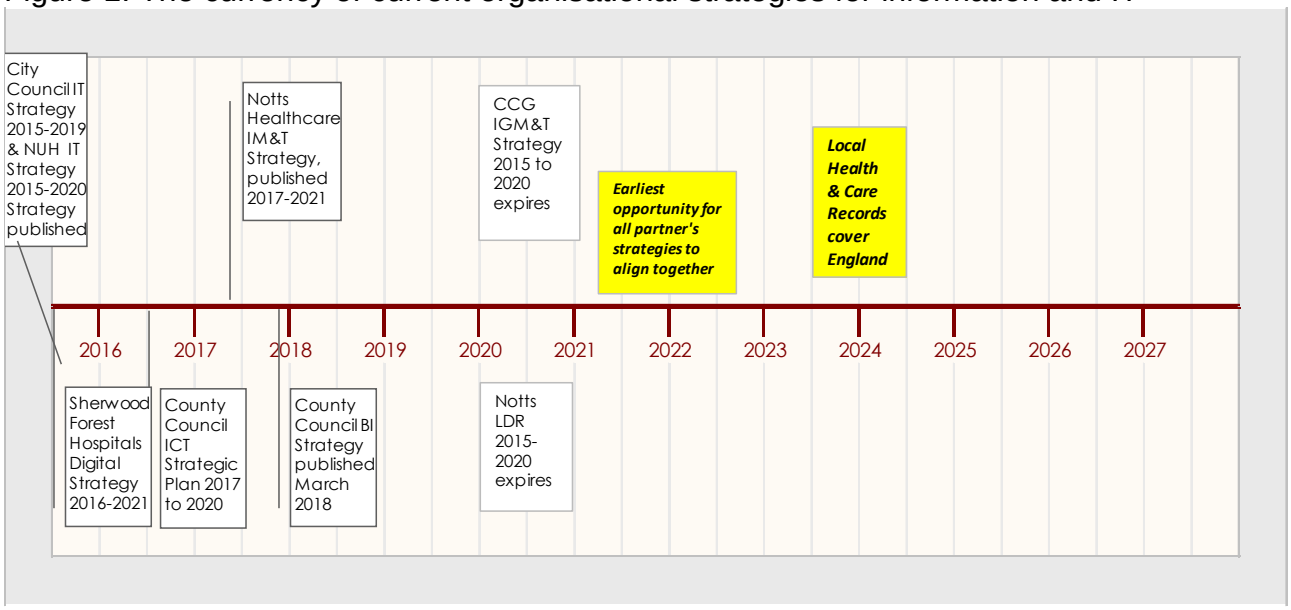
Purpose and Background

1. At an ICS Board development session on 24th April 2019, the Board agreed five priorities[1] and four enablers, one of which was 'digitalisation, IMT and analytics.' The Board agreed further consideration and work was required on all of the enablers and this paper is a first response to that.

2. In this paper the enabler is disaggregated into the strands of **Data, Analytics, Intelligence** and **Digital Technology** as differential progress has been made with each of these areas. The paper sets out the approach for developing a system wide strategy for data, analytics, intelligence and digital technology as a key enabler of the ICS's 5-year plan, over the next three months.

3. Each statutory organisation or group of CCGs already has their own strategy for IM&T or IT, and sometimes also a strategy for Business Intelligence. Most of these strategies were created before the advent of the Nottinghamshire ICS. There is no intention at this stage to require any changes to those existing strategies, although several are in the process of being refreshed or updated. All of the organisational strategies will need to be replaced by 2021 in any event. Figure 1 summarises the currency of these strategies.

Figure 1: The currency of current organisational strategies for information and IT



[1] Prevention; Proactive care, self-management and personalisation; Urgent and Emergency Care; Mental Health; and Value, resilience and sustainability.

4. The reasons we need to develop a system wide strategy for Data, Analytics, Intelligence and Digital Technology (DAIT) now are that:
    a) This forms an important contribution to the ICS 5 year plan, i.e. the system's response to the national Long Term Plan[2];
    b) The evolution towards a Strategic Commissioner, Integrated Care Providers and PCNs needs to recognise the different functions and therefore capabilities in DAIT required by them. The legal basis for processing data will also restrict what each body can do. All of the new and existing organisations will need to be powered by new insights that are derived from a deeper understanding of the data available and more sophisticated methods of manipulating that data to generate those insights;
    c) In common with other ICSs throughout the country we need to ensure that we have addressed the gaps in capability and capacity in this area. There needs to be both short term and long term actions to address the current gaps in analytical capacity;
    d) While the ICS, ICPs and PCNs are in development, there is the opportunity to agree some principles and sharing of work or approaches now that will avoid future duplications or gaps in each organisations' architecture;
    e) The Connected Notts Programme and the Local Digital Roadmap[3] are in the final year of their scope;
    f) Each of the existing organisational strategies is primarily focused on the specific needs of the organisation concerned. What is required now is a strategy comprised on those elements that the system needs to do in a consistent manner, for the benefit of all citizens, organisations and partners. The best example of this is the need for a unified approach to population health and population health management and the population health intelligence that underpins these;
    g) A specific requirement of the Long term Plan[4] is that by 2024, secondary care providers in England, including acute, community and mental health care settings, will be fully digitised. Data will be captured, stored and transmitted electronically, and Local Health and Care Record (LHCRs) will cover the whole country. LHCRs will seek to create integrate care records across GPs, hospitals, community services and social care, across a population footprint such as the East Midlands; and
    h) The need for collaboration and to minimise back office costs is at its greatest.

Current overall status

5. Each statutory organisation is at a different stage of development. Health provider organisations used to have their 'digital maturity' measured by NHS

[2] https://www.longtermplan.nhs.uk/
[3] See : https://www.connectednottinghamshire.nhs.uk/news/communications/connected-nottinghamshire-health-and-care-local-digital-roadmap/
[4] Paragraph 5.31 of Long term plan

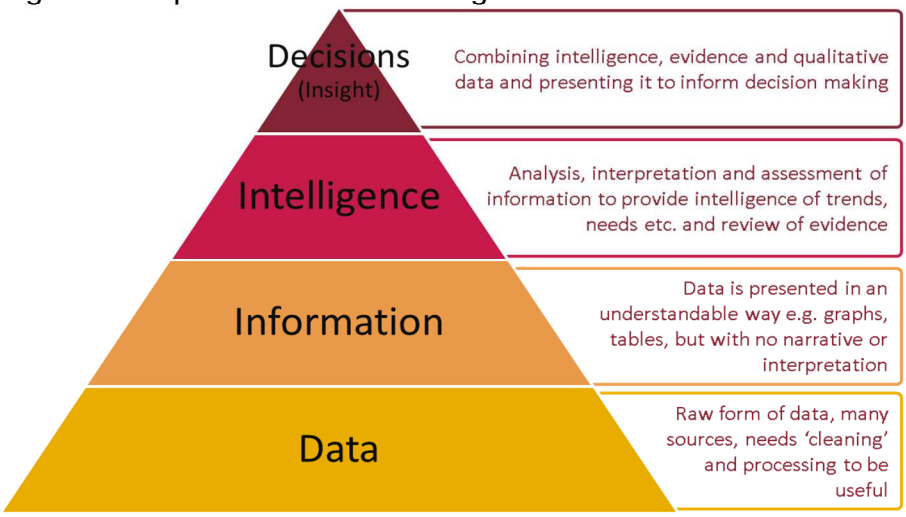
England (NHSE) and the differing levels of our organisations are summarised in the Local Digital Roadmap. This assessment has stopped now.

6. Also, director level portfolios are constructed differently; only in the City Council and Nottinghamshire Healthcare are Information / Intelligence and IT under the same leader, all other organisations have separate leaders for each, although these portfolios join up at the Executive Director level, most commonly the Director of Finance.

Definitions of data, analytics and intelligence

7. Each organisation uses its own terminology. For example, for many partners population health intelligence creates a unifying theme; others more readily identify with terminology which reflects public good related to place-shaping and wellbeing more generally, rather than to health in a narrower sense. Notwithstanding the important distinctions lying behind the differences in terminology, the diagram below at Figure 2, developed by Public Health England (PHE) describes the terms that have been used in this paper and which are of general relevance :

Figure 2: Population Health Intelligence: from data to decisions



8. In Nottinghamshire there has been some good but patchy collaboration around data, analytics and intelligence work across the system. However, as mentioned, the Population Health Management process is bringing organisations together so that there is a growing understanding by members, of the respective contributions that each organisation can make, both in understanding of data and the particular skills that each organisation has.

Status of collaboration on data

9. During the Greater Nottingham Phase 3 work it became clear that collecting the right data, at the right time and in the right way is a vital prerequisite to creating the environment in which the PCNs, the ICPs and the ICS can function effectively and prove that they have made a difference to the population and the system. Earlier work in Mid Nottinghamshire covered

similar territory. But not all of the data needed to manage the system are collected. This manifests itself in 5 ways:

a) There is a data gap, reflected in what data are collected, particularly in community care, mental health and social care;
b) There is a gap in terms of meaningful outcome measures that are calculated and used; many of the indicators calculated are of little value in an integrated care system;
c) There are inconsistencies between providers in how data are collected, which limits the ability to compare providers. For this to be rectified, providers would in some cases need to change the types of clinical and other assessments that are performed with patients and clients;
d) Data if collected are not always coded, or data dictionaries differ (i.e. what is collected and coded might not have same meaning creating difficulty when aggregating) or they are coded inconsistently across providers;
e) There is doubt whether some of the operational systems used by clinicians can cope with an increased frequency of extraction, i.e. there are limitations in how quickly and reliably data can move into a data warehouse.

10. The Greater Nottingham work also created a proposed logical information model, which if adopted, would ensure that our care givers and clinicians were collecting data in a consistent manner, thereby supporting the types of data linkages and comparative analyses that are going to be required across the whole system.

11. We know that the Strategic Commissioner will have different information needs from the provider functions (ICPs and PCNs), and a different legal basis for processing data. The Data Protection Law and GDPR will limit what type of data can be used by PCNs, ICPs and the ICS, which in turn will affect how individual functions can be performed at each level.

12. The Strategic Commissioner should only need to rely on aggregated data and indicators that can be disaggregated by a number of separate factors such as:
    - Health structures including PCNs, ICPs and the ICS
    - Areas of residence including Lower Layer Super Output Area (LSOA[5])s, Middle Layer Super Output Area (MSOAs) and other organisational boundaries
    - Deprivation across MSOAs, the ICS and other organisational boundaries
    - Protected characteristics such as age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, and other inequality metrics.

13. ICPs conversely will need both access to citizen and patient level data and consistent planning, analysis and modelling support. For each ICP to be

[5] Boundaries, published by: Office for National Statistics

entirely self-sufficient in these skills may lead to competition for resources in an already small pool of people with the appropriate skills. Therefore we should explore the creation of a single shared function that can support all ICPs. With careful system controls, that function could also provide the analytical support that both PCNs and the ICS will need. Work is continuing to arrive at a legal relationship between the types of data, the processing required and hence how functions can be legally performed by each partnership and organisation in the system.

14. Over the last 10 years in Nottinghamshire the GP Repository for Clinical Care (GPRCC) has been developed by local clinicians. The GPRCC is a clinically driven data warehouse and analytical system, supported by, and taking data from, GP practices, community services, secondary care and social services organisations across Nottinghamshire. Its focus is on improving the delivery of care to specific cohorts of patients with key medical conditions or those at risk of experiencing these. It uses algorithms to trigger the regular review of patients and identifies gaps in care for those who may be at risk of future deterioration, and opportunities for taking preventative action. It is currently only used to support direct patient care although aggregated (anonymised) data is available to support quality incentive schemes such as the General Practice Enhanced Delivery Scheme (GPEDS).

15. The GPRCC database has the potential to be the source of data and analytics wherever data about the care of citizens needs to be assembled, analysed and turned into actionable intelligence. However not every GP practice makes equal use of the system and it is not clear why, and part of the strategy work will aim to find out what factors contribute to the observed levels of usage. Similarly, the onward ownership, funding and direction of GPRCC need to be considered during the course of this work.

Status of analytics and intelligence

16. In order to deliver the underlying data and analytics required to understand and improve the health of our population, and develop an integrated analytical system to deliver this, we need to know what analytical capacity already exists locally, and could (theoretically) be deployed to support this new population health intelligence approach.

17. We also need to develop a shared view about the value of the analytical work undertaken at present. There is a view that not all of this work is enormously valuable, except to the extent that it services/monitors the current contractual arrangements and statutory requirements.

18. Using a tool recently developed by PHE and NHSE, an assessment has been made of the capability of most of the analytical workforce of the CCGs, the larger providers, all of the City Council and part of the County council. This is in the process of being fed back to heads of function at the time of writing.

19. Although this is a self-assessment tool and the findings should be interpreted with care, the initial findings from analysis of about 135 wte are as follows:

    Areas of strength include:
    - Routine monitoring
    - Database analysis
    - Analytics
    - Data visualisation

    And potential gaps in capability include:
    - Research and evaluation skills
    - Options appraisal
    - Population health approaches

20. No overall assessment has been made of the value derived from the current deployment of analytical activity across the system. It is possible that a reprioritisation of current requirements may release analytical resource for work which could deliver some of the more value-adding intelligence needed by the future system.

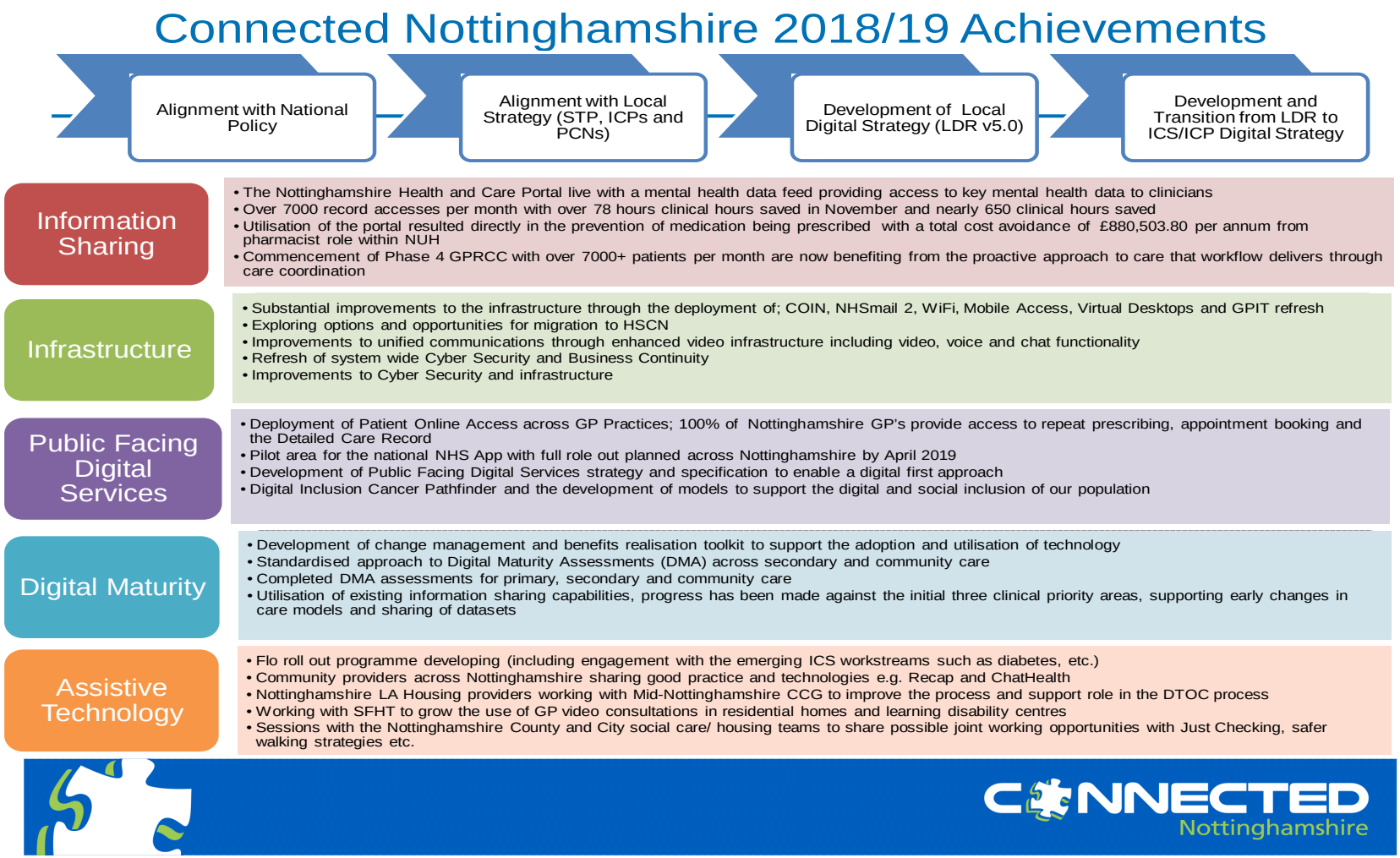
21. Overall we believe that the future system needs to develop its capability in data science[6] capability if new insights are to be powered by new data analytical approaches.

Status of Digital Technology

22. Working together through the Connected Notts Programme over the last 5 years, the community has made good progress across a number of technology focused initiatives. Figure 3 illustrates this.

[6] Health Research Data UK defines health data science as: 'Health Data Science is a discipline that combines maths, statistics and technology to study different types of health problems using data. It provides the tools to manage and analyse very large amounts of different datasets across our healthcare systems'.

Figure 3: Connected Nottinghamshire Achievements 18/19



23. Board members may also be familiar with the work to establish a Digital Health Collaborative across the main providers of IT services in healthcare across the County.

Scope

24. Although we have separated out the themes of data, analytics, intelligence and digital technology above, in strategy terms there are merits in considering all four elements together due to the inter-relationships between the components. Technology is the tool that underpins the ability to capture data and the ability of analysts and others to analyse data and turn it into meaningful analytics, new insights and actionable intelligence.

25. The ground to cover in the strategy should therefore include:
    a) The data, analytical and intelligence requirements of the Strategic Commissioner, Integrated Care Provider Partnerships and the PCNs, in particular:
        i. how each of these will underpin and enable the 5 ICS priorities of Prevention; Proactive care, Self-management and Personalisation; Urgent and Emergency Care; Mental Health; and Value, Resilience and Sustainability; and
        ii. how to support the production of intelligent outputs that combine population health management and value based healthcare (including allocative and technical efficiency) to allow decision makers to better prioritise planning and commissioning resource use to impact more predictably on ICS/ICP/PCN agreed outcomes;
    b) An assessment of where we are compared with the above requirements, including an identification of possible reductions in existing work caused by adopting a shared view of the value of existing analytical work;
    c) The digital implications of both (a) above and of the Long Term Plan;
    d) Anything that is not internal to one organisation – i.e. system wide needs for data, analytics, intelligence and digital technology;
    e) The links and dependencies between data, analytics, intelligence and digital technology e.g. key supporting infrastructure, people and their capabilities, the systems and processes used, the data that is captured, shared and integrated and the legal basis for all such processing of data;
    f) The future arrangements for ownership, management and funding of GPRCC; and
    g) The development of an implementation plan that identifies the work needed to deliver the strategy, including the work needed to directly support and enable the transformation and outcomes required for each of the 5 ICS priorities.

26. An area that is often overlooked in developing these types of strategy is the crucial importance of securing enough clinical and business change support, resource and leadership to take forward the approved initiatives. None of the improvements can be delivered without this. It will be the role of the Strategic Commissioner and each of the ICPs to identify and then provide the necessary clinical and business change support to underpin any subsequent agreed initiatives for digitalisation, IM&T or analytics.

Approach

27. The steps proposed include:
    - A synthesis of existing drivers into briefing papers;
    - A workshop of key stakeholders to both share the existing work in progress or in planning and to develop principles which all partnerships could agree with;
    - The development of emerging themes and potential new initiatives required, and socialisation of these with key stakeholder groups;
    - A draft strategy presented to the ICS board;
    - Briefing sessions to constituent organisations to obtain their feedback and
    - Production of a final strategy document and an implementation plan.

Work Plan

28. An outline plan has been developed, see Figure 4. Within the timescales for developing the strategy, the initial set of strategic decisions required will be confirmed. It is expected that sufficient decisions will have been made to allow the ICPs, PCNs and the ICS to be established as functioning partnerships.

Figure 4: Timetable for Developing the Strategy	v0.3	26 June
Activity	Milestone	**Output**
Summarise national direction and influences such as 10 year plan, National technology architecture, Topol Review, Population Health Flatpack etc	5-Jul	Briefing paper 1
Check what other leading organisations are doing in other ICS, the Local Health and Care Record Exemplars, Global Digital Exemplars[7] etc.	5-Jul	
Summarise current position and direction of existing strategies and plans e.g. Trusts, Local Authorities, CCGs IGM&T Strategy, Connected Notts / LDR, IT Collaborative, HSLI funded projects e.g. Portal, Patient Facing Digital Services, Interoperability etc.	5-Jul	
Confirm with Architecture Group where key decisions will be made; summarise existing and proposed governance arrangements	12-Jul	
Synthesise all ICS Work stream input requests	12-Jul	
List the key gaps, key decisions to be made, key principles to be adopted by September and those that can wait	12-Jul	Briefing paper 2
Run workshops to brief stakeholders about existing plans, and get stakeholders to participate in generating the strategic principles, new strategic initiatives required by the ICS, ICPs and PCNs, and their implications. Aim to run1 workshop per ICP and 1-2 others to help get everyone present who are relevant to building a consensus	22-Aug	Workshops July & Aug
Write up the workshops	23 Aug	Workshop paper 1
Session with Exec Director / Finance leads to review initial workshop outputs	06-Aug	
Key interviews with people who couldn't make it / have a view, to test emerging findings	19-Aug	
Test emerging principles and findings with each ICP, the ICS Organisation Architecture Group and IM&T Board, e.g. any new governance arrangements	27-Aug	Principles paper 1
Produce draft strategy document	06-Sep	Draft 0.1 strategy
Present to ICS Board	12-Sep	
Revise as necessary	20-Sep	Draft v0.2
Share with all statutory bodies and key working groups in the manner in which they want to do so	27-Sep	
Develop implementation plan and revise strategy as necessary	11-Oct	Draft v0.3
Formal adoption by ICPs, PCNs, and statutory bodies , if required	31-Oct	

Core Stakeholders

29. It is proposed to have a core stakeholder group and as time allows a wider group of stakeholders. The core stakeholder group would ensure that the following organisations were involved in this work :

[7] Global Digital Exemplar:" an internationally recognised NHS provider delivering improvements in the quality of care, through the world-class use of digital technologies and information. Exemplars will share their learning and experiences through the creation of blueprints to enable other trusts to follow in their footsteps as quickly and effectively as possible." See: https://www.england.nhs.uk/digitaltechnology/connecteddigitalsystems/exemplars/

- County Council, City Council, including representatives from Adults & Childrens Social Care and Public Health.
- Providers
- CCGs
- ICS, 3 ICPs and 20 PCNs

30. Each of the stakeholders would need to:
    - Identify a small number of senior managers, senior clinicians and leads for analytics, information management and digital technology who would be prepared to contribute some limited time to an internal workshop (see governance section below)
    - Attend either an ICP specific workshop (one per ICP) or a system wide workshop to develop common principles and themes for collective action
    - Review draft materials, provide comments and provide advice on how to obtain approval for the strategy with their partnership or organisation.

Wider stakeholders

31. As the work developed and as time / resources permit, the stakeholders group would be widened to include some or all of the following
    - District Councils
    - Patient groups and clinical service users
    - EMAS
    - The East Midlands AHSN
    - East Midlands PHE
    - Bassetlaw and possibly all of the Bassetlaw and South Yorkshire STP
    - The third sector.

Timing

32. For the work to be concluded in 3 months we need to aim for workshops to be in the middle of July so that a report could go to the ICS Board in September. Dates of 8, 18, 22 and 23 July are proposed (mornings).

Current governance arrangements for IM&T

33. The current governance arrangements for collaborative IM&T work were reviewed by the Population Health / Population Health Management coordination group, in the context of that work, and a number of issues with these arrangements were identified. One issue is that the current membership predominantly comprises the Heads of IT functions, and the membership needs to be broadened to include representatives from the social care and analytical communities.

34. Also the current SRO for the IM&T Management Board is leaving and a new SRO connected to the ICS Board is required. This person would both act as SRO for the development and delivery of the DAIT strategy and also oversee the refresh of the associated Governance arrangements.

Forums and Governance

35. With changes as described above, it is proposed to utilise a reformed IM&T Management Board as the day to day oversight for the work. It will be necessary for the PCNs and ICPs to make time to agenda one meeting of their governance group in the next 3 months. A single workshop for all stakeholders is proposed - probably to take place in July.

Staffing and effort

36. Leadership arrangements are in place across NHS partners to lead the development of the strategy.

37. The strategy will be developed from within current resources including the Connected Notts programme team.

Issues faced by the strategy development:

38. This list can be developed as the strategy development progresses:

- The requirements and legal bases for access to and processing of data are very different for the Strategic Commissioner and ICPs / PCNs and both need to be addressed by this work;
- Three of our main providers of health and care deliver services to the population of Bassetlaw, and Bassetlaw is part of the Bassetlaw and South Yorkshire STP and so areas of alignment and difference between Nottinghamshire and Bassetlaw need to be identified;
- The degree to which national bodies are providing guidance or are otherwise involved in the strategy and have influence e.g. the NHSD, NHSE/I, PHE and NHSX; and
- There needs to be a process to ensure that whatever is produced can become compatible with, or included within existing organisational strategies, or can be included at the next refresh of a statutory organisation's relevant strategy.

Conclusions

39. In conclusion, the time is right to begin the development of a system wide strategy for Digitalisation, IM&T and Analytics (DAIT) for the ICS. An approach has been set out that could be delivered in 3 months, and that will identify key principles of agreement and further work that would be required to take account of developments in the systems architecture and the development of new partnerships and organisations.

Recommendations

40. Board members are asked to agree that:

a) The scope, approach and the timing are acceptable
b) Each organisation / partnership can make time of key stakeholders available
c) The proposed staffing and governance arrangements are acceptable
d) A new SRO for this work needs to be identified

ENC. E

Meeting:	ICS Board
Report Title:	Update from Integrated Care Providers
Date of meeting:	Friday 12 July 2019
Agenda Item Number:	7
Work-stream SRO:	
Report Author:	Ian Curryer / Richard Mitchell / John Brewin
Attachments/Appendices:	None

Report Summary:

To update on Integrated Care Provider progress over the last month.

Ian Curryer to provide a verbal update on City ICP at the meeting.

Action:

☒ To receive
☐ To approve the recommendations

Recommendations:

Key implications considered in the report:

Financial	☒	
Value for Money	☒	
Risk	☒	
Legal	☐	
Workforce	☒	
Citizen engagement	☒	
Clinical engagement	☒	
Equality impact assessment	☒	

Engagement to date:

Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
☐	☐	☐	☐	☐
Performance Oversight Group	**Clinical Reference Group**	**Mid Nottingham-shire ICP**	**Nottingham City ICP**	**South Nottingham-shire ICP**
☐	☐	☒	☒	☒

Contribution to delivering the ICS high level ambitions of:

Health and Wellbeing	☒
Care and Quality	☒
Finance and Efficiency	☒
Culture	☒

Is the paper confidential?

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

Nottingham City Integrated Care Provider Update

12 July 2019

1. The City ICP has been meeting fortnightly as an informal development group since March. The approach has been highly inclusive with attendees including City VCS, CityCare, ICS leadership, Framework, Nottingham City Homes, NHS and LA commissioning, NUH, the Healthcare Trust and Local Authority social care and public health.

2. Full recruitment of the eight PCN Clinical Directors has been completed and all have started in their new roles as of 1 July. We are now out to appoint 8 deputy Clinical Directors to both further support and accelerate PCN development across the ICP and encourage new clinical leadership. Development work on PCNs to widen participation beyond GPs has been agreed with NHSE.

3. A focus on system leadership and culture has been at the forefront of thinking to date with a large emphasis on ensuring the setup of the PCNs, communications and launch of the ICP reflect this. A subset of the development group have also been engaged on systems leadership work with the NHS Leadership Academy Living Systems programme.

4. Governance and Senior Management Teams have been proposed and are moving forwards. The Governance is envisaged to be separate from the City Health and Wellbeing Board (HWBB) but to run back to back with the HWBB in order to build streamlined agendas. Discussions with the CCG on arrangements for clinical leadership and commissioning alignment to the ICP following CCG merger are ongoing.

5. A full time programme lead for the ICP will be recruited shortly and discussion with partners will follow in regard to resources to support the ICP/PCNs.

6. Immediate term priorities for the City have been proposed around social prescribing, end of life, smoking, childhood flu vaccination, excluded and vulnerable groups such as homelessness, admissions avoidance.

7. The ICP partners, including Framework and VCS colleagues, have been actively engaged in developing the ICS Transformation bid proposals (£1.3m for the City) which have been submitted to the ICS in line with the priorities in point 6. This has enabled cross checking with the South ICP for potential joint proposals such as the High Intensity Service Users bid.

8. An ICP wide protected learning time schedule for the PCNs has started and will run over the next 12 months. The sessions will focus on the domains that will have the biggest influence on population health in the longer term with respect to reducing inequalities and improving outcomes. The topics include diabetes, cancer, mental health, respiratory disease, frailty and cardiovascular disease.

9. Following local elections and the new City Council, induction of new councillors into the work associated with integration is taking place.

Ian Curryer
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12 July 2019

Mid-Nottinghamshire Integrated Care Partnership Board Update – June 2019

1. Below is a summary of the key discussions and decisions taken at the latest Mid-Nottinghamshire ICP Board which met on June 11, 2019.

Primary Care Network Update

2. David Ainsworth reported that there were four broad strategic workstreams underpinning the PCN work: governance and General Practice collaboration; community and mental health integration; non-health partners' engagement, and primary/ secondary care integration.

3. PCN Clinical Directors had been appointed and every practice within Mid-Nottinghamshire had signed up to the contractual specification. The Mid-Nottinghamshire system would also be working with the CQC to help shape national policy around the way in which PCNs would be regulated.

4. Members noted that Mid-Nottinghamshire PCNs intended to submit expressions of interest to become accelerator sites and a Social Prescribing Workshop had been held, with representation from all sectors, to co-design the model with PCNs.

ICP Transformation Monies

5. The 2019/20 £1.5m transformation monies proposal was discussed, noting that the focus of the transformation funding was on accelerating pre-existing 2019/20 schemes designed to deliver better health and wellbeing outcomes for citizens, reduce activity and cost for 2019/20 and reduce the risk of non-delivery of the ICP control total. The Integrated Rapid Response Service (IRRS) and Home First Integrated Discharge (HFID) schemes were critical programmes of work for this, taking up approximately £1million of funding.

6. The funding proposal presented at the ICP Board was established on the basis of the ICS Board criteria as discussed at the Transformation Board. However it became apparent that the Transformation Board membership does not include representation from all ICP partners and so there was not a common understanding at ICP Board level of the planned schemes and the need to ensure delivery. Richard Mitchell apologised for this oversight.

7. It was therefore agreed that the ICP Board was supportive of the broad principles around improving discharge and secondary care demand. However, further discussions with partner organisations were required around agreeing a collective way to best use the funding and will be signed off at July's Board.

Developing an ICP strategy and identity

8. The corporate plans and strategies of partners across Mid-Nottinghamshire have been pulled together to give three overarching priorities for the ICP which is to create:

    - Better places to live

- Better places to work
- Happy, healthier communities

9. Work will now be undertaken with partners to discuss potential strategic intentions which will underpin these.

10. Work on the ICP identity is ongoing with the narrative being further worked up. The Board took the decision that going forward it would be known as Mid-Nottinghamshire Integrated Care Partnership in keeping with Bassetlaw ICP.

End of Life Care collaboration

11. The Board received a presentation from Deb Elleston and Carl Ellis on the End of Life Care work which demonstrated the service had improved patient quality, delivered financial savings and ensured better quality at lower cost. There is still more work to be done to target people in the last 12 months of life rather than the last few days of life.

12. The ICP Board agreed to continue to support this service going forward. Mark McCall from Nottinghamshire County Council offered to support with in-reach and engagement with care homes.

Home First Integrated Discharge (HFID) Plan update

13. The Board received an update on the HFID plan which aims to navigate patients home through discharge to assess pathways. Phase one of the model had gone live, but it was too soon to see performance. There were some issues across the system which needed to be addressed to support delivery, particularly around culture change, responsiveness and communication.

14. Discussion took place around the HFID model with members agreeing that it was absolutely the right thing to do for patients and was consistent with the ICS work around discharge pathways.

Governance (Terms of Reference/Membership)

15. Work continues in this area to ensure the relevant documentation is fit for purpose by reflecting the membership and aims of the ICP. This includes reviewing and refreshing the Alliance Agreement legal document.

16. The next ICP meeting will take place on July 9 and key issues for discussion will be inequalities broken down to PCN level, and how engagement and involvement will be taken forward across the ICP.

Richard Mitchell
Mid Nottinghamshire ICP Lead
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12 July 2019

Update from South Nottinghamshire Integrated Care Provider
12 July 2019

Background

1. The South Nottinghamshire ICP has established a Development Group to set up the initial governance structures for the ICP, and to support the initial priority areas for delivery.

2. The Group meets on a fortnightly basis, alternating between a formal Development Group session, and an "Engine Room" meeting focused on delivery of the ICP's emerging priorities for both service transformation and the development of the ICP.

Developing the ICP's vision, goals and identity

3. An engagement approach has been agreed for the next 2 months to support the development of the ICP.

4. A facilitated development session is being held on 31st July with a broad stakeholder group including PCN Clinical Directors, District and Borough Councils, HealthWatch and clinical leaders from the ICP's provider organisations. The aim of this session is to develop a shared vision and purpose for the South Nottinghamshire ICP.

5. A further session is being held on 4th September to focus on the critical role of the District/Borough Councils and the wider community sector in the ICP and how to ensure that this is harnessed to maximise the opportunities offered by our partnership.

6. Work has commenced to define the ICP's priorities. These are aligned to the emerging system priorities and enablers agreed by the ICS and will be refined through the engagement work outlined above and the on-going work on the ICS five year plan.

ICP Transformational Funding

7. The ICP has identified five priority schemes for the £1.3m transformation fund allocated to South Nottinghamshire ICP that support the emerging priorities of the ICP.

8. Further work will take place in July and August to ensure the ICPs accelerates delivery of these schemes across the partnership, and the appropriate governance is in place to monitor delivery.

Meetings in common with City ICP

9. In recognition of the patient flows within Greater Nottingham, City and South Nottinghamshire ICPs have agreed to hold regular meetings in common.

10. The next meeting in common is planned for July/August to focus on ensuing alignment in the schemes supported through the transformational funding where the schemes will be delivered at a Greater Nottingham footprint.

John Brewin
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4 July 2019

ENC. F

Meeting:	ICS Board
Report Title:	Development of a single strategic commissioner and alignment of resources with the developing places and neighbourhoods
Date of meeting:	Friday 12 July 2019
Agenda Item Number:	8
Work-stream SRO:	
Report Author:	Amanda Sullivan
Attachments/Appendices:	Appendix 1 Overview of integrated care system and their priorities from the Long-Term Plan

Report Summary:

The Long Term Plan sets out a vision to put the NHS on a strong footing for the future. An important element of this is to create leaner more strategic commissioners, usually one per ICS. As such, the six Nottingham and Nottinghamshire CCGs are working towards merger.

The CCGs are also restructuring in order to develop into a single strategic commissioner and to align relevant functionality with the developing ICPs and PCNs. Proposed alignment is still subject to confirmation and the results of a staff consultation will be known later in July. However, proposals are consistent with the previous system architecture development across the ICS and recent national guidance.

CCG statutory duties, membership model and emphasis on clinical leadership will remain in the new structures. Strategic commissioning functions will be aligned to the single CCG, whilst other functions will be delivered as a joint system resource alongside provider and local government partners. In some cases, functions will need to be shared across ICPs, in order to make best use of resources. Some functions will be aligned with ICPs.

Action:

☒ To receive
☐ To approve the recommendations

Recommendations:

1.	Note the progress with staff consultation and restructuring across the CCGs
2.	Note and discuss the proposed alignment of functions in line with the developing system architecture
3.	Note that this is a developing area and will be subject to further iterations as the system develops

Key implications considered in the report:

Financial	☐	
Value for Money	☐	
Risk	☐	
Legal	☐	

Workforce	☒	The paper sets out the proposed alignment of the commissioning workforce with the developing system architecture
Citizen engagement	☐	
Clinical engagement	☐	
Equality impact assessment	☐	

Engagement to date:

Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
☐	☐	☐	☐	☐
Performance Oversight Group	Clinical Reference Group	Mid Nottingham-shire ICP	Nottingham City ICP	South Nottingham-shire ICP
☐	☐	☐	☐	☐

Contribution to delivering the ICS high level ambitions of:

Health and Wellbeing	☒
Care and Quality	☒
Finance and Efficiency	☒
Culture	☒

Is the paper confidential?

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

DEVELOPMENT OF A SINGLE STRATEGIC COMMISISONER AND ALIGNMENT OF RESOURCES WITH THE DEVELOPING PLACES AND NEIGHBOURHOODS

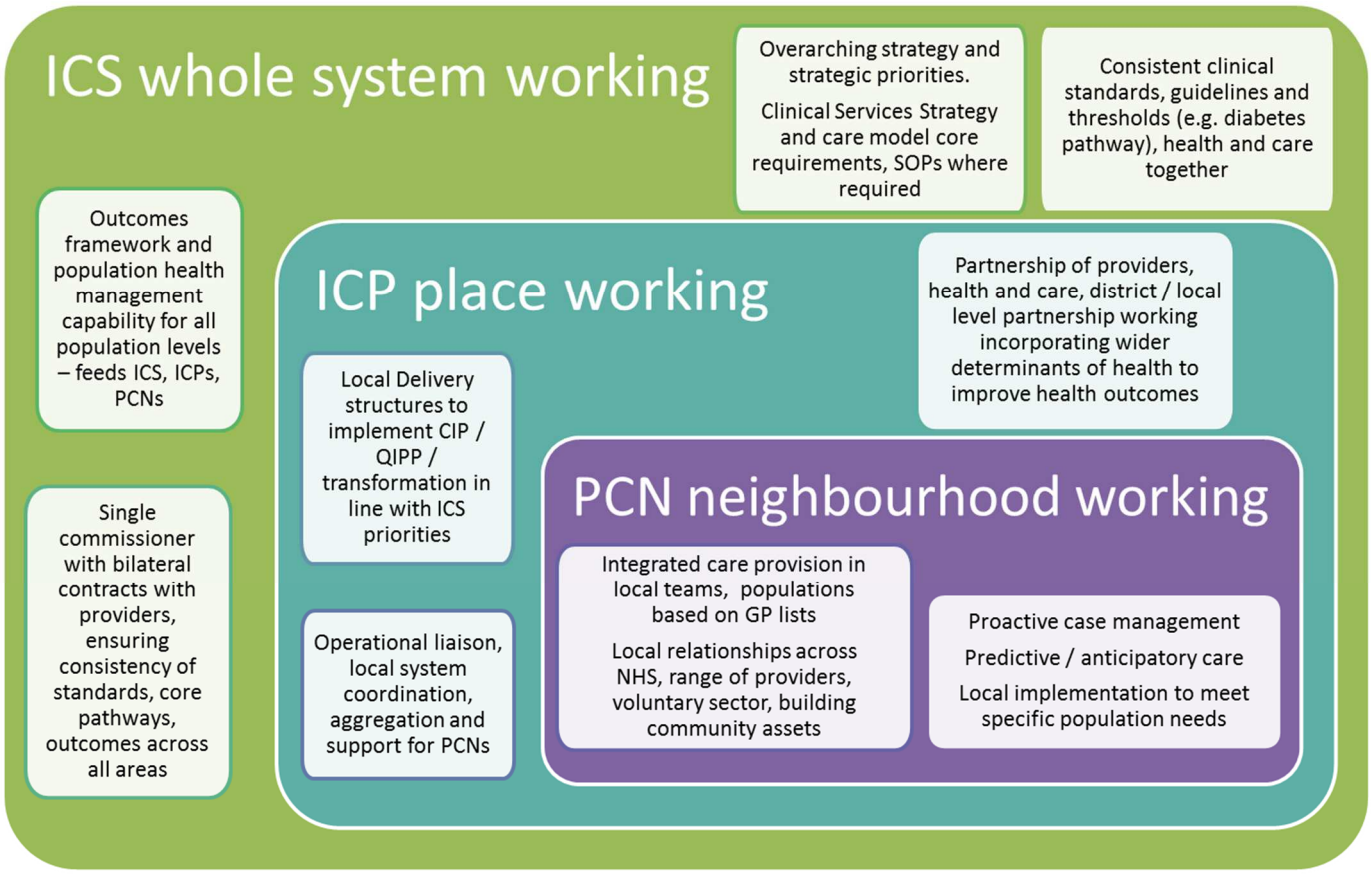
12 July 2019

The way in which CCGs operate is changing in order to be fit for the future.

1. The Long-Term Plan sets out a vision to put the NHS on a strong footing for the future, enabling it to provide high quality life-saving treatment whilst investing every penny wisely on what matters most. An important element is the move to streamline CCGs to become leaner, more strategic organisations. CCGs will have the capability to develop population health management and commission integrated care across provider groups.

2. There will typically be one CCG per ICS. Accordingly, the six CCGs in Nottingham and Nottinghamshire are aligning structures and processes and are working towards a full merger by 1 April 2020.

3. The ICS has undertaken significant work to design an integrated way of working at system, place and neighbourhood level. The CCGs are aligning structures in line with those design principles applied to these levels of population working, as shown below[1]:



The CCG changes will begin to create a single strategic commissioner and align relevant functions to local care delivery.

4. The CCGs appointed a single Accountable Officer in November 2018. During January-March 2019, a process was undertaken to establish a single executive and senior management team. Subsequently, team structures were designed and a staff consultation was commenced. Feedback on the outcome of this consultation will be presented to staff later in July. It is anticipated that the new structures will be populated by the end of August 2019. Staff will retain their CCG terms and conditions of service, whilst some will be aligned and then embedded within emerging places and neighbourhoods.

5. Staff structures have been designed on the basis of emerging national guidance, learning from other merged CCGs and ICSs, best practice in commissioning and developing relationships with places and neighbourhoods. All CCGs have to reduce running costs by 20%, so this has also been a factor.

CCGs were established as local, clinically-led groups to plan, buy and monitor local services.

6. The key functions of CCGs are shown below:

7. There has been significant clinical engagement and leadership within the CCGs and this will be retained in the future. CCGs are GP membership organisations and this will be retained in future structures. CCG directorates are designed in line with the commissioning cycle, including service planning, design and commissioning, contracting, finance, information and performance, quality and primary care. The primary care teams provide operational support for general practice as well as commissioning, since the independent contractor model requires a different level of support and coordination.

8. The way in which CCG functions are executed is changing and becoming more collaborative, particularly in relation to planning and service redesign. Strategic planning is undertaken in line with local authority Joint Strategic Needs Assessments and Health and Wellbeing Boards. The ICS Board now also has a role in determining overall strategy and the Clinical Services Strategy development is a system-wide endeavor. Capacity and demand planning and management are undertaken collaboratively, with leadership within the ICPs. Public and patient engagement is also hosted within the ICS team.

Although the NHS landscape will continue to evolve in the coming months and years, the future role of strategic commissioners is becoming clear.

9. The statutory duties of CCGs are unlikely to change substantively, although some tactical functions will be executed as part of local provider collaborations. There will also continue to be more collaboration across providers and commissioners in relation to service design and change, as well as resource prioritisation and demand management.

10. Local and national work points towards a range of functions as follows:

- Develop population health management processes and capability across the system
- Engage with local populations in the design and development of health services
- Develop a long-term system financial strategy alongside partners
- Deliver clinical and financial balance sustainability across the local system
- Commission transformation of services, designing and delivering large-scale change with partners
- Oversee and mitigate quality and equality impacts
- Monitor the quality of care provided and drive improvement where necessary
- Provide professional leadership across the system (nursing, therapies, pharmacy, linking general practice with secondary care)
- Drive the personalisation agenda

- Commission for outcomes across places through the development of ICP contracts and PCNs
- Provider / market development

11. It is likely that health and local government commissioning will be more joined up, if we are to maximise health outcomes and wellbeing. Over time, some commissioners may hold contracts with places rather than organisations, although this would require significant system development in order to transfer financial and operational risk on a population capitation basis.

Alignment of CCG staff will be in line with the functions required at each population level

12. Staff who undertake the functions that will remain at the strategic commissioning level will be aligned at CCG / ICS level. It will be important for the CCG team to continue to develop close working relationships with the ICS team, so that duties can be executed effectively and service commissioning is in line with overall ICS plans.

13. Teams that work in roles that relate to ICP / PCN core functions will be aligned to these areas. In some cases, individuals will be aligned to a specific ICP or PCN. In other cases, where there is only one team, they will need to work across more than one ICP in order to make the best use of resources.

14. The staff consultation outcomes will be fed back to teams later in July, but indicative alignment of core areas (WTE, subject to confirmation) is as follows:

Function	**Strategic Commissioner**	**System CCG / ICP / PCN enabling function (jointly resourced)**	**ICP / PCN**
Finance and business intelligence Indicative staff numbers	Financial strategy, oversight and management of key portfolio areas (acute, primary care, mental health, community, continuing healthcare) 25-30	Contract and performance monitoring, activity and analytics Data management and population health management 50	Primary care IT (hosted function across the ICS) PCN finance 10
Commissioning and contracting	Commissioning strategy, development and oversight of key portfolio	Operational contract management / supply chain management	ICP and PCN development

Function	Strategic Commissioner	System CCG / ICP / PCN enabling function (jointly resourced)	ICP / PCN
	areas (proactive and urgent care, planned care, mental health, community, primary care) Procurement and commercial development Place and neighbourhood development Joint commissioning Special projects Planning (jointly with ICS team) EPRR Research and evaluation	(aligning with ICPs over time) Implementation of service change (subject matter experts) Estates	Primary care service development Management of unwarranted clinical variation
Indicative staff numbers	55	45	40
Quality and Governance	Governance Nursing and pharmacy professional leadership Personalised care commissioning Provider quality assurance / oversight Patient experience Health outcomes Strategic medicines management	Continuing healthcare Personal health budgets Infection prevention and control Safeguarding Quality	Medicines optimisation
Indicative staff numbers	105	25	37

Alignment is likely to evolve over time, as the system develops further.

Amanda Sullivan
CCG Accountable Officer

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Appendix 1

Overview of integrated care system and their priorities from the NHS Long-Term Plan

Level	Functions	Priorities from the NHS Long-Term Plan
Neighbourhood (c.30,000 to 50,000 people)	• Integrated multi-disciplinary teams • Strengthened primary care through primary care networks – working across practices and health and social care • Proactive role in population heath and prevention • Services (e.g. social prescribing) drawing on resource across community, voluntary and independent sector, as well as other public services (e.g. housing teams).	• Integrate primary and community services • Implement integrated care models • Embed and use population health management approaches • Roll out primary care networks with expanded neighbourhood teams • Embed primary care network contract and shared savings scheme • Appoint named accountable clinical director of each network
Place (c.250,000 to 500,000 people)	• Typically council/borough level • Integration of hospital, council and primary care teams / services • Develop new provider models for 'anticipatory' care • Models for out-of-hospital care around specialties and for hospital discharge and admission avoidance	• Closer working with local government and voluntary sector partners on prevention and health inequalities • Primary care network leadership to form part of provider alliances or other collaborative arrangements • Implement integrated care models • Embed population health management approaches • Deliver Long-Term Plan commitments on care delivery and redesign • Implement Enhanced Health in Care Homes (EHCH) model
System (c.1 million to 3 million people	• System strategy and planning • Develop governance and accountability arrangements across system • Implement strategic change • Manage performance and collective financial resources • Identify and share best practice across the system, to reduce unwarranted variation in care and outcomes	• Streamline commissioning arrangements, with CCGs to become leaner, more strategic organisations (typically one CCG for each system) • Collaboration between acute providers and the development of group models • Appoint partnership board and independent chair • Develop sufficient clinical and managerial capacity
NHS England and NHS Improvement (regional)	• Agree system objectives • Hold systems to account • Support system development • Improvement and, where required, intervention	• Increased autonomy to systems • Revised oversight and assurance model • Regional directors to agree system-wide objectives with systems • Bespoke development plan for each STP to support achievement of ICS status
NHS England and NHS Improvement (national)	• Continue to provide policy position and national strategy • Develop and deliver practical support to systems, through regional teams • Continue to drive national programmes e.g. Getting It Right First Time (GIRFT) • Provide support to regions as they develop system transformation teams	

ENC. G1

Meeting:	ICS Board
Report Title:	ICS Performance Deep Dive Report - Cancer
Date of meeting:	Friday 12 July 2019
Agenda Item Number:	9
Work-stream SRO:	Richard Mitchell
Report Author:	Simon Castle
Attachments/Appendices:	Enc. G2 Performance Deep Dive – Cancer Enc. G3. Performance Deep Dive Report - Presentation

Report Summary:

At the 13 June ICS Board meeting the Board requested a deep dive into the performance of red rated areas. This report provides an overview of Cancer performance.

Action:

☒ To receive
☐ To approve the recommendations

Recommendations:

Key implications considered in the report:

Financial	☐	
Value for Money	☐	
Risk	☐	
Legal	☐	
Workforce	☐	
Citizen engagement	☐	
Clinical engagement	☐	
Equality impact assessment	☐	

Engagement to date:

Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
☐	☐	☐	☐	☐
Performance Oversight Group	**Clinical Reference Group**	**Mid Nottingham-shire ICP**	**Nottingham City ICP**	**South Nottingham-shire ICP**
☐	☐	☐	☐	☐

Contribution to delivering the ICS high level ambitions of:

Health and Wellbeing	☒
Care and Quality	☒
Finance and Efficiency	☒
Culture	☒

Is the paper confidential?

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

ICS Performance Deep Dive Report

Item 9. Enc. G2

PERFORMANCE AREA - Cancer	MONTH YEAR – June 2019
SRO :	Richard Mitchell
ICS Programme Lead :	Simon Castle
Date of report	01/07/2019

Performance Area – Key Indicators

Area	Cancer Indicator	Std	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
STP	Cancer 62 Days	85%	81.8%	83.8%	83.1%	79.6%	79.4%	80.3%
STP	Cancer 2 Week Waits	93%	95.0%	96.4%	95.0%	96.8%	94.8%	92.0%
STP	Cancer 2 Week Waits - Breast	93%	96.2%	99.3%	98.1%	96.6%	92.0%	94.6%
STP	Cancer 31 Days - First Definitive Treatment	96%	96.5%	97.4%	93.8%	96.1%	92.7%	92.9%
STP	Cancer 31 Days - Subsequent Treatment - Surgery	94%	82.2%	93.3%	83.9%	92.5%	85.6%	80.5%
STP	Cancer 31 Days - Subsequent Treatment - Anti Cancer Drugs	98%	99.2%	100.0%	98.3%	99.5%	98.9%	98.7%
STP	Cancer 31 Days - Subsequent Treatment - Radiotherapy	94%	99.4%	100.0%	97.5%	99.1%	99.0%	100.0%
STP	Cancer 62 Days - Treatment from Screening Referral	90%	87.9%	93.0%	84.0%	100.0%	93.3%	92.6%
STP	Cancer 62 Days - Treatment from Consultant Upgrade	n/a	84.4%	91.7%	87.8%	92.6%	90.9%	88.5%
NUHT	Cancer 2 Week Waits	85%	80.2%	78.9%	78.1%	75.3%	73.2%	74.7%
Circle	Cancer 2 Week Waits	85%	85.9%	92.4%	89.5%	89.2%	82.6%	90.8%
SFHT	Cancer 2 Week Waits	85%	85.1%	84.3%	84.5%	80.3%	88.4%	82.2%

Current Barriers to Achieving Required Performance

- Significant increase in demand as a consequence of national strategy to improve early diagnosis rates and therefore survival https://www.england.nhs.uk/cancer/early-diagnosis/ (national and local campaigns to raise symptom awareness https://www.nhs.uk/be-clear-on-cancer, reducing thresholds for GP referral https://www.nice.org.uk/guidance/ng12). 2WW referrals increased 35% in last 4 years, cancers treated up 20%.
- Difficulty recruiting to fill vacancies, particularly radiology and oncology, but also specialist consultant posts e.g. Head & Neck. National Cancer Workforce Plan developed in Dec 2017, however impact limited to date. https://www.hee.nhs.uk/sites/default/files/documents/Cancer%20Workforce%20Plan%20phase%201%20-%20Delivering%20the%20cancer%20strategy%20to%202021.pdf
- Specific increases in demand in Urology - referrals up 28% in 2018 (Fry and Turnbull effect, https://www.bbc.co.uk/news/health-45795337) and Lower Gi – referrals up 57% (local implementation of FIT test, https://www.bbc.co.uk/news/uk-england-nottinghamshire-47792829).
- Increasing specialisation of diagnostics and treatments leading to increased demand at tertiary centres
- Diagnostic capacity – notably MRI / CT Colon and Endoscopy. Both physical and staffing capacity

Current Barriers to Improvement

- Ability to recruit to vacancies / new posts – e.g. radiology (out to recruitment 4 times for Uro-radiology consultant, chemotherapy). National demand for similar posts
- Theatre capacity to meet demand in treatment numbers, and access to robotic surgery.
- Diagnostic capacity (imaging, endoscopy, pathology)
- Tax & Pension changes affecting number of waiting list initiatives being undertaken to address peaks in demand.

What needs to be done differently (confidence that this will deliver improvement)

• Implement National Rapid Cancer Diagnostic and Assessment pathways for Lung, Colorectal, Prostate, Upper GI - https://www.england.nhs.uk/publication/rapid-cancer-diagnostic-and-assessment-pathways/ .
  o National Transformational funding being provided via Cancer Alliances. Over £1m to the ICS in 18/19. Similar figure in 19/20.
  o Aim to deliver referral to diagnosis 28 day pathways via 'one stop shop' models (multiple tests in one visit – requires hot reporting)
  o Significant progress made to date – Pre biopsy MRI in Urology, FIT and straight to test colonoscopy in Lower GI, straight to test CT Lung.
• Maximise diagnostic capacity;
  o Increase utilisation of provider capacity e.g. expansion at NUH re Endoscopy
  o Increase use of private sector where appropriate (MRI, CT, endoscopy commissioned),
  o Share capacity across East Midlands providers (Cancer Alliance leading on this),
  o Utilisation of latest equipment and technology e.g. Fusion biopsy software in Prostate cancer, Artificial Intelligence in Radiology (Breast and Lung cancer imminent).
• Robust Demand and Capacity Modelling;
  o Being undertaken by providers. Completed by end of June.
  o A number of additional posts already approved and being recruited to (Urology, Gynaecology, Lower GI, Lung, Oncology). Concerns still around ability to fill posts.
• Workforce development;
  o E.g. reporting Radiologists, chemotherapy practitioners, nurse specialists undertaking triage, diagnostics and treatments.
  o Good progress in ICS, but concerns around time lag and ability to impact on performance in the short term.
• Improve quality of referrals to enable rapid access to correct tests and avoid inappropriate consultations;
  o Standardise referral forms, pre-populate from GP Systems – completed.
  o Ensure referrals are complete and appropriate tests undertaken before referral.

What is needed from the ICS Board
• Recognition that there is multiple root causes to the current performance position. • Recognition that demand will continue to rise in order to improve early diagnosis / survival rates. • Endorse and support implementation of National Diagnostic and Assessment Pathways. • Endorse and support utilisation of private sector where appropriate, until additional posts and capacity come on-line.

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ICS Performance Deep Dive Report

- **Cancer**

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National and Local Context

- **Current Barriers to Achieving Required Performance**

Integrated Care System
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Diagnosing cancer earlier and faster

Cancer survival rates in England are higher than they have ever been and earlier diagnosis is the key to improving survival rates further.

In 2016 NHS England made £200m available to ensure we can diagnose cancer earlier and faster, and achieve the Independent Cancer Taskforce ambition that 57% of patients would survive ten years or more by 2020, with 75% surviving one year. Earlier cancer diagnoses will enable us to meet this ambitious goal, as it means patients can receive treatment when there is a better chance of achieving a complete cure. Progress made on achieving early and faster diagnosis includes:

- Introduction of new models of care
- Launch of Be Clear on Cancer campaigns
- Developing new diagnostic tests
- Introducing Rapid Diagnostic and Assessment Centres
- Began to pilot a new 28-day faster diagnosis standard
- Released the new Cancer Workforce Plan
- Targeted Lung Health Checks

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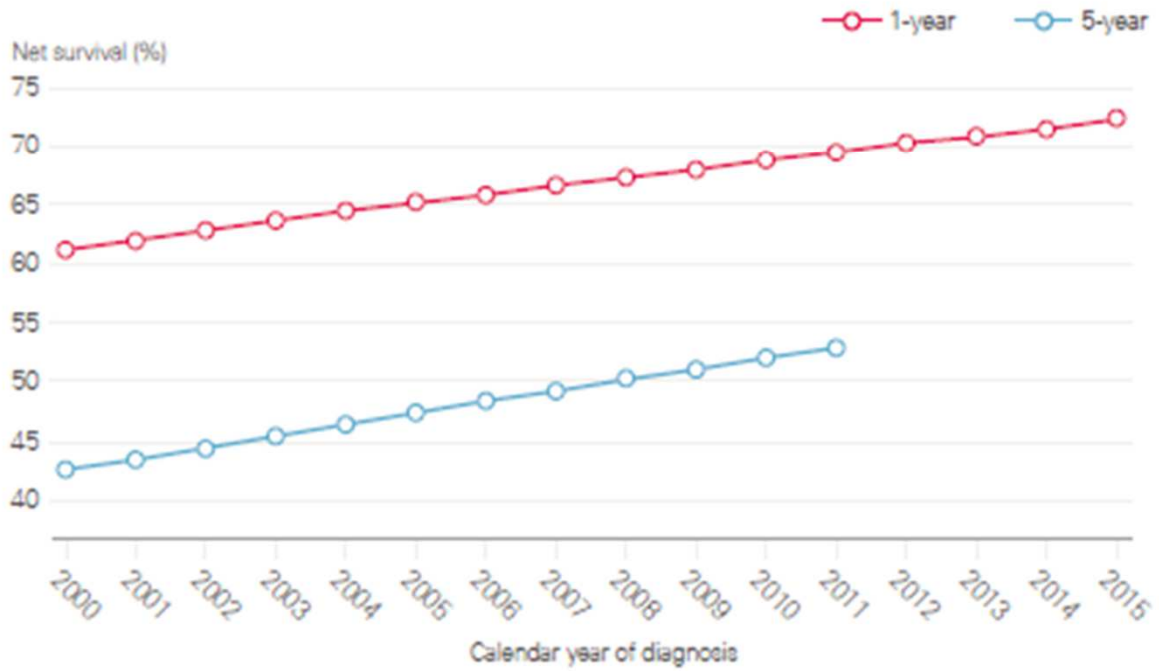
2.3 Cancer survival

Half of people diagnosed with cancer in England now survive their disease for 10 years or more, and both 1- and 5-year cancer survival (all cancers combined), has been steadily improving in England over the period covered by this report (Figure 9).

Figure 9: 1- and 5-year net survival for all adult cancers (15 to 99 years) between 2000 and 2015 (age, sex and cancer-type standardised), England



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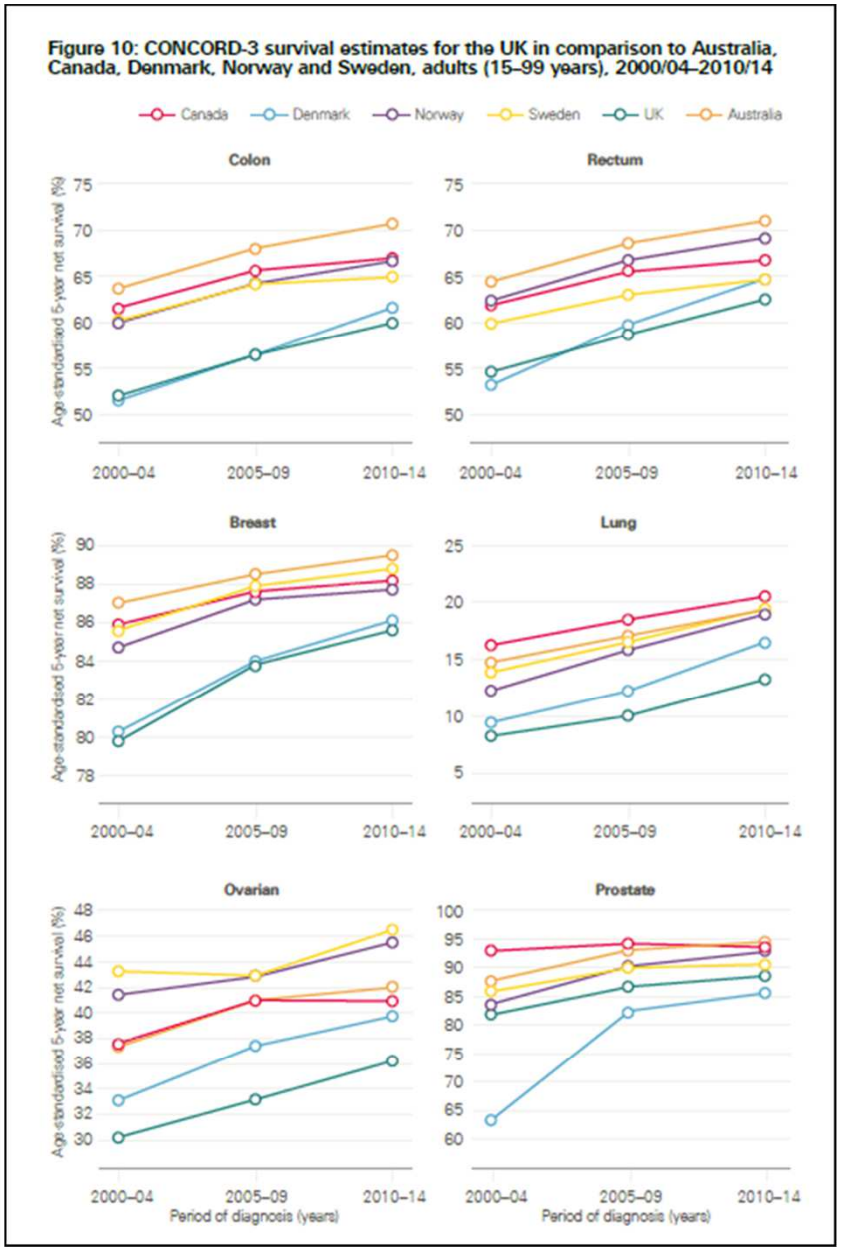

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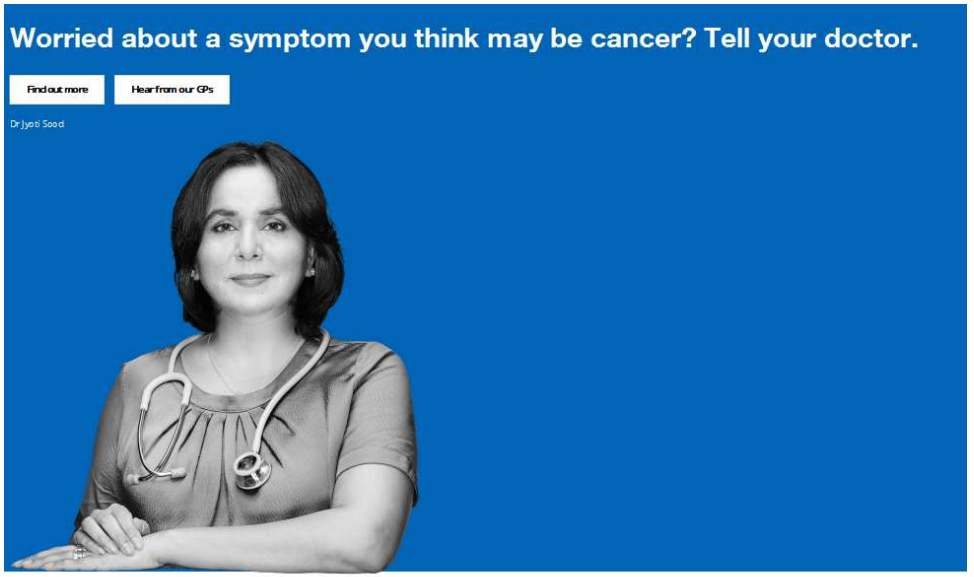

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Suspected cancer: recognition and referral

NICE guideline [NG12] Published date: June 2015 Last updated: July 2017

Guidance | Tools and resources | Information for the public | Evidence | History

Overview

- Introduction
- Patient–centred care
- Terms used in this guideline
- 1 Recommendations organised by site of cancer
- Recommendations on patient support, safety netting and the diagnostic process
- Recommendations organised by symptom and findings of primary care investigations
- 2 Research recommendations
- Update information

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Guidance

NICE interactive flowchart - Suspected cancer recognition and referral 4 Quality standards

Next >

This guideline covers identifying children, young people and adults with symptoms that could be caused by cancer. It outlines appropriate investigations in primary care, and selection of people to refer for a specialist opinion. It aims to help people understand what to expect if they have symptoms that may suggest cancer.

In July 2017, recommendation 1.3.4 was replaced by NICE diagnostics guidance on quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care.

Recommendations

This guideline includes recommendations on the symptoms and signs that warrant investigation and referral for suspected cancer.

The recommendations are organised by:

- the site of the suspected cancer

Have you...

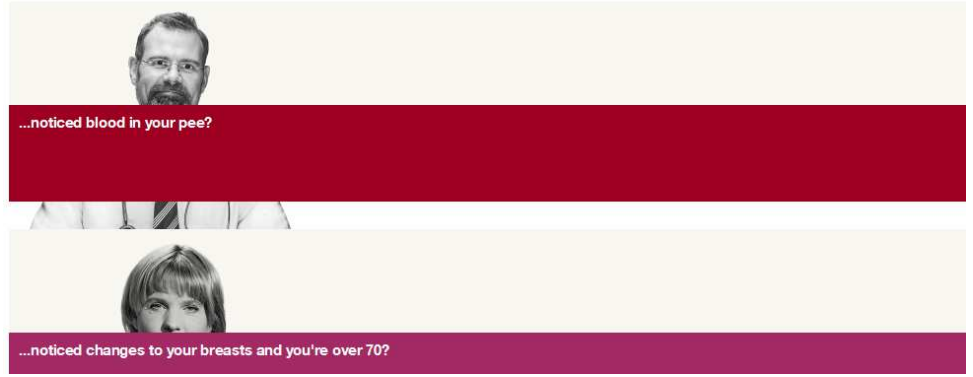

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Figure 21: Urgent GP referrals and proportion seen within 14 days between Q4 2008/09 and Q2 2018/19, England

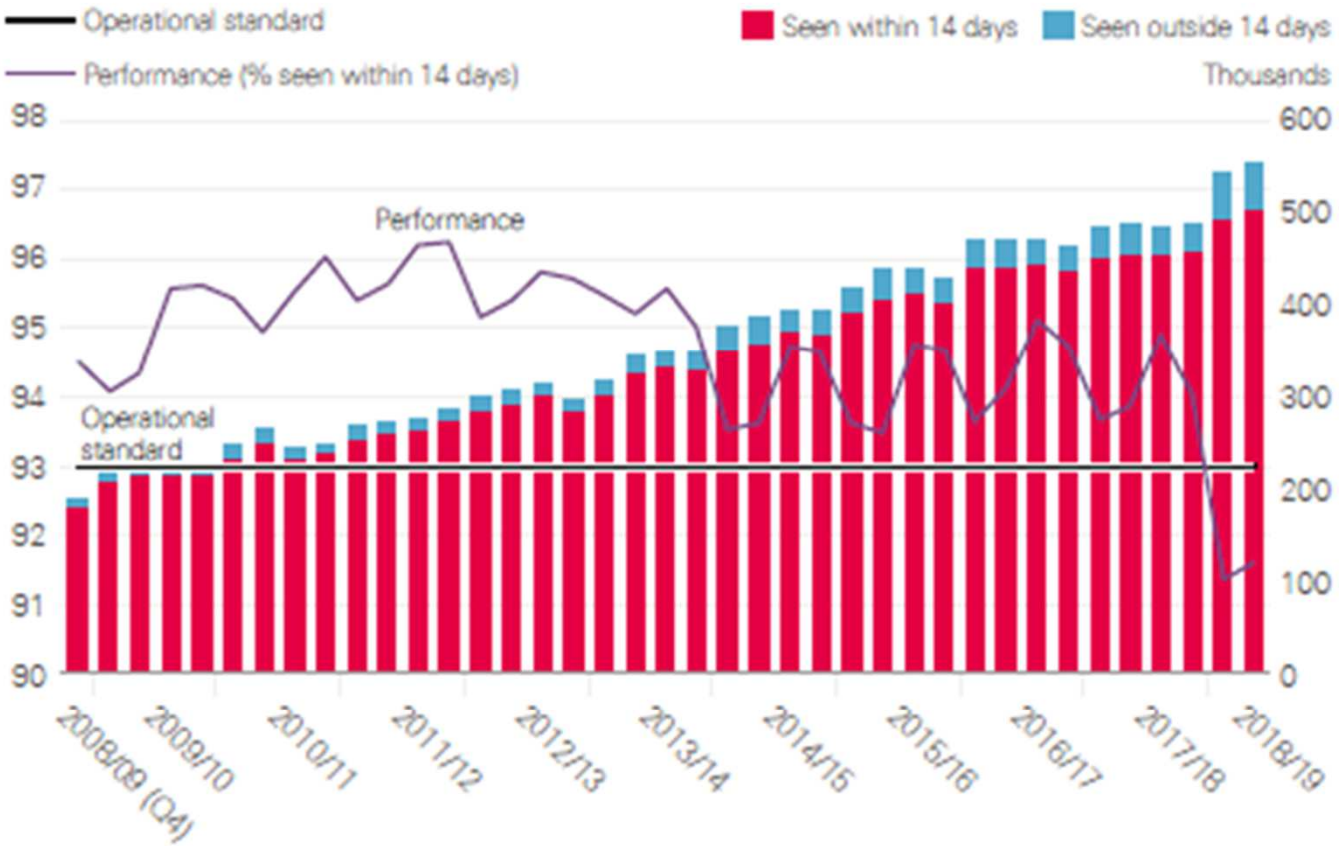

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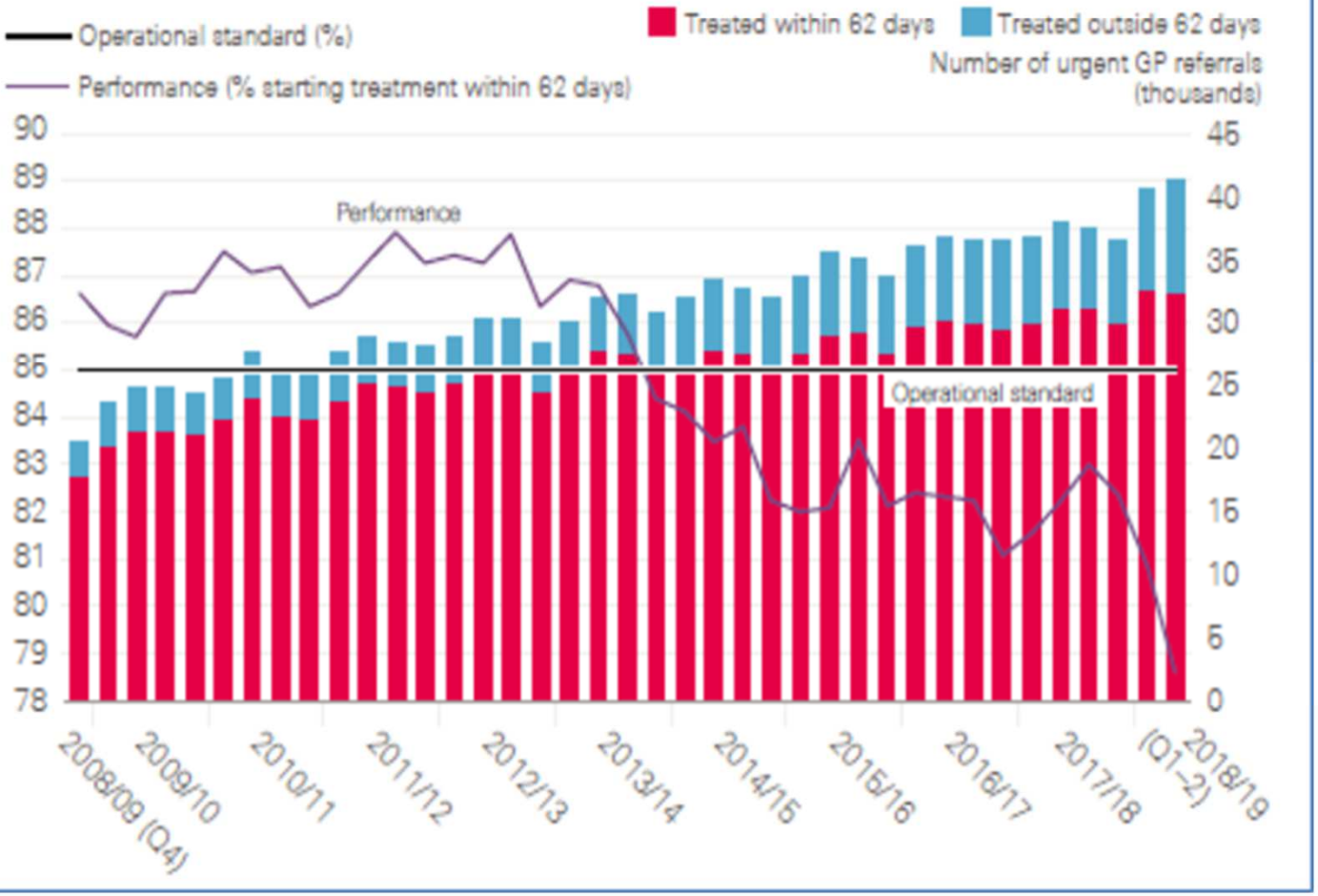
Figure 24: Urgent GP referrals resulting in treatment and proportion seen within 62 days between Q4 2008/09 and Q2 2018/19, England



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Cancer waiting times - 62 day (incl. rare cancers) - Apr-19 PUBLIC

Organisation Name	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Provider perspective													
ENGLAND	**82.3%**	**81.1%**	**79.5%**	**78.3%**	**79.2%**	**78.3%**	**78.4%**	**79.2%**	**81.0%**	**76.2%**	**76.1%**	**79.7%**	**79.4%**
Regions													
North East And Yorkshire	81.7%	82.1%	79.5%	78.1%	79.4%	78.4%	78.2%	78.9%	81.9%	76.7%	76.2%	80.4%	80.1%
North West	85.7%	81.5%	81.8%	80.7%	82.1%	80.8%	78.9%	79.8%	82.2%	79.3%	77.2%	81.1%	80.7%
Midlands	**81.8%**	**80.0%**	**80.0%**	**79.4%**	**79.2%**	**78.3%**	**78.8%**	**77.9%**	**80.3%**	**73.4%**	**74.2%**	**76.7%**	**75.8%**
East of England	**79.9%**	**78.7%**	**76.3%**	**75.2%**	**78.2%**	**77.3%**	**75.1%**	**77.3%**	**77.7%**	**73.0%**	**74.2%**	**78.0%**	**79.7%**
London	85.8%	85.3%	82.7%	79.3%	81.8%	81.7%	81.5%	82.3%	84.4%	79.0%	80.6%	83.0%	81.9%
South East	80.8%	79.4%	77.4%	76.7%	76.8%	75.4%	79.0%	79.2%	79.7%	76.3%	75.7%	80.6%	79.6%
South West	81.9%	81.8%	79.6%	78.5%	78.1%	77.4%	77.2%	80.3%	82.5%	77.4%	76.8%	79.4%	80.3%
STPs													
Derbyshire STP	88.8%	81.0%	79.6%	78.0%	81.3%	75.9%	77.0%	80.6%	80.9%	74.5%	75.6%	80.7%	78.8%
Nottinghamshire STP	86.1%	86.1%	85.5%	78.8%	81.7%	84.0%	80.6%	81.8%	83.8%	83.1%	79.6%	79.4%	80.3%
Shropshire and Telford and Wrekin STP	82.7%	84.7%	81.5%	83.5%	79.6%	83.0%	73.5%	81.9%	86.5%	65.8%	62.6%	67.8%	70.0%
Staffordshire and Stoke on Trent STP	84.4%	80.4%	83.1%	78.6%	79.6%	80.8%	82.8%	78.2%	82.8%	69.8%	76.3%	75.8%	70.7%
Birmingham and Solihull STP	71.3%	76.9%	88.6%	89.2%	81.8%	82.6%	84.6%	81.5%	83.8%	75.4%	78.6%	75.8%	75.3%
Coventry and Warwickshire STP	85.6%	84.7%	83.7%	80.8%	80.8%	75.5%	78.8%	77.8%	82.8%	77.7%	80.2%	78.7%	84.3%
Herefordshire and Worcestershire STP	78.3%	75.9%	73.7%	75.1%	77.0%	70.5%	69.3%	76.4%	72.4%	63.5%	69.8%	71.1%	69.3%
The Black Country and West Birmingham STP	79.3%	74.3%	80.4%	80.4%	76.0%	77.6%	80.8%	70.9%	80.4%	75.9%	77.2%	81.2%	75.5%
Leicester, Leicestershire and Rutland STP	79.0%	78.1%	75.2%	77.0%	73.6%	73.6%	77.3%	75.5%	81.5%	74.6%	72.4%	75.9%	77.0%
Lincolnshire STP	75.3%	75.2%	72.5%	73.2%	78.5%	77.4%	75.3%	74.0%	69.4%	68.1%	66.3%	74.6%	75.3%
Northamptonshire STP	84.0%	83.3%	75.5%	83.3%	82.4%	83.8%	85.9%	80.5%	80.4%	76.4%	77.6%	77.1%	76.3%
Hertfordshire and West Essex STP	79.2%	77.5%	75.3%	74.9%	79.9%	80.1%	77.2%	78.8%	78.2%	77.6%	76.5%	80.1%	80.3%
Bedfordshire, Luton and Milton Keynes STP	80.2%	78.8%	76.5%	83.1%	78.8%	82.1%	79.4%	83.0%	82.2%	71.8%	74.0%	79.9%	82.5%
Cambridgeshire and Peterborough STP	81.8%	80.8%	80.7%	82.9%	84.7%	82.9%	77.1%	82.7%	85.9%	81.7%	77.6%	81.2%	84.7%
Mid and South Essex STP	76.9%	76.3%	73.5%	68.2%	72.4%	72.8%	70.3%	67.0%	69.8%	64.5%	68.7%	72.1%	77.3%
Norfolk and Waveney STP	79.2%	81.3%	72.8%	72.1%	78.2%	76.4%	76.6%	75.7%	77.6%	70.9%	74.7%	77.1%	78.6%
Suffolk and North East Essex STP	82.9%	78.0%	80.2%	74.7%	77.1%	73.9%	72.8%	78.4%	76.7%	73.8%	74.9%	79.0%	77.3%
Cancer Alliance													
East Midlands	81.9%	80.8%	78.0%	78.1%	79.2%	79.1%	78.8%	78.3%	79.1%	75.2%	73.6%	76.9%	77.6%
West Midlands	81.3%	79.2%	81.8%	80.9%	79.1%	78.1%	78.7%	77.3%	81.2%	71.5%	74.6%	75.9%	74.2%
East of England	79.9%	78.7%	76.3%	75.2%	78.2%	77.3%	75.1%	77.3%	77.7%	73.0%	74.2%	78.0%	79.7%

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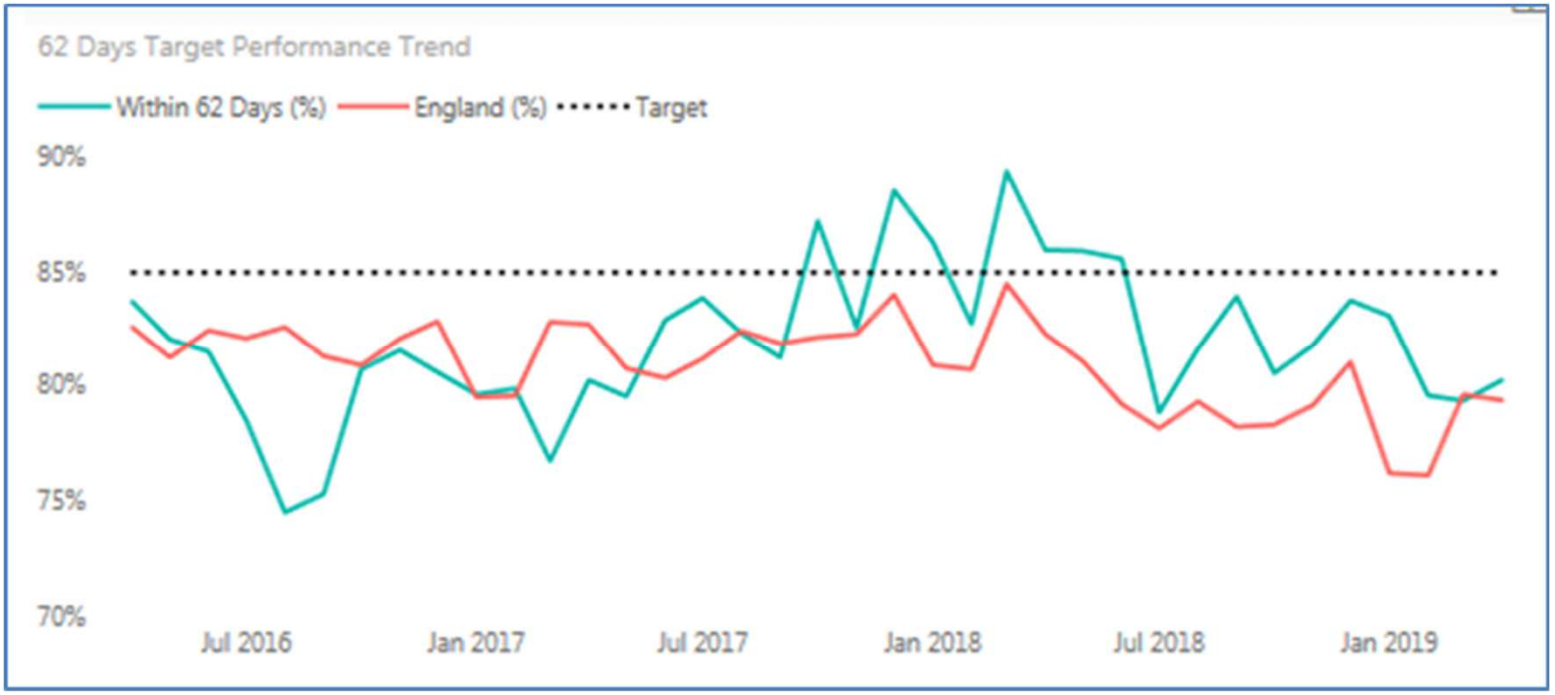
ICS 62 day referral to treatment performance



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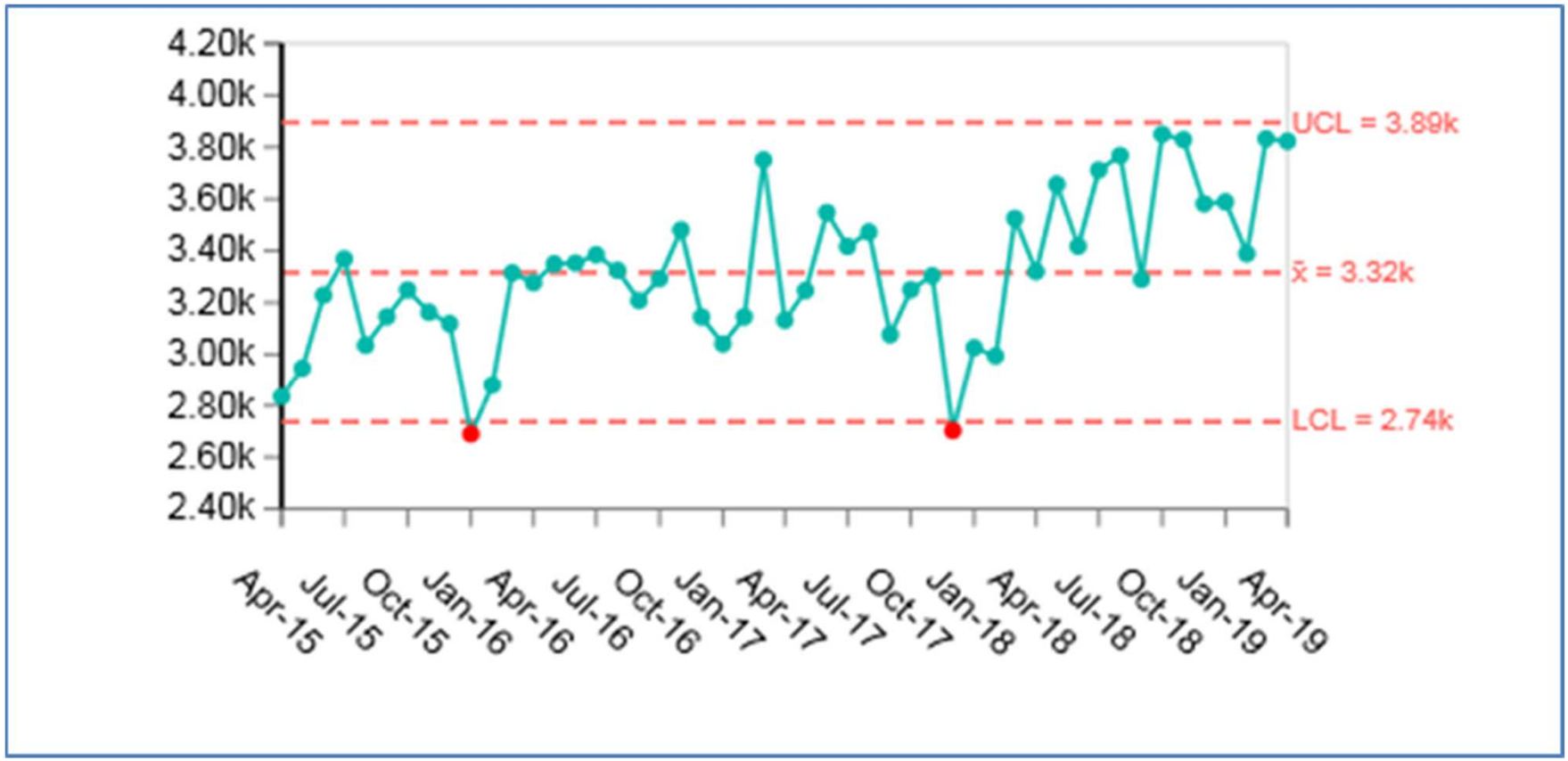
ICS Cancer 2WW referrals



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Health

'Fry and Turnbull effect' on prostate cancer

9 October 2018 | Share

Stephen Fry: "It's a bit of a business having an operation like that"

Hospitals are seeing and treating more men with prostate cancer, partly thanks to celebrities raising awareness of the disease by speaking out about their own experiences, says the head of the NHS.

NHS chief Simon Stevens will today thank former BBC Breakfast presenter **Bill Turnbull** and broadcaster **Stephen Fry** for the work they have done in urging men to come forward for help.

Both had treatment earlier this year.

England | Local News | Regions | Nottingham

Bowel cancer: Self-testing kit 'saved my life'

3 April 2019 Share

Wendy Lyons, 46, was offered a self-testing kit as a precaution when she visited her GP

A mother-of-three says a self-testing kit for bowel cancer saved her life.

Wendy Lyons, lives in Eastwood, Nottinghamshire, a county leading the way in the use of Faecal Immunochemical Tests or FIT.

The kit can tell doctors whether a more expensive and uncomfortable colonoscopy is needed.

Hospital bosses hope they can use it to find cancer earlier in people who would not normally be tested for the disease.

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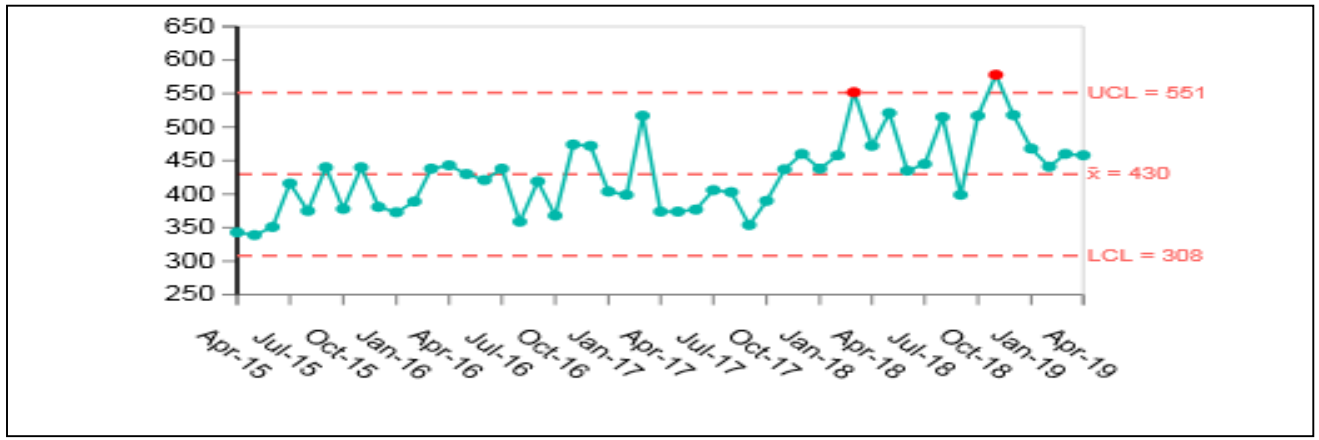
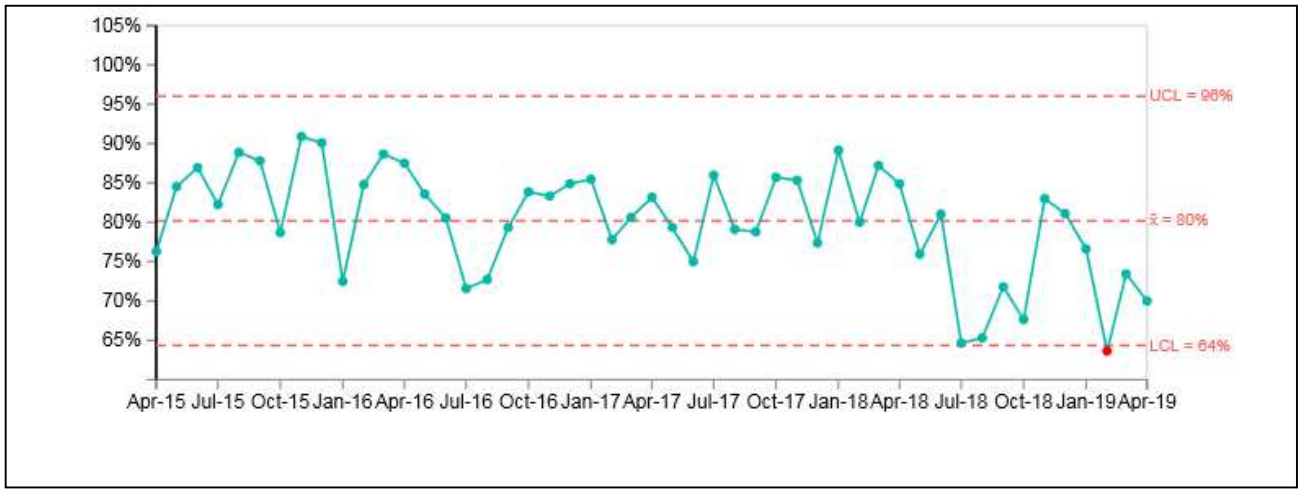
ICS Urology referrals & 62 day treatment performance





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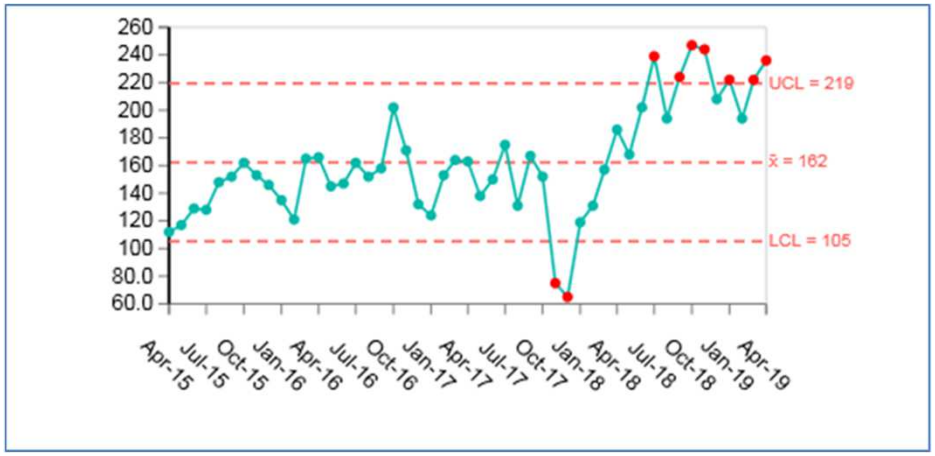
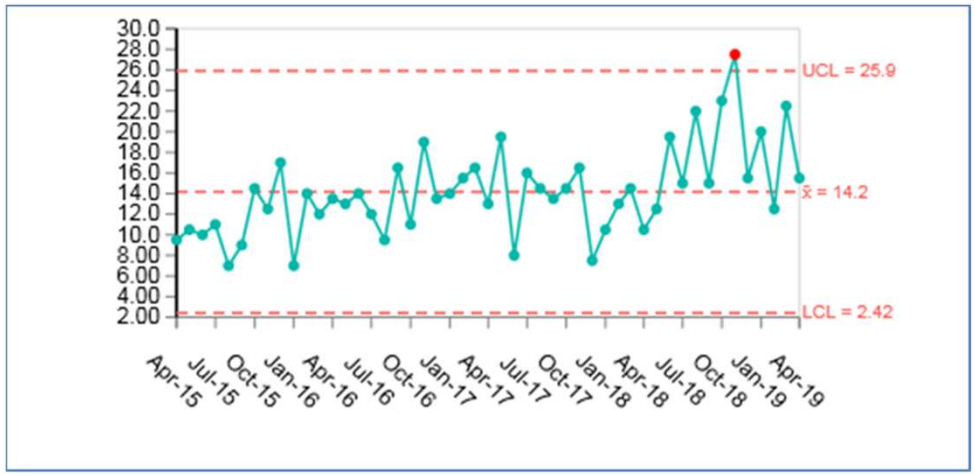
NUH lower GI referrals and treatments





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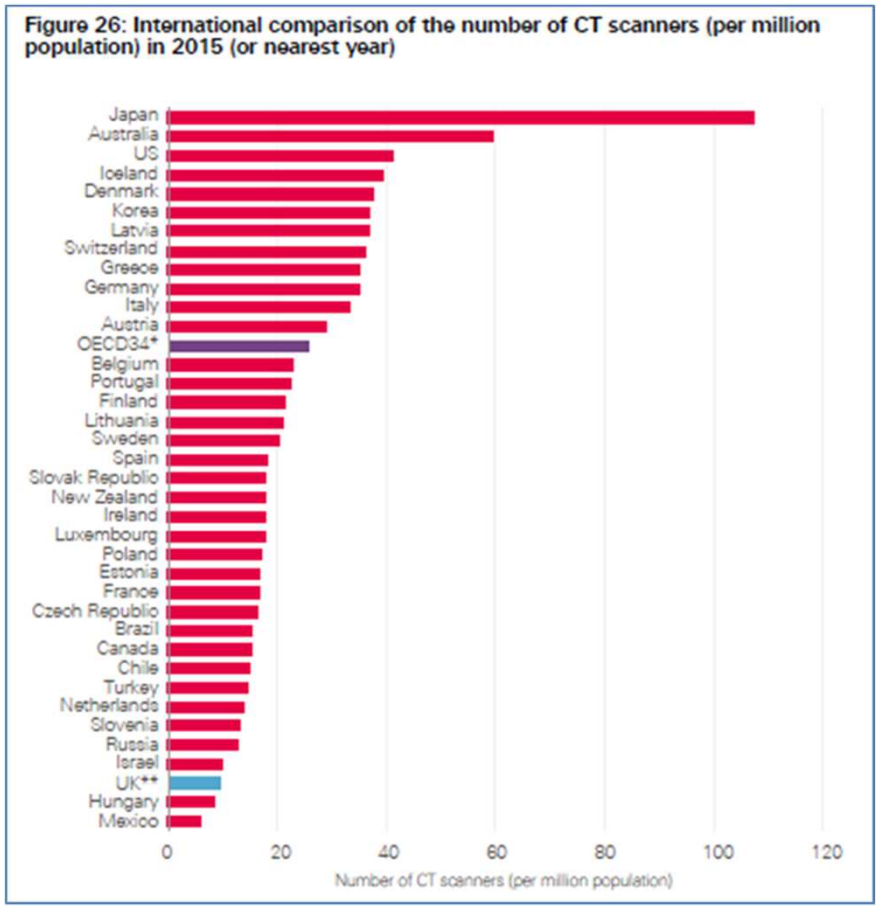
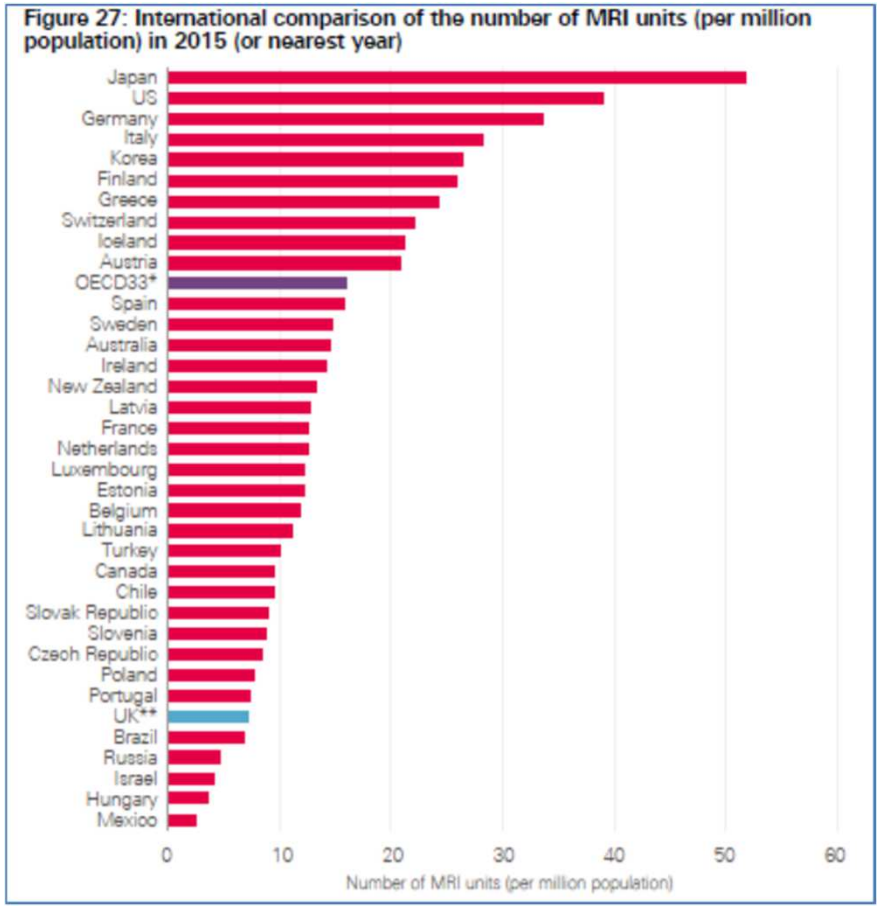
International comparison of MRI and CT units





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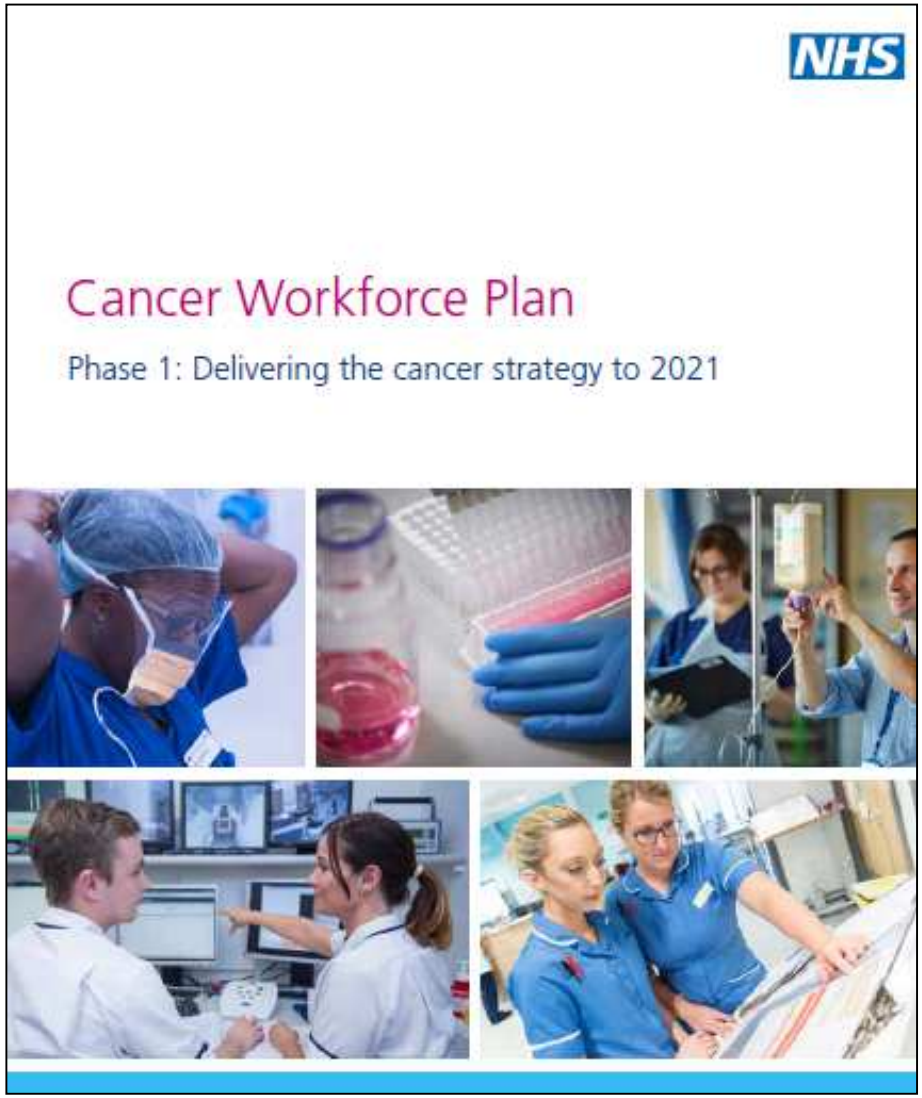

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Current Barriers to Improvement

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Capacity

- Ability to recruit to vacancies / new posts e.g. radiology (out to recruitment 4 times for Uro-radiology consultant), chemotherapy. National demand for similar posts.
- Theatre capacity to meet demand in treatment numbers, and including access to robotic surgery.
- Diagnostic capacity (imaging, endoscopy, pathology).
- Tax & Pension changes affecting number of waiting list initiatives being undertaken to address peaks in demand.

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What needs to be done differently

(confidence that this will deliver improvement)

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Implement National Rapid Cancer Diagnostic and Assessment pathways

https://www.england.nhs.uk/publication/rapid-cancer-diagnostic-and-assessment-pathways/

- National Transformational funding being provided via Cancer Alliances. Over £1m to the ICS in 18/19. Similar figure in 19/20.
- Aim to deliver referral to diagnosis 28 day pathways via 'one stop shop' models (multiple tests in one visit – requires hot reporting)

Significant progress made to date – Pre biopsy MRI in Urology, FIT and straight to test colonoscopy in Lower GI, straight to test CT Lung.

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Maximise diagnostic capacity

- Increase utilisation of provider capacity e.g. expansion at NUH re Endoscopy
- Increase use of private sector where appropriate (MRI, CT, endoscopy commissioned),
- Share capacity across East Midlands providers (Cancer Alliance leading on this),
- Utilisation of latest equipment and technology e.g. Fusion biopsy software in Prostate cancer, Artificial Intelligence in Radiology (Breast and Lung cancer imminent).

Robust Demand and Capacity Modelling.

Being undertaken by providers. Completed by end of June.
A number of additional posts already approved and being recruited to (Urology, Gynaecology, Lower GI, Lung, Oncology). Concerns still around ability to fill posts.

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Workforce development:

- E.g. reporting Radiologists, chemotherapy practitioners, nurse specialists undertaking triage, diagnostics and treatments.
- Good progress in ICS, but concerns around time lag and ability to impact on performance in the short term.

Improve quality of referrals to enable rapid access to correct tests and avoid inappropriate consultations:

- Standardise referral forms, pre-populate from GP Systems – completed.
- Ensure referrals are complete and appropriate tests undertaken before referral.

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What is needed from the ICS Leadership Board

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- Recognition that there is multiple root causes to the current performance position.

- Recognition that demand will continue to rise in order to improve early diagnosis / survival rates.

- Endorse and support implementation of National Diagnostic and Assessment Pathways.

- Endorse and support utilisation of private sector where appropriate, until additional posts and capacity come on-line.

ENC. H1

Meeting:	ICS Board
Report Title:	July 2019 Integrated Performance Report
Date of meeting:	Friday 12 July 2019
Agenda Item Number:	10
Work-stream SRO:	Wendy Saviour
Report Author:	Sarah Bray
Attachments/Appendices:	Enc. H2. Integrated Performance Summary Enc. H3. ICS MOU 2018/19 Review Letter

Report Summary:

This report supports the ICS Board in discharging the objective of the ICS to take collective responsibility for financial and operational performance as well as quality of care (including patient/user experience). Key risks and actions are highlighted to drive focus and strategic direction from across the system to address key system performance issues.

Current key risk areas are outlined below, with a summary of key performance enclosed.

Main areas of current risk:

- Mental Health – OAPs national outlier
- Urgent Care System delivery
- Cancer Performance
- Financial Sustainability

Emerging & Continuing Risks:

- Planned Care – whilst significant targets are not being met, the system remains in the upper quartile performance nationally.
- Quality, due to performance across Transforming Care and Maternity.
- Activity – month 1 positions indicate pressures against the plan, this will be included in the summary overview table from August.

Service Delivery Area	2019/20 ICS Performance		
	No. KPIs	% Not Achieved	% Achieved
Mental Health	10	30%	70%
Urgent & Emergency Care	8	50%	50%
Planned Care	5	80%	20%
Cancer	8	50%	50%
Nursing & Quality	5	20%	80%
Finance	6	67%	33%
Workforce	11	tbc	tbc
Overall Performance Delivery	42	48%	52%

Nottingham and Nottinghamshire ICS - Performance Overview - as at 3rd July 2019

Areas of Improvement:
Significant improvements have been made on IAPT Access, delivery of Month 12, mainly due to increase in Mansfield & Ashfield CCG performance.

ICS MOU 2018/19

A review meeting was held with NHSE/I on the progress made on the MOU during 2018/19. Areas of progress noted were the establishment of ICPs, agreement of

PCNs, moves towards a single CCG and the integrated system approach undertaken for the 2019/20 planning cycle.

Performance improvements were noted across RTT, Children's Wheelchairs, GP Extended Access and IAPT. Key challenges were discussed as areas of focus for the year ahead, which included financial sustainability, emergency care, cancer and mental health services.

The MOU for 2019/20 is in progress.

Action:
☒ To receive ☐ To approve the recommendations

Recommendations:	
1.	That the Board note the contents of the report

Key implications considered in the report:		
Financial	☒	Delivery against forecast and year to date
Value for Money	☐	
Risk	☒	Service delivery and performance risks
Legal	☐	
Workforce	☒	Delivery against workforce plans
Citizen engagement	☐	
Clinical engagement	☐	
Equality impact assessment	☐	

Engagement to date:

Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
☐	☐	☒	☐	☐
Performance Oversight Group	**Clinical Reference Group**	**Mid Nottingham-shire ICP**	**Nottingham City ICP**	**South Nottingham-shire ICP**
☒	☐	☐	☐	☐

Contribution to delivering the ICS high level ambitions of:	
Health and Wellbeing	☒
Care and Quality	☒
Finance and Efficiency	☒
Culture	☒

Is the paper confidential?

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

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Nottingham City Council | Nottinghamshire County Council | NHS

Integrated Performance Overview

3 July 2019

Red Risks to System Delivery		
RAG	***Performance Issues***	***Actions to Address***
A: Mental Health	***Performance*** concerns relating to: CYP Access & data capture issues ongoing EIP Concordant compliance & Data – Level 2 assessment May 2019. Further improvements potentially at risk due to CBTp training issues ***5YFV Transformation Areas*** issues: Out of Area Inappropriate placements – remain national outlier on volumes of placements. Revised trajectories have been agreed. National clinical support offered. Crisis – 24/7 CRHT service is being implemented during 2019/20 IPS – Service not delivered across the ICS. Wave 2 funding has been received to progress the service. Physical Health Checks are currently not in line with requirements, however the system is reviewing alternative service models.	There are a significant number of performance and 5YFV transformation area concerns relating to Nottinghamshire. As a result the system has developed Service Improvement plans for IAPT, EIP, CYP, Out of Area Placements (including Liaison & Crisis) and Physical Health Checks. Phased performance improvements to deliver requirements planned for 2019/20. ICS Executive Mental Health monthly oversight remains in place to progress the actions required through the service improvement plans. Mental Health Strategy Implementation Plans are being developed to enable clear oversight of the key milestones. Discussions are ongoing with Health Education England to progress potential barriers to success, including CBT and IAPT training programmes.
B: Urgent Care	ICS A&E performance remains below target and has marginally increased to 80.43% at 92.6% however this only now includes SFHT as NUH are trialling the new UEC metrics. There were 2 twelve hour ED waits at NUH, 1 mental health patient with an extended wait, and one patient awaiting availability of a medical bed. Re-admission rates have continued to increase at NUH since February, 5%. Urgent care attendances and admissions have continued on the growth trajectory seen during 2018/19, however are under the ICS plan. There are differential positions within the ICP areas, with Mid-Notts being over plan, and City and South Notts being under plan. EMAS performance has continued to improve over the recent months. Performance is more positive across Nottinghamshire, than EMAS as a whole.	NUH remains in regional escalation for performance as service difficulties continue. Significant volume increases have continued. Actions to address capacity gaps and front door service redesign continue to be implemented. Weekly executive calls continue to be in place to respond to the pressures across the system. Both A&E Delivery Boards continue to focus on DTOCs and are aligning to Length of Stay actions, focusing on Admission avoidance, flow and reducing delays, improvements in D2A processes, with focus on Newton 'Home First' approach, and specific actions to review mental health patient care pathways. Daily patient review processes and 'pull teams are now in place. ECIST support is being provided. Due to continuing activity increases, the ICS has commenced an activity driver deep dive into urgent care activity, which has completed analytical analysis and is progressing through clinical challenge and review, to enable directed actions to be implemented.
D:Cancer	Cancer 62 performance has remained below target at 80.3% April 2019. (SFHT 82.19% / NUH 74.66%). Backlogs have slightly reduced in month.	The trusts expected performance for April 19 to June 19 is 66-73%, which is a further reduction from expected levels. The trusts continue to work through the increased demand, and capacity constraints from revised pathways and workforce issues. Alternative capacity is being sourced, through workforce, providers

		and additional equipment / clinical capacity. However, recovery is not expected to be achieved before Q3 2019/20.
G: Financial Sustainability	There is no reporting of the Local Authority Position, both County and City Councils, due to timing issues and information not received. The NHS system has not delivered against the system financial plan or system control total for May 2019. The key variances are: * £1.1m NHS Providers (under delivery of savings requirement and less patient income than planned) * £0.3m NHS Commissioners (under delivery of savings requirements)	The system is forecasting to deliver against the financial plan and system control total by year-end. However, this is a very challenging position with key risks the under delivery of savings/efficiency programme and activity pressures across the system. The ICS Financial Sustainability Group are monitoring the year-to-date and forecast position and identifying where further actions are necessary.
Amber Risks To System Delivery		
C: Planned Care	RTT failed to achieve for the ICS 91.7%. Waiting lists remained are over March 2018 levels, however have continued to decrease, to 3.5% (March 19). SFHT will remain over March 18 due to additional Paeds PTL which was added during 2018/19. (NUH -0.3%, SFHT 5.5%). NUH had 5 long waiters at the end of April due to patient choice factors and capacity. Children's wheelchair waits have significantly improved over the year to 100% delivery Q4.	SFHFT failed to achieve the standard at April 2019 – 89.97%. SFHFT and the CCG are monitoring recovery plans at speciality levels, which include staffing and additional capacity, for recovery September 2019. SHFT Waiting lists recovery back to March 18 levels will not be achieved. The trust were unable to rebase their PTL during the planning cycle for Paeds and so will monitor against March 19 levels. 52+ waits recovery to nil at NUH is expected by Q2 2019/20 due to patient choice factors. This is being actively managed
E. Nursing & Quality	Transforming Care achieved May 19 trajectory -6 over planned levels. CHC: ICS achieved both QP standards for April 19. LeDeR – There has been an increase in the number of completed reviews to 36% (42). Maternity did not achieve the continuity of carer 20% requirement, 2.4% May 2019, which is the lowest in the Region. The ICS is assessed by NHSE as 'Requiring Some Support' because of delayed implementation.	TCP remains in regional escalation. Recovery plans are in place, focus on admission avoidance, with refreshed targets having been agreed for 2019/20. Maternity recovery plan is in place, revised trajectories are expected for June 2019, to progress towards the 35% requirement for March 2020. Pilots commenced March and April 2019, with proposals for dedicated resource within each provider to lead the implementation.
H. Workforce	Delivery of primary care workforce plans is a raising concern.	Primary Care and delivery of increased workforce is at risk of delivery against the planned trajectory, due to overseas recruitment not being as successful as planned. Contingencies including reviewing skill mix and further retention are being developed.

Integration of services, improving health of the population
While healthy life expectancy has increased both nationally and locally over recent years, Nottingham and Nottinghamshire remain below both national and core city averages. Additionally, there is a significant downward trend in female healthy life expectancy across the previous four rolling averages. Performance measures for the ICS relating to social care and population health are being developed by the respective teams. The three priority areas are alcohol, smoking & diet.
Strengthened Leadership
ICS Governance arrangements are continuing to be strengthened, with on-going work programmes related to management of risk, organisational and system arrangements, and workstream oversight. This includes development of the ICS Outcomes Framework. The performance report will continue to be developed during 2019/20 to reflect the emerging governance of the ICS and ICPs and the establishment of the ICS Outcomes Framework. CCG joint management arrangements are progressing.

Recommendations

The Board are asked to note the:

a. Integrated Performance Report and
b. Key risk areas:
   - Urgent Care System delivery
   - Mental Health OAPs
   - Financial Sustainability
   - Cancer Services Delivery
c. Areas of Improvement:
   - Mental Health IAPT Access

Sarah Bray
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3 July 2019
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Nottinghamshire ICS
System Integrated Performance Summary
July 2019

	Key Performance Indicator	19/20 ICS Basis	National 18/19 Required Performance	National 19/20 Required Performance	18/19 Reporting Period	2018/19 ICS Performance: Latest Period	2018/19 ICS Performance: National Month RAG	2018/19 ICS Performance: Month Delivery Trend	2018/19 ICS Performance: Forecast Delivery Risk	Exception Narrative
A. Mental Health Deliver the MHFV, with a focus on Children and Young Peoples services (CYP), reductions in Out of Area Placements, improved access to mental health services (EIP / IAPT / Crisis and Liaison services)	CYP Access Rate	CCG	32%	34%	Q4 18/19	17.3%				Due to concerns relating to performance and plans to progress the 5YFV requirements, ICS Exec level oversight remains in place. Joint Recovery plans in place. **CYP** - ICS reported 17.3% against 32% access standard in Q4 (based on national dataset). Local data indicates a Q4 position of 25% against the 32% target. **IAPT** - ICS exceeded the target of 4.75% for Mar 19. **EIP** - Exceeded target in March 2019, achieving 69.1%. Ongoing actions to improve service delivery to ensure NICE compliance. **OAPs** – Mar 19 saw an increase in out of area placement (OAP) occupied bed days (OBDs), remains national outlier. Trajectory revised for 2019/20 and detailed actions agreed.
	CYP Eating Disorders Urgent 1st <1 weeks	CCG	95%	95%	Q4 18/19	100.0%				
	CYP Eating Disorders Routine 1st <4 weeks	CCG	95%	95%	Q4 18/19	91.7%				
	IAPT Access - 22% (4.75% min, to 5.5% Q4) 2/3 of increase in IAPT-LTC	CCG	4.75%	5.50%	Mar-19	5.23%				
	IAPT Waiting Times - 6 weeks (Rolling Quarter)	CCG	75%	75%	Mar-19	78.3%				
	IAPT Waiting Times - 18 weeks (Rolling Quarter)	CCG	95%	95%	Mar-19	99.2%				
	IAPT Recovery Standards (Rolling Quarter)	CCG	50%	50%	Mar-19	54.6%				
	EIP NICE Concordant Care within 2 Weeks	CCG	53%	56%	Apr-19	70.2%				
	Inappropriate Out of Area Placements (bed days) Q1 3432, Q2 2024, Q3 1748, Q4 1440	CCG	1698	1080	Mar-19	3944				
	Maintain Dementia diagnosis rate at 2/3 of prevalence	CCG	66.7%	66.7%	May-19	76.2%				
B. Urgent & Emergency Care Improved A&E performance in 2018/19, reduce DTOCs and stranded patients, underpinned by realistic activity plans. Implementation of NHS 111 Online & Urgent Treatment Centres.	Aggregate performance of 4 Hour A&E Standard (SFHT performance only as NUH trialing new metrics)	Provider	90% Sept /95% Mar	95%	May-19	92.6%				Activity pressures continues with attendances and admissions up year on year. Although the activity across the ICS is below plan. **A&E** – A&E - NUH ED are part of the new NHSE reporting pilot and will no longer be reporting against the 4 hour target. SFHFT failed to achieve national standard and planned trajectory performance with 92.97% for May 19. It was acknowledged at A&EDB that Ramadan impacted upon staffing and sickness levels during the period **DTOCs -** NUH achieved 3.37% April. SFHFT failed to achieve target in April with 4.18%, an deterioration from March.
	12 Hour Breaches	Provider	0	0	May-19	2				
	NHS 111 50% population receiving clinical input	Provider	50%	50%	May-19	53.6%				
	Ambulance (mean) response time Category 1 Incidents (Notts Only)	Provider	00:07:00	00:07:00	May-19	00:06:51				
	Ambulance (mean) response time Category 2 Incidents (Notts Only)	Provider	00:18:00	00:18:00	May-19	00:20:26				
	Manage Optimal Length of Stay - reduction in >21 days	Provider	367	279	Apr-19	327				
	Reduce DTOCs across health and social care- NUH	Provider	3.5%	3.5%	Apr-19	3.37%				
	Reduce DTOCs across health and social care- SHFT	Provider	3.5%	3.5%	Apr-19	4.18%				
C. Planned Care Improvements in planned elective activity, reductions in patients waiting over 52 weeks as well as reductions in overall waiting lists	RTT Incomplete 92% Standard	Provider	92%	92%	Apr-19	91.7%				**RTT** perfomance missed 91.72%. ICS waiting lists have increased to +6.3% over March 18. **52 Week Waits** Breaches NUH reported 5 breaches for April 2019. **Wheelchairs** – 100% achieved for Q4 **Diagnostics** - Both ICS providers failed to meet the standard for the first time over 24 months with an ICS Performance of 97.1%. The main areas for breaches are Echocardiography, MRI's, sleep study tests and non-obstetic ultrasounds.
	RTT Waiting List - March 2019 incomplete pathway < March 2018	Provider	<March 18 56511	56511	Apr-19	60,081				
	+52 Week Waits - to be halved by March 2019, and eliminated where possible	Provider	15	0	Apr-19	5				
	Diagnostics +6 weeks	Provider	0.9%	0.9%	Apr-19	2.49%				
	Children's Wheelchair Waits < 18 Weeks	CCG	92%	92%	Q4 18/19	100.00%				

Nottinghamshire ICS
System Integrated Performance Summary
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D. Cancer Delivery of all eight waiting time standards, implementation of nationally agreed radiotherapy specifications and diagnostic pathways, progress risk stratified scanning and follow-up pathway	Cancer 2 weeks - Suspected Cancer referrals	Provider	93.0%	93.0%	Apr-19	92.0%				**NUH** -Adjusted Mar performance was –76.8%. Breeches high at x36– Urology 14, LGI 3, Lung 3. Un-validated May data for NUH is forecast at 65%. Breeches high at x40. Backlog has reduced slightly to 109. Urology continues to have the biggest impact. Oncology waits continue to have an impact across all specialties. Number of > 104-day waiters at NUH has increased slightly from 27 at the end March to 33 at the end of April. **SFHFT**- Apr 82.19%. 14.5 breaches, compared to 8.5 breaches in Mar, half the breaches due to pathways at different providers. Actions to reduce the overall time from referral to treatment lies in the early part of the pathway. Q1 showing signs of difficulty due to shift fill rates following changes in tax and pensions.
	Cancer 2 weeks - Breast Symptomatic Referrals	Provider	93.0%	93.0%	Apr-19	94.6%				
	Cancer 31 Days - First Definitive Treatment	Provider	96.0%	96.0%	Apr-19	92.9%				
	Cancer 31 Days - Subsequent Treatment - Surgery	Provider	94.0%	94.0%	Apr-19	80.5%				
	Cancer 31 Days - Subsequent Treatment - Anti Can	Provider	98.0%	98.0%	Apr-19	98.7%				
	Cancer 31 Days - Subsequent Treatment - Radiothy	Provider	94.0%	94.0%	Apr-19	100.0%				
	Cancer 62 Days - First Definitive Treatment - GP Referral	Provider	85.0%	85.0%	Apr-19	80.3%				
	Cancer 62 Days - Treatment from Screening Referral	Provider	90.0%	90.0%	Apr-19	92.6%				
	Cancer 62 Days - Treatment from Consultant Upgrade	Provider	n/a		Apr-19	88.5%				
E. Nursing & Quality										**Transforming Care** (Inpatient No.): Notts TCP collectively (Specialised Commissioning & CCG) didn't achieve 2018/19 trajectory (+16). Refreshed targets agreed for 19/20 and currently ICS/CCGs are achieving for May 19. **LeDeR**: Current Performance shows improvements achieving 36% for May 2019. Increase in number of completed reviews from 18% (21) to 36% (42). **Maternity**: Notts ICS assessed by NHSE as 'Requiring Some Support' as result of delayed progress in implementing the SBLCB, continuity of carer ambition, and higher than national average rates of SATOD. Notts LMS is lowest performing regionally against 20% trajectory for continuity of carer with just 2.2% recorded as at March 2019.During May 2019 23/939 women booked onto CoC p'way equating to 2.4%
Transforming Care Continued reduction of inappropriate hospitalisation of	Reductions in patients against Local planning trajectories - Total for Nottinghamshire	CCG	36	53	May-19	48				
	Learning Disability Mortality Reviews (LeDeR)	CCG	85%	85%	May-19	36%				
Continuing Health Care	Fewer than 15% of Continuing Health Care Full Assessments undertaken in acute setting	CCG	<15%	<15%	Apr-19	10%				
	More than 80% eligibility decisions undertaken within 28 days from receipt of checklist	CCG	80%	80%	Apr-19	88%				
Maternity Deliver improvements in safety for maternity services, and improve personal and mental health service provision	Continuity of Care	Provider	20%	20%	May-19	2.40%				
Quality Measures	Mixed Sex Breaches				Mar-19	TBC				CQC inspection at SFHT in April has improved overall rating to good. HCAI (Hospital Aquired Infections) have action plans to address the increased rates
	MSSA Breaches	Provider			Mar-19	0				
	MRSA	Provider			Apr-19	1				
	C-Difficile	Provider			Apr-19	13				
	E Coli	Provider			Apr-19	72				
F. Prevention & Public Health			To be developed and populated by public health and social care							Nottingham and Nottinghamshire remain below both national and core city averages. Additionally, there is a significant downward trend in female healthy life expectancy across the previous four rolling averages

Nottinghamshire ICS
System Integrated Performance Summary
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						Latest Period	National Month RAG	Month Delivery Trend	Forecast Delivery Risk	
G. Finance & Efficiency **Note: Nottingham City Council and Nottinghamshire County Council information not provided and therefore is not included in finance & efficiency reports**	Overall Financial Position (excluding Provider Sustainability Funding, Marginal Rate Emergency Threshold and Financial Recovery Fund)	ICS - Health & Social Care		Nil variance to the system financial plan of £65.7m in year deficit	May-19	-£1.4	🔴	↑	🔴	Year-to-date deficit higher than planned due to under delivery on savings target and lower than expected patient income. FORECAST - to deliver £65.7m in-year deficit. This is a very challenging position with key risks the delivery of savings/efficiency programmes and activity pressures across the system.
	Overall Financial Position (including Provider Sustainability Funding, Marginal Rate Emergency Threshold and Financial Recovery Fund)	ICS - Health & Social Care		Nil variance to the system financial plan of £8.3m in year deficit		-£1.4	🔴	↑	🔴	In line with the variance above as all organisations are forecasting to be on plan at end of quarter 1 and therefore receive their Provider Sustainability Funding. FORECAST - to deliver £8.3m in-year deficit. This is a very challenging position with key risks the delivery of savings/efficiency programmes and activity pressures across the system. This could impact on the receipt on provider sustainability funding in year.
	NHS System Control Total (excluding Provider Sustainability Funding, Marginal Rate Emergency Threshold and Financial Recovery Fund)	NHS		Deficit does not exceed System Control Total of £67.7m in year deficit		-£1.4	🔴	↑	🔴	Year-to-date deficit higher than planned in NHS providers due to under delivery on savings target and lower than expected patient income. FORECAST - to deliver £65.7m in-year deficit. This is a very challenging position with key risks the delivery of savings/efficiency programmes and activity pressures across the system.
	Savings & Efficiency Programme	ICS - Health & Social Care		Nil variance to plan - £159.7m (4.9%)		-£2.0	🔴	↓	🔴	Delivered £11.5m of savings year-to-date, under delivery in both providers and commissioners. No reporting against Local Authority savings plans available. FORECAST - NHS organisations are forecasting £134m (£145m plan).
	Provider Sustainability Funding (PSF)	NHS		Nil variance to available PSF of £27.5m		£0.0	🟢	↑	🔴	All provider organisations are expecting to be on plan at the end of quarter 1 and therefore receive provider sustainability funding. FORECAST - All provider organisations are forecasting to receive full provider sustainability funding but this is high risk.
	Mental Health Investment Standard (MHIS)	NHS		MH spend (exc LD & Dementia) is at least £165.1m						No formal reporting of MHIS at Month 2.
	Agency Ceiling	NHS		Agency Spend is within the ceiling limit of £45.4m		£0.0	🟢	→	🟢	All provider organisations are within the agency spend ceiling year-to-date. FORECAST - to deliver, low risk.

Nottinghamshire ICS
System Integrated Performance Summary
July 2019

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						Latest Period	National Month RAG	Month Delivery Trend	Forecast Delivery Risk	
H. Workforce	Substantive WTEs	ICS (NHS)		25748.26	Apr-19	-263.52				Excludes primary and social care and Nottingham City Care (plan & actual)
	Agency/Bank WTEs			1608.28		-769.55				Excludes NUH data as not included in NHSi return
	Working in A&E WTEs			438.24		-53.05				Taken from NHSi monthly returns
	Transformational Roles WTEs			TBC	n/a					Plan & Actual exclude primary and social care. Data accurate for 2018-2019 above plan by 56 apprentices.
	Apprenticeships WTEs		213.00	TBC	Mar-19	56.00				
	Vacancy Rates			10.0%	Apr-19	7.27%				Plan & Actual excludes primary and social care and Nottingham City Care
	12m Rolling Sickness Absence Rate %			3.0%		n/a				
	12m Rolling Staff Turnover %			10.0%		n/a				
	Primary Care Workforce - GPs			554.19	Mar-19	568.53				Data taken from primary care census March 2019, to be validated against the plan dataset
	Primary Care Workforce - Clinical			532.00		491.11				
	Primary Care Workforce - Non-Clinical			1273.13		1205.65				
	TBC									
	TBC									

ICS Board 12 July 2019
Item 10. Enc. H3

From the office of Fran Steele
Director of Strategic Transformation, North Midlands locality

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Wendy Saviour
Managing Director,
Nottinghamshire ICS

County Hall
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NG2 7QP

20 June 2019

Dear Wendy

ICS Memorandum of Understanding (MOU)

Many thanks to you and your team for meeting with us on 6 June 2019 to reflect on and review and progress against the 2018/19 MOU and to take a forward look to the 2019/20 MOU.

We discussed the progress made during the last year within the ICS, including the establishment of ICPs, with leads in place for each. Work is underway to move to a single CCG across the ICS, and primary care networks (PCNs) are agreed.

You outlined how governance structures within the ICS have developed noting that there are further opportunities for these to fully embed when the relationships between the ICS, key system partners, and the newly merged NHS England and NHS Improvement are more clearly defined.

The ICS took a lead role in ensuring a system approach to 2019/20 planning which improved the submissions from system partners, particularly in relation to finance and activity. This approach provides a good foundation upon which the system is developing its long-term plan for the Autumn. We noted that the system continues to refine its approach to workforce planning.

Finance discussions continue to evolve with improvements to overall system flexibility. This will further develop as the ICS develops its existing framework which needs to shift from system level reporting to one which drives system level financial decision making.

During 2018/19 the ICS has made good progress on RTT, children's wheelchair services, GP extended access and IAPT. You noted that the ICS still faces some significant challenges including emergency care, timely treatment for cancer patients and mental health services. The system also faces significant financial challenges.

We discussed some key elements of the ‘check in’ document you provided, including mental health workforce planning where you outlined improvements in the data available to understand current and future gaps, and how you have linked this with the ICS mental health strategy. You confirmed that the clinical services strategy will be presented to the ICS Board in June.

You highlighted some of the work that the ICS has done with specialised commissioning, for example on head and neck services and transforming care. We discussed that in some areas, the specialised commissioning function has passed to the ICS, but that Nottinghamshire is unlikely to have the scale required to deliver this.

We noted that the ICS Board planned to review its local priorities for inclusion in the 2019/20 MOU on 13 June 2019. You outlined priority areas for 2019/20, many of which are likely to continue on from 2018/19, but with additional focus on prompt diagnosis and treatment of cancer patients.

We discussed next steps in the development of the MOU for 2019/20 and agreed we need to take the opportunity to ensure that the MOU has meaning and purpose for the system as well as guiding the relationship between the ICS and NHS England and NHS Improvement in 2019/20.

We confirmed that the ICS Maturity Matrix has been refreshed following experiences in systems over the last 12-18 months and that it would be timely for the system to collectively review progress against this in order to inform system development priorities for the year ahead. Colleagues agreed to confirm timescales for completion of the 2019/20 MOU as all acknowledged that this needs to have a clearly defined purpose which is coproduced and owned by system partners.

Thank you for the contributions you and the wider team made to the discussion.

Yours sincerely

Fran Steele
Director of Strategic Transformation, North Midlands localityNHS England and NHS Improvement

cc: David Pearson, Chair, Nottinghamshire ICS

ENC. I1

Meeting:	ICS Board
Report Title:	2019/20 Operational Plan: ICP Proposals for Flexible Transformational Funding
Date of meeting:	Friday 12 July 2019
Agenda Item Number:	11
Work-stream SRO:	Wendy Saviour
Report Author:	Helen Pledger
Attachments/Appendices:	Enc. I2. Attachment 1: City ICP Proposal Enc. I3. Attachment 2: Mid Nottinghamshire ICP Proposal Enc. I4. Attachment 3: South Nottinghamshire ICP Proposal

Report Summary:

The ICS is participating in the incentive scheme (ICS Financial Framework) for 2019/20. As part of the scheme the ICS will receive flexible transformational funding of £5 million.

This paper presents the ICP proposals for utilisation of this funding in 2019/20.

Action:

☐ To receive
☒ To approve the recommendations

Recommendations:

1.	The Board is asked to APPROVE the ICP proposals. Although the criteria have not been fully met, all schemes fit with the strategic priorities of the ICS and it is important that schemes are progressed at pace to deliver maximum impact for 2019/20.

Key implications considered in the report:

Financial	☒	
Value for Money	☒	
Risk	☒	
Legal	☐	
Workforce	☐	
Citizen engagement	☐	
Clinical engagement	☐	
Equality impact assessment	☐	

Engagement to date:

Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
☐	☐	☐	☐	☐
Performance Oversight Group	**Clinical Reference Group**	**Mid Nottingham-shire ICP**	**Nottingham City ICP**	**South Nottingham-shire ICP**
☐	☐	☒	☒	☒

Contribution to delivering the ICS high level ambitions of:

Health and Wellbeing	☒

Care and Quality	☒
Finance and Efficiency	☒
Culture	☐

Is the paper confidential?

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

2019/20 Operational Plan:
ICP Proposals for Flexible Transformational Funding
2 July 2019

Background

1. As part of 2019/20 operational planning, the ICS agreed to participate in the incentive scheme included in the ICS Financial Framework. The overarching aims of the ICS Financial Framework are as follows:

    - putting the system at the centre of managing financial resources, promoting new ways of working and behaviours;
    - encouraging collaboration between individual organisations to support integrated models of care and achieve system financial balance;
    - strengthening system governance and decision-making mechanisms; and
    - acting as a test bed for further system-focused changes to the NHS financial framework, in the future.

2. To comply with the requirements of the incentive scheme NHS Providers have re-allocated £4.9 million of their provider sustainability to be paid on the delivery of the system control total (previously paid on delivery of organisation control total).

3. As a result of participating in the incentive scheme the ICS will receive £5 million flexible transformational funding. The Financial Sustainability Group agreed a high level allocation of the funding (to ensure that we can meet the requirements of the incentive scheme) as follows:

Address remaining pressures in system plan (ensure we can meet requirements of incentive scheme and MOU)	£0.8m
ICP Transformation – City ICP	£1.3m
ICP Transformation – South Nottinghamshire ICP	£1.3m
ICP Transformation – Mid Nottinghamshire ICP	£1.5m

4. The ICS issued guidance to the ICPs to support the development of proposals. This paper provides a summary of the ICP proposals and an assessment against the criteria in the ICS guidance.

ICP Proposals

5. The ICPs have developed proposals during May and June, which are attached (attachments 1-3). All ICPs have carried out a detailed review of their current Transformational Plans (QIPP and CIP/FEP) to support the development of the proposals.

6. The table overleaf provides a summary of the proposals for the ICP element of the flexible transformational funding.

ICS Strategic Priority	ICP Scheme	ICP Scheme Description	ICP	£Ms
Urgent and Emergency Care	Integrated Rapid Response Service (IRRS)	Strengthened rapid response service to provide urgent community based assessment and/or individualised intervention for patients at immediate risk of admission	MN	0.4
	Home First Integrated Discharge (HFID)	Implementation of an integrated discharge function	MN	0.3
	Community beds and intensive at home care	The scheme aims to right size the community capacity - both home based services and community beds - in Greater Nottingham to enable delays to discharge from NUH due to waits for community/home packages to be minimised	City/SN	1.1
	Community beds and intensive at home care	Home based services in Nottingham City to enable GPs to keep people at home delivering with provision to overnight care and a new delivery model of care at home, including a 2 hour response time.	City	0.4
Pro-active care, self-management and personalisation	End of life	Development of an end of life care system that is co-ordinated and personalised through care plan discussion.	City/SN	0.3
	High Intensity Service User (HISU)	Implement high intensity service users scheme to reduce ED attendance and admissions	All	0.3
	Let's Live Well in South Notts	Provides integrated social prescribing service for the population of South Notts.	SN	0.1
Mental Health	Primary Care Psychological Medicine	Service for people with complex persistent physical symptoms (PPS) which includes people with Complex Long Term Conditions and Medically	SN	0.4
Value, resilience and sustainability	Outpatient transformation	Transformation of elective pathways and the current through: working collaboratively, following best practice and adopting technology, supporting care closer to home, reducing unwarranted clinical variation and improving access.	MN	0.4
	Targeted support to improve efficiency	Targeted support to delivery of SFH and NHC workstreams to improve efficiency	MN	0.3
		Remaining balance - to be allocated		0.2
				4.2

7. Each ICP has assessed the impact of their overall proposal in relation to the criteria included in the guidance. The outcome of this assessment is:

- City ICP – meet all of the criteria with the exception of improvement in the forecast risk adjusted delivery of the overall Transformation Plan (to be at least 90%). The ICP expect the schemes to improve the risk adjusted delivery but further work is underway to achieve the 90% requirement.

- Mid Nottinghamshire ICP – meet all of the criteria.

- South Nottinghamshire ICP - meet all of the criteria with the exception of improvement in the forecast risk adjusted delivery of the overall Transformation Plan (to be at least 90%). The ICP expect the schemes to improve the risk adjusted delivery but further work is underway to achieve the 90% requirement.

8. Although the criteria have not been fully met across the ICPs, it is important that schemes are progressed at pace to ensure that maximum impact is delivered in 2019/20.

9. All ICP proposed schemes are aligned to the strategic priorities developed by the ICS, as part of the five-year plan (2019-24).

Recommendations

10. The Board is asked to **APPROVE** the ICP proposals. Although the criteria have not been fully met, all schemes fit with the strategic priorities of the ICS and it is important that schemes are progressed at pace to deliver maximum impact for 2019/20.

Helen Pledger
ICS Finance Director
2 July 2019
Helen.pledger@nhs.net

Item 11. Enc. I2.

Attachment 1: Nottingham City ICP proposal

1. Context

The Nottingham City ICP has commenced work to define its priorities for delivery.
In defining the ICP's priorities, consideration has been given to ensuring there is alignment with the agreed ICS priorities, and ensuring there is uniformity across Greater Nottingham where this is the best way to meet the needs of the population.

The draft ICP priorities are shown below. These are subject to further discussion and engagement with partners.

- Social prescribing
- Smoking & Alcohol
- Preventing admissions (EOL)
- Excluded Groups (Homelessness, BAME)
- DTOC (Joint with other ICPs)
- Childhood Flu

2. Nottingham City ICP Transformational Funding Proposals

In considering the schemes for transformational funding, the Nottingham City ICP proposed:

- A focus on a small number of key transformational areas to deliver the greatest impact
- To maximise the impact of the transformational funding across Greater Nottingham.

A rapid review of the following was undertaken to support prioritisation for transformational funding:

- Current QIPP/CIP priorities
- Opportunity to maximise local learning with rapid roll out of evidence based schemes
- Opportunities across Greater Nottingham to maximise system savings.

The schemes that are proposed were considered against the ICS criteria and whether they support the delivery of the ICP's priorities.

A list of proposed schemes was presented by constituent member organisations to the Nottingham City ICP Development Group on 12th June. Organisation leads presented their proposal to the Group outlining:

- Details of the scheme proposed
- Investment required
- Anticipated gross savings
- Return on investment (ROI).

The Group recognised that the schemes are at different stages of development with some having an evidence base for the ROI and others being at a proof of concept stage. This was taken into account in confirming support for schemes, meaning that some schemes are supported with less evidence about the impact they will have, but with an assessment of the anticipated impact on the system.

The proposed schemes are combinations of existing QIPP/CIP schemes with funding being used to pump prime/accelerate the pace of delivery, and new schemes.

The following schemes were agreed by the Nottingham City ICP Development Group for proposal to the ICS:

Scheme	Brief description	New/ existing	Bid	Gross savings (FYE)	RoI	Rationale for transformational funding
Community beds and intensive at home care	The scheme aims to right size the community capacity - both home based services and community beds - in Greater Nottingham to enable delays to discharge from NUH due to waits for community/home packages to be minimised	Existing: pump primes delivery	£534k	£1,500k	1:3	The transformation funding provides an opportunity to design and implement the new clinical model alongside current bed capacity. This removes the risk of negatively impacting flow. Work is on-going with system partners to confirm the clinical model. A fully developed proposal will be completed by mid-July with proof of concept implementation to commence in September 2019.
Community beds and intensive at home care	Home based services in Nottingham City to enable GPs to keep people at home delivering with provision to overnight care and a new delivery model of care at home, including a 2 hour response time.	New	£400k	£800K	1:2	Develops and implements a new clinical model based on admission avoidance to enable people to stay at home.
End of life	Development of an end of life care system that is co-ordinated and personalised through care plan discussion.	Existing: pump primes delivery	£194.4k	£501.5k	1:2.6	Enables project benefits to be accelerated due to appointment of dedicated staff to educate and train GPs and practice staff. Assuming successful recruitment, implementation would take place from September 2019.
High Intensity Users	The project aims to develop a service to identify and case manage high intensity service users attending ED	Existing: pump primes delivery	£103.2k	£440k	1:4	Enables earlier implementation of model in year across GN and therefore earlier impact on NEL activity. Implementation is planned for 1.9.19.
Total			**£1,231.6k**	**£3,241.5k**		

Financial information relates to Nottingham City only. Each scheme will continue to be worked up in accordance with the proposing organisations' own approval processes.

Governance for monitoring delivery against the schemes will be through the proposing organisations' approval processes with monthly reports to the ICP Development Group.

The ICS Board is asked to:

- **SUPPORT** the proposals for transformational funding proposed by the Nottingham City ICP Development Group

Item 11. Enc. I3

Attachment 2: Mid Nottinghamshire ICP Transformation Monies

Introduction

1. The purpose of this paper is for the ICS Board to consider and approve the Mid Nottinghamshire ICP plans for the use of the £1.5m ICS Transformation Funds.

Background

2. The ICP Board has discussed the use of the funds at meetings on 14 May 2019 and 11 June 2019 and will consider final agreement at its meeting on 9 July 2019.

3. A deep dive of the plans in place to deliver the Mid-Nottinghamshire ICP control total has revealed a risk of £16.4m which requires urgent action to mitigate. Therefore the focus of the uses of the transformation funding has been placed upon strengthening and supporting 2019/20 schemes designed to deliver better health and wellbeing outcomes for Mid-Nottinghamshire citizens, reduce activity and cost for 2019/20 and reduce the risk of non-delivery of the ICP control total. These schemes are part of the delivery plan for the ICP that has been committed to through the planning process.

4. Workshops have been held and more are planned for all ICP partners to contribute to the process of identifying specific purposes to which the transformation funding will be put in order to accelerate delivery.

5. It is proposed that all funding will be utilised to support delivery of existing schemes and no allocation has been identified to fund the ICP governance architecture.

ICS Board Criteria

6. The Mid Nottinghamshire Transformation Plan total target for 2019/20 is £53.3m. As at 29 April 2019 there was a remaining gap of £2.2m and a risk adjusted delivery forecast of £38.6m (72.4%). Delivery of the current schemes utilising the Transformation monies will ensure that there is no residual planning gap and confidence in delivery is increased by £9.37m to 90%. This represents an in-year return on investment (ROI) of 1:6.25. Other required criteria are met as the funding is to be used to support existing schemes which all have identified actions, timeline, funding required, the cost expected to be released from the system and EQIA.

7. The ICS Board is therefore requested to approve the use of the Transformation Funds as detailed in the following schedule.

Schedule of funding allocation

Workstream	***Allocation £k***	***Narrative***
Integrated Rapid Response Service (IRRS)	397	Strengthened rapid response service to provide urgent community based assessment and/or individualised intervention for patients at immediate risk of admission
Home First Integrated Discharge (HFID)	329	Implementation of an integrated discharge function
Outpatient transformation	362	Transformation of elective pathways and the current through: working collaboratively, following best practice and adopting technology, supporting care closer to home, reducing unwarranted clinical variation and improving access.
SFH & NHC FIP/CIP programmes	300	Targeted support to delivery of SFH and NHC workstreams to improve efficiency.
High Intensity Service User (HISU)	112	Implement high intensity service users scheme to reduce ED attendance and admissions with priority focus on mental health and alcohol related admissions
	1,500	

Item 11. Enc. I4.

Attachment 3: South Nottinghamshire ICP proposal

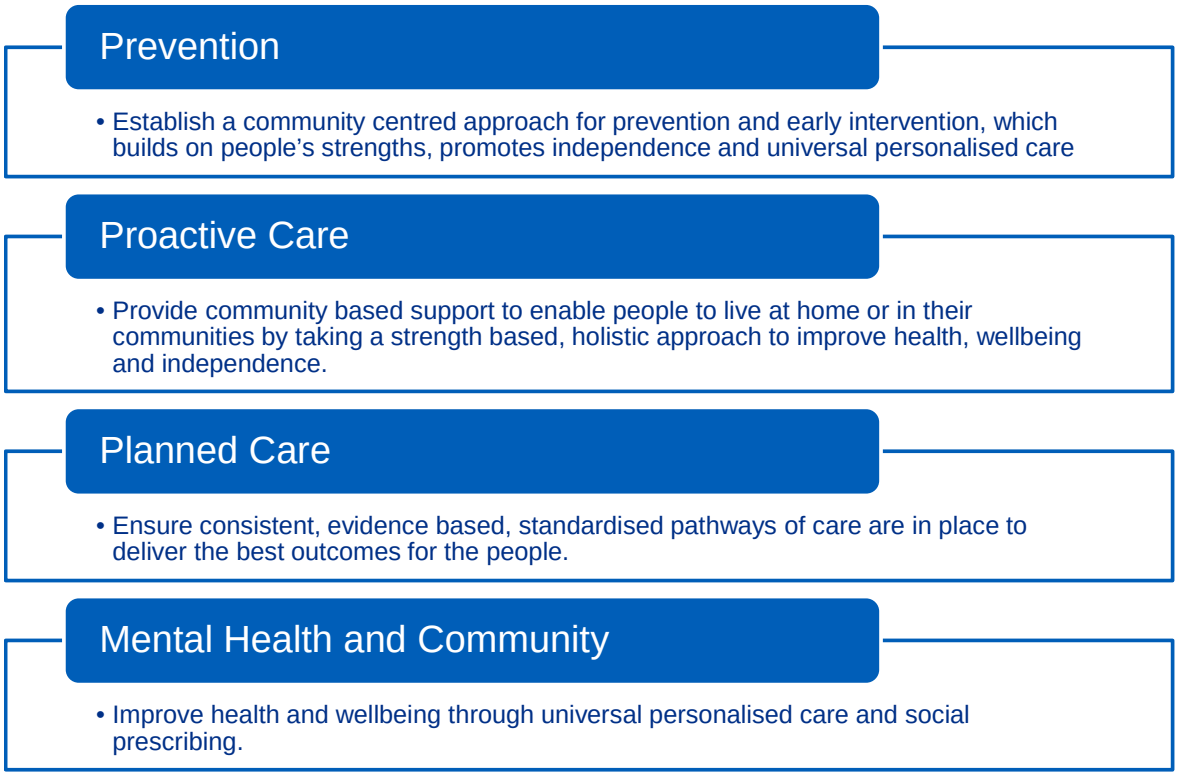
1. Context

The South Nottinghamshire ICP Development Group has been meeting since early May and is working towards the establishment of an ICP Board by September 2019.

As part of this development, the South Nottinghamshire ICP has commenced work to define its priorities for delivery.

In defining the ICP's priorities, consideration has been given to ensuring there is alignment with the agreed ICS priorities, and ensuring there is uniformity across Greater Nottingham where this is the best way to meet the needs of the population.

The draft ICP priorities are shown below. These are subject to further discussion and engagement with partners.



2. South Nottinghamshire ICP Transformational Funding Proposals

In considering the schemes for transformational funding, the South Nottinghamshire ICP proposed:

- A focus on a small number of key transformational areas to deliver the greatest impact
- To maximise the impact of the transformational funding across Greater Nottingham.

A rapid review of the following was undertaken to support prioritisation for transformational funding:

- Current QIPP/CIP priorities
- Opportunity to maximise local learning with rapid roll out of evidence based schemes
- Opportunities across Greater Nottingham to maximise system savings.

The schemes that are proposed were considered against the ICS criteria and whether they support the delivery of the ICP's priorities.

A list of proposed schemes was presented by constituent member organisations to the South Nottinghamshire ICP Development Group on 19th June. Scheme leads and/or organisation leads presented their proposal to the Group outlining:

- Details of the scheme proposed
- Investment required
- Anticipated gross savings
- Return on investment (ROI).

The Group recognised that the schemes are at different stages of development with some having an evidence base for the ROI and others being at a proof of concept stage. This was taken into account in confirming support for schemes, meaning that some schemes are supported with less evidence about the impact they will have, but with an assessment of the anticipated impact on the system.

The proposed schemes are a combination of existing QIPP/CIP schemes with funding being used to pump prime/accelerate the pace of delivery, and new schemes. The new schemes are expansions of schemes that have been developed as part of the Rushcliffe MCP Vanguard and have been subject to evaluation as part of this programme.

The transformational funding investment in the schemes proposed improves the level of confidence in delivery of the QIPP/CIP programme. The ICP recognises that the £1.3m investment is insufficient to bridge the entire gap to meet the 90% risk adjusted delivery target.

The Group recognised the need for wider engagement e.g. with District/Borough Councils on priorities and this will be taken forward as part of the ICP's work plan.

The following schemes were agreed by the South Nottinghamshire ICP Development Group for proposal to the ICS:

Scheme	Brief description	New/ existing	Bid	Gross savings (FYE)	RoI	Rationale for transformational funding
Community beds and intensive at home care	The scheme aims to right size the community capacity - both home based services and community beds - in Greater Nottingham to enable delays to discharge from NUH due to waits for community/home packages to be minimised	Existing: pump primes delivery	£529k	£1,500k	1:3	The transformation funding provides an opportunity to design and implement the new clinical model alongside current bed capacity. This removes the risk of negatively impacting flow. Work is on-going with system partners to confirm the clinical model. A fully developed proposal will be completed by mid-July with proof of concept implementation to commence in September 2019.
End of life	Development of an end of life care system that is co-ordinated and personalised through care plan discussion.	Existing: pump primes delivery	£128k	£698k	1:5	Enables project benefits to be accelerated due to appointment of dedicated staff to educate and train GPs and practice staff. Assuming successful recruitment, implementation would take place from September 2019.
High Intensity Users	The project aims to develop a service to identify and case manage high intensity service users attending ED	Existing: pump primes delivery	£103k	£440k	1:4	Enables earlier implementation of model in year across GN and therefore earlier impact on NEL activity. Implementation is planned for 1.9.19.
Let's Live Well in South Notts	Provides integrated social prescribing service for the population of South Notts.	New	£131k	£247k	1:1.88	Supports roll out of service across GN, building on vanguard work in Rushcliffe. Full implementation is planned from 1.10.19
Primary Care Psychological Medicine	Service for people with complex persistent physical symptoms (PPS) which includes people with Complex Long Term Conditions and Medically Unexplained Symptoms	New	£407k	£833k	1:2	Supports roll out of service across South Notts, building on vanguard work in Rushcliffe. The scheme significantly improves the quality of life of the patients seen within the service. There are impacts on the use of other services such as primary care, but these do not generate a financial saving. Full implementation is planned for 1.9.19.
Total			**£1.3m**	**£3.7m**		

Financial information relates to South Nottinghamshire only.

Each scheme will continue to be worked up in accordance with the proposing organisations' own approval processes.

Governance for monitoring delivery against the schemes will be through the proposing organisations' approval processes with monthly reports to the ICP Development Group.

The ICS Board is asked to:

- **SUPPORT** the proposals for transformational funding proposed by the South Nottinghamshire ICP Development Group

ENC. J

Meeting:	ICS Board
Report Title:	Risk Management Update
Date of meeting:	Friday 12 July 2019
Agenda Item Number:	12
Work-stream SRO:	-
Report Author:	Elaine Moss
Attachments/Appendices:	Appendix A

Report Summary:

The purpose of this paper is to provide the ICS Board with an overview of the risk management arrangements currently in place. The ICS Governance Group's primary focus has been the development and implementation of operational and strategic risk management processes and associated Assurance Framework.

Action:

☐ To receive
☒ To approve the recommendations

Recommendations:

1.	Note the risk management arrangements within the ICS
2.	Comment on the risk 'theme' analysis shown within this paper and those included within the Board Assurance Framework at Appendix A
3.	Highlight any risks identified during the course of the meeting for inclusion within the Board Assurance Framework or operational Risk Registers.

Key implications considered in the report:

Financial	☐	
Value for Money	☐	
Risk	☒	
Legal	☐	
Workforce	☐	
Citizen engagement	☐	
Clinical engagement	☐	
Equality impact assessment	☐	

Engagement to date:

Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
☒	☐	☐	☐	☐
Performance Oversight Group	**Clinical Reference Group**	**Mid Nottingham-shire ICP**	**Nottingham City ICP**	**South Nottingham-shire ICP**
☐	☐	☐	☐	☐

Contribution to delivering the ICS high level ambitions of:

Health and Wellbeing	☒
Care and Quality	☒

Finance and Efficiency	☒
Culture	☒

Is the paper confidential?

☐ Yes
☒ No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

ICS Risk Management Arrangements Update
12 July 2019

Introduction

1. The purpose of this paper is to provide the ICS Board with an overview of the risk management arrangements currently in place. The ICS Governance Group's primary focus has been the development and implementation of operational and strategic risk management processes and associated Assurance Framework.

2. The main focus of this report is to:
   - Provide an overview in relation to work being undertaken by the ICS Governance Group, including the development of risk 'themes';
   - Present a current version of the ICS Board Assurance Framework for comment and scrutiny (**Appendix A**); and
   - Describe 'next steps' being undertaken to align risk management arrangements with the ICS's agreed priorities and the Outcomes Framework.

ICS Governance Group

3. The ICS Governance Group has continued to meet, with its primary focus being the development, update and review of the ICS operational risk registers. The Group includes representatives from the ICS team, the CCGs, Nottingham University Hospitals NHS Trust, Nottinghamshire Healthcare NHS Foundation Trust and Sherwood Forest Hospitals NHS Foundation Trust. Discussions have been held regarding representatives from the Local Authorities.

4. Operational risk registers are in place for the following ICS groups which have been assigned to members of the Group. These individuals are responsible for engaging with Chairs of the respective ICS Groups, as well as Workstream Leads, to review and update their respective operational risks. Risk registers are in place for the:

   - ICS Planning Group;
   - ICS Performance Oversight Group;
   - ICS Finance Group; and
   - ICS Workstream Network (e.g. individual Workstream/Programme Leads).

5. The Group has taken a 'bottom-up' approach to risk identification (e.g. operational risks are identified via discussions with the leads). This will be reassessed following Board agreement of future ICS strategic objectives. These will allow strategic risks to be identified using a 'top-down' approach.

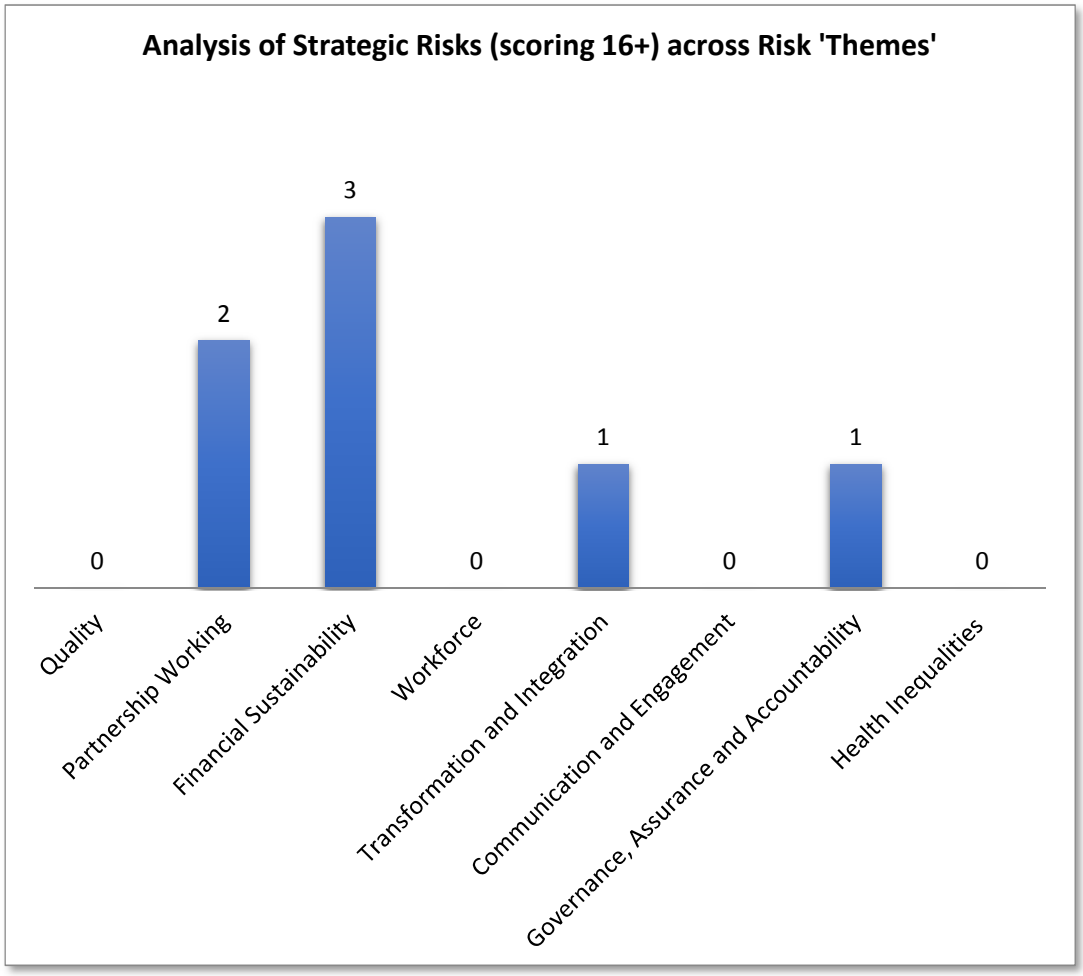
Identification of Risk 'Themes'

6. At the April 2019 meeting of the ICS Governance Group, it was agreed that a number of high-level risk 'themes' would be drawn together to support risk reporting to the ICS Board. The themes are described below:

Risk Theme	Risk Theme Description
Quality	Deterioration of health outcomes
Partnership Working	Lack of focus on system priorities and/or ineffective management of available resources
Financial Sustainability	Lack of available funding and/or ineffective prioritisation of investment
Workforce	Insufficient workforce capacity
Transformation and Integration	Lack of long-term focus
Communication and Engagement	Lack of stakeholder engagement and/or involvement
Governance, Assurance and Accountability	Ineffectual decision making
Heath Inequalities	Increasing health inequalities across the ICS's population

7. The identification of these themes supports risk reporting, as the themes enable Board members to be assured on the extent to which risks align with the Board's key priorities.

8. At present, there are seven risks identified within the Board Assurance Framework (**Appendix A**) and these are across the risk 'themes'. Members should note that there are no strategic risks currently identified across the quality, workforce, communications and engagement or health inequalities 'themes'.



Next Steps

9. The ICS Governance Group will continue to develop risk management processes over the coming months in parallel with the further development of the ICS strategic priorities and System Outcomes Framework.

Recommendations

10. The Board is asked to:

- **NOTE** the risk management arrangements within the ICS;
- **COMMENT** on the risk 'theme' analysis shown within this paper and those included within the Board Assurance Framework at **Appendix A**; and
- **HIGHLIGHT** any risks identified during the course of the meeting for inclusion within the Board Assurance Framework or operational Risk Registers.

Elaine Moss
ICS Chief Nurse

APPENDIX A

Integrated Care System
Nottingham & Nottinghamshire

Nottingham and Nottinghamshire ICS Assurance Framework

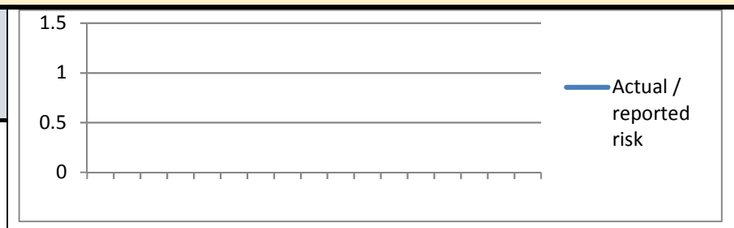
QUALITY

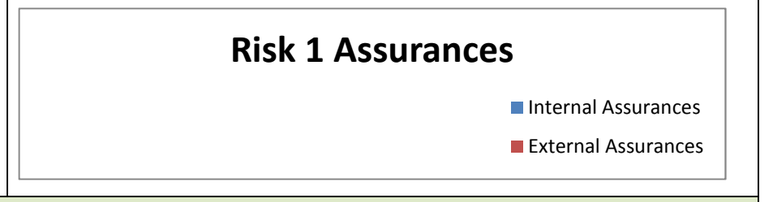
There are no risks scoring 16+ in relation to this risk ‘theme’.

FINANCIAL SUSTAINABILITY

STRATEGIC AIM: **Collective responsibility for managing financial and operational performance.**	**RISK NUMBER: ICS15**	**CURRENT RISK RATING (Likelihood & Impact)** **4 X 5 = 20**
	ASSURANCE FRAMEWORK	**TARGET RISK: 12**
	DATE ON REGISTER: 21/1/19	**RISK APPETITE: To be assessed**
	COMMITTEE: Finance Director's Group	**REASON FOR RISK APPETITE SCORE: To be assessed**
	RISK OWNER: ICS Chief Finance Officer on behalf of the FD Group	
	LAST REVIEWED BY RISK OWNER: June 2019	

RISK: Failure to develop and deliver a 2019/20 balanced single system financial plan recognising true cost may result in additional financial and operational pressures leading to short and medium-tem financial and operational objectives not being met.





Rationale for current score:

- Size of the challenge and affordability following receipt of allocations and control totals. Gap for 19/20 is £160m (excluding Nottm City Council) – represents a need for circa 5% savings against system resources.
- Underlying deficit position is a key driver of the financial position. In addition acute activity growth outstrips resources provided.
- Timescales to develop and deliver transformation plans pose a significant challenge.
- Short-term focus may have an adverse impact on the identification, prioritisation and implementation of transformation schemes that have a bigger medium-term impact.
- Limited access to transformation monies to accelerate transformation opportunities.

Controls (C) and Influences (I): *(What are we currently doing about the risk?)*
Planning Approach agreed by ICS Board and utilised by ICPs and organisations to develop single plan. Development of transformational schemes being undertaken at ICP level with a focus on activity, workforce and cost impact.
ICS and organisational plans agreed and submitted nationally.
External support procured by GN CCGs and NUH.
Director of Finance Group and Financial Sustainability Group in place.
ICS Board monthly performance oversight.

	Gaps in Controls (C) and Influences (I):		**Mitigating Actions for gaps in Controls (C) and Influences (I):**
a)	**Risk adjusted transformation plans not yet providing assurance of delivery.**	**a)**	**Financial Sustainability Group continues to have oversight.** **External support procured.** **ICS deep dive end of May 2019**
b)	**Medium-term ICS financial plan (aligned to the developing ICS 5 Year Strategy)**	**b)**	**5 Year plan in development, integrated with ICS 5 Year Strategy development.**
c)	ICS Financial Framework	**c)**	Financial framework in development through the Finance Directors Group. Objective to shift from organisational focus to system focus through a defined and agreed set of rules.

Assurances: *(How do we know if the things we are doing have an impact?)* Mark-up Internal Assurance (Int) or External Assurance (Ext)

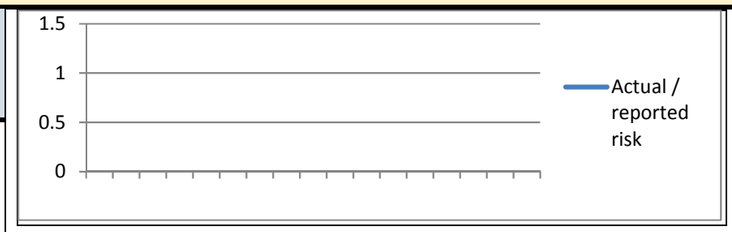
- Impact of plans at system level through FD Group and Planning Group (Int)
- Inter organisational sign-off of plans
- Planning Returns and regulatory assurance (Ext)
- Contract alignment process (Int and Ext)

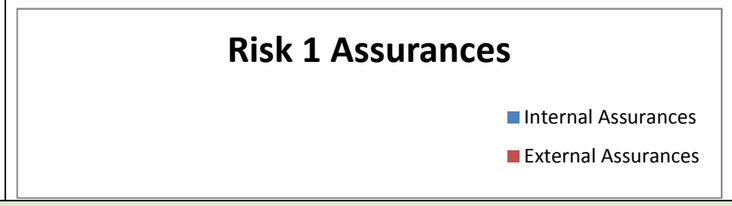
	Gaps in Assurance: *(What additional assurances should we seek?)*		**Mitigating Actions for gaps in Assurances:**
	• ICPs have required controls and maturity to take ownership of 19/20 transformation need. • Assurance on use of allocated transformation monies assigned to ICPs.		• Continued focus on ICS Director of Finance Group • ICPs required submitting plans by end of June 2019.
a)		**a)**	

FINANCIAL SUSTAINABILITY

STRATEGIC AIM:	RISK NUMBER: ICS17	CURRENT RISK RATING (Likelihood & Impact) 4 X 5 = 20
	ASSURANCE FRAMEWORK	TARGET RISK: 12
	DATE ON REGISTER: 4/2/2019	RISK APPETITE: To be assessed
	COMMITTEE: Finance Group	REASON FOR RISK APPETITE SCORE: To be assessed
	RISK OWNER: Chair of the ICS Finance Group on behalf of the group	
	LAST REVIEWED BY RISK OWNER: June 2019	

RISK: As a result of the national position on capital monies and the shortage of needed capital monies within the ICS when compared to current need there is a risk that the ICS may have insufficient access to needed capital monies to manage the significant short and medium term estate risks identified across the ICS.





Rationale for current score:

- Regulators have advised that current NHS demand for capital monies is greater than the capital monies available.
- Regulators have cautioned that the required capital monies are unlikely to be available during 19/20.
- Delivery of agreed plans will be at increased risk without the required capital monies.
- The estate across Nottinghamshire has some significant back log maintenance issues that need to be addressed. There are some critical risks that if not managed to an appropriate level may adversely impact on system capacity and patient services.
- Regulators currently rate ICS Estates Strategy as improving. This rating has some restrictions on ability to access capital monies.

Controls (C) and Influences (I): *(What are we currently doing about the risk?)*

- Ongoing discussions with regulators about access to required capital; including opportunities to access capital through other routes.
- Refresh of the ICS Estates strategy and priorities to align with national expectations and local priorities. Check point document to be submitted to regulators 15th July.
- Alignment of the developing ICS CSS with Estate requirements.

	Gaps in Controls (C) and Influences (I):		Mitigating Actions for gaps in Controls (C) and Influences (I):
a)	**Lack of clarity of how to access capital from alternative sources and the controls required to access and manage are not in place.**	a)	**Continuing engagement with regulators. Lack of clarity at national level.**
b)	**Estates rationalisation programme.**	b)	**Estates rationalisation programme in development.**

Assurances: *(How do we know if the things we are doing have an impact?)* Mark up Internal Assurance (Int) or External Assurance (Ext)

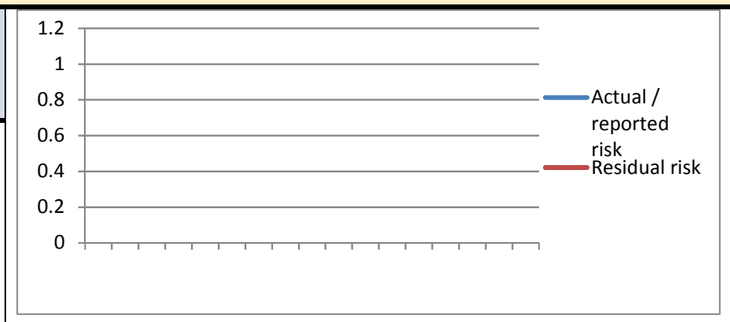
- Estates Task & Finish Group in place.
- Established link with regulator through strategic estates advisor.
- ICS Planning Group oversight.

	Gaps in Assurance: *(What additional assurances should we seek?)*		Mitigating Actions for gaps in Assurances:
a)	**Estates information availability at ICS level (utilisation, cost). Particularly relevant to NHS property services buildings**	a)	**Development of ICS wide estates database.**
b)		b)	

FINANCIAL SUSTAINABILITY

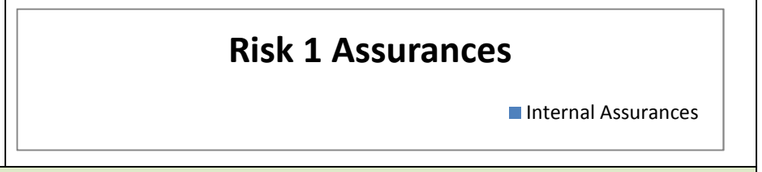
STRATEGIC AIM: **Collective responsibility for managing financial and operational performance.**	**RISK NUMBER: ICS W RR 004**	**CURRENT RISK RATING (Likelihood & Impact)** **4 X 4 = 16**
	ASSURANCE FRAMEWORK	**TARGET RISK: 12**
	DATE ON REGISTER: 19/1/19	**RISK APPETITE: To be assessed**
	COMMITTEE: Workstream Network	**REASON FOR RISK APPETITE SCORE: To be assessed**
	RISK OWNER: Workstream Leads	
	LAST REVIEWED BY RISK OWNER: June 2019	

RISK: Prioritisation on short term QIPP savings (e.g. disinvestment) may contradict the need to invest to support medium to longer term transformation. This, in turn, presents a risk that transformation deliverables / objectives may not be archived.



Rationale for current score:

- In development



Controls (C) and Influences (I): *(What are we currently doing about the risk?)*
In development

Gaps in Controls (C) and Influences (I):		**Mitigating Actions for gaps in Controls (C) and Influences (I):**	
a)		**a)**	
b)		**b)**	
c)		**c)**	

Assurances: *(How do we know if the things we are doing have an impact?)* Mark-up Internal Assurance (Int) or External Assurance (Ext)

-

Gaps in Assurance: *(What additional assurances should we seek?)*		**Mitigating Actions for gaps in Assurances**	
a)		**a)**	

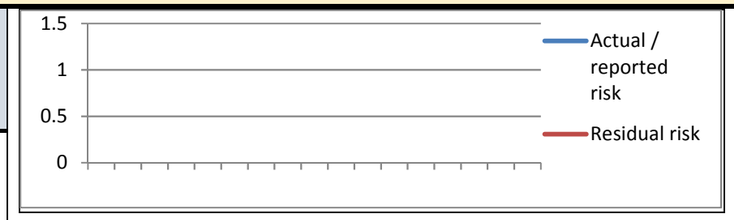
WORKFORCE

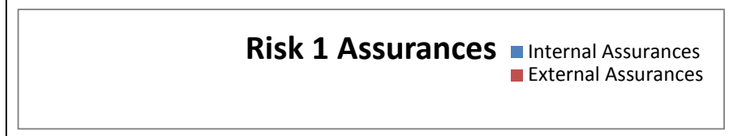
There are no risks scoring 16+ in relation to this risk ‘theme’

TRANSFORMATION & INTEGRATION

STRATEGIC AIM:	RISK NUMBER: ICS0X	CURRENT RISK RATING (Likelihood & Impact) 4 X 4 = 16
	ASSURANCE FRAMEWORK	TARGET RISK: To add
	DATE ON REGISTER: 17/1/2019	RISK APPETITE:
	COMMITTEE: Planning Group	REASON FOR RISK APPETITE SCORE:
	RISK OWNER: ICS CFO on behalf of ICS Planning Group	
	LAST REVIEWED BY RISK OWNER:	

RISKS: If acute activity continues to increase at historic rates and financial and operational performance continue to deteriorate there is a risk that the 'do nothing' planning gap in the short and medium will be larger than the credible plans in place and the ICS will be unable to meet financial and operational objectives in 2019/20 or as part of the long-term plan





Rationale for current score:

- 18/19 system control total not met - £18.9m shortfall
- Considerable underlying deficit across the system
- Highly challenging financial savings target in 1920 - £160m ICS of which £146m NHS system control total
- Delivery confidence of current plans evaluated to be 75% of target (May 2019)
- Operational performance shortfalls across a number of areas including ED and mental health and cancer targets
- Historic levels of acute activity growth are a significant driver of financial and operational performance

Controls (C) and Influences (I): *(What are we currently doing about the risk?)*

- QIPP and CIP plans in place across all organisations (£4m unidentified gap remains at end May 2019)
- Further development of transformation plans to improve delivery confidence – organisations and ICPs
- 2019/20 contracts have aligned incentives with a focus on system cost reduction

	Gaps in Controls (C) and Influences (I):		Mitigating Actions for gaps in Controls (C) and Influences (I):
a)	Use of ICS transformation funds	**a)**	ICPs working up plans for approval at July ICS Board ensuring that they are used to support delivery of system control total (see assurances)
b)	Full development of contingency plans	**b)**	Under development through financial sustainability group
c)		**c)**	

Assurances: *(How do we know if the things we are doing have an impact?)* Mark up Internal Assurance (Int) or External Assurance (Ext)

- Criteria for use of ICS transformation resources agreed to support delivery of savings plans and deliver in-year ROI
- Financial reporting through FD group
- Integrated Performance report to ICS Board
- Financial Sustainability Group meet monthly to oversee plans and progress
- Transformation Boards in Mid Notts and Greater Nottingham
- POG maintains oversight of activity and performance risk (see POG risk register)

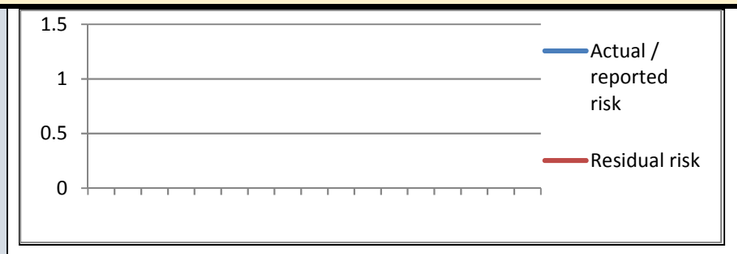
Gaps in Assurance: *(What additional assurances should we seek?)*	Mitigating Actions for gaps in Assurances:
South Notts and City ICP currently forming – focus may not be on financial and operational delivery	Responsibilities of different system layers to be made clear through governance

PARTNERSHIP WORKING

STRATEGIC AIM:	RISK NUMBER: ICS0X	CURRENT RISK RATING (Likelihood & Impact) 4 X 4 = 16
	ASSURANCE FRAMEWORK	TARGET RISK: 8
	DATE ON REGISTER: 17/1/2019	RISK APPETITE:
	COMMITTEE: Planning Group	REASON FOR RISK APPETITE SCORE:
	RISK OWNER: ICS Planning Group	
	LAST REVIEWED BY RISK OWNER: APRIL 2019	

RISKS: The following 3 risks all will have similar impacts on patient services and system performance. They require similar actions to address the risk. For this reason the ICS Planning Group have included these under a single item on the Board Assurance Framework.

If partners do not have the capacity to deal with both the organisational and system responsibilities; OR
If organisations prioritise organisational goals over system goals; OR
If the different levels being developed as part of the system architecture (ICS, ICPs, PCNs) are not mature enough to prioritise and deliver system requirements;
Then we may not be able to integrate clinical and care pathways effectively resulting in clinical, operational and financial objectives not being met.



Rationale for current score:

- Strategic planning capacity in the system is heavily reliant on existing organisational capacity. However, the ask of individuals and organisations is increasing as we now need to produce system plans as well as organisational plans – it has been agreed that a single system plan will deliver the best outcomes for our population. In addition the regulatory assurance requirements at an organisational and system level are increasing.
- Organisations remain sovereign including the requirement to meet organisational duties such as financial control totals and operational performance. These may conflict with the requirements of the system.
- ICPs and PCNs are currently forming. The focus of these new system levels may initially be on architecture distracting from the objectives and challenges.
- If we are unable to produce a single system plan due to lack of capacity we will continue to work in our organisational silos and not develop the transformation required to provide safe, high quality care not meet financial and operational performance requirements – Impact 4.

Controls (C) and Influences (I): *(What are we currently doing about the risk?)*

- Development and delivery of a single system plan as per the agreed ICS planning approach.
- Alignment of incentives through contracts
- System in place to recognise organisational impact of system plans - cost, demand and capacity, workforce, quality, patient experience
- Development of system architecture and alignment of resources at ICS, ICP and PCN level
- Move to single CCG by April 2020
- Open book planning approach.

Gaps in Controls (C) and Influences (I):		Mitigating Actions for gaps in Controls (C) and Influences (I):	
a)	Lack of alignment between system and organisational objectives	**a)**	Development of ICS outcomes framework to be used and embedded by all bodies
b)	Finance and contracting can act as a blocker to transformational change. Management capacity focussed on moving money around the system rather than best use of system resources	**b)**	Development of system financial framework and aligned incentive contracts to ensure that financial incentives align to system goals

c)	Transformational and efficiency plans have been developed at an ICS level. However there is significant risk to delivery of these plans leading to the need to strengthen and identify additional schemes.	**c)**	Commitment to strengthen plans and improve risk adjusted delivery throughout May.
Assurances: *(How do we know if the things we are doing have an impact?)* Mark up Internal Assurance (Int) or External Assurance (Ext) • Sign off of single system plan by ICS board – translation into organisational plans (Int) • Regulatory sign-off of organisational and system plans (Ext) • Quarterly ICS Assurance Meetings with NHSE/I (Ext) • Ongoing monitoring of system performance through POG, FD Group, Planning Group and ICS Board (Int)			
Gaps in Assurance: *(What additional assurances should we seek?)*		**Mitigating Actions for gaps in Assurances:**	

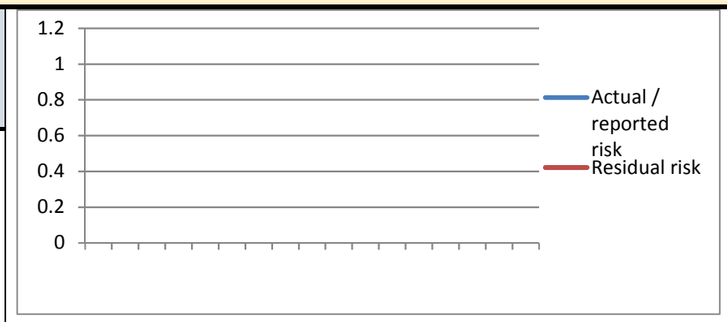
PARTNERSHIP WORKING

STRATEGIC AIM:	RISK NUMBER: ICS W RR 004	CURRENT RISK RATING (Likelihood & Impact) 4 X 4 = 16
	ASSURANCE FRAMEWORK	TARGET RISK: 9
	DATE ON REGISTER: 19/1/19	RISK APPETITE: To be assessed
	COMMITTEE: Workstream Network	REASON FOR RISK APPETITE SCORE: To be assessed
	RISK OWNER: Workstream Leads	
	LAST REVIEWED BY RISK OWNER: June 2019	

RISK: Due to competing priorities, and statutory organisations 'business as usual', there is a risk that individuals'' capacity to deliver the requirements of the ICS Workstreams / Programmes will be limited. This, in turn, may result in the objectives of the Workstreams / Programmes not being met (or not being met in line with required deadlines).

Rationale for current score:

- In development



Controls (C) and Influences (I): *(What are we currently doing about the risk?)*
In development

Gaps in Controls (C) and Influences (I):		Mitigating Actions for gaps in Controls (C) and Influences (I):	
a)		a)	
b)		b)	
c)		c)	

Assurances: *(How do we know if the things we are doing have an impact?)* Mark-up Internal Assurance (Int) or External Assurance (Ext)

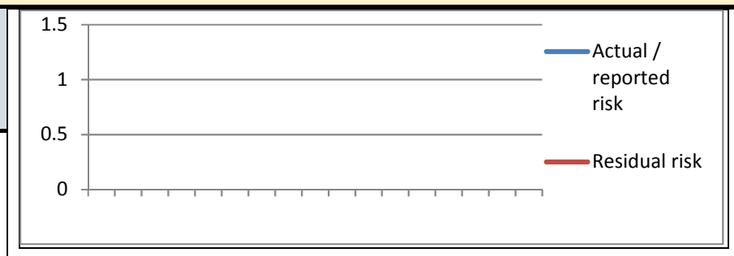
-

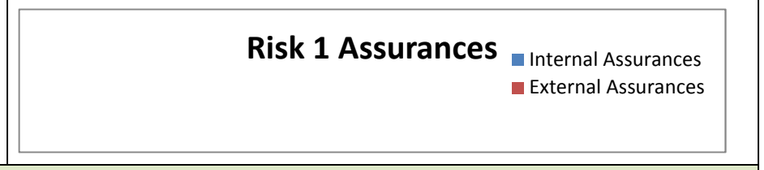
Gaps in Assurance: *(What additional assurances should we seek?)*		Mitigating Actions for gaps in Assurances	
a)		a)	

GOVERNANCE, ASSURANCE & ACCOUNTABILITY

STRATEGIC AIM: To understand the available capacity within the Nottinghamshire Health system, and the current and future demand on the Nottinghamshire Health system. Comparing the two to understand the current and future constraints to enable strategic decision making and ensure the long-term sustainability of the Nottinghamshire Healthcare System.	**RISK NUMBER: ICS0X**	**CURRENT RISK RATING (Likelihood & Impact) 4 X 4 = 16**
	ASSURANCE FRAMEWORK	**TARGET RISK: 3x3 =9**
	DATE ON REGISTER: 17/1/2019	**RISK APPETITE:**
	COMMITTEE: Planning Group	**REASON FOR RISK APPETITE SCORE:**
	RISK OWNER: ICS Planning Group	
	LAST REVIEWED BY RISK OWNER: APRIL 2019	

RISKS: If we do not have a full understanding of system demand and capacity across all sectors then we may make poor strategic decisions in relation to service provision leading to adverse impact on financial and operational objectives





Rationale for current score:

- Current system capacity information is not well established in providers and unavailable in other health sectors, hence a likelihood score of 4. The impact of this is that strategic decisions are difficult to make based on an incomplete data set resulting in a high probability that uninformed decisions could be made which would have a high impact on the Nottinghamshire Healthcare System, hence an impact score of 4

Controls (C) and Influences (I): *(What are we currently doing about the risk?)*

- We are currently working with providers to establish the capacity information available and ensure this is available in a currency which matches the demand information to enable comparison. It is envisaged that Point of Delivery Acute, mental health and community data will be available at the end of July ahead of the 5-year planning process and to support strategic decision making.
- The ICS Planning group recently agreed a paper to resource the project with 2x analytical resource for 3 months to progress the project at pace, the Planning Group members also agreed to release a member of their analytics team for 1 day a week for three months to support the full-time analyst and provide capacity data from their host organisation.

	Gaps in Controls (C) and Influences (I):		**Mitigating Actions for gaps in Controls (C) and Influences (I):**
a)	**Primary care activity data can be sourced; however, this is not currently being prioritised as it does not reflect capacity or latent demand**	**a)**	**Primary care data would not give the comparison between demand and capacity therefore the added value would be muted**
b)	**Capacity data from non-NHS Trust providers has proved difficult to source, and collection of this data has been deprioritised over Trust data which forms the bulk of the capacity within the healthcare system**	**b)**	**It is understood that this data may not be available and as it only makes up a small proportion of the capacity data may not have a huge bearing on strategic decisions**
c)	**The categorisation of capacity is both subjective and flexible, it has therefore proved difficult to produce definitive capacity numbers by point of delivery, where operationally this capacity could be utilised differently daily**	**c)**	**Trusts understand the quantum of their capacity and are working hard on categorising this capacity into point of delivery information.**

Assurances: *(How do we know if the things we are doing have an impact?)* Mark up Internal Assurance (Int) or External Assurance (Ext)

- Capacity constraints currently manifest as delays to pathways and constraining factors in solving performance issues within the healthcare system, this work is an attempt to provide an evidence base to understand the true extent of these constraints and inform decisions to build resilience into future systems.

Gaps in Assurance: *(What additional assurances should we seek?)*	**Mitigating Actions for gaps in Assurances:**
The gaps in data and the validity of information will result in a lack of assurance, which may in turn effect strategic decision making	The project is an iterative process, it is anticipated that the credibility of data will improve as more data is available and this data is validated

COMMUNICATION & ENGAGEMENT

There are no risks scoring 16+ in relation to this risk ‘theme’

HEALTH INEQUALITIES

There are no risks scoring 16+ in relation to this risk ‘theme’

RISK MATRIX SCORING

A&B - Likelihood and severity RAG rating matrix (Risks scoring 16+ go on to the Assurance Framework and <15 go on the risk register)							
IMPACT	Very High	5	A	A/R	R	R	R
	High	4	A	A	A/R	R	R
	Medium	3	A/G	A	A	A/R	A/R
	Low	2	G	A/G	A/G	A	A
	Very Low	1	G	G	G	G	G
			1 RARE	2 UNLIKELY	3 POSSIBLE	4 LIKELY	5 ALMOST CERTAIN
			LIKELIHOOD				